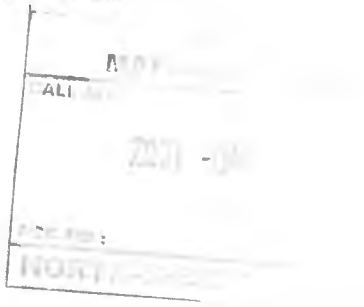
AN EXPLORATORY STUDY OF PERCEPTION AND TOLERANCE OF NOCTURNAL ENURESIS AMONGST BATSWANA MOTHERS



BY

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Submitted in part fulfilment of the requirements for the degree of Master of Social Science (Clinical Psychology) in the Department of Psychology at the University of Bophuthatswana.

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DEDICATION

To my mama ANN SORISA MABASA

A devoted persevering mother and a teacher.

And

In memory of my father MAGEZI JOHN MABASA

My source of inspiration

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DECLARATION

I declare that the dissertation for the degree of Master of Social Science (Clinical Psychology) in the Department of Psychology at the University of Bophuthatswana hereby submitted, has not previously been submitted by me for a degree at this or any other university, that it is my own work in design and execution and that all material contained herein has been duly acknowledged.

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ABSTRACT

An exploratory study was carried out to investigate which explanations mothers commonly give for their childrens' nocturnal enuresis. The relationship between these explanations and maternal tolerance for nocturnal enuresis were investigated. The study also investigated whether maternal perception and tolerance for nocturnal enuresis have implications for mothers to seeking psychological treatment for their nocturnal enuretic children.

A convenient sample of 51 Batswana mothers of nocturnal enuretic children were selected. The nocturnal enuretic children were identified according to the diagnostic criteria of enuresis in the Diagnostic and Statistical Manual of Mental Disorders -III- Revised (DSM-III-R). Respondents were selected at Bophelong hospital located in Mafikeng, North West Province, South Africa. The respondents either completed a questionnaire or were interviewed according to the questionnaire items. The questionnaire was designed to collect data about maternal perceptions about causes, concerns, tolerance

and management of nocturnal enuresis. The data was analyzed using test of associations in contingency tables and descriptive statistics.

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The main finding of this study was that mothers perceived nocturnal enuresis to be caused by heavy sleeping. They attributed the cause of nocturnal enuresis to be global and uncontrollable by the child. Concern for extra washing and financial burden were expressed as the main negative consequence of nocturnal enuresis. The results also showed that mothers expressed intolerance for nocturnal enuresis. Maternal educational level was found not to have an influence on maternal tolerance for nocturnal enuresis and maternal concern about the negative consequences of nocturnal enuresis. This finding could be due to the fact that the sample was not representative enough with regard to their educational level, thus limiting valid comparison. Seeking psychological treatment was found to be independent of tolerance for nocturnal enuresis. The most reported management strategies were talking to the child about the problem, making the child aware of the problem and restricting fluid after dinner. Consulting a physician was the most popular means of seeking help.

The implications of research findings are discussed.

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CHAPTER 1

INTRODUCTION

1.1 NOCTURNAL ENURESIS: AN INTRODUCTION

Functional enuresis is manifested as a repetitive and inappropriate passage of urine - voluntary or involuntary. The essential feature is repeated involuntary voiding of urine during the day or at night, after the age at which continence is expected. This disorder is somewhat arbitrary defined as involuntary voiding of urine at least twice a month for children between the ages of five and six and once a month for older children (Kaplan & Sadock, 1988; Sahakian, Sahakian & Nunn; 1986).

In his review of the history of enuresis, Glicklich (1951) concluded that "enuresis was born with the dawn of civilization and is still with us. Its history is long and colourful with prognosis for a longer and more exciting life before its problems are, if ever resolved" (p. 874).

It is indeed still with us. Although it may seem a fairly minor or trivial complaint compared to other childhood problems and illnesses, if one considers the effects it has on those involved, a picture of conflict, fear and intolerance emerges. Swanepoel (1989) views enuresis as a problem that affects the whole family, it evokes anger by caretakers and social ostracism by siblings and peers. Enuretic children are faced with consequences such as urine odour on their clothes, secrecy, a sense of isolation from peers through fear of staying at a friend's house overnight and avoidance of school organised holidays. Parents are faced with the practicalities of loads of washing and a confusion over how they should react and deal with the problem (Butler, 1987; Steinhauer & Rae-Grant, 1977).

The Diagnostic and Statistical Manual of Mental Disorders -III- Revised (DSM-III-R) indicates that functional enuresis is more prevalent in males than in females. The prevalence is at age 5 (7 percent for males, and 3 percent for females); at age 10 (3 percent for males, and 2 percent for females); and at age 18, (1 percent for males, and almost nonexistent for females) (American Psychiatry Association [APA],

1987). Data from the United States' National Health survey on nocturnal enuresis show that as many as 25 percent of boys and 15 percent of girls are enuretic at the age of 12 years. Primary enuresis accounts for 90 percent of these cases (Friman & Warzak, 1990).

The Abromovitch and Abromovictch (1988) study of enuresis in cross-cultural perspective amongst three Israeli ethnic groups (the Moroccans, Kurdish and Ashkenazi) found that sex differences was not related to the rate of enuresis. There were higher rates of primary enuresis and lower rates of secondary enuresis. Moroccans had the highest rate (37,3%), Kurds intermediate (25%), and the Ashkenazi group had the lowest rate (16,1%). The higher rates were related to the inability to seek effective assistance.

In South Africa, Pillay, Vawda and Pollock (1989) investigated the incidence of secondary enuresis in 16 institutionalized conduct-disordered children (13 boys and 3 girls) at Northdale general hospital in Pietermaritzburgh, Natal. The investigators found enuresis to be less common among girls. However, "the overall number of girls in the sample was too small to consider this a significant finding" (p. 625).

1.2 PROBLEM STATEMENT

The purpose of the present study was to investigate which explanations mothers commonly give for their children's nocturnal enuresis.

The following issues were investigated:

(a) Maternal concern and perceptions of causes and management about nocturnal enuresis.

(b) The relationship among these explanations, maternal educational level and tolerance for nocturnal enuresis.

(c) The relationship between maternal tolerance for nocturnal enuresis and maternal seeking psychological treatment for their nocturnal enuretic child.

1.3 RATIONALE FOR THE STUDY

There seems to be gaps in the available literature about enuresis. Most research studies on enuresis are based on western societies (Abromovitch & Abromovitch, 1988). According to a computer search for database for current and completed research of the Human Science Research Council (1993), no research has been done on parental perceptions of enuresis in South Africa. Thus this study attempts to extend research findings of

British, American and Israeli ethnic groups samples to Batswana mothers in South Africa.

Moreover the bulk of research has focused on questions of etiology and treatment rather than cultural factors, even though such factors have implications for understanding beliefs and perceptions about enuresis. Societal beliefs as to cause and management of enuresis have implications towards the understanding and the treatment of enuresis (Abromovicth & Abromovitch, 1988). Little agreement and much conjecture exist about the causes and management of enuresis despite the great concern by enuretic children and their parents (Haque et al., 1981). Moreover, little is known about the attitudes of parents towards enuresis, although such information could help health professionals to deal with the problem effectively (Haque et al, 1981).

Folk perspective on psychopathology may differ from those of formal professional diagnosis in terms of etiology and management. One study of cross-cultural indicators of help seeking behaviour with a Zulu aggressive sample in general hospital patients indicated that symptoms serving the family as the most

common indicator of mental disorder requiring treatment are not the ones commonly diagnosed from the Western perspective (Schlebusch, Wessels & Razdkowosky,1990). This phenomenon warrants special attention in research on child psychopathology, for child psychopathology should be seen as both the actual behaviour and the lens through which adults in the society view that behaviour (Weisz et al., 1988).

In contrast to adults, children rarely instigate a referral or seek help from clinical services. Instead parents, teachers and mental health professionals play these roles in serving, in effect, as gatekeepers to child mental health care (Weisz et al., 1988; Verhulst & Akkerhust, 1989). It is mostly parents who seem faced with fears and desperation of children they perceive as failing to develop normally, behaving deviantly or suffering emotionally. It is also parents who mostly seek advice, support and techniques to resolve their child's difficulties (Butler, 1987).

During the 1992/3 period of practical training for Clinical Psychology at Ipelegeng Child and Family Centre in Mafikeng, Weskopies hospital and Kalafong hospital in Pretoria, the present researcher observed

that black parents of different ethnic groups referring their enuretic children for other psychological problems tended to lack concern for their children's enuresis. The present study was therefore an attempt to explore how enuresis is perceived among black South African mothers. To address the issue, one must first ask what problems and questions parents want answered (Mesibove, Schroeder & Wesson, 1977).

To provide mental health services in Southern Africa, mental health specialists need to understand their patients' explanatory health model regarding symptomatology , etiology and treatment, and should compare their models with those of their patients (Schlebusch et al., 1990).

In order to deal with the problem of enuresis, clinics for enuresis in America have moved from the position where they were solely staffed by medical officers operating purely on pragmatic lines, to a position where a multidisciplinary team established a more rigorous and systematic treatment regime that has yielded satisfactory results (Street & Broughton, 1990).

1.4 OBJECTIVES OF THE STUDY

1.4.1 To determine the maternal perception and tolerance for nocturnal enuresis.

1.4.2 To determine whether maternal educational level influences maternal tolerance for nocturnal enuresis.

1.4.3 To determine whether maternal educational level influences maternal concerns about the negative consequences of nocturnal enuresis.

1.4.4 To determine whether maternal tolerance for nocturnal enuresis influences mothers to seek psychological treatment for their nocturnal enuretic children.

CHAPTER 2

2.1 LITERATURE REVIEW

2.1 ETIOLOGICAL THEORIES OF ENURESIS

Enuresis was initially recognized as a medical problem by Egyptians in 1550 B. C. Since then, it has been attributed to a variety of unverified causes such as internal parasite, laziness, dreams, deep sleep, weak bladder, acidic urine, excessive secretion of urine, and allergy (Glicklich, 1951). The origin of nocturnal enuresis is multifactorial. There are numerous theories about the underlying causes of enuresis, yet none has been conclusively proven (Schaefer, 1979; Herbert, 1991).

2.1.1 PSYCHODYNAMIC THEORY

The psychodynamic theory considers enuresis necessarily to be a symptom of an underlying emotional disturbance (Lovinbond, 1964; Williams, 1974; Baller, 1975; Schaefer, 1979; Quay & Werry, 1986; Butler, 1987). Many of the specific symptom theories of enuresis take a form of highly speculative

interpretations based on psychoanalytic symbolism (Lovinbond, 1964; Butler, 1987). For example, enuresis represents an attempt to escape a masochistic situation and to expel outwards the destructive tendencies by way of considering urine to be a corrosive liquid and the penis as a dangerous weapon (Lovinbond, 1964).

The psychodynamic theorists explained enuresis in various ways such as: (a) A substitute form of gratification of repressed genital sexuality; (b) An indirect expression of deep-seated anxieties and fears; (c) A disguised form of hostility towards parents or parent substitutes which the victim does not dare to express openly; (d) A sign of emotional immaturity; (e) An attempt to show a need for parental attention and help (Lovinbond, 1967; Williams, 1974; Butler, 1987).

However, there is little support for this theoretical point of view. Although anxiety and depression have been linked with enuresis, the nature of the association is unclear (Schaefer, 1979). Evidence to date indicates that the majority of enuretic children are not emotionally disturbed (Schaefer, 1979; Bollard

& Nettelbeck, 1989). The research community has generally abandoned psychodynamic speculations that enuresis is an outward manifestation of some underlying conflict (Friman & Warzak, 1990; Houts, 1991).

2.1.2 PHYSIOLOGICAL THEORY

The physiological theory views enuresis as resulting from failure to develop cortical control over subcortical micturition reflex mechanisms (Schartz & Johnson, 1985; Bollard & Nettelbeck, 1989). The theory posits that enuresis results from the immaturity of neurophysiological structures responsible for bladder control. It emphasises abnormalities and dysfunctions of the urinary tract or nervous system as the cause of enuresis (Williams, 1974; Bollard & Nettelbeck, 1989).

This view precludes a diagnosis of functional enuresis (Lovinbond, 1964; Kaplan & Sadock, 1988). Yet parents tend to view enuresis from a physiological perspective (Butler, 1987). Although an organic etiology precludes a diagnosis of functional enuresis, Kaplan and Sadock (1988) suggest that the correction of an anatomical defect does not always cure enuresis. Thus etiology

may still be functional in these cases. Possible organic causes such as genito-urinary pathology must therefore be ruled out.

(i) ORGANIC FACTORS

According to Steinhauer and Rea-Grant (1977) physiological mechanisms are more likely to contribute to continuous enuresis while intermittent enuresis is almost invariably of psychogenic origin. While diurnal enuresis does occur and fits the definition of functional enuresis, nocturnal enuresis is far more frequent and common. Diurnal enuresis rarely occurs in the absence of nocturnal enuresis (Knopf, 1984).

According to Jarvalin, Morlanen, Vikevainen-Tervonen and Huttunen (1990) diurnal enuresis is associated more often with organic urological or neurological abnormalities, or with urinary tract infections, with less importance of environmental factors in the etiology. However, Norgaard Ritting and Djurhuus' (1989) study of 31 mono-symptomatic (diurnal and nocturnal) enuretics found that nocturnal enuretic episodes are urodynamically normal and similar to diurnal voiding. This suggests that mono-symptomatic

(either diurnal or nocturnal) enuresis is not caused by a functional neurogenic bladder problem.

Years of routine investigation of mono-symptomatic enuresis with intensive techniques such as cystoscopy and intravenous pyelogram failed to show organic abnormalities. Therefore, the Committee on Radiology of the American Academy of Paediatrics issued guidelines to discourage physicians from performing such diagnostic tests on mono-symptomatic enuretics (American Academy of Paediatrics [AAP], 1980; Houts, 1991).

Accordingly, it is recommended that all cases of enuresis be investigated by routine examination, that is, urinalysis and bacterial culture. Herskowitz and Rosman (1982) describe standard urinalysis as a qualitative analysis of glucose and measurement of specific gravity. Additional examination may be warranted only if abnormalities are detected from history and routine examination (AAP,1980; Herkowitz & Rosman, 1982). The first doctor, not necessarily a specialist in urology, can in effect, eliminate enough of the potentials for physical disease (Rowan, 1974).

(ii) GENETICS

The incidence of enuresis is related directly to the closeness of the genetic relationship (Kaplan & Sadock, 1988; Bollard & Nettelbeck, 1989). This is supported by Bakwin (1973) study of the genetics of enuresis. The study found a concordance rate of 68 percent for monozygotic twins and 36 percent for dizygotic twins.

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Thus family history is the most consistently supported etiological variable (Friman & Warzak, 1990). However, Hallgren (1960) argues that simple genetic models are not likely to explain the patten of positive family history. In his study of the genetics of enuresis, Hallgren (1960) found that the concordance rates of enuresis were higher in dizygotic twins than in monozygotic twins, a finding which cannot be explained by a genetic model.

Kaffman and Elizurs' (1977) study of 161 Kibbutz children who became enuretic, suggests that families transmit tolerant attitudes towards nocturnal enuresis, and not "enuretic genes". It can be supposed that parents who suffered the problem of enuresis

during their childhood would be more accepting of it, and would be more likely to provide faulty toilet training to their youngsters. The confounding of genetic and environmental variables in studies of this sort makes it difficult to evaluate either set of conditions in identifying the etiology of enuresis (Houts, 1991).

(iii) SLEEP DYNAMICS

According to Whelan and Houts (1990) enuretic children have a sleep arousal problem. That is, compared to nonenuretic children, enuretic children sleep more soundly and are difficult to arouse. Friman and Warzak (1990) regard nocturnal enuresis as a parasomnia, that is, an undesirable behaviour which occurs exclusively during sleep or is exacerbated by sleep. According to Houts (1991) the hypotheses that conceptualized enuresis as caused by sleep abnormalities have been virtually eliminated by research conducted in the past decade. He contends that to call some behaviour a sleep disorder merely because they occur during sleep is uninformative when there is little evidence that abnormal sleep patterns produce the behaviour of interest.

The evidence as assessed by EEG studies have not revealed a reliable differences between the sleep patterns of enuretic and non-enuretic children, with both groups spending about the same time in various stages of sleep identified as reflecting relative depth of sleep (Norgaard et al. , 1989; Bollard & Nettelbeck, 1989). For example, in their review of 12 EEG studies, Mikkelsen, Rapport, Nee, & Gruneau (1980) showed that enuresis occurs at any stage of sleep and that there is no evidence of any abnormality in the EEG or sleep pattern.

(iv) THE PROBLEMS OF BLADDER CAPACITY

Enuresis may be associated with diminished functional bladder capacity. That is, the volume of urine a child can retain prior to the urgent need to void, in essence, a "small bladder" (Herkowitz & Rosman; 1982). Butler (1987) defines bladder capacity as the "point at which the volume of urine in the bladder initiates the urge to micturate", that is, a point at which bladder contractions begin (p. 15). According to Bollard and Nettelbeck (1989) nocturnal enuresis is the result of an under-developed functional bladder capacity. The small functional bladder capacity makes

it difficult for the child to retain all the urine produced throughout the night (Butler, 1987).

The hypothesis about the problems of bladder capacity states that enuretic children continue to wet their beds because their kidneys fail to concentrate urine during sleep. Failure to concentrate urine during sleep is due to the inadequate level of antidiuretic hormone (ADH) which results in nocturnal urine production that exceeds normal bladder capacity. Houts (1991) argues that bladder capacity is not a reliable discriminator between enuretics and non-enuretics. Instead, low bladder capacity is a correlate rather than a cause of nocturnal enuresis.

(v) MATURATIONAL LAG

The maturational lag theory posits that acquisition of dryness at night is slow in children whose maturation of the mechanisms involved in micturition is delayed (Butler, 1987). The higher incidence rate of enuresis in boys suggests a maturational lag. Boys generally have a slower rate of development than girls throughout childhood and adolescence (Friman & Warzak, 1990).

The maturational lag appears to be more anatomical or physical than intellectual, and its cardinal expression is a reduced bladder capacity. This is indicated by enuretic children, who despite the apparent maturational lag, have their scores on standardized intellectual tests at an average range (Friman & Warzak, 1990). The counter arguments to maturational lag alone as being responsible for nocturnal enuresis posits that enuretic children have occasional dry nights, an indication that maturation of the necessary mechanisms for micturition has occurred (Butler, 1987).

2.1.3 BEHAVIORAL THEORY

Similar to the physiological theories, behavioral theory attributes nocturnal enuresis to a failure to develop cortical control over subcortical reflex mechanisms (Bollard & Nettelbeck, 1989). However, instead of involving processes like neural maturation, under-developed functional bladder capacity or faulty arousal from sleep, behaviour theorists emphasize the role of learning in the development of processes necessary for achieving continence (Bollard & Nettelbeck, 1989; Houts, 1991).

Behaviour theorists explain nocturnal enuresis from a habit deficiency theory's point of view. The theory posits that normal toilet training teaches the child an awakening response to bladder stimulation. Enuresis therefore results when learning does not occur. It results from a failure to develop necessary conditioned reflexes (Williams, 1974). Thus enuresis is an incorrect habit which results from inefficient toilet training and becomes fixated as a consequence of the atmosphere of anxiety and frustration it engenders (Lovibond, 1964).

Explanations that emphasize inadequate learning seem to be less compelling for behaviour of children displaying secondary enuresis. Psychosocial stressors appear to account for some causes of secondary enuresis. These stressors interfere with the development and maintenance of dryness (Schartz & Johnson, 1985; Kaplan & Sadock, 1988).

Coercive training by parents, with punishment and threats for wetting, makes it difficult for the child to acquire control and would thus produce a reversion to wetting (Schartz & Johnson, 1985; Graham, 1986; Meyer & Salmon, 1988). Premature efforts to pressurize

and to toilet train the child may result in loss of self confidence. The child might become anxious and experience difficulty staying dry at night (Butler, 1987).

Behaviour theorists posit that behaviour brought about by application of learning and conditioning principles may affect the physiological mechanisms involved (Houts, 1990). Behaviour techniques, with urine alarm as the most effective, are regarded as the most effective methods of treating enuresis (Friman & Warzak, 1990; Houts, 1991; Herbert, 1991). If medication is to be used, at present imipramine is the drug of choice (Steinhauer & Rue-Grant, 1977; Kaplan & Sadock, 1988, Houts, 1991).

2.2 FACTORS THAT INFLUENCE HELP SEEKING BEHAVIOUR

2.2.1 THE THRESHOLD MODEL OF CULTURAL INFLUENCE

The threshold model of cultural influence "holds that culture helps to set adult threshold for distress over child problems, thus determining whether such problems are considered serious and what action will be taken in response to them" (Lambert et al., 1990, p. 146).

The model has two forms, the general and pattern-specific forms. A general form of the model holds that cultures may differ in their thresholds for child problems. A pattern-specific form of the model holds that cultures may differ with respect to behaviour type, with certain types of child problem behaviour arousing greater concern in some cultures than in others (Weisz et al., 1988).

Cultures have their own means of identifying those who are disordered in order to afford them treatment (Schlebusch et al., 1990). Judgement about whether a particular behaviour pattern represents a serious problem or pathology may be shaped by the cultural context in which the behaviour occurs (Weisz et al., 1988).

In the study of adult attitude towards child's problems amongst the Thai and American samples, Weisz et al. (1988) concluded that prevailing social values may help set adult thresholds for concern over children's problems. The study explored the threshold model with regard to perspectives on over- and under-controlled behaviour. The results indicated that Thai adults expressed less concern than Americans about how

serious, unusual and worrisome over- and under-controlled problems are.

A similar study by Lambert et al. (1992) on Jamaican and American adult perspective on child psychopathology found that Jamaican and American adults perceive behaviour differently. Jamaican adults were more tolerant of behavioral problems in their youngsters as compared to their American counterparts. Such tolerance is based on the Jamaican adult's attitude that maladaptive behaviour reflects a transient and not ingrained personality state. The highly educated, in both groups, expressed more worry and a higher level of perceived seriousness about the child's problem. Thus educational level may modify the impact of culture on adult's attitudes.

The findings from these studies suggest that cultures and adult groups within them may differ in their thresholds for child's problems in general. The findings further indicate that problems of clinic-referred children may reflect tolerance thresholds of referring adults. Thus threshold may be affected by the socio-cultural arena in which the child's problems occur (Weisz et al., 1988; Lambert et al., 1992).

According to Bollard and Nettelbeck (1989) cultural expectations about the development of continence vary widely. The problem of enuresis as indicated by numbers of parents seeking treatment for their children appear to be more prevalent in the United States of America and Australia than in the United Kingdom and Sweden. In South Africa, cultural and racial factors have influenced the cause, definition and treatment of psychopathology. Yet literature on black psychopathology is scarce (Gobodo, 1990).

2.2.2 THE ATTRIBUTION THEORY OF EMOTION AND HELP GIVING

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The attribution theory is concerned about how people try to find appropriate causal explanations for one another's behaviour (Butler et al., 1986; Elser, 1986; Jones, 1990). Butler (1987) identifies four dimensions of attributional causes of enuresis. They are:

(a) Internal/external dimension: The degree to which the cause of enuresis has something to do with the child or external circumstances.

(b) Stable/unstable dimension: The degree to which the cause of enuresis is long lasting or temporary.

(c) Global/specific dimension: The degree to which the

cause of enuresis affect other areas of the child's life or is specific to enuresis.

(d) Controllable/uncontrollable dimension: The degree to which the child is perceived as having control over enuresis or not.

Butler (1987) states that controllability and external/internal dimensions are the only ones relevant to maternal perceptions of enuresis. The interaction of these dimensions of causality influences judgement of help seeking and presumably help giving.

According to the attribution theory of emotion and help giving, person A is more likely to offer help to person B if person A perceives person B as not responsible or unable to control their situation. Attribution theory therefore mediates help giving (Weiner, 1980). A person who is in trouble through no fault of his own is likely to evoke pity, whereas a person who is perceived as in difficulty because of factors over which he has some control tends to evoke anger (Butler et al., 1986).

The perception of personal control is negatively

related to a feeling of sympathy, positively related to a feeling of disgust, and negatively related to a feeling of help. Ascriptions to internal controllable factors maximize affect (disgust and anger) and promote parents' avoidance of help giving or help seeking (Weiner, 1980).

Help giving/seeking is determined by attribution, tolerance/intolerance and concern or worry about the negative consequences of a behaviour (Weiner, 1980). Butler et al. (1986) illustrates maternal attributional account of intolerance of nocturnal enuresis as follows:

(a) Mothers search for the most likely explanations of their child's enuresis. (b) They make the attributions (particularly in older children) to causes which the child has some control over. (c) They become angry. (d) They are unwilling to seek help or to invest their time and energy in determining treatment program and withdraw prematurely from treatment.

This example indicates that when sympathy or disgust (tolerance) is held constant, the correlation between personal control and

judgement of help is no longer significant. Sympathy

correlate positively and disgust negatively with help ratings (Weiner, 1980). Thus the problems of clinic referred children reflect tolerance thresholds for referring adults (Lambert et al., 1992).

2.3 NOCTURNAL ENURESIS: THE MATERNAL PERSPECTIVE

The bulk of research on enuresis has focused on questions of etiology and treatment. Limited focus is given to maternal perceptions. Maternal perceptions can help to examine the relationship between scientific notions and maternal theories of enuresis (Haque et al., 1981).

According to Butler (1987) mothers have realistic expectations over when their children will achieve night time dryness. When these expectations are not fulfilled and enuresis persists beyond five years of age, feelings of guilt and failure as a parent may appear, and mothers may develop ideas and explanations to account for this (Schaefer, 1979). The following are the areas of maternal construing about nocturnal enuresis.

(i) BELIEFS AS TO CAUSES

According to Butler (1987) there are predominantly the following maternal beliefs as to causes of nocturnal enuresis:

(a) Heavy or deep sleep: The belief is based on the notion of irascibility. That is nocturnal enuretic children find it difficult to awaken and are harder to arouse from sleep.

(b) Emotional cause: Mothers believe that being prone to worry, easily upset and lacking confidence can cause enuresis

(c) Failure to learn bladder control.

(d) Family history: Some parents remember having the same problem in their own childhood and attribute their children's enuresis to familial vulnerability.

(e) The child is not bothered: This suggest that mothers construe the child as accepting of the enuresis and lacking motivation to become dry.

(f) The child drinks too much fluid before bed time.

(g) The child is afraid of the dark: Nocturnal enuresis is attributed to fear of dark and monsters at night, such that the child is afraid to leave the bedroom and go to use the toilet.

(h) Excretion of large amounts of urine at night.

(i) Weak bladder.

(j) Allergy.

Butler (1987) suggests that mothers firmly believe that heavy sleeping is the major cause of nocturnal enuresis. Haque et al. (1981) studied parental perceptions of enuresis in nine American medical centres amongst parents of enuretic and non-enuretic children. The findings showed that parents attributed enuresis primarily to heavy sleeping and then emotional causes. The educational level of mothers was found to be unrelated to reported causes.

Similar results were obtained by Butler et al. (1986) in their study of maternal attribution and tolerance for nocturnal enuresis with a British sample. Mothers endorsed being a heavy sleeper as the cause of enuresis. Blaming the child was found to be an infrequent response.

Although the British results (Butler et al., 1986) support the American results (Haque et al., 1981), differences concerning the attributional causes of nocturnal enuresis do occur. This is indicated by the Abromovitch and Abromovitch (1988) study of Israeli

sample mentioned in 1.1 above. The findings indicated that 63 percent of Israeli women attributed enuresis to physiological factors when discussing children of their own. Differences emerged when they discussed nocturnal enuresis in general. The Kurdish group was consistent in attributing nocturnal enuresis to physiological causes. The Ashkenazi and Moroccans were more likely to attribute nocturnal enuresis to physiological causes when discussing children of their own, and emotional causes when discussing children of others. The Ashkenazi mothers strongly felt that there was a familial tendency for enuresis.

Regarding the attributional causes, the British sample (Butler, et al., 1986) perceived the causes of nocturnal enuresis as internal and controllable. The exception to this tendency occurred when mothers considered the attributional causes in girls. In this regard, and when nocturnal enuresis is considered to be caused by anxiety, external attributions were made.

(ii) MATERNAL CONCERNS

Butler (1987) identifies the following areas of maternal concerns about the negative consequences of

nocturnal enuresis:

(a) Emotional well-being of the child: The concern is about the shame, embarrassment and lowered self-esteem a child experiences when he wets the bed.

(b) Social relations: The shame and embarrassment may lead to shyness and withdrawal from others. Enuretic children are prevented from many social activities such as going on school trips and sleeping over night at a friend's house. This may affect friendship and development of social relationships.

(c) Financial aspects: such as cost of buying detergents and new sheets/blankets to replace the rotten ones.

(d) Extra washing.

(e) Smell (urine odour).

Mothers of enuretic children are mostly concerned about the emotional and social well-being of their children (Butler et al., 1986). A study by Haque et al. (1981) suggests that mothers with less education are more worried and troubled about the negative consequences of nocturnal enuresis than those with more education, especially with regard to changing sheets and the smell. Butler, Brewin and Forthythe (1988) indicate that greater concern over enuresis,

and causal attributions to less stable and uncontrollable factors is associated with superior treatment outcome.

(iii) MATERNAL TOLERANCE

Morgan and Young (1975) developed a Tolerance Scale to measure maternal tolerance/intolerance about nocturnal enuresis. Using the scale, Butler et al. (1986) found that there is a strong association between intolerance and maternal anger and annoyance at nocturnal enuresis. Maternal intolerance of nocturnal enuresis is associated with maternal perceptions of enuresis as being controllable by the child. For example intolerance occurs when nocturnal enuresis is attributed to laziness and the child getting back at the mother.

The amount of discomfort about enuresis that parents encounter is related to their educational level. Haque et al. (1981) found that highly educated parents had greater discomfort, especially when they considered changing sheets and the smell. Amongst the Israeli mothers, Abromovitch & Abrmovitch (1988) found that there were more feelings of anger and impatience

towards the enuretic child in the Ashkenazi mothers as compared to the Moroccans and Kurdish mothers.

(iv) **BELIEFS AS TO MANAGEMENT**

According to Haque et al. (1981) waking the child to urinate is the most common strategy amongst the American parents of enuretic children. Amongst the three Israeli ethnic groups, Abromovitch and Abromovitch (1988) found that the Moroccans and the Kurdish mothers tended to believe that enuresis will resolve on its own without outside intervention. The Moroccans claimed that they might seek help from a physician or folk healer but not from a relative or family member. The Ashkenazi women spoke of turning to a physician or psychologist but not a folk healer or family member. The Kurds stated that they would consult a physician, psychologist or a family member but not a folk healer. This indicates that although these three ethic groups are all of Eastern European descent, they tend to differ in their perceptions of enuresis.

For the American sample, Haque et al. (1981) found that failure of parents to seek help from physicians

at any time in the past, was due to lack of confidence in the physicians. Parents perceived physicians as uninterested in dealing with the problem of enuresis. Educational level of parents was found to be unrelated to reported methods of treatment (Haque et al., 1981).

2.2 HYPOTHESES FOR THE STUDY

The maternal perception of nocturnal enuresis as controllable by the child influences maternal feelings of intolerance (Butler et al., 1986). The theory of emotion and help giving postulates that when sympathy or disgust (tolerance) is held constant, the correlation between personal control and judgement of help is no longer significant (Weiner, 1980). Thus tolerance influences help giving.

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The threshold model states that problems of clinic referred children reflect tolerance threshold for referring adults (Lambert et al., 1992). Literature (see 2.2 & 2.3.) suggests that maternal educational level influences maternal tolerance and maternal concern about the negative consequences of nocturnal enuresis. Based on the above rationale, the following hypotheses are considered for testing:

2.2.1 Mothers who perceive the cause of their children's nocturnal enuresis to be controllable by the child would be more likely to be intolerant for nocturnal enuresis than mothers who percieve it as uncontrollable.

2.2.3 Maternal educational level influences maternal concern about the negative consequences of nocturnal enuresis.

2.2.3 Maternal educational level influences maternal tolerance for nocturnal enuresis.

2.2.4 Mothers who are tolerant of their children's nocturnal enuresis would be more likely to consider seeking psychological treatment for their nocturnal enuretic children than mothers who are intolerant.

2.4 OPERATIONAL DEFINITION OF TERMS

(i) ENURESIS

Enuresis in this study implies functional enuresis as

defined in DSM-III-R. The DSM-III-R offers the following specific diagnostic criteria of functional enuresis:

"A. Repeated voiding of urine during the day or night into bed or clothes whether involuntary or intentional.

B. At least two such events per month for children between the ages of five and six, and at least one event per month for older children.

C. Chronologic age at least five, and mental age at least four.

D. Not due to a physical disorder, such as diabetes, urinary tract infection, or a seizure disorder.

Specify primary or secondary type.

Primary type: the disturbance was not preceded by a period of urinary continence lasting at least one year.

Secondary type: the disturbance was preceded by a period of urinary continence lasting at least one year.

Specify nocturnal only, diurnal only, or nocturnal and diurnal" (APA, 1987, P.85).

(ii) NOCTURNAL ENURESIS

Nocturnal enuresis refers to functional enuresis of nocturnal (night-time) variety. It can be of either primary or secondary type, or a combination of both.

(iii) PERCEPTION

Perception in this study implies ways of maternal construing of their children's nocturnal enuresis. It involves maternal explanations of nocturnal enuresis with regard to beliefs as to causes, attribution, and management of nocturnal enuresis; concern about the negative consequences of nocturnal enuresis; and tolerance for nocturnal enuresis.

(iv) MOTHER

A mother is a female parent or a female primary care giver to the child with nocturnal enuresis.

(v) TOLERANCE

Tolerance refers to a dimension of maternal feelings of disgust and anger (intolerant) or maternal feelings

of sympathy and understanding (tolerant) in their children with nocturnal enuresis, as measured by Morgan and Young (1975) tolerance scale for nocturnal enuresis.

(vi) CONCERN

Concern in this study refers to maternal worry about the negative consequences of nocturnal enuresis either to themselves or their nocturnal enuretic children, or a combination of both. The levels of concern involved are the child's social relationship, emotional impact to the enuretic child, smell, extra washing and financial aspects. The level of concern was categorised in terms of "worried", "neutral" and "not worried" dimensions.

(vii) PSYCHOLOGICAL TREATMENT

Psychological treatment implies psychotherapy. Wolberg (1988) defines psychotherapy as "the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with object of (1) removing,

modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behaviours and (3) promoting positive personality growth and development" (p.3).

(viii) TO SEEK PSYCHOLOGICAL TREATMENT

To seek psychological treatment in this study implies a way of regarding or considering to consult a psychologist who offers psychological treatment

(ix) EDUCATIONAL LEVEL

Educational level in this study implies the highest level of education attained by the mother. Levels of education are classified as follows:

(a) No schooling, this implies lack of formal education.

(b) Primary education, which ranges from grade one to standard five

(c) Secondary education, which ranges from standard six to standard ten.

(d) Tertiary education, which refers to attainment or/being in the process of obtaining a degree or a diploma in a tertiary institution.

(e) Post primary educational level, it comprises of both secondary and tertiary educational levels.

CHAPTER 3

METHODOLOGY

3.1 RESEARCH SUBJECTS

A convenient sampling procedure was used to select subjects at Bophelong community hospital located in Mafikeng, North West Province, South Africa. Mothers of enuretic children with organic disorders as possible causes of nocturnal enuresis were not included in the study. The subjects had to meet the following criteria for inclusion in the study:

(a) Mothers who have a child with nocturnal enuresis of either primary or secondary type.

(b) Nocturnal enuresis has to meet the DSM-III-R diagnostic criteria.

(c) Mothers have to speak Setswana as their first language (mother tongue).

A total number of 51 subjects were selected.

3.2 RESEARCH INSTRUMENT

The complete questionnaire is presented in appendix A (an original English version) and appendix B (a translated Setswana version).

A cover note preceded the questionnaire. The aim of this note was to request the subjects for participation, explain the purpose of the study, give guide lines as to who should, and how to complete the questionnaire as well as to emphasize the confidentiality of the information gathered.

Except for the biographical information which needed to be filled in, subjects indicated their responses to the items by marking "YES", "NOT SURE", or "NO".

(i) BIOGRAPHICAL INFORMATION

The biographical information section requested the subjects to fill in six items. Items 2, 3 and 5 were included specifically to make sure that only the responses of subjects who met the criteria for inclusion in the study were considered. The other items were included to provide relevant information in the interpretation of the data.

(ii) MATERNAL QUESTIONNAIRE ON NOCTURNAL ENURESIS

This has been described by Butler et al. (1986) and comprised of:

(a) Section A: Sixteen items concerning beliefs as to the perceived causes of nocturnal enuresis. The researcher added items 17 and 18 to make the study relevant to the South African context. The two items aimed at measuring African beliefs in regard to causes of illness. They explored whether the mothers believed nocturnal enuresis is caused by witchcraft and possession by ancestral spirits.

(b) Section B: Four items rating the cause of enuresis on attributional dimensions of controllability, internality, stability and global.

(c) Section C: Five items assessing maternal concern along the following dimensions: extra washing, additional cost incurred by having a bed wetting child, smell, emotional effect on the child and the effect on the child's social relationships.

(e) Section E: Management strategies for nocturnal enuresis.

Masibove, Schroeder and Wesson (1977) used the items contained in the scale developed by Butler et al.

(1986) to measure maternal beliefs about enuresis in their study of maternal concerns about their children. Haque et al. (1981) also used similar items contained in the scale for their collaborative study of maternal perception of enuresis in nine American medical centres. The scale as used by Haque et al. (1981) included the maternal views as to management of enuresis.

Butler et al.'s (1986) scale was chosen for the present study because it is descriptive and has been substantiated empirically. It is regarded by Butler et al. (1986) as a comprehensive, sensitive and accurate measure of maternal perception of nocturnal enuresis. However, no information regarding the validity and reliability of the scale could be obtained.

(iii) TOLERANCE SCALE

The scale was developed by Morgan and Young (1975). The scale measures maternal feelings about nocturnal enuresis on a dimension of tolerant\intolerant. It is regarded as an accurate, and sensitive measure of maternal tolerance about nocturnal enuresis. The scale also has a predictive value of treatment outcome for

nocturnal enuresis. Mothers who are tolerant for nocturnal enuresis are more likely to persevere with treatment (Butler, Brewin & Forsythe, 1990). No information regarding reliability and validity of the scale could be obtained.

Items in this section appear in alternate form for tolerance and intolerance. That is a "YES" to item 1 implies being tolerant and a "NO" implies being intolerant. While a "YES" to item 2 implies being intolerant and a "NO" implies being tolerant. Thus tolerance\intolerance is measure alternatively up to the last item. The tolerance scale appears in section D of the questionnaire.

3.3 RESEARCH PROCESS

The first step in the research process was to compile a questionnaire to collect the required data for the present study.

Secondly it was decided before hand that the researcher would approach the superintendent of Bophelong hospital to ask for permission to obtain the research subjects in the hospital. The superintendent

referred the researcher to the Department of Health and Social services in Mmabatho, where permission was finally obtained. The permission allowed the researcher to liaise with the hospital personnel for the purpose of identifying mothers with enuretic children. Permission was also requested from the research subjects verbally and in a written form (see cover letter of the questionnaire). The verbal requests were based on the written request in the cover letter of the questionnaire.

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The research subjects were selected from the hospital's Child Out-Patient Department (COPD) as they bring their children for any form of treatment (not necessarily treatment for nocturnal enuresis). The medical practitioners helped to rule out organic disorders as the possible cause of nocturnal enuresis in children (see 2.1.2 (i) above).

The subjects had a choice of responding either to the English version or the translated Setswana version questionnaires. A structured interview based on the questionnaire was conducted to assist the subjects who had difficulty in responding to a questionnaire in writing because of such problems as illiteracy. Thus

subjects responded either verbally or in writing.

The third step in the research process involved the analysis of data, which will be presented in the next chapter.

3.5 THE DATA ANALYSIS PROCEDURE

The procedure involved coding, capturing of data and checking it to ensure accuracy.

There were only two respondents with tertiary education. To enable meaningful interpretation of data, subjects with secondary and those with tertiary eduction were treated together as post primary education subjects.

Basic descriptive statistics were calculated first. Then tests of associations in contingency tables were used for statistical analysis. The first table was the observed contingency table where the entries were the mean responses. The second table consisted of expected frequencies, that is, a product of the total of raw and total of column divided by the grand total. The two tables were used to calculate the Chi square

statistics which were then compared to a tabled Chi square values to indicate any significant association.

CHAPTER 4

RESULTS

4.1 PARTICIPANTS' EDUCATIONAL LEVEL

The educational level of mothers who participated in the study is shown in Table 1. The data showed that 19.6 percent of mothers had no formal education (no schooling), 37.3 percent obtained primary education and 43.1 percent have post primary education.

TABLE 1

Maternal Educational Level

Educational level	%	
No schooling	19.6	(n=10)
Primary education	37.3	(n=19)
Secondary education	39.2	(n=20)
Tertiary education	3.9	(n=2)

N=51

4.2 PARTICIPANTS' NOCTURNAL ENURETIC CHILDREN

Maternal responses in the present study were based on mothers of children with nocturnal enuresis. The data showed that 49 percent of the children were girls and 51 percent were boys.

Table 2 summarizes the ages of children with nocturnal enuresis whose mothers participated in the study. A quarter of the children were between the ages of 13 and 18 years. The age group 11 to 12 years were also a quarter. There were 16 percent of mothers with enuretic children between 9 and 10 years.

TABLE 2

Ages of children with nocturnal enuresis

Years	%
5-6	17.6 (n=9)
7-8	17.6 (n=9)
9-10	15.7 (n=8)
11-12	23.5 (n=12)
13-18	25.5 (n=13)

N=51

4.3 PARTICIPANTS' ANTICIPATED AGE OF DRYNESS FOR THEIR NOCTURNAL ENURETIC CHILDREN

Table 3 indicates percentages of the age at which respondents expected their nocturnal enuretic children to be dry. According to the data most mothers (84.3%) were not sure of the age at which their children should be dry. Only 5.9 percent of mothers expected their children to be dry between the age of five and six years. That is the age at which DSM-III-R defines the beginning of enuresis.

TABLE 3

The age at which mothers expect their nocturnal enuretic children to be dry

Expected age of dryness	% of respondents
Not sure	84.3 (n=43)
5-6	5.9 (n=3)
7-8	3.9 (n=2)
9-10	2.0 (n=1)
11-12	3.9 (n=2)
13-18	0.0 (n=0)
Total	100.00

4.4 MATERNAL PERCEPTIONS OF THE CAUSES OF NOCTURNAL ENURESIS

The data about maternal causal perception and attribution of nocturnal enuresis is summarized in Table 4. The data indicates that heavy sleeping was the most (76.5%) frequently reported cause of nocturnal enuresis. The other most common causes reported by mothers were temperature at night (72.5%) and no bladder control (68.6%). Twenty three percent of the respondents believed that nocturnal enuresis was related to genetics (family history). Only 1.9 percent of mothers believed that nocturnal enuresis was caused by a child getting back at mother, physical problem or being possessed by ancestral spirits. None of the mothers attributed nocturnal enuresis to witchcraft.

Data about the attributional dimensions indicate that the cause of nocturnal enuresis was usually perceived as global (86.3%) and uncontrollable (54.9%). Almost 10 percent expressed external attributions to their children's nocturnal enuresis and 5.9 percent attributed the cause of nocturnal enuresis to something to do with the child (internal attribution).

TABLE 4

Maternal perceptions of causes of nocturnal enuresis

Beliefs as to causes	%
Heavy sleeper	76.5
Too cold at night	72.5
No bladder control yet	68.6
Easily upset	45.1
Afraid of the dark	33.3
Lazy	31.4
Drinks too much fluid	25.5
Family history	23.3
Goes to bed too late	15.7
Lacks confidence	15.7
Inadequate toilet training	11.8
Won't do as is told	9.8
Possessed by ancestral spirits	1.9
Physical problem	1.9
Getting back at mother	1.9
Has been bewitched	0.0
Worrier	0.0
Not bothered about it	0.0

Table 4 continued:

Maternal Perception of Nocturnal Enuresis

Attributional causes	%
Global	86.3
Controllable	9.8
External	9.8
Unstable	7.8
Internal	5.9

4.5 MATERNAL CONCERNS ABOUT THE NEGATIVE CONSEQUENCES OF NOCTURNAL ENURESIS

Level of agreement by mothers with five areas of concern about nocturnal enuresis and its associated effects is shown in Table 5. Most concern was expressed about extra washing (94.1%), financial burden (92.2%) and the impact of nocturnal enuresis on the child's emotional development (82.4%). Eighty percent of the respondents expressed concern about the smell. Lastly, 62.7% of the respondents expressed concern about the impact of nocturnal enuresis on the child's social relationships.

TABLE 5

Maternal Concern about the negative consequences of Nocturnal Enuresis

Concern	% of respondents
Extra washing	94.1
Financial aspects	92.2
Emotional well-being	82.4
Smell	80.4
Social relationship	62.7

Table 6 summarizes data about the relationship between maternal educational level and maternal concern about the negative consequences of nocturnal enuresis. More than three quarters of respondents (78.4%) expressed concern while 21.6 percent were not concerned about the negative consequences of their children's nocturnal enuresis. Mothers expressed concern according to their educational level as follows:
No schooling: 80% (n=10), primary education: 84.2% (n=19) and post primary education: 72.7% (n=22).

Analysis of the data using Chi-square statistics showed that educational level made no significant difference in maternal concern about the negative consequences of nocturnal enuresis. The hypothesis that maternal educational level influences maternal concern about the negative consequences of nocturnal enuresis was therefore not supported.

TABLE 6

The relationship between maternal educational level and maternal Concern about the negative consequences of nocturnal enuresis

	Maternal concern		
Educational level	Worried	Neutral	Not Worried
No Schooling	8	0	2
Primary education	16	0	3
Post primary ed.	16	0	6
Total	40	0	11

4.6 MATERNAL TOLERANCE FOR NOCTURNAL ENURESIS

The data indicate that 56.9 percent of respondents were intolerant of nocturnal enuresis, 33.3 percent were tolerant and 9.8 percent were neutral to the items that measured tolerance for nocturnal enuresis.

Table 7 summarizes information about the relationship between maternal tolerance for nocturnal enuresis and maternal educational level. Sixty percent (n=10) of respondents without any formal education expressed intolerance, while 68.4 percent (n=19) of respondents with primary education expressed intolerance.

The data was analyzed using Chi square statistics and the results showed that there was no significant difference in maternal tolerance for nocturnal enuresis among respondents of different educational levels. The hypothesis that maternal educational level influences their tolerance for nocturnal enuresis was therefore not supported by the data.

TABLE 7

The relationship between maternal educational level and maternal tolerance for nocturnal enuresis.

	Tolerance		
Educational level	Tolerant	Neutral	intolerant
No schooling	3	1	6
Primary education	7	2	10
Post Primary ed.	6	2	12
Total	17	5	29

Data about the relationship between maternal perception of nocturnal enuresis as controllable by the child and maternal tolerance for nocturnal enuresis is summarized in Table 8. The attributional columns indicate that 54.9 percent of the respondents attributed the cause of nocturnal enuresis to uncontrollable factors, while 9.8 percent expressed controllable attributions. The percentage of controllable/tolerant and that of uncontrollable/tolerant column are very close, 40 percent and 36 percent respectively. The Chi-square statistics was 0.97. There was therefore no significant difference in maternal tolerance for nocturnal enuresis between respondents who perceived it as controllable and those who considered it to be uncontrollable.

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The hypothesis that mothers who perceive the cause of their children's nocturnal enuresis as controllable by the child are likely to be tolerant for nocturnal enuresis was therefore not supported by the data.

TABLE 8

The relationship between maternal attribution of nocturnal enuresis as controllable by the child and maternal tolerance for nocturnal enuresis.

	Attribution		
Tolerance	Controllable	Uncertain	Uncontrollable
Tolerant	2	5	10
Neutral	0	2	2
Intolerant	3	11	16
Total	5	17	28

Table 9 summarizes the data about the relationship between maternal tolerance for nocturnal enuresis and maternal consideration to seek psychological treatment. More than half of respondents (52.9%) expressed that they would seek psychological treatment for their enuretic children, 45.1 percent were uncertain about seeking psychological treatment and 2 percent indicated that they would not consult a psychologist. For those who indicated that they would seek psychological treatment, 81.1 percent (n = 19) expressed intolerance for nocturnal enuresis, while 51.4 percent (n = 17) were tolerant. For those who indicated that they would not seek psychological treatment, 5.9 percent (n = 17) are tolerant and 5.3 percent (n = 19) are intolerant.

The analysis of data analysis using Chi-square statistics indicated that there was no significant difference in maternal seeking psychological treatment between respondents who were tolerant of enuresis and those who were intolerant. The hypothesis that mothers who are tolerant of their children's nocturnal enuresis are likely to consider seeking psychological treatment for their nocturnal enuretic children than those who are intolerant was therefore not supported by the data.

TABLE 9

The relationship between maternal tolerance for nocturnal enuresis and maternal consideration to seek psychological treatment for the nocturnal enuretic child.

	Seek psychological treatment			
Tolerance	Yes	Uncertain	No	Total
Tolerant	9	8	0.5	17.5
Neutral	3	2	0	5.0
Intolerant	15	13	0.5	28.5
Total	27	23	1	51

4.7 PERCEIVED METHODS OF TREATMENT FOR NOCTURNAL ENURESIS

Table 10 shows the variety of methods for dealing with nocturnal enuresis as mothers of nocturnal enuretic children. Waking the child, making the child aware of the problem and talking about the problem were mentioned as an effect treatment strategies by all the respondents. Other treatment strategies were consulting a physician (92%), a psychologist (54.9%), a traditional healer (23.5%), and a spiritual healer (5.9%). Twenty two percent indicated that they used home remedies. Fifty three percent indicated that they never tried anything. None of the respondents indicated that they ignored the problem.

TABLE 10

The Maternal perceived methods for treating nocturnal enuresis.

Treatment strategies	%
Make the child aware of the problem	100.0
Wake the child up to urinate	100.0
Talk to the child about the problem	100.0
Fluid restriction after dinner	98.0
Take child to physician	92.1
Punish for wet nights	64.7
Take child to psychologist	54.9
Never tried any thing	52.9
Wait for problem to get better on its own as time goes by	37.3
Take child to traditional healer	23.5
Give home remedies	21.6
Take child to spiritual healer	5.9
Ignore the problem	0.0

CHAPTER 5

DISCUSSION

The chapter deals with interpretation of the research results. Comparisons with findings by other researchers are made in the discussion. Limitations of the study are also discussed.

5.1 GENERAL DISCUSSION

Consistent with overseas studies mothers who participated in this study tended to attribute nocturnal enuresis to heavy sleep even though there is no consistent research evidence for this point of view (eg. Houts, 1991; Bollard & Nettelbeck, 1989; Norgaard et al. , 1989). Endorsing heavy sleeping, a physiological cause, might have been enhanced by the fact that mothers were responding about their own children.

This idea is supported by Abromovitch and Abromvitch (1988) study with the three Israeli ethnic group. The Kurdish group consistently attributed enuresis to physiological causes while the Ashkenazim and

Moroccans were more likely to attribute the cause of enuresis to psychological causes only when discussing children other than their own. This would appear to be an example of a common attribution error, whereby people over-attribute the behaviour of others to dispositional factors and underestimate the importance of situational factors (Ross, 1977).

Helplessness is also apparent in their tendency to make uncontrollable attribution for the disorder. Mothers who were critical to their children were very much in the minority, and were likely to attribute the cause of enuresis at least in part to laziness, going to bed too late and getting back at mother. As proposed by an attributional analysis of emotions and help giving, these factors are perceived as being controllable by the child,and are associated with intolerance (Butler et al. , 1986). Mothers in the present study attributed the cause of nocturnal enuresis to be uncontrollable by the child - this is associated with tolerance.

The results were, however, not statistically significant. Thus no significant relationship was found between maternal tolerance for nocturnal

enuresis and maternal perception of nocturnal enuresis as uncontrollable by the child in this study. The findings differ with those obtained by Butler et al. (1986) with the British sample where controllable dimension was found to be related to intolerance. The results raise the possibility that people of different background may tend to make causal attributions of nocturnal enuresis differently. According to Butler, Brewin and Forsythe (1988) greater concern over the enuresis, and attributions to less stable and uncontrollable factors is associated with superior treatment outcome. It might therefore be interesting to do a follow-up studies with the sample of the present study to find out if positive treatment outcome can be predicted.

One interesting finding in the present study was that mothers did not believe that nocturnal enuresis was caused by witchcraft. Also very few mothers believed that nocturnal enuresis was caused by possession with ancestral spirits. One can speculate that enuresis in children is seen by mothers as a developmental phase which each child has to go through thus not warranting to consider it as caused by ancestral spirits or witchcraft. Acculturation, especially towards cultures

from the western, might have also influenced mothers in this study to look at enuresis from the western perspective as seen by them indicating that they would consult a physician for their children's nocturnal enuresis.

Nocturnal enuresis in children is a frequent and upsetting problem for mothers, and one that causes discomfort. Most of the mothers were however not sure of when to expect dryness from their children. Very few mothers expected their children to be dry at about the time that the average child should actually achieve dryness - that is according to DSM-III-R. The results are discrepant with those obtained in Haque et al. (1981) study where American parents expected their children to be dry at the mean age of 3.18 years, though a conservative age of 4 years was used in the definition of "enuresis". It would seem thereof that the Batswana mothers are not concerned about the age at which their children should be dry, an indication of laxity in toilet training.

The findings about maternal concern show that mothers were very concerned about the negative consequences of

nocturnal enuresis. Their concern was more of the personal impact - that is financial aspects and extra washing - than the emotional well-being of the child. This finding differ with that obtained by Butler et al., (1986) with the British sample whose main concern was about the emotional and social wellbeing of their children. One may therefore speculate that lack of material resources led mothers in the present study to ignore their nocturnal enuretic children's emotional well-being.

Maternal concern about smell in this study should also not be overlooked. Their tendency to be concerned about the smell also may reflect the fact that the item didn't distinguish between negative consequences of the smell for the mother and for the child. The hypothesis that maternal educational level influences their concern about for the negative consequences for nocturnal enuresis was however not supported by the present study. This finding could be due to the fact that the sample was not representative enough with regard to their educational level, thus limiting valid comparison.

Another interesting finding of the present study was

that mothers expressed intolerance for nocturnal enuresis. They tended to attribute the cause of nocturnal enuresis to be uncontrollable by the child: Uncontrollable attribution is related to tolerance (Butler et al., 1986). Hence the hypothesis that mothers who perceive the cause of nocturnal enuresis to be uncontrollable by the child are more likely to be tolerant for nocturnal enuresis than those who perceive it to be controllable could not be supported by the data.

The relationship between maternal educational level and their tolerance for nocturnal enuresis could also not be supported the data obtained in the present study. Again, the sample limited any valid comparison with regard to the educational level variable. The results indicated that seeking psychological treatment was independent of tolerance for nocturnal enuresis. A finding that does not support the theory of emotion and help giving (see 2.2.2 above for the elaboration of the theory). This may suggest that those who are tolerant may be influenced by their sympathy to seek psychological help, while those are who intolerant may hastily seek psychological help to get rid of the undesired problem as soon as possible.

Another significant finding of the present study was that mothers indicated that making the child aware of the problem, waking the child up to urinate and talking to the child were management strategies. The results support Haque et al. (1981) and Wagner and Johnson (1988) studies which also found that awakening a child to urinate, talking about the problem and fluid restriction after dinner as the modes of management reported by parents. While only 5.25 percent of 362 parents of children with enuresis did nothing about the problem in Haque et al. (1981) study, it is interesting that 52.9 percent of 51 mothers in this study reported doing nothing about the problem. This finding warrants further investigation for it can be interpreted as a sign of helplessness or lack of knowledge about the potential sources of treatment. The assumption is based on the finding from the present study that Batswana mothers, unlike the Moroccans and Kurdish mothers (Abromovitch & Abromovitch,1988), tended not to believe that nocturnal enuresis could resolve on its own without intervention. Consulting a physician or a psychologist were mentioned as ways of seeking help or treatment. This is followed by consideration to consult a psychologist. Very few mothers expressed that they

will consult a traditional healer , a spiritual healer or that they will use home remedies. This finding may suggest that there is a move away from the traditional African healing to Western healing methods, at least for nocturnal enuresis.

5.2 LIMITATIONS OF THE STUDY

As an exploratory study the present study had many limitations in assessing perception and tolerance for nocturnal enuresis among the Setswana speaking mothers, and the implication for their seeking psychological treatment. First, the study was limited to Setswana speaking respondents in South Africa. Therefore the information obtained in this study cannot be inferred to apply to other population groups in South Africa. However, one purpose of the study was to compare its findings with those of other researchers on a similar topic using different population groups.

Second, the study was conducted in a community hospital. People a with higher educational level tend to prefer consulting private physicians and mental health practitioners. Thus only two subjects with

tertiary education participated in the study. This restricted the interpretation of results involving the educational level variable. The results obtained in this regard are therefore not conclusive. Time constraints did not allow including more subjects with tertiary education.

Third, the method of data collection also had its practical limitations. Translation of the questionnaire from English to Setswana may have influenced responses. Although both versions of the questionnaire were available for the respondents to complete, very few completed the questionnaire on their own. While some respondents did not have formal education, others didn't feel confident enough to complete the questionnaire on their own. A structured interview based on the questionnaire had to be implemented for the completion of some of the questionnaires.

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One limitation of an interview is the interviewer bias where responses are mediated by interviewer characteristics or other demands characteristic of the situation (Phares, 1984). Although the interviews in this study were structured, the interviewers'

idiosyncratic personal or attitudinal characteristics might have influenced their behaviour, and thus in turn prompted the subjects to respond differently.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The study explored how Setswana speaking mothers perceive nocturnal enuresis, their tolerance for nocturnal enuresis and whether the mothers would consider seeking psychological treatment for their nocturnal enuretic children. One purpose of this study was to compare its findings with those of other researchers on a similar topic using samples of different population groups. For example, the British, American and Israeli population groups.

The present study supports international findings regarding perceived causes of nocturnal enuresis by mothers. Mothers perceive nocturnal enuresis to be caused mainly by heavy sleeping. Inconsistent with traditional African beliefs that most illnesses are caused by witchcraft (Gobodo, 1990), none of the mothers believed that nocturnal enuresis is caused by witchcraft.

One significant finding of this study is that mothers expressed concern about the negative consequences of nocturnal enuresis. Most concern was expressed about the consequence of extra washing and financial burden. This concern differs with that of the American parents (Haque et al. 1981) and that of the British mothers (Butler et al. 1986) whose main concern was about the child's emotional development and social relationships.

Another significant finding is that mothers perceived the cause of nocturnal enuresis to be uncontrollable by the child. Perception of nocturnal enuresis as uncontrollable by the child was found to be independent of maternal tolerance for nocturnal enuresis. The findings do not support the first hypothesis that mothers who perceive the cause of nocturnal to be uncontrollable by the child will show tolerance for nocturnal enuresis than those who perceive it to be controllable by the child.

The results also showed that mothers expressed intolerance for nocturnal enuresis. It is interesting that the results indicate that maternal tolerance for nocturnal enuresis does not influence them to seek

psychological treatment for their nocturnal enuretic children. There was no support for the fourth hypothesis that mothers who are tolerant for nocturnal are likely to consider seeking psychological treatment than those who are intolerant. The second and third hypotheses about the relationship of educational level to maternal concern about the negative consequences of nocturnal enuresis and maternal concern for nocturnal enuresis were not supported either. The small number of subjects with higher educational level limited the interpretation of the results in regard to the educational level variable.

A significant finding about the perceived methods of treatment is that mothers reported making the child aware of the problem, waking the child up to urinate and talking to the child about the problem as the most management strategies. Mothers didn't believe that nocturnal enuresis could be resolved on its own. Consulting a physician was the most popular reported means of seeking help/treatment by the mothers. Consulting a psychologist was also reported by the mothers. Very few of respondents indicated that they would consider consulting a traditional healer.

6.2 RECOMMENDATIONS

Medical services in South Africa need to move away from operating purely on pragmatic lines to a position where there is multidisciplinary team involvement in dealing with the problem of enuresis. This warrants a need to train more clinicians and other mental health professionals who are able to work with communities at grass roots level.

Community awareness about the available psychological means of treating enuresis is recommended. Failure by parents to seek help in case of enuresis should be investigated. According to Haque et al. (1981) failure of American parents in the past to seek help from physicians signify a lack of confidence in the physicians' ability or desire to deal with enuresis. A significant question to ask is whether a similar situation prevails in South Africa.

In dealing with the problem of enuresis, therapists should be cognisant of the background of their patients. Mothers' explanations of enuresis should be elicited. Discussion of the causes of enuresis may help to alter their perceptions (such as bedwetting is

caused by heavy sleeping) and reduce criticism of the child.

Studies need to be done into mothers main source of annoyance. Strategies for reducing this could be discussed, such as sharing the burden of washing among family members. As indicated by Butler et al. (1986) attention to such factors would appear to have a good chance of improving maternal tolerance and cooperation with treatment.

A pretreatment assessment is recommended to determine parents' previous treatment experience and their attitude towards enuresis. When parents' prior experience is limited, clinicians can provide pretreatment education to ensure that parents understand all aspects of treatment procedures.

When parents describe themselves as intolerant, the clinician can attempt to change this attitude by providing basic information about bedwetting. For example, explaining the etiology and prevalence rates.

It is clear, however, that investigations using larger samples need to be conducted nationally if we are to

gain a wider perspective on this problem.

The way a child makes sense of bedwetting influences treatment outcome (Butler et al. (1990). Future research might therefore seek to explore this relationship further by inviting children to relay the experiences of bedwetting in their own personal terms.

Factor analysis of the causal factors of nocturnal enuresis and correlation of variables such as attributional dimension, maternal concerns, sex and age of the child, primary or secondary enuresis could give a comprehensive picture of the problem .

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APPENDIX A: RESEARCH INSTRUMENT

ENGLISH VERSION

Dear Participants

I am currently conducting a study about bedwetting of children.

I would appreciate your helping me with my research by completing the attached questionnaire. Anonymity and confidentiality will be maintained. An English and Setswana version of the questionnaire is available.

Please note that this questionnaire is to be completed by Setswana speaking mothers or primary care givers who have a bedwetting child of five years or above. If needed, assistance will be given to fill in the questionnaire.

The questionnaire consists of a list of statements and questions about bedwetting. They are grouped into sections A, B, C, D and E. Please read each one carefully and feel free to respond to what you honestly think.

Put a cross on the word "YES" if you think it describes your own feelings or ideas. Put a cross on the word "NO" if you think it does not describe your own feelings or ideas. Put a cross on the words "Not sure" if you think you are not sure it describes your own feelings or ideas.

Thank you for your help and co-operation.

Ms L F Mabasa
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UNIBO

BIOGRAPHICAL INFORMATION

Please fill in the following:

1. Maternalducationalevel:.....

2. Home language:.....

3. Age of the child who wets his bed.....

4. Sex of the child who wets his bed.....

5. How often does he/she wets his/her bed....

6. Expected age at which he/she should stop bedwetting.....

SECTION A

The items in this section are aimed at determining your views on the causes of bedwetting.

1. His/her toilet training has not been adequate.

Yes	
No sure	
No	

2. He/she has something physically wrong that causes the bedwetting.

Yes	
Not sure	
No	

3. He/she has not yet learnt to control his/her bladder.

Yes	
Not sure	
No	

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4. He/she is afraid to leave his/her bedroom/bed to go to the toilet at night.

Yes	
Not sure	
No	

5. There is a history of bedwetting in the family.

Yes ☐
Not sure ☐
No ☐

6. He/she is not bothered by wetting his/her bed.

Yes ☐
Not sure ☐
No ☐

7. He/she is lazy to get up and go to the toilet.

Yes ☐
Not sure ☐
No ☐

8. He/she drinks too much fluid before bedtime.

Yes ☐
Not sure ☐
No ☐

9. He/she is a worrier.

Yes ☐
Not sure ☐
No ☐

10. He/she sleeps deeply.

Yes ☐
Not sure ☐
No ☐

11. He/she would not do as he/she is told.

Yes ☐
Not sure ☐
No ☐

12. Bedwetting is more frequent on cold nights.

Yes ☐
Not sure ☐
No ☐

13. He/she easily becomes upset.

Yes ☐
Not sure ☐
No ☐

14. It is his/her way of getting back at me.

Yes ☐
Not sure ☐
No ☐

15. He/she goes to bed too late.

Yes ☐
Not sure ☐
No ☐

16. He/she lacks confidence.

Yes ☐
Not sure ☐
No ☐

17. He/she has been bewitched.

Yes ☐
Not sure ☐
No ☐

18. He/she has been possessed by ancestral spirits.

Yes ☐
Not sure ☐
No ☐

SECTION B

This section also consists of questions aimed at determining your views about the causes of bedwetting.

1. Is your child's bedwetting due to reasons which he/she can control?

Yes ☐
Not sure ☐
No ☐

2. Does your child's bedwetting occur because of something inherent about him/her?

Yes ☐
Not sure ☐
No ☐

3. Does your child's bedwetting occur because of something about the situation/circumstances.

Yes ☐
Not sure ☐
No ☐

4. Does your child's bedwetting occur because of something which changes from day to day?

Yes ☐
Not sure ☐
No ☐

5. Does the main cause of your child's bedwetting also affect other areas of his/her life?

Yes ☐
Not sure ☐
No ☐

SECTION C

The following set of statements embrace the areas of concern about the consequences of bedwetting.

1. He/she cannot go on school trips or camps.

Yes ☐
Not sure ☐
No ☐

2. He/she cannot sleep at a friend's or relative's house.

Yes ☐
Not sure ☐
No ☐

3. He/she can't have a friend to stay overnight at his/her home.

Yes ☐
Not sure ☐
No ☐

4. He/she cannot let people come into his/her bedroom.

Yes ☐
Not sure ☐
No ☐

5. I have to buy lots of sheets/blankets.

Yes ☐
Not sure ☐
No ☐

6. I spend a lot of money on buying soap to wash his/her linen/blankets.

Yes ☐
Not sure ☐
No ☐

7. The bed/blankets get rotten.

Yes ☐
Not sure ☐
No ☐

8. He/she is ashamed and embarrassed.

Yes	☐
Not sure	☐
No	☐

9. There is lots of extra washing.

Yes	☐
Not sure	☐
No	☐

10. I am concerned about the smell in the house.

Yes	☐
Not sure	☐
No	☐

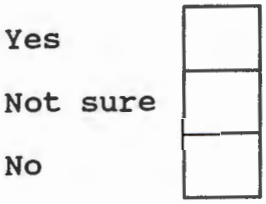
SECTION D

This section consists of items to determine your feelings and actions regarding the child's bedwetting.

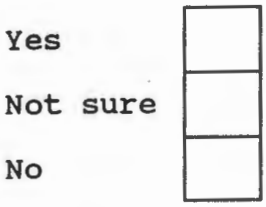
1. A child who wets the bed needs help and sympathy.

Yes	☐
Not sure	☐
No	☐

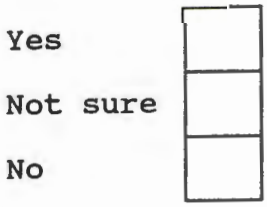
2. If only he/she would grow up a bit I wouldn't have all this trouble with wet beds.



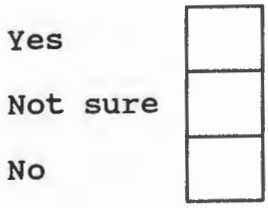
3. Bedwetting is not really much of a problem.



4. Children could stop bedwetting if they tried hard enough.



5. I have got used to wet beds/blankets by now.



6. I punish the child for wetting the bed.

Yes ☐
Not sure ☐
No ☐

7. Bedwetting usually clears up on its own.

Yes ☐
Not sure ☐
No ☐

8. My child's bedwetting is a nuisance to me.

Yes ☐
Not sure ☐
No ☐

9. When my child wets the bed I tell him/her that it does not matter.

Yes ☐
Not sure ☐
No ☐

10. I let him/her see that I am disappointed when he/she has wet the bed.

Yes ☐
Not sure ☐
No ☐

11. I worry more about other things about my child than a few extra sheets/blankets to wash.

Yes ☐
Not sure ☐
No ☐

12. Bedwetting is nothing but a dirty habit.

Yes ☐
Not sure ☐
No ☐

13. I try to help him/her not to be upset by his/her bedwetting.

Yes ☐
Not sure ☐
No ☐

SECTION E

This section consists of statements aimed at determining your views about the management of bedwetting.

1. I punish my child for wet nights.

Yes	
Not sure	
No	

2. I try to make my child realize the unpleasantness his/her bedwetting causes for others.

Yes	
Not sure	
No	

3. Smacking a bedwetter may do a lot of good to help him stop bedwetting.

Yes	
Not sure	
No	

4. I wake him/her up to go to the toilet.

Yes	
Not sure	
No	

5. I talk to him/her about the bedwetting problem.

Yes	☐
Not sure	☐
No	☐

6. I restrict his/her fluid intake after dinner.

Yes	☐
Not sure	☐
No	☐

7. His/her bedwetting problem needs consultation with the doctor/hospital/clinic for help.

Yes	☐
Not sure	☐
No	☐

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8. His/her bedwetting problem needs consultation with the psychologist for help.

Yes	☐
Not sure	☐
No	☐

9. He/she needs home remedies for bedwetting.

Yes ☐
Not sure ☐
No ☐

10. He/she needs consultation with the spiritual healer for help.

Yes ☐
Not sure ☐
No ☐

11. He/she needs consultation with the traditional healer for help.

Yes ☐
Not sure ☐
No ☐

12. I just ignore my child's bedwetting problem.

Yes ☐
Not sure ☐
No ☐

13. I wait for bedwetting to get better on its own as time goes by.

Yes	☐
Not sure	☐
No	☐

14. I have never tried anything for my child's bedwetting problem.

Yes	☐
Not sure	☐
No	☐

APPENDIX B: RESEARCH INTRUMENT

CROSS TRANSLATION: SETSWANA VERSION

Batsayakarolo

Ke tshwaragane le go dira dipatlisiso mabapi le bana ba ba rotelang dikobo.

Ke rata go go kopa go tsaya karolo ka go tsibogela dipotso tse di mo lenaanepotsong le le tlapisitsweng fa. Re tla tshola tsibogela ya gago ele khuparama ka dinako tsotlhe. Lenaanepotso le, le teng ka Setswana le Sejatlhapi (English).

Tsweetswe lemoga gore lenaanepotso le le tshwanetse la tsibogelwa ke bommabana le, kgotsa baneedi ba tlhokomelo ya kalafi ba puo ya bona e leng Setswana. Gape bommabana ba, le baneedi ba tlhokomelo ya kalafi ba tshwanetse ba bo ba na le bana ba ga jaanong ba rotelang dikobo ba bogolo ba dingwaga di le tlhano kgotsa go feta, ba dintlha tsa lenaanepotsa di ba amang.

Lenaanepotso le le latelang le na le dipolelo le dipotso mabapi le go rotela dikobo. Di arogantswe ka dikarolo tsa A, B, C, D, le E. Tsweetswe buisa nngwe le nngwe ya tsona ka keletlhoko mme o phuthologe go ka di tsibogela ka boammaruri.

Dira sefapaano mo lefokong "Ee" fa o lemoga gore le tlhalosa maikutlo kgotsa dikakanyo tsa gago. Dira sefapaano mo lefokong "Nnyaa" fa o lemoga gore ga le tlhalose maikutlo kgotsa dikakanyo tsa gago. Dira sefaapano mo mafokong "Ga ke tlhomamise" fa o sa tlhomamise gore le tlhalosa maikutlo kgotsa dikakanyo tsa gago.

Ke leboga thuso le tirisano mmogo ya gago.

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Department of Psychology
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TSHEDIMOSETSO KA GA GAGO

Tsweetswee tlatsa tse di latelang:

1. Maemo a thutho ya mme:.....

2. Puo ya kwa gae:.....

3. Bogolo ba ngwana yo o rotelang dikobo:.....

4. Bong ba ngwana yo o rotelang dikobo:.....

5. Ngwana o kolobetsa dikobo ga kae:.....

6. Bogolo ba ngwana a solofetsweng go
   emisa go rotela dikobo ka bona:.....

KAROLOLO YA A.

Dintlha tse di mo karolong e di mabapi le go tlhomamisa dikakanyo tsa gago ka ga mabaka a a bakang go rotela dikobo.

1. Go katisediwa ntlwana ga gagwe go ne go sa lekana.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

2.O na le bokoa bongwe bo bo bakang go rotela dikobo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

3. Ga a ise a ithute go laola setlha sa gagwe.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

4. O boifa go tswa mo kamoreng/bolaong ba gagwe go ya kwa ntlwaneng.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

5. Go na le histori ya go rotela dikobo mo lelapeng la gaabo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

6. Ga a tshwenyege le fa a rotela dikobo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

7. O itsapa go ema go ya kwa ntlwaneng.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

8. O nwa diela thata pele ga go robala.

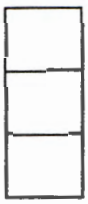
Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

9. O na le mathata.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

10. O robala la go swa.

Ee
Ga ke tlhomamise
Nnyaa



11. Ga a dire jaaka a bolelelwa.

Ee
Ga ke tlhomamise
Nnyaa



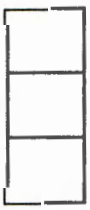
12. O rotela dikobo gantsi fa go le maruru bosigo.

Ee
Ga ke tlhomamise
Nnyaa



13. O kgopisega bonolo.

Ee
Ga ke tlhomamise
Nnyaa



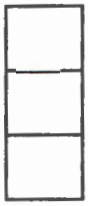
14. Ke ka mokgwa o a ipusolosetsang ka ona mo go nna.

Ee
Ga ke tlhomamise
Nnyaa



15. O robala bosigo thata.

Ee
Ga ke tlhomamise
Nnyaa



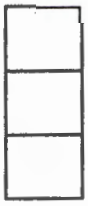
16. Ga a itshepe.

Ee
Ga ke tlhomamise
Nnyaa



17. O loilwe.

Ee
Ga ke tlhomamise
Nnyaa



18. O na le mewa ya badimo.

Ee
Ga ke tlhomamise
Nnyaa



KAROLO YA B.
Karolo e le yona e na le dipotso tse di mabapi le go tlhomamisa dikakanyo tsa gago ka ga go rotela dikobo.

1. A go rotela dikobo ga ngwana go bakwa ke mabaka a o ka a laolang?

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

2. A go rotela dikobo ga ngwana wa gago go diragala ka ntlha ya sengwe ka ga gagwe?

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

3. A go rotela dikobo ga ngwana wa gago go bakwa ke sengwe sa maemo a tikologo?

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

4. A go rotela dikobo ga ngwana wa gago go bakwa ke sengwe se se fetogang letsatsi le letsatsi?

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

5. A lebaka le legolo le le bakang go rotela dikobo ga ngwana wa gago, le ama dikarolo dingwe tsa botshelo ba gagwe?

Ee	
Ga ke tlhomamise	
Nnyaa	

KAROLO YA C.

Dipolelo tse di latelang di akaretsa dikarolo tsa botshelo tse di ke ditlamorago tsa go rotela dikobo.

1. Ga a kgone go tsaya maeto a dikolo kgotsa go kampa.

Ee	
Ga ke tlhomamise	
Nnyaa	

2. Ga a kgone go robala kwa gaabo tsala kgotsa kwa ntlong ya wa losika.

Ee	
Ga ke tlhomamise	
Nnyaa	

3. Ga a ka ke a etelwa ke tsala go tla go robala fa ga gago.

Ee	
Ga ke tlhomamise	
Nnyaa	

4. Ga a ka ke a letlelela batho go tsena mo phaposing ya gagwe ya borobalo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

5. Ke pateletsega go reka dilakane kgotsa dikobo tse dintsi.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

6. Ke dirisa madi a le mantsi thata go reka sesepa go tlhatswa dilakane/dikobo tsa gagwe.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

7. Bolao/dikobo di a bola.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

8. Go mo tlhabisa ditlhong.

Ee	
Ga ke tlhomamise	
Nnyaa	

9. O re bolaisa go tlhatswa.

Ee	
Ga ke tlhomamise	
Nnyaa	

10. Ke tshwenngwa ke monko mo ntlong.

Ee	
Ga ke tlhomamise	
Nnyaa	

KAROLO YA D.

Karolo e, e na le dintlha tse di mabapi le go tlhomamisa maikutlo a gago ka ga go rotela dikobo.

1. Ngwana yo o rotelang dikobo o tlhoka thuso le kutlwelobotlhoko.

Ee	
Ga ke tlhomamise	
Nnyaa	

2. Fa a ka gola go se nene ga ke ne ke nna le mathata a malao a a rotelwang.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

3. Go rotela dikobo tota ga se bothata.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

4. Bana ba ka emisa go rotela dikobo fa ba ka leka thata go dira jalo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

5. Ke setse ke tlwaetse maloa/dikobo tse di rotelwang.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

6. Ke otlhaela ngwana go rotela dikobo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

7. Ka gale go rotela dikobo go iphedisa ka bogona.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

8. Go rotela dikobo ga ngwanake go a ntshwenya.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

9. Fa ngwanake a rotela dikobo ke mo raya ke re ga go tshwenye.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

10. Ke dira gore a lemoge gore o a ntshwabisa fa a rotela dikobo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

11. Go rotela dikobo ga se sepe fele fa e se mokgwa o o maswe.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

12. Ke tshwenyega thata ka dilo tse dingwe ka ga ngwanake go na le go oketsega ga dilakane/dikobo tse ke tshwanetseng ka di tlhatswa.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

13. Ke leka go mo thusa gore a se ka a hutsafadiwa ke go rotela dikobo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

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KAROLO YA E.

Karolo e, e na le dipolelo tse di mabapi le go tlhomamisa dikakanyo tsa gago ka ga go laola go rotela dikobo.

1. Ke otlhaya ngwanake fa a rotetse dikobo bosigo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

2. Ke leka go lemosa ngwanake mathata a go rotela dikobo ga gagwe go a bakelang ba bangwe.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

3. Go otlhaya ngwana yo o rotelang dikobo go ka mo thusa thata go emisa go di rotela.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

Ke a mo tsosa gore a ye ntlwaneng.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

5. Ke buisana le ena ka ga bothata ba go rotela dikobo.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

6. Ke mo itsa go nwa diela morago ga dijo tsa maitsiboa.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

7. Bothata ba gagwe ba go rotela dikobo bo tlhoka gore a isiwe ngakeng/boekelong/tliliniking go bona thuso.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

8. Bothata ba gawe ba go rotela dikobo bo tlhoka gore a bone mosaekholoji go mo thusa.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

9. O tlhoka kalafi ya selegae mabapi le go rotela dikobo ga gagwe.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

10. O tlhoka go bona ngaka ya semoya go mo thusa.

Ee ☐
Ga ke tlhomamise ☐
Nnyaa ☐

11. O tlhoka go bona ngaka ya setso go mo thusa.

Ee	
Ga ke thlhomamise	
Nnyaa	

12. Ke ikgatholosa go rotela dikobo ga ngwanake.

Ee	
Ga ke tlhomamise	
Nnyaa	

13. Ke emetse gore go rotela dikobo go iphedise fa nako e ntse e tsamaya.

Ee	
Ga ke tlhomamise	
Nnyaa	

14. Ga ke ise ke leke sepe mabapi le go rotela dikobo ga ngwanake.

Ee	
Ga ke tlhomamise	
Nnyaa	