

# **ELIMINATION DISORDERS: Enuresis/Encopresis**

## **DSM-IV**

307.6 Enuresis (not due to a general medical condition)

307.7 Encopresis without constipation and overflow incontinence

787.6 Encopresis with constipation and overflow incontinence

The *DSM-IV* defines enuresis/encopresis as repeated involuntary (or, much more rarely, intentional) voiding/passage of feces into places not appropriate for that purpose, after attaining the developmental level at which continence is expected. If continence has not been achieved, the condition can be termed “functional” or “primary.” The period of continence necessary to differentiate between primary and secondary enuresis/encopresis is now considered to be 1 year. There does seem to be a significant relationship between enuresis and encopresis, although neither condition can be the direct effect of a general medical condition (e.g., diabetes, spina bifida, seizure activity) to be included in this category.

## **ETIOLOGICAL FACTORS**

### **Psychodynamics**

Numerous psychological interpretations exist speculating on the dynamics of toilet training and the significance of flushing bodily fluids down the toilet. Freudian theory places the fixation at the anal stage of development whereby the child fails to neutralize libidinal urges, and the aggressive impulses are fused with the pleasure of controlling bodily functions. Expulsion of feces or urination and untimed feces or urination or intentionally placing the feces in inappropriate places elicits hostility from parents. Loss of bodily functions leads to loss of self-respect, loss of friends, and feelings of shame and isolation.

### **Biological**

Learning to control urination/defecation is a developmental task most likely achieved by age 4 or 5 and requires a mechanically effective anatomy. In some enuretic children, abnormalities in regulation of vasopressor/antidiuretic hormone (ADH) have been evidenced, with ADH regulation being linked to both the dopaminergic and serotonergic systems. A theory of developmental delay suggests there is a common underlying maturational factor that predisposes children to manifest both enuresis and behavioral disturbances. Enuresis and encopresis are normal responses to environmental stresses that occur in certain situations (e.g., when a child is separated from his or her family or is abused). In either case, as the child matures and the environmental stressors are alleviated, normal bodily control is resumed. Children who are hyperactive may have occasional accidents, as they do not attend to the sensory stimuli until it is too late.

Enuresis and its relationship to bladder capacity and urinary tract infections has been explored, as has nocturnal enuresis occurring during deep sleep with no response to arousal signals. In addition, research has been conducted to investigate the physiological basis for encopresis. These studies indicate that the act of bearing down led to decreased anal sphincter control in almost all cases.

Soiling may result from excessive fluid buildup caused by diarrhea, anxiety, or the retention overflow process, whereby leakage occurs around a retentive fecal mass. This mechanism is responsible for 75% of encopretic children.

Genetically, a child is at risk for enuresis if the parent has a history of enuresis after the age of 4. Recent research suggests a genetic mutation on chromosome 13.

### **Family Dynamics**

As mentioned previously, the parental attitude toward cleanliness and the rigidity with which this behavior is controlled may perpetuate the fear associated with loss of bodily control. Parents often get caught up in the volitional aspects, blaming the child for “acting like a baby.” Further social embarrassment ensues when school personnel target the problem in terms of “the dirty child from a dirty family.” Attempts to deny the problem lead to covert behaviors such as hiding soiled clothing in lockers, under the bed, or in the trash. The child may in fact be using the only weapon available, as in the case of severe neglect and/or sexual assault.

## **CLIENT ASSESSMENT DATABASE**

### **Activity/Rest**

May/may not be awakened when bed-wetting occurs  
Unusual sleep habits, increased incidence of sleepwalking or sleep terror disorders

### **Ego Integrity**

Expressions of poor self-esteem (e.g., “I am bad”)  
Shy, withdrawn, feelings of isolation, shame  
Overly anxious around adult figures  
Stressors may include family conflicts/change in structure (e.g., divorce, birth of a sibling)

### **Elimination**

History of delayed or difficult toilet training  
Inattention to cues of need for elimination  
Episodes of urinary incontinence twice a week for at least 3 consecutive months in child of at least 5 years of age (or equivalent developmental level)  
Pattern of diurnal and/or nocturnal enuresis  
One episode of soiling per month over a 3-month period in child at least 4 years of age (or equivalent developmental level)  
Fecal incontinence; seepage secondary to fecal retention/colorectal loading  
Anal self-stimulation may be noted in nocturnal pattern of soiling

### **Hygiene**

Deliberate attempts to hide evidence of soiled clothing

### **Neurosensory**

May have developmental (neuromuscular or gross motor) delays  
Less than 1/3 of enuretic children have documented emotional disorders (regression is rarely reason for problem)  
Acting-out behaviors (e.g., placing feces or defecating in inappropriate places for retaliation)

### **Safety**

History/evidence of abuse may be present (condition may be related to abuse and/or the cause of abuse)

### **Sexuality**

Avoidance of sexual activity in older adolescents

### **Social Interactions**

Impaired social, academic functioning  
Power struggles with family/school to maintain personal hygiene, change bed linens

Reluctance to engage in peer activities; social rejection (body odor)  
Uncomfortable spending the night with friends either in own home or away

### Teaching/Learning

Usual age of onset 5–7 years, developmental age of at least 4 (encopresis) or 5 (enuresis) years  
Prevalence as high as 22% of 5-year-olds, 10% of 10-year-olds  
Boys more often affected than girls (3:1)  
History of parental enuresis  
Bed-wetting suppressed only as long as medication is taken; relapse usually occurring within 3 months

### DIAGNOSTIC STUDIES

**Urinalysis:** Rule out UTI.

**Electrolytes:** Identify imbalance in presence of chronic diarrhea.

**Abdominal, Lower GI X-Rays:** Evaluate anatomical abnormalities such as anal fissure, obstruction.

**Cystometrogram (CMG):** Test for bladder capacity when in question.

**Detailed Toilet Training History:** Baseline continence data clarifying problem and evaluating for secondary vs. primary enuresis/encopresis.

**ECG:** To provide baseline when starting antidepressant medication.

### NURSING PRIORITIES

1. Promote understanding of condition.
2. Identify and support change in parent/child patterns of interaction.
3. Enhance self-esteem.
4. Assist client in achieving continence.

### DISCHARGE GOALS

1. Condition/therapy needs are understood.
2. All parties are participating in therapeutic regimen.
3. Achieves as near a normal pattern of bowel/bladder functioning as individually possible.
4. Plan in place to meet needs after discharge.

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#### NURSING DIAGNOSIS

##### May Be Related to:

##### Possibly Evidenced by:

##### Desired Outcomes/Evaluation Criteria— Client/Family Will:

#### URINARY ELIMINATION, altered/ BOWEL incontinence

Situational/maturational crisis

Psychogenic factors: predisposing vulnerability; threat to physical integrity (child/sexual abuse)

Constipation

Nocturnal and/or diurnal enuresis

Involuntary passage of stool at least once monthly

Strong odor of urine/feces on client

Hiding fecal material/soiled clothing in inappropriate places

Verbalize understanding of contributing factors and appropriate interventions.

Participate in appropriate toileting program.

**Client Will:**

Achieve continence.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Identify times of occurrence, preceding/precipitating events, amounts of oral fluids, and family/client response to incontinence.

Check for fecal impaction.

Discuss measures client/family have tried and successes/failures to date.

Suggest use of bladder-stretching exercises (e.g., ask child to drink favorite beverage and wait to urinate until the urge becomes very strong, then measure the amount of urine voided). Gradually increase amount of liquid and waiting period.

Discuss use of conditioning programs and ask parents/caregivers to maintain a record of occurrences for a specified period before either program begins.

Instruct client/family in use of electronic nighttime monitoring device (bell and pad).

Instruct parents/caregiver initially to get child up each time the urine alarm buzzer sounds, shifting the responsibility gradually to child by stating, "I want you to know you can do this all by yourself." Keep a record of how often the alarm sounds and how sound the child's sleep is.

Active-listen and involve client in developing the plan for remaining dry/clean. Institute a system of positive reinforcement. Use rewards that the child would like or agrees to. Use the previously determined baseline data to determine parameters of the reward system and when to increase schedule.

Baseline data will help identify patterns and document improvement after treatment begins

This may be a contributing factor.

Typically, parents/caregivers have tried various methods, usually getting child up periodically at night, limiting fluids before bedtime, and having older children change soiled bed linens. These methods are not very effective and usually lead to frustration, power struggles/battles.

Although this method can have good results, the length of time needed may be discouraging and result in the family discontinuing the program.

The use of conditioning therapy and/or behavior modification usually does not begin until the child is age 7 or older. The child needs to make a commitment to be involved for the program to succeed. Information regarding the current individual pattern provides a baseline for future evaluation.

Urine alarms (e.g., Wet-Stop) have an effective cure rate of 75% to 90%. Once treatment is started, the alarm should be used every night.

Client may be fearful at first because of previous family interactions. In the beginning, the parents will probably awaken before the child and take the child to the bathroom. However, as the program progresses, the child will awaken more quickly and assume control. Empowerment promotes feelings of being in control.

Establishing a plan to which the client agrees has more chance of success than using aversive operant behavioral interventions (e.g., bell alarm) alone. Behavioral therapy may be useful when client is included in the planning, with rewards, such as tokens having value, if client agrees to their use. **Note:** If client is not involved in planning/vested in behavioral program, then therapy becomes an external control manipulating

Establish toileting routine with positive reinforcement for “sitting time” and depositing urine/feces in lavatory appropriately.

Treat occasional relapses with matter-of-fact attitude and follow through with procedures for self-hygiene.

Discuss length of treatment with parents/client and make plans for maintaining dry/clean status.

### **Collaborative**

Administer medications as appropriate, e.g:  
Imipramine (Tofranil);

Desmopressin acetate (DDAVP);

Amphetamines;

Laxatives and/or mineral oil.

Refer for evaluation of other therapies (e.g., hypnotherapy).

the client rather than promoting internal control and growth.

Client may begin to establish bowel/bladder habits often missing prior to treatment.

Relapse (whether intentional or not) is to be expected but may be minimized when the client does not feel pressured/blamed for lack of cooperation.

Knowing that treatment is ongoing prevents becoming discouraged and giving up treatment.

May be used after age 7 for enuresis. However, drug therapy is only a temporary treatment, not a cure, as condition recurs within 3 months after medication is discontinued. Pharmacological studies indicate improvement in encopresis with relatively low doses over 2-week period. **Note:** Factors such as child’s age, duration of problem, and child’s motivation to change are factors that affect decision to include pharmacological agents in combination with behavioral interventions.

Used for enuresis that has been intractable to other approaches.

These drugs lighten sleep; therefore, client is more likely to awaken to arousal signals.

Given daily for a specific period of time, these agents may promote bowel motility, ease evacuation of stool.

Used alone or in conjunction with conditioning, the use of hypnosis can help the child access the subconscious mind allowing the child to work through emotional conflicts and develop positive suggestions that he or she has good muscle control and will be dry in the morning. **Note:** This technique is contraindicated in the presence of child abuse.

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### **NURSING DIAGNOSIS**

**May Be Related to:**

**Possibly Evidenced by:**

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### **BODY IMAGE disturbance/SELF ESTEEM, chronic low**

Negative view of the self, maturational expectations

Social factors; stigma attached to loss of bodily functions in public

Family’s belief that soiling/ enuresis is volitional

Shame related to body odor

Angry outbursts/oppositional behavior

**Desired Outcomes/Evaluation Criteria—**

**Client Will:**

Verbalization of powerlessness to change/control bodily functions

Reluctance to take social risks with friends (e.g., overnights, dancing)

Verbalize acceptance of self in situation.

Acknowledge own responsibility and control over situation.

Participate in treatment program to effect change.

Engage in social activities.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Establish a therapeutic nurse/client relationship.

Within a helping relationship, the individual will begin to trust and try out new thinking and behaviors.

Promote self-concept without moral judgment by use of therapeutic communication skills. Discuss how elimination habits are formed and fact that new habits can be learned.

Individual may see self as weak, even though he or she acts as if in control. Age-appropriate information can help the child/family understand there is nothing wrong with the child and the problem can be solved.

Explain to child/family that many children have this problem. Suggest stories child can read (e.g., *Clouds and Clock*, by M. Galvin [1989]).

There is an increased risk for poor self-esteem/isolation when client views self as being “the only one.” Use of bibliotherapy can help child to identify with others.

Promote active problem-solving and self-hygiene behaviors around some of the disagreeable aspects of enuresis/encopresis (e.g., control of odor, management of laundry, and successful overnight visits with friends).

Gives sense of control, supports ability to overcome stigma, enhancing self-esteem.

Be aware of own reaction to client’s behavior. Avoid controlling attitude or arguing with child about hygiene or toileting routine.

Feelings of disgust, hostility, and wanting distance from these clients are not uncommon. The child may in fact be projecting his or her own negative feelings onto the caretaker. The nurse needs to deal with own responses/feelings to avoid having them interfere with care of the child.

Give positive reinforcement and encouragement for all attempts to join in peer activities or take additional risks in social situations.

Promotes repetition of desired behaviors, strengthens client’s willingness to change, and enhances self-esteem.

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**NURSING DIAGNOSIS**

**FAMILY COPING: ineffective (specify)**

**May Be Related to:**

Inadequate/incorrect information or understanding by primary person; belief that behavior is volitional

Disagreement regarding treatment, coping strategies

**Possibly Evidenced by:**

Attempts to intervene with child are increasingly ineffective

Significant person describes preoccupation with personal reaction (excessive guilt, anger, blame regarding child's condition/behavior)

Significant person displays protective behavior disproportionate (too little or too much) to client's abilities or need for autonomy

**Desired Outcomes/Evaluation Criteria—**

Express feelings openly and honestly.

**Family Will:**

Identify resources within self to deal with situation.

**Desired Outcomes/Evaluation Criteria—**

Verbalize realistic understanding and expectations of client.

**Family Will (cont.):**

Provide opportunity for client to deal with situation in own way, as appropriate.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Identify behaviors of/interactions between family members.

Withdrawal, anger/hostility toward client/others, ways of touching among family members, and expressions of guilt provide clues to problems within family related to or contributing to problem.

Assess for signs of child/sexual abuse.

These issues may be contributing factors to this problem. (Refer to CP: Problems Related to Abuse or Neglect.)

Note verbal/nonverbal expressions of frustration, guilt/blame.

Problems of enuresis/encopresis are difficult for family members to deal with because of the long-term aspect of the problem. More support may be needed to deal with high level of frustration.

Determine willingness of family members to be involved in treatment program.

Success of any program depends on all members being positively committed to therapy. Uncommitted members may sabotage the program.

Encourage expression of feelings openly and honestly.

Feelings of frustration and fear are common and, unless discussed, can interfere with progress of therapy.

Discuss with the parents/caregivers the importance of being neither too strict nor too permissive in dealing with this problem.

Effective use of "win-win" methods (e.g., Active-listening, I-messages, and problem-solving) can enhance the parent/child relationship and

promote good feelings about selves and others.  
(Refer to CP: Parenting.)

Recommend avoidance of spanking or other harsh punishment.

The use of harsh discipline usually results in power struggles where no one wins, making the problem worse and damaging the relationship between adult and child.

Help parents recognize they are not responsible for, and need to separate themselves from, the child's behavior.

Parents often believe they have been "bad" parents and are responsible for the child's failure to achieve what they view as a "natural" behavior. When they see the child as a separate individual who has responsibility for own self, they can let go and be more comfortable in resolving the problem.