Emotional Problems in Childhood and Adolescence

Wetting and Soiling

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Wetting and soiling, when not due to organic disease, may arise in any of three ways: (1) as a result of the normal absence of cerebral control in early life (infantile incontinence); (2) as an integral part of the (non-specific) physiological syndrome of fear (reactive incontinence); (3) as an indirect result of a (specific) fear of incontinence, largely caused by attempts to terminate either of the other types (paradoxical incontinence).

Infantile Incontinence

All babies are incontinent at first, but all (except a very few with physical defects) will gain sphincter control in their own good time if allowed to do so. Nevertheless, this time varies considerably from child¹⁻⁵ (for instance, some 10%—or more—of all children are still wetting their beds at the age of 5); though it is difficult to know how far the age range given by various authors¹⁻⁵ means that many children's cortical maturation is slow by nature, or how far it indicates delay due to toilet training or other pressures.

Reactive Incontinence

Enuresis has long been considered a sign of emotional disturbance; and there is good evidence of its frequent association with various upsetting experiences,⁴⁻⁸ and with other psychiatric symptoms in the affected children⁴⁻⁷—including adolescents.⁹ Likewise, soiling is often very obviously related to conflict and distress;⁵⁻¹⁰⁻¹² thus in a recent series of 60 encopretic children¹² every one showed other definite signs of emotional disorder or was under considerable stress (usually both), and the majority appeared to have been persistently punished.

It is well known that children—and even adults—may suddenly lose control of their sphincters in an emotional crisis; and this non-specific primitive "protective reaction"¹³ to immediate stress seems to be the cause of much enuresis (especially diurnal¹⁴) and of encopresis—including, for example, that of more than half the subjects in the series just mentioned.¹²

Paradoxical Incontinence

GENERAL CONSIDERATIONS

In many cases incontinence appears to be a more indirect result of a specific fear—namely, that of actually being incontinent—which (as explained below) may lead to bed-wetting or to the various distinctive types of soiling related to constipation; so

the more a child is made to dread being wet or soiled, the more likely he is to be so. If his parents then regard him as lazy or defiant, and become angry and punitive, they will defeat their own purpose; for the child cannot prevent his symptoms and his only refuge will be to simulate unconcern, which will further exasperate the parents and aggravate the vicious circle.

The objection sometimes raised that the punishment is provoked by the incontinence—rather than the other way about—is less a contradiction (since both are true) than a way of saying that the parents' basic problem lies not in their child's inability to control his sphincters, but in their own inability to control their consequent anxious and hostile feelings.⁵⁻¹⁰⁻¹²⁻¹⁴⁻¹⁶ Unfortunately, many parents are prey to such feelings even before the child is old enough to be clean and dry; hence, though it is quite unnecessary (as well as impossible) to "train" a child's bladder¹⁻² or bowel,¹²⁻¹⁷⁻¹⁸ they are irresistibly impelled to do so—and thereby to perpetuate the very wetting¹⁻²⁻¹⁴⁻¹⁶ and soiling⁵⁻¹¹⁻¹²⁻¹⁵ they are trying to stop (at the same time generating any degree of emotional disturbance²⁻⁹⁻¹¹⁻¹²⁻¹⁵).

SLEEP ENURESIS

Perhaps it is because parental annoyance seems an obvious reaction to nocturnal enuresis that the converse proposition is apt to be overlooked. But it is also obvious that shaming or punishing a child for bed-wetting will make him afraid of waking in a wet bed; and as he comes to expect his bed always to be wet he will not dare to wake up even when his bladder is distended or (corroborating the tradition that enuretics sleep deeply) when his parents try to rouse him, so that eventually his bladder is bound to empty itself and soak his bed—thus reinforcing his fear and perpetuating the disorder. Moreover, believing this to be inevitable, he will lack the incentive to hold his urine for even short periods (hence the small bladder capacity reputed to be typical of enuretics¹⁻⁷⁻⁸).

This explanation helps to elucidate—and is in turn supported by—results claimed for the electric enuresis alarm (though this is not necessarily to endorse a procedure whose aim ought to be attainable by more appropriate and less distressing means). At first, the device rudely wakens the child and cuts short his micturition just after it starts; and subsequent developments seem to be largely prompted by the child's urge to avoid repetitions of that unpleasant experience. Since a built-in signal is already available to herald the onset of the reflex for micturition—namely, the sensation of bladder distension, which is the normal (unconditioned) stimulus for its initiation—that same signal can also serve to elicit (conditioned) inhibition of the reflex, which will tend to persist as a "rewarded" response because it forestalls the alarm, in addition to (and as a result of) keeping the bed dry.

However, that any child should apparently need so contrived (and even traumatic) an aid to acquire the normal ability to keep dry while still asleep—and to wake up while still dry—cannot be credibly explained by supposing he does not mind the "somatic discomfort"¹ of lying in a wet bed as much

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as other people (especially when children accused of bed-wetting seem as a rule to be most unhappy individuals with a great deal to gain by becoming dry); but cogently suggests the existence of an opposing fear strong enough to prevent him from waking even when he can no longer hold his urine. For the alarm can be made loud enough to waken the child despite such a fear, and by doing so when his bed is still dry (or almost so) it will dispel his conviction that this is impossible; while the indirect function of the alarm (inhibiting micturition through the night) will reassure him that he can be dry even when he wakes naturally.

CONSTIPATION AND SOILING

There is no way of hastening the maturation of cortical control, and both theory and practice indicate that the only conditioning procedure likely to make a permanent change in a child's bowel habit is repeatedly punishing him for having a motion,¹² which will undoubtedly tend to inhibit his defaecation reflex. (Fear of defaecation may, of course, be initiated by other factors, such as a painful fissure or hard stools—or perhaps a distressing diarrhoeal illness—though even then its perpetuation is apt to be due to coercion.) But, apart from the more general objections to punishment, such inhibition will be outside the child's volitional control, so that he will be unable to prevent his rectum filling until its distension overrules the inhibition and activates the reflex, causing his bowel to empty suddenly and irresistibly wherever he happens to be. This "exigent"¹² (or "imperative") type of defaecation is similar to what will eventually overtake anyone forced by circumstances to wait too long.

Since the toilet situation (including the mother's presence) is particularly associated with the inhibitory stimuli, the child will tend to have even greater difficulty in opening his bowel when he is meant to than when he is not; hence the common complaint that a child "refuses" to perform in the lavatory, but fills his trousers (with a large but otherwise normal stool) as soon as he runs off to play and is relaxed. Such "respite"¹² soiling, though involuntary, is all too likely to be taken for defiance.

If the child is then further punished his inhibition will increase, greater and greater degrees of rectal distension will be needed to initiate the defaecation reflex, and rectal emptying will become more and more incomplete. As the process continues the rectum gets more and more tightly packed, and involuntary defaecation tends to occur from time to time whenever the rectal tension reaches its (increasingly high) threshold level, and stops as the pressure falls again with the passage of a small stool. This relatively common "displacement" soiling is often mistakenly called "constipation with overflow"—though the latter term more suitably denotes the final stage (that of complete stasis), which is probably rare in childhood.¹²

PURPOSIVE EXCRETORY MISPLACEMENT

Clinical experience does not support the view that a child may soil deliberately for pleasure or revenge,¹² and it is indeed difficult to see how he could do so; for either his rectum is full, which implies an inability to defaecate, or it is empty and there is no stool to pass. It is obviously possible to micturate deliberately and belligerently, but this and smearing and related activities are to be regarded as conduct disorders independent of incontinence—though no doubt stemming from similar interpersonal conflicts, and generally denoting severe disturbance.

Clinical Management

PREVENTION

The family doctor can hardly render a more valuable service to young parents (or to the cause of preventive mental health)

than by helping them not to worry about their children's excretory progress. A normal child, on good terms with his elders, wants to be like them and will adopt their toilet customs when his sphincter control is mature enough to make this possible (and cannot by any means be made to do so earlier). But the longer this takes the more the parents may require sympathetic encouragement to withstand their neighbours' disapproval or their own misgivings; and to accept that trying to force a toddler to be clean and dry before he is ready, besides prejudicing his future well-being, will tend to prolong his incontinence—and so enhance, not ease, the mother's burden. Moreover, if for any reason a child does have difficulty in opening his bowel he will have an especial need for comforting and freedom from coercion (otherwise the difficulty is likely to persist), and his parents may find it hard to meet this need unless the doctor gives them plenty of similar support.

More generally, prevention depends on allaying parents' anxieties, resentments, and guilt feelings, whenever possible (preferably before their children are born), in order to ease their relations with each other and with their children, and thus promote in turn the latter's freedom from anxiety and fear. It goes without saying that parents who are unable to accept advice must not be admonished, or even argued with, but should be regarded as presenting the doctor with a chance to help them with their emotional conflicts.

DIAGNOSIS

Investigating a child's incontinence—when it cannot be confidently attributed to immaturity—should start with reasonable, but not excessive, measures to exclude organic disease. If no evidence of this emerges during routine case taking, including physical examination of child and urine, recourse to more exhaustive procedures (which may themselves be seriously upsetting) should be postponed until any emotional disturbance has been attended to.

Many a child has suffered years of distressing tests and treatments (even surgical operations) to appease a parent's unrealistic expectation of early sphincter control, or because his (actual or alleged) wetting or soiling was not recognized as the "presenting symptom"¹⁹ of his parent's own emotional disorder. Child and parent should therefore be seen apart, each being regarded as a patient in his own right, and the problems (both subjective and objective) of each considered on their merits.

Since the various forms of psychogenic incontinence have in common that they arise (if often by different—even diametrically opposite—processes) from some kind of fear, it is possible for a particular child to be afflicted by more than one variety at the same time.¹² However, for clinical purposes a clear diagnosis is less important than identifying the actual causal fear (though it is often necessary to confirm or exclude dyschezia—which can be done readily and reliably by rectal examination).

TREATMENT

Apart from the mechanical emptying of a persistently loaded bowel (which may be made less irksome by the use of proprietary "micro-enemas" if it has to be repeated for long), wetting and soiling seldom indicate that anything should be done directly to the child: on the contrary, they generally mean he needs rescuing from what is already happening to him.^{2 9 10 12 14 15} Day-time wetting and fear soiling usually respond to a genuine cessation of scolding and punishment at home and at school, though psychotherapy may also be needed for longstanding problems in older children.

The specific treatment of sleep wetting is to emancipate the child from his dread of waking in a wet bed. (Though the electric alarm may sometimes dispel enuresis in the way de-

scribed, it does not do so by improving relationships; and if the relationships are first repaired enough to make it reasonably safe to use the alarm, its use may be no longer necessary.) Likewise, early dyschezia—and its associated types of soiling—can be reversed by enabling the child to lose his fear of defaecation (which may entail helping his parents to realize that the soiling is actually to be welcomed while it lasts, as far better than severe constipation). Evidently the treatment of a child who is wetting or soiling should be the very opposite of the usual injunctions (whether threatening or merely exhortatory) to “try harder”; for, unless he has given up in shame or despair, he will be already trying too hard. Moreover, it is essential for him to be able to learn that his parents are more concerned for his happiness than his sphincter control, and that he can be sure of friendly sympathy even (indeed, especially) when he is wet or soiled.

Yet the doctor will often find that advice alone is not enough to enable parents to modify their methods, and that he will need to use psychotherapeutic skill¹⁹⁻²¹ to overcome their anxious doubts, or to alleviate a parental disturbance whose existence the child's symptoms (though undoubtedly important in themselves) have served to bring to light.

References

- ¹ Crosby, N. D., *Medical Journal of Australia*, 1950, **2**, 533.
- ² Klackenberg, G., *Acta Paediatrica*, 1955, **44**, 513.
- ³ Blomfield, J. M., and Douglas, J. W. B., *Lancet*, 1956, **1**, 850.
- ⁴ Miller, F. J. W., Court, S. D. M., Walton, W. S., and Knox, E. G., *Growing up in Newcastle upon Tyne*, London, Oxford University Press, 1960.
- ⁵ Bellman, M., *Acta Paediatrica, Supplement*, No. 170, 1966.
- ⁶ Cust, G., *Lancet*, 1958, **2**, 1167.
- ⁷ Hallgren, B., in *Acta Paediatrica, Supplement*, No. 118, 1959, p. 66.
- ⁸ Young, G. C., *Medical Officer*, 1965, **113**, 19.
- ⁹ Woodmansey, A. C., *British Journal of Medical Psychology*, 1969, **42**, 353.
- ¹⁰ Shirley, H. F., *Journal of Pediatrics*, 1938, **12**, 367.
- ¹¹ Anthony, E. J., *British Journal of Medical Psychology*, 1957, **30**, 146.
- ¹² Woodmansey, A. C., *British Journal of Medical Psychology*, 1967, **40**, 207.
- ¹³ Wolff, H. G., *Stress and Disease*. Springfield, Thomas, 1953.
- ¹⁴ Bostock, J., and Shackleton, M. G., *Medical Journal of Australia*, 1951, **2**, 110.
- ¹⁵ Pinkerton, P., *Archives of Disease in Childhood*, 1958, **33**, 371.
- ¹⁶ Newson, J., and Newson, E., *Four Years Old in an Urban Community*, 1968, London: Allen and Unwin.
- ¹⁷ Whiting, J. W. M., and Child, I. L., *Child Training and Personality*, Newhaven, Yale University Press, 1953.
- ¹⁸ Sears, R. R., Maccoby, E. E., and Levin, H., *Patterns of Child Rearing*. Evanston, Row, Peterson, 1957.
- ¹⁹ Balint, M., *The Doctor, his Patient, and the Illness*. London, Pitman Medical Publishing Co. Ltd., 1957.
- ²⁰ Woodmansey, A. C., *Lancet*, 1970, **1**, 610.
- ²¹ Woodmansey, A. C., *Developmental Medicine and Child Neurology*, 1971, **13**, 243.

Therapeutic Conferences

Diabetes Mellitus—Refractory Obesity

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DR. J. M. STOWERS: We have already discussed the treatment of patients who have diabetes mellitus and obesity by dietary measures. Theoretically diet should control about 30-40% of diagnosed diabetic patients but most clinicians recognize that many patients do not lose weight despite encouragement and careful explanation.

A Woman with Diabetes Mellitus and Refractory Obesity

HOUSE PHYSICIAN: This 55-year-old obese woman was diagnosed as having maturity-onset diabetes mellitus 18 months ago. She had presented with a classical anterior myocardial infarction and while in the ward was found to have glycosuria without ketonuria.

DR. R. A. WOOD: It is important to recognize that the oral glucose tolerance test may be abnormal for some weeks after a myocardial infarction, and it was for this reason that we delayed doing the oral test.

DR. STOWERS: Yes. The immobility of bed rest and the metabolic changes associated with the stresses of recent myocardial infarction temporarily reduce the glucose tolerance.

HOUSE PHYSICIAN: She has sporadically attended the diabetic clinic but in spite of careful explanation she has lost only 3 kg in weight. She now complains of lassitude. Venous blood sugars two hours after lunch are around 200 mg/100 ml. She does not have ketonuria.

STUDENT: If the patient could return to her ideal weight, would the complications of diabetes mellitus be reduced or prevented?

DR. STOWERS: That would depend on how completely the intolerance to sugar responded to dietary control and on other ill-defined factors which produce the large variation in the incidence of complications in patients with diabetes of similar degree and duration.

DR. J. C. PETRIE: Whatever else the dietary restrictions achieved, she would avoid or reduce the complications of obesity.

TOLERANCE TESTS

STUDENT: You have discussed the oral glucose tolerance test, but do you carry out intravenous glucose tolerance tests instead of oral tests?

DR. STOWERS: The oral glucose tolerance test relates blood and urine glucose levels and thus helps in diagnosing renal glycosuria. The intravenous test avoids the variable factor of gastrointestinal absorption and measures only the rate of disposal of the injected glucose. Results may be expressed

Appointments of Speakers

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