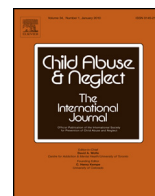




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Child Abuse & Neglect



Punishment for bedwetting is associated with child depression and reduced quality of life

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ABSTRACT

This study assessed the relationship between parental punishment and depression as well as quality of life in children with primary monosymptomatic nocturnal enuresis (PMNE). A consecutive sample of 65 children (7–13 years) with PMNE and 40 healthy children, selected as controls (Group III), were included in the study. The children with PMNE were further sub-classified into two groups: Group I, which included children who received parental punishment for enuresis and Group II, which comprised children who were not punished for bedwetting. Depression and health-related quality of life (HRQL) were assessed among the three groups. The number of wet nights per week was significantly increased in Group I compared with Group II ($P < .001$). In addition, the severity of depressive symptoms increased in Group I as compared to the other two groups ($P < .001$). Similarly, the psychosocial HRQL lower in Group compared to the control group (Group III) ($P < .001$). Prior parental discipline, including corporal punishment ($B = 0.55, P = .008$), as well as the frequency ($B = 0.73, P < .001$) and duration of punishment ($B = 0.33, P = .02$) were strong predictors of increased depressive symptom severity. It was also found that prior punishment ($B = -0.42, P = .01$) and the frequency ($B = -0.62, P < .001$) and duration of punishment ($B = -0.34, P = .02$) were strong predictors for poor psychosocial HRQL. Overall, parental punishment has a poor outcome in children with PMNE.

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Introduction

Nocturnal enuresis is one of the most prevalent problems that affects about 15% of children aged 5 years, with approximately 15% of children spontaneously achieving night-time bladder control annually (Ramakrishnan, 2008). Nocturnal enuresis is three times more common than day-time wetting (Bower, Moore, Shepherd, & Adams, 1996; Stein, Mendelsohn, Obermeyer, Amromin, & Benca, 2001), and it occurs three times more often in boys (Miller, 1993). It is classified as primary (nocturnal bladder incontinence in a child who has never achieved urinary control for at least six months and is older than five years) or secondary (night-time dryness is achieved for at least six months) (Ramakrishnan, 2008).

According to the International Children's Continence Society (Neveus et al., 2006), primary monosymptomatic nocturnal enuresis (PMNE) is defined as intermittent urine leakage at night during sleep in children who are at least 5 years old and who have not achieved dryness for at least six months without concomitant diurnal incontinence, any other lower urinary tract symptoms, and a history of bladder dysfunction. PMNE is the most common type of nocturnal enuresis, accounting

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for about 85% of all cases (Hallgren, 1957). Treatment is typically medical, behavioral (dry bed training with or without an alarm) or a combination of both. Treatment may span several months (De Paepe et al., 2002), and it requires long-term compliance.

Epidemiologic studies reported that 20–30% of children with nocturnal enuresis have behavioral problems, which are 2–4 times higher than in non-wetting children. More so, the rate of behavioral problems in children with nocturnal enuresis are comparable with the rate of psychosocial problems in other pediatric chronic illness groups (Hirasing, van Leerdam, Bolk-Bennink, & Bosch, 1997; Liu, Sun, Uchiyama, Li, & Okawa, 2000). Primary nocturnal enuresis has a negative impact on a child's emotional state, social relationships, self-esteem (Butler, 1998; Von Gontard et al., 1998), every day activities and the child's capabilities to leave home with friends and family (Morison, 2000). Enuretic children are known to be unhappy or depressed (Assiri, Al-Yousif, & Al-Mahmoud, 2007), always under stress in society because they are ashamed and try to cover the disorder (Warzak, 1993) and have impaired quality of life (Bower, 2008).

Enuresis has an impact on both children and their parents, as extra washing and cost, smell and the parents' attribution of the causes of bed wetting to controllable factors (particularly the child's behavior) cause feeling of annoyance and, consequently, punitive actions on the part of parents (Butler, Brwein, & Forsythe, 1986; Butler, Redfern, & Forsythe, 1993). Parents attempt several treatment methods to solve bedwetting, including threats and punishment, resulting in frequent punishment of children with enuresis (Ouedraogo, Kere, Ouedraogo, & Jesu, 1997). Up to one-third of parents have been found to punish their children for bedwetting (Butler et al., 1993). A punitive approach, may on the contrary increase the severity of the problem and have an adverse psychological effect on enuretic children.

To the best of our knowledge, no study has evaluated the impact of parental punishment on the psychological status of children with PMNE. The aim of this study was to assess the relationship between parental punishment and depression as well as the quality of life in children with PMNE.

Methods

Study Design and Participants

We performed a cross-sectional, case–control study between September 2013 and April 2014 on a consecutive sample of 65 children (7–13 years) with PMNE who attended the psychiatric outpatient clinics of King Abdulaziz University Hospital. A control group of 40 age- and gender-matched healthy children were selected from the family members of the cases with enuresis. The diagnosis of PMNE was made according to the classification of the International Children's Continence Society (Neveus et al., 2006). As defined by the Diagnostic and Statistical Manual for Mental Disorders (DSM IV) criteria (American Psychiatric Association, 1995), at least twice weekly episodes of urine incontinence for three consecutive months were necessary for the diagnosis of nocturnal enuresis.

The children with PMNE were previously examined by pediatric nephrologists and pediatric neurologists, and clinical investigations (including complete blood counts, blood urea, serum creatinine, serum glucose levels, serum thyroid-stimulating hormone level, urine analysis and culture, measurement of residual urine, as well as renal and bladder ultrasonography) were conducted to rule out lower urinary tract symptoms, bladder dysfunction, and neurogenic bladder. The results of these investigations were normal in all cases. The children had received several treatment trials with imipramine and desmopressin; however, the condition was refractory to treatment.

We assessed whether parents used punitive methods in their children with urinary incontinence by asking close-ended questions such as "Did you punish your child for bedwetting?" If the response was "Yes", further questions were asked as follows:

1. "What punishment method did you use?" This question had four response choices: (a) verbal only, for example, shouting or using aggressive words; (b) verbal and physical punishment without contact, for example, leaving the child wet for long, making the child stand up for long, locking up the child in his room for long periods, or forcing the child to take a cold shower after each incontinence episode; (c) verbal and punishment with physical harm, including spanking, beating, hitting the child's penis with the hand, or searing the child's hand or arm; and (d) a combination of (b) and (c).
2. "What was the frequency of punishment?" This question had two responses, "sometimes" and "frequent".
3. "What was the duration of punishment?" Three responses were allowed: (a) less than six months; (b) six months to one year; and (c) more than one year.

Based on the parents' response to the first question, the children with PMNE was further subdivided into two groups: Group I included children who received punishment and Group II included those who were not punished for enuresis (Fig. 1).

We assessed depression symptom severity and the health-related quality (HRQL) of in all three groups. The socio-demographic data of the participants were recorded. The severity of symptoms (assessed by the frequency of wet nights per week) was recorded for children with nocturnal enuresis. Poor academic performance was also assessed for all the children based on the grades obtained as follows: (1) A, excellent; (2) B, very good; (3) C, good; and (4) D, poor. These four categories were dichotomized into good (which included the first three categories) and poor (which included the last category). Socio-demographic characteristics, severity of enuresis, as well as the method, frequency and duration of punishment were used as independent predictors for depression and HRQL in children with nocturnal enuresis.

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