Soiling Solutions®: An Internet and Manual Based Approach to Treating Encopresis by Robert W. Collins, Ph.D., P.C. This article appeared in the Spring 2009 issue of *Digestive Health Matters* published by the *International Foundation for Functional Gastrointestinal Disorders*. This organization's professional membership is made up primarily of leading internationally known Gastroenterologists.

History and Theory:

In 1998 I registered the soilingsolutions.com domain name with a view toward casting a wider net for treating children with encopresis (fecal soiling) or enuresis (nighttime bedwetting). I had received a lot of positive clinical feedback from my private practice for treating these problems in Western Michigan after I left a tenured position in 1981 at Grand Valley State University near Grand Rapids. I had earlier established a good reputation for my work in validating the specific mechanism underlying the successful use of the bedwetting alarm. [I] The bedwetting alarm rationale relied on the classical conditioning paradigm reported on by Ivan Pavlov in his address on receipt of the Nobel Prize for Medicine and Physiology in 1904. [2]

In 1981 a colleague was very encouraging when I first shared my treatment protocol for encopresis with him. My Soiling Solutions® (SS) protocol for encopresis was inspired by and derived from my earlier work with the bedwetting alarm and the discovery of Logan Wright's protocol [3,4] using suppositories for school age children with encopresis before leaving home for their school day.

A key to my approach in using the internet was the publication of the Clean Kid Manual (CKM) and the Dry Bed Manual (DBM) to allow parents as well as their physicians to have a ready "cookbook" reference for applying the relatively definitive and specific steps of my interventions. [5,6] Interestingly sales of the CKM have far outnumbered those for the DBM by at least 10:1. Clearly, parents have been much more distressed by the aversive nature of this bowel difficulty, its resistance to treatment by prevailing pediatric practices, and the tendency toward shame and secrecy about this problem. The CKM appears to have been the first treatment manual ever to be published for this disorder.

My protocol's use of "bottom up" agents to assure consistent daily voidings is very different from the current dominant pediatric practice of using "top down" oral agents to promote softening and easier bowel movements (BMs). The former approach, by virtual of carefully timed escalating steps, emphasizes a Pavlovian analysis to promote more timely and powerful voiding urges (stimuli) more closely and reliably followed by a successful voiding response on the toilet stool.

The CKM Protocol:

The child does 2 brief sits 10 or so minutes apart. If there is less than a half of a cup of stool produced, the child is immediately administered a glycerin stick suppository and receives two more sits. If he/she still does not meet the criterion of one-half of a cup of accumulated stool, then the enema is administered at the end of the fourth sit and the child remains sitting until a BM occurs. A bisacodyl suppository or a "liquid suppository" of glycerin or bisacodyl may be substituted for the usual phosphate enema. This description is very bare and hardly captures the resistance and fear of these children with the act of inserting a suppository or enema nozzle. They clearly don't want anything to go in or come out. The children do desensitize as the parents proceed and use techniques elaborated on in the CKM. The protocol is conditioning-based and not predicated on punishment which would be sensitizing and escalate fear rather than desensitizing.

Daily BMs by this more aggressive approach assures a greater likelihood of success which leads also to desensitization of any fears and anxieties that the child has over his/her BMs. In addition, all of the bathroom and more appropriate postural cues become associated with successful BMs. Another

benefit is that successful daily voidings lowers the pressure in the GI tract and reduces soiling instances in much less time than is typical for the "top down" approach. This is a good morale booster for all concerned as bowel competence is more rapidly demonstrated and the parents are heartened in continuing treatment.

Oral agents act throughout the entire gastrointestinal (GI) tract which results in more delayed and confused urges. This makes the associative conditioning for relevant stimuli and response much less likely. The "top down" protocol itself may become genuinely punishing and may promote more bathroom avoidance behaviors with repeated failures. Parents may also come to feel like failures or get angry with continuing insistence on the "gentle" approach by their physicians. They want a solution.

Resistance to the Aggressive Soiling Solutions® Protocol:

I was not aware early on of the bias introduced in the medical literature by Levine [7] and Levine and Bakow [8] who labeled the use of "bottom up" agents as "anal assault" or "anal stamp." This has actually resulted in too many pediatricians failing to conduct a digital (finger) exam in up to 85 per cent of these children.[9,10] The use and sole reliance on "top down" oral agents became hallmarks of the so-called "gentle" approach to encopresis. Logan Wright's protocol with suppository if needed before school came to be ignored in the literature. Add in cultural considerations and there is a lot of resistance across the board to my protocol. However, this has been overcome by many desperate parents seeking a solution to the very aversive and culturally offensive problem of anal leakage after all else fails and they find SS on the Internet. It is not unusual for me to see 12-14 year olds where the standard "top down" approaches have failed after years of application. My experience demonstrates the use of "subjects as their own control" in a longitudinal single case sense with the prior applications of the "gentle" approach. When relapses occur, if the parents become less vigilant and fail to maintain the protocol, and they reinitiate the SS protocol with repeated successes, then you again have more confidence in the "subject as his/her own control" demonstration.

Internet-Based Approach:

The benefits of everyone and the physician "being on the same page" with a convenient treatment manual at hand have proved to be incalculable. In 2004 with the third revision of the CKM (CKM-III) I established a "free" email forum for CKM Parents which allowed purchasers of the CKM to communicate with and support one another. This innovation led me to view this very active email forum as my "clinical lab" for learning what difficulties the parents run into with my protocol, which has permitted me to revise future ongoing editions of the CKM. Interestingly, professionals have sought admission to this same forum while they also have exclusive access to a CKMPros Forum for them alone. The former forum is much more active and revealing at this time.

When Standard Approaches Fail:

I support the standard "top down" oral agent approach to encopresis, but believe it should default to my "bottom up" approach when it fails for up to a maximum of six months. Physicians now have an alternative before going to extensive additional and exotic medical diagnostic tests. The suppositories and enemas are powerful "primers", "bowel alarms", or unconditioned stimuli which initiate a voiding response to overcome the child's defensive "holding" response which has become over-learned and extremely resistant to change (even under anesthesia) in the development of his/her encopresis. [11] Suppositories and enemas have to be timed to foster successful voiding on the toilet. For some children the voiding response has become strongly connected to

disposable diapers. Some children actually go to their mothers to request a towel or diaper to poop in, but absolutely object to sitting on the toilet for a BM or fail to void when they do sit on it. The child's own natural voiding urges with the SS protocol become sufficient in time and are connected to successful voiding on the toilet. The bathroom and toilet stool becomes a "release" stimulus taking over from disposables or going in street clothes. The increased ability to tolerate suppositories, enemas, and successful voidings lead to desensitization of the anxiety components underlying the defensive holding or "clamping up" response which was likely over-learned during toilet training or stressful events later in life.

Special relaxation training may be required by a behavioral specialist to help the child (and parents) to manage and tolerate the administration of the suppositories and enemas. Children typically are very pleased and excited at successful elimination in the toilet. This is very reinforcing for all concerned and the child's fear often wanes with continued adherence to the protocol. However, children are very quick to detect any reluctance or ambivalence by the parent which they exploit to the fullest. Parents need a lot of support to initiate and maintain the protocol in the early stages. A professional and the Clean Kid Parents' forum are very helpful in helping these parents to initiate treatment and forge ahead.

A recent study by van den Berg and colleagues [12] suggested that there are children who are unresponsive to conventional "top down" treatment for constipation/encopresis and have rectums that are too stretched out by comparison to healthy children. They showed that even if children did respond to their top down treatment protocol that the children still had modestly stretched out rectums at a 4 year follow up. My hope is that the SS protocol may succeed where the standard pediatric approaches have failed. Certainly the possibility of a lasting physical deficit should be avoided and this suggests that the SS protocol should be attempted at a much earlier time as a default treatment rather than continuing with the same old approach for months and years. Such continuation only infuriates the parents, disaffects them from professionals, and drags down the child's well-being.

Conclusions:

No manual or internet-based approach can handle all of the contingencies that may occur to stall or sabotage progress toward bowel competence. The encouragement and support of a professional would be invaluable as the parents encounter difficulties or a failure to progress. The advantage of the manual-based SS protocol is that it can provide a firmer basis for making a referral for more medical evaluation. If further medical evaluations reveal nothing significant then the parents in turn have a firmer basis for continuing the SS protocol if it is maintaining the child in a soil free state before defaulting to biofeedback or surgery. Finally, the CKM can serve as a research instrument for randomly assigned subjects to comparison treatment groups.

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