Tips & Techniques To Address Encopresis And Enuresis

3 CE Training (3 CE APT Non-contact)

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TREATING ENCOPRESIS IN CHILDREN | Dr Kimberley O'Brien

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PRACTICAL WEBINAR AGENDA - ENCOPRESIS

1. INTRODUCING ENCOPRESIS
2. DSM-V DIAGNOSIS OF ENCOPRESIS
3. NON-DIRECTIVE VS. DIRECTIVE PLAY THERAPY WITH ENCOPRESIS
4. THREE DIRECTIVE PLAY THERAPY TECHNIQUES (VIDEO PRESENTATION)
5. BIRD'S EYE VIEW OF THE BATHROOM TECHNIQUE
6. BEFORE, DURING & AFTER TECHNIQUE
7. CUTTING THE DIAPER TECHNIQUE
8. RECOMMENDED READINGS
   Q & A / ENCOPRESIS QUIZ

WHAT IS ENCOPRESIS?

Encopresis (or faecal soiling) is the repeated passing of stools in inappropriate places, **after the age at 4 years,** when toilet training is expected to be accomplished.

Of all children diagnosed with Encopresis, **80%** have a history of constipation or painful bowel movements (Borowitz et al., 2002).

An estimated 5% of school children in the USA have Encopresis and **1.5%** of children worldwide. (von Gontard, 2013).

Encopresis is **more common in boys.**

Encopresis is responsible for **25-30%** of paediatric gastroenterology referrals in the USA (Donring et al., 2019).

Encopresis is a common complaint amongst parents who visit the Quirky Kid Clinic as it often occurs in the context of other behavioural issues such as **oppositional defiant disorder (ODD) or separation anxiety.**

According to the Diagnostic Statistical Manual (DSM-V) (American Psychiatric Association, 2013) encopresis (or otherwise known as **Elimination Disorder**) is essentially the repeated.

TO DIAGNOSE ENCOPRESIS

(Diagnostic and Statistical Manual of Mental Disorders - 5th Edition)

The following four features must be present:

- The child must be at least **4 years old.**
- At least o**ne incident must occur every month for at least 3 months.**
- There must be a **repeated** passage of faeces into inappropriate places, which is either intentional or involuntary.
- The behaviour **can not be attributed** to the effects of substances (e.g., laxative) or any other medical condition.

TWO CATEGORIES OF ENCOPRESIS

1

Primary Encopresis which refers to children who have never attained bowel control.

2

Secondary Encopresis which refers to soiling after successfully attaining toilet control usually triggered by stress, such as family conflict.

TYPES OF PLAY THERAPY TO TREAT ENCOPRESIS

DIRECTIVE PLAY THERAPY

- The play therapist chooses an activity designed to trigger a toileting discussion (such as a LEGO toilet).
- The play-based activity is time-limited to increase structure.
- There is visual evidence of your intervention (e.g., a sand play scene, an art work or ac display of feelings cards around the LEGO toilet).

TYPES OF PLAY THERAPY TO TREAT ENCOPRESIS - CONT'D

NON-DIRECTIVE PLAY THERAPY

- Play therapist gives child unstructured time and space to for free play.
- The child's play is observed and recorded overtime.
- Themes emerge for interpretation, such as fear of toileting, shame, parental frustration or soiling at school.

RISK FACTORS FOR ENCOPRESIS?

What are the potential risk factors for Encopresis?

In Western cultures, bowel control is established in 95% of children by age 4 in 99 % of children aged 5 (von Gontard, 2013). Around primary school age (10-12 years old) 1.5% of children develop encopresis.

Although every case is different, studies have shown that there are a number of risk factors, which are associated with the development of encopresis including:

- Presence of chaos or unpredictability in a child's life.
- Inadequate water intake.
- Lack of physical exercise or a diet that is high is fats and sugars.
- Family history of constipation.
- Presence of neurological impairment such as brain damage, Autism Spectrum Disorder, developmental delay and intellectual disability.

THE IMPACT OF ENCOPRESIS ON CHILDREN AND FAMILIES

- Encopresis becomes a family preoccupation, impacting family outings and activities.
- Issues with bowel control impact of school functioning and friendships.
- Children with Encopresis often feel scapegoated (or blamed) within their family.
- At school, Encopresis has been linked to inattention, disruptive behaviours, poor academic performance and social difficulties (Mosca & Schatz, 2014).

WHAT CAUSES ENCOPRESIS?

Biological factors:

90% of children with Encopresis experience Functional Constipation whereby defecation is typically incomplete. This occurs without a structural or biochemical explanation (Har & Croffle, 2010).

Spinal cord damage, Celiac Disease or bowel damage can result in Encopresis.

Withholding stools to avoid a painful bowel movement can lead to Chronic Withholding causing children to become unaware of partial bowel movements.

Laxative abuse can trigger severe soiling and long-term incontinence, while Tricyclic anti-depressants, narcotics, and iron supplements can trigger constipation.

WHAT CAUSES ENCOPRESIS?

Psychological factors:

1

Overall 30-50% of children with Encopresis have a co-morbid emotional or behavioural disorder (von Gontard, 2012, such as Separation Anxiety (4.3%), Specific Phobias (4.3%), Generalized Anxiety (3.4%), ADHD (9.2%) and Oppositional Defiant Disorder (11.9%) (Joinson et al., 2006).

2

In some cases, children who present with Oppositional Defiant Disorder or Conduct Disorder may use inappropriate soiling as a form of retaliation, an expression of anger or negative attention seeking.

3

Children with Encopresis are more likely to experience anxiety and depressive symptoms due to toileting difficulties and social stigma.

WHAT CAUSES ENCOPRESIS?

Family and Social Factors:

Children may develop delays in toileting due to unsuccessful toilet training methods, such as avoidance, intrusiveness, shaming or punitive practices.

1

In other cases, Encopresis may occur when there is a stressful family situation during toilet training such as parental divorce, the birth of a sibling or a transition to a new school.

2

In severe cases, frequent soiling may occur in a child who have experienced a traumatic stress or abuse (sexual, emotional or physical) during early childhood.

3

ENCOPRESIS TREATMENT OPTIONS

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TREATMENT OF ENCOPRESIS

Medical

Determine the cause - Refer to a paediatrician to arrange a stool sample to explore biochemical issues related to diet. A medical examination and/or scan of the bowel is recommended to explore any physical cause of painful bowel movements or constipation. Laxatives are commonly prescribed in the USA. Dietary changes with the support of a children's dietician or naturopath is preferred.

TREATMENT OF ENCOPRESIS

Behaviour Modification

1

Parents engage a psychologist or play therapist to provide support in the treatment of Encopresis.

2

The therapist engages the parents and the child together to develop a plan.

3

This may include encouraging the child to sit on the toilet for 10 minutes after meals 2-3 times a day using a reward system.

4

Parents engage a psychologist or play therapist to provide support in the treatment of Encopresis.

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This may include encouraging the child to sit on the toilet for 10 minutes after meals 2-3 times a day using a reward system.

NB: A meta-analysis by Freeman, Riley, Duke & Fu (2014) found that behavioural intervention is the most effective treatment for Encopresis.

TREATMENT OF ENCOPRESIS

Treat Co-morbidities:

- Co-morbid issues, such as Anxiety, Depression, or Oppositional Defiance, should be treated concurrently to reduce symptoms of Encopresis.

- Untreated co-morbid disorders will reduce adherence and compliance to the Encopresis treatment and reduce the likelihood of progress with the toileting issue.

IMPORTANT TIPS FOR PARENTS AND EDUCATORS

Never tease, embarrass or direct your frustration towards a child.

Boost self-esteem in other areas wherever possible.

Increase supervision in social situations to monitor social dynamics between children.

Encourage children to drink water regularly and eat fibre-rich foods, such as fruit, vegetables and whole grains.

Refer children for evidence-based psychological intervention if they are experiencing shame, guilt, depression, low self esteem, avoidance or other behaviours related to Encopresis.

If there is no improvement in toileting for 6 months, refer to a Gastroenterologist for an additional assessment.

DR KIMBERLEY'S APPROACH TO ENCOPRESIS

Use a combination of Directive and Non-Directive Play techniques. This allows time for play observations and intervention addressing the issues.

Use structure to separate each clinical technique. This gives the client a sense of safety and gives the psychologist or play therapist a sense of control.

Strike a balance between the client's interests and the issues to be addressed.

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‘IF ALL GOES WELL’ TECHNIQUE

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VIDEO DEMONSTRATION #1:

BIRD'S EYE VIEW OF BATHROOM TECHNIQUE

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VIDEO DEMONSTRATION #2:

“BEFORE, DURING & AFTER” TECHNIQUE

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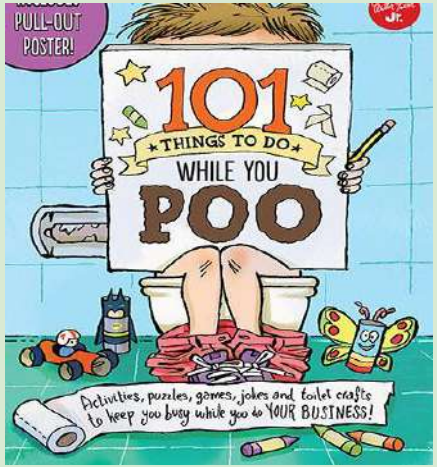
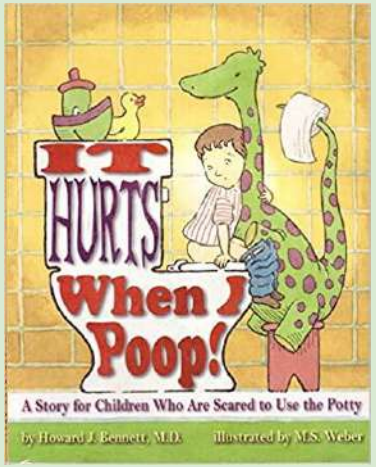
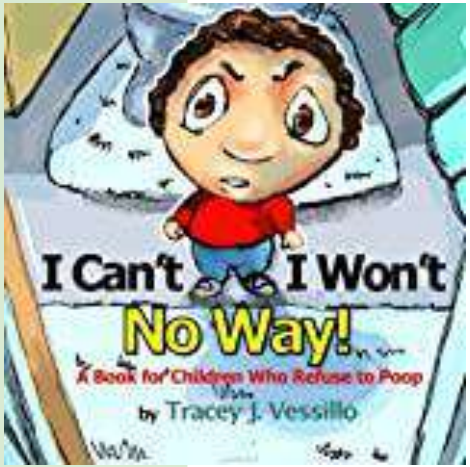
VIDEO DEMONSTRATION #3:

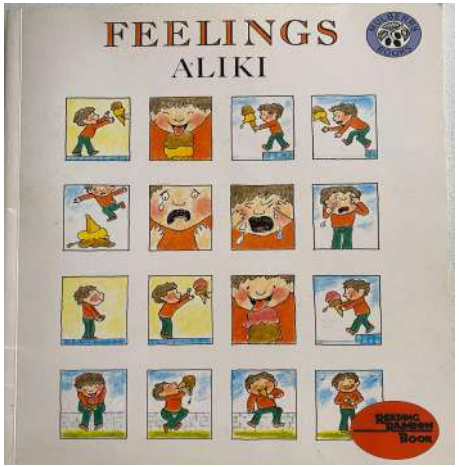
“CUTTING UP DIAPERS” TECHNIQUE

RECOMMENDED READINGS









ABOUT QUIRKY KID

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Award winning programs and content for social emotional learning, which can be used in schools by teachers, counsellors and other professionals working with children

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3,000 + ORGANISATIONS USED OUR PRODUCTS

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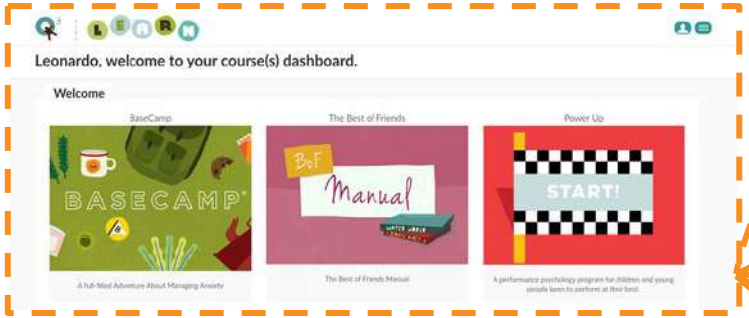
50 + TEACHERS/SCHOOLS USING/USED OUR PROGRAMS

QUIRKY KID - EXAMPLES OF PLAY THERAPY TOOLS



SOCIAL AND EMOTIONAL LEARNING PROGRAMS

Professional Development for
Play Therapists and Child Psychologists

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Checklist for Encopresis Management For Parents, Teachers and Therapists

Developed by Dr Kimberley O'Brien (kimberley@quirkykid.com.au) and based on research by Freeman, Riley, Duke & Fu (2014)

SIX STEPS TO REDUCE ENCOPRESIS	DATE ACHIEVED	COMMENTS / DETAILS
1. Teacher or parent refer child to a psychologist or play therapist specialising in Encopresis.		
2. First session involving both parent/s and child to explain Behaviour Modification plan. Weekly sessions are scheduled over three months.		
3.Child is rewarded with an outdoor activity for sitting on the toilet after meals for 10 minutes x 3 times per day.		
4. Child receives extra rewards for tuning into bodily cues for toileting (without prompting from parents or teacher).		
5. Weekly rewards are provided as the number of diapers or Pull-Ups used per week is gradually decreased.		
6. Teachers and parents meet on a weekly basis initially to review toileting progress at home and school. Rewards or special responsibilities at school are recommended to sustain progress.		

Susan Stutzman, LCPC, RPT-S

Tips & Techniques to Address Enuresis

Susan Stutzman, LCPC, RPT-S

Enuresis:

The involuntary discharge of urine : incontinence of urine - merriam-webster

Childhood Enuresis - Some Quick Facts

- According to the American Academy of Pediatrics (AAP), nocturnal enuresis affects 5 million children older than age 6 in the U.S.
- Nocturnal enuresis occurs more frequently in boys than in girls.
- Of the children with bedwetting, most have wetting at night.
- Primary enuresis is the most common form of urinary incontinence among children.

- John Hopkins Medicine

Daytime wetting (sometimes called “diurnal enuresis,” or “daytime urine accidents”) is twice as common in girls as it is boys. About 3 to 4 percent of children between the ages of 4 and 12 have daytime wetting. It is most common among young school-aged children.

Objectives

At the End of this workshop participants will be able to:

1. Discuss play therapy treatment planning for a child presenting with encopresis and/or enuresis
2. Apply 4 interventions to use in play therapy treatment for Diurnal Enuresis
3. Apply 2 interventions to use in play therapy psychoeducation with parents to aid decreasing Diurnal and Nocturnal Enuresis

Objective 1: Play therapy treatment planning for a child presenting with enuresis

Assess:

1. Gather History of Family Members with possible encopresis or enuresis
2. Rule out Medical Causes/Recommend a complete physical
3. Assess for any child abuse, recent traumas or life stressors for the client
4. Assess parent(s) attempts to address the issues prior as well as their ability to be consistent at home
5. Assess frequency, duration and settings for the enuresis

Objective 1: continued

Psychoeducate and Involve Parents with Empathy and Care:

1. Share Research on common causes and reasons for childhood encopresis or enuresis
2. Problem solve their need for support to provide consistency
3. Create 1 or 2 (at most) specific, measurable goals around enuresis presentation
4. Consider creating a plan for individual parent sessions or 15 minute check in's to provide them tools to respond with words, body language and specific interventions.
5. Educate Parents to utilize parent report in waiting area or wait for private check in when sharing updates

Objective 1: continued

Create a Specific Plan:

1. Set small measurable goals
2. Use specific interventions tailored to the client
3. Check in each week (Directive with parent, directive or non-directive with client)
4. Tailor Plan as needed
5. Celebrate all success!

Objective 2:

4 interventions

to use in play therapy treatment for

Diurnal Enuresis

Intervention 1: Bathroom Maps

Intervention 2: Bathroom Break Calendar:

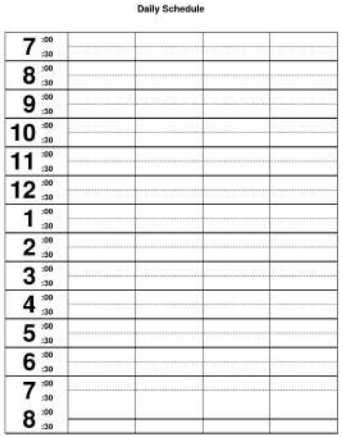
Set the child up for Success - Try and Try Again

Calendar Specific Bathroom “Try” times

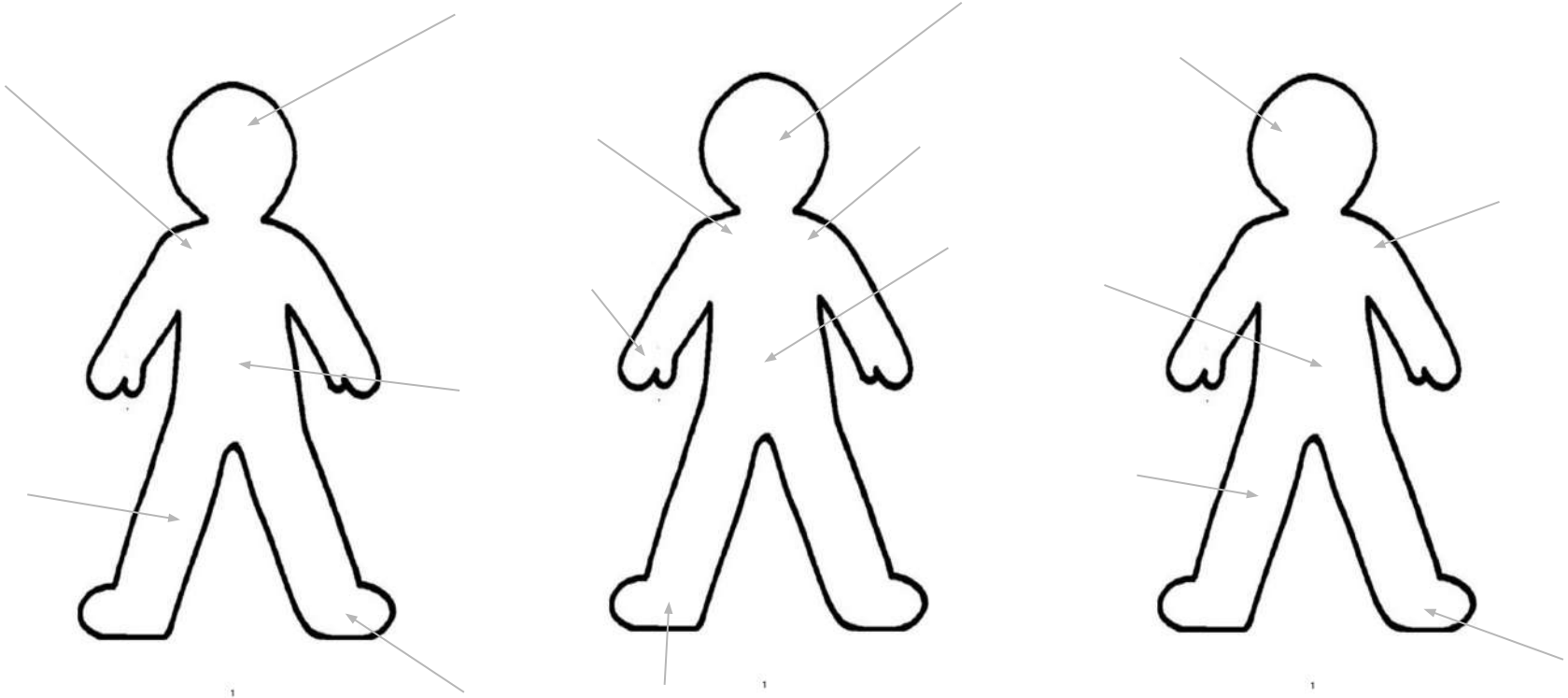
Have special stickers or dots with the child to use for “trying”

Practice in Sessions with Puppets and Timer

Look for patterns - modify for needs



Intervention 3: Mindful Self Check IN



Intervention 4: Where Does Liquid Go?

Image Credits: Nutty Toys

Objective :

2 interventions

to use in play therapy psychoeducation with parents

to aid decreasing **Diurnal and Nocturnal Enuresis**

Intervention 1: Listen 1st

Try asking: "*Tell me how living with a child with enuresis is for you*"

BEFORE you ask the following:

Tell me about when your child was potty trained?

Has your child ever been dry through the day? Night?

How often does Diurnal or Nocturnal Enuresis occur?

How frustrating on a scale of 1-10 is this for both parents/siblings?

Who cleans the child and the bed up?

What are the caregivers typical response?

Intervention 2: Assess through Experiential Play

Please describe through art what it was like potty training your child

Please describe through art what it is like to have your child struggle with Enuresis

Use Lego Builds, Paint, Clay or Sandtray

Key Psychoeducational Information to share in SMALL BITS

- The child is not at fault and should not be punished. The child cannot control the wetting or leakage.
- According to the AAP, enuresis usually goes away on its own in about 15 percent of affected children each year.
-

Mainstream Treatments include:

- Positive reinforcement of the child - (for example, the use of sticker charts for dry nights)
- Use of night-time alarms to help tell the child when wetting is occurring
- Medications, as prescribed by your child's doctor (to help control the wetting)
- Bladder training to help increase the bladder size and the child's ability to know when he or she has to urinate. (This is done by having the child wait as long as possible during the day to urinate and let the bladder get full.)
- Decrease fluids (AAP suggests this approach if the child believes it helps) and avoid caffeine at night

How Can We Modify For Felt Safety/No Shame

Discuss modified, Child Centered Approaches to Mainstream Methods

- Positive reinforcement of the child -NON Shame Based (for example, the use of sticker charts for dry nights)
- Use of night-time alarms to help tell the child when wetting is occurring Try Parent WAKING Child Gently to try
- Medications, as prescribed by your child's doctor (to help control the wetting or softening of poop) Discuss Options
- Bladder training to help increase the bladder size and the child's ability to know when he or she has to urinate. (This is done by having the child wait as long as possible during the day to urinate and let the bladder get full.)Use Playful Games to teach this to a child in a developmentally appropriate way
- Decrease fluids (AAP suggests this approach if the child believes it helps) and avoid caffeine at night Make a Water Chart so the child knows when drinking will stop and they don't feel deprived. Cease when child is sick.

References

Bedwetting (Enuresis). (n.d.). Retrieved from https://www.hopkinsmedicine.org/health/conditions-and-diseases/bedwetting-enuresis

Baird, D., Seehusen, D. A., & Bode, D. V. (2014, October 15). Enuresis in Children: A Case Based Approach. Retrieved from https://www.aafp.org/afp/2014/1015/p560.html#afp20141015p560-b5

Denham, J. M. (Ed.). (2018, July). *Soiling (encopresis) (for parents) - nemours kidshealth*. KidsHealth. Retrieved October 14, 2021, from https://kidshealth.org/en/parents/encopresis.html.

Pediatric Urinary Incontinence or Enuresis (bedwetting). (n.d.). Retrieved from https://childrensnational.org/visit/conditions-and-treatments/urology/urinary-incontinence-enuresis-bedwetting

Urinary Incontinence (Enuresis) in Children. (n.d.). Retrieved from https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=90&contentid=P03083

Daytime wetting (DIURNAL Enuresis). (n.d.). Retrieved September 24, 2019, from https://www.cincinnatichildrens.org/health/d/wetting

Urinary tract infection: Causes, symptoms, and prevention. (n.d.). Retrieved September 24, 2019, from https://www.medicalnewstoday.com/articles/189953.php

Ucuz, I., & Cicek, A. (2021). Therapeutic approaches to children with enuresis: A retrospective study. *Medicine Science | International Medical Journal*, *10*(1), 7. https://doi.org/10.5455/medscience.2020.11.232

Safiullina, G. I., Yakupov, R. A., & Safiullina, A. A. (2020). Neurophysiological aspects of enuresis in children. *Russian Osteopathic Journal*, (1-2), 58–65. https://doi.org/10.32885/2220-0975-2020-1-2-58-65

Smit, M., & Bakker, N. (2021). From defence mechanism to insufficient bladder control: Dutch experts on enuresis nocturna in an age of developing child sciences (c. 1950-1990). *History of Education*, 1–15. https://doi.org/10.1080/0046760x.2021.1884757