Chapter 6

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6.3 Discussion on the Results
6.1 Introduction:

The aims of this study were (A) to study the effect of therapeutic treatment on the continence of functional enuresis, and (B) to assess functional enuresis and its psycho-social correlates.

After an extensive reading about Functional Enuresis, its causes and treatment modalities, the researcher combined a few techniques mentioned in the past literature. For example, Dry bed training developed by Axrin et al, Enuretic Bell and Pad Alarm Clock and Motivational Counselling and Psychotherapy, discussed in chapter 2. Thus the intervention or the therapeutic treatment technique used in the study uses a combination of all the following:

(1) Dry Bed Training
(2) Frequency Chart / Token Economy
(3) Parent's Counselling
(4) Help the Child by Counselling
(5) Group Discussions
6.2 DISCUSSION ON THE THERAPEUTIC TREATMENT INTERVENTION TECHNIQUE:

(1) DRY BED TRAINING

After the initial basic information like name, age, sex were gathered, enquiries were made regarding the parent’s complaint of the child and its duration, whether it was Primary or Secondary type of enuresis. If it was Secondary type, then when did the child attain control. Further details regarding the frequency of bed-wetting of each child was obtained from the mother or the guardian. In this study it was found that 12.5% of children would wet their bed daily, 62.5% would wet once or twice a week, while 25% of children would wet two or three times a month. The mothers were also asked to specify the quality of sleep of their child. Sleep quality was divided into three types - light, heavy or normal. Only 5% of the children were light sleepers, 55% were heavy or deep sleepers while 40% had normal sleep. The sleeping habit meant to inquire if the child slept alone, with his parents or with his siblings. Data obtained showed 10% of children slept alone; when compared to 40% of children who slept with their parents while 52.5% of the children slept with their siblings, grand parents or other members of the family apart from parents.
In this study, it was found that most of the children would wet their bed during early hours of their sleep while few were more prone towards early hours of the morning. Keeping in mind each child’s tentative bed wetting timings he/she was supposed to be awakened and use the toilet, so that accidentally it might not happen in the bed. To facilitate awakening each child would have his personal alarm clock. If the child was unable, anyone in the family would help him set the alarm for the first two weeks till the time the child would learn to set his own alarm habitually. Since 55% of the children were deep sleepers, for the first two weeks some one in the family generally took the responsibility to awake the child. But gradually and eventually the child had to learn to wake up by himself and use the toilet when the alarm clock buzzed. Dry bed training laid emphasis on two habits to be learnt by the child. As discussed one was to set his alarm and awake accordingly, to use the toilet. The second was to develop a habit of using the toilet before going to bed.

Even with the help of alarm, many a times the child would fail to get up and hence he or she would wet the bed. When such an incident happened the child would need to change his own clothes and make a new dry bed for oneself. The mothers were
given strict instructions by the researcher to let the child do his own bed independently, without any help or co-operation from anyone in the family. The underlying objective was to make and train the child to be responsible for his/her own act of wetting rather than punishing him.

The third component of Dry Bed Training was that the child would wash all his wet and soiled clothes on the following day. During this training if necessary the mother would just guide the child but not really help him.

Lastly, it was suggested to the mothers as well as the child, to keep away from soft-drinks, juice and other drinks after six in the evening, and no intake of water 45 minutes before going to sleep. Gradually, within three months, thirty two children achieved 14 consecutive dry nights which was the criteria for therapeutic success in this study. Though eight children could not achieve 14 consecutive dry nights, their frequency of bed-wetting had substantially reduced as compared to their base line frequency.
2. FREQUENCY CHART / TOKEN ECONOMY

As already discussed in Dry Bed Training and also seen in the table for Background Information (Chapter 4, Table No.G), the frequency of bed wetting of each child was different. The mothers were asked to concentrate only on the last two months before undertaking the therapeutic treatment and give data as to how frequently in the past two months their child had wet his bed; was it daily, once or twice a week or once or twice a month. Thus the "baseline frequency" of each child was obtained before the intervention stage.

At the start of the intervention stage which was three months, the researcher gave a Frequency Chart to each child. The Frequency Chart was like a log book of each child individually containing all days of the week that is from Monday to Sunday for a period of twelve weeks. The utility of the Frequency Chart was that each child undertaking therapeutic treatment, would give himself a star if he or she accomplished keeping their bed dry but if they failed in doing so, that is if they would wet their bed, they would give themselves a cross. In this study, maintaining the Frequency Chart was done by all the children themselves.
As the therapeutic treatment progressed, in many children the frequency of bed-wetting gradually started diminishing when compared to the baseline frequency. In other words, the child was able to obtain a star and when he would earn himself seven stars then he would be duly rewarded. The reward was a positive reinforcement which was a kind of understanding between the child and the mother. The reward would vary from getting more time to watch T.V. to going out for dinner. As per each child's age and family background the reward was decided. But the underlying aim to give a reward was to induce a positive reinforcement for appropriate behaviour. Moreover, the dryness of the child was to be acknowledged, appreciated and encouraged by the family at large.

Thus the token economy worked as a positive reinforcement for the child. The child was in fact enthusiastic and motivated to help himself and get rid of his problem, which was very essential because without the child's motivation and involvement the therapeutic treatment intervention could not be implemented.
3. MOTHER'S COUNSELLING

Since the problem of bed-wetting of the child directly affected the child, mother and thereafter the environment of the family, the therapeutic intervention also aimed at involving the mother of the respective child, and provide counselling as and when required. So the researcher would meet each mother individually (only the mother, without the child) once every two weeks. Hence in all there would be six sessions for fifty minutes each, where the following factors were dealt with and discussed with the mothers.

(a) Sleeping Arrangements:

If the child was sleeping with his parents, it was given to understand that after a certain age level it is important for the child to learn to take separation from parents, so as to enhance child's autonomy. Whenever it was found that the child had fear sleeping alone, the researcher helped the child as well as the mother to work them out. At times it was found that the child had great difficulty in getting sleep without mother's presence, in such a case the mother would be in the child's bed to put him / her to sleep, and then leave for her own room.

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(b) **Dealing with Day Time Carelessness and Inducing a Sense of Responsibility:**

Most of the mothers were required to be mentally prepared and trained that as per age level, the child must learn to do his / her own work. Over-mothering or too much involvement on the part of the mother would be a hindrance in the child's personal growth and maturity. Due to mother's involvement the Child's would be careless and lazy even in small work like putting his school bag in its proper place. As per the age of the child, he/she was gradually put into the habit of small work and also induce a sense of responsibility in the child.

(c) **Work out Child's Dependent Behaviour:**

During the study it was observed that most mothers spent a great deal of time in feeding the child, help him in self care etc. so the child remained dependent on his mother or his care taker. Part of the training was also to enhance independence in self care, eating habits, studies etc. For this the mothers were given to understand age appropriate behaviour of the child, also each child's ability and positive aspects were highlighted to the
mother. The mothers were suggested to treat their child like an autonomous independent person. At times the child was also motivated to be independent, and to be more self-sufficient for small and daily routine.

(d) Dealing with Associated Emotional Problems:

The behaviour check-list (table 22) vividly shows that each child had his own associated emotional problem or characteristic like refusal to eat, food fads, temper tantrums, aggression, school refusal etc. Such underlying emotional problems could be very disturbing to the child and needs to be resolved before it becomes persistence and intense in nature. Along with behaviour management techniques such as positive reinforcement by praise to the appropriate behaviour while rejecting faulty behaviour, the mothers were also mentally trained. Their mental training was about handling the child in a firm and consistent way. Consistency and firmness were laid a lot of emphasis and it was something mothers found hard to adopt. This required a great effort, and mental preparation on her part. But once the mother's approach became consistent the child would himself understand what part of his behaviour his
mother will not accept, and what would be the consequences of his act. Thus there were unsaid rules and understanding between the child and the mother. At times, the mothers found themselves to be practising firmness but other members of the family would let the child have his way. For such instances the mothers were further asked to explain to the other members of the family that such expression of love was no good to the child, and the handling of the child should be in a manner which is appropriate.

(e) Enhancing Self-Esteem:

An important facet of self esteem is the evaluation of the individual's favourable or unfavourable assessment for oneself. After reviewing recent studies of self esteem in children and adolescents (Baumrind, 1972), it was concluded that children with high self-esteem seemed to do better academically at school, saw themselves as in control of their own destiny, had more friends, and got along better with their family members. Children with high self-esteem tend also to come from families where independent achievements are valued and praised and
in which there is a warm, affectionate relationship between children and parents with clear limits set upon the children's behaviour.

In the present study to enhance the self-esteem of the child, the mothers were asked not to focus on the short falls of their child but accept his abilities and duly acknowledge them. Appreciation of positive behaviour including dry nights would enhance the self-esteem of the child, which in turn would help the child to accept himself as a person.

4. HELP THE CHILD BY COUNSELLING

During the intervention stage that is three months of therapeutic treatment, the child would visit the Child Guidance Centre twice every week. Therefore, in all, the child would meet the researcher for 24 sessions. Each session was for 50 minutes, when the child alone would spend time with the researcher. During this duration the researcher would make general inquiries such as has he/she wet his bed during the past few days. If so what does the child think the reason for it. Did he simply fail to get up in the night, or did he get a scolding from
his parents during the day or his forthcoming examinations troubling him. Initially some children were shy and unforgettable regarding their problems. But once rapport was established after three or four sessions, most of the children felt comfortable. They would then vividly and easily narrate their hurtful experiences and also the bad and sad feelings that goes parallel with it. Hence the researcher would facilitate the child to ventilate his "emotional feelings" at the same time find clues which were stressful for the child. Since the children were from the age ranging between 5 and 13 years, different activities were given (Keeping in mind their age level and family background). Activities would be such as draw-a-person, write on "My School", "My Family", "My Daily Routine". Some children also shared about their aggression. They would narrate what makes them feel angry and how they feel about it.

A verbatim presentation of the child's emotional experience is:

"I used to feel so much ashamed if someone came to know about my bed-wetting, now I am free from all those worries and anxieties. I am happy that I can go and stay anywhere now. Previously when I would wet my bed, everyone kept criticising and scolding me, even my friends and cousins would tease me."
I used to feel helpless. Now that I am no more a bed-wetter even my parents are happy and satisfied with me. I think they understand me better" - Manan Dalal

5. GROUP DISCUSSION

Also part of the therapeutic treatment intervention was group discussion. There were three group discussions of one hour each where by all the parents or a concerned family member of the child (without the presence of the child) would meet. Here each parent was given a chance to express his/her thoughts and feelings. How they used to handle their child's bed-wetting and his unacceptable behaviour previously and in comparison how they have changed their approach. Certainly with the change in parents attitude, the reaction of the child is also bound to be different. Some children who had never known what "limits" means, had never been denied of anything because they would always have their way found their parents firmness very hard to accept. But eventually with consistency and firmness the child needed to give in, when he was wrong. In group discussion each parent would share his/her experience and observation of their child. This would give new insights and exposure to some
parents. This would also be a very rich and motivating talk for the parents who were newly joining the therapeutic treatment or lacked motivation and faith in therapeutic treatment.

Since it was an active participation and involvement exercise some doubts would also be raised. The researcher would clarify their doubts and questions, but apart from this the researcher would remain a passive observant and let the parents exchange and express their own feelings and experiences.

Thus the therapeutic treatment intervention was a blend of the above mentioned techniques, which was implemented for three months. Since the research design was a pre and post type, at the end of three months, intervention stage came to an end and post intervention stage was set into motion. The same procedure of administration and scoring of tools was adopted as at pre-interventional stage. The rationale for this was to measure the effect of therapeutic intervention, if at all, it was effective on the study sample. Therefore, when both the pre and post data were collected from 40 enuretic children and their mothers, the data obtained were analysed by a statistical professional using SPSS (Statistical Package for Social Sciences). As per the research
design, three methods of statistical analysis were used, namely ANCOVA, "t" test for repeated measures and Sign test. Family Environment Scale (FES), Interview Schedule for Children and Adolescence (ISCA), and Self Esteem rating scale (SE) were analysed by using ANCOVA and "t" test for repeated measures. All these three tools were analysed independently for

(1) Sex (Boys and Girls together)
(2) Type (Primary and Secondary Type of Enuresis)
(3) "t" score for repeated measures for the total sample
(4) "t" score for repeated measures for boys only
(5) "t" score for repeated measures for girls only
(6) "t" score for repeated measures for Primary type
(7) "t" score for repeated measures for Secondary type.

ANCOVA was performed for Sex (boys and girls together). Here the post Mean scores of boys were compared with post Mean scores of girls after removing the effect of pre Mean scores. The result obtained thereby would give us a picture of the effect of therapeutic intervention on Sex (boys and girls together). The result of ANCOVA for Sex for FES, ISCA and SE are shown in tables 1, 8 and 15 respectively.

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Similarly ANCOVA was performed for types of enuresis (Primary and Secondary types). Here again the post Mean scores of primary type are compared with the post Mean scores of secondary type, after removing the effect of pre Mean scores. The results obtained thereby would give us a picture of effect of therapeutic intervention on types of enuresis (Primary and Secondary types). The result of ANCOVA for FES, ISCA and SE are shown in tables 2, 9 and 16 respectively.

Further SPSS package was performed using "t" test for repeated measures. "t" test for repeated measures was firstly calculated for the total sample, where the pre-Mean data is compared with the post Mean data, that is pre v/s post. If the result obtained was significant here, it meant that intervention had effect on the study sample. The results obtained for "t" test for FES, ISCA and SE are shown in tables 3, 10 and 17 respectively.

Similarly "t" test for repeated measures was performed only for boys, so as to study if the therapeutic intervention had its effect on boys independently. The results for "t" test for boys only for FES, ISCA and SE are shown in tables 4, 11 and 18 respectively.
Likewise \( t \) test for repeated measures was performed only for girls, so as to study if the therapeutic intervention had its effects on girls independently. The results for \( t \) test for girls only for FES, ISCA and SE are shown in tables 5, 12 and 19 respectively.

Further \( t \) test for repeated measures was performed only for Primary type, so as to study if the therapeutic intervention had its effect on Primary type independently. The results for \( t \) test for Primary type only for FES, ISCA and SE are shown in tables 6, 13 and 20 respectively.

Lastly, \( t \) test for repeated measures was performed only for Secondary type so as to study if the therapeutic intervention had its effect on Secondary type independently. The results for \( t \) test for Secondary type only for FES, ISCA and SE are shown in tables 7, 14 and 21 respectively.

In case of behaviour check list, Sign test was performed using SPSS. Sign test was used for Behaviour Check List (BCL) because the data obtained on administration of this tool was not numerical in nature. The behaviour characteristic was either
present (+) or not present (-) so the results were algebraic signs and not the magnitude of differences between the scores of each pair.

Sign test was performed for the total sample. (The results are presented in table 22). Further, Sign test was performed for boys only (the results are presented in table 23). Similarly Sign test was performed for girls only (the results of which are presented in table 24). Sign test was then performed for Primary type (the results are presented in table 25). Lastly, the Sign test was performed for Secondary type (the results are presented in table 26).

6.3 Discussion on the results:

The Therapeutic treatment was an intervention which needed to be assessed, in terms of effectiveness, if any, on the frequency of bed-wetting while the psycho-social variables in this study were (a) Family Environment, (b) Psychological Symptoms, (c) Self Esteem, and (d) Behaviour Characteristics. Do these four variables have any significant relationship with Functional Enuresis.
Hypothesis One:

States "There will be an impact of the therapeutic treatment intervention on the enuretic boy and girls leading to significant change on family environment dimensions; namely (a) on relationship (b) on personal growth (c) and on system maintenance."

The results of ANCOVA for the three dimensions of FES with Sex is presented in table no. 1 (pg167-169). The results indicate that of the three dimensions of FES only the organisational (sub-scale) of the System maintenance dimension was found to be statistically significant ($F = 4.737$, $p = 0.036$). On the other hand the $F$ values obtained from the other two dimensions namely on Relationship and on personal growth dimensions are not statistically significant.

In the FES, Organisation sub-scale is defined as "the degree of importannce of clear organisation and structure in planning family activities and responsibilities". The results obtained, indicate that due to the effect of therapeutic treatment intervention, there was a change in the System maintenance of
the family and with a change in this dimension in the family, continence in functional enuresis has been noted. So it can be easily concluded that with a right kind of System maintenance approach, in the family, there will be positive impact on the enuretic boys and girls. Just as seen in the results above the entire enuretic group showed significant relationship of functional enuresis and system maintenance dimension, of the family environment.

**Hypothesis two:**

States "There will be an impact of the therapeutic treatment intervention on the primary type and secondary type of enuretic children, leading to significant change on family Environment dimensions; namely (a) on relationship (b) on personal growth (c) and on system maintenance".

The results of ANCOVA for family environment scale (FES) for type (Primary type and secondary type) can be seen in table 2 (pg170-172.) The F values obtained (F=5.406) for personal growth dimension was found to be statistically
significant. The F value obtained for the other two dimensions namely on Relationship & on system maintenance dimension are not significant.

In the FES, Achievement orientation sub-scale is defined as "the dimension which assess the extent to which activities such as school and work are cast into an achievement oriented or competitive framework".

The results obtained indicate that though primary enuresis and secondary enuresis are two types of Enuresis but with therapeutic treatment intervention both these type shows a positive relationship with Achievement Orientation. This shows that with the impact of the therapeutic treatment intervention there is a change in personal growth dimension, and with a positive change in this dimension, continence in functional enuresis has been noted.
Hypothesis Three: States "There will be an impact of the therapeutic intervention on the total sample of Enuretics leading to significant change on family environment dimensions; namely (a) on relationship (b) on personal growth (c) and on system maintenance.

Further analysis was performed using "t" test for repeated measures for each of the sub-scale for the three dimensions of FES. The results obtained are presented in table 3 (pg.173-175) The results obtained show that of the ten 't' test carried-out the cohesion sub-scale of the relationship dimension (p. 004) and the organization sub-scale of the system maintenance dimension (p.006) were found to be highly significant. However the personal growth dimension was not found statistically significant.

The Mean score of cohesion subscale at pre intervention level was 45.875 while at post intervention level it was found to be 40.725 and SD was 7.28 at pre level while at post level it was found to be 10.03. Similarly the Mean scores & SD for organization at the pre intervention level were 49.375, 6.54 while at post level it were 52.625; 5.83.
Cohesion as defined in the scale is "the degree of commitment, help & support family members provide for one another. While organisation is, "the degree of importance of clear organisation and structure in planning family activities and responsibilities".

The family environment scale helps to understand the multi-disciplinary factors of the family dynamics. The interaction of the family members and its effect on the child is well reflected in the relationship dimension. During the span of therapeutic treatment intervention the attitude of the family members towards the enuretic child was not just firm and consistent but also continuous in nature. Such approach helped in decreasing confusion and misunderstanding in the family, eventually enhancing cohesion and organisation among the members of the family. This indicates that with high cohesion & well organisation in the family environment, there will be a positive impact on the enuretic boys and girls irrespective of primary type or secondary type. The results seen above shows a significant relationship of cohesion and organisation in the family environment and functional enuresis.

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Graph 1 (pg.312)

In the "t" test for repeated measures the Mean and SD scores for cohesion subscale were 45.565 and 6.45 at pre level, while at the post level, it was 40.261 and 10.64, while the Mean and SD for organization subscale were 49.375 and 6.45 at pre level, at the post level it was 52.625 and 5.83, as shown in the bar graph (Pg.312). Thus the graph vividly represents that Cohesion and Organization sub-scale’s significant relationship with functional enuresis.

Hypothesis Four:

States: "There will be an impact of therapeutic treatment intervention on the enuretic boys leading to significant change on family environment dimensions namely (a) on relationship (b) on personal growth (c) and on system maintenance.

Further "t" test for repeated measures was performed for enuretic boys independently. The "t" test results obtained are presented in table 4 (pg 176-179.) the Mean scores obtained show that of the ten "t" test, carried out the cohesion sub-scale
of the relationship dimension (P. 037) was found to be significant. The Mean score obtained for the other two dimensions namely on personal growth and system maintenance dimensions are found as not significant.

It would be interesting to compare the results of "t" test for the total sample (table. 3, pg.173-175) over here. As "t" test for the total sample show significant results in cohesion and organisation sub-scale but the results of "t" test for boys independently shows significance in cohesion and not in organisation sub-scale. This indicates that relationship dimension is positively significant with enuretic boys. But the system maintenance dimension, as seen from the result obtained here, is not statistically significant.

**Graph 2 (Pg.313)**

Shows the Mean scores of enuretic boys indicating significant reduction in scores from pre to post level in cohesion sub-scale. The total Mean & SD score at pre intervention level are 45.5 and 6.45 while at post intervention level they were 40.2 and 01.64.
Hypothesis Five:

States "there will be an impact of therapeutic treatment intervention on the enuretic girls leading to significant change on family environment dimensions namely (a) on relationship (b) on personal growth (c) and on system maintenance".

Next "t" test for repeated measures was performed for enuretic girls independently. The results obtained from the analysis is presented in table 5 (pg. 180-182). The results obtained shows that of the ten "t" test carried out the cohesion sub-scale of the relationship dimension (p. 046) and the organization sub-scale of the system maintenance dimension (p. 013) were found to be significant. However, the third dimension of the scale that is personal growth dimension was not found to be significant. Clinical studies and observation of boys and girls development and behaviour characteristics shows that girls development process and maturity is comparatively earlier than boys. They are more cleaner and better organized than boys. (Rutter et al.) this is evident in this study also, the results obtained for enuretic boys independently (table 4) is not found to be significant in organisation sub-scale while enuretic
girls have shown positive significant relationship. This indicates with a right kind of system maintenance approach and high cohesion in the family environment, there will be a positive impact on the enuretic girls as shown in the results above.

**Graph 3 (Pg 314)**

Shows the Mean scores of girls independently, indicating significant reduction in scores from pre to post level in cohesion and organisation sub-scale. The Mean and SD for cohesion subscale at pre level are 46.294; 8.45 while at post level it was 41.353; 9.42. The Mean and SD for organisation subscale are 50.706; 4.96 at pre level while 55.118; 4.47 at post level.

**Hypothesis Six:**

States "There will be an impact of therapeutic treatment intervention on the primary type leading to significant change on family environment dimensions namely (a) on relationship (b) on personal growth (c) and on system maintenance dimension.”
Further analysis was performed using "t" test for repeated measures for primary type independently. The results obtained are presented in table 6 (pg 183-185.). The results obtained show that of the ten 't' test carried out the cohesion sub-scale of the relationship dimension (p. 038) was found to be significant. However the other two dimensions of the scale namely personal growth and system maintenance Dimensions were not found to be significant.

"Primary type" enuretics are children who have never achieved dryness. As per DSM III in "Primary type" the individual have never established urinary continence. By definition primary enuresis begins at the age of five years. So going by definition as in DSM III R primary enuretic children are relatively younger in age. Hence with the effect of therapeutic treatment intervention when cohesion was enhanced, primary enuretic type children showed positive significance. This indicate a significant relation of primary type of enuresis and relationship dimension in the family environment, as seen in the result above.
**Graph 4 (Pg. 315)**

Shows the Mean scores of primary type, indicating significant reduction in scores from pre to post level in cohesion sub-scale. The Mean and SD for cohesion at pre level are 46.704, 5.48 while at post level the Mean and SD were 42.407 and 9.71.

**Hypothesis Seven:**

States “There will be a impact of therapeutic treatment intervention on the secondary type leading to significant change on family environment dimensions namely (a) on relationship (b) on personal growth (c) on system maintenance”.

Lastly "t" test for repeated measures for secondary type was performed, for each of the sub-scale for the three dimensions of FES. The results obtained are presented in table 7 (pg186-188.). The results obtained show that of the ten "t" test carried out the cohesion sub-scale of the relationship dimension (p .047) and the organisation sub-scale of system maintenance dimension (p .004) were found to be highly significant. However the results of the personal Growth dimension are found to be not significant statistically.
The “Secondary type” are enuretic children who had achieved continence but after having achieved dryness, have started bed wetting again, as defined in DSM III R thus the most common time for the onset of Secondary type Enuresis is between the age of five and eight years but it may occur any time. Therefore the assumption is that secondary type children are basically toilet trained, but due to various emotional disturbances and psycho social distress bed wetting results as a symptom. Here, it would be interesting to compare the results of primary & secondary type. In primary type (table 6), only relationship dimension (cohesion) has shown significance but the secondary type results have shown significance not only in relationship dimension (cohesion) but also in system maintenance dimension (organisation) this indicates that secondary group is comparatively more mature than the primary group, as seen in the results.

**Graph 5 (Pg.316)**

Shows the Mean and SD scores of the “Secondary type”, indicating significant reduction in scores from pre to post level in cohesion and organisation sub-scale. The Mean & SD score
at pre level were 44.154; 10.12 while at post level they were 37.231; 10.13 in Cohesion. In organisation the Mean & SD scores at pre level were 47.692; 6.91 while at post level they were 54.308; 4.25.

As seen in the results obtained from family Environment Scale, there is a significant change in all the three dimensions, that is, (a) Relationship Dimension, (b) Personal Growth Dimension, and (c) System Maintenance Dimension. The seven subs-scales Expressiveness, Conflict, Independence, Intellectual cultural orientation, Active Recreational Orientation, Moral Religious emphasis and Control are not found to be significant in this study. This could be because the duration of the therapeutic treatment intervention, was only three months.

During the intervention period the researcher did meet the mothers of enuretic children individually, which was once in two weeks. Again due to lack of time and other reasons, involvement of the Fathers of enuretic children’s, and other members of the family was done in a very limited way in the present - study. So only one sub-scale in each dimension is found to be significant. These three sub-scale are, Cohesion in
Relationship Dimension, Achievement Orientation in Personal Growth Dimension and Organisation in System Maintenance Dimension of Family Environment.

**Hypothesis Eight:**

States "There will be an impact of the therapeutic treatment intervention on the enuretic boys and girls leading to significant reduction in the psychological symptoms."

The results of ANCOVA for Interview Schedule for Children and Adolescence (ISCA) for Sex is presented in (table 8 pg 189-200.). The F values obtained was found to be significant in only three psychological symptoms. They are, namely, Worrying \((F=6.883, \ P=0.014)\), Distractability \((F=4.002, \ P=0.053)\) and General Anxiety \((F=3.812, \ P=0.058)\) while due to lack of data or missing cells the following symptoms could not be processed. They are suicidal ideation / threat, Burglary, Fire setting, Drug use/ abuse, Hysterical symptom, Phobia, Truancy, and Encopresis.
This result is in compliance with a study conducted at (Meyer Rehabilitation Institute, Omaha where Wargak WJ., 1993) had concluded that enuretic children are at increased risk for emotional or even physical abuse from family members. Irrespective of the type of enuresis that is primary type enuresis or secondary type enuresis the clinical profile of an enuretic child shows general anxiety, worrying and distractibility. In the present study undertaken, these psychological symptoms were found in the enuretic children. With the therapeutic treatment intervention, these psychological symptoms of the enuretic child were worked out, which lead to continence of functional enuresis. This indicate that psychological symptoms have a significant relationship with functional enuresis as seen in the above results.

Hypothesis Nine:

State "There will be an impact of the therapeutic treatment intervention on the primary type and secondary type of enuretic children leading to significant reduction in the psychological symptoms".
The results of ANCOVA for Interview Schedule for Children and Adolescence (ISCA) for type (Primary type and secondary type) are presented in the table 9 (pg 201-213.). The results indicate that of the fifty psychological symptoms only three psychological symptoms were found to be statistically significant. They are; Disobedience (F=5.406, P=0.026) Low self esteem (F=4.737 P=0.036) and Enuresis (F=5.188 P=0.029). However, due to missing cells or lack of date the following psychological symptoms could not be processed. They are namely; Suicidal ideation/ threat, Phobia, Truancy, Burglary, fire setting, Drug use / abuse and Encopresis.

Hypothesis Ten:

There will be an impact of the therapeutic treatment intervention on the total sample of Enuretics leading to significant reduction in the psychological symptoms.

Further analysis was performed using "t" test for repeated measures, for each of the Interview Schedule for Children and Adolescence on fifty psychological symptoms. The results obtained are presented in table 10 (Pg.214-225). The results
obtained shows that of the fifty "t" tests carried out only seventeen were found to be significant. They are as follows: Diurnal Variation of Depressed Mood (P=0.048), Worrying (P =0.019), Irritability (P=0.048), Guilt/Blame (P=0.000), Shame (P=0.000), Low Self Esteem (P=0.000), Loss of Pleasure (P=0.004), Reduced / Disturbed Sleep (P=0.044), Restless / Disturbed Sleep (P=0.014), Psychomotor Retardation (P=0.021), Inability to Respond with Pleasure (P=0.011), Physical Restlessness (P=0.004), Distractibility (P=0.002), General Anxiety (P=0.023), School Refusal (P=0.002), Disobedience / Rule Breaking (P=0.003) and Enuresis (P=0.000).

The symptoms which could not be processed due to lack of sufficient data or missing cells are Fire Setting, Drug Use/Abuse and Encopresis.

Evidence from epidemiological studies documents an association between Enuresis and psychological symptoms. (Rutter et al, 1973; Essem and Peckam, 1976). Unfortunately, given the recent advances in classification of child psychopathology, there is only limited knowledge regarding the type of psychological symptoms associated with enuresis.
Moreover, these symptoms do not follow any consistent pattern (Shaffir 1985) Mikkelson et al (1980) among a very small sample of 20 enuretic children, reported the following diagnosis: Depressive disorder, mixed disturbance of adjustment and conduct, mixed anxiety - depressive disorder, with hyperactivity and under-socialized conduct disorder, aggressive type.

This diagnosis holds true even in the present study. Psychological symptoms like diurnal variation of depressed mood, general anxiety, Physical restlessness are positively associated with functional enuresis as indicated in the above results.

Graph 6 (Pg. 317)

Shows the Mean and SD scores for the total sample of enuretic children, indicating significant reduction in the scores from Pre to Post level. At the Pre level, the Mean and SD for Diurnal variation for Mood were 0.606 and 0.9; for Worrying 0.424 and 0.79; for Irritability 1.139 and 1.15; for Guilt / Blame 0.914 and 0.89; for Shame 1.553 and 1.11; for Low Self Esteem 0.861 and
0.87; for Loss of Pleasure 0.964 and 1.04; Reduced / Disturbed Sleep 0.359 and 0.74; Restless / Disturbed Sleep 0.400 and 0.125; Psychomotor Retardation 0.400 and 0.930; Inability to Respond with Pleasure 0.325 and 0.100; Physical Restlessness 0.575 and 0.100; for Distractability 1.385 and 1.29; for General Anxiety 0.525 and 0.15; for Refusal 0.55 and 0.075; for Disobedience / Rule Breaking 0.600 and 0.840, and for Enuresis they were 2.15 and 0.86. However, at the post level the Mean and SD have substantially reduced. For Diurnal Variation for Mood there were 0.333 and 0.65; for Worrying 0.091 and 0.29; for Irritability 1.15 and 0.83; for Guilt / Blame 0.89 and 0.28; for Shame 1.11 and 0.44; for Low Self Esteem 0.87 and 0.38; for Loss of Pleasure 0.464 and 0.79; Reduced / Disturbed Sleep 0.154 and 0.43; Restless / Disturbed Sleep 0.125 and 0.34; Psychomotor Retardation 0.400 and 0.100; Inability to Respond with Pleasure 0.100 and 0.300; Physical Restlessness 1.08 and 0.30; for Distractability 0.718 and 0.83; for General Anxiety 0.15 and 0.36; for Refusal 0.075 and 0.27; for Disobedience / Rule Breaking 0.275 and 0.51, and for Enuresis they were reduced to 0.225 and 0.48.
Hypothesis Eleven:
States: "There will be an impact of the therapeutic treatment intervention on the Enuretic boys leading to significant reduction in the psychological symptoms".

Next analysis was performed using "t" test for repeated measures for each of the fifty psychological symptoms of Interview Schedule for Children and Adolescence (ISCA) for boys independently. The result obtained are presented in table 11 (Pg.226-238). The result obtained show that of the fifty "t" test carried out eighteen psychological symptoms were found to be significant. They are namely: Worrying (P=0.025), Anger (P=0.053), Irritability (P=0.020), Loss of Pleasure (P=0.029), Increased Sleep (P=0.057), Psychomotor Retardation (P=0.059).

However, psychological symptoms which were found to be highly significant are the following: Guilt/Blame (P=0.003), Shame (P=0.00), Low Self-Esteem (P=0.01), Social withdrawal (P=0.01), Impaired Concentration (P=0.01), Distractibility (P=0.00), School Refusal (P=0.008), Disobedience / Rule Breaking (P=0.05), Physical fighting (P=0.01) and lastly, Enuresis (P=0.00).
There were some psychological symptoms which could not be analysed due to missing cell or lack of data are namely, Suicidal ideation / threat, Reduced need for sleep, Compulsive behaviour, Phobia, Fire Setting, Drug Use/Abuse, Hysterical symptoms and Encopresis.

**Graph 7 (Pg. 318)**

Shows the "t" test for repeated measures for ISCA for boys. It presents the Mean and SD score both at pre and post levels. At the Pre level the Mean and SD for Worrying 0.429 and 0.81; for Anger 1.13 and 1.25; for Irritability 1.238 and 1.18; for Guilt / Blame 0.933 and 0.799; for Shame 1.546 and 1.14; for Low Self Esteem 0.714 and 0.85; for Loss of Pleasure 0.938 and 1.06; Social Withdrawal 1.15 and 1.04; Increased Sleep 0.261 and 0.54; Psychomotor Retardation 0.478 and 0.99; Inability to Respond with Pleasure 0.391 and 0.94; Physical Restlessness 0.652 and 1.19; Impaired Concentration 1.174 and 1.34; Distractability 1.773 and 1.27; School Refusal 0.783 and 1.28; Disobedience / Rule Breaking 0.652 and 0.78; Physical Fighting / Aggression 0.87 and 1.01; and for Enuresis they were 1.87 and 0.92
However, at the Post level, the Mean and SD have been the following: For Worrying 0.000 and 0.000; Anger 0.652 and 0.83; for Irritability 0.619 and 0.67; for Guilt / Blame 0.100 and 0.308; for Shame 0.227 and 0.53; for Low Self Esteem 0.191 and 0.40; for Loss of Pleasure 0.500 and 0.816; Social Withdrawal 0.55 and 0.76; Increased Sleep 0.044 and 0.21; Psychomotor Retardation 0.087 and 0.42; Inability to Respond with Pleasure 0.130 and 0.34; Physical Restlessness 0.130 and 0.344; Impaired Concentration 0.478 and 0.51; Distractability 1.000 and 0.873; School Refusal 0.130 and 0.344; Disobedience / Rule Breaking 0.217 and 0.42; Physical Fighting / Aggression 0.435 and 0.66; and for Enuresis they were 0.217 and 0.42.

**Hypothesis Twelve:**

States: "There will be an impact of the therapeutic treatment intervention on the Enuretic girls leading to significant reduction in the psychological symptoms."

Again analysis was performed using "t" test for repeated measures, for each of the fifty psychological symptoms of the
ISCA for girls independently. The results obtained are presented in table 12 (Pg 229-251). The result obtained shows that of the fifty "t" test carried out only eight psychological symptoms were found to be significant. They are the following: Reduced Sleep / Disturbed Sleep ($P=0.048$), Initial Insomnia ($P=0.056$), Restlessness ($P=0.049$). The psychological symptoms which were found to be highly significant are: Guilt/Blame ($P=0.000$), Shame ($P=0.000$), Low self esteem ($P=0.000$), General Anxiety ($P=0.018$) and Enuresis ($P=0.00$).

However, due to lack of missing cells or sample size some symptoms could not be analysed. They are Truancy, Burglary, Lying, Fire Setting, Drug Use/Abuse and Encorposis.

It is interesting to note here that "t" test of enuretic boys independently have shown significant relationship in 18 psychological symptoms (table 11), but the "t" test results of enuretic girls independently have shown significant relationship in only eight psychological symptoms.

These results are in compliance with previous studies and research, that boys are twice more likely to be enuretic than
girls (Oppel et al, 1968, Rutter et al, 1973, Essen and Peckham, 1975). Another argument forwarded is that girls are more aware of their cleanliness as compared to boys (Fergusson and Horwood, 1990). Moreover, the psychological as well as physical development and maturity in general is comparatively earlier in girls than boys.

**Graph 8 (Pg. 319)**

Shows the Mean scores and SD obtained from "t" test for repeated measures of ISC A for enuretic girls independently at pre and post level. The Mean and SD of Guilt/Blame at pre level were 0.933, 0.80 which were reduced to 0.067 and 0.26 at post level. Mean and SD scores of Shame at pre level were 1.563 and 1.09 which substantially reduced to 0.063 and 0.25. Similarly Self Esteem was 1.067 and 0.88 which at post level came down to 0.133 and 0.35. The Mean and SD of Reduced Sleep were 0.563 and 0.96 at pre level, and at post level they were 0.125 and 0.34. Initial Insomnia had Mean and SD as 0.353 and 0.61 at pre level, and at post level it was 0.059 and 0.24. Restlessness at pre level was 0.588 and 1.00 at pre level which decreased to 0.177 and 0.39 at post level. General
anxiety at pre level was 0.824 and 1.29, and at post level it was 0.059 and 0.24. The Mean and SD scores of enuresis at pre level were 2.529 and 0.62, but at post level they reduced to 0.235 and 0.56.

**Hypothesis Thirteen:**

States: "There will be an impact of the therapeutic treatment intervention on the Primary type leading to significant reduction in the psychological symptoms."

Further analysis was performed using "t" test for repeated measures for each of the fifty psychological symptoms of the ISCA for primary type independently. The results obtained are presented in table 13 (Pg.252-264). The results obtained shows that of the fifty "t" test carried out only four symptoms were found as significant. They are namely, Depressed dejected mood (P=0.052), Shame (P=0.005), Low Self Esteem (P=0.007), and Enuresis (P=0.000).
Due to lack of data or missing cells, the following psychological symptoms could not be analysed. They are: Suicidal ideation / Threat, Thoughts of wanting to die / Death, Initial Insomnia, Fire Setting, Drug Use/Abuse, Hysterical Symptoms and Encopresis.

**Graph 9 (Pg. 320)**

Shows the "t" test for repeated measures for ISCA. It presents the Mean and SD scores both at pre and post levels. At pre level, the Mean and SD for Depressed Dejected mood were 1.100 and 1.10, for Shame it was 1.000 and 1.16, for Low Self-Esteem it was 1.083 and 1.17, for Enuresis it was 2.154 and 0.99. When the Mean and SD were calculated again at the post level, they had significantly decreased to: for Depressed Dejected Mood it was 0.600 and 0.70, for Shame it was 0.154 and 0.38, for Low Self-Esteem it was 0.083 and 0.29, for Enuresis it was 0.462 and 0.66.
**Hypothesis Fourteen:**

States: "There will be an impact of the therapeutic treatment intervention on the Secondary type leading to significant reduction in the psychological symptoms".

Lastly, analysis was performed using "t" test for repeated measures, for each of the fifty psychological symptoms of the ISCA for Secondary type. The results obtained are presented in table 14 (Pg. 265-277). The results obtained shows that of the fifty "t" test carried out, thirteen psychological symptoms were found to be significant. They are, namely, Worrying (P = 0.056), Guilt / Blame (P=0.000), Shame (P=0.000), Low Self Esteem (P=0.001), General Anxiety (P=0.054), School Refusal (P=0.016), Disobedience / Rule Breaking (P=0.018), Inability to Respond with Pleasure (P=0.022), Physical Restlessness (P=0.025), Impaired Concentration (P=0.056), Loss of Pleasure (P=0.016), and Enuresis (P=0.000).

The symptoms that could not be processed due to missing cells or lack of sufficient data are: Stealing, Truancy, Burglary / Vandalism, Fire-Setting, Drug Use / Abuse, Hysterical Symptoms and Encorposis.
As defined in DSM III R Primary type of enuresis is – in which the individual has never established urinary continence and the Secondary type is the one in which disturbance develops after a period of established urinary continence. Therefore, the onset of Secondary Enuresis is often because of stress or some underlying emotional distress like separation anxiety, change of school etc.

Mac Keith R.C. (1972) postulated that enuresis may result from a transient episode of stress occurring at a critical developmental stage. A stressful or anxiety provoking episode or environment at this critical time could prevent the development of the behavioural skills necessary for nocturnal bladder control. This concept is supported by frequent association between secondary onset of enuresis and stressful events.

Keeping this in mind it is very obvious that the associated psychological symptoms with secondary enuresis are higher than those found in primary enuresis. Even in this study, there are thirteen associated psychological symptoms with secondary enuresis (table 14) while only four symptoms are associated with primary enuresis as shown in table 13.
Graph 10 (Pg. 321)

Shows the Mean and SD scores of "t" test for repeated measures of ISCA for secondary enuresis independently. The Mean and SD at pre level for Worrying was 0.364 and 0.66; for Guilt/Blame it was 1.217 and 0.85; for Shame it was 1.840 and 0.99; for Low Self-Esteem it was 0.750 and 0.68; for General Anxiety 0.519 and 1.09; for School Refusal it was 0.556 and 1.12; for Disobedience / Rule Breaking it was 0.444 and 0.70; for Inability to Respond with Pleasure to Praise it was 0.222 and 0.51; for Physical Restlessness / Agitation it was 0.556 and 1.05; for Impaired Concentration it was 0.815 and 1.18; for Distractibility it was 1.423 and 1.33; for Loss of Pleasure 0.833 and 0.99; and for Enuresis it was 2.148 and 0.82.

While at the post level the Mean and SD were: for Worrying was 0.091 and 0.29; for Guilt/Blame it was 0.087 and 0.29; for Shame it was 0.160 and 0.47; for Low Self-Esteem it was 0.208 and 0.42; for General Anxiety 0.111 and 0.32; for School Refusal it was 0.111 and 0.32; for Disobedience / Rule Breaking it was 0.148 and 0.36; for Inability to Respond with Pleasure to Praise it was 0.037 and 0.19; for Physical Restlessness / Agitation it was 0.087 and 0.29; for Impaired Concentration it was 0.160 and 0.47; for Distractibility it was 0.208 and 0.42; for Loss of Pleasure 0.222 and 0.51; and for Enuresis it was 2.148 and 0.82.
Restlessness / Agitation it was 0.111 and 0.32; for Impaired Concentration it was 0.370 and 0.57; for Distractibility it was 0.615 and 0.75; for Loss of Pleasure 0.389 and 0.85; and for Enuresis it was 0.111 and 0.32.

**Hypothesis Fifteen:**

States: "There will be an impact of the therapeutic treatment intervention on the boys and girls leading to significant increase in the Self-Esteem".

The results of ANCOVA for the Self Esteem rating scale (SE) for Sex (boys and girls) is presented in the table 15 (Pg. 278). The F value obtained shows no significant increase in the Self Esteem. Thus the results obtained, shows no significant increase in the Self Esteem of the Enuretic boys and girls.

**Hypothesis Sixteen:**

States: "There will be an impact of the therapeutic treatment intervention on the Primary type and Secondary type of Enuretic children leading to significant increase in the Self Esteem".
The results of ANCOVA for the Self-Esteem rating scale (SE) for Primary type and Secondary type can be seen in the table 16 (Pg. 278). The F value obtained, here again, shows no significant increase in the Self Esteem. Thus the results obtained, shows no significant increase in the Self Esteem of the Primary and Secondary type.

**Hypothesis Seventeen:**

States: "There will be an impact of the therapeutic treatment intervention on the total sample of Enuretics leading to significant increase in the Self Esteem.

The results of "t" test for repeated measures, for Self Esteem rating scale (SE) for the sample is presented in the table 17 (Pg.279). The results indicate that "t" test when performed on the total sample, was found to be highly significant (P=0.000). Perhaps the most deleterious effect of bed wetting is its impact on the child's Self Esteem. Although some youngsters respond to their enuresis with apparent indifference (Schaefer C.E., 1979), parental disapproval, sibling teasing, and repeated treatment failures may embarrass and shame the child, thereby
lowering Self-Esteem and threatening normal development. Children who wet both nocturnally and diurnally experience even more distress and have lower self esteem than those who wet only at night. Few enuretic children are aware that enuresis is a common condition, affecting classmates as well as family members. This lack of knowledge, coupled with the tendency among many families to treat the child's enuresis as a secret, contributes to the child's sense of being "different" and further diminishes self esteem. Low self esteem presents an additional problem for the child's provider to address, complicating the treatment of enuresis or any other disorder the child may experience. Most studies suggest that enuretic children who are successfully treated show improvement in self perception. The result obtained in the present study also indicate that with continence in functional enuresis there is an increase in the self esteem of the child.

Graph 11 (Pg. 322)

Shows the "t" test for repeated measures for self esteem. It shows the Mean and SD scores which were 70.575 and 12.52 at pre level, while at the post level they were 82.100 and 11.93 which is a significant increase.
Hypothesis Eighteen:

States: "There will be an impact of the therapeutic treatment intervention on the enuretic boys leading to significant increase in the Self Esteem".

Further analysis was performed using "t" test for repeated measures for Self Esteem rating scale for enuretic boys, independently. The results obtained are presented in the table 18 (pg.279). The results indicate that "t" test when performed on enuretic boys independently was found to be highly significant (P=0.000).

Graph 12 (Pg. 323)

Shows the "t" test for repeated measures for the Self Esteem rating scale. It presents the Mean and SD scores which were 71.217 and 11.83 at pre level, while at the post level they increased significantly to 82.913 and 12.12.
Hypothesis Nineteen:

States: "There will be an impact of the therapeutic treatment intervention on the Enuretic girls leading to significant increase in the Self Esteem".

Again analysis was performed using "t" test for repeated measures for Self Esteem rating scale for enuretic girls, independently. The results obtained are presented in the table 19 (Pg. 280). The results indicate that "t" test when performed on enuretic boys independently was found to be highly significant (P=0.000). Hence it can be concluded that with the therapeutic treatment intervention and continence of bed-wetting the Self Esteem of enuretic boys increases.

Graph 13 (Pg. 324)

Shows the "t" test for repeated measures for the Self Esteem rating scale. It presents the Mean and SD scores which were 69.706 and 13.72 at pre level, while at the post level they increased significantly to 81.000 and 11.93.
Hypothesis Twenty:

States: "There will be an impact of the therapeutic treatment intervention on the Primary type leading to significant increase in the Self Esteem".

Next analysis was performed using "t" test for repeated measures for Self Esteem rating scale for Primary type, independently. The results obtained are presented in the table 20 (Pg.280). The results indicate that "t" test when performed on Primary type independently was found to be highly significant (P=0.000). From the results obtained it can be interpreted that enuresis and Self Esteem have a significant relation.

Graph 14 (Pg. 325)

Shows the "t" test for repeated measures for the Self Esteem rating scale. It presents the Mean and SD scores which were 70.148 and 14.06 at pre level, while at the post level they increased significantly to 80.519 and 11.53.
Hypothesis Twenty one:

States: "There will be an impact of the therapeutic treatment intervention on the Secondary type leading to significant increase in the Self Esteem".

Lastly analysis was performed using "t" test for repeated measures for Self Esteem rating scale for Secondary type, independently. The results obtained are presented in the table 21 (Pg. 281). The results indicate that "t" test when performed on Secondary type independently was found to be highly significant (P=0.000).

Michael Edward knowler Moffat et al (1987) in the results of his study suggest that there are measurable improvements in the way children feel about themselves after they have mastered their bed-wetting. In his study the improvements in Self Concept in the treatment group were statistically significant even under the rigorous analysis of repeated measures and ANCOVA and the fact that the control group showed the same degree of change when they were latter treated add consistency to his observation.
In this study, the results of "t" test for sample (table 17) "t" test for boys independently (table 18), "t" test for girls independently (table 19), "t" test for Primary type (table 20) and "t" test for Secondary type (table 21) - all these tables show a significant increase in the Self Esteem.

**Graph 15 (Pg. 326)**

Shows the "t" test for repeated measures for the Self Esteem rating scale. It presents the Mean and SD scores which were 71.462 and 8.94 at pre level, while at the post level they increased significantly to 85.385 and 12.53.

**Hypothesis Twenty two:**

States: "There will be an impact of the therapeutic treatment intervention on the total sample of enuretics leading to significant reduction in behaviour characteristics".

Further analysis was performed using "Sign test" for the behaviour check-list. The results obtained are presented in the table 22 (Pg. 282-287). In the results of Sign test for thirty
behaviour characteristics, only the following were found to be significant, namely: Refusal to eat (P=0.000), Other eating problems (P=0.0039), Problems with sleep (P=0.0001), Soiled Cloths (P=0.0000), Quarrelsome (P=0.0005), Weap / be withdrawn (P=0.0313), Stubborn and Demanding (P=0.0074), Inattentive (P=0.000), Problem in School (P=0.0078), Refusal to Attend School (P=0.0156), Easily Frightened (P=0.002), Resistance to Change (P=0.0010), Talks Irrelevantly (P=0.0156) and Day Dreaming (P=0.0002).

The behaviour characteristics which could not be analysed due to lack of adequate sample size or missing cells are the following: Stammering/Stuttering, Repeated body movement, Problems with Arithmetic, Specific fears and Excessively happy.

From this results it is evident that there is an association of behaviour symptoms and enuresis which has been demonstrated by some previous authors also. (Steward M.A., Ann Gath D.M., 1978, and De Souza A, De Souza D.A., 1987), Tapia F, Jekel J, Domke H.R. (1960) also found a much higher level of behavioural symptoms reported by parents of enuretic children.
Baker B.L. (1969) showed no difference between subjects and controls on behaviour checklist. However, Moffat M.E.K. (1989) reported that enuresis was more frequent in children who had emotional problems.

**Hypothesis Twenty three:**

States: "There will be an impact of the therapeutic treatment intervention on the enuretic boys leading to significant reduction in behaviour characteristics".

Next analysis was performed using "Sign test" for each of the behaviour characteristics for the behaviour check-list, for the boys independently. The results obtained are presented in the table 23 (Pg.288-293). The following characteristics were found to be significant, namely: Refusal to eat (P=0.002), Other eating problems (P=0.031), Problems with sleep (P=0.031), SoilsCloths (P=0.0001), Quarrelsome (P=0.015), Inattentive (P=0.001), Easily Frightened (P=0.031), Resistance to Change (P=0.015) and Day Dreaming (P=0.015).
The behaviour characteristics which could not be analysed due to missing cells are: Stammering/Stuttering, Repeated body movement, Masturbation, Thump-sucking, afraid, fearful, Problems with Arithmetic, Specific fears, Self Mutilation, Excessively happy and Excessively sad.

Hypothesis Twenty four:

States: "There will be an impact of the therapeutic treatment intervention on the Enuretic girls leading to significant reduction in behaviour characteristics".

Again analysis was performed using "Sign test" for each of the behaviour characteristics for the behaviour check-list, for girls independently. The results obtained are presented in the table 24 (Pg. 294-299). Of the 30 characteristics, only the following characteristics were found to be significant, namely: Refusal to eat (P=0.0078), Problems with sleep (P=0.0078), Soils Cloths (P=0.0010), Stubborn and Demanding (P=0.0313), Inattentive (P=0.0313), Easily Frightened (P=0.0156), and Day Dreaming (P=0.0313).
The behaviour characteristics which could not be analysed due to missing cells or lack of data are: Stammering/Stuttering, Repeated body movement, Problems with Reading, Problems with Arithmetic, Specific fears, Self Mutilation, Excessively happy, Hyperactive and Aggressive.

For several decades it has been reported in nearly all studies that boys are more likely than girls to suffer enuresis. Reasons for this difference have been ascribed to social attitudes in child rearing, whereby girls are not permitted to be untidy, hence they are trained to greater fastidiousnes. Other reasons ascribe the known decreased incidence in girls to easier submission to training in girls and the fact that female enuretics have relatively few problems in other areas of their lives, so that they are not brought to medical attention. Various authors have reported more cases of enuresis among males (Hussain S.A., 1984; Dodge W.F., West E.F., Bridgeforth E.B., Travis L.B., 1979) perhaps due to secretiveness and seclusiveness about wetting and its associated symptoms in girls.
Hypothesis Twenty Five:

States: "There will be an impact of the therapeutic treatment intervention on the Primary type leading to significant reduction in behaviour characteristics".

Analysis was then performed using "Sign test" for each of the behaviour characteristics for the 30 behaviour characteristics of the behaviour check-list, for the Primary type independently. The results obtained are presented in the table 25 (Pg.300-305). The following characteristics were found to be significant, namely: Refusal to eat ($P=0.002$), Other eating problems ($P=0.0078$) Problems with sleep ($P=0.0010$), Soils Cloths ($P=0.0000$), Quarelsome ($P=0.0078$), Stubborn and Demanding ($P=0.0391$), Inattentive ($P=0.0001$), Refusal to Attend ($P=0.0313$), Easily Frightened ($P=0.0078$), Resistance to Change ($P=0.0156$) and Day Dreaming ($P=0.0020$).

The behaviour characteristics which could not be analysed due to missing cells or lack of data are: Stammering/Stuttering, Repeated body movement, Problems with Reading, Problems with Arithmetic, Specific fears, Excessively happy.
Hypothesis Twenty Six

States: "There will be an impact of the therapeutic treatment intervention on the Secondary type leading to significant reduction in behaviour characteristics".

Lastly, analysis was performed using "Sign test" for each of the behaviour characteristics for the 30 behaviour characteristics of the behaviour check-list, for the Secondary type independently. The results obtained are presented in the table 26 (Pg.306-311). Only one Behaviour characteristic was found to be significant, namely, Soils his/her Clothes (P=0.0156). It is interesting to note that of the thirty characteristics fourteen characteristics could not be processed due to lack of adequate data. They are Stammering/Stuttering, Other eating problems, Repeated body movement, Masturbation, Nail biting, Thump-sucking, Refusal to attend School, Problems with Arithmetic, Specific fears, Self Mutilation, Excessively happy, Excessively sad, Hyperactive and Aggressive.
Many authors including DSM III R have emphasized that enuresis is rarely mono-symptomatic. This is also substantiated by the present study. Anders, T.F and Freeman (1979), Kanner, L. (1971), Pierce C.M. (1985) have also found strong association of enuresis with other behaviour characteristics, e.g. Stubborn and Demanding, Refusal to eat, Easily frightened etc. These associated behaviour characteristics further substantiate the fact that enuresis is an expression of various stress factors and they must be dealt in time so as to prevent further personality or emotional problems. Although information concerning behaviour characteristics or habits could be gathered directly from the child or any other guardian but in this study the mothers completed the checklist with a view that it would provide optimal accuracy about the child. However, the results obtained for Secondary only (table 26) shows just one behaviour characteristics associated with enuresis. Mothers of secondary enuretic children seems to be reluctant to talk honestly and openly perhaps generated by shame or even a sense of personal failure. This could be a reason in obtaining reliable data.
The relationship between enuresis and psychological problems is intriguing. Overactive, Refusal to eat, aggression and other behaviour symptoms are more often found in enuretic children. Moffat M.E.K. (1989) It seems unlikely that the behaviour problems are a consequence of bed-wetting since they often persist after children become dry. Jarvelin M.R., Vikevainen T.L., Moilanen I., Huttunen N.P. (1988). This theory is supported by the finding that the persistence of enuresis is more likely if (a) the child shares bed with parents, (b) the parents pay a great deal of attention to the symptoms and (c) the parents help to change the night clothes.

There is an increase likelihood of enuresis in children having difficulty in behavioural adaptation, strict methods of training and parents with more anxiety and negative attitudes. Cohen M.W. (1975)

**Hypothesis Twenty Seven:**

States: "There will be an impact of the therapeutic treatment intervention on the total sample of enuretics leading to continence or decrease in frequency of bed-wetting".
In this study, the sample was forty enuretic children. Out of which there were twenty three boys and seventeen girls between the age of five and thirteen years. When further classified into types, they were twenty two secondary type and eighteen primary type of enuretics, as presented in the background information table (Chapter 4: table G).

Necessary data was collected and tools administered during the pre interventional phase. Baseline frequency was recorded as 12.5% were wetting their bed almost daily, 62.5% were wetting their bed two or three times a week while 25% would wet their bed occasionally i.e. two or three times a month (Background information table G., Chapter 4).

During the three months intervention phase, the therapeutic treatment technique was administered. At the end of intervention period, tools were again administered in the same sequence and the frequency charts were collected back from the children. Thirty two children were reported as having achieved continence, or in other words therapeutic success. (The criteria for therapeutic success was fourteen consecutive dry nights). However, eight enuretic children that is five boys and three girls
could not achieve fourteen consecutive dry nights. However, their frequency of bed wetting at the termination of therapeutic treatment was much less than the baseline frequency.

Of the many reasons for no complete therapeutic success, one of them is the non-compliance on the part of parents.

Moreover, the "Dry Bed Training" needed to be practiced sincerely every day. For example, if the child would forget to set his alarm clock, it was very likely that he would not be able to wake up during his sleep and use toilet or if the child would not use the toilet before going to the bed, then the probability of wetting his bed would surely be high. Hence the co-operation, motivation and involvement from the child was essential. Moreover, the degree of each child's motivation and involvement was also different.

Lastly, enuresis is a symptom of some underlying emotional disturbance. It cannot be overlooked that the research sample was collected at a Child Guidance Centre in Ahmedabad. Most of the children had associated problems apart from enuresis. So
it is possible that three months therapeutic treatment was inadequate time period for these children to resolve their underlying emotional problems.

However, due to lack of time and also lack of motivation on the part of parents, these eight children could not be taken for further follow up.