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Effect of enuresis on perceived parental acceptance-rejection in children

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What is already known on this topic?

- *Enuresis can affect both mother's and child's psychology and quality of life.*
- *Parental acceptance is very important in the psychosocial development of children.*
- *It has been shown that there is a relationship between high parental rejection and depression, loss of social skills, and emotional lability in patients.*

What this study adds on this topic?

- *The effect of enuresis on parental acceptance-rejection in children was studied for the first time.*
- *In children with urinary incontinence, no difference was found between the levels of acceptance/rejection expressed by mothers and perceived by children.*
- *Children with enuresis perceive their mothers' behavior as more hostile than they are.*

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ABSTRACT

Objective: Enuresis is a major problem affecting both the child and his family. This study aimed to investigate the effect of enuresis on mother acceptance-rejection perceived by children.

Material and Methods: Fourty-six children and their mothers with the diagnosis of primary enuresis were included in the study. Parental Acceptance-Rejection Scale which consisted of 60 questions and consisted of four subscales: affection, hostility, neglect, and undifferentiated rejection was applied to both mothers and children. A dependent Sample t-test was used to compare the scale results of mothers and children, and an independent sample t-test was used to determine the factors affecting perceived high mother hostility in children.

Results: The mean age was 10.12±1.34 years and 58.70% of the children were boys. There was no statistically significant difference between total acceptance-rejection, affection, neglect, and undifferentiated rejection scores of mothers and children's perceptions. The perceived hostility score of the children (25.71±8.05) was higher than the mothers' hostility score (22.52±6.26) ($p<0.05$). The presence of maternal chronic disease was found to increase the perceived high hostility, while other factors were not statistically significant. Thirteen cases with chronic illnesses were excluded and re-analysis revealed that the difference between perceived and mother hostility persisted ($p<0.05$).

Conclusion: Children with enuresis perceive their mother's behavior as more hostile than they are. It should be kept in mind that enuresis may affect the mother and child relationship, the family should be informed about the approach to the child.

Keywords: Enuresis, parental acceptance-rejection, perceived hostility

Introduction

Enuresis is one of the most common urinary system problems in childhood. In children over 5 years of age who do not have congenital or acquired central nervous system disease, involuntary bedwetting is defined as enuresis. Primary enuresis is the inability of urine control after birth, while secondary enuresis is the recurrence of urinary incontinence after a dry period of more than 6 months. Although the frequency of primary enuresis varies between societies, it has been reported that this frequency is 15-20% at the age of 5, and although it decreases with age, 7% of 10-year-olds continue to leak urine (1). Although it was previously thought that child psychology is an important cause in the development of enuresis, studies suggest that psychological problems might actually appear as consequences not just the cause of the situation (2, 3). Due to recurrent bedwetting, the quality of life of the mother and child decreases, and the relationship of the child with their peers may be adversely affected. Also, the parent's hu-

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miliation and condemnation of the child can damage the child's self-confidence (1, 4-6). It has been reported that the parents of children who cannot gain urine control feel under pressure, question their parenting abilities, and feel disappointed (7). Butler et al. (8) stated that the family may be strained due to extra workload such as constantly washing clothes, waking up many times at night, and bad smell of the room and this situation may lead to punishment behavior. As a result of all these factors, enuresis can disrupt the parent-child relationship.

It has been known for many years that all children need positive relationships with their parents. When this relationship cannot be developed, it has been shown that children can exhibit more aggressive and dependent behaviors, have lower social skills and self-esteem, and these children are more unsuccessful in relationships with their peers (9, 10).

One of the cornerstones of a positive parent-child relationship is that the child is accepted by the parents. Rohner and Rohner (11) tried to explain the effects of the parent-child relationship on the psychological development of the person and developed the Parental Acceptance-Rejection Theory. This theory is based on the idea that all people in the world need to receive a sense of warmth from those who are important to them and suggests that acceptance or rejection by parents in childhood affects an individual's emotional, behavioral, and social-cognitive development. According to Rohner, there is no other experience that affects children as much as being accepted or rejected by their parents. The theory mainly focused on the warmth dimension of parenting. While acceptance behavior defines the warmth, affection, care, interest, and support of the family towards their children, in short, the love that comes to the fore, rejection is defined as the absence of these feelings and behaviors, as well as the display of various physical or psychological behaviors or emotions that hurt the child (11, 12).

At the positive end of the warmth dimension is parental acceptance with the parental rejection at the other end. There can be different forms of parental rejection. Parents may behave cold and loveless, hostile and aggressive, indifferent and negligent, or exhibit undifferentiated rejection behavior. In undifferentiated rejection, although parents do not like their children, they do not exhibit one of the behaviors clearly stated about it. However, the child's perception of acceptance-rejection may not always be parallel with parental behavior (13). Sometimes, even if the parent is not warm to the child, the child may not perceive this as rejecting or, on the contrary, the child may feel the parent's non-cold behavior as cold or aggressive. Therefore, whatever the parental acceptance level is, what is more, important for child psychology is how the child perceives this situation (13, 14).

Studies on the parental acceptance-rejection theory since its definition have revealed the importance of this theory in the child's psychology and future life. Publications are stating that as the parent's warmth increases, the child's low self-perception and aggressive behavior decrease, on the contrary, children who perceive rejection from their mothers show more depressive symptoms (15, 16).

Despite the increase in the number of publications on parental acceptance and rejection theory in recent years, what is known about children is very limited (10, 15-22). Also, there is no previous study investigating parental acceptance-rejection in children with enuresis. This study aims to examine the effect of enuresis on the maternal acceptance-rejection level and the child's perception of acceptance-rejection.

Material and methods

Sample

The study was conducted at Ankara Yıldırım Beyazıt University, Yenimahalle Training and Research Hospital Hospital between 01.07.2019-01.10.2019. The population of the study consisted of children over 8 years old and their mothers who applied to the pediatric nephrology outpatient clinic for the first time with the complaint of incontinence at night and were diagnosed with primary enuresis. Mothers and children were informed about the study, written consent was obtained from the mothers and verbal consent was obtained from the children. The mothers were asked to fill in the demographic information form and the Parental acceptance-rejection questionnaire (PARQ) adult form, and the children were asked to fill the PARQ child form. The forms were filled in separate rooms not to affect the mother-child couple from each other. Mothers or children with neurological or psychiatric diseases were not included in the study. Children whose parents were divorced were not included in the study considering that it might affect the parent-child relationship.

Data collection tools

Demographic Information Form: A demographic information form was prepared to record the sociodemographic data of the participants. The age of the child and mother, the gender of the child, the education level of the parents, the income level, the number of children, the history of enuresis in the family members, and the presence of chronic disease were questioned in the form, The Parental Acceptance-Rejection Questionnaire (PARQ) Adult and Child Form: It was developed by Rohner and Rohner (11) to evaluate parental acceptance-rejection.

The parent form was adapted to Turkish by Anjel (23) in 1993, and its validity and reliability were made by Erkman and Varan (17). The child form measures perceived parental acceptance-rejection, and its Turkish validity and reliability were made by Polat (24) and Erdem (25). The scales consist of four subscales: 20-item warmth/affection, 15-item hostility, 15-item neglect, and 10-item undifferentiated rejection, and a total of 60 items. Both forms consist of items measuring the same behavior. For example, the first item in the child form, "She says good things about me", is included in the parent form as "I say good things about my child". The scales are 4-point Likert (1 = never true, 4 = almost always true). The sum of the scores from the four subscales expresses parent / perceived parental acceptance-rejection. Items measuring affection are scored by reversing. In total, a minimum of 60 and a maximum of 240 points can be obtained from the scales. The scale does not have a cut-off point, the higher the score, the higher the rejection level (17, 26).

Statistical analysis

Statistical analysis was performed using IBM Statistical Package for the Social Sciences version 23.0 (IBM SPSS Corp.; Armonk, NY, USA) statistical package program. Descriptive statistics were given as mean ± standard deviation (SD) for numerical data with normal distribution and as percentages

for categorical data. The dependent sample t-test was used to compare the scale scores of the mothers and their children. An independent sample t-test was used to determine the factors that may affect perceived maternal hostility. A p-value of <0.05 was considered significant.

Ethics committee approval for the study was received from the Ankara Yıldırım Beyazıt University, Yenimahalle Training and Research Hospital Clinical Research Ethics Committee (Approval date: 12/11/2019, number: 2019/10/01). The study was conducted following the Helsinki declaration principles. No financial support was received for the study.

Results

Twenty-seven (58.70%) Of the total 46 children were boys, 19 were girls, their mean age was 10.12 ± 1.34, and the mean age of mothers was 37.00±5.90. The siblings of 43.47% of the children also had enuresis. The rate of those whose parents had a history of enuresis was 52.17%. 74% of the families had a middle-income level and the average number of children was 2.43±0.82. Approximately half of the parents were found to have an education in high school or above. It was observed that 4 of the children and 13 of the mothers had chronic diseases. It was learned that children with chronic diseases were followed up for short stature, allergic rhinitis, precocious puberty, and chronic constipation, while four mothers were followed up for hypertension, three for Diabetes mellitus, two for kidney stones, and the others for heart disease, asthma, thrombophilia, and peptic ulcer. No child or mother had any psychiatric or neurological disease. None of the mothers and children had a life-threatening disease.

The sociodemographic data of the children and their families participating in the study are summarized in Table 1.

Table 1. Sociodemographic data of children and families

Category		Mean±SD n (%)
Gender	F	19 (41.3)
	M	27 (58.7)
Age		10.12±1.34 years
Mother's education level	Primary school and below (<5 years)	14
	Secondary school graduate	10
	High school graduate	13
	University and above	9
Father's education level	Primary school and below (<5 years)	11
	Secondary school graduate	11
	High school graduate	14
	University and above	10
Income rate	<2000 TL	9 (19.56)
	Between 2001 - 5000 TL	34 (73.91)
	>5001 TL	3 (6.52)
Family history of enuresis		24 (52.17)
Enuresis history in siblings		20 (43.47)
Chronic illness in the mother		13 (28.3)
Chronic illness in the child		4 (8.69)

When the acceptance-rejection levels expressed by the mothers and perceived by the children were compared, no statistically significant difference was found between the total acceptance-rejection, warmth, neglect, and undifferentiated rejection scores (p>0.05). It was observed that the hostility perceived by the children (25.71±8.05) was higher than the hostility score expressed by the mothers (22.52±6.26) (p<0.05). The perception of the children and the acceptance-rejection scores of the mothers are shown in Table 2.

The perceived hostility to the mother did not change statistically according to gender, age, maternal age, chronic illness in the child, enuresis in the sibling, chronic illness in the sibling, and maternal education (p>0.05). However, it was observed that the perceived maternal hostility score of children with a chronic disease in their mothers was higher than those without (27.84±6.05, 24.87±8.69, p<0.05, respectively) (Table 3).

Table 2. The evaluation of mothers' acceptance-rejection scores and perceived acceptance-rejection scores of children

Category	Scoring range of points	Children's scores (mean±SD)	Mothers' scores (mean ± SD)	p
Warmth	20-80	31.13±10.4	30.60±8.8	0.756
Neglect	15-60	24.02±7.6	22.84±6.9	0.357
Hostility	15-60	25.71±8.05	22.52±6.26	0.018
Undifferentiated rejection	10-40	15.54±4.8	15±4.7	0.501
Total score (Acceptance-rejection)	60-240	96.41±27.2	90.97±24.1	0.206

Dependent Sample t-Test was used.

Table 3. Evaluation of the factors affecting perceived maternal hostility

Variables		n (%)	Perceived hostility to the mother (mean±SS)	P
Gender	F	19 (41.3)	24.473±7.06	0.503
	M	27 (58.7)	25.94±8.75	
Age	<10 years	21 (45.7)	28.09±9.26	0.452
	≥10 years	25 (54.3)	23.72± 6.40	
Maternal age	<40 years	29 (63)	26.20±9.34	0.141
	≥40 years	17 (37)	24.88±5.36	
Mother's education level	Secondary education and below	24 (52.2)	25.33±7.44	0.740
	High school and above	22 (47.8)	26.13±8.83	
Chronic illness in the child	Yes	4 (8.7)	25.47±8.36	0.517
	No	42 (91.3)	25.47±2.87	
Chronic disease in sibling	Yes	5 (10.9)	25.14±8.18	0.171
	No	41 (89.1)	30.4±5.4	
Chronic illness in the mother	Yes	13 (28.3)	27.84±6.05	0.043
	No	33 (71.7)	24.87±8.69	
Enuresis in sibling	Yes	20 (43.5)	24.64±5.45	0.437
	No	26 (56.5)	26.53±9.62	

Independent Sample t-Test was used.

Since 13 cases with chronic diseases in their mothers were excluded because it might be a confounding factor, and the analysis was repeated, it was seen that the difference between perceived hostility to the mother and hostility expressed by the mother continued ($p<0.05$).

Discussion

In this study, the perceptions of children with enuresis and the levels of acceptance-rejection expressed by their mothers were compared, and no significant difference was found between levels of warmth, neglect, and undifferentiated rejection. However, it has been shown that children with enuresis perceive their mothers' behavior more hostile than they are, regardless of age, gender, and socioeconomic status.

A positive parent-child relationship plays a key role in raising psychologically healthy individuals. The deterioration of this relationship can manifest itself with depression, aggression, or loss of social skills in later years. Another dimension of the healthy mother-child relationship is the acceptance of the child by the mother. Studies have proven the importance of parental acceptance in psychological development (9, 11, 13, 15, 19, 21).

Finkenauer et al. (19) examined 1359 students between the ages of 10-14 in terms of the relationship between parental behavior and children's emotional and behavioral problems and showed that the emotional problems of the child decreased with the increase in parental acceptance level. In another study, a parental acceptance-rejection scale was applied to 366 undergraduate and graduate students, and it was found that parental rejection predicted depression (22). Similarly, it was stated that as the parental acceptance level of 5-6-year-old children increases, children's social skills also increase and the acceptance level of the family has a predictive effect on the child's social skills (18). This information reveals the importance of parental rejection for the psychosocial development of children. It is very important to know the situations that may affect the parent-child relationship badly and to take precautions in this regard.

One of the conditions that can disrupt family relationships in childhood is enuresis. Many factors are known to play a role in enuresis. Although it has been suggested in previous studies that psychiatric causes are important in the etiology of enuresis, more recent publications have stated that enuresis is an organic pathology and psychiatric causes do not play the main role in etiology (2). On the other hand, it has been reported that many families can cope with enuresis, but the expectation of providing urine control increases with the age of the child, and this increases the anxiety level of both the child and the family. An increase in the anxiety level can lead to wrong attitudes such as humiliation, or punishment of the child, which may adversely affect the child's relationship with their parents. Again, the increase in the anxiety level of the child and the feeling of insufficiency in providing urine control causes a decrease in his self-confidence and increases the possibility of facing psychiatric problems in the following years (6, 27, 28).

When we take a closer look at the publications published in recent years, in a study examining 46 children with enuresis between the ages of 6 and 18, the self-confidence level of children who wet their bed was lower and this situation affects friendship relations (28). In a similar report, it was stated that enuresis significantly reduced the quality of life of both mother and child, the self-confidence of these children decreased and the low self-esteem became more pronounced as the age increased. Therefore, the authors emphasized that when encountering children with enuresis, psychiatric evaluation should be done to evaluate the results rather than etiology (6).

Although there has been no study regarding the maternal acceptance-rejection level in children with enuresis, it seems plausible that the mother-child relationship may be disrupted due to the additional workload caused by recurrent incontinence at night, the child feeling inadequate, and the increase in anxiety level. In our study, it was observed that children with urinary incontinence perceive their mothers' behavior as more hostile than they are. In further analysis, it was seen that this change in perception was not affected by factors such as gender, age, socioeconomic status, education level, and the presence of another individual with enuresis in the family.

In our study, it was observed that the mother's chronic illness increased the perceived high maternal hostility statistically, while other factors had no significant effect. Studies have shown that chronic diseases reduce the quality of life and lead to psychiatric problems, especially depression (29, 30). It is also known that parental illness can cause anxiety for children (31). In a study evaluating the coping capacities of children whose parents are ill, it was reported that parental depression affects the child's level of coping with the disease. For this reason, the authors argued that correcting the depression of sick parents also affects child psychology (32). Also, in a study examining the children of divorced mothers, it was shown that children of mothers with chronic diseases consult a doctor with more emotional problems (33). Although the warmth scores of mothers with an ongoing disease in our study were found to be similar to healthy mothers, the higher perceived hostility can be explained by the ongoing disease both indirectly by affecting the maternal psychology, and by the direct reflection of the disease on the child psychology. Based on this, it was seen that the difference between perceived hostility to the mother and hostility expressed by the mother continued when 13 cases with chronic diseases in their mothers were excluded and re-analyzed considering that there might be a confounding factor. Thus, it was concluded that children with enuresis perceive their mothers' behavior as more hostile, independent of other factors.

Some studies found that older children with enuresis had a lower level of self-confidence, and it was stated that this situation rapidly improved with the treatment of enuresis (6). In our study, no relationship was found between the age of children and perceived hostility to the mother. This may be because the younger age group was not included in the study. However, the children included in the study were on average 10 years old and were brought to the physician for the first time with a complaint of enuresis. From this point of view, it was thought that the high perceived hostility to the mother in our study might be related to the prolongation of the process. Also, by increasing the knowledge level of families about enuresis, blaming and humiliating behaviors of the family towards the child will be prevented and it will be ensured that they seek a solution to

this problem before the family relations are affected by applying to the health center earlier. Knowing the psychological consequences of enuresis by physicians may enable families who are at risk to be referred to a psychiatrist without delay, by evaluating the child in terms of the mother-child relationship, rather than examining the child only from a medical perspective. Considering that enuresis is so common in our country, it can be better understood how important consequences these measures can have in terms of public health.

The limitations of our study are that it was performed in a single and tertiary health center and it included a small number of patients. Also, the mother-child relationship was evaluated only at the application, the effect of the response to treatment on the mother-child relationship was not examined. However, the fact that the sample of our study consisted of middle-income families, most of whom were primary-high school graduates, suggests that although it does not reflect our country, it does not contradict the general picture of our country. Multi-center and prospective studies with more patients should be conducted on this subject.

In conclusion, although there was no difference in the total acceptance-rejection level in our study, it was shown that children with enuresis perceived their mothers' behaviors more hostile than they were. It should be kept in mind that enuresis can affect both mother and child psychology and may disrupt the mother-child relationship. Families should be informed about the approach to the child. Children presenting with enuresis should also be evaluated in terms of the mother-child relationship, and families deemed to be at risk should be referred to psychiatry.

Ethical Committee Approval: Ethics committee approval was received for this study from the ethics committee of Ankara Yıldırım Beyazıt University, Yenimahalle Training and Research Hospital Clinical Research Ethics Committee (Approval date: 12/11/2019, number: 2019/10/01).

Informed Consent: Mothers and children were informed about the study, written consent was obtained from the mothers and verbal consent was obtained from the children.

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