

COMMUNITY PSYCHIATRIC CENTERS

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THE "ANSWERS" SERIES



ENCOPRESIS

What is soiling (encopresis)?

A child with encopresis passes part or all of his normal bowel movements into his underwear or diaper rather than the toilet. Sometimes this can happen because the child is constipated but soiling can also occur without any signs of retention.

What is the cause?

When encopresis begins suddenly, and there is no sign of constipation, the cause can be a stress in the child's life. The stress may be a physical illness such as severe diarrhea or an emotional upset such as the birth of a sibling. These children usually regain control of their bowels when the stress is reduced or removed.

Are there different theories as to the cause and treatment of encopresis?

The following is based in excerpts from the writings of: B.D. Schmitt, M.D., author of "Your Child's Health," Bantam Books.

Yes, there are. For example, there are those who believe that soiling is based in a power struggle between the parent and child, with the child using such soiling to "win" the battle. This will be referred to as the "**Strong Willed**" Theory as described below by Dr. Schmitt:

"Strong-Willed" Theory of Encopresis:

Some suggest that a common cause of long-standing soiling is resistance to toilet training. According to this theory, a related feature is that many of these children are also refusing to sit on the toilet, or will use the toilet only if their parent brings up the subject and marches them into the bathroom. In that regard, any child who is over 3 years old, healthy, and not using the toilet after several months of encouragement to use it is assumed to be resisting using the toilet.

According to this way of thinking, a common cause of resistance to toilet training is that a child is "strong-willed" and has been reminded or lectured too much. Some children have been forced to sit on the toilet against their will, occasionally for long periods of time. A few have been spanked or punished in other ways for not cooperating. Many parents make these mistakes, especially if they have a child with a difficult temperament. Most children less than 5 or 6 years old, it is thought, with encopresis, are simply engaged with their parent in a power struggle. More practice runs, such as what is used in toilet training, will

not help. Instead, your child now needs full responsibility and some incentives to spark his motivation.

How can I help my child overcome soiling according to the Strong-Willed Theory Approach?

Children who have chronic encopresis can be helped, according to this theory, with the following suggestions. If your child holds back bowel movements (BMs) and becomes constipated, medicines will also be needed.

1. **Transfer all responsibility to your child for using the toilet.** Your child will decide to use the toilet only after he realizes that he has nothing left to resist. Have one last talk with him about the subject. Tell your child that his body makes "poop" every day and it belongs to him. Explain that his "poop" wants to go in the toilet and his job is to help the "poop" get out. To help him function independently, put him in loose-fitting underwear or training pants (not diapers or pullups). Tell your child you're sorry you punished him for not using the toilet, forced him to sit on the toilet, or reminded him so much. Tell him from now on he doesn't need any help from you or other people. Then stop all talk about this subject. Pretend you're not worried about this subject. When your child stops receiving attention for not using the toilet, he will eventually decide to use it to gain some attention.
2. **Stop all reminders about using the toilet.** Let your child decide when he needs to go to the bathroom. Don't remind him to go to the bathroom or ask if he needs to go. Your child knows what it feels like when he has to "poop" and where the bathroom is. Reminders are a form of pressure, and pressure doesn't work. Stop all practice runs and never make him sit on the toilet against his will because this always causes resistance to the whole process. Don't accompany your child into the bathroom or stand with him by the potty chair unless he asks you to. He needs to gain the feeling of success that comes from doing it on his own and then finding you to tell you what he did.
3. **Give incentives for using the toilet.** Your main job is to find the right incentive. Special incentives, such as favorite sweets or video time, can be invaluable. For using the toilet for BMs, initially err on the side of giving her too much (for example, several food treats each time). Remember that incentives work even better if it is a special treat that your child doesn't get everyday. If you want a breakthrough, make your child an offer she can't refuse (such as going somewhere special). In addition, give positive feedback, such as praise and hugs every time your child uses the toilet. On successful days consider taking 20 extra minutes to play a special game with your child or take her to her favorite playground.

What are some incentives that can be used for toileting:

Give stars for using the toilet. Get a calendar for your child and hang it where he sees it all the time. Place a star on it every time he uses the toilet. Keep this record of progress until your child has gone 1 month without any accidents.

If your child has never sat on the toilet, try to change his attitude. First, give him choices by asking if he wants to use the big toilet or the potty chair. If he chooses the potty chair, be sure to keep it in the room he usually plays in. Your child may need a pleasant reminder once a day, but only if he is clearly holding back. You can say "The poop is trying to get out and go in the toilet. The poop needs your help." Ask him to play the "see if you can poop before the timer goes off" game and set the timer for 5 minutes. Then let your child decide how he wishes to respond to the pressure in his rectum. Some children temporarily may need treats for simply sitting on the toilet and trying.

Should I still use diapers?

Use diapers and pull-ups as little as possible. If your child refuses to sit on the toilet, having bowel movements in diapers is better than holding back the BMs. Preventing stool-holding is very important. However, don't let your child wear diapers all day. Keep your child in loose-fitting underwear or training pants, so that he has to decide each time he has an urge to pass a BM whether to use the toilet or to come to you for a diaper. To help him make the right choice, offer major incentives for using the toilet successfully--for example, a trip to a favorite restaurant, ice cream stand, or the zoo.

Help your child change his clothes if he soils himself. Don't ignore soiling. As soon as you notice that your child has messy pants, clean him up immediately. The main role you have in this new program is to enforce the rule "we can't walk around with messy pants." Make changing pants a neutral, quick interaction without any show of anger. If your child is soiled, he will probably need your help with cleanup. If your child refuses to let you change her, ground her in her bedroom until she is ready.

What about school staff?

Ask the preschool or day care staff to use the same strategy you are using. Ask your child's teacher or day care provider to let your child go to the bathroom any time your child wants to. Keep an extra set of clean underwear at the school or with the day care provider. Ask them to read this discussion of soiling. Be sure your baby sitter knows how to handle the situation positively and will not punish your child for soiling his pants.

Does Constipation also cause soiling? Please tell me more about that.

The following was updated and reviewed by: Stephen Shaffer, MD and Wendy Kutz, MSN, RN.

If you're the parent of a child who has bowel movements (BMs) in places other than the toilet, you know how frustrating it can be. Many parents assume that kids who soil their pants are simply misbehaving or that they're too lazy to use the bathroom when they have the urge to go. The truth is that many kids beyond the age of toilet teaching (generally older than 4 years) who frequently soil their underwear have a condition known as encopresis. They have a problem with their bowels that dulls the normal urge to go to the bathroom - and they can't control the accidents that typically follow.

Although encopresis is estimated to affect 1% to 2% of children under the age of 10, problems with encopresis and constipation account for more than 25% of all visits to pediatric gastroenterologists (doctors who specialize in disorders of the stomach and intestines).

Ninety percent of encopresis cases are due to functional constipation - that is, constipation that has no medical cause. The stool (or BM) is hard, dry, and difficult to pass when a person is constipated. Many kids "hold" their BMs to avoid the pain of constipation, which sets the stage for having a poop accident.

Is it correct to punish a child for soiling?

Well-intentioned advice from family members and friends isn't always helpful because many people mistakenly believe that encopresis is a behavioral issue - a simple lack of self-control. Frustrated parents, grandparents, and caregivers may advocate various punishments and consequences for the soiling - which only leaves the child feeling even more alone, angry, depressed, or humiliated. Up to 20% of children with encopresis experience feelings of low self-esteem that require the intervention of a psychologist or counselor.

If your child has encopresis, humiliating or punishing him or her will only make matters worse. Instead, talk to your child's doctor, who can help you and your child through this challenging but treatable problem.

Please tell me more about encopresis and how it relates to constipation.

Three to six times more common in boys, encopresis isn't a disease, but rather a symptom that may have different causes. To understand encopresis, it's important to understand constipation.

There's a wide range of normal when it comes to having a BM. The frequency of BMs varies with a person's age and individual nature. "Normal" pooping might range from one or two BMs per day to only three or four per week. Some children don't poop on a regular basis, but a child who passes a soft BM without difficulty every 3 days is not constipated. However, a child who passes a hard BM (small or large) every other day is. Other children may go every day, but they only release little, hard balls and there's always poop left behind in the colon.

So, what causes the hard poop in the first place? Any number of things, including diet, illness, decreased fluid intake, fear of the toilet during toilet teaching, or limited access to a toilet or a toilet that's not private (like at school). Some children may develop chronic constipation after stressful events occur in their lives, such as a divorce or the death of a close relative. Whatever the cause, once a child begins to hold his or her BMs, the poop begins to accumulate in the colon and a vicious cycle begins.

The colon's job is to remove water from the poop before it's passed. The longer the poop is stuck there, the more water is removed - and the harder it is for the child to push the large, dry poop out. The large poop also stretches out the colon, weakening the muscles there and affecting the nerves that tell a child when it's time to go to the bathroom. Because the flabby colon can't push the hard poop out, and it's painful to pass, the child continues to avoid having a BM, often by dancing, crossing the legs, making faces, or walking on tiptoes.

Eventually, the lower part of the colon becomes so full that it's difficult for the sphincter (the muscular valve that controls the passage of feces out of the anus) to hold the poop in. Partial BMs may pass through, causing the child to soil his or her pants. Softer poop may also leak out around the large mass of feces and stain the child's underwear when the sphincter relaxes. The child can't prevent the soiling - nor does he or she have any idea it's happening - because the nerves aren't sending the signals that regulate defecation (or pooping).

At first, parents may think their child has a simple case of diarrhea. But after repeated episodes, it becomes clear that there's another problem - especially because the soiling occurs when the child isn't sick.

Parents are often frustrated by the fact that their child seems unfazed by these accidents, which occur mostly during waking hours. Denial may be one reason for the child's nonchalance - the child just can't face the shame and guilt associated with the condition (some children even try to hide their soiled underpants from their parents). Another reason may be more scientific: Because the brain eventually gets used to the smell of feces, the child may no longer notice the odor.

When to Call Your Child's Doctor

Although rectal surgery or birth defects such as Hirschsprung disease and spina bifida can cause constipation or encopresis without constipation, these are uncommon. You should call your child's doctor if your child shows any of the following symptoms:

- poop or liquid stool in the underwear when your child isn't ill
- hard poop or pain when having a BM
- toilet-stopping BM
- abdominal pain
- loss of appetite

Treating Encopresis

If you think your child has encopresis, it's extremely important to call your child's doctor immediately. That's because the longer you wait, the harder it is to treat. As the colon is stretched by the buildup of stool, the nerves' ability to signal to the brain that it's time for a BM is diminished. If untreated, not only will the soiling get worse, but kids with encopresis may lose their appetites or complain of stomach pain. A large, hard poop may also cause a tear in the skin around the anus that will leave blood on the stools, the toilet paper, or in the toilet. Constipation can also lead to wetting and urinary tract infections (UTI), which can also occur because the poop-filled colon puts pressure on the bladder.

You have outlined three phases of treatment for constipation?

Yes, the treatment for encopresis includes three phases performed under the care of your child's doctor. Most cases of encopresis can be managed by the child's doctor. If initial efforts with your child's doctor fail, he or she may refer you to a gastroenterologist.

1. The first phase involves emptying the colon of hard, retained poop. Every doctor may have a different way of helping your child. Depending on the child's age and other factors, the doctor may recommend medicines, including a stool softener (such as mineral oil), laxatives, and/or enemas. (Laxatives and enemas should be given **only** under the supervision of your child's doctor; **never** give these treatments at home without first checking with your child's doctor.) As unpleasant as this first step sounds, it's necessary to clean out the bowels to successfully treat the constipation and end your child's soiling.
2. After the large intestine has been emptied, the doctor will help the child begin having regular BMs with the aid of stool-softening agents, most of which aren't habit-forming. At this point, it's important to continue using the stool softener to give your child's bowels a chance to shrink back to normal size (the muscles of the intestines have been stretched out, so they need time to be toned without the poop piling up again). Parents will also be asked to schedule potty times twice daily after meals (when the bowels are naturally stimulated), in which the child sits on the toilet for about 5 to 10 minutes. This will help the child learn to pay attention to his or her own urges. It's especially helpful for parents to keep a record of their child's daily BMs.
3. As regular BMs become established, your child's doctor will reduce the child's use of stool softeners.

Keep in mind that relapses are normal, so don't get discouraged if your child occasionally becomes constipated again or soils his or her pants during treatment, especially when trying to wean the child off of the medications.

A good way to keep track of your child's progress is by keeping a daily poop calendar. Make sure to note the frequency, consistency (i.e., hard, soft, dry), and size (i.e., large, small) of the BMs.

Patience is the key to treating encopresis. It may take anywhere from several months to a year for the stretched-out colon to return to its normal size and for the nerves in the colon to become effective again.

What about diet and exercise?

Diet and exercise are extremely important in keeping stools soft and BMs regular. Also, make sure your child gets plenty of fiber-rich foods such as fresh fruits, dried fruits like

prunes and raisins, dried beans, vegetables, and high-fiber cereal. Because kids often cringe at the thought of fiber, come up with creative ways to incorporate these foods into your child's diet so that it doesn't become a chore to eat the high-fiber fare needed to treat encopresis:

- Bake cookies or muffins using whole-wheat flour instead of regular flour. Add raisins, chopped or pureed apples, or prunes to the mix.
- Add bran to baking items such as cookies and muffins, or to meatloaf or burgers, or sprinkled on cereal. (The trick is not to add too much bran or the food will taste like sawdust.)
- Serve apples topped with peanut butter.
- Create tasty treats with peanut butter and whole-wheat crackers.
- Top ice cream, frozen yogurt, or regular yogurt with high-fiber cereal for some added crunch.
- Serve bran waffles topped with fruit.
- Make pancakes with whole-grain pancake mix and top with peaches, apricots, or grapes.
- Top high-fiber cereal with fruit.
- Sneak some raisins or pureed prunes or zucchini into whole-wheat pancakes.
- Add shredded carrots or pureed zucchini to spaghetti sauce or macaroni and cheese.
- Put lentils in your child's favorite soup.
- Make bean burritos with whole-grain soft-taco shells.

In addition to making sure your child is eating a balanced diet high in fiber, don't forget to have your child drink plenty of fluids each day, including water and 100% fruit juices like pear, peach, and prune to help draw water into the colon. Try mixing prune juice with

another drink to make it a little tastier. Also be sure to limit your child's total daily dairy intake (including cheese, yogurt, and ice cream) to 24 ounces or less.

Successful treatment of encopresis depends on the support the child receives. Some parents find that positive reinforcement helps to encourage the child throughout treatment. Give the child a small incentive, such as a star or sticker on their poop calendar, for having a BM or even just for trying, sitting on the toilet, or taking medications. Whatever you do, don't blame or yell - it will only make your child feel bad and it won't help manage the condition. Show lots of love and support and, assure your child that he or she isn't the only one in the world with this problem. With time and understanding, your child can overcome encopresis.

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Please tell me more about soiling that is not caused by constipation. What are the prevalence rates and how often does it usually occur during the day?

Encopresis affects 1 to 3 percent of children, with higher rates in boys than in girls. However, encopresis may go undetected unless health professionals directly inquire about toileting habits.

From 80 to 95 percent of encopresis cases involve fecal constipation and retention. Although several excellent reviews cover retentive encopresis, encopresis in which fecal

retention is not a primary etiologic component is under-represented in the literature. Typically, children with the latter condition soil on a daily basis, with bowel movements of normal size and consistency.

What are the terms used to describe this problem and are there sub-groups?

Various terms have been used to describe this problem, including functional encopresis, primary nonretentive encopresis and stool toileting refusal. These children may be further divided into at least four subgroups: (1) those who fail to obtain initial bowel training, (2) those who exhibit toilet "phobia," (3) those who use soiling to "manipulate" their environment and (4) those who have irritable bowel syndrome. Although the toileting dynamics and behavioral characteristics of children with nonretentive encopresis are well described, few specific treatment guidelines have been available.

Please tell me more about the causes.

While the treatment of retentive encopresis has progressed substantially in the past 20 years, less attention has been paid to the 5 to 20 percent of cases in which constipation is not contributory, or where a child "refuses" the toilet-training process. The family physician is likely to be the first to identify this problem and to provide "front line" intervention. Occasionally, a child presents who is not physically, cognitively or emotionally prepared for toilet training. In these cases, waiting until the child matures is the sensible choice. However, many times the reason is not a lack of readiness skills, but a child who is behaviorally resistant or parents who need information on effective behavior management or toilet-training strategies.

Treatment options?

Once the reason for a child's resistance is identified, specific interventions can be initiated. If the problem is related to a skill deficit (e.g., opening the bathroom door, disrobing, seating self on the toilet, wiping), then modeling, teaching and reinforcement are preferred to passive waiting. In similar fashion, if the child is oppositional or noncompliant with adult instructions, it's best to seek consultation at Community Psychiatric Centers to discuss compliance training protocols. In either case, without active intervention, the "strong-willed" child may resist toilet training and create unnecessary stress on the parent-child relationship.

Guideline 1: Identify Potential Medical, Developmental or Behavioral Pathology

Medical

First, a complete physical examination is indicated when a child presents with a history of soiling. The history and physical examination may be the only diagnostic tools necessary to

identify retentive encopresis and related organic factors. Few cases of retentive encopresis and even fewer cases of nonretentive encopresis have an organic etiology.

Children with retentive encopresis often soil small quantities of loose fecal matter several times a day but periodically pass very large bowel movements. They may present with urinary complaints and abdominal pain or distention. The physical examination is usually suggestive of constipation.

A consistent soiling pattern characterized by stools that are normal in size and consistency and the absence of constipation usually suggests nonretentive encopresis. If the physician is unable to confirm the presence of constipation or impaction following the history and physical examination, a flat plate radiograph of the abdomen will aid in diagnosis. Further diagnostic investigation using laboratory tests, barium enemas, rectal manometry or biopsy is reserved for use in children who fail conservative therapy or whose history and physical examination suggest an organic etiology. Finally, Hirschsprung's disease is frequently mentioned in the differential diagnosis of encopresis; however, children with Hirschsprung's disease do not typically pass large bowel movements and rarely soil.

Developmental

Unrealistic expectations or family priorities (particularly the birth of another child) may prompt parents to begin toilet training before the child is developmentally prepared. Initiating training when parents are under time constraints or during periods of family adaptation and stress will be difficult.

Child readiness is determined by the presence of the prerequisite physiologic, developmental and cognitive/psychological skills to master the complexities of independent toileting. Physiologic readiness is demonstrated by sphincter control, which is usually present by the time the child crawls or walks, and by bladder and bowel readiness, shown by the ability to remain dry for several hours at a time and to fully empty the bladder on voiding.

Some children make facial expressions, assume certain body postures (e.g., squatting) or go to a specific location to urinate or defecate. Developmental criteria include attainment of major motor skills such as being able to walk to the bathroom, sit on the toilet, lower and raise pants and flush the toilet. Cognitive/psychological readiness criteria involve both receptive language adequate to understand toileting-related words such as "wet," "dry," "pants" and "bathroom," and instructional readiness, as indicated by a child who desires to imitate and please parents and to follow simple instructions. Most children meet the above criteria and are ready to be toilet trained between 24 and 30 months of age.

Behavioral

The most important areas of behavioral assessment of toileting include ruling-out the presence of disruptive behavior problems such as aggression, oppositional behavior, noncompliance and temper tantrums, and establishing the child's compliance with adult instructions and obtaining a daily diary of toileting habits.

Coexisting behavior problems are a predictor of poor outcome in toilet-training protocols. Disruptive behavior and childhood noncompliance across multiple settings (e.g., dressing, bath time, bedtime) require direct attention before toilet training is attempted. It is critical that the child be cooperative and compliant with adult instructions; the child should be able to consistently follow at least seven of 10 parental instructions in a timely manner.

Rather than relying on a parental report, the clinician can simply observe the child during sessions to see if the child complies with parental instructions.

Finally, an important component of the behavioral assessment is pretreatment information on daily toileting patterns. A daily toileting diary provides a wealth of information that can be incorporated into the treatment plan. For example, the diary may help identify times to schedule toilet sits. Continued use of the diary may provide clues regarding treatment compliance and the effectiveness of the intervention.

Guideline 2: Address Toilet Refusal Behavior

What is "toilet phobia" and how is it treated?

Many children with fecal soiling have a history of painful defecation, toilet "phobia" or toilet refusal behavior. Positive toilet sits are one strategy to help children overcome negative associations regarding the bathroom. The goal of positive toilet sits is to associate the bathroom and the toilet with enjoyable activities and parent-child interactions. Initially, sits can be scheduled three to five times daily at the family's convenience. The strategy starts with very short sits (e.g., 30 seconds) that gradually increase to a maximum of five minutes each, using a portable timer to signal completion. The child can remain in underpants or diapers because there is no expectation of producing a bowel movement. While the child is sitting on the toilet, proper foot support, access to enjoyable (relaxing and noncompetitive) activities and individual parental attention should be ensured.

If a child is extremely resistant to approaching the toilet or potty chair, the parent may employ a gradual shaping procedure. For example, a parent begins by modeling appropriate toileting behavior for a few weeks; after this, the parent starts playing games or reading

books with the child in or near the bathroom. The parent and child gradually progress to engaging in these activities while the child is sitting on the potty chair for longer periods of time. During the modeling process, it is recommended that fathers and male caretakers sit during urination. Boys should be encouraged to sit while urinating until they are fully bowel trained.

Guideline 3: Ensure Soft, Well-Formed Stools

It is critical to ensure that the child is having relatively frequent, soft and well-formed bowel movements before engaging in any intervention for soiling. Dietary changes or short-term use of supplements such as flavored fiber drinks or bran sprinkles may be needed to increase the number of bowel movements and to maximize daily toileting opportunities.

If obtaining frequent, soft and well-formed bowel movements continues to be a problem, the addition of stool softeners or laxatives may be considered. Suitable daily regimens, at the pediatrician's discretion, include Milk of Magnesia; mineral oil; or sorbitol. These agents can be given in one or two doses per day. Mineral oil is not indicated in children who are at risk for aspiration.

Any of these supplements may make it more difficult for the child to withhold bowel movements, resulting in more soiling accidents. Consequently, it is a good idea for parents to develop a standard clean-up procedure that can be carried out in a matter-of-fact, emotionally neutral manner. The appropriate reaction is for parents to use a neutral tone of voice while directing the child through developmentally appropriate clean-up activities. Parents should avoid blaming, criticizing or name-calling during this time.

Guideline 4: Schedule Prompted Toilet Sits

When the child is no longer resistant to sitting on the toilet and is having normal bowel movements, it is time to begin prompted toilet sits during times when the child is likely to defecate. These sits can be scheduled up to five times daily for three to five minutes each. The portable timer, which previously signaled the end of positive sits, now terminates the end of each prompted sit. The best time to schedule prompted sits is five to 20 minutes after each meal--to take advantage of the gastrocolic reflex. Additional sits can be scheduled during high-frequency opportunities as indicated by the daily toileting diary. From the child's perspective, these prompted sits will appear to be no different than the earlier positive sits, as foot support, toys, activities and individual attention are still available. The child's behavior has simply been shaped to the point where he or she can now sit on the toilet without pants or diapers, in a pleasant and relaxed atmosphere, during a time when he or she is likely to defecate.

Once this guideline is satisfied, the family is ready to hold a "graduation ceremony." This ceremony involves having a small party and informing the child that he or she is now a "big boy" (or girl) and that diapers will no longer be used. It is important that parents do not use diapers occasionally during the day (e.g., on a shopping trip) because that sends a mixed message to the child about toileting expectations.

Guideline 5: Provide Incentives for Appropriate Bowel Movements and Self-Initiation

Although some authors recommend using incentives to target clean pants or diapers, this practice may encourage fecal withholding and increase the risk of constipation. Incentives can instead be tied to the passage of fecal material in the toilet. Incentives will be most effective if they are age-appropriate, given immediately after the desired behavior is displayed and provided after every occurrence of the behavior during the early phases of teaching.

Many types of incentive programs can be developed, depending on the age of the child, including access to candy, star charts, dot-to-dot pictures, grab bags and special privileges or activities with parents and peers. Selected incentives should be made available only after appropriate toileting, and access to these incentives should be restricted at other times.

When the child is eliminating in the toilet and no longer having daily soiling accidents, self-initiation skills can be targeted. Parents will want to gradually reduce verbal prompts to use the toilet, train the child to recognize the need to urinate or defecate and teach the child to request to use the bathroom each time. Incentives are now provided any time the child requests access to the bathroom and produces a bowel movement. Young children should inform the parent or caregiver before using the bathroom to ensure proper monitoring and hygiene.

Guideline 6: Arrange for Physician Contact in Case of Stool Withholding

Although ensuring frequent, soft and well-formed bowel movements should reduce the likelihood of a child withholding fecal material, a back-up plan is necessary. For example, the family could be asked to contact the physician if the child withholds for four consecutive days. A daily regimen of dietary supplements or stool softeners, as outlined in Guideline 3, may be all that is needed. If stool withholding leads to impaction, the physician may suggest hypertonic phosphate enemas (one to two per day, for up to three days) or suppositories, both of which work efficiently. If parents prefer an oral plan, the physician may use electrolyte solutions or high-dose mineral oil, in a dosage of 15 to 30 mL per year of age per day (maximum: 8 oz). Electrolyte solutions often require inpatient admission and nasogastric tubes to administer the volume and rate needed for effective evacuation. Mineral oil usually takes longer to work than enemas and may result in

increased soiling, cramping and abdominal pain until the fecal mass is passed. Once the child is no longer impacted, the physician can return to the daily regimen.

Example of a Toileting Diary from: American Academy of Family Physicians

Toileting Diary

Child's name:

Day/date	Time	Time	Time	Time	Time	Time	Time	Time
Mon/22	9 a.m. BMB, UB	12 noon PS, UT	2 p.m. BMP, UP					

BMT=bowel movement in toilet
 BMP=bowel movement in pants
 BMB=bowel movement in bed
 PS=practice sits

UT=urinates in toilet
 UP=urinates in pants
 UB=urinates in bed

Directions: When your child has a bowel movement or urinates:

1. Put day of week and date in the first column.
2. Put time of day in "Time" column.
3. Add the code to the "Time" column.
4. Continue each day.