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Association between elimination disorders and abusive maternal attitudes

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ABSTRACT

Objective: Enuresis and encopresis, both conditions are very distressful to children and their family members and it is responsible for significant social and psychological consequences in children and adolescents. The present study aims to determine the rate of abusive maternal attitudes towards children and adolescents with elimination disorders (EDs) and to investigate the maternal psychological and socio-cultural factors associated with abusive parenting attitudes.
Method: N = 180 children with ED were included in the study. Family Assessment Device (FAD), and Symptom Check List (SCL-90-R) were administered to mothers.
Results: Our results indicated that prevalence of abusive maternal attitudes in our sample was 73.8%. Children and adolescents with ED who live with low-educated parents ($p = 0.008$), low socio economic status ($p = 0.014$), and in cases with living in a large or divorced family ($p = 0.014$), disorganized or chaotic families can be considered a population at risk ($p < 0.05$), since it is more likely that they suffer more severe abusive maternal attitudes.
Conclusion: Present study showed high rates of abusive parenting attitudes in cases of EDs in a sample of Turkish children and adolescents. Further research on the etiological and therapeutic importance of the family in the case of ED referred to a psychiatry clinic should be carried out.

1. Introduction

Enuresis and encopresis are considered as elimination disorders (EDs). Enuresis involves the repeated voiding of urine onto clothes or bedclothes that persists beyond the normative age of the maturation of urinary control. Encopresis is involuntary fecal soiling in children who have already been toilet trained.[1] According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-V; American Psychiatric Association [APA], 2013), a diagnosis of enuresis may be warranted if the individual at least 5 years of age, repeatedly voids in inappropriate places at least twice a week for a period of at least 3 consecutive months, or there is a significant impairment in daily functioning, and medical/physiological factors have been ruled out. The diagnostic criteria for encopresis are similar except that the individual must be only 4 years of age or older and experiences repeated passage of feces in inappropriate places at least once a month for 3 consecutive months.[2]

However, based on current research and validation studies, the most precise taxonomy was proposed by the International Children's Incontinence Society (ICCS) for enuresis and urinary incontinence and the ROME-III criteria for functional gastrointestinal disorders. For example, the term constipation is not clearly defined in DSM-V. It has been operationalized and defined in the ROME-III classification system. The ICCS standardization provides international, research- and consensus-based recommendations for terminology that are already being used by colleagues in many different fields.[3,4] Unfortunately, the proposed DSM-5 criteria are not very useful and may even constitute a step back from ICCS and ROME-III criteria.[5]

The prevalence estimates of enuresis and encopresis are highly variable, with a range of 3.8%–24% for enuresis and 0.1%–3% for encopresis.[6–8] Both conditions are very distressful to children and their family members and have significant social and psychological

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consequences in children and adolescents.[9] Familial factors like maternal depression and/or anxiety symptoms are associated with elimination disorders in school age.[10] Since depression and/or anxiety reduce/s the capacity of coping with stress, elimination disorders may be accelerated or exacerbated.[11] Ineffectual, disorganized, and chaotic families might also have difficulty in handling encopretic symptoms.[12]

Child abuse is a serious problem with complicated causes and tragic results in medical, legal, developmental, and psychosocial contexts.[13] The World Health Organization (WHO) defines the intentional or unintentional behaviour of an adult that negatively affects the health and physical and psychosocial development of a child as child abuse.[14] Unfortunately, children with enuresis are frequently punished by their parents as a result. Previous studies have determined that enuretic children are frequently exposed to psychological and physical abuse; parents with low tolerance levels are at higher risk for having children who develop diurnal enuresis in terms of child abuse.[13,15,16]

Abusive parenting attitudes towards children with EDs has been studied and has been a reason for concern around the world.[9,17] However, there are very few studies describing its frequency in Turkey. Therefore, the objective of the present study is to describe the frequency of abusive maternal attitudes due to EDs in a clinical sample of Turkish children and adolescents and also to investigate the maternal psychological and socio-cultural factors associated with the abusive parenting attitudes.

2. Method

2.1. Procedure

We performed a cross-sectional, case study between December 2013 and October 2014 on a consecutive sample of 180 children (5–15 years) with ED who were admitted to child and adolescent psychiatric outpatient clinics of Afyon Kocatepe University Hospital. The inclusion criteria were admission to the child and adolescent psychiatry outpatient clinic with a complaint of incontinence and diagnosis of ED; lack of medical causes of incontinence; volunteering for participation; and being aged of 5–18 years. We excluded all children who had a diagnosis of developmental delay, severe intellectual disability, pervasive developmental disorders (such as autism and Asperger's disorder), schizophrenia or other psychotic disorder, concomitant medical disorders and refusal to participate in the study.

The children were predominantly referred from the Pediatrics Unit of the Afyon Kocatepe University due to absence of organic causes for incontinence. Other children who admitted directly were evaluated by physical examination and laboratory tests (urinalysis to be sure that no signs of bacteriuria) and there were no identified medical causes of urinary or fecal incontinence in any children.

The diagnostic procedure included clinical interview by a certified child psychiatrist, with the child and mothers, and filling out DSM-based specific ED criteria. To acquire a diagnosis of enuresis in this study, the child had to fulfil the following criteria: repeated voiding of urine onto bed or clothes, whether involuntary or intentional; the behaviour was deemed clinically significant as manifested by either a frequency of twice per week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic, or other important areas of functioning; chronological age was at least 5 years; and the behaviour was not due exclusively to the direct physiological effect of a substance (e.g., a diuretic) or a general medical condition (e.g., diabetes, spina bifida, a seizure disorder). To acquire an encopresis diagnosis in this study, the child had to fulfil the following criteria: repeated passage of feces onto inappropriate places (e.g., clothing or floor), whether involuntary or intentional; at least one such event a month for at least 3 months; chronological age of at least 4 years; and the behaviour not exclusively due to the direct physiological effect of a substance (e.g., laxatives) or a general medical condition, except through a mechanism involving constipation. The diagnosis is corroborated with the Schedule for Affective Disorders and Schizophrenia for School-Aged Children, Lifetime Version (Kiddie- SADS-PL); a structured clinical interview of parents. The Kiddie-SADS-PL is also used to diagnose the presence of comorbid disorders, including conduct disorder, oppositional defiant disorder, anxiety disorders, and mood disorders. Enuretic children were subdivided into two groups as primary enuresis and secondary enuresis. Primary enuresis means that the child has been dry for less than 6 months (or not at all). Secondary enuresis means that a relapse after a dry period of at least 6 months has occurred. Encopretic children were subdivided into two groups as with constipation and overflow incontinence and without constipation and overflow incontinence. Three children with encopresis were excluded due to incompleteness of their data, and one child was excluded due to unwillingness to participate in the study.

Mothers were interviewed and requested to complete a Symptom Check List-90-Revised (SCL-90-R) and Family Assessment Device (FAD) to assess maternal psychiatric symptoms and family functioning, respectively. We assessed whether mothers used punitive methods in their children with incontinence by asking open-ended questions such as “How do you react when your child has incontinent?” Based on the mothers' response to the first question, further questions were asked. Mothers were further subdivided into three groups: Group I included neutral or supportive mothers, Group II included verbal abuser mothers only, and Group III included physical abuser mothers (See appendix 1).

The present study and its written consent form were approved by the local Research Ethics Committee. Mothers of children were informed about the purpose and design of this investigation and written informed consent was obtained for participating in the study.

2.2. Data collection form

A socio-demographic questionnaire was developed for the study that assesses the age, gender, economic situation, family type, and medical histories of the children with features of an ED. Their socio-economic situation was determined based on their responses to the question, “what is your household's economic status?” The response categories were high, moderate, and low. Parents' educational level was divided into two categories based on their number of years of schooling: 1 (<8 years); 2 (>8 years). In the questionnaire, the maternal reactions to children's EDs were widely investigated, e.g., supportive behaviour, empathic attitude, verbal aggressive words, verbal offence, scolding, spanking, beatings. According to response categories, neutral or supportive mothers, verbal abuser mothers, and verbal and physical abuser mothers groups were defined.

2.3. Kiddie-schedule for affective disorders and schizophrenia for school-age children, present and lifetime version (K-SADS-PL)

K-SADS-PL is a semi-structured interview that was developed by Kauffman et al.[18] A reliability and validity study of K-SADS-PL for the Turkish population was conducted. The validity, interrater reliability and test–retest reliability of K-SADS-PL were found to be excellent for elimination disorders.[19] K-SADS-PL is used to