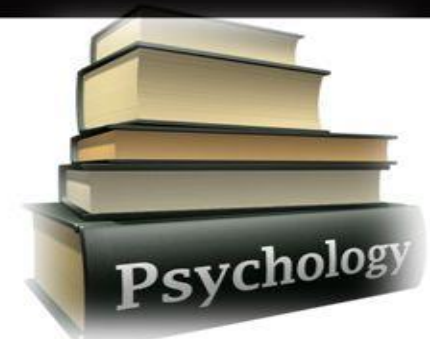


«أكلوا من ثمره إذا شئتم»

Elimination Disorders





Elimination disorders

Submitted by:

Aqsa Sajid(023)

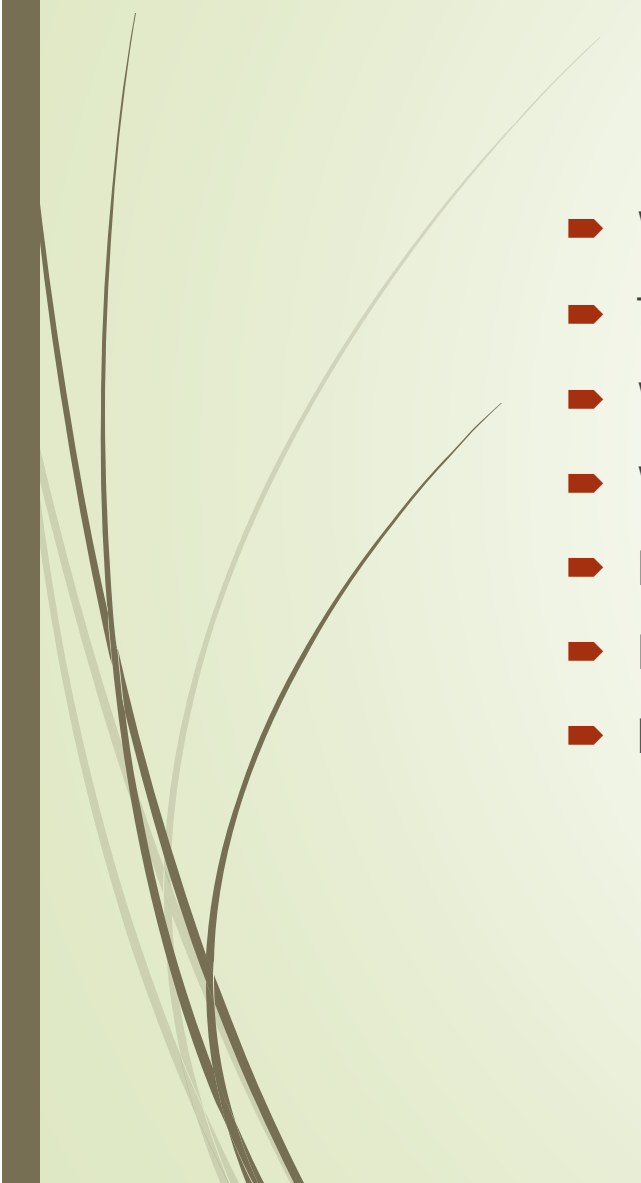
Bs applied psychology (5th semester)

Submitted to:

Maam samar




What are we here to learn:

- What are elimination disorders
 - Types of elimination disorders
 - What is encopresis
 - What is Enuresis
 - Diagnostic criterion of the disorders
 - Etiology
 - Intervention
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What are Elimination disorders ?

- Elimination disorders occur in children who have problems going to the bathroom -- both defecating and urinating. Although it is not uncommon for young children to have occasional "accidents," there may be a problem if this behavior occurs repeatedly for longer than three months, particularly in children older than 5 years.
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Elimination Disorder




Enuresis





Enuresis


- ▶ Enuresis is diagnosed when children repeatedly urinate in inappropriate places, such as clothing (during the day) or the bed (during the night). In most cases, the child's urination problem is involuntary in nature, and is perceived by the child as an unavoidable loss of urinary control.
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DSM-V table 307.6 (F98.0)


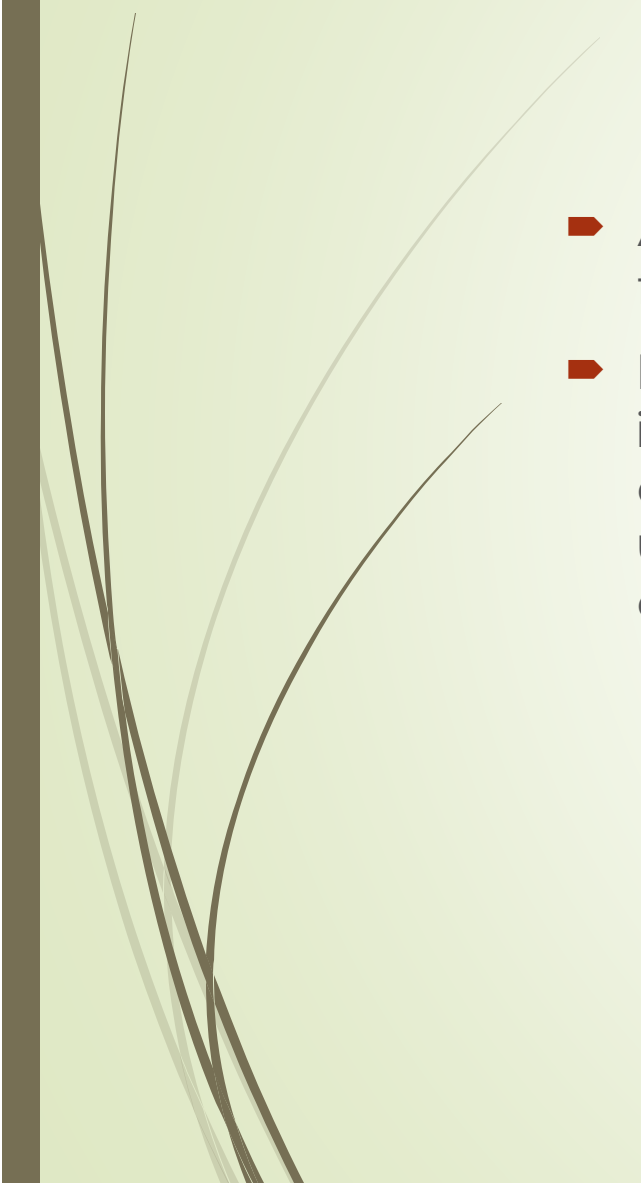
Diagnostic criteria

- **A.** Repeated voiding of urine into bed or clothes, whether involuntary or intentional.
- **B.** The behavior is clinically significant as manifested by either a frequency of at least twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- **C.** Chronological age is at least 5 years.
- **D.** The behavior is not attributable to the psychological effects of a substance (e.g., a diuretic, an antipsychotic medication) or another medical condition (e.g., diabetes, spina bifida, a seizure disorder).



Types of enuresis

- There are three subtypes of Enuresis: **Nocturnal (night-time) Only**, **Diurnal (day-time) Only**, and **Nocturnal and Diurnal**. The DSM criteria for diagnosis state that the urination problem (whether involuntary or intentional) must occur with regularity, at least twice a week, for three consecutive months before the diagnosis applies. The diagnosis cannot be made unless there is evidence that the urination problem causes distress or impairment in the child's social or academic functioning.
- In **Nocturnal Only Enuresis**, the most common form of enuresis, children wet themselves during nighttime sleep. Typically, wetting occurs during the first third of the night, but it is not uncommon for wetting to occur later, during REM sleep. In this latter case, children may recall having a dream that they were urinating.
- **Diurnal Only Enuresis**, where children wet themselves only during waking hours, is less common than nighttime bedwetting. This type of enuresis is more common in females than in males, and is uncommon altogether after age 9. Children who are affected by this type of disorder will typically either have urge incontinence (i.e., they feel a sudden overwhelming urge to urinate) or voiding postponement (i.e., they know they need to urinate, but put off actually going to the bathroom until it is too late).

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- As the name suggests, children with **Nocturnal and Diurnal Enuresis** suffer from a combination of the two scenarios described above.
 - Predisposing factors that contribute to increased risk of developing enuresis include: delayed or lax toilet training, psychosocial issues (e.g., social anxiety), abnormal urinary functioning, reduced bladder capacity, or unstable bladder syndrome, a condition wherein the child's bladder contracts involuntarily, resulting in sudden urine leakage.



Etiology of Enuresis

- ▶ The most severe form of dysfunctional voiding is called Hinman's syndrome and is through od as non- neurogenic bladder resulting from habitual, voluntary tightening of external sphincter during urges to urinate.

- ▶ **Voluntar:** ODD, psychotic disorder

- ▶ **Involuntary**

Familial: In families where both parents have history on enuresis 77% of children will have enuresis. In families where 1 parent has had enuresis, 44% of children will be affected.

Only about 15% children will have Enuresis if either parents was enuretic.



Intervention

► Lifestyle treatments

1. **Monitor fluid intake.** Try to slow your fluid intake in the afternoon and evening. Drink more in the early morning when you can use the bathroom easily. Set limits for evening consumption.
2. **Wake yourself at night.** Setting an alarm for the middle of the night can help you prevent bed-wetting. Getting up once or twice a night to urinate means you won't have as much urine if an accident occurs.
3. **Make regular urinating a part of your routine.** During the day, set a schedule for when you'll urinate and stick to it. Make sure to urinate before bed, too.
4. **Cut down on bladder irritants.** Caffeine, alcohol, artificial sweeteners, and sugary drinks may irritate your bladder and lead to more frequent urination.



► Medications

Primary types of medications are prescribed to treat adult bed-wetting, depending on the cause:

1. **antibiotics** to treat urinary tract infections
2. **anticholinergic drugs** can calm irritated or overactive bladder muscles
3. **desmopressin acetate** to boost levels of ADH so your kidneys will stop producing as much urine at night
4. **5-alpha reductase inhibitors**, such as finasteride (Proscar), shrink an enlarged prostate

► Surgery

1. **Sacral nerve stimulation.** During this procedure, your doctor will implant a small device that sends signals to the muscles in your bladder to stop unnecessary contractions.
2. **Clam cystoplasty (bladder augmentation).** Your doctor will cut open your bladder and insert a patch of intestinal muscle. This extra muscle helps reduce bladder instability and increase control and capacity so you can prevent bed-wetting.
3. **Detrusor myectomy.** The detrusor muscles control the contractions in your bladder. This procedure removes some of these muscles which helps decrease contractions.
4. **Pelvic organ prolapse repair.** This may be needed if you have female reproductive organs that're out of position and pressing down on the bladder.

Elimination Disorders




Encopresis






Encopresis



Encopresis sometimes called fecal incontinence or soiling, is the repeated passing of stool into clothing. Typically it happens when impacted stool collects in the colon and rectum: the colon becomes too full and liquid stool leaks around the retained stool, staining underwear. Eventually, stool retention can cause swelling (distention) of the bowels and loss of control over bowel movements



DSM-V 307.7(F98.1)

Diagnostic criteria

- **A.** Patient's chronological age must be at least 4 years;
- **B.** A repeated passage of feces into inappropriate places, e.g., clothing or floor. This can be either intentional or involuntary;
- **C.** At least one such event must occur every month for at least 3 months;
- **D.** The behavior is not attributable to the effects of a substance, e.g., laxative, or another medical condition, with the exception of a mechanism involving constipation.



Types of encopresis

These types of encopresis are-

- **Retentive encopresis:** This is the most common form of encopresis among children. When a child has this type there is a physical problem that is occurring that is keeping the child from having a bowel movement. The child may actually wish to defecate in the toilet but be unable to due to lack of sensation, pain being experienced, or even a blockage. One of the major side effects of this condition is chronic constipation. This can be made worse by a lack of fiber, physical activity, and water.
- **No-retentive encopresis:** This type happens when the child simply refuses to have a bowel movement in the appropriate place. This is most often a behavioral issue rather than a physical one. Constipation is usually not a factor in this type of encopresis. In addition, the child may seem fearful or even defiant and use this type of behavior as a control mechanism.



Etiology of Encopresis

Retentive

- Painfull defecation
- Inadequate or punitive toilet training
- Fear of school toilets or toilet related fears
- Mechanism include alerted Colon motility and contraction factors, obstruction, stretched and thinned colon walls, decreased sensation second to neurological disorder.

Non_retentive

- Maybe deliberate attempt, as a mean of avoiding stressors or commutating anger.



Intervention

Clearing the colon of impacted stool

There are several methods for clearing the colon and relieving constipation. Your child's doctor will likely recommend one or more of the following:

- Certain laxatives
- Rectal suppositories
- Enemas

Your child's doctor may recommend close follow-up to check the progress of the colon clearing.

Encouraging healthy bowel movements

Once the colon is cleared, it's important to encourage your child to have regular bowel movements. Your child's doctor may recommend:

- Laxatives, gradually discontinuing them once the bowel returns to normal function.
- Training your child to go to the toilet as soon as possible when the urge to have a bowel movement occurs.
- A short trial of going off cow's milk or checking for cow's milk intolerance, if indicated.

