Toileting Gone Wrong – Made Right

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A child is more complex than a single developmental milestone delay and we need to avoid pathologizing a bio-behavioral issue specific to a child's self regulation of a toileting routine. The behavior may have many aspects more than the obvious pediatric-gastroenterological one.

In our culture we avoid talking about feces and bowel movements. Yet a social contextual approach to treating encopresis is noted by most researchers, even those who cite the need for medical treatment (laxatives for regulation) to address chronic and severe constipation. This is because a child who soils his underwear has a personal and social problem as a result of soiling.

Constipation is the underlying factor in treating bowel incontinence, according to Nancy Glass-Quattrin, R.N. of the Encopresis Treatment Center in Edmunds, Washington. She describes a team approach that gives the child laxatives to ensure bowel movements and support to reduce the shame and anger of not having control of your body.

A child's self regulation of bowel control is associated with early habits, diet and sensory integration sufficient to perceive physical signals that cue the need to release. Further, children who are curious, intelligent, and able to focus on their interests are often unwilling to shift attention from what they're doing and so make urine or bowel "tasks" a secondary concern. Children do not judge time accurately, their estimation of time is a problem--so the child may intend to do the "right" thing but not have a time perspective.

Routines and habits teach the reliability of signals to use the bathroom early in toilet training. If that early experience is complicated by a child's being impacted, and having painful bowel movements, then avoidant behavior compounds the issues associated with bowel control.

The mastery of toileting is a developmental task, and as with any other developmental task, not all children move to complete the task in a uniform, linear way. As children move into situations away from home, comparisons are drawn between self and peers. Being different in one aspect of development can become a focus.

The American Family Physician offers "Treatment Guidelines for Primary Non-Retentive Encopresis....." (Attached) and notes that "constipation is noticeably absent in 1 –3% of children with "stool toileting refusal." That article outlines factors associated with retentive and non retentive encopresis, and notes the scarcity of information about non-retentive encopresis.

Toileting successfully is a condition with heavy emphasis at home and school because of the inconvenience of "accidents," the intimate nature of care and correction, and comparisons with siblings and peers. So over time a child may be "told" in direct and indirect ways that he/she is failing in a first major task of self regulation and a task that has social implications for peer and family acceptance.

Mastery of any developmental task has components of physical, social and psychological readiness. Information and attention that is brought into sharp focus on the child's "failure" with toileting can be distorted. For children ---how their experience is labeled by themselves and others becomes very significant.

Toilet training is not just a medical, laxative intervention to remediate compaction in the bowel, and pain, and avoidance. Toilet training must also address the child's perceptions—must address how the child perceives the influence of this one aspect of his or her life on self-definition. A successful approach must address questions about the child's perspective. Is the child competent – incompetent? Resilient or resistant? Solution driven or denial oriented? Under self control, or externally managed? These are central questions for the child to answer and for others to answer as well.

Children, Self Regulation, and Problem Solving

The remediation of toilet training is an opportunity to teach self regulation. Whether intended or not, the process of remedial toileting gives the child a message about self regulation. The perception of the "problem" must be communicated to the child in terms that the child can understand. Toileting offers an opportunity for the child to develop a personal solution to a problem. When you teach self regulation, one part of which is toilet training, you are also teaching problem solving.

Concepts to be communicated are:

Lack of bowel and urine control is related to the physical-biological aspects of self regulation--Also related to other factors such as diet, routine, cues, nurturance, and timeliness.

Toileting is a process that illustrates evidence of self regulation.

"W.E. Krill, Jr. defines steps in "Treating Episodes of Encopresis and Enuresis in Stress Disordered Children".

1. Work at the continuing process of stress inoculation.
   Why: The stronger the child's ego and self esteem, the more they can manage the stress that may be one source for the wetting and soiling behaviors. When stress levels and reactivity are lessened, the wetting and soiling may become less frequent.

2. Continue to help the child to develop healthy differentiation.

Why: As the child develops a clearer sense of their own identity away from the source of their trauma, they gain ego strength. The child then feels that they have a source of control inside themselves. Often, the trauma led the child to an overwhelming sense of being out of control of what was happening to them.

3. Reassure the child when the wetting or soiling is discovered that they are not in trouble. Use a kind, firm, and neutral tone of voice.
   Why: The child likely has had very difficult and frightening response from adults when they wet or soil. The child may be anticipating that you too, will become very angry and perhaps punish them with some kind of abusive response.

4. Tell the child when the wetting or soiling happens: “I don’t like when you wet or dirty. Wet and dirty belong in the toilet.” Use a kind, firm, and neutral tone of voice.
   Why: The child needs to learn that the behavior is not desirable or age appropriate, but this stress inoculation must be done in a way that does not trigger a stress reaction in the child.

5. Give the child a standard set of directives to clean up that use more or less the exact same words each time.
   Why: The standard set of directives is to create a routine for the clean up procedure. This also places a control on your frustration at the repeated wetting and soiling. It’s only human nature to want to speak in stronger terms to “get through” to the child, but the risk is that you will begin to sound like other angry adults that may have been in their lives. Greater intensity will likely trigger a stress reaction.

6. Make sure your directives include not only the child cleaning their body, but also taking their clothing or bed sheets to the laundry. If they have wet or soiled carpeting, floors, or walls, be sure to have them a don a pair of rubber gloves and clean the area affected. Be sure to allow the child to bathe before they do the clean up of the environment or the laundry. Make sure your tone of voice is kind, firm, and neutral.
   Why: By having the child clean their body first, you demonstrate to them that they are more important than the clothing, bed, or floor. If it bothers you very much, go ahead and clean the area when they are in the tub, then have them clean the area again for “good measure”.

7. Once clean up is complete, have a brief talk with the child: if you sense that the wetting or soiling has its source in anger, tell the child that they are allowed to be angry, and they can learn to express their anger in a better way. If you sense that the wetting or soiling occurred due to the child having been frightened or in a stress episode, reassure the child that they have nothing to fear while in your care; you will protect them.

Why: We need to address the (possible) cause of the behavior directly. This begins the process of the child bringing into consciousness why the behavior is happening, and that there are alternative ways to express frustration and anger, or that they have nothing to fear while in your care."

We don't want to emphasize rigid routines, external demands and a laxative curative but rather a respectful sensitivity to an intelligent child's desire to be free of a burden and the often experienced humiliation.

Children will develop a complexity of thoughts, feelings and actions as they try to cope with different situations, authorities, environments and responses to their bowel dyscontrol.

The notion that children may show "counter-control", or a pattern of resistance to performance on demand, may be accurate. But to perceive that as a cause of bowel dyscontrol is an oversimplification and may lead to a punitive response and a message that the child is deliberate in his/her inability to manage bowel control.

Bright children may perceive a power struggle and incorporate that into a pattern [perception] of expected behavior with important adults. Secretive behavior may also develop to deal with the humiliating aspects of bowel movement "accidents." This is often done because other alternatives are not learned or perceived to be accepted by the adults in the child's life.

A child may be taught to change clothing, to deal with soiled clothes and body in a non judgmental and effective way--While not diminishing the importance of a self regulated pattern of bowel movements. The issue is primarily to focus on explaining and teaching to the child's level of understanding and including the child in a process of self management and regulation. It is important to establish early that problems have solutions when openly managed within the support, of the primary support system – the family. And experts can assist in solutions.

The larger context needs to be understood. How the family behaves in relation to this issue of remedial toileting is an important signal as to how nurturance is provided. and how signals are delivered to children in a reliable way . . .a safe way.

Menu planning, shopping, meal schedules, <u>unhurried</u> time at meal time, conversation, parents and people sitting, dining.....----<u>not</u> employing a plan to <u>feed</u> in an atmosphere of 'Let's get it done and then on to the next thing.'

The same sense of relaxation and comfort may be taught with regard to toileting – not to rush to complete but a time to relax and experience relief. Let's not manage this important developmental task like we would a toothache.

I have spoken with five sets of parents whose children are in treatment at TLC for other issues and have encopresis as an aspect of a pattern of issues. Parents are professionals and non professionals and all very intelligent.

We have been most successful when we put the issue of bowel control in the larger perspective. I have outlined an approach to remedial toileting that enables the child to be a partner in a shared process of learning to develop a sense of success around self regulation and developmental skill mastery.

In today's world we demand rapid solutions and are impatient with anything less. We believe we are working hard under immense demands on our time and thought. We believe we are entitled to have experts fix "it."

Some issues remain in our personal domain and require patience and thoughtful individual solutions for each child. A child's self regulation of his/her bowels is that type of issue, and requires a patient individual-child perspective and plan for assistance. We aren't going to be successful and helpful if we use a "cookbook approach." Each child is unique in person and circumstance.

A plan that utilizes medical consult, medication, environmental management, child involvement and partnership and parent direction will get the desired results without unintended outcomes.

References:
Kuhn BR, Ph.D., Marcus BA, Ph.D., Pitner SL, M.D., M.P.H. (1999). Treatment Guidelines for Primary Nonretentive Encopresis and Stool Toileting Refusal. American Family Physician *4,* 1-8 .