

HYPNOSIS IN A CASE OF PRIMARY ENURESIS

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This case study describes the treatment of a 13-year-old boy for enuresis using hypnosis. The referring psychiatrist specifically requested hypnosis after physical causes had been eliminated and previous behavioural interventions had not resulted in a successful outcome. Intervention was based around that described by Kohen (1990) and Olness and Kohen (1996). Promising progress was shown over the three sessions. Issues associated with the intervention are discussed.

William, the younger of two brothers in a single-parent family, was referred by a child and adolescent psychiatrist for treatment of primary enuresis. At the age of 13, William had never had a prolonged period of consecutive dry beds.

William had been seeing a psychiatrist for several years for attentional difficulties and social issues, which were reported to have greatly improved. The psychiatrist noted, however, that the boy's enuresis remained intractable and had not been resolved using behavioural strategies (including a bell and pad), or pharmacotherapy. At the time of referral William was rarely having a dry night. Wetting only occurred at night and there was no soiling, although William's mother noted that he had trouble maintaining complete bowel control, only achieving this at 10 years of age. William was also reported to have had night terrors as a child, his mother reporting that he "hardly slept." William's older brother had no significant problems with toilet training or bed-wetting.

William had a history of asthma but, at the time of referral, the only medication he was taking was dexamphetamine for ADHD, which had been prescribed since he was eight years of age. He rarely drank caffeinated

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beverages, just the occasional hot-chocolate. His mother noted, however, that he drank a lot of milk and lots of water.

William had no allergies, but it was reported that if he had too much sugar he became hyperactive. It used to be the boy's responsibility to put wet bedclothes in the washing machine but his mother reported that this resulted in arguments between herself and the boy when he did not do so. At the time of intervention, William was wearing incontinence pants during the night.

TREATMENT FOR ENURESIS

Two controlled studies suggest that hypnosis may be an effective intervention for enuresis and preferable to the most commonly used medication for this problem (Milling & Costantino, 2000).

Edwards and van der Spuy (1985) evaluated the effectiveness of hypnosis in treating 24 primary (i.e., never dry) and 24 secondary enuretic boys between the ages of 8 and 12. Following a baseline period in which the number of wet nights per week were tallied, children were randomly assigned to one of four conditions: no intervention, induction plus suggestions, suggestions without induction, and induction alone without suggestions. Suggestions were aimed at general tension reduction and enhancement of self-confidence and contained "dry night" suggestions for: (a) increased bladder capacity, (b) reduction of fluids before bedtime, (c) visiting the toilet before bedtime, and (d) awakening at night to go to the toilet if the bladder was full.

Results showed that by the end of the 6-week treatment period the number of wet nights per week for the "induction plus suggestion" and "suggestion only" groups had significantly decreased relative to the other conditions. Furthermore, at 6-month follow-up, all three treatment groups averaged between four and five dry nights per week which represented significantly greater reductions in wet nights than the non-treatment group, which averaged three dry nights per week. Overall, this study indicated that suggestions for dry nights, provided in or out of hypnosis, might be a useful intervention for enuresis.

Banerjee, Srivastav, and Palan (1993) treated 50 enuretic children, ranging from 5 to 16, with either hypnosis or imipramine, the most common drug therapy for this problem. Children in the hypnosis condition attended three sessions in which they were taught the anatomy and physiology of the bladder. Thereafter, these children listened to a hypnotic induction followed by suggestions for appropriate use of the toilet during the night. The children

were encouraged to practise self-hypnosis before going to sleep. Children assigned to the imipramine condition were treated with 25 mg every night for the first week. Doses were increased an additional 25 mg each week as necessary to produce dry nights. Comparable results were found between groups after three months of treatment, with 76% of the imipramine group and 72% of the hypnosis group achieving positive responses (as defined by all dry beds or decreased frequency of wetting). After three months of treatment and reinforcement, imipramine was discontinued, and active follow-up visits were discontinued for both groups, while the hypnosis group was encouraged to continue self-hypnosis practice. At follow-up six months later, only 24% of the imipramine group had maintained a positive response whereas 68% in the hypnosis group had maintained a positive response without clinical reinforcement. This difference between the two treatments was largely accounted for by the substantial number of youngsters in the medication group who had relapsed without the medication. The results of this study parallel those of other investigations of enuresis treated with imipramine; initially the medication produces a positive response followed by a high relapse rate when it is withdrawn (Blackwell & Currah, 1973).

A number of behavioural interventions have proven to be effective for enuresis including "enuresis alarm" and "Dry Bed Training" (Walker, Kenning & Faust, 1989). Hypnosis for enuresis was provided in this instance because it was specifically requested by the referring psychiatrist after physical causes had been eliminated and previous behavioural interventions had not resulted in a successful outcome. There were no contra-indications for the use of hypnosis.

TREATMENT PLAN

The agreed aim of therapy was to achieve dry beds and to accomplish this through hypnosis.

Session 1

William and his mother were seen together at the beginning of the session. I noted that interactions between them suggested a relationship affected by conflict. William's mother appeared tense and taciturn. William attempted to avoid interacting with either myself or his mother by focusing on a fantasy novel. His mother gave him instructions to "pay attention," "put the book

down,” and “concentrate.” I attempted to build rapport with William by asking about his book.

A brief history of the problem was obtained and statistics about the incidence of enuresis were presented. When asked what he wondered might be the reason for the problem, William indicated that he didn't know. His mother answered that she didn't know either. I explained that while the specific cause cannot always be discovered, and although many things had been tried in the past that “didn't work,” the method I was going to teach would help William help himself, as long as he didn't mind having dry beds.

Anatomy was discussed with the aid of a simplified diagram of the physiology and anatomy of urination drawn on a whiteboard. Suggested explanations provided by Kohen (1990) and Olness and Kohen (1996) were used. A drawing of the heart, kidneys, bladder, a “gate” or “door” on the bladder, a urethra, a brain, and a toilet were made while teaching about the function of each. The heart was described as a pump muscle that sends blood all over the body. The kidneys were described as a washing machine for the blood. The bladder was described as a place where the “pee” is stored. William was asked how he would know if he had to pee right at that moment. He answered that he “didn't know.” I explained that the bladder would say something to the brain like, “hey brain, I'm full.” Arrows were drawn going back and forth between the brain and the bladder. I explained that the brain and the bladder communicate with each other. As the bladder tells the brain when it is full, the brain tells the bladder to keep the gate or door closed, and sends messages to other parts of the body so that it can get to the toilet to pee. The brain might have to send messages to the mouth and tongue to ask where the bathroom is, to the ears to listen to the answer, to the legs to walk to the bathroom, and to the hands to close the door. *Then* the brain sends a message to the bladder to open the gate and let the pee out in the toilet where it belongs, and then to close the gate again. William was told that since the brain and bladder have been communicating with each other for a long time in the daytime, it would be relatively easy to remind them to communicate with each other at night too.

Using suggestions provided by Kohen (1990), I explained to William that the brain is the boss of the body. Even when we are asleep the brain may be resting, but it is paying attention, taking care of us, dreaming, keeping our heart pumping, our lungs breathing, telling us how to kick the covers off if we're too hot and so on. Sometimes the brain and the bladder get in the bad

habit of not talking to each other at night, and they need some reminders and some training.

Using this metaphor of the problem potentially served a number of purposes. The reference to “the brain” and “the bladder” is a dissociative suggestion to distance William from responsibility and guilt. It provided a useful way of thinking about the problem and a positive response expectation that the problem could be resolved.

William was instructed to make his own version of the diagram of the body and study this before going to sleep at night and “just think about what we talked about.”

Explanation of hypnosis William was told that now that he knew how the body works I was going to show him how to use a relaxation and imagination exercise to help teach the brain and bladder to talk to each other during the night. I explained that the success of this exercise would depend on how involved he became in it, and how regularly he practised it. We discussed the best time to practise the exercise and mutually agreed that the best time would be when he first got to his bed, before reading his novel, so he wasn't too tired. We also agreed that William's mother would place a card on his pillow to remind him to do his exercise, but would provide no other reminders.

At this point, William's mother was given a description of enuresis and I explained her part in the self-hypnosis treatment program and then I asked her to leave the room. I noted that William become more responsive when he was on his own.

I asked William to draw the layout of his house, then asked him to describe his likes and dislikes. He explained that he loved eating and told me some of his favourite foods. He also stated that he really enjoyed reading Terry Pratchett books and inventing fanciful machines.

Hypnotic induction I used an imagery induction in which William was asked to imagine himself in his favourite place — an imaginary warehouse with tables laden with his favourite foods, his favourite characters from Terry Pratchett and with several of his inventions in corners of the building. William spontaneously closed his eyes and verbalised that he was imagining trying out one of his inventions — a machine that was able to simulate the experience of skiing snow slopes. During the induction William conversed naturally, describing in detail the contents of the warehouse. At times he opened his eyes to tell me what he was doing or to explain one of his inventions.

Deepening To deepen the experience and provide some ego-strengthening suggestions provided by Kohen (1990) were used.

You've probably already noticed that your face muscles are relaxed and that your breathing is slower than it was before. That's because you are doing this exactly the right way, and since you and your brain are the boss of your body, you can even make your relaxation even more than it already is, because our bodies already know how to relax, and we even relax a little bit each time we breathe out. Just notice how your shoulders go down every time you breathe out . . . that's right. So, to help relax even more, take a slow, deep breath, in and out, and when you breathe out, say "relax" to yourself, and just notice what happens as your shoulders go down and relax. Floppy and relaxed.

With each exhalation the muscle groups from the feet up to the head were labelled, and William was given suggestions for the muscles to get loose and floppy.

Ideomotor signalling William was told that while he continued to enjoy his imagination, I was going to ask him a number of questions. I asked him to show me a "yes" finger and a "no" finger. After this he was asked a series of questions: "Do you like the colour purple?" "Do you like to eat doughnuts?" "Would you like to have all dry beds?" To this last question, William's "no" finger raised, but then he quickly verbalised that he had made a mistake and raised his "yes" finger. His correction was accepted and he was asked to signal a "yes" when he was ready to have instructions to his bladder.

Trance utilisation Various therapeutic suggestions from Kohen (1990) and Olness and Kohen (1996) were then made, including:

1. "Before you go to sleep you can remind them to be sure to talk to each other tonight, just the same way they talk to each other so well during the day, because your brain is the boss of your body and the main computer. And when you practise this way, the way you are doing so well, you are really programming the computer, just the same way you teach your brain to teach you to do so many of those other things you do so well: riding your bike, reading, inventing amazing machines. So, the more you practise, the better you get." [metaphor for control]
2. "If your bladder fills up with pee, it will send a message to your brain to let it know. And I don't know what instructions you will give the brain and

bladder about how to talk to each other. Maybe you will tell them to have the brain wake up so that you can walk to the bathroom, open the gate, pee in the toilet and walk back to your nice warm, comfortable dry bed, or maybe you'll have the brain simply tell the bladder to keep the gate closed through the night. I don't know which." [presupposition, double-bind, positive expectancy, expectancy of control]

3. "Think of yourself awakening in a dry bed, knowing you will have a good day." [positive expectancy]
4. "Enjoy knowing your bed is dry because of your efforts, because you're the boss of your bladder muscle. Enjoy the good feeling of waking up in a dry bed as long as you like." [positive expectancy, expectancy of control]
5. "I don't know who is going to be the most proud of you when you have given yourself a dry bed every morning, whether yourself, or mum, or me, or who." [positive expectancy, expectancy of control]

Self-hypnosis instruction While in trance, William was given instruction in self-hypnosis:

It's nice before you finish to remind yourself of what you did to help give yourself the good feelings you have now, so that when you practise this each day for 10 or 15 minutes, you'll know exactly how to do it. So, just picture in your mind where you might sit at home when you practise, and then see yourself closing your eyes and thinking of something fun to start off your special thinking practice. Great . . . now notice that as your eyes close and you start to get comfortable that you can imagine anything you want . . . perhaps it will be your warehouse with all your incredible inventions and favourite foods . . . and you can notice everything about it . . . and when you practise this at home in this same way, you'll be able to notice, just as you have today, and even right now, the way your muscles relax as you breathe out. And you can allow the relaxation feeling to move up your body all the way . . . that's right . . . and then, just like today, as soon as the relaxation has gotten all the way to your head, then you can let your finger lift, and that will be the signal to yourself that you are as comfortable as you want to be for that practice time. And then when you're ready, be sure to give instructions to the bladder and brain about how you want them to talk to each during the night. And when you're finished, then you'll be done. When you're practising at night you can then just fall asleep, and if you're practising in the day, you can just gradually come back to

where you were at the start, but be sure to bring your proud and relaxed feelings with you.

Posthypnotic suggestions William was given the posthypnotic suggestion that, “whenever you practise this thinking exercise, it will get easier and easier to do, and you will get better and better at teaching yourself to wake up every day in a nice, dry bed.” He was then given the instruction, “When you’re ready, you can open your eyes and enjoy the rest of the day.”

Debriefing William was told that he did a great job. When asked what he noticed that he liked the most, he told me that he enjoyed trying out some of his inventions.

Homework William was engaged in a commitment to practise this relaxation/imagination exercise daily. I also asked him to keep track of numbers of dry beds at home, to bring his own rendition of the diagram of the body to the next session, and to “just think about” the communication between the brain and bladder prior to his next visit. This initial session took 60 minutes.

Session 2

William’s mother reported that he was dry on one out of the five nights since the previous session. Although William had refused to let his mother participate in the reminder system and his mother was sceptical that he was practising his hypnosis exercise, the boy stated that he had practised on all but one night.

William was seen alone for the first part of the session. He had not completed his own rendition of the diagram of the bladder and the brain and needed assistance to draw his own version as part of the session.

Assessment of hypnotic capacity Despite verbalisations suggesting strong visual imagery, because William had fidgeted, opened his eyes and made comments, and his responses to the ideomotor signalling appeared volitional, I had doubts as to whether he had achieved hypnosis in the previous session. I used the Stanford Clinical Scale for Children (SHCS-C: Morgan & Hilgard, 1979) to assess his hypnotic capacity. William was responsive to all of the test items except the posthypnotic suggestion. Interestingly, he did not respond immediately to the cue to exhibit the posthypnotic response, but then demonstrated recognition as to why I had clapped by stating, “Oh, I forgot [to

do what you wanted me to].” William’s responses on the SHCS-C indicated a willingness to cooperate with suggestions, if not his hypnotic capacity.

Hypnosis A similar induction and suggestions were used as in session 1. When given the double bind suggestion that, “if your bladder should fill up with pee, I don’t know whether your brain will send a message to your body to wake up and go to the toilet or send a message to the bladder to keep the gate firmly shut until the morning,” William said that he would keep the gate shut.

Debriefing I praised William for his efforts. When asked what he liked the most, William said that he enjoyed eating foods that he’s not normally allowed to have.

Homework William was again engaged in a commitment to practise his self-hypnosis exercise on a daily basis and keep track of dry beds. He was asked to “think about how the brain and bladder are communicating with each other” when he went to the toilet at other times during the day.

Consultation with mother William’s mother was seen alone for a short period of time. She indicated that she did not believe that William was practising and found it difficult not to remind him. I explained that the more she tried to encourage William to practise, the more he may resist. Self-hypnosis is not something that can be forced. Instead, we discussed ways to increase William’s motivation to achieve dry nights. She decided to reward William with a chocolate frog for each dry night and give him permission to skip his dreaded morning shower.

She expressed concern that William was having a friend to sleep over on Friday night. He did not want to wear his incontinence pants, and mother felt that, if he did not, she should cancel the visit. She was concerned that if William wet the bed, his friend would gossip about him. It was agreed to alert him of the risks and leave the decision to him. William was called back into the room and the situation was discussed.

He confirmed his decision not to wear incontinence pants. When asked what he could do to make it more likely he would be dry, he said that he could have fewer drinks in the evening. I explained that this might help in the short-term, but may not be helpful in the longer term because it would mean that his bladder would get smaller and get full more quickly. William was reminded that he needed to keep practising his imagination/relaxation exercise. This session took 60 minutes.

Session 3

William's mother prompted him to report that he had been dry on four out of seven nights. Although he reported that he had been practising his relaxation/imagination exercise, he attributed some of his success to restricting drinks in the evening. As it turned out, William's friend could not come around on the Friday night, thus avoiding the dilemma.

Hypnosis A similar induction and suggestions were used as in the first two sessions.

Homework William was again engaged in a commitment to practise his self-hypnosis exercise on a daily basis and keep track of dry beds.

Consultation with William and his mother Since William had demonstrated his competence in the strategy, it was agreed to suspend further contact. This session took 45 minutes.

OUTCOME

Twelve months after intervention, I made phone contact with William's mother. She informed me that although William had made progress in the weeks after receiving instruction in hypnosis, this was not maintained. Four months after the last session, however, William's father resumed regular contact with him. Soon after this time William stopped wetting, and has mostly remained dry ever since.

William's mother reiterated her belief that the hypnotic approach did not have a fair trial. She expressed her belief that William did not practise his self-hypnosis exercises, commenting that she used to check up on him by looking through his bedroom window when he was supposed to be doing his exercise. At these times, she noted, he would be reading a book or playing on a computer game.

DISCUSSION

This case study describes the hypnotic treatment of enuresis in a 13-year-old boy. At 12 month follow-up William was reported to have been having dry nights for about eight months. It is impossible to know what to attribute this improvement to, although it seems plausible that the resumption of contact with his father is related. It is also possible that the instruction outlined in this paper contributed to his subsequent success. Promising progress was shown

over the course of the intervention, despite several factors that may have impacted on the intervention's success. These issues are discussed below

First, it was apparent that the relationship between William and his mother was affected by conflict. Olness and Kohen (1996) observed that the process tends to go less well if parents teach, reinforce, or are otherwise involved in the process. Although I did not have a mandate to work on the parent-child relationship, a number of steps were taken to reduce mother's involvement and reinforce the idea that dry beds were primarily William's responsibility. The boy was seen on his own for hypnosis, his mother was encouraged not to provide verbal reminders, and she was encouraged to allow William to make his own decisions in relation to risks with his friends. Despite this, there were signs that William's mother remained very much involved in the boy's progress. It was William's mother who would spontaneously report on his progress at the beginning of sessions, and she remained sceptical that he was actually "trying" or doing his homework.

Kohen, Colwell, Heimel, and Olness (1984) identified that lack of motivation on the part of the child is another major reason for the failure of hypnotic treatment for enuresis. Concerns about William's level of motivation were raised by his spontaneous response to the question, "Would you like to have all dry beds?" To increase the boy's motivation, I encouraged his mother to reinforce dry nights with small rewards and permission to escape the "dreaded" morning shower. Although parents have been involved in providing rewards in other studies (e.g., Baumann & Hinman, 1974), this strategy would certainly have reinforced mum's involvement. Other attempts to build William's motivation could have been usefully employed. For instance, self-monitoring his success on a calendar or a cumulative graph could have potentially led to the self-reinforcement of both William's increased bladder control and his efforts to change his behaviour. Achieving increased self-efficacy would have been an important accomplishment given his tendency to attribute his dry nights not to his own ability, but to the restriction of fluids.

Squirming, moving about, opening eyes and making spontaneous comments during hypnotic inductions and throughout the hypnotic procedure are reported to be more common in children than in adults (Olness & Kohen, 1996). Despite this, some of William's behaviour left me with some doubts as to whether or not he achieved hypnosis. I nevertheless continued with the suggestions given his willingness to cooperate and the fact that

formal trance induction is not essential for suggestions to be effective (Edwards & van der Spuy, 1985).

The literature suggests that most of the gains from hypnosis occur in the first three sessions. Olness (1975) found that most children resolved their bedwetting within the first month of treatment and Stanton (1979) reported that the majority of children in his sample stopped wetting after one to three sessions. Hypnosis with William was concluded after three sessions since it was judged at the time that prolonged treatment would not produce gains commensurate with the investment of time and money involved. In retrospect, however, it could be argued that the marked improvement over the three sessions could have been consolidated with additional contact. This seems even more relevant given his mother's insistence that he was not practising his self-hypnosis exercise. Phone contact might have been a productive compromise.

Olness and Kohen (1996) mention offering suggestions for integrating the alarm and hypnotic approach by asking the child to give him or herself a challenging message during self-hypnosis, such as "Tonight while I'm sleeping, bladder, when you fill up with urine be sure and send the message to the brain that you're full and, brain, be sure to keep the gate on the bladder shut until you wake me so I can beat the buzzer" (p. 144). William had some short-term success with the bell and pad. Given this, it would have been of interest if the two treatments could have combined to provide a successful outcome.

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