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PREFACE

Bladder and bowel incontinence are disorders of physiological function, which leads people to see them as medical issues. Medicine follows a scientist-professional model and looks to codify it's interventions by setting out "best practice treatment guidelines" for this or that disorder. Physicians are hesitant to step out beyond these guidelines unless there is good scientific evidence to justify doing so. This is well motivated to prevent "quack" medicine of which there is already too much. Insurance companies and health agencies may regard alternatives as experimental and not deserving of reimbursement until proven by randomly assigned subjects to comparison treatment groups. What if treatment guidelines are failing for about 40 percent of children? Urine and feces are obnoxious foul smelling body byproducts and can cause horrific distress and shame for parents and children, disrupting family unity. A chronic lack of control over these intimate bodily functions can have severe long-term psychological and physical consequences. Fortunately, medicine has a tradition of clinical case studies that can suggest new approaches.

The Clean Kid Manual offers a treatment alternative based on the notion that the incontinent child has failed or lost a critical learned brain link between an urge Stimulus(S) and a voiding Response(R). This link is automatic or spontaneous for many of us and takes place without forethought. Parents may try to "install" that link by attempting to explain it to a puzzled child. However, it has to be learned by providing a learning S-R experience over and over again during just one daily Power Hour where the results are weighted for success at the end of one of four short sits. Fortunately, this is a case study approach that has proved successful over and over again after the "best practice guidelines" have failed. This is called the "subject as his own control" design. In time instances like this can become a basis for more controlled comparison treatment group studies.

The Clean Kid Manual is divided into Chapters 1-6 dealing primarily with encopresis (fecal soiling after age 4 years) and Chapters 7-8 for enuresis (bladder incontinence after age 5 years). While both disorders are notable for odors and regarded with shame, fecal soiling is by far the most distressing. If both conditions are present then encopresis should be treated first.

Ideally, Chapters 1-6 should be read in their entirety before undertaking the treatment of encopresis.

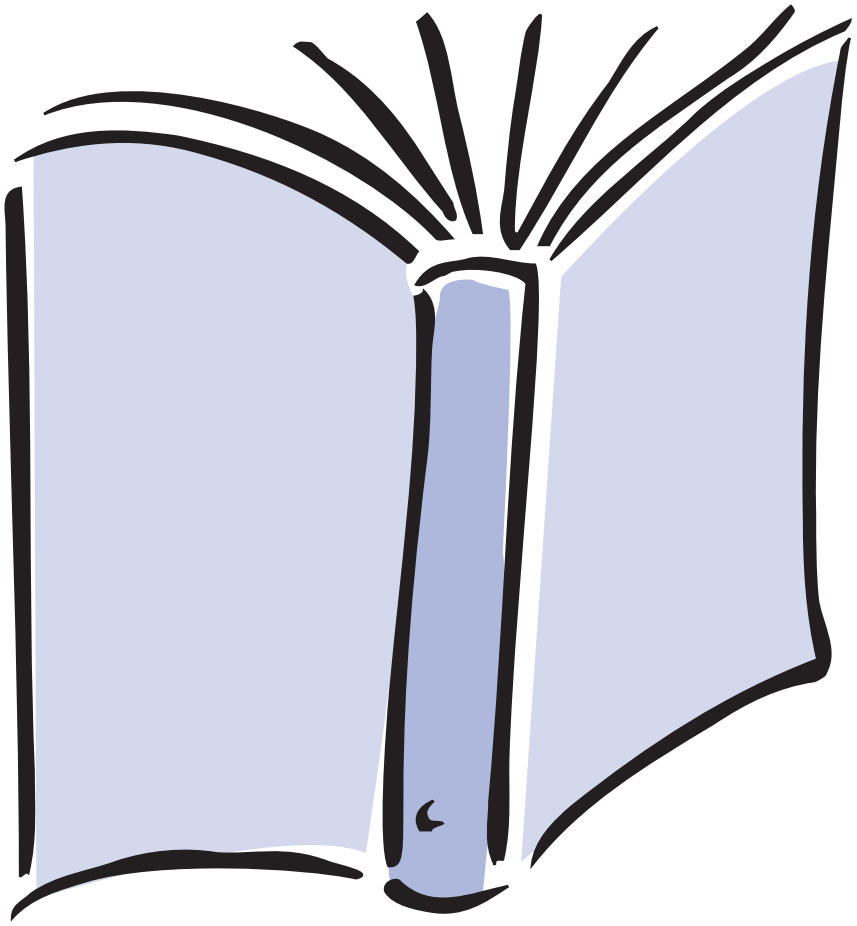
- Chapters 1 and 2 lend an understanding of these two disorders and my unique treatment based on psychological learning theory and basic physiological factors.
- Chapter 3 is the nuts and bolts "recipe" chapter for just what to do and pages 36 - 37 have the ultimate distilled version of what is called the daily Power Hour.
- Chapter 4 is a must read for how to overcome the difficulties that you are

likely to encounter in following Chapter 3.

- Chapter 5 deals with indicators for relapse and
- Chapter 6 deals with preventing relapse and sustaining recovery.

In this, the internet age, attention spans have been considerably shortened and my forums for treatment noted in Chapter 2 have been of considerable utility for parents to fine tune their understanding and to find specific guidance and emotional support for the unique issues that they may encounter.

Chapter 7 focuses on daytime bladder control. Steven J. Hodges, MD, a pediatric urologist and author of *It's No Accident*, emphasizes an empty bowel as central to bladder control. I believe more may be involved, especially for bedwetting where a sleep disorder may be present. My research on the bedwetting alarm addresses this more effectively and is the subject of Chapter 8.



Chapter 1

OLD AND NEW VIEWS ON ELIMINATIVE DISORDERS

Encopresis

The Clean Kid Manual© (CKM) is a specialized *how to* manual for treating encopresis and enuresis. It is available only from the Soiling Solutions®[1] store at the www.encopresis.com website. Encopresis is a disorder of bowel control marked by at least once a month soilings for at least three consecutive months in children aged four years and older, according to the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-5), or the same for at least once per month over a period of several months according to the International Classification of Diseases-Revision ICD-11). In addition, organic factors or a disease basis must be *ruled out* by a physician. When this is done, you are left with two to four percent of children who are or have returned to soiling. *This is encopresis*. It is a *functional medical disorder*. The medical specialist for dealing with encopresis is the Pediatric Gastroenterologist or a Colorectal Surgeon. Psychology can be important. I combine the medical and psychological approaches.

Enuresis

A condition closely related to encopresis is enuresis, which is another eliminative disorder. It is a bladder disorder of once a month daytime wetting (diurnal enuresis) or bedwetting (nocturnal enuresis) in children five years and older for three consecutive months. It is also regarded as a *functional medical disorder* once physical causes are ruled out. It affects about 10-15 percent of children (mostly as bedwetting). If day or night wetting is present it should be addressed only *after* bowel control is achieved. An overly full colon adds to abdominal pressure and pelvic floor tension which destabilizes bladder function. Enuresis will be addressed later in chapters 7 and 8 of this manual. The earlier chapters will be devoted to encopres-

[1] Soiling Solutions® is a "doing business as" (dba) name registered with the State of Michigan for Robert W. Collins, PhD, an author and sole proprietor. All policies in this manual are subject to change. Updated policies may be found on the main Soiling Solutions® website at www.encopresis.com.

is. The medical specialist for children's bladder problems is a Pediatric Urologist.

Acute or Chronic

Another distinction about these disorders is important. They are defined as *chronic or long lasting at* three months or longer. They become harder to treat. When we say something medical or psychological is *acute,* we mean that it is just getting started with the implication that early treatment is likely to be more successful. If a disorder like pain following injury or anxiety following a trauma is not treated early, it becomes more *wired in* or *chronic* and resistant to change. There are more psychological or brain-connection components that come into play.

Functional Disorders

Functional disorders can frustrate physicians and parents. We prefer the simple disease or medical model that has proved to be very effective for a variety of problems by treating a physical cause. When physicians offer a simple biomechanical treatment of oral stool softeners or laxatives to drain the colon it makes physical sense, but if accidents continue or learning to go on the toilet fails, everyone will want to look deeper. Assurances that the child will "grow out of it" begin to sound empty if fecal accidents persist for a year or longer. Waiting for the *Continence Fairy* is not a viable strategy. This explains why parents often find themselves in a kind of *twilight zone* debating a psychological or medical basis as an origin for their child's problem.

Psychological or Medical or…?

Parents will frequently express what appear to be psychological issues.

> *"Why doesn't he feel the accident?" "How come he ignores such a smell when it is so obvious to everyone else?" "Why does he fight me about sitting on the toilet?" "Why is he hiding his soiled clothing?" "I know he knows about bowel movements and he has to take responsibility for it, but he just won't and completely denies having to go and sit on the toilet." "I see him in the oddest postures and it is clear that he is desperately "holding" and fighting having a bowel movement." "It is so obvious to me and everyone else that it is easy to sit and go when we feel voiding urges." "He is very smart, but just does not appear to get it." "He is just plain stubborn."*

It is almost as if these just cited instances could be about a messy bedroom and why doesn't the child keep it clean and orderly? One thing is certain, we can tolerate messy bedrooms, even wet sheets, but anything involving feces is much more intensely provoking and distressing. The degree of emotional conflict, the contest of wills, is all magnified when it involves this foul, smelly, disease-bearing body product. It is nothing like *"*Wash your hands.*"* Or, *"*Brush your teeth.*"* Or, *"*Clean your room.*"* This failure of bowel control has very high stakes for the role of a parent. The whole family is affected. It can contribute to divorce.

Behavioral Medicine

I am a doctoral level clinical psychologist, not a physician. However, I have published in both medical and psychological literature. I have a lot of sympathy for parents, physicians, and psychologists alike who find themselves in a kind of twilight zone. The field I worked in is called Behavioral Medicine. It brings light to this mysterious zone and offers more effective approaches to these frustrating conditions. Encopresis involves higher level brain functions. It has a behavioral and a physical expression. Focusing on the gastrointestinal or urinary tract alone is misleading. My research has examined the brain mechanisms involved in bladder and bowel elimination.

From Bedwetting to Encopresis and Back

My professional career got off to a good start by validating the most effective treatment for nocturnal enuresis[2], the bedwetting alarm. This research brought me a lot of professional recognition and a nine-month invitation to the University of Western Australia in Perth, Australia. This is when I began to turn my attention to encopresis, which is experienced as much more distressing by the parent and child. However, enuresis remains a major interest for me as it is strongly associated with encopresis. Much of this association has been very persuasively addressed by Pediatric Urologist, Steve J. Hodges, MD in his 2012 book, *It's No Accident*. Visit his website at *www.bedwettingandaccidents*.com. He has excellent resources for children.

[2] Collins, R.W. (1973). Importance of the bladder-cue buzzer contingency in the conditioning treatment for enuresis. Journal of Abnormal Psychology, 82(2), 299-308.

Encopresis Tolerance?

Encopresis is ill-tolerated by other children, schools, and parents. It is socially isolating and everyone is distressed when it appears to resist the standard medical approaches to treatment. It cannot be ignored! It can have both long-term emotional and physical consequences. Fortunately, early recognition and the Soiling Solutions® treatment protocol with the help of the Soiling Solutions® Parents' Forums can head off these complications.

Home Treatment

There are two basic home-based treatments for encopresis. The dominant one is by the top-down oral route preferred by the vast majority of physicians. This means addressing diet and the use of stool softeners and laxatives with long sits after meals. The other route is bottom-up or rectal, using safe over-the-counter suppositories and enemas. This method is resisted by doctors, parents, and children for cultural and anxiety reasons. Soiling Solutions® uses this latter approach because it stops soiling much more effectively and can establish a lasting learned behavioral connection or habit if my protocol is closely followed.

Holding and constipation as causes

Your food contents leave the stomach for a long journey through the small intestines from which nutrients are extracted. At the end of the small intestines this liquefied waste is emptied into the larger diameter colon where the foodstuff now is dried with liquid being drawn into the surrounding tissues. The colon is a *dryer*, but also serves as a storage bag, which is typically emptied once a day for older children. Some colons are too efficient in drying out the food waste, causing extremely dried and hard stools that can be painful on passage. Diet can play a factor. Either can be a cause for *constipation* and it is thought that these children come to avoid toileting and make great efforts to *hold* their stools back because of the associated pain. However, it is also possible that *holding* in and of itself for any of a variety of weird child-based reasoning can be a primary cause. Simply holding the stool for a longer period will dry it out, too. So holding can be a cause as well as an effect of backed up stool and accidents. There is a great illustrative video describing the "Poo in You" at *www.gikids.org/*. Scroll down the opening page, and you will find it.

Physical Consequences

The effect of holding can cause the colon to become overstretched and weakened. The colon becomes less able to detect filling signals, and the holding response becomes a more dominant and automatic habit. Colonic contractions become weakened and elimination less effective and more uncoordinated by overactive obstructing muscles. The child becomes confused between the holding and pushing muscles. Pushing and holding can occur together making a bowel movement impossible. This is called *dysnergia* or *functional fecal retention*. It becomes habitual, automatic, and the parent and child cannot untangle this. Overflow incontinence or leakage is inevitable. This contributes to urinary tract infections (UTIs), especially for girls. The enlarged colon puts pressure on the bladder, increasing the likelihood of wetting accidents. Since the colon may not be able to physically recover, surgical alternatives may become necessary in older children and adults.

Oral vs. Rectal

Top down oral agents have delayed effects — by 6 to 10 hours — promoting strong urge feelings and then voiding relief! The rectal route promotes immediate urge signals and much more rapid and predictable voiding relief. This permits a better learned Stimulus-Response (S-R) connection between brain recognition and response by the child, which is not otherwise available. Simple daily clean outs by oral or rectal medications to return the colon to near normal is insufficient to restore a normal bowel habit. Relearning is required. All the talk and explanations in the world, while helpful, simply cannot do this. They have to experience the connections for themselves.

Stool Softeners

The predominate *top down* oral stool softener brands favored by physicians today are

- Miralax® (*Active Ingredients*: *Polyethylene Glycol, PEG or PEG-3350*). Its equivalents are Restoralax®, Osmolax® or Movicol® in the Commonwealth countries.
- Other brands are Lactulose® (*a synthetic, nondigestible sugar*),
- Colace® (D*ocusate Sodium*),
- Milk of Magnesia® (*Magnesium Hydroxide*),
- Natural Calm® (*Magnesium Citrate*), and
- Kondremul® (*a Mineral Oil emulsion*)

These oral Agents make the stools easier to pass.[3] They are thought to reduce the likelihood of pain and toileting resistance.

Laxatives

Oral laxatives are different from stool softeners. They stimulate the gastrointestinal tract directly to produce contractions that speed up the foodstuff waste down the colon. Bowel movements result with sits some 6-10 hours later. Their delay and unpredictability hinder any learning process. Brand names include:

- Ex-Lax® in the form of a chocolate bar (containing *senna*, a vegetable laxative),
- Senokot® liquid or tablets (*senna*),
- Pericolace® (*senna* and *docusate sodium*), a combined laxative and stool softener and
- Dulcolax® (*bisacodyl)*

Diet and Allergy Concerns

Parents often obsess over fiber intake and diet restriction (e.g., dairy, gluten, etc.) as potential factors affecting gastrointestinal tract activity. Probably the most significant and often overlooked factor for parents is to encourage adequate fluid intake regardless of diet. Fiber can encourage too much bulk and/or hardened and dried out stool. Citrucel® (Pectin-used in canning) is likely best as a fiber for a more normal stool. Probiotics are receiving more attention and becoming more available. Soiling Solutions® with its *bottom up* approach allows a clearer, daily look at fuller natural stool production, so that the effects of diet can be better judged over time.

The Old *Apple Sauce* Approach

Generally, the purpose of the *top down* approach is to achieve apple sauce quality stools with softening agents alone and to have the child sit for 10 minute periods after meals to encourage a bowel movement. The use of behavioral charts with reinforcing consequences is often advised. This approach works in up to 60 percent of children within a year, but only approaches 80 percent after eight years![4] I find it interesting that the medical commu-

[3] Brand names are mentioned throughout this manual for ease of recognition. I have no financial interest in any of these brands. Generic and often cheaper versions are usually stocked next to these major well-recognized and advertised brands. Be sure to check for their active ingredients.

[4] Van Ginkel,R., Reitsma, J.B., Buler, H.A., Van Wijk, M.P., Taminiau, J.M., & Benninga, M.A. (2003). Childhood constipation: Longitudinal follow-up beyond puberty. Gastroenterology, 125(2), 357-363.

nity has called this approach *maintenance therapy*. In some sense it is not so much regarded as a treatment for halting the disorder as much as it is intended to prevent serious medical complications like blockage or a ruptured colon. If the child leaks or oozes stool, well, no big deal! At least he[5] is safe, and you are avoiding physical complications — or are you?

Beyond *Apple Sauce*?

My observations suggest that the top down approach may actually train more holding because of fear of accidents and negative parental and peer reactions. The Soiling Solutions® protocol assures daily, complete elimination with more normal hot dog or well-formed stool that is better recognized by the brain. Soiling is quickly arrested within two weeks for the majority of children.

Added Accident Risk

The problem with very soft stool is that the colorectal sampling mechanism, which includes brain recognition, has trouble recognizing it. It is difficult to distinguish from gas. You likely have experienced this yourself with diarrhea. Also, when a child gets backed up with soft stool and he runs, jumps, changes posture, coughs, sneezes, laughs or giggles, he is more likely to lose control of it. The colorectal pressure becomes too high from holding, so accidents are more likely. The accidents are often described by parents as tire tracks in the undies. Curiously, Miralax, as a solution, has now become the problem.

Nose Blindness

Initially, children are alarmed at accidental poop squirts, dry chunks or oozes, so they often redouble their efforts at control by excessive holding or hiding their failure. The smell is rotten and terrible. Imagine food waste being kept for hours in your kitchen at 98.6 degrees Fahrenheit. Of course they become *nose blind* and their denial and resistance strengthens. This is extremely frustrating for you and for them. Repeated failure is to be denied and hidden with a brave front, anger, crying or depressed withdrawal. Chances are that you have become a part of this vicious cycle and you will have to learn to forgive yourself. The sooner you catch on to what has been happening and properly address it, the sooner you and your child will recover your parent-child relationship. You will be seen as wise and heroic for taking effective action,

[5] The masculine pronoun will be used throughout the rest of this manual.

however difficult it may be. Soiling Solutions® will reverse the vicious circle creating a virtuous cycle.

Sneaky Poo and Everyone Poops

Indeed, the war is really on *Sneaky Poo* itself. There is a free book containing that title at *www.dulwichcentre.com*. The idea is that, instead of fighting or struggling with and blaming one another, you become allies in fighting this common enemy that you both hate. Other books are available on the web that help the child to desensitize and view poop as more normal. However valuable these sources are, they really do not provide actual solutions for children suffering from this disorder for six months or longer.

Soft vs. Brutal, Really?

I do not agree with continuing the top down approach with stool softeners and/or laxatives after it has had a reasonable trial for up to a year. Its many advocates have even called it the soft or gentle approach and actually induced guilt and avoidance among physicians and parents for considering suppositories and enemas. I've had physicians command parents, "Don't touch his butt!" And, it can work both ways: one physician was intimidated by a parent calling him a "Poop Nazi" for suggesting enemas. Believe it or not, doctors can be intimidated.

Passive vs. Active Approaches

When the *soft* approach fails, some physicians will say he'll outgrow it, instead of finding alternative treatments that work. This latter approach is an appeal to do nothing. Advocating a passive approach fails to understand the urgency that parents have to overcome this problem. A more direct and active intervention is required. Here is where parental responsibility has to come to the fore. I have come to view the formation of an adequate voiding habit as an emergency priority for these children and parents when the top down approach fails. The Soiling Solutions® protocol can stop soiling for most children within two weeks.

Cultural Bias

Our cultural fears about sexual abuse, trauma, and inhibitions in dealing with this very private sexual area of our bodies play a large role in resistance to the Soiling Solutions® protocol with inserting bottom up or butt medicine.

The *Trauma* Question

The power of the Soiling Solutions® protocol is that it can all be done in the home by firm and loving parents there-

by mitigating these very powerful fears. I do not see trauma in kids if the parents maintain their course. If insulin shots or eye drops are required, which raise very natural fears, the parents somehow overcome their fears in the best interests of their children. Children will detect any fear and ambivalence on your part and react to it. They can be real drama queens and kings. They may manipulate you or their anxiety may be fed by your anxiety. It is amazing how much power they have! Nonetheless, in a week or two, the children begin to realize that they feel better and are happier with no accidents.

Parental Trauma

On our forums and in my earlier clinical practice, I saw tremendous parent ambivalence and anxiety surrounding *butt medicine* before and after initial administration. The child by virtue of their holding and resistance may suffer severe cramping and pain or even nausea and vomiting. These dramatic reactions can foster parental retreat, but assure years of future agony as the accidents continue unabated.

Overcoming fear to overcome encopresis

I am a psychologist; I have treated anxiety and pain disorders. The scientific consensus is that avoidance of necessary confrontation results in driving the anxiety and fear even deeper. “Face the fear and the fear will disappear” became my favorite mantra as fear exposure and reprocessing became a major means of treatment. Relaxation and new insights will become necessary for both the parent and child to see my protocol through for successful accident control.

Medical Trauma

Did you ever wonder why teenagers and young adults have poor judgment? It is because the forebrain matures very slowly. I have seen traumas result when medical personnel have to administer more powerful enemas, or if overnight hospitalization is required for a nasal drip to dissolve a severe blockage. Enemas are common in Emergency Rooms and the personnel really do not have the time and skills to assure parents and children. This can create a fear of doctors and hospitals. Physicians see all of these fear reactions and assume that home enemas will have a similar effect and have trouble imagining you doing this on a daily basis. Even for office visits, physician time is limited and assurances and explanations can get them way behind schedule. Often a nurse

who is their clinic expert for encopresis may be your best ally with the help of my Clean Kid Manual©. Administering enemas in a loving home is best.

Best Practice Guidelines?

Many of my Soiling Solutions® parents report horror, anger, and rejection by physicians when they learn that my protocol requires the daily use of suppositories and enemas. I have become controversial in pointing out that the standard pediatric top down approaches should be abandoned after a one year trial. Why is there so much resistance to change? The reason is the publication of *Best Practice Guidelines* for many disorders. This constrains your physician because of peer and legal concerns. Better guidelines are needed in pediatric practice. I see way too many older children coming to Soiling Solutions® as a last resort even into their teenage years.

Emotional and Physical Recovery?

Failure is not a good option. Fortunately, even for older children, much of it can be reversed. Parents and teachers report dramatic psychological changes as children recover from this debilitating disorder. Some have noted growth spurts with improved appetites. Since the physical recovery of the colon can take considerably longer, the daily Soiling Solutions® treatment hour may have to be applied for months or even years for some children. Surgery may even be required for older children. Fortunately, this is rare and is addressed in a troubleshooting chapter later in this manual.

What Is Really Missing?

The missing critical element of the top down approach is that just sitting on the toilet cannot train how to change from holding to releasing stool. That transition from holding to releasing their stool on the toilet is a critical missing link in today's approaches to encopresis. Holding is a natural initial response to voiding urges. It is hard-wired in our brains. This is called a *reflex arc*. It is: colorectal urge stimulus >>> brain recognition >>> colorectal (hold) response. This initial holding becomes overly powerful in encopresis. It will not give way to the voiding reflex arc in a timely manner when sitting on the toilet. For lack of a better term, I will call this a *brain lock*. This is a *habit*. Habits can be good or bad. They are very resistant to change. The ability for us to go seems natural and easy, but it's not the same for these children.

The *Plank* Child

Many parents observe that when the child is required to sit and go that he will stiffen his body and clench his butt in order to hold back his bowel movement. One mother described her child turning into a plank on the toilet. At other times the child can be observed standing on his toes, bending backwards, clenching his buttocks, stiffening his body, or sitting on his heels in obvious efforts to not have a bowel movement. The child gets so good at this, it becomes automatic and habitual. One child actually told his mother when asked to sit, "Wait, wait, it will go back in!" It can be so overlearned that they are not even conscious of these holding efforts. Some children on the toilet stool may even turn red as they push in apparent efforts to eliminate when at the same time they are, reflexively, tightening their External Anal Sphincter (EAS)[6] and another muscle (the Levator Ani) to choke off a bowel movement. Parents may remain clueless about this battle. It looks like he is trying to push as his face turns red and, sadly, he truly may be trying!

Vicious Cycle >> Virtuous Cycle

This form of holding and failure to relax so as to release a bowel movement on a reliable basis is called dysnergia or dyscoordination of the proper muscles in the proper sequence. Other terms are animus, dyschezia, outlet obstruction, functional fecal retention (FFR) or holding the Rectal Anal Inhibitory Reflex (RAIR). The bathroom sit for these children has become a stimulus to hold in what has become a *vicious* cycle. If a child could learn this so that a bathroom sit results in a transition to a release reflex arc or bowel movement, you would have a *virtuous* cycle!

Cats, Kids and a Litter Box?

Sometimes parents are delighted when their child asks for a pull up and he is able to have a bowel movement in it. But the moment of truth has not yet arrived and at some later time a battle will ensue with requests to sit on

[6] A dual sleeve of two different kinds of muscle tissue surrounds the anal opening. The EXTERNAL ANAL SPHINCTER (EAS-outside rim of the anal opening) is striated, voluntary muscle tissue, which can voluntarily or automatically contract to block the anal opening. The INTERNAL ANAL SPHINCTER (IAS) is involuntary smooth muscle, with a passive tension or tonus level that is sufficient to prevent leakage of normal stool under most instances as we go through our daily activities. Under ordinary circumstances the urge or signal to void will cause EAS contractions sufficient to hold back the stooling urges until they pass or we find a toilet to sit and relax the EAS so that the stool will overcome the little resistance offered by the IAS and a bowel movement results.

the toilet to go. Literally, the toilet stool and the bathroom have become powerful holding cues. The pull-up or diaper has become a well-established release cue. In toilet training our cat to use the toilet stool, I had to remove the litter box and loose rugs. Guess what pull-ups or diapers are equivalent to here? We want the toilet stool sit to become the proper release cue to replace the diaper release cue. Pull-ups cannot be worn forever and poo cannot be retained forever!

Causes, Causes, and More Causes!

The most common onset for encopresis is during ordinary toilet training. All kinds of factors come into play here such as parental demands, parenting styles and attitudes. Oh yes, there is the child! They are NOT blank little tablets that we write on and program. They are striving for autonomy and have their own temperaments. They have learned the power of "NO," "dun wanna," and "ain't gonna." They bargain, resist, cry, scream, hide, and run away. They become a *plank* if you sit them on the toilet. Some will become fantastic future lawyers with their dramatic and verbal skills that pierce you to your core or render you a blithering idiot.

School Holding

The second most likely onset of encopresis occurs with going to school where children tend to avoid the school lavatories and hold all day long away from home. This may be made easier because the gastrointestinal tract slows down under the stress of school demands and activities (a so-called *sympathetic nervous system dominant state*). This can start up the holding habit and set up failure. When the child approaches the end of the school day, relaxes and anticipates going home, that is when the gastrointestinal tract is unleashed with a vengeance and accidents are most likely to occur. This is called a *parasympathetic rebound effect.* It is extremely powerful. When I mention this to parents, I frequently see a light bulb go off in their heads as they connect it to their child's soiling.

Divorce Holding

A condition similar to school can occur for children of divorce going between households. The dynamics of the parent-child interaction can lead to more holding in one household than the other. The child may develop a pattern of having soiling accidents in the household where they are more relaxed after returning from a household

where they have been more stressed. This can lead to very unfair charges between alienated parents.

The Profit Motive?

Diaper manufacturers have become highly inventive and produce larger and better diapers and pull-ups every day. This can delay training for many children today because of an overworked single parent or two parents. The child forms the habit of going anywhere at any time with maximum convenience and may resist demands to leave the convenience of his pull-ups behind. Diaper cleaning services can also make delaying training more acceptable. Delay may result in a developmental age where the child is more stubborn and resistant to parental demands as he seeks more control and autonomy. Also, he is older, smarter and has gotten to know your weaknesses better!

The Toilet Bowl Suck Hole

The toilet bowl can be scary and cold with its horrible sucking sounds upon flushing. Later, I will describe a device, a bidet insert, which can make the toilet more attractive for the whole family.

Innocent Causes

Changes like going camping or on vacation can be occasions for initial holding. The result: dried out stools, and painful bowel movements, which can initiate and lock in encopresis. It just does not take much at all to cause months and years of emotional and physical distress.

The Idea from *Down Under!*

Upon my return from Australia in 1976, I began to apply my ideas on the use of suppositories and enemas in the private practice I had in Grand Rapids, MI. I reasoned that a daily adequate evacuation of stool while sitting on the toilet would encourage the correct connections and assure prevention of a backing up and more dried up hardened stool. Fresh and more normal soft hot dog stools would be available the next day. This would make stool softeners less necessary. I was astonished at the excellent results. The first edition of the Clean Kid Manual© (CKM) was written in 1998 when I recognized that a reliable and effective home-based treatment could be more readily and widely disseminated with the emerging dominance of the internet. I sought to further spread the protocol with professional publications in hopes that the professionals would research it and make it more available to their patients.

A History and Rationale for Soiling Solutions®

My medical journal article, "Soiling Solutions®: An Internet and Manual Based Approach to Treating Encopresis" was published by the International Foundation of Functional Gastrointestinal Disorders (www.iffgd.org) in 2009. The majority of the professional membership of this organization is made up of gastroenterologists. The article is available in Appendix 1 of this manual. Appendix 1 and my website *www.encopresis.com* also contain a letter to your physician. Recruit your physician to be available to monitor you or at least be on stand-by. You may copy or tear out both of these items for him or her to review.

The Breakthrough!

My approach is radical! It has to be parent-led. It is a stepped desensitizing approach of using suppositories and enemas with minimal short two- to three-minute sitting requirements four times over the course of a daily *treatment hour*. The parents on our forums call it the *Power Hour.* Punishment or threats are to be avoided. This is a rational clinical procedure. The bathroom and sitting on the toilet must become a sufficient and reliable cue for an automatic bowel movement to readily take over from the initial holding response. The toilet has been associated with distress and holding, which any threat would make worse. We want successful sits that will surprise and please your child!

Rectal Primers

The suppositories and enemas are *rectal primers.* They are used to promote training! The colorectal brain mechanism recognizes voiding sensations, distinguishes between gas and solid (not liquid), and signals the brain to hold and then release successfully when the toilet is reached. This sequence is reinforced by relief from colon pressure and urges. It must reliably overcome the holding habit. Virtually all children who fight the suppositories and enemas express surprise and great happiness with a successful bowel movement. The relief and success are themselves natural reinforcers.

Immediate and Early Success!

A daily bowel movement literally disarms most kids from another bowel movement until the next day's treatment hour. A majority of the children will stop soiling within two weeks, even though the daily treatment hour may need to be continued for weeks or even months until self-initiation becomes well-established. The changes in the child and in the family dynamics are just incredible as normalcy re-

turns. Teachers frequently note positive changes in the child as they have better concentration; coaches note better performance, and parents note that the children become more outgoing and happy. Children's appetites markedly improve in many instances and even growth spurts have been noted. These are all natural and highly reinforcing consequences.

Age limits

This manual was written for children 4 years old and up into late adolescence. Holding may be present earlier, but my protocol may need to be adapted with a shortened Power Hour to abet compliance for them. Young adults may have physical damage if they did not achieve earlier continence. They should be evaluated by a colorectal surgeon.

A Confession From the Past

I am from the generation before the World War II Baby Boomers, The Silent Fifties, when suppositories and enemas were actually quite common. My bio is on the inside of the back cover. Most families back then had a red rubber hot water bottle with tubing that doubled as an enema bag. They are still found in most pharmacies, often in the feminine hygiene aisle where they can also serve as a douche bag! Perhaps this history made me less subject to the fears that modern adults experience at the thought of enemas for children. Likely, my memory has dimmed, but I recall thinking of them only as noxious as eye drops, inoculations, haircuts, and taking a bath. If you stick a finger into your mouth into your throat you *throw up*. What happens when you do that down at the bottom? You *throw down*! It often explains fecal smearing that some parents and teachers report on with horror. I hope that desensitized you a little! Move on.