Psychotherapy for Children with Encopresis:

A Hermeneutic Literature Review.

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Abstract

Encopresis or faecal incontinence is a common medical condition among many children and can be a result of medical and/or psychological causes. As a trainee child and adolescent psychotherapist, I want to gain a deeper understanding of the emotional needs of encopretic children and their psychological internal world. The goal of this study is to explore various therapeutic approaches that can help support their emotional needs and answer the following research question: *How can psychotherapy benefit children with encopresis?*

Hermeneutics epistemology involves understanding the meaning of lived experiences for individuals and exploring how these experiences influence their engagement with the world through interpretation. In utilising hermeneutic phenomenology as my methodology and conducting a hermeneutic literature review, I hope to understand the subjective experiences of encopretic children and the reasoning behind the various psychotherapeutic approaches used to support them. The data for this study comes from existing literature on psychotherapy with encopretic children, including my reflections based on my understanding and interpretation of the literature. In reviewing the literature, three key themes emerged, denial, control and disruptions in attachment, as some of the common underlying distresses for encopretic children. The psychotherapist's ability to build and work within the therapeutic relationship, remain attuned and move at the child's pace, allow space for them to express themselves and work through underlying distresses, and work closely with parents to help them mentalise their child's needs were some of the key findings across the themes. Analysing the literature offered insight on the reasoning and effectiveness of these therapeutic approaches. The findings can contribute to future research on effective psychotherapeutic interventions, as well as support and inform child psychotherapy students, child psychotherapists and other mental health professionals working with encopretic children.

Table of Contents

List of Figures

List of Tables

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature _____Smrithi Sriram_____

Date _____30/09/2023_____

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Chapter 1 – Introduction

Overview

I will be covering the initial context of the research in this chapter. This will include a personal statement on why I chose the research topic, the research aim, question, scope, and a definition of the key terms in the research question. A summary of what has been covered in this chapter and an overview of the following chapters will also be included.

Personal Statement

As a child and adolescent psychotherapy student, I became interested in understanding the lived experiences of children with encopresis and how a child psychotherapist could best support them. During my training, I encountered children with this condition. I noticed that my understanding of working with encopretic children was limited. I wanted more resources to improve my ability as a child psychotherapist to effectively support these children. I had discussions with my supervisors, lecturers, and peers to gain more knowledge on how I could effectively design a therapeutic approach.

I started wondering about what bowel movements meant to me as an Indian girl growing up and the shame, stigma, and need for discretion associated with this. Toilet training was considered vital, and "accidents" while sleeping or in school were associated with a loss of impulse control and resulted in mockery and feelings of embarrassment and shame. I remember feeling embarrassed to even ask to go to the toilet in the classroom at the age of six.

I searched for articles on psychological interventions for encopretic children and noticed that many of the existing research leaned heavily on the use of biofeedback and

behavioural therapy. This prompted my interest in wanting to work on a research paper outlining what occurs within the therapy process, the therapeutic approach used, and how psychotherapeutic interventions could benefit encopretic children.

Research Topic and Question

Although encopresis is known to be a common condition during early childhood, gaining control over bowel movements is considered an essential developmental milestone (Joinson et al., 2008). I wondered what it would mean for children and their families, when children have encopresis, and the accompanying struggles or challenges this may bring in being unable to gain control over bowel movements. Encopresis can significantly affect a child's quality of life, leading to negative impacts on their self-esteem and social functioning (Baroud et al., 2022; McGrath et al., 2000). They may have increased anxiety, shame, irritability, aggression, fear, reduced capacity for attention, and psychosocial and behavioural problems (Baroud et al., 2022; Joinson et al., 2006).

Overall, there seemed to be multiple psychological interventions that have been deemed effective while working with encopretic children. Family therapy, behavioural therapy, and biofeedback, along with standard medical treatments, have been identified as helpful for children to regain control over bowel movements (Axelrod & Fontanini-Axelrod, 2022; Cox et al., 1998; Van Dijk et al., 2007; White, 1984). In reviewing the literature, I noticed that most of the existing literature on psychological interventions for encopretic children appears to have a particular focus on symptom reduction or management to help children acknowledge, come to terms with, and manage their encopretic symptoms through behaviour modifications, reward systems and attachment-focused work.

Some studies have documented the efficacy of psychotherapeutic interventions for children with encopresis (Dossetor et al., 1998; Shabad, 2000; Thapar et al., 1992). However, during the preliminary search, I noticed that there has been little research on psychotherapeutic interventions for encopretic children in the past 20 years. As a trainee child psychotherapist, I wanted to learn more about how I could work with encopretic children to best support them. Although psychotherapy is considered to be a treatment option for encopresis, little research has been conducted on what occurs during sessions and how these interventions can support the emotional needs of encopretic children. In this study, I seek to answer the following research question:

"How can psychotherapy benefit children with encopresis?"

Key terms

Psychotherapy has its traditional roots from psychoanalysis, which aims to address psychic pain and disruptions for children through exploring their internal and external worlds and early childhood experiences (Rustin, 2009). In this study, I will be focusing on child psychotherapy practice that is grounded in psychoanalytic and psychodynamic theory. A child psychotherapist works relationally and within the therapeutic relationship with their clients and their families and attempts to understand the inner world of their client and the underlying feelings and behaviour (Rustin, 2009).

Children or minors, according to the New Zealand Legislation, Age of Majority Act 1970 (Ministry of Justice, 2021), are all persons below the age of 20 years. In this study, I will be focusing on children above the age of 4 years, as the general expectation is for them to be toilet trained by this age. I acknowledge that there are various mental states and needs

that may categorize older people as children; however, these considerations are beyond the scope of this study.

Encopresis, also known as faecal incontinence, is the regular passing of bowel movements in the underwear or outside of regular toileting settings by children above the age of four years without any natural causes (Benninga et al., 1994). This condition can be a result of anorectal malfunction, constipation, neurogenic disorders, “non-retentive faecal soiling” where there is no constipation, or “retentive encopresis” because of constipation with no underlying medical causes (Loening-Baucke, 2002). I acknowledge that some of the causes of encopresis require additional medical support and varying approaches to treatment. However, this study will focus on children with encopresis and the psychological difficulties they face due to this condition, not on the individual medical causes.

Aim and Scope

For this research, my aim is to understand how encopresis children can benefit from psychotherapeutic interventions in general and consider therapeutic approaches that best support the emotional needs of the child. The goal of this study is to add to the body of psychotherapeutic literature in Aotearoa (New Zealand).

During the literature search process detailed in Chapter 2, I found that there was no New Zealand-based research regarding psychotherapeutic interventions for encopretic children. Referring to the Research Hub website, this study would be classified as Level 1, "Research with no specific Māori component" (University of Auckland, 2023). However, the findings have the potential to contribute to child psychotherapy practice across Aotearoa (New Zealand), including Māori. The research findings can also offer insight to other

healthcare professionals while either working with these children or referring them for mental health support.

Findings from this research could provide insight into the challenges faced by children with encopresis and how psychotherapy can benefit them. This research has the potential for further development of effective psychotherapeutic interventions in the area of encopresis and for children and families managing this, and to offer guidance to child psychotherapy trainees and child psychotherapists working with encopretic children.

Summary

This chapter provides the context for this dissertation, including information on my personal inclination for and pre-existing understanding of the research topic. The research question, aim of the study and scope of the research findings, and definition of key terms have also been outlined in this chapter.

Chapters overview

Chapter 1 provides an overview of the research topic and the initial context for this dissertation. The methodology and the various steps involved in the method, including an audit trail of how the data analysis was conducted, are included in Chapter 2. The following three chapters outline the findings from this research, with each chapter detailing one of the three main themes identified: control in Chapter 3, denial in Chapter 4, and disruptions in attachment in Chapter 5. The discussion of the findings, limitations of the study, and practical implications and recommendations for future research are discussed in Chapter 6.

Chapter 2 - Methodology

Overview

In this chapter, I will outline the reasoning behind my use of hermeneutic phenomenology as the methodology conducted for my research question: "How can psychotherapy benefit children with encopresis?". I will explain how this methodology relates to my research question and the various processes involved in conducting a hermeneutic literature review. This will include my method of searching for relevant literature, my process of reading and interpreting the literature, and how I have positioned myself within the framework.

Methodology

Hermeneutic phenomenology is a combination of both hermeneutics and phenomenology and aims to explore and interpret the subtleties and intricacies of lived human experiences (Geniusas & Fairfield, 2018). Phenomenology values human subjective experiences and seeks to understand the meaning of these lived experiences for that individual (Wojnar & Swanson, 2007). According to Gardner (2010), hermeneutics, through interpretation, offers an understanding of how these experiences contribute to their way of engaging with the world.

I will be using hermeneutic phenomenology as the methodology for this study, as my aim for the study is to explore the potential benefits of psychotherapy for children with encopresis, by reviewing existing literature. This methodology falls within the qualitative interpretive paradigm (White, 1997) and values that human experiences to be complex and non-linear (Schuster, 2013).

The epistemology of hermeneutic phenomenology values the understanding that knowledge can be acquired through insight and reflecting on subjective experiences (Gardner, 2010)**.** This methodology enables a researcher to move between what is explicitly available and the interpretation of the material available in the literature, moving from an idealistic to a more realistic understanding of lived experiences (Geniusas & Fairfield, 2018).

As the research question focuses on understanding the intricacies of the process taking place during psychotherapy and the experiences of encopretic children, using this methodology seems most appropriate as opposed to a systematic approach that focuses on uniformity and objectivity of the knowledge acquired (Popay et al., 2006). Given the complexity of the psychological distress experienced by encopretic children as outlined in Chapter 1, using hermeneutic phenomenology enables me, as the researcher, to explore and interpret the subjective experiences of children who have received psychotherapy.

Method

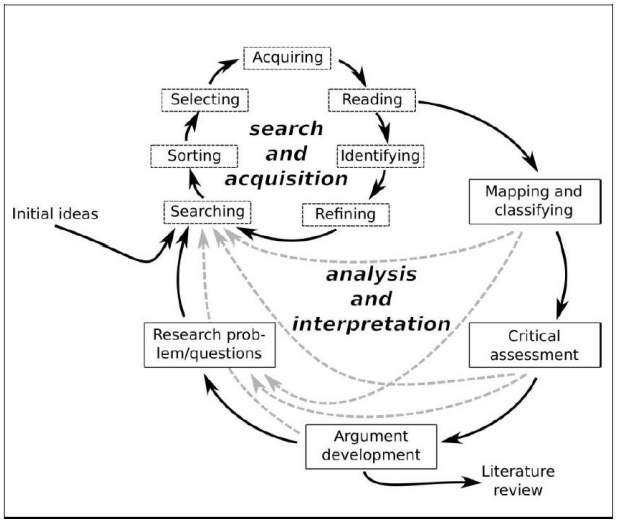
I will be doing a hermeneutic literature review to answer my research question. Hermeneutics emphasizes the interpretation of the meaning and context behind texts and the exploration of various perspectives and interpretations of existing literature (Boell & Cecez-Kecmanovic, 2014). Therefore, using a hermeneutic literature review will allow for a comprehensive understanding of the existing literature on psychotherapy for children with encopresis by reviewing and interpreting the meaning behind and across the texts. I have chosen this method to answer my research question as it sits within the philosophical underpinning that human experiences are complex (White, 1997). Using a hermeneutic literature review would help me gain insight on how psychotherapy can support exploring these experiences and benefit encopretic children.

Hermeneutic circle

Boell and Cecez-Kecmanovic (2014) proposed two hermeneutic circles in their framework (see Figure 1), "the search and acquisition circle" which includes acquiring the literature, reading and identifying, refining and continuing the search, and sorting and selecting literature; and "the analysis and interpretation circle" which includes mapping, classifying, and assessing the literature, argument development and identification of literature pertinent to the research question, and looping back to the searching process to acquire further relevant literature (pp. 263-264).

Figure 1

A Hermeneutic Literature Review Framework



Note. This figure shows a framework for conducting a hermeneutic literature review, which includes the movement between two hermeneutic circles. From "A Hermeneutic Approach for Conducting Literature Reviews and Literature Searches" by S. K. Boell & D. Cecez-Kecmanovic, 2014, Communications of the Association for Information Systems, 34(1), p. 266. Copyright 2014 by Communications of the Association for Information Systems.

Literature Search

I followed this hermeneutic framework proposed by Boell and Cecez-Kecmanovic (2014) (see Figure 1), for the literature search and review process (p. 263). I moved between the literature search and reading process to develop a more comprehensive understanding of the research question, refined my literature search, and interpreted the text I read in relation to other literature for my argument development.

I started my literature search process by doing a preliminary search of the AUT databases. I used university databases, the American Psychological Association's (APA) PsycINFO, PsycARTICLES, and PsycBOOKS, Psychoanalytic Electronic Publishing (PEP) and AUT Google Scholar to conduct the literature search for this study. The main keywords for the search were "psychotherapy," "encopresis," and "children." Other relevant search terms associated with the keywords, such as "psychodynamic," "psychoanalytic," "child," "adolescent," "faecal incontinence," AND "involuntary bowel movement," were also used to ensure that relevant articles using alternate terminologies are included in the study. Some literature recommended by lecturers, my supervisor, and peers relevant to my research question were also included. Additionally, some articles referenced by existing literature that were relevant to the research question, following a search of their reference list, were included in the preliminary search.

Following this search, along with some suggested articles from my supervisor, colleagues, and lecturers, I initially selected twenty-three articles. After reading the articles, I refined my search process and continued my search for more relevant articles that would help answer the research question. Using the exclusion criteria, I narrowed down my chosen literature to 15 (refer to Table 1). I understand that there may have been more articles that could offer further insight into the research question; however, given the size of the

dissertation, I limited my chosen articles to fifteen to arrive at a conclusion for my research.

Table 1

Chosen Literature

Literature	Type
Amsterdam (1979)	Article
Aruffo et al. (2000)	Article
Barrows (1996)	Article
Bonovitz (2003)	Article
Cuddy-Casey (1997)	Article
Di Francesco and Rodriguez (2014)	Article
Downey (2000)	Article
Edgcumbe (1978)	Article
Forth (1992)	Article
Goldblatt et al. (2022)	Article
Goodman (2013)	Article
Grimwade (2009)	Article
Lehman (1944)	Article
Shane (1967)	Article
Smirnow and Bruhn (1984)	Article

Note. This table contains a list of the literature I have chosen for the hermeneutic literature review.

Exclusion criteria. Articles that do not focus on psychotherapy (as defined in chapter 1) as the mode of therapy and primarily focus on other modalities or medical conditions were excluded. Articles focusing on adults with encopresis were also excluded. I understand that medical interventions are necessary for some encopretic children; however, articles primarily focusing on medical interventions with limited exploration of psychotherapeutic interventions were excluded.

Analysis of Data

I followed the framework proposed by Boell and Cecez-Kecmanovic (2014) for analysing the literature identified (see Figure 1) (p. 266). The data analysis process included reading the chosen literature, identifying key themes and interpretations of the findings, and synthesising of the findings. This involved identifying patterns across the literature and developing a more in-depth understanding of the potential benefits of psychotherapy for children with encopresis.

As I went through the process of searching and acquiring my data, I started noting themes that referred to encopretic children's experiences at home, how they presented in the playroom, and the therapeutic approaches described in each of the articles. Once I had narrowed down the fifteen articles, I re-read the articles and started writing down my reflections and understanding of each article in relation to the research question. As I read through the articles again, I noticed similarities in the experiences and presenting problems for encopretic children across the literature.

Given the complexity of the distresses identified for encopretic children across the data, I struggled with narrowing down the themes and subthemes that focused merely on the therapeutic approaches. I took a couple of weeks away from thinking about the themes, and

immersed myself in reading my notes on the articles, and started wondering about the meaning of these lived experiences for the children and their families. I thought about my clinical work as a trainee psychotherapist. A child psychotherapist designs therapeutic plans based on the needs of the child and their family. The therapeutic approach would depend on the emotional needs of the child and is used to understand the meaning the child's experiences hold in their inner world, explore the underlying feelings in their unconscious, and work through and come to terms with their distressing feelings.

Focusing on the underlying emotional distresses seemed essential in thinking and learning about how a psychotherapist could effectively support an encopretic child's needs in the playroom. As I sought to understand the meaning of the lived experiences of children with encopresis and their families from a hermeneutic position, the literature revealed themes of control, denial, and disruptions in attachment. I realised that the themes and subthemes needed to focus on the feelings associated with the experiences of encopretic children to consider how a psychotherapeutic approach could help in addressing their needs.

Limitations

During the preliminary search on the AUT databases, I found a few articles that seemed relevant to the research question; however, I was unable to search through the articles for inclusion due to their lack of availability in the AUT library and lack of resources to acquire these articles.

Schuster (2013) acknowledges that, as much as a researcher attempts to remain objective in their approach to research, there will always be a degree of subjective bias in how the method is applied. I am aware of the limitation that there may have been subjective bias during my selection of literature that I deemed relevant to the research question. I

ensured that sufficient key words were used during the literature search and scanned the articles to ensure that they helped answer the research question to help mitigate this.

As the researcher interpreting the literature, I am aware of the existence of my own bias based on my pre-existing understanding of the research topic. Boell and Cecez-Kecmanovic (2014) acknowledge that though pre-understanding can be a limitation and result in bias, this offers a foundation for the researcher to understand and interpret the literature, while highlighting that the researcher needs to be open to their pre-conceived notions being challenged. I maintained a journal where I noted the information offered by the new literature, my interpretation of it and how it aligned or disputed with my pre-conceptions to ensure I remained open to acquiring a wider understanding of the knowledge. Having monthly discussions with my supervisor also helped me understand my potential biases.

Summary

In this chapter, I have identified hermeneutic phenomenology as my methodology and hermeneutic literature review as the method and explained my reasoning behind choosing these for my research question. I have outlined my strategies for data collection and data analysis and the limitations of my methods. This chapter includes what I have done, the procedures I followed, and the problems I encountered during the research process**.** The next three chapters will include my findings - the three themes and subthemes identified.

Chapter 3 – Control

Overview

In reviewing the literature, there was a theme of *control,* which will be discussed in this chapter. This will be followed by a discussion of the subthemes - *battle for control, omnipotent control* and *difficulty with separation*, and the therapeutic approaches identified in the literature under each subtheme. A brief summary outlining what has been discussed will conclude the chapter.

Introduction

During the second year of life, children typically experience a struggle for power and control, and through positive experiences with their caregivers, they internalise their caregivers' attitude towards toilet training and regain a sense of control over their bodily functions or psyche (Amsterdam, 1979). When children have early experiences of parents being overassertive or inconsistent with their responses, the battle for control may remain unresolved.

Loss of control can be a difficult experience to comprehend, even for adults. Thinking about encopretic children, this loss could either be due to medical conditions resulting in encopresis, where they experience losing control over their bodily functions, or due to other psychological factors where controlling their bowel movements offers them a sense of being in control of their psyche. When children have inadequate experiences during infancy of being able to possess and take control of their caregivers through projective identification, their desire for omnipotent control over their objects and oedipal conflicts of having an

exclusive relationship with their caregiver remain unresolved (Barrows, 1996; Goodman, 2013).

When the struggle for control remains unresolved, children may develop an ego conflict where they struggle between their desire to please themselves and their caregivers (Edgcumbe, 1978). Upon reviewing the literature, I wonder if their desire to exert complete control over their caregivers remains, and feelings of jealousy and fear of the unknown may become predominant (Barrows, 1996; Cuddy-Casey, 1997; Edgcumbe, 1978; Forth, 1992; Goodman, 2013; Lehman, 1944; Shane, 1967). Their desire for oneness and difficulty separating from their caregivers indicate a continued struggle with individuation. It appears that separation from their caregivers can result in strong feelings of rejection, loneliness, jealousy, and severe separation anxiety (Forth, 1992; Goodman, 2013; Lehman, 1944). Children may turn to the primitive pleasure of their bodily functions for self-regulation and to exert omnipotent control over their parents, through retention of faeces and relieving themselves in their underpants like infants, expressing a desire for oneness and to become a baby again (Barrows, 1996; Forth, 1992; Goodman, 2013; Lehman, 1944).

Omnipotent control, battle for control and difficulty with separation were the three subthemes identified under this theme: Control.

Omnipotent Control

Infants begin to express a desire to exert complete (omnipotent) control over the caregivers around them for sustenance. In a case study with an encopretic child, Goodman (2013) demonstrates how the child uses omnipotent control in sessions in an attempt to exert control over their internal and external world. Barrows (1996) provides a case example to indicate that a child may exert omnipotent control over their bodily functions and their faeces

due to unresolved oedipal conflicts. This made me wonder if encopresis could be a symptom of a child having inadequate experiences with an object they could control during infancy, resulting in a lack of a strong internalized object.

The case study by Smirnow and Bruhn (1984) demonstrates that when children feel uncontained, they may turn inwards for self-regulation, lose trust in others and their ability to turn to others when distressed, or develop a fear of the unknown. It seems likely that children may develop fear of loss and rejection and implement strategies to maintain proximity with their caregivers.

Children have the tendency to test the limits and strengths of boundaries in their desire to regain omnipotent control over their caregivers. When there are firm boundaries set by parents at home, where the child is given sufficient autonomy over their body and mental activity, the child develops the capacity to relinquish their desire for omnipotent control over their parents and move to a more relational way of associating with them (Amsterdam, 1979). However, consistency with boundaries is essential for children to feel contained. This posed two questions: When the limits of boundaries are pushed by children, do parents struggle with remaining consistent? Could children's exertion of their desire for omnipotent control over their parents result in a reduction in boundary setting at home?

Therapeutic Approach

The literature shows that for encopretic children, separation from parents and expression of anger when boundaries are set are common themes in the playroom. Amsterdam (1979), Barrows (1996) and Downey (2000) provided their case study to demonstrate how strong boundary setting can be a holding experience, even when the child tries to push the boundaries, especially with leaving the playroom towards the end of the

session. Firm boundaries with pre-discussed rules regarding the use of the space and their safety and time in the playroom seem essential when working with encopretic children. I wonder if the physical boundaries of the room, clear but limited rules, and pre-defined limit of the child's time in the playroom offer a containing environment for the child, and over time, this could promote self-expression. According to Forth (1992), this experience can facilitate increased tolerance and acceptance of firm boundaries and expectations from parents.

It is important to pay close attention to transference and countertransference in the playroom (Grimwade, 2009). In reviewing the literature, it seems like encopretic children express their desire for omnipotent control through dismissal or devaluing of the therapist's opinions, attempting to controlling the therapist's actions, or retaliating with defiance and anger when they are unable to exert control. The article by Goldblatt et al. (2022) indicates how essential it is for the therapist to develop strong observational skills to notice the child's projections of control or expressions of lack of control in the playroom.

This poses an important question: How can a therapist facilitate an environment that enables an encopretic child to feel sufficiently held, safe, and understood in order to express their conflicting feelings about their desire for control and closeness?

A therapist offers a secure base and builds strong rapport with the child through empathic understanding (Di Francesco & Rodriguez, 2014) and empathic connection (Goodman, 2013). Through their case study, Cuddy-Casey (1997), Forth (1992) and Shane (1967) demonstrate the importance of being non-directive and offering fewer interpretations in the playroom to help build comfort for the child to express themselves freely. The therapist needs to allow expression of control and aggression without judgement and show the child that these feelings can be tolerated by the therapist (Forth, 1992). The case study by Aruffo et

al., (2000) demonstrates that allowing children to play out their issues with control and normalizing their feelings in the playroom is essential for the child to not feel alone in their process. Reflect on their underlying fears (Cuddy-Casey, 1997) either through their play or when the child is ready, through direct reflections on their feelings. The ability to work through their need for control can increase the child's capacity to tolerate boundaries and relinquish their desire for omnipotent control over those around them and over time, over their bowel movements as well (Barrows, 1996).

Battle for Control

Retention and soiling are used by toddlers as a way to take control over their bodily and mental activities (Edgcumbe, 1978). Cuddy-Casey (1997) states that children have a drive for independence and self-direction. Considering this, two questions emerged for me: Could restricting their drive for autonomy result in children regressing towards wanting to control their bodily functions as a way of regaining control from their caregivers? Conversely, could prolonged experiences of needing to be cared for result in feelings of helplessness, self-blame, and guilt, while also desiring proximity and emotional closeness with their caregivers?

How parents respond to their child's bowel movements seems to play a vital role in the child's outlook towards their own bodily functions. Lehman (1944) and Shane (1967) illustrated through case examples how angry outbursts and tantrums towards parents or caregivers when feeling rejected were common themes when working with encopretic children. During this battle for control, I was curious if the increase in tantrums at home and resentment towards parents stems from the child's pleasure in controlling their faeces being met with withdrawal, disgust, or hostility.

Increased anxiety and fear, obsessive behaviour and a constant struggle with parents to control their environment seemed to be a common theme in Smirnow and Bruhn's (1984) case study with an encopretic child. According to Edgcumbe (1978), toddlers usually experience a conflict in their ego between their desire to please themselves and gain approval from their caregivers, and over time, they develop reaction-formation, where shame and disgust replace their pleasure for faeces. It seems likely that for an encopretic child, this developmental conflict has remained unresolved due to external stressors. Case studies by Aruffo et al., (2000), Forth (1992) and Goodman (2013) identified sado-masochistic traits of guilt and self-blame in encopretic children as a way of relating to others. This then poses the question of whether children may struggle with the conflict between the pleasure of their faeces and the shame associated with this due to inadequate superego formation.

Therapeutic Approach

I believe that a therapist's goal must be to help children gain object constancy and positive identification with their caregivers, which can help resolve any internal conflicts for encopretic children. According to Shane (1967) bowel control can only be achieved once these conflicts are resolved to some extent and children begin to progress along the developmental line.

Containment of the child's feelings in the playroom is essential to helping the child work through their conflicting feelings. Allowing space for the child to work through these conflicting feelings of love and hate towards their love object and their underlying fears facilitates movement towards the child accepting their perceived damaged parts of self (Forth, 1992).

From the literature, it seems essential to focus on the here-and-now, reflect on their feelings, and notice the transference in the room. Downey (2000) uses a case example to demonstrate how a child's need for constancy, predictability, and control comes across as sadomasochism in sessions. I believe that it is important for the therapist to tolerate the encopretic child's expressions of sadomasochism in the playroom while focusing on making meaningful contact. Reflecting on their feelings in a tolerable manner would enable the child to develop the capacity to tolerate their affect and mentalize the feelings of guilt, self-blame, and hostility, over time (Goodman, 2013). Furthermore, I believe remaining non-directive and having a non-judgmental space will allow the child to move at their own pace and express themselves in a safe manner. This could help resolve underlying fears and doubts (Cuddy-Casey, 1997).

Preparing children for breaks during sessions seems essential during therapy, as they can reactivate their fears of loss and rejection. Separation anxiety, regression, and fear of losing their love object were common fears noted by Forth (1992) for encopretic children during breaks, emphasising the importance of preparing them for breaks to help eliminate their feelings of being left out.

Difficulty with Separation

In reviewing the literature, the difficulty with separation from the parent and the struggle with functioning independently seem to be one of the possible underlying causes of encopresis. Separation-individuation usually takes place during the first two years of life, where, through positive experiences of being held and contained, an infant begins to develop a sense of self and view their caregiver as a separate individual. In most families, this is usually the age when toilet training begins, and a child gains a sense of control over their

bodily sensations and bowel movements. However, for an encopretic child, parental involvement and control regarding the child's intimate bodily functions can become very common and ongoing (Amsterdam, 1979).

Loss or feared loss of a love object (caregivers) seemed to be a common factor contributing to difficulties with separation and the onset of encopresis in the literature. Bonovitz (2003) and Lehman (1944) used case examples to demonstrate how jealousy towards the birth of a sibling and early or perceived forced separation from their caregivers were common themes identified in the playroom with encopretic children. Barrows (1996) illustrated how a young encopretic girl from a dysfunctional family demonstrated difficulty separating from her mother and played out her desire to possess objects and people around her through displays of anger and excessive control in the playroom. As I reflected on this, I began to consider if children experiencing difficulty separating from their caregivers may express a desire to become babies again to regain closeness. Could this result in a regression in their developmental age?

Therapeutic Approach

The literature suggests that it is essential for the therapist to allow space for the child to explore and work through their wishes for controlling the objects around them and their struggles with identifying as a separate entity. Using a case study, Bonovitz (2003) illustrates that mirroring the child and moving at their pace is a preverbal form of holding and expressing to the child that they are being understood, which enables a shift to a more relational space where the child can begin to develop a sense of self. Through meaningful emotional contact, the therapist offers a secure base for the child where they can feel sufficiently contained and safe to explore the unknown parts of their mind and work through

their anxieties related to this at their own pace (Goodman, 2013). Downey's (2000) case study demonstrates that the therapist's ability to tolerate the child's projections and reflect on their feelings in the here-and-now interactions with the therapist shows the child that their messes can be tolerated by the therapist, which can promote self-expression. Reflecting on this, I was curious if this allows room for the child to test the strengths and boundaries of the therapeutic relationship, which could in turn facilitate the development of trust in familial relationships and object constancy.

Parents' ability to relinquish control over the child's intimate bodily functioning enables separation and individuation between parent and child (Amsterdam, 1979). Barrows (1996) suggests that seeing the parents and therapist work together to support the child could establish the presence of a strong parental couple in the child's internal world and help the child relinquish their desire for oneness and control. In reviewing the literature, it seems essential for the therapist, wherever possible, to work closely with the parents to help them be responsive towards their child while gently encouraging their child to take responsibility for their own bowel movements. These experiences of being understood and encouraged by the parents could promote self-observation and autonomy, where the child can begin to read their own bodily signals.

Summary

This chapter began with the introduction of the first theme of the dissertation findings – *control*, followed by the discussion of the subthemes – *omnipotent control, battle for control,* and *difficulty with separation.* The therapeutic approaches I identified in the literature for each subtheme on how psychotherapy benefits encopretic children were outlined.

Chapter 4 – Denial

Overview

The second theme I identified in the dissertation findings was *denial*. In the chapter, I will be introducing and discussing the theme, subthemes, and therapeutic approaches identified in the literature, followed by a brief summary of the chapter.

Introduction

Children begin to develop a sense of self and a desire to succeed around the same age as toilet training, between the ages of 24-36 months. Shane (1967) suggests that children may use denial as a defense mechanism to avoid coping with the shame experienced due to encopresis. Children may also use denial to avoid accepting that they have encopresis (Aruffo et al., 2000; Goodman, 2013; Lehman, 1944). Children are likely to withdraw from their environment and deny their own emotional needs following the onset of encopretic symptoms (Barrows, 1996; Cuddy-Casey, 1997; Di Francesco & Rodriguez, 2014; Forth, 1992; Goldblatt et al., 2022; Smirnow & Bruhn, 1984). Perhaps encopresis is perceived by children as a failure, and given the developmental age of the child, they may also experience shame due to accidents or the smell.

The literature suggests that displays of anger and aggression in the playroom were common among children with encopresis (Amsterdam, 1979; Cuddy-Casey, 1997; Di Francesco & Rodriguez, 2014; Downey, 2000; Edgcumbe, 1978; Forth, 1992; Grimwade, 2009; Shane, 1967). I began to consider whether anger may come about as a result of the children attempting to mask and externalize the effects of painful emotions on their psyche. The case studies by Goldblatt et al. (2022) and Lehman (1944) indicate that children may

respond with disruptive behaviours like yelling, kicking, and physical violence when they feel helpless or cornered.

Lower self-esteem is highly likely when children withdraw from the environment and reject aspects of themselves. The case studies by Cuddy-Casey (1997), Goldblatt et al. (2022), Grimwade (2009), Forth (1992), Edgcumbe (1978), Lehman (1944), Shane (1967) and Smirnow and Bruhn (1984) noted that encopretic children had underlying fears of being left out or hated by those around them. With the underlying assumption that children are social beings who desire relational experiences, I wonder if the lack of emotional closeness with others due to withdrawal from their environment could increase feelings of loneliness and fear of being left behind or ignored for encopretic children.

In the next section, I will aim to provide an overview of the two subthemes identified in the literature under the theme, denial, are – *anger and self-esteem.*

Anger

In my literature review, I found that fear often tended to be an underlying feeling behind anger. Barrows (1996) also noted that encopretic children fear the unknown. Using a case study, Forth (1992) explains how children with encopresis may unconsciously use denial as a defense mechanism and anger to help mask this fear from being recognised by others around them. They may use angry projections towards their parents or others around them when faced with uncertainty and feeling uncontained (Downey, 2000; Edgcumbe, 1978). Some researchers noted that encopretic children demonstrate feelings of loneliness in the playroom (Cuddy-Casey, 1997; Goldblatt et al., 2022; Grimwade, 2009). As I reflected on this, I considered whether avoidance of these feelings may result in children feeling alone and withdrawing from those around them.

In reviewing the literature, it seems likely that children are either conscious of their anger or have repressed feelings of anger, both of which can be a difficult experience for them. When young infants feel overwhelmed, defecating can be seen as their attempt at expelling these feelings out of their system or an involuntary spilling out of these feelings when feeling uncontained. Aruffo et al., (2000) state that encopretic symptoms are involuntary, and treating the underlying symptoms of anger is essential, as many encopretic children tend to exhibit anger and self-punitive behaviour in the playroom. Amsterdam (1979) and Goodman (2013) illustrate using case examples how faecal incontinence may be a result of uncontained anger, and addressing this anger can help the child process their underlying feelings, promote self-expression, and reduce the encopretic symptoms.

Therapeutic Approach

In order to address the underlying fears behind the anger, it seems essential for a psychotherapist to allow space for aggression to be expressed and worked through in the playroom without judgement. However, it is also important to understand that when working with encopretic children, there may be strong projections of anger and primitive rage towards the therapist (Barrows, 1996). Downey (2000) emphasises on the importance of tolerating and interpreting these projections, as this shows the encopretic child that their messy feelings can be tolerated by the therapist. I wonder if this promotes self-expression and trust in the therapeutic relationship. Could this experience enable the child to express their feelings without fear of being judged or rejected and to feel contained in the playroom?

The literature identified that children use denial as a defense mechanism to cope with overwhelming feelings like fear and rejection. When they begin to express these feelings in the playroom, the therapist needs to stay attuned to the child's needs and move at their pace

(Bonovitz, 2003). Through reflection, empathy, and emotional contact, the therapist demonstrates their ability to understand and psychologically and emotionally hold all parts of the child (Goodman, 2013). According to Goldblatt et al. (2022) and Shane (1967), the therapist must offer less of their interpretations during sessions and focus on noticing the transference experienced and offering reflections in the here-and-now within the therapeutic relationship.

The literature revealed that moving at the child's pace allows the child to express themselves freely and work through their distressing feelings, which is crucial in the therapeutic process. Rather than offering interpretations, it seems important for the therapist to mirror the child and maintain emotional contact with them to gently challenge defensive patterns and promote good affect regulation. In my own practice, I have seen the value in working within the therapeutic relationship and moving alongside the child at their own pace to promote a child's self-expression and capacity for reflection.

Self-esteem

Goodman (2013) suggests that encopretic children may use the pleasure derived from their bowel movements as a way of avoiding painful affects, like their experiences of feeling vulnerable and ashamed due to (perceived/real) rejection. Aruffo et al., (2000) state that encopretic children may use the autoerotic pleasures of bowel movements as a way to externally regulate their self-esteem to combat their feelings of self-blame, loneliness, and isolation. I wonder if children may use the pleasure derived from their bowel movements as a form of self-regulation. Could this be a form of denial where the child focuses on the pleasure of faecal movements as a way of distracting them from their painful affects?

Cuddy-Casey (1997) and Di Francesco and Rodriguez (2014) noted themes of low self-esteem in the playroom in their case study with encopretic children. It seems evident from the literature that when children use defense mechanisms like denial to reject their feelings, they may become vulnerable and feel shameful towards themselves. I was curious if rejecting and minimising their own feelings and thoughts affect a child's self-esteem. In a case study with an encopretic child, Goldblatt et al. (2022) noted self-demanding behaviour with themes of exhaustion, withdrawal, and self-criticism. Forth (1992) uses a case study to demonstrate that children who use denial to cope with powerful and frightening feeling may be left with feelings of isolation, loss and guilt, and have reduced self-esteem.

Forth (1992), Downey (2000) and Goodman (2013) noted themes of sadomasochism in sessions with encopretic children. Smirnow and Bruhn (1984) noted themes of violent thoughts and dreams and aggressive impulses, with underlying feelings of fear, helplessness, and guilt, in their case study with an encopretic child. Could it be possible that encopretic children feel ashamed of their own emotional responses and humiliated by others' responses to them? As I sought to understand the subjective experiences of encopretic children, I began to consider if these experiences may lead to self-blaming or self-punitive behaviour, resulting in feelings of reduced self-worth. Shane (1967) suggests that children may resort to aggression towards themselves when they experience shame and denial as a way of avoiding conversations regarding their encopresis.

Therapeutic Approach

Aruffo et al., (2000) state that the therapist must have the skills to truly listen and communicate with an encopretic child about their inner world and understand that the child will express themselves in their own time when they feel safe doing so. Focusing on the here-

and-now feelings expressed in the playroom and remaining non-directive allows the child to express themselves safely and resolve underlying fears and doubts, which can increase their self-esteem (Cuddy-Casey, 1997). A therapist's ability to acknowledge and normalise feelings underlying an encopretic child's feelings of shame, guilt and loneliness seems crucial in minimising the child's self-blame and anger towards themselves.

A child psychotherapist needs to offer containment and safety for open expression, notice the transference in the playroom, and reflect on or name the feelings noticed. According to Downey (2000) the therapist needs to move alongside the child in their transference play and remain a helpful companion while they work towards making sense of and resolving their underlying painful feelings. The literature indicates that the therapist must pay close attention to transference and countertransference in the playroom and reflect on these when appropriate (Goodman, 2013; Grimwade, 2009; Lehman, 1944). When the child demonstrates reduced aggression and increased capacity to tolerate their feelings, reflecting on the countertransference felt in the playroom can promote the child's exploration of underlying feelings of fear and hurt and acceptance of all parts of themselves, including the ones they perceive as damaged (Forth, 1992). I wonder if accepting damaged parts of oneself and working through painful feelings helps the encopretic child develop a stronger sense of self and autonomy. Could this help reduce their denial of encopresis and work towards understanding and resolving their encopretic symptoms?

Summary

I provided an overview of the theme – *denial* in this chapter. This was followed by an introduction to the two subthemes –*anger and self-esteem*. I explored the therapeutic

techniques used for encopretic children in the literature to gain an understanding of how psychotherapy can benefit them.

Chapter 5 – Disruptions in Attachment

Overview

The third theme identified in the literature, *disruptions in attachment*, will be discussed in this chapter. The chapter begins with an introduction to this theme, followed by an overview of the subthemes identified. Some of the psychotherapeutic approaches revealed in the literature focusing on resolving disruptions in the parent-child relationship for encopretic children will be discussed. This will be followed by a brief summary of the chapter.

Introduction

From my own experience and understanding, helping children achieve bowel and bladder control seems to be considered an essential part of parenting and children's development for families across multiple cultures. I wonder if situations where this has not been possible or there has been a regression in this development can cause a strain in the family dynamics. Could encopresis result in disruptions in the parent-child relationship? The literature revealed that parents of encopretic children may withdraw from their children, express disgust towards bowel movements, become extremely critical and controlling, and/or develop unrealistic cleanliness and behavioural expectations incongruent with their children's developmental age (Amsterdam, 1979; Aruffo et al., 2000; Di Francesco & Rodriguez, 2014; Goodman, 2013; Grimwade, 2009; Smirnow & Bruhn, 1984).

In my attempt to understand the trauma caused by disruptions in attachment for children with encopresis, the literature revealed that children may develop defense mechanisms like denial (Amsterdam, 1979; Aruffo et al., 2000; Barrows, 1996; Di Francesco

& Rodriguez, 2014; Forth, 1992; Goodman, 2013; Shane, 1967), regression (Edgcumbe, 1978; Lehman, 1944; Shane, 1967) or sublimation (Downey, 2000) to cope with this traumatic separation and help maintain some form of relationship with their caregivers. Encopretic children may experience these disruptions in attachment as rejection and a potential loss of their love object (Aruffo et al., 2000; Bonovitz, 2003; Edgcumbe, 1978; Forth, 1992; Goodman, 2013; Lehman, 1944)**.** They may experience difficulties with separating from their caregivers and/or develop guilt and negative attention-seeking behaviour (Amsterdam, 1979; Aruffo et al., 2000; Barrows, 1996; Bonovitz, 2003; Edgcumbe, 1978; Forth, 1992; Goodman, 2013; Grimwade, 2009; Lehman, 1944; Shane, 1967; Smirnow & Bruhn, 1984).

However, it is essential to keep in mind that attachment disruptions can also occur due to situations out of the parents'/caregivers' control, like inconsistent early attachment experiences due to medical interventions, maternal post-natal depression, parental separation, or the loss of a parent. In a case study, Downey (2000) explains working with a five-and-a-half-year-old encopretic girl who had difficulties with attachment due to early experiences of inconsistent caregiving at an orphanage prior to her adoption.

In reviewing the literature, I identified two subthemes under the theme: disruptions in attachment - *insecure attachment* and *parental responses.*

Insecure Attachment

Edgcumbe (1978) states that early experiences of how parents respond to their child's bowel movements influence their outlook towards this and suggests that encopresis could be a form of regression due to preexisting vulnerabilities in early relationships. Looking further into encopretic children with medical causes, I found there to be multiple disruptions in early

attachment relationships due to hospitalization or disruptive medical procedures at home. The literature highlighted inconsistencies in early attachment experiences and insecure attachment styles as predisposing factors for encopretic children with functional causes.

Aruffo et al., (2000) compare bowel movements to autoerotic pleasures similar to thumb-sucking during infancy. Edgcumbe (1978) suggests that children turn to these pleasures as a form of replacement for people when they feel unloved or have emotionally distant caregivers. “Focusing on the pleasure derived from one’s own bodily products simultaneously distracts the child from painful affects and obviates the need to rely on the parents to deactivate the attachment system” (Goodman, 2013, p. 441). In reviewing the case studies discussed in the literature, I wonder if encopretic children may develop an avoidant style of attachment and turn inwards for affect regulation and containment.

Therapeutic Approach

Barrows (1996) acknowledges the value of working closely with parents whenever possible, given the difficulty in coping with and complexities of encopretic symptoms, and to help mitigate the risk of early termination from therapy. It seems essential for a child psychotherapist to work closely with parents to help mentalize their child and promote a more secure and trusting environment for them.

The literature revealed that having a trusting and secure therapeutic relationship with the child and family is essential for treatment. Lehman (1944) highlights that a therapist works closely with parents and children to repair the rupture in the parent-child relationship by allowing space for the parents to freely express themselves and offering interpretations and reflections to help them realise how their responses affect their child. I wonder if this helps the parents feel comfortable in sharing their emotional needs with the therapist and

work through their difficulties, enabling them to be present for their child and support their child's needs. It seems important for a therapist to not only allow space for the parents or caregivers to express their frustrations towards the child's symptoms but to also help them become conscious of their child's wishes and their love for their child (Lehman, 1944).

In reviewing the literature, I have gained the understanding that the therapist's ability to offer a secure base, and consistent and non-judgemental responses could help an encopretic child feel more contained. An environment where a child feels safe and unjudged to express their feelings around their encopresis can offer them a sense of relief and make them feel understood, which can help improve their self-confidence and their familial attachments (Aruffo et al., 2000). Creating a secure base in the therapeutic relationship and providing consistent responses to the child can reduce the child's anxiety, increase impulse control, and promote object constancy (Shane, 1967).

Parental Responses

From my understanding, encopresis can be a distressing experience for the child as well as their caregivers, mainly those supporting the child with care and clean-up. Grimwade (2009), Lehman (1944), and Smirnow and Bruhn (1984) acknowledge the difficulty faced by parents with an encopretic child while highlighting how parents' frustration towards the encopresis can result in hostility, excessive criticism, and withdrawal from their child. Most of the literature identified parental anger, disgust towards defecation and smell, blame, and/or punitive responses towards their encopretic child.

The literature revealed negative parental attitudes towards their child, harsh parental punishments, and excessive control over their child's bodily functions to be common themes for encopretic children. Aruffo et al., (2000) noted that dysfunctional family interactions and

the withdrawal of parents from their children seemed common for children with encopresis. Di Francesco and Rodriguez (2014) from a case study, demonstrated the persistence of encopretic symptoms in a 14-year-old boy in a residential home due to the lack of familial support and a history of neglect and excessive criticism from parents. Using a case study, Shane (1967) illustrates that these experiences can rupture family dynamics and hinder a child's development. I wonder if encopretic children's experiences of loneliness and isolation may also be a result of ruptures in familial attachments. Could improving the parent-child relationship help in reducing encopretic symptoms or with the child and family accepting the medical condition?

Therapeutic Approach

Amsterdam (1979) suggests that a shift in parental responses enables the child to feel more in control of their bodily functions, increases their self-worth, and improves the parent-child relationship. Bonovitz (2003), Forth (1992) and Goldblatt et al. (2022) emphasise the importance of working with parents to promote a shift in their attitude towards their encopretic child, as their responses to their child influence the onset or persistence of encopretic symptoms. Using a case example, Shane (1967) demonstrates the value of a therapist working closely with the parents and child to help rebuild a healthy attachment style between them. This reduces hostile and critical interactions and promotes empathetic, consistent, and reliable responses towards their children (Amsterdam, 1979). In offering a safe space for parents to freely express themselves and work towards understanding their child more, I wonder if the parents' attitude towards their child can shift from being overly critical to more consistent and encouraging.

By helping build a healthy relationship between the parent and child by working closely with parents and offering the child a non-directive space to freely express themselves and containing their feelings without withdrawing from them, the child begins to progress along the developmental phase (Shane, 1967). Bonovitz (2003) states that psychoanalytic psychotherapy involves making emotional contact and exploring their inner world, and a psychotherapist must work within the therapeutic relationship to help the child form new ways of relating to others. This led me to consider whether progress in therapy takes place from the child's experiences of the therapist's reactions and responses and the child's introjection of these experiences.

Summary

In this chapter, I provided an overview of the third theme, *disruptions in attachment*, along with my understanding of the two subthemes – *insecure attachment* and *parental responses*. An outline of the therapeutic approaches used with children and families in addressing each of the subthemes revealed in the literature was detailed to demonstrate how psychotherapy can benefit encopretic children with disruptions in familial attachments.

Chapter 6 – Discussion

Overview

In this chapter, I will provide a brief summary of my findings from the research, including implications for psychotherapy practice and areas of further psychotherapeutic research. Furthermore, I will be discussing the strengths and limitations of the research, followed by a brief conclusion.

Discussion

When I set out to do this research, I endeavoured to do a study that could offer child psychotherapists a paper that outlined how they could work with encopretic children. I wanted my themes to only focus on therapeutic approaches that would aid child psychotherapists. As I went through the literature search and review process and immersed myself in the literature, as detailed in Chapter 2, my position evolved. I remembered that as a child psychotherapist, our goal is to understand the internal world of our clients (Teyber & Teyber, 2017, p. 28) and we utilise the framework offered by psychoanalytic/psychodynamic theory to do so (McWilliams, 2011, p. 21). Hence, I focused my research findings, in Chapters 3, 4, and 5, on the themes I identified in the literature that highlighted the underlying internal distresses experienced by children with encopresis and their caregivers, and how a psychotherapist works with them to address these needs.

In reviewing the literature, I found that children with encopresis showed strong themes of denial, desire for control and difficulties with attachment, and the subthemes noted under denial were *anger and self-esteem*, control were *omnipotent control, battle for control and difficulty with separation*, and disruptions with attachment were *insecure attachment and*

parental responses. Additionally, the literature indicated that traumatic experiences such as abuse or neglect resulting in attachment disruptions, and/or children holding on to anger or denial as coping mechanisms, can also manifest as encopresis, possibly as a result of regression and children's unconscious attempts to regain control (Bonovitz, 2003; Di Francesco & Rodriguez, 2014; Shane, 1967; Smirnow & Bruhn, 1984). Psychotherapists need to help encopretic children work through their underlying distresses and gain object constancy (Barrows, 1996; Bonovitz, 2003; Downey, 2000; Forth, 1992; Shane, 1967). In doing so, children may feel less isolated, anxious, and/or fearful, gain trust in their caregivers and others around them, and develop a strong sense of self. Some of the therapeutic approaches identified in the literature that spanned across all the themes were allowing space for the child, remaining non-directive, staying attuned and noticing the transference and countertransference in sessions, and working closely with family to care for the child and in helping them mentalise the child's needs. The literature indicates that addressing encopretic children's needs and allowing space for them to work through their distressing feelings has been effective in reducing encopretic symptoms and helping them regain bowel control. In reflecting on this, I wondered how this approach would benefit encopretic children with medical causes, where children cannot gain control over their bowel movements.

There were a range of psychoanalytic theories identified in the literature that were used as a baseline for understanding the internal world of encopretic children and offers insight for child psychotherapists on how to support them in the playroom. Some of the theories used across the literature were Melanie Klein's separation-individuation and projective identification, Sigmund Freud's autoeroticism and Oedipal Complex, John Bowlby's attachment theory, and Donald Winnicott's object relations. Difficulties in separation-individuation may increase a child's emotional distress and could result in controlling behaviour and projection of their distress onto their bodily functions leading to

encopresis, retention, and soiling (Amsterdam, 1979; Smirnow & Bruhn, 1984). Barrows (1996) suggests that encopretic children experiencing difficulties with separation may unconsciously turn to projective identification to assert their desire for control and need for sameness with their caregivers. Additionally, encopretic symptoms can also be viewed as a physical manifestation of the complexity of feelings experienced by children due to unresolved oedipal conflicts, where the soiling may occur due to regression and their desire to stay in relationship with and retain close proximity with their caregivers (Forth, 1992; Goldblatt et al., 2022). Viewed through the lenses of object relations and attachment theory, intrapsychic conflicts and disruptions in early attachment experiences may limit a child's ability to regulate their emotions. In such cases, they may associate faeces with rejected aspects or parts of self, resulting in encopresis or soiling incidents (Bonovitz, 2003; Downey, 2000; Goodman, 2013; Grimwade, 2009; Lehman, 1944; Shane, 1967). Furthermore, for children experiencing emotional distress, autoeroticism could become a coping mechanism where they may turn to the pleasures derived from their bodily functions for self-regulation, potentially resulting in encopresis (Aruffo et al., 2000; Edgcumbe, 1978).

When I originally started working on this research, I wanted to focus on children with encopresis with both medical and functional causes, as defined in Chapter 1. As I started doing my literature search process, I noticed that the majority of the literature identified in the search on psychotherapy for encopretic children focused on encopresis with functional causes. Many of the literature on psychological interventions for encopresis with medical causes seem focused on symptom management at home rather than the underlying distresses faced by children (Garman & Ficca, 2011; Reid & Bahar, 2006). This made me curious about why there was limited psychotherapeutic research focusing on supporting the emotional needs of encopretic children with medical causes. I wonder if there is an assumption that psychological intervention for encopretic children is only required when the symptoms are

functional or when children do not adhere to the medical plan for toileting and symptom management when the encopresis is due to medical causes. This made me consider the following question: Could psychotherapy, alongside the medical interventions and toileting plans offered by medical professionals, offer them a space to express their needs, come to terms with their medical condition, and help them regain a sense of control over their bodily functions?

Some of the literature demonstrated the effectiveness of a family-based approach and dyadic work with children and parents for encopresis (Amsterdam, 1979; Bonovitz, 2003; Grimwade, 2009). Even literature that mainly focused on individual psychotherapy for encopretic children, as detailed in Chapter 5, strongly suggested the importance and value in working closely with parents or caregivers (Aruffo et al., 2000; Barrows, 1996; Edgcumbe, 1978; Forth, 1992; Goldblatt et al., 2022; Lehman, 1944; Shane, 1967; Smirnow & Bruhn, 1984). As I reflected on this, I became curious about whether working with encopretic children also includes working with the system around them, with their caregivers or parents. This posed the following questions for future research: Could family based psychotherapeutic intervention be a more appropriate approach for children with encopresis? Or would individual psychotherapy with the psychotherapist working closely with caregivers or parents be as effective?

Clinical Implications

The findings from this research can be used as a foundation for understanding some of the challenges faced by encopretic children and their families and how psychotherapy can best support them. This research can offer support for trainee child psychotherapists and child psychotherapists in understanding the value of using the various psychotherapeutic

approaches highlighted in the findings to support the psychological needs of encopretic children. The psychoanalytic and psychodynamic theories identified in the literature, as noted in the previous section, can offer a baseline for child psychotherapists to help understand an encopretic child's internal world.

The research provides other clinicians, like general practitioners and medical specialists, with an understanding of how psychotherapists work and how psychotherapeutic interventions can support encopretic children. This research could help provide them with further insight on whether psychotherapy can benefit their encopretic patients while making referrals on their behalf for psychological support. The research findings could also help families of encopretic children understand what may be going on in their child's internal world and how psychotherapy could benefit their child.

As I conducted the search for literature, I noticed that there was no New Zealand-based research regarding psychotherapy for children with encopresis. I realised that my research paper would be the first Aotearoa (New Zealand) study on psychotherapy for encopresis. This research opens up avenues for further psychotherapeutic research around encopresis in Aotearoa (New Zealand) and adds to the existing body of psychotherapeutic literature.

Areas of Further Research

The findings in Chapter 5 indicated that working with encopretic children's families can be vital in supporting the child's emotional needs. Further research is required to understand if dyadic or family work is more effective for encopretic children than working with parents alongside individual psychotherapy for the child. Barrows (1996) suggested that working with parents of pre-latency encopretic children could be more effective. Further

research is required to understand the differences in therapeutic approaches for encopretic children of different age groups.

As there is no New Zealand-based research on psychotherapy for encopretic children, it would be helpful for future research to explore and understand how psychotherapeutic approaches can integrate cultural aspects pertinent to Aotearoa (New Zealand). Given the increase in the number of child psychotherapists working in the Te Whatu Ora (District Health Board, DHB), further empirical research can also be conducted to develop a better understanding of the effectiveness of current psychotherapeutic approaches used by child psychotherapists with encopretic children.

Many of the existing psychotherapeutic literature are based on working with encopretic children with functional symptoms. I wonder if psychotherapy is used more to reduce functional encopretic symptoms than to address the challenges and emotional distresses faced by them, regardless of the causes leading to encopresis. Given that Aotearoa (New Zealand) is transitioning to incorporate a more holistic approach into health care and the increase in the number of child psychotherapists working in the DHB, it would be beneficial to further explore how psychotherapy can effectively support the emotional needs of encopretic children with medical causes.

Strengths and Limitations

Using hermeneutic phenomenology and doing a hermeneutic literature review facilitated my understanding of the subjective experiences of children with encopresis through reflectively exploring what may be going on for them internally and how a child psychotherapist can support their needs in the playroom. Using this method also facilitated

reflective exploration of the different therapeutic approaches used across the literature as well as the benefits of these approaches for an encopretic child.

Even though all the articles chosen had case examples by the authors, given the nature of hermeneutic methodology and the personal nature of interpretation of the literature, it would be difficult to replicate this research. However, this research provides a baseline for further empirical research to understand the effectiveness of psychotherapy for encopretic children. Given the size of the dissertation, I needed to limit the information provided in the findings to the key themes identified in my interpretation of the literature. Some of the other themes or concepts identified may have contributed to further insight into the research question, which was beyond the scope of this study.

Even though my research initially included literature related to encopresis with both medical and functional causes, as detailed in the discussion, the literature search indicated that all the articles were focused on encopresis with functional causes. Hence, even though the research findings indicate how to work with the underlying emotional distress of children with encopresis, they do not offer much insight on whether psychotherapy can benefit encopretic children with medical causes. Further research would be helpful to understand whether psychotherapy can benefit encopretic children with medical causes alongside medical interventions.

Conclusion

I was drawn to this research because of my own experience of struggling to find a research paper that clearly outlined how child psychotherapists work with encopretic children. The research question was based on my preliminary research and my desire to get a better understanding of the effectiveness of psychotherapy in supporting encopretic children.

The methodology and method used helped address the research question: *How can psychotherapy benefit children with encopresis?* The structure of the research findings helped me develop a better understanding of some of the underlying distresses experienced by encopretic children and how I could effectively work towards addressing their emotional needs. The study can offer the same for trainee psychotherapists and other child psychotherapists working with children with this medical condition.

A hermeneutic literature review was an appropriate approach to answer my research question and to better understand why psychotherapists use specific therapeutic approaches with encopretic children. As I continued reading and reflected on the role of a psychotherapist, my position evolved. Using hermeneutic phenomenology as my methodology aided in this exploration. The epistemology of hermeneutics is to seek to understand the meaning of lived experiences for an individual and, through interpretation, offer an understanding of how these experiences contribute to their way of engaging with the world. As I went through the research process of exploring and interpreting the literature, more questions came up for me, as detailed in the findings and discussion chapters, and my position evolved from remaining focused on the therapeutic approaches to better understanding an encopretic child's inner world. I realised the value of exploring the subjective experiences of encopretic children while considering the therapeutic approaches used in the literature to benefit them in working through their distressing feelings. Contemplating the need for working closely with parents/caregivers and the child led me to wonder whether an approach centred around the dyad or family would be more effective while working with encopretic children or if individual psychotherapy with the child alongside parent/caregiver sessions would be equally beneficial. Future research would be advantageous to understand this further.

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