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Parental Perception and Management of Enuresis

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ABSTRACT

The present study evaluated possible environmental development, physiological and emotional factors as a cause of enuresis. Sixty enuretic children and twenty controls aged 5-12 years were examined. 85% of cases were primary and 15% were secondary enuretics. Parents' views as regards the cause of the problem were evaluated, and they considered it either a developmental or emotional problem or related to deep sleep.

Most parents try simple measures like waking the child, fluid restriction and only 11% tried medications. Stressful life events did not seem to play a role in the causation of the problem. The concept is that enuresis is a manifestation of developmental delay that will remit spontaneously.

INTRODUCTION

Enuresis is manifested as a repetitive inappropriate, involuntary passage of urine after the age when bladder control should have been achieved. The determination of this age varies depending on the cultures and the discipline (psychiatry, urology, paediatrics etc. . .) that is assessing the child.

By the age of five, 75-80 % of children are dry (Arneil, 1984), after age 6 there is spontaneous cure rate of 15% a year, so that by age 10 only about 5% are still enuretic.

Traditionally, the symptom has been thought to be due to one or a combination of factors from psychological, sociological and biological sources. Now the growing corpus of opinion hold that maturational or developmental factors are more critical in causation than are psychodynamic considerations.

From the psychiatric point of view enuresis is classically considered as evidence of both a disturbed family and maladjusted child. Nevertheless, more recent studies suggest the symptoms may indeed be the cause rather than the result of emotional problems in children and families (Feldmann, 1983).

An association with stress and anxiety is often observed. Okasha (1966) related this to the reaction of parents and others to the problem.

Anxiety-provoking life events especially in the third and fourth years of life are frequently associated with enuresis (Kolvin *et al.* 1973).

Developmental factors are undoubtedly involved in the pathogenesis of enuresis largely based on established familial incidence.

It is assumed that genetic influences may determine the development and the training capacity of the bladder (Bakwin 1961, Klockenberg, 1981).

The age and method of toilet training have controversial effects.

Dynamically, enuresis can be viewed

as a desire to regress, a bid for attention, an active plea for help, a stated resentment of parents, and a masturbatory equivalent (Kaplan, 1985), other theories suggest sibling rivalry, feelings of being unwillingness to grow up and a need to deny strength

Three important factors intervene in the presumed pathophysiology of enuresis. The first, genito-urinary factors, sees enuresis as a failure to obtain bladder enlargement. The second sleep physiology factors relates the disorder to certain characteristics of the child's sleep cycle. Yet, most recent studies do not support the concept that enuresis is an arousal disorder.

The third, water regulation factors, views enuresis as an expression of nocturia. The latter may be related to a variety of renal, endocrine and other disorders (Noll *et al.* 1967).

The present work was carried out to evaluate the parents perception of the problem of enuresis and how this may affect their reaction to it.

MATERIAL AND METHODS

The study was carried out on 60 enuretic children selected at random from cases presenting to the out-patient clinic of Cairo University Children Hospital and Ahmed Maher Hospital.

The were males and females ranging from 5-12 years. A control group of 20 healthy children of the same age and sex distribution was included. They had complete urine continence not later than the age of three years.

An interrogation sheet was filled out by the parents including the information about personal and family history of enuresis, age and ways of toilet training, possible stressful events in the child's life, depth of sleep, developmental delays and the parent's view of enuresis.

Patients were categorised into primary and secondary enuretics (relapse after being dry for six months or more).

Complete physical examination was done and only functional enuretics were included in the study. Assessment of motor and mental development was carried out, as well as complete urine and stools analysis to all cases and controls.

RESULTS

Table 1 shows the ages and sex of both groups of children. Of the enuretic group 85% were primary enuretics while 15% were secondary enuretics.

Table 2 shows parental perception of causes of enuresis It is apparent that there was no significant difference between the views of the parents of both groups.

Table 3 outlined the methods used in dealing with the problem by parents of enuretics.

Table 4 showed the incidence of stressful life events in life of both groups.

There was no significant difference between the two groups concerning the age of starting toilet training or the means of training.

There was a statistically significant difference between the two groups concerning the depth of their sleep as the number of heavy sleepers was more among enuretics.

The other difference was concerned with milestones of maturation where there was delayed development among enuretic children significantly more than among normal children.

DISCUSSION

The inter-relationship between the enuretic child and his parents is an issue of considerable controversy. According to one point of view the cultural and standard emotional setting of the parents as well as the pattern of relation with their children may play a considerable role in the pathogenesis of enuresis. On the other hand parents may get frustrated by not clearly knowing which the best reaction should be, when facing the problem of

TABLE I

Ages and Sex of the Sample

Age	No	Sex	
		Males	Females
5-6	18	10 (55.5%)	8 (44.6%)
6-8	22	13 (59.0%)	9 (41.0%)
8-10	15	8 (53.5%)	7 (46.5%)
10-12	5	2 (40.0%)	3 (60.0%)
Total	60	33	27
Mean Age	7.8	7.6	7.9
S.D.	1.9	1.6	2.0

TABLE II

Parental Perceptions of the Cause of Enuresis

	% of Parents Indicating Specific Causes		S.E.	Z With P< 0.05
	Enuretics %	Controls %		
Developmental Problem (Something Child Outgrows)	51	45	12.7	0.3 N.S.
Emotional Problem	50	48	12.8	0.08 N.S
Heavy Sleeping	42	24	10.8	1.1 N.S
Familial (Runs in the Family)	36	17	9.7	1.3 N.S

TABLE III

Parental Methods of Treating Enuresis

Method	% of Parents of Enuretics
1.Wake Up To Urinate	89
2.No Fluid After Supper	85
3.Punish For Wet Night	76
4.Reward Dry Child	63
5.Reassurance of Child	72
6.Give Medicine	11
7.Nothing	0

TABLE IV

History of Stressful Life Events

The Cause	Enuretics 60%	Controls 20%	Test of Significance	Result
I.Maternal Loss	2 (3%)	- (0%)		
2.Birth of Sibling	3 (5%)	2 (10%)	S.E.=11.9	
3.Divorce of Parents	5 (8%)	- (0%)	P1-P2	N.S.
4.School Problems	6 (10%)	3 (15%)	Z=0.2	
5.Hospitalization	2 (3%)	- (0%)		
Total	18 (30%)	5 (25%)		

an enuretic child. A train of secondary emotional and behavioral consequences may follow as a result rather than a cause of enuresis.

The present study addresses this question through comparing certain physical, cultural, psychological and emotional parameters in two groups of parents, those with an enuretic child and those without.

Our data have failed to identify any statistically significant difference among the two groups, as both groups were similar in the way the parents looked at the problem, e. g. 51 % of enuretics parents regarded it as developmental delay as compared to 45% of control parents.

Regarding the problem as emotional was seen by 50% and 48% respectively. 42% of the enuretic group's parents said their children were heavy sleepers as compared to 24% of normals but it did not amount to a statistical difference.

Being a familial disorder was viewed by 36% of the enuretic's parents as compared to 17% of controls, still not significant.

Stressful life events was almost equal in the history of both groups. So apparently it was not the determining factor (although on individual basis it was the immediate cause for the occurrence of enuresis in some cases who were secondary enuretics).

There was no difference among the two groups concerning the commencement and means of toilet training which excluded the importance of this factor in this study.

Enuretics were heavy sleepers in 45% of cases as compared to 20% only in controls (a statistically significant difference). Yet the parents of enuretics when asked about their views on the causation of enuresis deep sleep was not a prominent point of view.

These data seem to rule out any significant psychological built or emotional factors on enuresis. They also seem to deny significant reflection of this disorder on their behaviour. They are in accordance with Bakwin (1961) Klockenburg (1981), and Noll *et al.* (1967) who all exclude the possibility of a psychodynamic factor in the precipitation of enuresis. Yet they do not conform with the observation of other authors like Okasha (1966), Kaplan, Kolvin and others who view enuresis as emotional disorder or at least partly emotional problem. By these observation we come to support the growing concept of enuresis being a developmental disorder. According to this theory we contend with having an age factor in maturation of each child. Also it explains the equivocal experience of psychological manipulation of enuretic children. In fact, when we see a group of enuretic children, they don't seem to have any other problem than their symptom.

So we come to the conclusion that most enuretics remit spontaneously just as physicians have reassured parents for centuries.

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ABSTRAIT

La Perception des Parents et Leur Traitement des Enfants Enuretiques

Les facteurs qui peuvent causer l'énurésie nocturnel chez les enfants Egyptiens et la facon que leur parents percoient le problème étaient etudié.

Les facteurs d'environnement, des émotions et de la psychologie etaient considerés. 60 enfants entre 5 et 12 ans souffrant de l'énurésie et 20 controlés etaient examinés, 85% avaient l'énurésie primaire et 15% secondaire. Les parents considèrent le problème comme un retard de développement, un problème emotional ou à cause du sommeil profond. La plupart essaie les methodes simples comme reveiller l'enfant ou limiter les liquides. Seulement 11% utilise les medicaments. II ne semble pas de l'étude que l'âge de l'entrainement pour le pot ou bien les evenements troublants de la vie des enfants jouent une role. On peut voir le problème comme un retard de développement qui s'arrange avec le temps.

الموجز

مفهوم الآباء وعلاج التبول اللاارادى (البوال)

تبحث هذه الدراسة الاختلافات البيئية والنموية والفسيولوجية والعاطفية المتوقع وجودها عند المقارنة بين الاطفال الذين يعانون من التبول اللاارادى.و تمت هذه الدراسة على ٦٠ طفلا مريضا بالتبول اللاارادى و٢٠ طفلا كمجموعة ضابطة من المتحكمين فى التبول قبل سن ثلاث سنوات ، ولقد تراوحت أعمارهم بين 5 و ١٢عاما ، وكانت نسبة البوال الاولى ٨٥٪ والثانوى ١٥٪ .

وقد قيمت وجهة نظر الوالدين فى سبب المشكلة : هل هو فى النمو أو متعلق بالنوم العميق أم أنها مشكلة عاطفية . وقد استخدم معظم الآباء وسائل بسيطة مثل إيقاظ الطفل، أو/و التقليل من السوائل، واستخدم ١١٪ فقط العلاج بالعقاقير ، ولم تظهر الدراسة أن مشاكل الحياة الضاغطة تلعب دورا مسببا فى المشكلة . وتخلص هذه الدراسة إلى أن التبول اللاارادى (البوال) اختلال فى التطور الوظيفى وتأخير لا يلبث أن يشفى تلقائيا فى معظم الحالات .