ENCOPRESIS — AN OVERVIEW

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INTRODUCTION

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The aim of this paper is to provide an overview of treatment for encopresis, within a behaviourist framework. Whilst behaviourists' methods demonstrate merit, many studies omit long term follow-up, and there is a tendency to view the child in isolation from his family. Behaviourist programs can be enhanced by viewing the child in the context of his family which the author sees as crucial when planning an appropriate and effective treatment regime.

DEFINITION

Doley (1978) proposed the following definition: "The passage of fecal material of any amount or consistency into the clothing or other generally unacceptable areas in the absence of any organic pathology beyond the age of 3". Herbert (1975) adds ". . . involuntary defecation not caused by organic defect or illness". Doleys makes a distinction between **continuous**(primary), and the **discontinuous** (secondary or acquired) types of encopresis. The continuous encopretic has never demonstrated appropriate bowel control and toileting behaviour, and the discontinuous encopretic has been known to be continent for at least 6 months prior to the onset of soiling. Herbert adds another category to those of Doley, i.e. **retentive**, meaning the child with persistent constipation and only occasional encopresis. Some studies have considered the relationship between nocturnal enuresis and encopresis. Doley states that data point to a functional independence of bed wetting and soiling, however variables such as order in which the problems are treated, history and age of subjects, may have affected the outcome. Developmentally, bowel control generally precedes bladder control.

ETIOLOGY – Theories

Psychoanalytically oriented writers have postulated encopresis to be (like enuresis) a sign of some deeper, underlying conflict. For example, separation anxiety, expression of aggression, troral and anal stages. Rutter (1975) maintains that perfectionistic obsessional parents who demonstrate excessive concern about toileting, investing it with a high degree of tension and importance, are more likely to experience problems with their children in this area.

He states that toileting can be used as a battle ground between parent and child, and believes this can be a factor in a child refusing to open his bowels, resulting in constipation. Another factor, according to several writers, is that the infant may not yet have learned to be aware of the sensation of a full bowel. Additional learning is then required to postpone opening until he is in the proper place — and what the proper place is. Interestingly, Herbert (1976) states animals learn this — for example, cats and pigs. Piglets reared with the mother use a corner of the pen, those without a mother, soil at random. Encopresis can also be caused by a medical condition, for example, Hirstprung's disease. Also, chronic constipation can result in a distended abdomen and require medical intervention. A cut, fistula or any condition (however small) which results in the child experiencing pain on defecation can eventually result in constipation, as the child becomes unwilling to empty his bowels.

DIAGNOSTIC ASPECTS

As there are obviously many aetiological aspects, both a clinical interview and medical evaluation are necessary. The medical evaluation is a necessity in order to rule out any organic pathology. This can be helpful even if the problem is constipation, as a medical practitioner is more skilled at diagnosing bowel distention. Whether soiling is due to overflow and constipation is present, is important, as suppositories may be necessary.

During the general clinical interview, attention should be paid in particular to determining what events may be maintaining the soiling (for example, parental attention). The distinction between continuous and discontinuous should be made as the treatment will be slightly different for a child who has never acquired basic toileting skills, as more emphasis will need to be placed on the chain of events which must be learned for appropriation toileting.

The frequency and type of stools should be noted, as with chronic constipation they are usually very fluid. If the child is avoiding the toilet, because of fear of it, this should be ascertained, as desensitization techniques will have to be employed.

It is crucial to gain information as to whether the parents are able and willing to participate in a treatment program. Also whether physical or emotional pathology exists in the child and/or parents is of importance, as this may influence the expectations and type of program chosen.

TREATMENT

A. Overview

Doley writes that, due to lack of controlled studies, in which psychotherapy is compared with non-treated control groups, or other treatment methods adequate evaluation of psychotherapeutic and play therapy methods is not possible.

Herbert (1975) suggests that the continuous encopretic is in need of habit training rather than psychotherapy, but that the discontinuous encopretic has a more serious problem.

Even when there is no disease, for those children who have chronic constipation, enemas and/or suppositories can be of great importance to clear the bowel, in order to begin other treatment strategies, to prevent this recurring. The child may need to learn to recognise when the bowel is full, as one aspect of chronic constipation is that the bowel becomes so engorged that normal pressure sensation which warns the child of a full bowel is absent, and leaking occurs.

Behaviourist approaches to encopresis have varied considerably. For example, some have relied on positive reinforcement alone (rewards of time with parents, sweets, small toys, money, praise, extra priveleges). Some reward the child for using the toilet, dry pants, or 'trying' on the toilet (Bach & Moylan 1975). Others have combined this with punishment or used punishment alone (fines, extra chores, less television watching, cold baths).

Also some have involved the child more with taking responsibility for his behaviour — some (Neale 1963) "Full Cleanliness Training", which entails cleaning himself and his soiled clothes. Other studies have also used positive practice by the child performing the pre-requisite toileting behaviours (e.g. running to the toilet, sitting on it), as a means of strengthening these behaviours (Butler 1975).

There are, in the main, various combinations of the above. Foxx and Azrin (1973) quoted by Doleys, conducted a program for retarded children, and used full cleanliness training, positive and mechanical devises, toilet signal and pants alarm to aid in detections of accidents; and positive reinforcement immediately following appropriate toileting behaviour. Some programs instructed parents to ignore or be matter-of-fact about soiling.

According to Doleys, medication other than laxatives, suppositories, stool softeners, or bulk producers are not often given. In one study (Gavanski 1971), imipramine (Tогranil) was given to obtain temporary relief of high soiling as it is believed it may have an inhibitary effect upon the internal anal sphincter.

B. Study (i) – Ashkenazi (1975)

An interesting study was done by the above at a Children's Diagnostic and Rehabilitation Centre, Israel. Sixteen out of 18

children were successfully treated, all of these suffering from discontinuous encopresis. The youngest age was 39 months, eldest 12 years; the average age being 6 years 4 months. Duration of treatment was from 3 to 8 weeks.

The main aspect was the use of a glycerine suppository to make the rectum distend. The procedure consisted of potting after eating (with suppository — after eating, as bowel movements are increased at this time). Suppositories (which were a discriminatory stimulus for elimination) were withdrawn after 5 consecutive days of appropriate elimination and reinforced following a soiling episode. Prizes were given for appropriate behaviour and then gradually faded out (mother then praised intermittently).

In this study, because the children were not easily accessible to the clinic, either through transport or telephone, the local health nurse was the instructor. The children with phobic reactions to the toilet were deconditioned until the child could sit comfortably on the toilet for 3 minutes. The article does not state if this was done prior to the suppository program, or during. The very high success rate should be noted.

Study (ii) — Bach & Moylan (1975)

This study indicated that an operant method could be effectively used with disturbed parents administering it.

The client was a six year old boy with a two and a half year history of incontinence of urine and secondary encopresis. The parents gave money rewards for appropriate toileting and ignored soiling. The rate of urine incontinence dropped immediately, but the effects on the encopresis were not initially so successful. However, a big improvement was obtained when his parents began to reward the child for simply attempting to defecate (5c) as compared with 25c for each bowel movement in the toilet, 10c for every time he urinated appropriately, and 10c for every morning the bed was not wet.

When the rate of inappropriate soiled dropped to near zero, the money rewards were reduced and faded into a weekly allowance. At 2 years follow-up there was no remission. Interestingly, the number of praising interactions between parents and child were greatly increased. Also of interest is that these successful results were achieved in spite of the parental pathology — the authors stated "There was no observed change in either of the parents' individual problems."

Study (iii) — George, Coleman and Williams (1977)

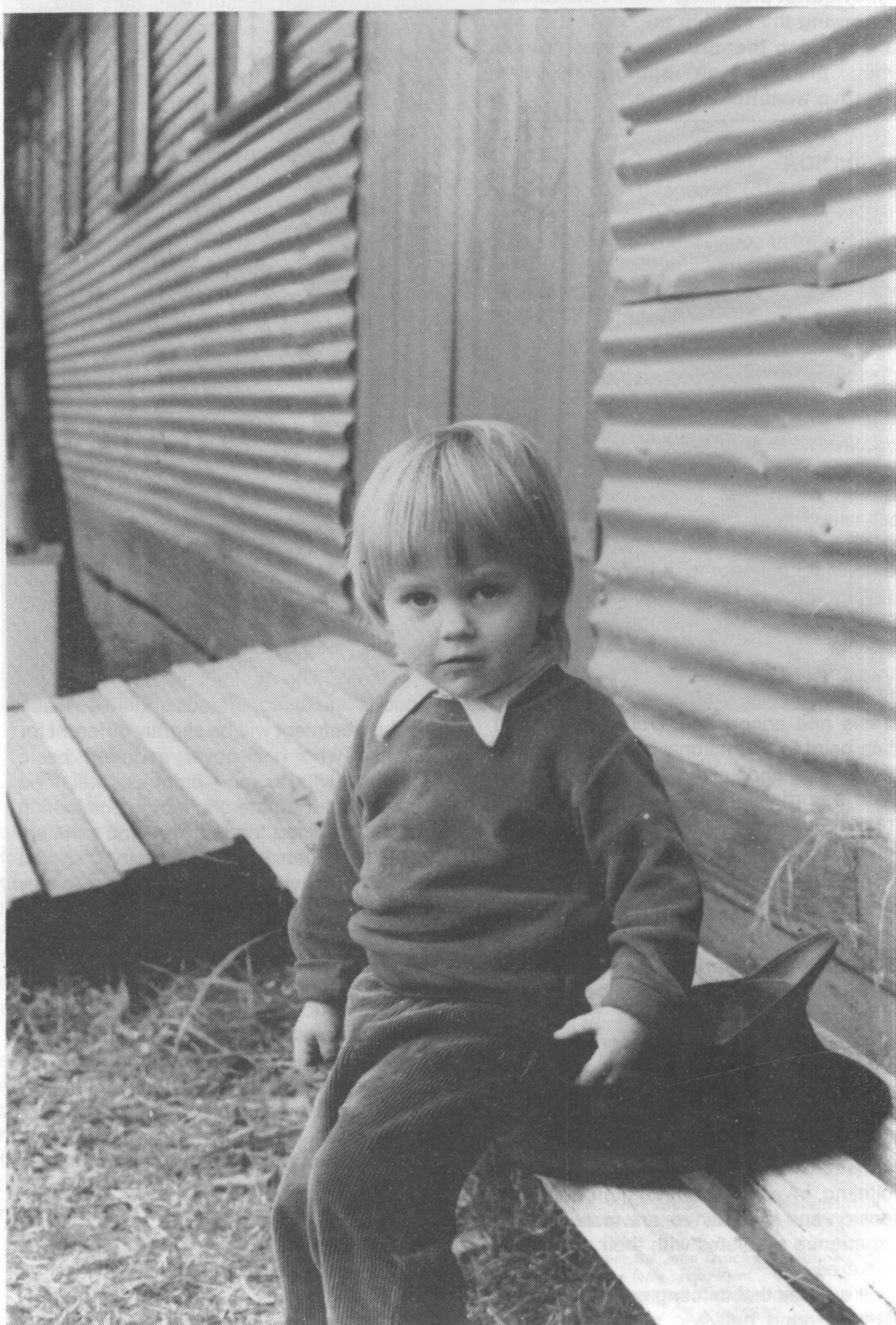
This study involved an 11 year old boy with a history of chronic encopresis successfully treated at school, with the teacher administering the program. Both positive reinforcement and punishment were used — the positive reinforcers were social, token and activity, and the punishment, the requirement to wash himself and denied access to activity reinforcers. The soiling behaviour was reduced from 80% daily occurrence during baseline to two occasions only, during the final 5 month treatment phase. A six month follow-up revealed no soiling.

Study (iv) — Doleys (1977)

This used a three part treatment program for 14 subjects. One aspect was periodic pants checks and toileting (parents to check pants regularly, initially every hour). Secondly, when soiling did occur, the child was exposed to full cleanliness training which involved parental expression of displeasure and the child scrubbing his soiled clothes for 20 minutes each, and taking a bath in cool or cold water. If the child cried he was not "let off". Thirdly, a token or point was given for each successful toileting. After a child earned from 10-15 points, he was given a reinforcer (e.g. truck, etc.). Soiling was stopped in each of the four subjects placed on the program. Treatment duration 9-15 weeks. One subject relapsed and this was attributed to parental non-cooperation.

Study (v) — Butler (1975) in Doleys (1978)

In the treatment of three children (ages 28, 30 and 60 months of age), Butler employed a similar procedure of pants checks, full cleanliness training, parental reinforcement for dry pants and appropriate toileting. In addition to the above, the children had ten positive trials following each soiling episode. This involved the child running rapidly to the toilet from the original site of the accident. The 3 children all achieved continence within 8 weeks of treatment, and only one accident during 6 months follow-up.



DISCUSSION

The effectiveness of these programs appears to rest very much on the co-operation of the parents. A number of writers comment on the strong feelings encopresis engenders in the parents. These feelings can result in high motivation for the program to succeed and the maximum co-operation, or, can sabotage programs by undue attention being paid to the soiling behaviour. The therapist must be prepared to be as supportive as possible to the parents. Some authors (Revitch 1958) claim that hospitalisation can be effective when it appears that parental co-operation will be a problem. The main gain is that it can convince the parents their child can become continent. Ashkenazi maintains that a very big factor involved in the success of his project, was that the child health nurse was able to visit the homes frequently and build up a relationship with the parents. This he thought was a more effective way than a consultant who met with the family in a clinic at greater intervals.

Medical aspects of treatment can be very important, and often an invaluable part of treatment. However, according to Doleys, medical programs are often not properly integrated — often they don't take into account the necessity of parent support, development of appropriate toileting behaviour and the maintenance of positive changes when they occur.

Programs which give positive reinforcement for non-soiling behaviour, i.e. clean pants, do not have as much merit as those which give reinforcement for a bowel motion in the right place. The former could be a danger in encouraging retention.

A good program should enable the child to make a connection between cause and effect. As Dreikurs (1964) maintains, learning takes place when this connection is made. Connecting the soiling and the responsiblity of having to correct the effects of it, can be a maturing experience. It is also a good model for the parents, to allow a child (when appropriate) to experience the effects of its own behaviour.

It concerns me that there is such a heavy emphasis on punishment in some programs — some use punishment alone, some, as part of the program. When punishment is considered, great care should be taken in the selection of families; in some families where there is already a high degree of punishment, this could strengthen the tendency to child abuse.

Whenever a particular treatment program is considered, it should be kept in mind that this could be generalised and used by parents in other areas of child rearing. This is more likely if the parent is having parenting problems which, for many, is the likely reason why they presented for help in the first place.

As stated previously, it was interesting to note Bach and Moylan's (1975) comments following a program which relied solely on positive reinforcement, to quote — "More important, the number of praising interactions between parents and child multiplied considerably. It was very clear that they enjoyed one another more, even though there was no observed change in either of the parents' individual problems."(p. 241) One notes that no punishment was used in this program which was nevertheless effective.

There appear to be no studies to my knowledge of the effectiveness of punishment as against positive reinforcement and mixed programs. This could be studied with the addition of a control group. Doleys quotes a study from Frendrair and Van Handel (1970), who required the child to clean himself and his clothes, with strong soap and cold water, as the only treatment mode. Soiling was eventually stopped, but took the relatively long period of 5 school months.

While full cleanliness training can provide helpful learning, it requires careful and sensitive handling, as it could be a disadvantage to promote a confrontation between the parents and child. It is particularly important that confrontation be minimised; some writers believe a rigid confrontational stance when toilet training, can contribute to an encopretic problem.

Some studies have insisted that the child use cold water for cleaning. This would seem to be unnecessary: it makes the job even more distasteful than it intrinsically is, and therefore, more likely to increase the child's resistence and hostility, and thus could then prevent constructive learning taking place. Doleys states that the cleaning could be negatively reinforced by removal of the parents, i.e., the child would wash his clothes quietly in order to escape from the parent's supervision. Therefore Doleys states, cleanliness training would not necessarily serve to teach the child responsibility for his soiling, and motivate him to engage in more appropriate behaviour. He suggests that this may be achieved more effectively by having the child repeat "I am cleaning my pants because I soiled them and will have to do this each time it happens", in order to understand the contingent relatonship between cleanliness training and soiling.

Doleys states that the notion of symptom substitution has not been systematically investigated with encopretics. Several writers have noted positive changes in other aspects of the child's behaviour, and the responses he obtains from his environment. Doleys mentions Balson (1973) who described an increase in tantrums following the suppression of soiling. Balson suggested that this behaviour was substituted by the child, in order to receive the parental attention which was no longer elicited by the soiling. The tantrums were stopped using time-out and teaching the child to express anger more appropriately.

There is a paucity of long term follow-up data. This information is important as I query whether some children from disturbed families would be able to maintain their changes. I would speculate that they might either relapse or develop substitute symptoms in reaction to the dysfunction which had not been treated or recognised in the family. The diagnostic interview should preferably include both parents. When family disturbance is indicated, this should also be treated if possible — the child being seen in context as part of his family system. To quote Sager & Kaplin (1972) "... whenever a group of people are closely related to each other, as in a family, they reciprocally carry part of each other's psychology and form a feedback system which, in turn, regulates and patterns their individual behaviours." (p. 271).

SUMMARY

Behaviourist techniques have demonstrated some success in dealing with the symptoms of both continuous and discontinuous encopresis. However, many studies have omitted long term follow-up. Behaviourist methods are versatile and can be administered by parents, teachers and nurses once the diagnosis has been made and the program drawn up. It is noted in Doleys (1978) that Christoffersen and Rainey (1976) stress the importance of the manner in which the program is explained and implemented, as being critical to the outcome. An additional factor should be taken into consideration when deciding on treatment techniques; the child should be seen in context of his family. If there is family dysfunction this should be treated or, at least, taken into consideration when planning treatment procedures. For example, if punishment (which I find generally unacceptable) were employed where a child is scapegoated by his family, this would only serve to reinforce this pattern.

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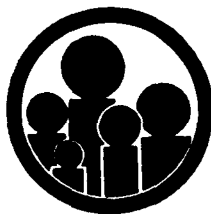

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