

# THE LINKS BETWEEN CONTINENCE AND CHILD PROTECTION

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Childhood incontinence and child protection are both issues that do not always receive the financial or research attention that they deserve and there is a paucity of literature on the link between the two. In this article, the author draws both on the available research and also his own practice to examine any links between the two fields, such as night-time wetting, learning difficulties and neglect. The article uses case studies to illustrate some of the issues that arise when incontinent children are referred to child protection services and provides guidance on care pathways.

## Key Words

Continence  
Paediatrics  
Child protection  
Abuse

Much of the current thinking on child protection issues is documented in the Children's Acts of 1989 and 2004 and the document *Working Together to Safeguard Children* (Department for Education and Skills [DfES] and the Home Office, 1989, 2004, 2006) and child protection is not longer simply about the battered, bruised or sexually assaulted child. It is also about trying to ensure that every child grows up in a positive and nurturing environment. The major focus of child protection work lies in identifying families in need of help and support and trying to provide this in order that all of the family members are able to flourish.

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The Royal College of Paediatrics and Child Health have recently published an excellent handbook, which explains all the legal and medical aspects of child protection (RCPCH, 2006). Essentially, the message is that child protection is everybody's concern. When faced with a child protection issue, healthcare professionals can no longer expect that somebody else will deal with it. The days when concerns about a family could simply be passed onto another healthcare or social care professional are in the past.

This means that whenever healthcare professionals encounter a patient, they cannot simply consider that patient's needs in isolation, but must also look at the needs of his or her family. Healthcare professionals are very good at thinking about how family factors may impact on the patient in front of them, but are rather less ready to think about how the patient may affect their family.

A striking example of this can be seen in attempted suicide. The children of a parent who attempts suicide are at an increased risk of becoming victims of abuse (Hawton et al, 1985) and this is a perfect example of how healthcare professionals need to see the presenting patient not only as a victim, but also as a potential cause of problems for other members of the family.

Similarly, an adult's medical presentation may suggest a lifestyle that would put children at risk. This could include mental health issues, drug and alcohol abuse or domestic abuse. If any of these conditions are present in a presenting patient, then it is imperative to think about the welfare of any children present in the household.

In practical terms, this requires a change of focus, particularly for those healthcare professionals who deal largely with adults, and healthcare professionals have to make the leap from patient-centred care to family centred care. For example, many children act as carers for their parents, carrying out tasks that are entirely unsuitable for them, e.g. changing catheter bags. The attendant loss of social life for the child would almost certainly mean that a referral to social services would be appropriate, not because of any child abuse, but in order to try to give the child a more 'normal' life.

However, there are some shortcomings with our current approach to child protection, the most obvious being that social issues can be turned into medical ones. Also, healthcare professionals may be able to identify a good deal of abuse and treat some of its consequences, but it requires serious political will and social change to really prevent it.



**Figure 1. Clinical issues involved in the relationship between childhood continence and child protection.**

A further shortcoming is that healthcare professionals tend to measure abuse by the outcome rather than intention. Southall et al (2003) have argued very convincingly that healthcare professionals should look at the reason why somebody has abused a child rather than focusing on what they have actually done. They argue that many people who abuse do so because of limited resources, be they personal, educational social or financial. These people can be helped to provide a safe home for their children. Only very few have an inherent desire to 'harm' the child.

**The link between continence and child protection**

Both childhood continence and child protection are so-called 'Cinderella' specialties. Disappointingly, there is little published work on the direct child protection implications of childhood continence issues and the literature reviewed in this article seems to suggest that the link between continence issues and child abuse may be weaker than one might think.

However, although the scarcity of any research means that it is hard to draw any specific conclusions, the anonymised, real case studies outlined below highlight some of the complexities involved in daily practice and in these extreme cases there are

some clear clinical issues that can be identified (Figure 1).

Childhood continence issues are extremely common. A recent study from the USA (Vera Loening-Baucke, 2007), showed that in a primary care setting almost one in four children had constipation, compared with an older UK study where one-third of primary school children were reported to be constipated (Yong and Beattie, 1998). About one child in 20 will experience daytime urinary incontinence and a smaller number will experience faecal incontinence (Young and Beattie, 1998).

The latest figures show that, of nearly 15 million children in the UK,

only 32,000 are on the Child Protection Register (National Society for the Prevention of Cruelty to Children [NSPCC], 2007) (Figure 2). About two-thirds of these are placed on the register because of neglect or emotional abuse. However, the DfES calculates that in 2004 over 570,000 referrals were made to social services and in 2005 there were 385,000 'children in need' (Table 1) (NSPCC, 2007).

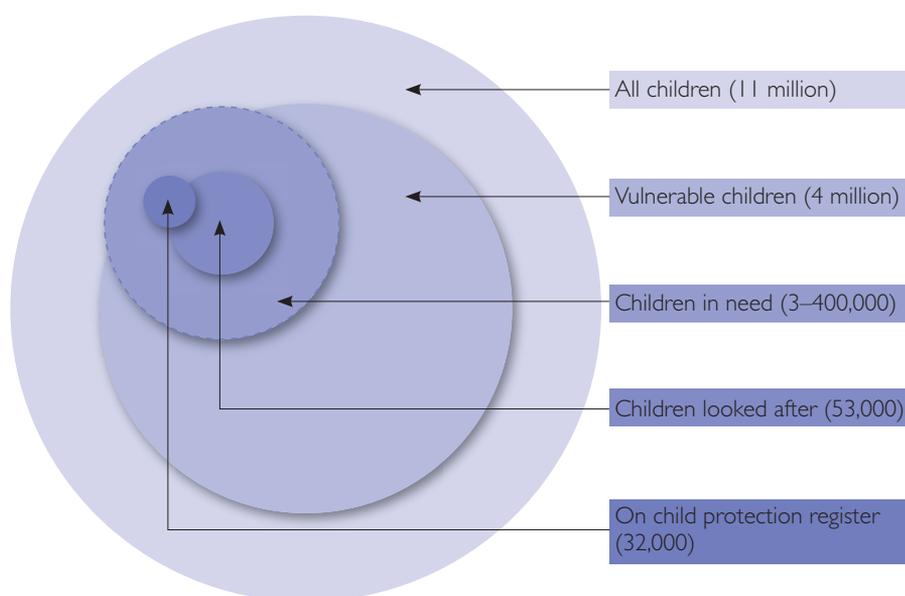
There is also copious evidence that abuse in childhood can cause long-term psychological consequences (Roberts et al, 2004). However, a UK study comparing adults with organic and functional gastrointestinal conditions did not find a higher rate of abuse survivors in the group with functional bowel disease (Hobbis et al, 2002). They conclude that although child abuse can cause victims to suffer long-term psychological consequences, these are not necessarily manifested in an increase in gastrointestinal symptoms, including constipation.

A US study adds some weight to this, by showing that faecal soiling is by itself a poor predictor of previous sexual abuse (Mellon et al, 2006). However, there are some weaknesses in the study. For example, there is not a clear differentiation between retentive and non-retentive incontinence and the abused group have a higher rate of incontinence than the 'normal' population, although the same rate as those referred for 'externalising problems.'

**Table 1**

**Breakdown of child protection issues in the UK**

- ▶▶ 7% of children experienced serious physical abuse at the hands of their parents or carers during childhood.
- ▶▶ 1% of children aged under 16 experienced sexual abuse by a parent or carer and a further 3% by another relative during childhood.
- ▶▶ 11% of children experienced sexual abuse by people known but unrelated to them.
- ▶▶ 5% of children experienced sexual abuse by an adult stranger or someone they had just met.
- ▶▶ 6% of children experienced serious absence of care at home during childhood.
- ▶▶ 5% of children experienced serious absence of supervision during childhood.
- ▶▶ 6% of children experienced frequent and severe emotional maltreatment during childhood.



**Figure 2. Breakdown of UK child protection figures.**

One has to be wary of interpreting results across cultures, but a report from Turkey showing an unusually high incidence of night time wetting, also illustrates a chilling amount of associated abuse or punishment (Can et al, 2004). Almost 90% of mothers were involved in some form of abuse related to the wetting, with 60% hitting or beating their children.

UK studies from the 1980s suggest that 20–36% of parents, punished children who wet the bed (Butler et al, 1986). This ranged from removal of privileges and increasing household chores, such as washing the sheets, to physical abuse. Although there is little up-to-date data, the fact that every organisation and website that deals with bedwetting emphasizes that punishment is entirely inappropriate and counterproductive implies that there is still a perception that children are being punished for wetting the bed.

Clearly, both continence and child protection issues are common, which means that any healthcare professional dealing with children is likely to encounter them both frequently. However, continence difficulties issues in children are widespread and for the vast majority these are not related to child protection issues. The families of these children may well need help and support, but do not need the added

burden and stigma of being suspected or accused of child abuse.

It is also unlikely that continence issues will be the sole presenting feature of child abuse. Normally, child protection concerns are raised due to healthcare professionals' knowledge of a family or from a child presenting with evidence of neglect or severe injuries. Children who are abused are at least as likely as others to have continence issues and this needs to be taken into account when instituting a treatment plan.

### Case studies

#### Case study 1

Simon was a six-year-old boy who had a long history of withholding stools, which had recently deteriorated. He was also showing increasing signs of oppositional behaviour. This included a refusal to take any medication.

Simon lived with his mother and half brother. His father was in prison for sexually abusing his half-brother. His mother, who was abused herself as a child, had broken off all contact with Simon's father. The whole episode had caused an emotional schism in the family, as well as significant financial hardship.

Determined to try and protect her children from the experiences of her own childhood, Simon's mother would

try to do 'everything' for her children. However, Simon had not been told why his father was in prison and this was causing him great distress.

Simon's mother needed to address her own childhood experiences, as without an appropriate parenting template, she needed help in establishing rules and boundaries. For example, it was clear that Simon was winning the 'medication battle.' Simon's mother also had to contend with the knowledge that she was unable to protect her older son.

The healthcare professional involved needed to help Simon negotiate his relationship with his father. When Simon was told that his father was in prison, he had particular issues with trying to understand this. Despite this, he still had very positive feelings towards his father.

As a victim of sexual abuse, Simon's brother also needed help to deal with the psychological issues that this has brought up, both for him and the rest of the family.

The following services were involved in Simon's care:

- ▶▶ Health: the Child and Adolescent Mental Health Team, the family's GP, paediatrician and the community paediatric nurse were all involved in assessing Simon's healthcare needs
- ▶▶ School: both children needed support at school, with the involvement of the school nurse
- ▶▶ Social services: social workers and support workers offered support, especially with regard to re-housing
- ▶▶ Council: the family were re-housed in order that they could live away from the abuser's family
- ▶▶ Voluntary organisations: the NSPCC provided counselling (<http://www.nspcc.org.uk>). MOSAC, a charity that supports non-abusing parents and carers of sexually abused children, also offered support (<http://www.mosac.org.uk>).

#### Case study 2

Arthur was a 14-year-old boy with moderate learning difficulties. His parents had a history of learning difficulty and mental health issues.

Arthur's school nurse made the initial referral to the GP, as he turned up in school with faeces in his underwear and the teachers had to shower him every day before school.

Although he attended all his specialist continence clinic appointments neither Arthur nor his family could provide any medical/social history at all and their response to any question was, 'I don't know'.

It was clear that both Arthur and his parents had problems with hygiene. When parents have mental health/ learning difficulty issues, this clearly impacts on their children, however, as the children reach their teenage years they are often capable of taking some initiative themselves and can be influenced by peer pressure. For example, a four year old may not mind having dirty clothes, and even if they do, may not have the personal resources to change things. However, teenagers develop the desire to bathe themselves and wash their own clothes and, even if the parents are not supportive for whatever reason, begin to improve their own situation. However, this is less common in children who have learning issues and indeed, in Arthur's case, he did not begin to develop personal hygiene skills.

Due to the presence of learning difficulties in the family, it was impossible to measure the effectiveness of any plan that was suggested as the family had difficulty implementing it and reporting back. In this case, the only way to ensure sufficient input was to call for a strategy meeting with the option of placing Arthur in the child protection register-under Section 17. His parents did not intend to harm him, but were not capable of providing him with adequate care and support.

The following services were involved in Arthur's care:

- ▶ Health: the GP and paediatrician were both involved in assessing Arthur's health needs
- ▶ Education: Arthur now attends a school for children with moderate learning difficulty

- ▶ Learning disabilities: the adult learning disability team offered parental support.

### Conclusion

Continence issues in children are very common and for the vast majority of children, are not related to issues of child protection. The families of these children may well need help and support, but do not need the added burden and stigma of being suspected of child abuse.

It is unlikely that continence issues will be the sole presenting feature of child abuse. Normally, child protection concerns are raised from specific allegations, from a strong history of abuse or when a child presents with obvious evidence of neglect or severe injuries. Children who are or have been abused are at least as likely to others to have continence issues. This may need to be taken into account when instituting a treatment plan. **CUK**

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### Key Points

- ▶ The major focus of child protection work lies in identifying families in need of help and support and trying to provide this in order that all of the family members are able to flourish.
- ▶ Both childhood continence and child protection are so-called 'Cinderella' specialties.
- ▶ About one child in 20 will experience daytime urinary incontinence and a smaller number will experience faecal incontinence.
- ▶ Both continence and child protection issues are common, which means that any healthcare professional dealing with children is likely to encounter them both frequently.
- ▶ Normally, child protection concerns are raised from specific allegations, from a strong history of abuse or when a child presents with obvious evidence of neglect or severe injuries.
- ▶ Children who are or have been abused are at least as likely to others to have continence issues. This may need to be taken into account when instituting a treatment plan.