PSYCHOLOGICAL ISSUES IN CHILDHOOD INCONTINENCE

ESTHER TAKAC

Incontinence disorders

Primary NE – never continuously dry for 6 months

Secondary NE – relapse after 6 months of dryness

MNE – NE without any daytime symptoms of bladder dysfunction

NMNE – NE with daytime symptoms such as:

Day wetting: frequency, urgency, jiggling – suggest an overactive bladder (OAB) – a "filling" problem

Dysfunctional voiding – incomplete bladder emptying – an "emptying" disorder

Faecal incontinence – constipation, encopresis

Categories are used in overlapping inconsistent ways – affects research outcomes

Co-morbidity of Incontinence and Psychological Problems

- Co-morbidity = concurrence of ≥ 2 disorders - concurrent or sequential

- What is the relationship between psychological problems and incontinence?

Co-morbidity of Incontinence and Psychological Problems

- Psychological problems may
  - precede incontinence and induce relapse (causal?)
  - be a result/consequence of incontinence
  - incontinence and a psychological disorder may both be due to a common neurobiological dysfunction
  - may co-exist by chance

Psychological disorder is...

- "A clinically significant behavioural or psychological syndrome or pattern, associated with present distress, disability or impairment and carries a risk for future development of the individual" (DSM IV: APA, 2000)

- Externalising disorders – visible behaviours: conduct disorders, ADHD
- Internalising disorders – inwardly-directed: anxiety, depression, phobias
- Other- eg anorexia nervosa, tic disorders, autism disorders

Co-morbidity of Incontinence and Psychological Problems

- Primary NE- no more psychological problems than normal children
- MNE –had lowest co-morbidity, no higher than in normal population (von Gontard 1999) show fewer behavioural symptoms than day wetting (Butler et al 2006)
- Although in the past (1950s-1960s) psychological /psychiatric factors were thought to be related to NE/MNE, they are no longer considered a primary cause
- Children with NE and MNE often do have poorer self esteem, higher anxiety, feel blamed and stigmatized especially as they get older ... however once they attain continence, these problems can resolve over time with no long term psychological issues

Co-morbidity of Incontinence and Psychological Problems

- Secondary NE – preceded by a higher rate of stressful life events (Jarvelin 1990) (study by Durkin 1993 found 33% of children previously dry developed NE after flood disaster in Bangladesh)
- Researchers have found NMNE (both primary and secondary) –33% have an ICD-10 diagnosis (Zink et al 2008)
- One study (von Gontard 1999)found secondary NE have clinical disorders in up to 75% of cases and require more attention to psychological issues

Types of psychological disorders co-morbid with incontinence

- Mainly externalising disorders
- Most common specific co-morbid disorder is ADHD - 9.6% enuretic children had ADHD symptoms compared to 3.4% non-wetting children (von Gontard, 2008)
- Children with ADHD
  - More difficult to treat
  - Worse outcome on alarm
  - Less dry at 6 and 12 months
  - Less compliant (38% ADHD kids non compliant compared to 22% controls)

- Enuresis and ADHD require special attention –both need treatment

Daytime Incontinence

- Children with daytime wetting have more psychological problems (study of 8213 children aged 7 – 9, Joinson et al, 2006)
- Attention deficit – 25%, Oppositional behaviour – 11%, Conduct problems – 12%, Separation anxiety – 11%
- Externalising disorders predominate and interfere with treatment

- Delayed development, difficult temperament and maternal depression/anxiety also associated with daytime wetting and soiling

The psychology of bowel training

- Prof. Selma Fraiberg – Director of Infant – Parent program at San Francisco hospital and Prof of Child Psychoanalysis
- The Magic Years – Understanding and Handling the Problems of Early Childhood
- "If we understand the process of toilet training from the point of view of the pre-verbal child and his primitive thinking we can help the child accept his training and cooperate with it, understand his difficulties and not increase them..." p95

The psychology of bowel training and why difficult parent-child interactions interefere

- In toilet training – "we want to avoid pressure, contests of will, anxiety about getting to the toilet and shame about failure. We want to find ways in which we can enlist the child's interest and cooperation in achieving bowel and bladder control"
- We can imagine how this process can become challenging and stressful for the parents of children who are
- Developmentally delayed
- Have difficult temperament
- Have AHDH – poor attention, impulsive, hyperactive
- Imagine how this process can become challenging and stressful for children of parents who are:
- Depressed (withdrawn, unavailable)
- Anxious/stressed

Daytime Incontinence

- Urge incontinence – slightly increased rate of psychological problems only, internalising symptoms predominate
- Voiding postponement - >50% have at least 1 ICD-10 diagnosis:
  - Often associated with externalizing disorders especially Oppositional Defiant Disorder
  - Family functioning impaired
  - Children with voiding postponement have highly increased psychiatric risks

- Few studies on psychological issues related to: underactive bladder, dysfunctional voiding, giggle incontinence

Faecal incontinence

- Both externalising and internalizing disorders (ADHD – 9%, ODD – 12%, separation anxiety – 4%, phobias – 4%, generalized anxiety – 3%)
- Studies show that 3.5-5 times more children with FI have total behaviour scores in clinical range on CBCL (Child behaviour check list)
- No difference in psychological problems for children with and without constipation
- Children with both urinary and faecal i/c –have higher rates of behavioural and emotional problems than wetting alone (von Gontard and Hollman 2004)

Incontinence and psychological problems

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ADHD, ODD, CD and Incontinence

- Do the neuropsychological difficulties comprising ADHD (poor attention, impulsiveness, hyperactivity):
- Contribute to incontinence
- OR
- Do ADHD (ODD, CD) and incontinence share a common neurobiological basis??

Child's experience and perception of wetting

- Most children experience high levels of distress
- 60% of children wetting are so embarrassed that they do not discuss it outside family
- 50% of children perceived family intolerance and were teased by siblings
- Children are concerned re social implications – can't participate in sleep overs and school trips

Effect on child's self esteem

- Most bedwetting children are not aware it is fairly common - contributes to sense of being different and reduces self concept
- Study of 8000 British children rate bedwetting 8th most highly endorsed difficulty – more difficult than ill often, worrying a lot, always being in trouble
- Child suffers sense of failure and inferiority

Effect on child's self esteem

- Studies show that incontinence worsens "Quality of Life" of school children and negatively influences their social situation, self esteem and self confidence (from age 7 up)
- Methodological problems with research on self esteem (mixed studies of MNE, NMNE, FI)
- Self esteem improves with dryness
- Self esteem improves with good care and doctoring even without success

Effect on child's self esteem

- Boys with encopresis show anxiety, negativism, difficulties in relationships, poor tolerance to stress (Bellman1996)
- Children with encopresis show lower emotional and social functioning (Bongers et al 2009)
- Children with encopresis have lower self esteem than children with other chronic conditions, feel less in control of positive life events (Landman et al 1986)

Effect on parents

- Incontinence may be just as distressing for parents as for children
- 2/3 parents worry about impact on their child's emotional development and social relationships
- Also worry re extra washing, financial cost and smell
- Restricts social mobility of family –holidays

How do parents understand child's incontinence?

- For younger children parents attribute cause of bedwetting to uncontrollable factors such as maturational lag, heavy sleeping (can generate a tolerant attitude with feeling of helplessness)
- As child gets older parents become less tolerant, perceive child as having more control over bedwetting and see behaviour as negative characteristic of child
- Research re parents' perceptions of NMNE, FI?
- Is child being lazy? Stubbornly wait till the last minute to go to toilet? Being oppositional?

Emotional impact on parents

- 20-36% of parents punish child for wet nights
- Cultural differences exist: 5.6% (German) 37% (English) 54% of migrant children of Turkish and Moroccan origin were punished
- Parental annoyance is associated with families under stress
- Contributes to tensions in family

Emotional impact of incontinence

- Adversely affects parent-child relationship
- Children internalize parents' annoyance leading to feelings of guilt and lowered self esteem
- Parental annoyance also associated with drop out from alarm based treatment
- Psychological problems for child and family as consequence of incontinence

The psychological effect of no treatment vs treatment

- The longer a child has incontinence problems, the greater the chance for developing behavioural and emotional problems (Fergusson 1994)
- Successful treatment will improve the child's self esteem (Hagglof et al 1998) and long term emotional development (Stromgen 1990)
- The quicker incontinence is treated, the chances of long term psychological harm are reduced

Using psychology to optimize treatment compliance and success

- Best predictor of good adherence to treatment is positive self esteem (perception of one's physical appearance) and low levels of stress re treatment

  (Baeyens et al 2008)

- Children with psychological problems are less compliant (but few studies)
- If child has low self-esteem, shows behavioural problems or distress with treatment regime it is more likely they will not comply and treatment will fail

Using psychology to optimize treatment compliance and success

- Reduce stress in child and family
- Guide parents to be positive coaches for child
- Increase child's self esteem - Enlist child's strengths
- Predictor for negative treatment outcome is child's lack of motivation/discomfort re problem
- Find best motivators for child

Reducing stress on child and family

- Psycho-education
- Explain high frequency of incontinence using age appropriate examples – eg how many kids in classroom are likely to suffer from it (1 in 14 of 7 year olds wet bed – 7 %)
- Focus on involuntary nature of incontinence - reassure child that it is not their fault
- Reduce sense of blame and guilt

Lilli case study

- Aged 8
- Referred to peadiatrician at age 6
- Primary NE (every night)
- Day wetting (several times daily)
- Faecal incontinence (every 2nd day with some constipation)
- Does not comply with regular toileting program

Lilli's motivation

- Look at Lilli's motivation to fix enuresis and encopresis – scale of how much she wants to fix problem.
- Enuresis and encopresis don't make Lilli feel bad because – dirty, smelly, uncomfortable, babyish wearing a nappy – none of these issues bother Lilli, are not motivators for her to fix problem.
- There are secondary gains for Lilli from having incontinence problems....
- Set up chart to monitor sitting on toilet with appropriate reinforcers.

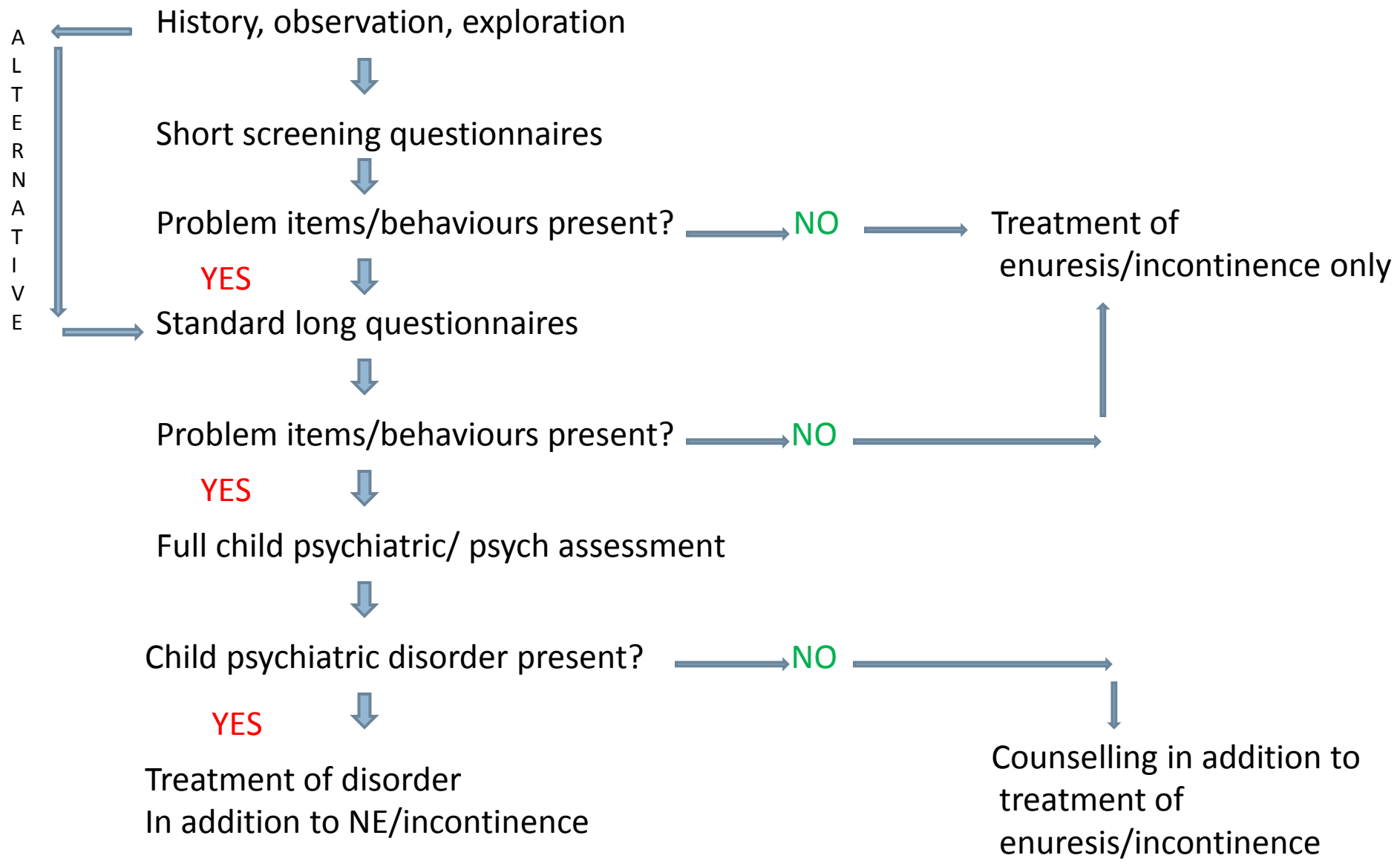
Psychology and Incontinence

- *..... "comorbid disorders interfere with treatment for enuresis/incontinence. Affected children show lower compliance and treatment results are lower. Therefore, children with incontinence should be screened for psychological disorders .... Children with a severe condition should be referred to the mental health service (child psychiatrists and child psychologists).An interdisciplinary approach is needed for optimal care in daytime wetting children."*
  (Kuhn et al 2009)

Psychology and Incontinence

- Co-morbidity between incontinence and psychological disorders – complicates treatment – need to treat both disorders
- Incontinence often results in psychological difficulties for the child and family
  - Emotional and self esteem difficulties for the child
  - Stressed/frustrated parents
  - Effects on parent-child relationship
- Interfere with compliance and treatment success
- Psychology can be used to increase treatment motivation, compliance and success

Screening all children



Best screening

- Good history
- Careful clinical observation
- Questionnaires
  - Short screening instrument for psychological problems in enuresis. SSIPPE (Van Hoecke 2007) Validated. 13 items. Yes/no
  - Parental Questionnaire Enuresis/Urinary Incontinence (von Gontard 2003) Non-validated. 15 items. Yes/no
- Standard long CBCL (Achenbach 1991) 113 items
- QoL –generic, disease specific eg PinQ (Bower et al.)

Published ICCS standardisation documents

- Von Gontard, A., Baeyens, D., Van Hoecke, E., Warzak, W., Bachmann, C.. Psychological and psychiatric issues in childhood bladder disturbances: a standardisation document from the International Children's Continence Society. J Urol (in press)
- Chase, J., Austin, P., Hoebeke, P., & McKenna, P. The management of dysfunctional voiding in children: a report from the Standardisation Committee of the International Children's Continence Society. J Urol, 183(4), 1296-1302.
- Hoebeke, P., Bower, W., Combs, A., De Jong, T., & Yang, S. Diagnostic evaluation of children with daytime incontinence. Journal of Urology, 183(2), 699-703.
- Neveus, T., Eggert, P., Evans, J., Macedo, A., Rittig, S., Tekgul, S., et al. Evaluation of and treatment for monosymptomatic enuresis: a standardization document from the International Children's Continence Society. J Urol, 183(2), 441-447.
- Neveus, T., von Gontard, A., Hoebeke, P., Hjalmas, K., Bauer, S., Bower, W., et al. (2006). The standardization of terminology of lower urinary tract function in children and adolescents: report from the Standardisation Committee of the International Children's Continence Society. Journal of Urology, 176(1), 314-324.