

Managing Encopresis in Schools

What is Encopresis:

Encopresis, also known as fecal incontinence or soiling, “refers to the repetitive, voluntary or involuntary, passage of stool in inappropriate places by children four years of age and older, at which time a child may be reasonably expected to have completed toilet training and exercise bowel control” (Sood, 2023) “in the absence of overt neuromuscular anorectal dysfunction (Sood, 2023). Encopresis is a medical condition which must be diagnosed by a health care provider. It is usually related to underlying constipation and the treatment depends on whether there is underlying constipation.

Common triggers of encopresis include:

- Start of school
- Separation from parents
- Schedule changes

These triggers can lead to a painful, frightening, or otherwise distressing experience associated with defecation. Because the child wishes to minimize this experience, they attempt to avoid evacuation ("stool withholding"), which further contributes to the constipation.

Student:

A student with encopresis should be evaluated by a health care professional. The goal of the evaluation includes:

- Excluding any underlying organic or anatomic disease as a cause of the incontinence.
- Determining whether the child has underlying constipation.
- Assessing for psychosocial precipitants that may contribute to the underlying constipation or to nonretentive fecal incontinence.
 - Attention deficit hyperactivity disorder (ADHD) is associated with higher prevalence of fecal and urinary incontinence.

It is not uncommon for a student with encopresis to deny both the visible and olfactory signs of soiling of their underwear. The student may appear unaware or unconcerned about the problem, even though it may cause the student to be teased by their peers. For some students, the episodes appear to be triggered by emotional stress. Some students may have abdominal pain associated with their fecal incontinence but it is not always an associated symptom.

Evaluation:

It is recommended to evaluate the student’s relationships with:

- Their family
- Friends
- Peers
- School staff
- Adults who they have frequent interaction with

Talking with the student may uncover “a troublesome, threatening, or confusing event associated with certain important persons (power figures such as a parent or teacher), places (such as the school and school bathroom), events (such as parental divorce), or things (such as the toilet itself)” (Sood, 2023). Students with encopresis should also be evaluated for psychological symptoms, including anxiety, depression, and behavioral symptoms.

Students experiencing encopresis could be the victims of sexual abuse. These students may also show signs of sexual acting-out behavior which can also be a sign of sexual abuse and warrants referral for further evaluation, if not already done.

Management and Treatment:

Having a student who experiences encopresis can be frustrating, not only for the student but for their parents, teacher, & peers. Teachers and parents should be advised that the student’s symptoms are involuntary & will not respond to blaming or disciplining the student. All involved should be informed that treatment can take months to years & that relapses are not uncommon.

The management of encopresis depends on the type of fecal incontinence. For students with constipation-associated (retentive) functional fecal incontinence, management focuses on treating the underlying constipation using both behavioral modification and laxatives. For children with non-retentive fecal incontinence, management involves similar behavioral interventions, with particular attention to identifying the trigger for the episodes of incontinence but without laxative therapy (Sood, 2022). The treatment of encopresis can take months to years, so patience and understanding are vital. It may be helpful for the student to be referred to a physician who specializes in managing encopresis.

When a child has encopresis from chronic constipation, their colon becomes distended and becomes unresponsive. The bowel needs to be “retrained” to work on its own, also known as “bowel retraining”. There are four steps involved in “bowel retraining”:

- Disimpaction (for children with a large rectal stool mass or fecal incontinence).
- Prolonged laxative treatment and behavioral therapy (see Toilet Sitting) to achieve regular evacuation and avoid recurrent constipation.
- Dietary changes (primarily increasing fiber and fluid content) to maintain soft stools.
- Gradual tapering and withdrawal of laxatives as tolerated (Sood, 2023).

The goal of therapy is the passage of soft stools, ideally once per day and no less than every other day. This goal of frequent defecation is important to overcome constipation.

Toilet sitting: The toilet sitting plan should be developed in collaboration with the parents, teacher, and school nurse. During school, the student should sit on the toilet shortly after breakfast, if applicable, and lunch for 5 to 10 minutes. The toilet sitting sessions should occur at the same time each day and be timed with a timer or stopwatch. The student’s adherence to the program should be encouraged with positive reinforcers instead of negative reinforcers. A stool should be provided for students whose feet do not touch the floor sitting on a regular toilet seat

as a foot support that raises the knees above the level of the hips can help relax the pelvic floor and is particularly helpful for a child who tends to withhold stool.

Positive reinforcement: In collaboration with the parents, it may be helpful to implement a reward system that is tailored to the student and in which the reward is provided for effort (i.e., sitting on the toilet for the allocated amount of time) rather than success (i.e., evacuation in the toilet) (Sood, 2023).

The Role of the School Nurse:

The school nurse should be involved in the development of an Individualized Health Care Plan (IHCP) for a student diagnosed with encopresis. As part of the IHCP development the school nurse should complete a health history and physical assessment of the student. The health history should include talking with the parents/guardians and possibly the health care provider.

The health history should identify if there is:

- Any history of altered bowel function
- Toilet training
- Diagnostic testing
- Surgeries
- Treatments
- Systemic diseases
- Abnormalities in the GI tract that cause constipation
- Family history of GI disorders or rectal bleeding
- Details of current bowel patterns:
 - Stooling pattern in toilet
 - Soiling accidents
 - Diarrhea
 - Stool size
 - Color
 - Amount
 - Consistency
 - Urge to defecate
 - Pain with defecation
 - Blood in/on stool
- Withholding behaviors witnessed by parents or teachers (i.e., crossing the legs, tightening the anal sphincter to avoid defecating, squatting).
- Medications: misperception of diarrhea and treating of firm stool
- Dietary history: changes or decrease in appetite
- Social difficulties, bullying, or lack of friends

As parents may not understand the cause of the encopresis, it may be helpful to ask them questions that gauge their level of understanding. These could include:

- What do you know about your child's diagnosis of encopresis?
- How do you refer to the diagnosis?
- How do you explain it to other people?
- What caused it?

- What has been different about your child's life since receiving the diagnosis?
 - Home
 - School
 - Friends
 - Extra-curricular activities
 - Food
 - Medicine
- (Fein, Goetz, & McKee, 2020)

The following questions may clarify the impact of the diagnosis on the student and family:

- What has been difficult since receiving the diagnosis of encopresis?
 - Does having encopresis interfere with your child socializing with peers?
 - Has school attendance been affected?
 - Has academics been affected?
 - Do your siblings/parents understand what encopresis is?
 - What do you need to do to manage your health concern(s) (encopresis)?
 - What are some things that make you feel sad?
 - What are some things that you worry about?
 - When was the last time you felt happy?
 - What do you like to do for fun?
- (Fein, Goetz, & McKee, 2020)

The interventions included in the IHCP could include:

- Evaluation for a Section 504 Plan.
- Implementing a Toilet Sitting schedule.
- Developing an incentive plan in collaboration with parents/guardians/teacher.
- Tracking of toilet sitting and bowel movements.
- Teaching the student relaxation techniques.
- Arrange for increased fiber in diet at school.
- Encourage the student to drink water throughout the day; allow water bottle in class.
- Arrange for bathroom privileges and privacy any time needed.
- Arrange for extra clothes and other supplies (i.e., wipes), as needed.
- Establish a private cleanup procedure for soiling episodes: provide soap, towels, and cleansing wipes, and change of clothes as needed in a private, accessible place.
- Refer the student to school counselor for individual supportive counseling surrounding positive self-esteem and social interactions with peer group issues.
- Encourage participation in school activities and provide support and reassurance to reduce negative associations around toileting (Jakubowski & Perron, 2019, p. 354).

Toileting and cleaning up after an accident would be considered activities of daily living (ADL) and do not require the intervention of a school nurse. The school nurse should be involved in the development of the Individualized Health Care Plan but the school nurse should not be expected or required to assist the student with toileting or cleaning up after an accident. The school nurse should collaborate with school administration and the teacher to determine who is the most appropriate school personnel to be responsible for these tasks.

Important Points:

- Fecal incontinence due to overflow does not constitute willful and defiant behavior by the child but actually represents physiologic loss of continence.
 - The child shouldn't be scolded or otherwise punished for incontinence episodes.
- Both behavioral interventions and laxatives are important parts of treatment.
- Behavioral interventions are geared towards reversing the cycle of pain and/or fear and stool withholding.
- The process of bowel retraining, with readjustment of the nerves and muscles in the rectum, can take as long as six months to several years.
- Relapse is not uncommon.

Resources:

- Kids Health: <https://kidshealth.org/en/parents/encopresis.html>
- Children's Mercy: Unstuck– <https://www.childrensmercy.org/siteassets/media-documents-for-depts-section/departments/gastroenterology/getting-unstuck.pdf>
- Children's Mercy Bowel Retraining in Constipated Kids Clinic: <https://www.childrensmercy.org/departments-and-clinics/gastroenterology/constipation-and-encopresis/>
- Brief Interventions: Encopresis–Maryland Chapter American Academy of Pediatrics: https://www.mdaap.org/pdf/Bi_Ped_Brief_Interv_Encopresis.pdf
- Nationwide Children's: <https://www.nationwidechildrens.org/conditions/fecal-incontinence>
- Evaluation and Treatment of Functional Constipation in Infants and Children: Evidence-Based Recommendations From ESPGHAN and NASPGHAN: https://www.naspghan.org/files/documents/pdfs/position-papers/Constipation_Feb_2014.pdf
- Constipation Care Package: https://naspghan.org/files/documents/pdfs/medical-resources/Constipation_Care_Package.pdf
- Constipation in Kids video: https://www.youtube.com/watch?v=_5ZHvQLv2dM

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