

# Encopresis

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September 26, 2025

## RECOMMENDED CITATION

mohammad looti (2025). *Encopresis*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=29145>

## Encopresis

**Primary Disciplinary Field(s):** Pediatrics, Child Psychology, Gastroenterology, Psychiatry

### 1. Core Definition

Encopresis, also known as fecal incontinence or soiling, is an elimination disorder characterized by the repeated passage of feces into inappropriate places, whether voluntary or involuntary. This condition is formally diagnosed when such incidents occur at least once a month for a minimum of three consecutive months. A critical diagnostic criterion stipulates that the individual must have reached a developmental age of at least four years, a point by which most children are expected to have achieved complete bowel control. This age threshold is vital as it differentiates a medical condition from typical developmental variations in toileting mastery during early childhood.

The diagnostic framework for encopresis, as outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), further specifies that the behavior must not be solely attributable to the direct physiological effects of a substance (e.g., laxatives) or another medical condition, except through a mechanism involving constipation. This distinction is crucial for directing appropriate medical and psychological interventions. The involuntary nature of soiling often leads to significant distress for both the child and their caregivers, impacting social development, self-esteem, and family dynamics.

Understanding encopresis as more than just a behavioral issue is paramount; it typically involves a complex interplay of physiological, psychological, and environmental factors. While the visible symptom is fecal soiling, the underlying mechanisms often relate to chronic bowel dysfunction, particularly constipation, which can lead to a loss of normal bowel control signals. This condition requires a comprehensive assessment and a multi-faceted approach to treatment to ensure effective resolution and prevent long-term complications.

### 2. Etymology and Historical Development

The term "encopresis" originates from Greek roots: "en-" meaning "in," and "kopros" meaning "dung" or "feces," literally translating to "feces in." This etymology directly reflects the primary symptom of the disorder--the inappropriate passage of fecal matter. Historically, the understanding and conceptualization of encopresis have evolved significantly. In earlier eras, particularly in the mid-20th century, encopresis was often viewed predominantly as a psychological or behavioral problem, frequently associated with emotional disturbance, defiance, or inadequate toilet training. This perspective sometimes led to punitive or shaming approaches, which inadvertently exacerbated the child's distress and the underlying condition.

As medical and psychological research advanced, particularly in pediatrics and gastroenterology, a

more nuanced understanding emerged. By the latter half of the 20th century, clinical observations increasingly highlighted the strong association between encopresis and chronic constipation. This shift in perspective underscored the physiological basis of the disorder, recognizing that physical factors often precede and contribute to the psychological and behavioral manifestations. The recognition of fecal impaction and subsequent "overflow incontinence" as the most common underlying mechanism marked a pivotal change in diagnostic and treatment paradigms.

The inclusion of encopresis in diagnostic manuals like the DSM, with specific criteria and an emphasis on distinguishing between types (retentive versus non-retentive), further solidified its recognition as a legitimate medical and psychological condition. This formalized understanding has guided clinicians towards integrated treatment approaches that address both the physiological roots and the psychological sequelae of encopresis. This historical progression from a purely psychological explanation to a biopsychosocial model reflects a broader trend in medicine towards understanding complex conditions through multiple interacting lenses.

### 3. Key Characteristics and Types

Encopresis manifests through several identifiable characteristics, primarily centered around the inappropriate passage of stool. The most common and defining symptom is the presence of liquid stool on underwear, often described as "skid marks" or larger, more noticeable accidents. This occurs due to the overflow phenomenon, where liquid stool bypasses a hardened, impacted fecal mass in the rectum. Children with encopresis frequently experience frequent constipation, characterized by infrequent, hard, and painful bowel movements, or a history of struggling to pass stool. This chronic retention of feces is a central component for the most prevalent type of encopresis.

Beyond the primary symptom of soiling, other physical symptoms often accompany encopresis. Children may report abdominal pain or discomfort, which can range from mild cramping to severe, persistent pain due to the distension of the bowel. A noticeable lack of appetite is also common, particularly during periods of significant impaction, as the full colon can create a sensation of satiety or nausea. Furthermore, the pressure from a distended rectum and colon on the bladder can lead to urinary symptoms, including increased frequency of urination, urgency, and even bladder infections (UTIs).

Encopresis is typically categorized into two main types: **retentive encopresis** and **non-retentive encopresis**. Retentive encopresis is by far the more common type, accounting for over 80-95% of cases. It is directly linked to chronic constipation and subsequent fecal impaction. In this scenario, the rectum becomes chronically stretched and insensitive due to prolonged fecal retention, leading to a diminished ability to sense the urge to defecate and a weakened internal anal sphincter. Non-retentive encopresis, conversely, occurs in the absence of constipation or fecal impaction. This

type is less common and is often associated with behavioral issues, oppositional defiance, anxiety, or other psychological stressors, where the child may intentionally or subconsciously withhold stool or pass it inappropriately without a physiological basis of impaction.

#### 4. Etiology and Contributing Factors

The etiology of encopresis is typically multifactorial, although chronic constipation remains the most common underlying cause, particularly for retentive encopresis. This process begins when a child, for various reasons, withholds stool, leading to a build-up of fecal matter in the colon and rectum. Over time, this retained stool becomes hard, dry, and difficult to pass, resulting in fecal impaction. The continuously distended rectum loses its sensitivity, meaning the child no longer receives the normal physiological signals indicating a need to defecate. This diminished sensation, coupled with a weakened anal sphincter from constant stretching, allows softer, liquid stool to leak around the hard, impacted mass, leading to overflow incontinence.

Several factors contribute to the development of chronic constipation in children. Dietary habits play a significant role; a diet low in fiber and insufficient fluid intake can lead to harder stools that are more difficult to pass. Additionally, children may engage in stool withholding behaviors due to painful bowel movements (often from previous episodes of constipation), a fear of public restrooms, reluctance to interrupt play, or a general aversion to toileting. These learned behaviors perpetuate the cycle of retention and impaction. Certain medical conditions, though less common as primary causes of encopresis, can contribute to constipation, such as hypothyroidism, spinal cord abnormalities, or in rare cases, Hirschsprung's disease.

Beyond the physiological basis, emotional issues and stress are significant contributing factors, as noted in the source content, especially in cases of non-retentive encopresis or as exacerbating factors in retentive forms. Major life changes, such as moving to a new home, starting school, family conflicts, or the arrival of a new sibling, can induce stress or anxiety that interferes with a child's ability to maintain bowel control. Traumatic experiences, including physical or sexual abuse, can also manifest as encopresis. Psychological comorbidities like anxiety disorders, depression, ADHD, or oppositional defiant disorder can further complicate the picture, either by directly influencing toileting behavior or by creating a stressful environment that makes resolution more difficult.

#### 5. Diagnosis and Assessment

The diagnosis of encopresis involves a comprehensive assessment that integrates medical history, physical examination, and, in some cases, imaging studies. A detailed clinical history is paramount, often beginning with an in-depth interview with the child's parents or primary caregivers. This interview typically covers the onset, frequency, and characteristics of soiling episodes, the child's

bowel habits (frequency, consistency, and pain associated with bowel movements), dietary patterns (fiber and fluid intake), and the presence of any associated symptoms like abdominal pain, lack of appetite, or bladder infections. Information about psychosocial stressors, family dynamics, and the child's developmental milestones, especially regarding toilet training, is also critical.

A thorough physical examination is essential to rule out other medical causes and to assess for signs of constipation and fecal impaction. The examination often includes abdominal palpation to check for a palpable fecal mass, which would indicate significant stool retention. While controversial and not always necessary, a digital rectal examination (DRE) may be performed by a healthcare professional to assess for rectal distension, the presence of an impaction, and sphincter tone. The DRE can provide direct evidence of the physiological changes associated with chronic fecal retention and is particularly relevant when evaluating for retentive encopresis.

In some instances, imaging studies, such as an abdominal X-ray, may be used to confirm the extent of fecal impaction, although clinical history and physical examination are often sufficient. It is also important to consider and exclude other medical conditions that can cause similar symptoms, such as intestinal malformations, neurological disorders, or metabolic conditions, before confirming a diagnosis of encopresis. This comprehensive diagnostic process ensures that the underlying cause is correctly identified, paving the way for targeted and effective treatment strategies that address both the physiological and psychological dimensions of the disorder.

## 6. Management and Treatment

The management of encopresis is typically a multi-stage process that requires patience, consistency, and a collaborative approach involving the child, parents, and healthcare providers. The initial and most critical step, especially for retentive encopresis, is **disimpaction**. This involves clearing the impacted stool from the colon and rectum. This is usually achieved through high doses of oral laxatives, such as polyethylene glycol, or in some cases, the use of enemas, administered under medical guidance. The goal is to evacuate the large, hardened stool mass, thereby relieving the pressure and restoring the rectum's normal function and sensitivity.

Following disimpaction, the focus shifts to **maintenance therapy**, which aims to prevent re-impaction and re-establish regular bowel habits. This phase is crucial and often lasts for several months, sometimes even years. It involves several key components: **dietary modifications**, including a significant increase in dietary fiber and fluid intake, to soften stools and promote easier passage. Regular, low-dose oral laxatives are often continued to ensure daily soft bowel movements and allow the stretched rectum to regain its tone and sensation. A structured **scheduled toileting program** is also implemented, where the child is encouraged to sit on the toilet for 5-10 minutes, usually after meals, to take advantage of the gastrocolic reflex.

**Behavioral therapy** and psychological support are integral to successful treatment. This includes

positive reinforcement for sitting on the toilet and for clean days, rather than punishment for accidents, which can worsen anxiety and resistance. Addressing any underlying emotional issues or stress, as identified during the assessment, is vital. This might involve individual child psychology sessions or family counseling to improve communication, manage family conflicts, and reduce the child's shame or guilt. In some specific cases, biofeedback therapy may be used to help children relearn to sense rectal fullness and coordinate anal sphincter relaxation. Consistent follow-up with a healthcare provider is essential to monitor progress, adjust medications, and provide ongoing support and education to the family.

## 7. Prognosis and Long-Term Impact

The prognosis for children with encopresis is generally good, especially with early diagnosis and consistent adherence to a comprehensive treatment plan. The vast majority of children achieve full bowel control and resolution of soiling incidents. However, success is heavily dependent on sustained effort from the child, parents, and medical team. It is important to acknowledge that the treatment process can be lengthy, often spanning several months to a year or more, and relapses are not uncommon, particularly during periods of stress or changes in routine. Families need to be prepared for this extended commitment and understand that consistency in dietary changes, laxative use, and toileting routines is key to long-term success.

If left untreated, encopresis can have significant and detrimental long-term psychosocial impacts on a child. The persistent soiling can lead to profound feelings of shame, embarrassment, and guilt, often resulting in low self-esteem and social withdrawal. Children may avoid social activities, sleepovers, or school trips due to fear of an accident, leading to social isolation and difficulties forming friendships. They may also become targets of bullying, further compounding their emotional distress. These psychosocial consequences can persist even after the physical symptoms resolve, potentially contributing to anxiety, depression, and behavioral problems later in life.

Therefore, the importance of addressing encopresis promptly and effectively extends beyond resolving the physical symptoms; it is crucial for supporting the child's overall emotional well-being and healthy development. A supportive and understanding family environment, coupled with professional medical and psychological intervention, can mitigate the negative impacts and help the child regain confidence and social integration. Education for parents and teachers about the medical nature of encopresis, rather than viewing it as a behavioral fault, is also critical in fostering a compassionate and effective support system.

## 8. Debates and Criticisms

While the understanding of encopresis has evolved significantly, certain debates and challenges

persist within its conceptualization and management. Historically, one of the most significant debates centered on whether encopresis was primarily a psychological or a physiological disorder. Early psychoanalytic theories often attributed it to deep-seated emotional conflicts or passive-aggressive behaviors, which sometimes led to treatment approaches that overlooked the physiological component. While the predominant view now recognizes the physiological basis (especially chronic constipation) as primary for most cases, the role of psychological factors in initiating, exacerbating, or maintaining the condition, particularly in non-retentive forms, remains an area of ongoing discussion and research. The challenge lies in accurately discerning the primary driver in individual cases and tailoring interventions accordingly.

Another area of concern revolves around treatment compliance and the long duration often required for successful resolution. The daily regimen of laxatives, dietary changes, and scheduled toileting can be taxing for both children and parents, leading to frustration, burnout, and inconsistent adherence. This lack of compliance is a major factor in treatment failure and relapse. Critics also point to the potential for over-reliance on pharmacological solutions without adequately addressing the behavioral and psychological aspects, which are crucial for long-term success. The effectiveness of various biofeedback techniques and the precise role of specialized psychological interventions in addition to standard medical management are also subjects of ongoing research and clinical debate.

Furthermore, the societal stigma associated with fecal incontinence remains a significant barrier to seeking timely help and open discussion. Despite increased awareness, encopresis is often shrouded in shame, leading to delays in diagnosis and treatment. This stigma can affect how parents perceive the condition and how children experience it, impacting their willingness to participate in treatment. Addressing these psychological and social dimensions, alongside the medical management, requires a holistic and empathetic approach from healthcare providers and a greater public understanding of encopresis as a treatable medical condition, not a sign of poor parenting or deliberate misbehavior.

## Further Reading

[Encopresis - Wikipedia](#)

[Elimination disorder - Wikipedia](#)

[Constipation - Wikipedia](#)

[Fecal impaction - Wikipedia](#)

[DSM-5 - Wikipedia](#)

[Pediatrics - Wikipedia](#)

[Child psychology - Wikipedia](#)

[Gastroenterology - Wikipedia](#)

[Psychiatry - Wikipedia](#)

[Overflow incontinence - Wikipedia](#)

[Rectum - Wikipedia](#)

[Anal sphincter - Wikipedia](#)

[Urinary tract infection - Wikipedia](#)

[Hypothyroidism - Wikipedia](#)

[Hirschsprung's disease - Wikipedia](#)

[Biofeedback - Wikipedia](#)

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