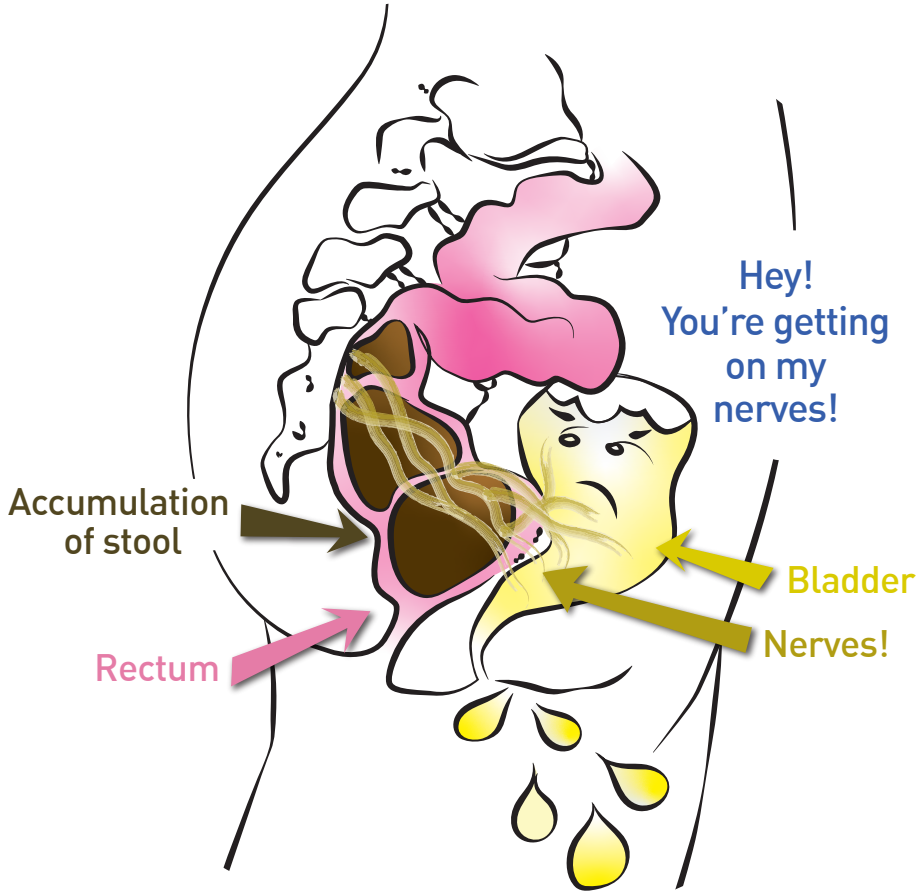
The Mental Health Professional's Guide to Enuresis & Encopresis

Here's how psychologists, family therapists, social workers, and school counselors can help.



By Steve Hodges, M.D., Pediatric Urologist, and
Amanda Arthur-Stanley, Ph.D., Psychologist

AUTHORS

Steve Hodges, M.D.
Associate Professor of Pediatric Urology
Wake Forest University School of Medicine

Steve Hodges is a professor of pediatric urology at Wake Forest University School of Medicine and an authority on potty training, chronic constipation, enuresis, encopresis, urinary tract infections, and other childhood toileting issues. He has authored numerous journal articles and co-authored eight books with Suzanne Schlosberg, including *Bedwetting and Accidents Aren't Your Fault* and *The M.O.P. Book: The Proven Way to STOP Bedwetting and Accidents in Toddlers Through Teens*. His mission is to dispel the myths about enuresis and encopresis and to communicate to families that accidents are never a child's fault. Dr. Hodges lives in Winston-Salem, North Carolina, with his wife and three daughters. He blogs at BedwettingAndAccidents.com

Amanda Arthur-Stanley, Ph.D.
Psychologist
Denver, Colorado

Amanda Arthur-Stanley, Ph.D., is a licensed psychologist and credentialed school psychologist. The co-author of two texts related to family-school-community partnering, Dr. Arthur-Stanley completes developmental evaluations of young children. In her private practice, Bluewater Psychology, she works with kids experiencing anxiety, school engagement issues, encopresis, and enuresis. Dr. Arthur-Stanley is passionate about supporting kids with encopresis and enuresis and reducing feelings of shame and anxiety related to these conditions. She lives in Denver, Colorado, with her husband and three children.

BedwettingAndAccidents.com

Illustrations by Cristina Acosta

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INTRODUCTION

Myths About Enuresis and Encopresis Have Created a Role for Well-Informed Therapists

By Steve Hodges, M.D.

As a pediatric urologist, I treat dozens of medical conditions, but only two consistently generate family tension: enuresis and encopresis. When a child has blocked kidneys or refluxing ureters, there's no talk in my exam room of emotional exhaustion, power struggles, anxiety, or a child's "stubbornness" or "acting out."

But when a clinic visit pertains to bedwetting or daytime pee or poop accidents, the family friction is often palpable. Some parents express frustration openly, reporting their child's "refusal" to use the toilet ("Then she has an accident three minutes later!") or to acknowledge an accident has happened ("The smell is so obvious. How can he not notice?"). Meanwhile, the child sits silently, no doubt embarrassed and hoping the appointment will end soon.

This unfortunate scenario stems from a massive misunderstanding about what causes enuresis and encopresis and how best to treat these conditions. Ironically, this misunderstanding, pervasive in popular culture and in mental health literature, has created a role for well-informed therapists. **There is much that you, as a mental health professional, can do to help!**

Enuresis and encopresis have long been assumed to have psychological or behavioral roots. In TV, film, and fiction, bedwetting serves as shorthand for anxiety. The child who wets the bed is inevitably the one neglected by a parent! Mental health authorities also make that same leap. The *DSM-5*, the *Handbook of DSM-5 Disorders in Children and Adolescents*, and *Psychology Today* are among the respected resources that include entries for enuresis and encopresis. The underlying assumption is that accidents signal psychological distress — that enuresis and encopresis stem, in some way,

In TV, film, and fiction, bedwetting serves as shorthand for anxiety. The child who wets the bed is inevitably the one neglected by a parent!

from anxiety, stress, attention seeking, behavioral disorders, "unmet needs," trauma, or parental depression or divorce.

But that assumption is erroneous. **Enuresis and encopresis are not psychological or behavioral conditions. They are symptoms of a rectum enlarged by the pile-up of poop — in other words, chronic constipation**. You can see the stool mass plain as day on an x-ray. In the case of enuresis, the stretched rectum aggravates the bladder nerves, prompting the bladder to "hiccup" and empty without warning. With encopresis, the rectum has lost sensation and tone, so stool just drops out of the child's bottom. The child does not feel the urge to poop or notice an accident has happened.

Just as depression and anxiety do not merit entries in urology textbooks, enuresis and encopresis do not belong in psychiatry or psychology manuals. Yet there they are. As a result, you may treat patients who struggle with these symptoms. You may even use the *DSM-5* to diagnose enuresis or encopresis for insurance purposes. I hope this guide will inform your approach to these cases.

Certainly, children with enuresis and encopresis often feel stressed and anxious and behave in ways that baffle and exasperate their parents. But in the mental health world, a critical fact is often overlooked: **These emotions and behaviors *are not causing the accidents.* Quite the opposite.** The child's distress *is caused by* the accidents — or, more accurately, by living with a medical condition that has gone untreated or undertreated.

When constipation resolves — when the child's enlarged rectum is cleared out daily and allowed time to shrink back to size — accidents cease. So do the power struggles, "tantrums," anxiety, and the rest. I hear this from parents all the time.

> **"We went from daily outbursts and heightened anxiety to cooperation and logical discussions," the mom of a 7-year-old posted. "The cycle of shame and frustration stopped."**

As another mom wrote, learning that her 10-year-old's enuresis was an entirely physiological condition "may have saved our family." She explained: "When the daytime accidents started, we blamed it on stress due to an upcoming move and changing schools. After all that settled down, things still got worse, and my son was depressed." Now that his constipation has resolved and the accidents have stopped, she continued, "his emotional state is in a good place. I no longer worry about him being depressed for the rest of his life."

These children, like most of my patients, went years without receiving appropriate treatment — that is, enemas and laxatives. Instead, many children are referred for counseling, offered sticker charts, questioned about their "potty refusal," even prescribed psychiatric medication.

Among school-aged children, encopresis accounts for 3% to 6% of psychiatric referrals.[1]

"When my son was 8 years old, he was medicated with serious anti-psychotic meds because a psychiatrist thought he had signs of pediatric bipolar," one mom told me. What were these "signs"? Poop accidents.

Over the years, the boy visited multiple mental health professionals, "all of whom were 100% stumped" by the cause of the boy's encopresis, according to his mom. "They made charts to try to correlate the accidents to stress and other behavioral issues. Of course, none of the theories ever seemed to fit." Eventually, a urologist confirmed the boy's rectum was clogged and enlarged. A regimen of daily enemas plus Ex-Lax halted his poop accidents in *one week* — the week before the boy started middle school. Five months later, his bedwetting stopped. (Encopresis always resolves more quickly than enuresis.) "We literally went through torture for years," his mom wrote.

No form of counseling will empty out a clogged rectum. Incentive charts, mindfulness techniques, and art therapy won't get a child who has lost rectal sensation pooping on the toilet. The child simply is not receiving the signal to poop, so treatment along these lines only heightens frustration among children and parents. However, therapists can be of great assistance to families in other ways. Many of my patients have endured teasing or bullying by peers, have missed out on birthday sleepovers and sleepaway camps, and have been subjected to eye-rolling, scolding, and worse from ill-informed adults. Many of these kids suffer from low self-esteem, anxiety, even serious depression, all because their constipation went undiagnosed, untreated, or undertreated.

> **Helping children cope with the fallout from untreated constipation is an arena for mental health professionals, not pediatric urologists.**

"My son was repeatedly hospitalized for suicidal ideation with encopresis and enuresis as the primary triggers," one mom emailed me. Only after months on an enema regimen — a regimen he tried after a decade of wild goose chases — did her son's accidents stop. "He is 16 1/2 now," she wrote, and just recently stopped wearing diapers."

Helping children cope with the fallout from untreated constipation is an arena for mental health professionals, not pediatric urologists. I can assure my patients that accidents are not their fault — I do it all the time. But I'm not equipped to help kids regain confidence they've lost after years of internalizing blame. My skills also fall short when it comes to encouraging my patients to comply with constipation treatment. I get it: **These kids have endured years of useless remedies and are often in no mood to try yet another approach. A therapist's expertise can be invaluable.**

1 Hardy, L. T. (2009). Encopresis: A guide for psychiatric nurses. Archives of *Psychiatric Nursing*, 23(5), 351–358. https://doi.org/10.1016/j.apnu.2008.09.002

Therapists can help parents too, as the stigma of enuresis and encopresis burdens the whole family. **Parents are often judged and blamed by relatives, friends, and school directors for "failing" to properly toilet train their children.** Many parents feel guilty for having assumed the accidents were behavioral and for waiting years to seek medical treatment. Once a child starts down the right path, parents may feel overwhelmed by the treatment regimen that is needed.

I'm out of my depth here!

Luckily, I can refer families to Amanda Arthur-Stanley, Ph.D., a psychologist well versed in the causes of and treatments for enuresis and encopresis. In her private practice, Dr. Arthur-Stanley helps families tackle myriad issues that arise from these conditions. In addition, thanks to her experience as a school psychologist, she can help families navigate the educational system, ensuring children have unrestricted restroom access, 504 plans when needed, and other accommodations. All this makes Dr. Arthur-Stanley a valuable resource for therapists seeking to learn more about enuresis and encopresis.

IN PART 1 of this guide, I explain in detail how constipation causes enuresis and encopresis and delve into the supporting evidence. I also introduce the Modified O'Regan Protocol (**M.O.P.**), the treatment regimen I favor for preschoolers and high school students alike.

IN PART 2, Dr. Arthur-Stanley explains how therapists can support families struggling with enuresis and encopresis, including those who have chosen to implement **M.O.P.**

We welcome your feedback!

PART 1: Unpacking the Myths About Enuresis and Encopresis

By Steve Hodges, M.D.

What Really Causes Bedwetting and Daytime Accidents

Enuresis and encopresis are often described as complex conditions caused by an interplay of physiological and psychological issues. An underdeveloped bladder, an overproduction of urine, excessively deep sleep, psychosocial stress, delayed toilet training — all are mentioned in mental health texts as possible explanations for either or both conditions. In truth, these explanations are not supported by scientific evidence, as I explain in detail in the *The M.O.P. Book: Anthology Edition*, my guide for parents. It's much simpler than that.

In the case of encopresis, there is but one cause: a clogged, dilated rectum. Garden-variety constipation is the root cause of virtually all enuresis, too, with a handful of exceptions. For example, neurological conditions such as spina bifida and tethered cord syndrome can cause wetting in the absence of constipation. I discuss these exceptions in "Medical Conditions to Rule Out," on page 40 of the Anthology, and I screen for these conditions in my examinations, on the off chance a neurological condition or anorectal malformation went undiagnosed. (It happens.)

But I can't emphasize how rare these causes are. In a healthy child with an intact spinal cord, daytime and nighttime accidents are invariably caused by chronic constipation that was overlooked or undertreated. This applies to children

Healthcare professionals often assume, erroneously, that accidents are "part of the deal" with ADHD, SPD, and autism. So, in these kids, the underlying constipation tends to go untreated even longer.

with ADHD and sensory processing issues as well as autistic children. Healthcare professionals often assume accidents are "part of the deal" with ADHD, SPD, and autism. So, in these kids, even more than in other children, accidents are assumed to have behavioral origins, and underlying constipation tends to go untreated even longer.

Unfortunately, the *DSM-5* does not recognize an enlarged rectum as even a possible cause of enuresis, let alone as virtually the *only* cause. The manual does acknowledge that encopresis is usually caused by constipation but also invents a category of encopresis called "soiling without constipation." I assure you this phenomenon does not exist. **The *DSM-5* combines enuresis and encopresis in its Elimination Disorders entry but fails to recognize that pee and poop accidents are two symptoms of the same condition: a dilated rectum.**

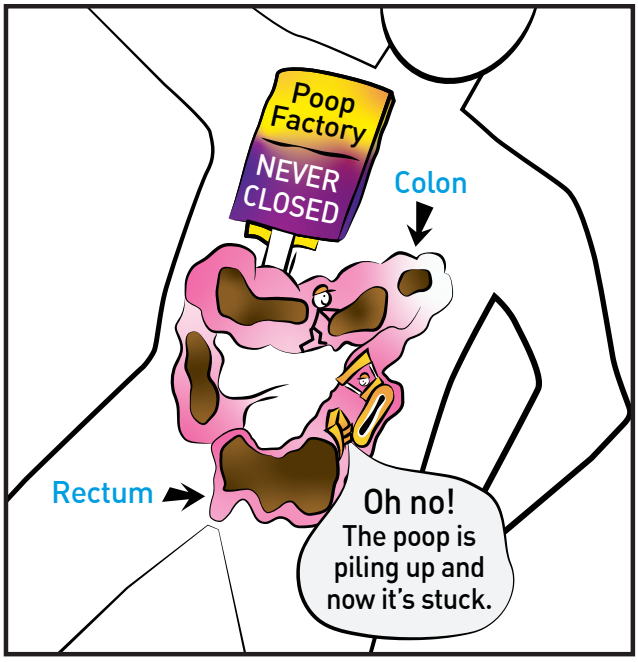
Further, the *DSM-5* states that both enuresis and encopresis can be "voluntary or involuntary." In truth, accidents of both types are always involuntary. It is critical for therapists, children, and parents to understand this. The suspicion among adults that a child's accidents may be voluntary leads to frustration and inappropriate treatment. **Parents often think, *He's 7 years old. He knows better than to poop in his pants* or *She's 10. She knows she'll have an accident if she holds her pee too long. Why doesn't she just use the darned toilet?***

If you understand what's happening inside the child's body, accidents are easily explained.

How Chronic Constipation Causes Enuresis and Encopresis

Children who have accidents appear to disregard their body's signals to pee or poop, but appearances are deceiving. In reality, these kids are not receiving the signals.

The rectum and bladder sit right next to each other, practically touching. Some children have such sensitive bladders that even a slight bulge in the rectum can wreak havoc on the bladder nerves. In other kids, the bulge is so large that the bladder nerves inevitably become aggravated. Either way, the upshot is an overactive, unpredictable bladder.



When a child's rectum has become stretched and floppy due to the chronic pile-up of stool, the child doesn't get the signal to poop. So, more poop piles up.

Those of us with a healthy bladder sense

the urge to pee gradually, as the bladder fills up. Though we may override the urge at first, because we're at the supermarket or in the car, eventually the discomfort forces us to find a toilet. But a child with irritated bladder nerves doesn't get that grace period. Instead, the bladder randomly and forcefully contracts, emptying before it's even full, daytime or nighttime. Like a hiccup, the contraction happens without warning and can't be stopped. That's enuresis in a nutshell.

Encopresis is simply a different symptom of the same bulging rectum. Under normal circumstances, the arrival of stool into the rectum prompts a newsflash: *Get thee to a toilet!* **But when a child's rectum has become stretched and floppy due to the chronic pile-up of stool, the communication mechanism fails**. The arrival of a poop load signals . . . nothing. So, more poop piles up. What's more, a floppy rectum is a weakened one, so the rectum may not have the oomph to evacuate the full load. On top of that, if the child has a well-established habit of clenching the pelvic floor muscles, these muscles can fatigue. The upshot: poop drops out of the child's bottom. The child does not feel it, and **because kids with encopresis tend to become desensitized to the odor, the child may not even smell what is horrifying to everyone else in the vicinity.**

This is hard for parents to process, so they may ask why their child is "lying" about having accidents. One mom in our support group posted: "My son had a poop accident in class and kids made fun of him. Later, when I asked him if he felt the urge, he said yes, but he just didn't go to the bathroom. In the past, he has said, 'Going to the bathroom is boring.' I suspect he either didn't feel the accident coming or it came on too fast for him to stop it. Still, why wouldn't he just tell me that?"

Good question! My guess is the boy was embarrassed to admit he couldn't control his bowels, and it's less mortifying to insist that using the toilet is "boring." Countless parents have reported the "boring" explanation to me. As a physician, I'm not qualified to opine on why children say what they do. But I know enough about physiology to know the child did not get the memo. This is a situation in which a therapist can be of help — by educating parents to back off rather than cajole the child to use the toilet. With treatment, rectal tone and sensation will return, and the accidents will stop, no cajoling needed.

Therapists can help by educating parents to back off rather than cajole the child to use the toilet.

In some children, chronic constipation leads only to bedwetting. Other children experience both nighttime and daytime wetting. A few, oddly, have daytime but not nighttime accidents (a scenario that really frustrates parents). Many children have encopresis only. A substantial and unlucky minority have all three types of accidents. **As I explain in the M.O.P. Anthology, encopresis almost always clears up first and quickly, followed by**

daytime wetting. When children have all three symptoms, bedwetting is almost always the last one to resolve.

Chronic constipation is extremely prevalent among children today, but not all these kids develop enuresis or encopresis. In fact, most don't. Not every bladder is sensitive to the effects of a bulging rectum, and not every bulging rectum loses enough sensation and tone to cause poop accidents. Many chronically constipated kids have lesser symptoms, such as urinary frequency, urinary urgency, stomachaches, or underwear skid marks — symptoms that are not listed in the *DSM-5* (and rightly so!) but have the exact same etiology. **Genetics play a big role; pure luck allows many constipated kids to skate by.** However, if a child with an intact spinal cord has pee or poop accidents, you can be sure constipation is the culprit. An x-ray can confirm it.

> **Parents are baffled when constipation strikes a child who is extremely active and eats a stellar diet. I hear, "How can she possibly be constipated? She loves vegetables and is on the gymnastics team."**

When parents learn their child's enuresis or encopresis is caused by constipation, they often ask: "How did my child get so constipated?" Of course, the specific answer will vary from child to child, but the general answer is: Because we live in the 21st century. **Basically, we modern humans are too smart for our own good. It would not occur to a cat, or to our prehistoric ancestors, to delay pooping when the urge strikes.** But today's humans constantly postpone pooping. If we're not near a toilet when we get the signal — if we're on the playground or watching a video — we're likely to override the signal by tensing our pelvic floor muscles and anal sphincter.

Humans have the capacity to delay pooping for hours, even days. Children, especially, are masters of delay. Problem is, the human body is designed to poop on a daily basis. When that schedule is interrupted, stool starts to pile up. The longer stool dwells in the rectum, an organ that was not designed as a storage facility, the more water is absorbed and the drier the stool becomes. With each delay, more stool piles up. **Eventually, the hard, dry mass can become so large — the size of a softball, even! — that the rectum stretches, losing the tone required to fully empty. The child also loses the ability to sense when it's time to poop.**

The vicious cycle often begins with a single episode of painful pooping. Chronic constipation can even begin in infancy — for example, when a baby switches from breast milk to solids or eats a new food that doesn't agree with them. Even babies can remember that pooping hurts, so they avoid doing it. Avoiding pain is human nature, not a sign of a psychological disorder.

Countless adults today suffer from constipation, so it's no surprise that children — especially young children, with a lesser grasp on the importance of pooping every single day — are

constipated, too. **Some children are more prone to constipation than others, because of their genetics and personality.** One preschooler may feel perfectly comfortable marching over to the toilet in the middle of story circle, whereas another might find the idea unthinkable. Some kids are cool with pooping in public restrooms. Others feel self-conscious and will not do it.

Parents are particularly baffled when constipation strikes a child who is extremely active and eats a stellar diet. I often hear, "How can she possibly be constipated? She loves vegetables and is on the gymnastics team." But low activity levels and a poor diet — while certainly contributing factors to many cases of constipation — typically don't explain enuresis or encopresis in my patients.

At any rate, as I tell parents, it doesn't really matter how a child became constipated. The important thing is to clear out the rectum and keep it clear on a daily basis. Full evacuation every day is critical. **By the time a child is constipated enough to have enuresis or encopresis, all the cajoling and incentivizing and anxiety-reduction techniques in the world will not fix the situation. You have to go straight to healing the rectum.** Once that is accomplished — once tone and sensation are restored and the bladder nerves are no longer aggravated — accidents will cease. As I will explain later, the same treatment that heals the rectum also helps the child overcome the habit of delaying pooping.

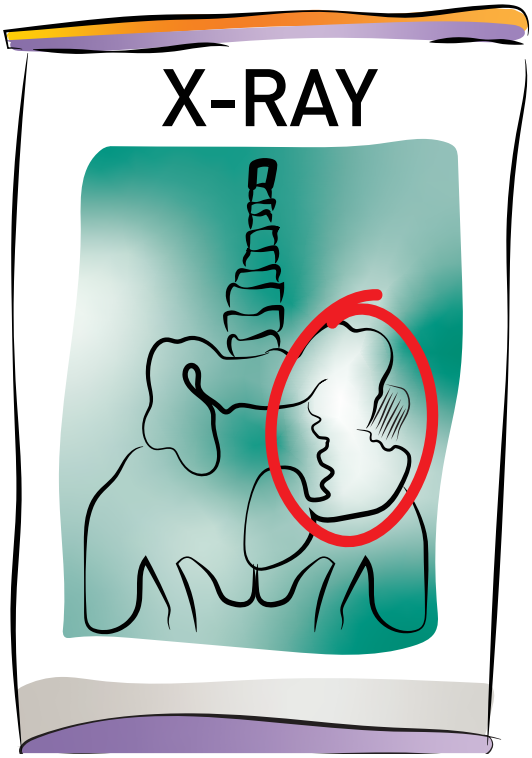
Proof That a Clogged Rectum Is the Culprit

You may wonder: If constipation is such a clear explanation for enuresis and encopresis, why are these conditions presented in the mental health literature as mysterious and complex? You may even wonder if what I'm saying is true, given the inclusion of enuresis and encopresis in the most authoritative handbook of mental disorders. Where is the proof? Fair question.

The first person to definitively prove constipation is the root cause of enuresis and encopresis was Sean O'Regan M.D., a pediatric kidney specialist who practiced at a hospital in Montreal in the 1980s. Dr. O'Regan was also the father of three boys, including a 5-year-old who wet the bed nightly. He was bewildered by the boy's enuresis, since his other two sons had achieved overnight dryness around age 3. Dr. O'Regan rejected the common assumption that bedwetting was a psychological issue, and he knew his son did not have any congenital conditions. He went searching for answers at the McGill University Medical Library, whose famous collection included European medical journals dating to the 19th century. **Dr. O'Regan was surprised by what he discovered: several articles, published as far back as the 1890s, that found children with severe constipation had high rates of urinary problems.** Contrary to the conventional wisdom, peeing and pooping were intimately related.

Intrigued, Dr. O'Regan asked a colleague to test his son for constipation using anorectal manometry, a procedure whereby a small balloon is inserted into the child's bottom and gradually inflated. The more inflation the child can tolerate, the more the rectum has been stretched by a

build-up of stool. Now, a child with normal rectal tone would notice the balloon inflated with just 5 ml to 10 ml of air, whereas a severely constipated child might not even detect the balloon until it's inflated with 40 ml of air. **The O'Regan boy's results were astounding: Even when the balloon was fully inflated, to 110 ml, the size of a small tangerine, Dr. O'Regan's son felt no discomfort. Dr. O'Regan's colleague to him: "The boy's got no rectal tone."**



I x-ray my enuresis patients and measure their rectal diameter. A normal rectum measures less than 3 cm in diameter. Most of my patients have a rectal diameter of 6 cm to 9 cm.

So, Dr. O'Regan turned to the most reliable treatment for severe constipation: enemas. Dr. O'Regan gave his son one enema every night for a month, every other night for a second month, and twice a week for a third month. Within a week, Dr. O'Regan's son was having his first dry nights. Within two months, he'd stopped wetting the bed completely.

Based on this success, Dr. O'Regan and his colleague began a series of studies on children with enuresis and encopresis.[1, 2, 3] (The full text is posted on the Research page of my website.) Anorectal manometry showed these patients were severely constipated. The enema regimen Dr. O'Regan used on his own son worked dramatically well for hundreds of patients. **Counseling was not needed to stop the accidents. Cleaning out the rectum did the job.**

After finding his studies many years ago, I tracked down Dr. O'Regan, now retired and living in Arizona. He told me he felt pleased that he was able to help so many children who had been blamed or shrugged off by their doctors. "These kids were told that it was all in their heads, that they were psychologically disturbed," he recalled.

Forty years later, not much has changed. While anorectal manometry is the gold standard for detecting constipation, it's also a cumbersome procedure. Constipation can also be detected with a plain old x-ray. I x-ray my enuresis patients and measure their rectal diameter. **A normal rectum measures less than 3 cm in diameter. Most of the kids I treat have a rectal diameter of 6 cm to 9 cm.** I see rectal stool masses the size of a grapefruit. The contrast with a normal rectum is stunning.

When my patients get cleaned out using the same regimen Dr. O'Regan used, or a regimen that's similar, accidents stop. If stress, anxiety, urine overproduction, or deep sleep caused enuresis or encopresis, cleaning out the rectum would not stop the accidents. But it does.

1 O'Regan, S., Yazbeck, S., et al. (1986). Constipation a commonly unrecognized cause of enuresis *American journal of diseases of children, (1960), 140*(3), 260-261. https://pubmed.ncbi.nlm.nih.gov/3946360/

2 Yazbeck, S., Schick, O'Regan, S. (1987). Relevance of constipation to enuresis, urinary tract infection and reflux. A review. *European Urology*, 13(5):318-321. https://pubmed.ncbi.nlm.nih.gov/3315689/

3 Yazbeck, S., Schick, O'Regan, S. (1985). Constipation, bladder instability, urinary tract infection syndrome. *Clinical Nephrology*. 23(3):152-154. https://pubmed.ncbi.nlm.nih.gov/3987104/

Notably, the *DSM-5* and related texts observe — very briefly — that many children with enuresis also have encopresis, constipation, and urinary tract infections. However, these texts fail to connect the dots: Chronic constipation *is the cause* of enuresis, encopresis, and chronic urinary tract infections! **Reading these texts is like watching a television crime show in which detectives overlook obvious clues. You're hollering at the TV, "No! You've got the wrong guy!"** Back in the '80s, Dr. O'Regan proved the connection masterfully, solving the case beyond a reasonable doubt.

Dr. O'Regan's studies are hardly the only ones linking enuresis to chronic constipation. They're just the best studies. Today's doctors use far inferior — I would say worthless — methods of detecting constipation in children, such as feeling the child's belly and asking parents how often the child poops. Dr. O'Regan recognized these methods as useless and noted in his studies that most of his patients' parents were shocked to learn their children were constipated.

The problem is with the definition of constipation. Most people think it means "infrequent pooping." But in reality, a child can poop every day and still be backed up.

The same is true in my clinic. The problem is with the definition of constipation. Most adults think the term means "infrequent pooping." But in reality, a child can poop every day and still be chronically backed up. Dr. O'Regan pinpointed the definition problem. Constipation means "incomplete evacuation," regardless of how often the child poops. **In fact, pooping two or three times a day is actually a sign of constipation, suggesting the child is not fully evacuating each time.**

If a physician can't find evidence of constipation in a child with encopresis, it's because a physical examination and pooping history are inferior diagnostic tools, not because the child's rectum is empty. **If you want proof of constipation, don't feel the child's belly or ask how often the child poops. Have the child x-rayed.** (The Anthology explains how to get an accurate x-ray reading.)

Where Mental Health Literature Strays From the Evidence

When discussing enuresis and encopresis, mental health texts are generally a mix of both accurate information and misleading statements based on shoddy or misinterpreted research. I do not recommend that mental health professionals look to the *DSM-5* or related literature for assistance in diagnosing, treating, or understanding these conditions.

What does the psychiatry and psychology literature get right? For one thing, the *DSM-5* concedes that when a child has poop accidents due to constipation, "the incontinence resolves after treatment of constipation." Theravive, an online network of licensed therapists, states the case quite well: "It remains a fact that if the bowel is kept empty, soiling cannot occur." What's more, the *Handbook* concedes that "research has not been able to demonstrate a causal relationship whereby mental health conditions cause encopresis."

So far so good. **Several texts indicate that encopresis 1.) starts with a painful pooping episode, 2.) causes the rectum to lose sensation, and 3.) is not caused by mental health conditions. Then why is encopresis listed in the *DSM-5*?** And why are kids with this condition being referred to mental health professionals for treatment? Perhaps encopresis is included in mental health texts because children with this condition quite often experience psychological distress. The *Handbook* cites a UK study linking children with encopresis to elevated rates of "bullying behavior (both as a victim and perpetrator), antisocial activities, attention and activity problems, obsessions and compulsion, and oppositional behavior." But the wrong conclusion is drawn. The more accurate lesson is: *Children suffer when their encopresis goes untreated.*

> **Whereas parents gravitate to the "stressful events" theory of enuresis, schools tend to assume daytime accidents are "associated with symptoms of disruptive behavior."**

While mental health texts agree that encopresis is usually caused by constipation, the same texts do not recognize enuresis has the very same cause. Instead, cited causes for enuresis are all over the map. For example, the *Handbook* attributes bedwetting to "the interplay of three elements: defective sleep arousal, lack of inhibition of bladder emptying during sleep, and nocturnal urine production." The *DSM-5* notes that bedwetting runs in families.

In fact, deep sleep and urine production play no role in enuresis, myths I dispel in the M.O.P. Anthology, and the bedwetting-gene theory also does not explain accidents. What does run in families is the predisposition toward constipation and sensitivity of the bladder to rectal stretching. But even if these physiological factors actually did cause enuresis, wouldn't that disqualify the condition from inclusion in a book on diagnosing mental disorders? **Instead, the mental health literature defaults to an assumption that enuresis has both physiological and psychological origins. The *DSM-5* cites "predisposing factors" such as "delayed or lax toilet training and psychosocial stress."**

Also common is the "attention seeking" explanation for enuresis. As *Psychology Today*'s Diagnosis Dictionary puts it, wetting accidents may signal "a child has deep feelings they're struggling to express or a need for attention and care that is not currently being met."

This theme surfaces often in therapy. One mom in our support group posted screenshots of texts from a behavioral therapist who insisted her son was having wetting accidents as a way to get his "wants and needs met" and insisted this mom was "reinforcing" attention-seeking behavior by allowing him to wear pull-ups. The therapist added: "Urinating on his bedroom floor doesn't have anything to do with constipation."

The *Handbook* cites poorly conducted studies linking daytime wetting to "difficult temperament and maternal depression/anxiety." Also, the book attributes secondary enuresis — the resumption of bedwetting after a long dry period — to "stressful life events," particularly separation or divorce of parents. "The most vulnerable age for secondary enuresis was 5 and 6 years," the book states. **But there is a good reason bedwetting commonly returns around age 5 or 6: That's when children go to kindergarten.** Suddenly, children have less restroom access than they did in preschool and, often, more worries about interrupting the teacher. For a whole host of reasons, kindergarteners and first-graders use the toilet less often than they did in preschool, and they're typically in school longer hours. As a result, constipation that may have been held at bay reaches a point of critical mass, literally. I see this often. How can I be sure it's constipation and not divorce or the birth of a sibling that's causing the accidents? Again, because I x-ray my enuresis patients.

No enuresis study has validity without verification of a child's constipation status via x-ray or anorectal manometry.

Even after an x-ray confirmed her daughter's rectum was stuffed with stool, one mom emailed me: "I'm not 100% convinced [her enuresis] isn't just laziness/attention. In the last 12 months we have moved to a new house in a new town, and we've had another baby. She's expressed a lot of jealousy regarding my time with the baby. I try my hardest to give her one-on-one time, and it doesn't make a difference. Recently she's been complaining of tummy aches, but she does seem to mention them at really 'convenient' times." **Adults tend to look far and wide for psychological causes of accidents when none exist. A stretched rectum simply cannot be repaired by quality time with Mom.**

> **"Stressful life events" and "a need for attention" play no role, yet this myth pervades the literature and is hard for parents to get past.**

Whereas parents often gravitate to the "stressful events" theory of enuresis, schools tend to adopt an alternate explanation espoused by the *DSM-5*: that daytime accidents "may be associated with symptoms of disruptive behavior." **Children who have pee accidents in class are often referred by schools for behavioral therapy and some are even threatened with suspension from school.** I've known some schools to follow through on the threat.

All this just makes parents feel lousy for no reason, blames kids for embarrassing episodes that are beyond their control, and diverts the family from seeking appropriate medical treatment, prolonging the entire family's agony. What's more, many parents are consumed with guilt.

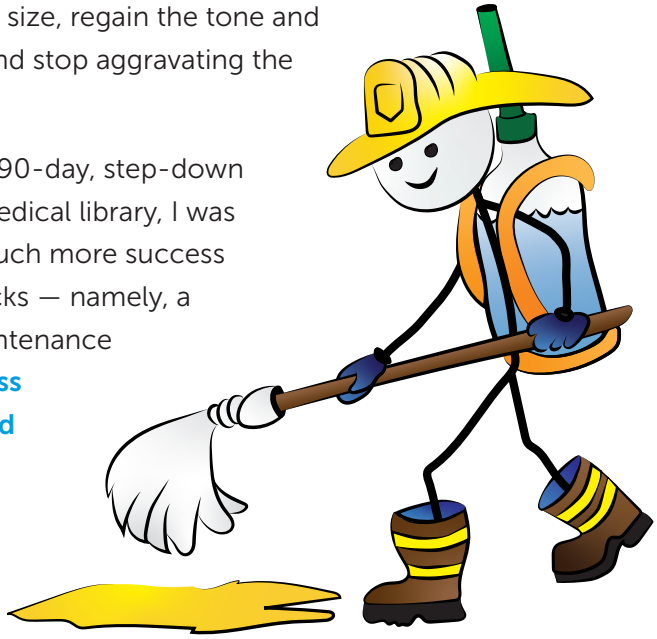
"My biggest regret was how much time I wasted thinking my son's enuresis was behavioral or cognitive or that if I was a 'better mom,' he'd stop having accidents," one mom posted in our Facebook support group.

Treating the Root Cause of Accidents

The various mental health texts fill lots of space dividing enuresis into subtypes — nighttime and daytime, primary and secondary, voluntary and involuntary, and so on — asserting these are separate conditions that require different treatment approaches. Echoing other resources, Theravive insists that diagnosing the correct subtype of enuresis has a "major impact on the sequence and types of treatment." In truth, all these so-called subtypes are all just manifestations of the same condition: a bladder aggravated by a stretched rectum. The same treatment approach will fix all forms of enuresis and all cases of encopresis, too.

What's needed: an aggressive regimen to 1.) clear the rectum of impacted stool, 2.) fully evacuate the rectum every day for months, and 3.) keep stool soft so pooping doesn't hurt. Only then can the rectum shrink back to size, regain the tone and sensation needed for complete evacuation, and stop aggravating the bladder nerves.

Dr. O'Regan had remarkable success with his 90-day, step-down regimen, and once I dug up his studies in a medical library, I was excited to test it on my own patients. I had much more success with the regimen than I had with my usual tricks — namely, a high-dose Miralax clean-out followed by maintenance Miralax. **But for several years I had less success than Dr. O'Regan reported, and that bothered me.** I suspect it was because childhood constipation is more severe and more prevalent today than it was in Dr. O'Regan's time, for multiple reasons. For example, preschool enrollment has increased over these decades, which means more kids are subjected to potty-training deadlines and, therefore, pressure to toilet train



The Modified O'Regan Protocol a.k.a. M.O.P., is an enema-based regimen based on Dr. O'Regan's original research. Switching to this approach has dramatically increased my success.

before they're ready. **Public school bathrooms today are scarier and filthier than they were in the 1980s, and school restroom policies are more restrictive.**

In response to these trends, I modified Dr. O'Regan's regimen in a number of ways, to keep the rectum clear longer and to make pooping easier, and I dubbed this regimen the "Modified O'Regan Protocol." For example, I recommend daily enemas for at least 30 days, tapering only after the child has completed 30 enemas and has remained dry for at least 7 consecutive days and nights. I find that many children need to extend Phase 1 of **M.O.P.** well beyond 30 days.

In addition, I recommend a daily osmotic laxative along with enemas. While enemas do a powerful clean-out job, osmotic laxatives keep stool mushy, so pooping is less painful. (However, for children with encopresis, PEG 3350 often makes the situation worse, so I recommend holding off on an osmotic laxative for at least two weeks, if not entirely.) In many cases, particularly for children with a strong habit of holding poop, I also recommend adding senna-based stimulant laxatives, such as Ex-Lax. The many nuances and variations of **M.O.P.**, discussed at length in the Anthology, are outside the scope of this guide.

Early in my practice, before I discovered Dr. O'Regan's research, I followed the Miralax approach, and this worked well for about one-third of my patients. But even then, success was often short-lived. Since switching to Dr. O'Regan's methods, my success has increased dramatically.

When you treat a child's dilated rectum, rather than a child's behavior or family background, the prognosis is excellent.

Enemas are, hands down, the most effective treatment, as confirmed by several studies and by my experience treating thousands of children. Yet physicians today routinely push Miralax, even when it fails to help their patients *for years on end*. As a result, children are left to experience mortifying accidents at school and live in a state of distress and/or discomfort. Certainly, oral laxatives are a better approach than sticker charts, because the treatment is at least trying to tackle the root cause, but PEG 3350 just doesn't do it very well, and in the case of encopresis, often makes accidents messier and more frequent.

My years of clinical experience and my own research confirms that to resolve encopresis and enuresis for good, an enema-based regimen is the way to go. Yes, many physicians tell parents that the insertion of solution in the rectum is "unsafe," "traumatic," "overly aggressive," but none of that is true, as I explain in the Anthology.

We physicians like to think medicine inexorably advances, that today we offer patients more effective treatments than existed before. Mostly, we do. **But on occasion, we drive medicine in reverse, promoting therapies that are considerably less valuable, often entirely useless, and sometimes detrimental**.

The mental health manuals are more concerned with linking certain "subtypes" of enuresis and encopresis to certain behavioral symptoms, such as classroom disruption, and psychiatric disorders, such as ODD. A common theme is that children with both daytime and nighttime wetting have "more behavioral symptoms" than a child with just one symptom. Well, of course! **Having accidents at school and wetting your sheets makes your life more miserable than just wetting your bedsheets. And having poop accidents on top of wetting makes your life that much more distressing.**

Among the most discouraging themes in the psychiatry literature is that for many children, the prognosis is grim — that only 30% to 50% of children with encopresis, for example, typically recover after a year. The *Handbook* cites particularly poor treatment outcomes in children with parents of "low education level, low socioeconomic status" or with families "characterized as divorced, disorganized, or chaotic."

"For years, we were told our daughter's toileting struggles were something she would outgrow and likely a product of our child being on the spectrum," one mom emailed me.

I strongly disagree. **In my experience, there's only one factor that leads to a poor prognosis: an ineffective treatment protocol. I have plenty of patients whose parents are divorced or have little education. I have plenty of autistic patients, patients with ADHD and anxiety, and patients who've experienced trauma. All these kids do great on M.O.P.** So do teenagers. Absolutely, enuresis and encopresis become more challenging to treat as kids get older; a rectum stretched for a decade won't bounce back as quickly as a rectum stretched for a year. But with aggressive and persistent treatment, the rectum will bounce back.

I believe that all children with an intact spinal cord and without congenital malformations can overcome accidents and deserve the most effective course of treatment. I will leave you with an email I recently received from the mother of a 6-year-old who struggled with encopresis and enuresis:

"For years, we were told our daughter's toileting struggles were something she would outgrow and likely a product of our child being on the spectrum. It felt to me like everyone was interested in blaming the kid and not in investigating that something else was causing a problem. Even with daily Miralax and Ex-Lax, our daughter was having stooling accidents in front of her peers every day. I was terrified about the social, psychological, and medical implications of this problem continuing. This sort of continued struggle could have been truly disastrous for her emotional and social well-being. Three weeks ago, we started using enemas, and she has only had one accident. We have only just started, but already, her life has completely changed."

PART 2 : The Therapist's Role in Enuresis and Encopresis Treatment

By Amanda Arthur-Stanley, Ph.D.

What Grad School Doesn't Teach You About Toileting Dysfunction

When I was in graduate school, I learned a great deal about child development including developmental milestones and planning interventions when kids demonstrate delays or differences in their development. During internships and practicum experiences, I learned information that was both broad and deep and helped me become a better practitioner and researcher. I read books about toilet training and feeding but had very limited information shared about encopresis and enuresis. I knew that encopresis and enuresis were diagnoses in the *DSM*, but I had little experience understanding the causes and the implications of these conditions.

Fast forward a decade and I started having my own children, two of whom exhibited varying symptoms of functional constipation. One child responded easily to a small amount of osmotic laxative and has needed no additional treatment. Another needed more intervention. **I sought to learn about treatment for encopresis and enuresis and found very little practical information available for families and practitioners beyond toilet training strategies and stool softeners.**

Only when a colleague referred me to Dr. Hodges' work with **M.O.P.** did I gain a clear understanding of a stretched-out colon and rectum and the reasons accidents happen. I now understand that a floppy colon

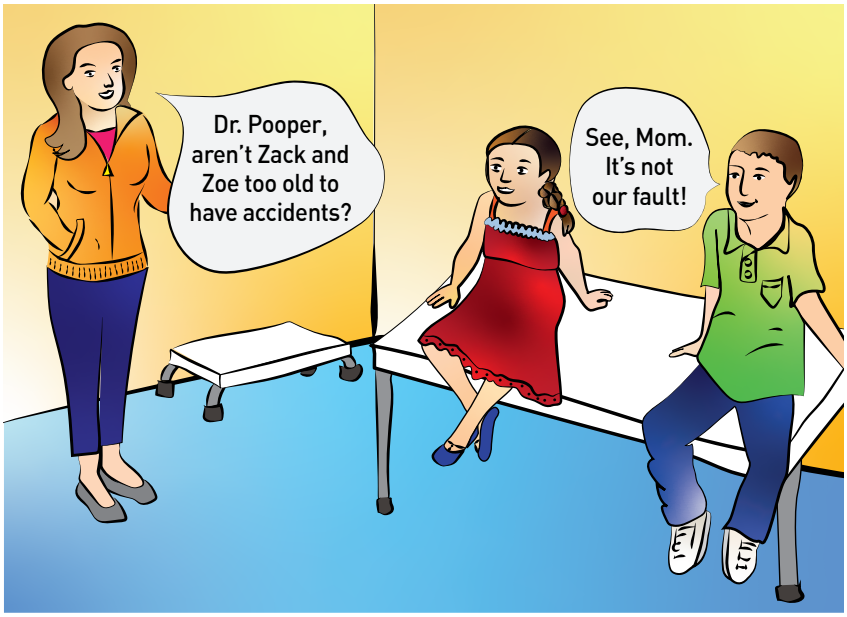
As therapists, we need to convey to families that these conditions actually have physiological rather than psychological roots, with clear psychological repercussions.

and stretched rectum reduce a child's ability to feel the sensations in their body that would lead them to use the bathroom when needed. This understanding has shaped the way I approach toileting with my own kids and has become a professional passion. **So many families I work with have experienced years of difficulties with little resolution.** Many have encountered therapists who consider the child to be willfully having accidents, rather than approaching the issue from the understanding that kids have accidents due to loss of rectal tone/sensation and suffer psychologically because of their accidents.

Shame, Blame, Frustration, and Guilt: The Impact of Untreated Enuresis and Encopresis

When families hear from mental health professionals that kids are being intentionally naughty, lying, hiding accidents, purposefully refusing the potty, or being lazy, this casts blame on both the child and the caregivers! As parents field calls from the school concerning their child's accidents or learn that their child cannot move to the next daycare class, they may feel frustrated and upset, not to mention isolated. People so rarely talk about encopresis and enuresis, or even constipation, despite how common these conditions are.

What I've come to learn about enuresis and encopresis is that our culture's interpretation is faulty. There's no doubt that enuresis and encopresis can have a significant psychological impact on children, leading to anxiety, low self-esteem, family conflict, and more. I've seen it both personally and professionally. However, as therapists, we need to convey to families that these conditions actually have physiological rather than psychological



Parents often assume children "should know better" than to have accidents. Bedwetting and Accidents Aren't Your Fault*, one of Dr. Hodges' children's books, clarifies that accidents are beyond the child's control.*

roots, with clear psychological repercussions. These issues can then become intertwined to the point that a child experiences anxiety around toileting or taking a laxative or feels depressed to be left out of a sleepover due to fear of their friends finding out.

When therapists treat the problem as if it were primarily psychological, this is a disservice to kids and parents and can throw a wrench into their relationship. Parents can feel highly pressured to "help" their kid poop, whether through toilet-training charts, various incentives and rewards, threats of taking toys/phones/etc. away, and constant monitoring of their diet/water intake. **Waiting for your kid to poop or sleep through the night without wetting the bed can feel all-encompassing, and it's easy to lose sight of your child's overall well-being (including their many strengths!) when you feel judged by others for your child's recurrent accidents.**

Removing the blame and stopping the emotional roller coaster is like releasing a pressure valve for parents and kids alike. It's critical for both parents and children to understand that accidents are medical in nature and quite common.

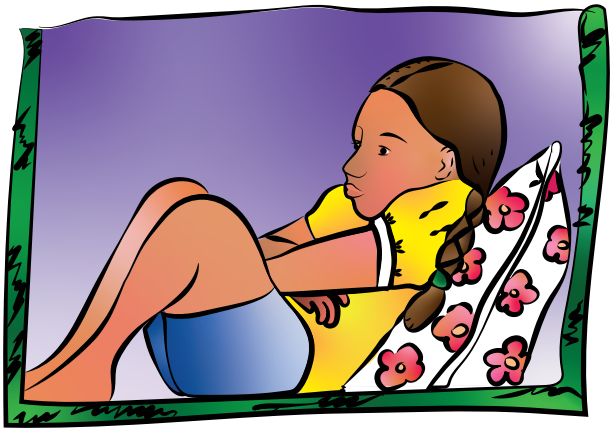
At the same time, many kids experience a devastating loss of self-esteem. Accidents can lead to feelings of shame, embarrassment, hopelessness, anxiety, and depression and can have a big impact on a child and family's life. Many children miss out on sleepovers, overnight camps, and playdates and feel anxiety about going to school or other social situations. **Kids wonder: *What happens if I have an accident? Where will I change? Who will notice? What will my teachers think? Will my parents be upset with me?*** All these worries can spiral out of control, especially when well-meaning therapists consider accidents as an intentional or even provocative occurrence.

There are many ways a therapist can support a child and family as they recover from encopresis or enuresis. The first place to start is understanding the physical problem and resulting psychological impact. Many therapists are well trained in supporting kids and families through cognitive behavioral therapy, motivational interviewing, and play therapy. Children with encopresis and enuresis likely have endured months, perhaps years, of feeling distressed by toileting. Therapy works when it reduces feelings of shame and blame and helps a child feel more efficacious and able to communicate their emotions and move through the ups and downs of life. **Adding therapy to a child's life can foster a sense of connection, clarify other needs the child might have, and build self-confidence, empathy, and emotional regulation**.

Four Ways Therapists Can Support Families

1. EDUCATING FAMILIES ABOUT CHRONIC CONSTIPATION

Many kids experience varying degrees of constipation, some with more impact than others. Constipation can cause tummy aches, which can affect a child's whole day and outlook. Or the child might remember a painful pooping episode and withhold at times, in fear of having another painful poop. Withholding can then cause the rectum to stretch, compromising a child's ability to sense when they need to poop or pee.



Constipation can cause tummy aches, which can affect a child's whole day and outlook.

Dr. Hodges has described medical support for functional constipation as akin to dental work for cavities, in that it is a common problem that can typically be resolved — in this case by fully evacuating the rectum daily. Therapists can support families (and kids) by helping them understand the underlying physical process and helping problem-solve ways to reduce stress for everyone involved, especially the child. Removing the blame and stopping the emotional roller coaster is like releasing a pressure valve for parents and kids alike.

On the other hand, when families are told by therapists that their child is purposefully having accidents or being lazy, this reinforces adults' negative views of their child and exacerbates the stress cycle. Instead of getting credit for doing the very best they can in a difficult situation, the child is often blamed. I also believe that it's crucial for parents and caregivers to understand that they are not alone in this situation and that many other families are finding ways to resolve constipation, enuresis, and encopresis without casting blame on anyone in the family.

2. GIVING CHILDREN A VOICE

Imagine being 16 years old and waking every night to change your bedding (sometimes multiple times!), feeling terrified about being in a classroom and not having access to the bathroom when you need it, heaping blame on yourself for not being able to control your accidents.

As we already discussed, helping kids and teens (and their families) understand that constipation and resulting accidents are not their fault is the first step in reducing shame and blame. But where do therapists go from here? **I advocate giving kids as much voice and control over the treatment process as possible. Invite them into discussions (at a developmentally appropriate level) that take into consideration their hopes, dreams, and fears.** Try to understand what is working and what is not working for them. Do they need more bathroom access at school?

Does the laxative upset their stomach, and do they need to try a different one? If their treatment plan includes enemas, can they shift the time and place so that they have more privacy?

When working with kids, it's also crucial to have the whole picture in your mind. In addition to helping the child cope with encopresis/enuresis, are there other ways you can offer support? Are they experiencing comorbid anxiety and depression that needs treatment? How can you work to build protective factors such as clubs, sports, faith, family, or friendships in their lives and increase their ability to move through different emotions? Would mindfulness and relaxation be a helpful addition to their toolbox?

My experience working with kids and families has shown that kids are more distressed by their accidents than caregivers assume.

3. HELPING PARENTS SUPPORT THEIR CHILDREN

Resolving enuresis and encopresis can be a long road, and while it's children who suffer the most, this road can feel never-ending, frustrating, and lonely to parents as well. It's important for therapists to normalize what families are going through. Constipation is common among children, and enuresis and encopresis are more common than families realize. Parents should know that other families have experienced similar issues and found support through community. Dr. Hodges has a private Facebook support group that gives parents a space to problem-solve, ask questions, and share treatments that worked and didn't work. **Some parents might feel ashamed that they initially blamed and perhaps even punished their children for accidents. I always say, "When we know better, we can do better."**

It's so challenging when popular culture and news reinforce myths about enuresis and encopresis rather than present accurate information about the causes of these conditions. **But therapists can remind parents they now have an opportunity to model that we are all learning and growing.** Therapists can suggest that parents model this attitude for their kids — for example, telling their child, "I didn't understand what was going on with your colon until the doctor explained it to me. It's not your fault, and we can find ways to make it better together."

My experience working with kids and families has shown that kids are more distressed by their accidents than caregivers assume and that the whole family system can feel the impact when there are concerns around toileting. It is important for children to know that their family is supportive and working actively toward resolving this concern. **Therapists play a key role in a child's recovery process as they support parents in advocating for their child's needs and help the child feel less blame and shame and more empowered.**

4. WORKING WITH SCHOOLS

It's crucial for therapists to consider the systems (e.g. schools, neighborhoods, places of faith, community centers, sports) that surround kids and to reflect on how parents and staff might shift practices so that kids feel empowered and permitted to use the bathroom when they need to. School nurses have varying backgrounds and expertise, and I would not assume that they will approach encopresis and enuresis from the same vantage point as Dr. Hodges. On his website, Dr. Hodges has a great letter that parents can download for free (see the Resources section of this guide) and share with school staff about their child's bathroom needs. He also offers free guides for teachers and school nurses that explain the medical origins of enuresis and encopresis and the importance of restroom access for students.

In addition, many children can benefit from a 504 plan. These plans involve specific school-based accommodations that will protect the child's access to bathroom breaks and accommodate related needs. Possible accommodations might include unrestricted bathroom access, frequent bathroom breaks, the opportunity to change clothes in the health office, and so on. Dr. Hodges offers some specific ideas for parents in his free guide "4 Tips to Help Your Child Manage Toileting Troubles at School." Therapists might recommend the guide to parents.

> **While bathroom access is important for all kids, it is especially important for students with a history of chronic constipation.**

Certainly, teachers and school administrators face varying pressures around bathroom access. With large classes and limited instructional time, some schools strictly limit the number of times a student can use the bathroom during class time or restrict access altogether during class. Typically, schools enact these policies in an attempt to address truancy or vandalism, but it is children with constipation who bear the brunt. I remind families that schools are not trying to penalize kids or make bathroom access a hardship. **The vast majority of school staff are very focused on getting kids what they need to be healthy and successful, but they may need additional training or information around the student's particular situation.** As a therapist, I urge parents to explain and communicate their child's bathroom needs and advocate on their behalf. It can be helpful for therapists to connect a family with a school administrator, school counselor, or school psychologist to discuss the possibility of a 504 plan.

While constipation, encopresis, and enuresis are not common topics of discussion, these conditions affect many families and can greatly impact the daily lives of children and their parents. **Though I have worked with kids and families on a wide variety of concerns in my 17 years of practice, I have found nothing more compelling or rewarding than working with families experiencing encopresis and enuresis.**

PART 3 : Resources to Recommend to Families

BedwettingAndAccidents.com offers a wide variety of books for parents and kids of all ages, as well as free downloads and blog posts. We also offer discounts and free coupon codes, so please contact Suzanne Schlosberg at Suzanne@BedwettingAndAccidents.com if you work with families in need of discounted materials.

Relevant Blog Posts

"Potty Regression," "Potty Refusal," "Not Fully Potty Trained": Why These Terms Should be Canceled

Dear Bedwetting Teenagers: Your Condition is 1.) Common, 2.) Not Your Fault, and 3.) Totally Fixable

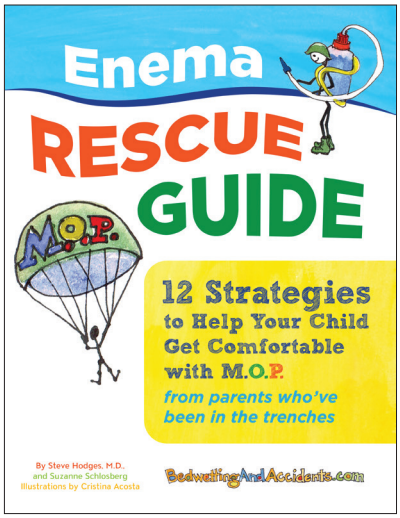
What Preschool Potty Accidents and Teenage Bedwetting Have in Common (Spoiler Alert: Everything)

Enuresis and Encopresis Are Not "Mental Disorders." Let's Remove Them from the DSM-5

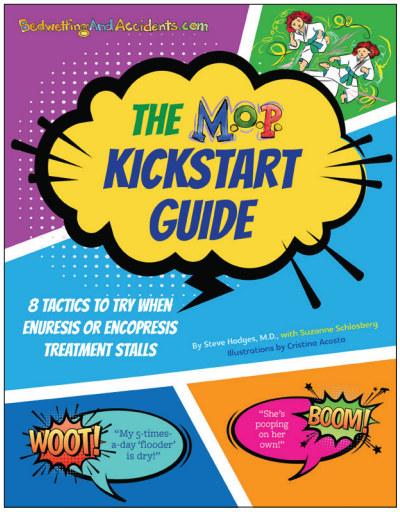
Children with Encopresis and Enuresis Deserve the Best Treatment, But Most Aren't Getting It

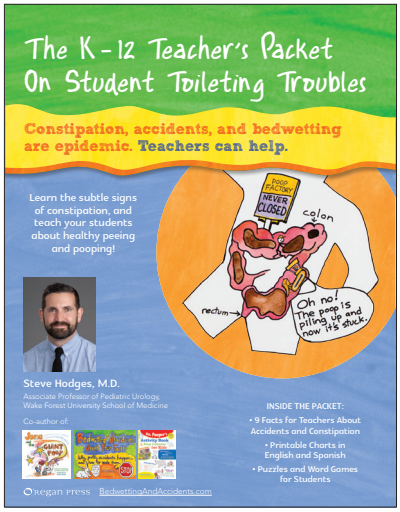
Why Is Your Child Constipated? Because We Live in the 21st Century

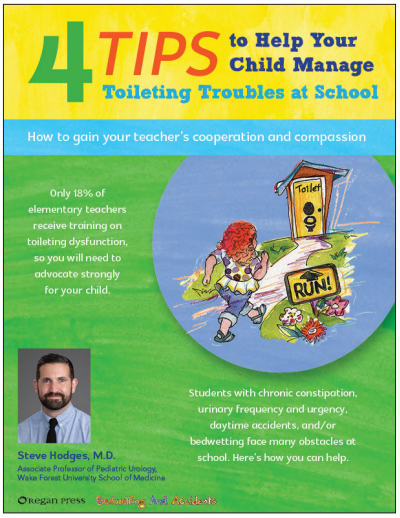
Free Downloads for Parents



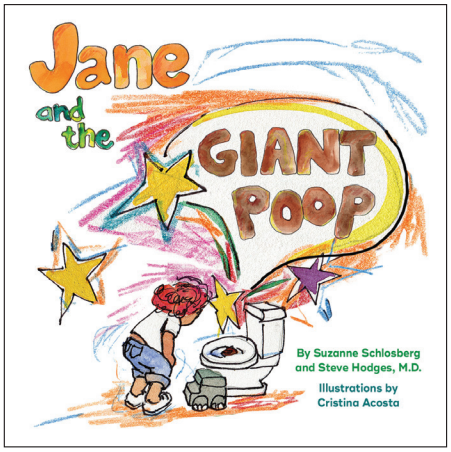
(free with book purchase)







Books for Younger Children



Jane and the Giant Poop — a rhyming story

For ages 3 to 8

"Beautiful illustrations and a wonderful message about taking care of our bodies."

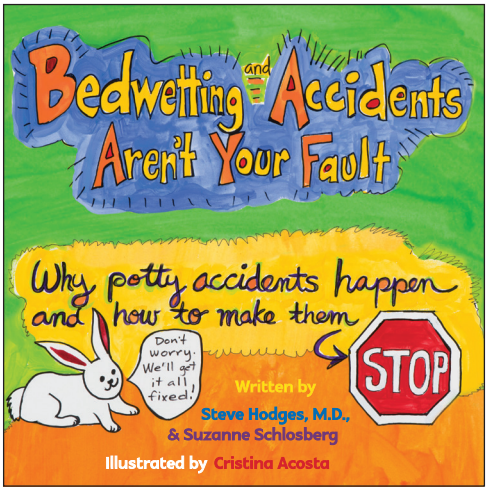
– Erin Wetjen, P.T., Pediatric Continence Specialist, Department of Urology, Mayo Clinic

Dr. Pooper's Activity Book and Poop Calendar for Kids — word games, puzzles, drawing

For ages 3 to 10

"A great resource for kids with constipation and potty accidents! It helps them talk about it without embarrassment."

– Mike Garrett, M.D., Family Physician, Direct MD, Austin, Texas



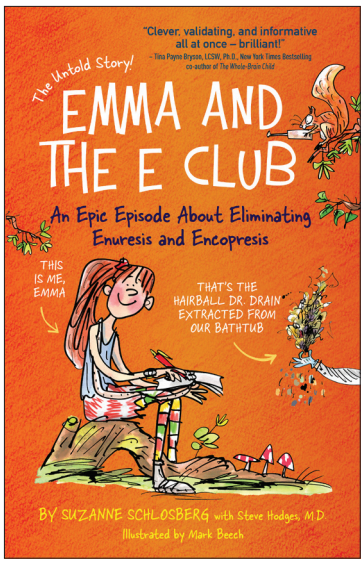
Bedwetting and Accidents Aren't Your Fault — informational fiction

For ages 4 to 10

"Terrific! The illustrations are so much fun they remove any possible embarrassment."

– Laura Markham, Ph.D., author of *Peaceful Parent, Happy Kids: How to Stop Yelling and Start Connecting*

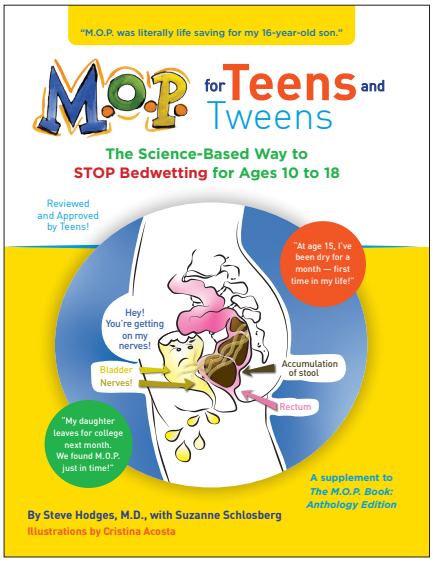
Books for Older Children



Emma and the E Club — a novel
For ages 8 to 12

"Clever, validating, and informative all at once — brilliant!"

– Tina Payne Bryson, Ph.D., co-author
The Whole-Brain Child and *No-Drama Discipline*

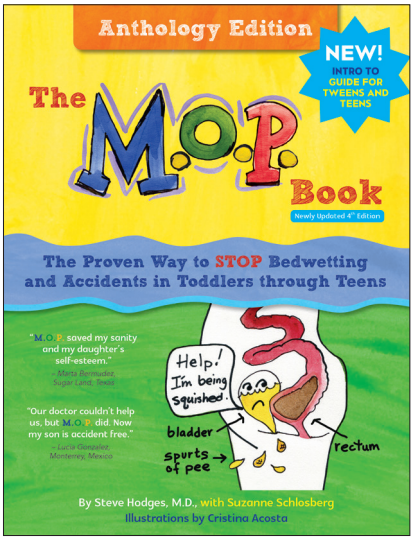


M.O.P. for Teens and Tweens — an informational guide
For ages 10 to 18

"Thanks to this book, I know I'm not the only teenager dealing with bedwetting, and it is not my fault."

– 14-year-old with enuresis

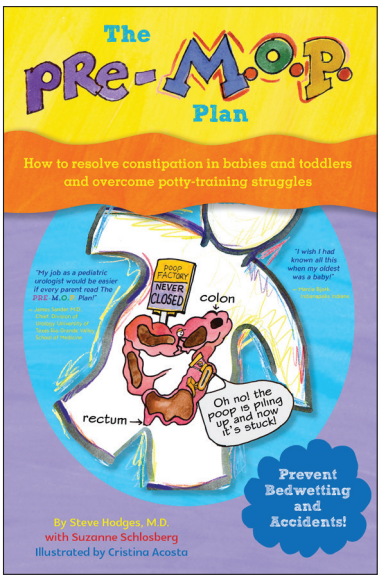
Books for Parents



The M.O.P. Anthology: 4th Edition

"M.O.P. works radically better than anything else."

– James Sander, M.D., Director of Pediatric Urology, Doctors Hospital at Renaissance, Edinburg, Texas



The Pre-M.O.P. Plan

"A book that will change lives! So many of the problems I treat could be prevented by Pre-M.O.P."

– Irina Stanasel, M.D. Pediatric Urologist, UT Southwestern Medical Center, Dallas, Texas