Heterogeneity of Diaper Dependency in Three to Six Year-old Children: Implications for Management

Key words: toilet training; encopresis; diapers

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ABSTRACT

A retrospective review of 395 charts of children referred for pediatric gastroenterologic evaluation of fecal soiling and other toileting difficulties revealed that thirty (8%) of this series were children between 3 and 6 years of age who persisted in the use of diapers for urination and/or defecation. They could be categorized as those with *permitted diaper dependency*, whose parents were vague regarding use of the toilet and in their expectations for progress towards that goal, and those with *contentious diaper dependency*, whose parents' expectations and demands were abundantly clear, but met with stubborn resistance. Children with permitted diaper dependency are helped by clarification of the goals of age-appropriate toileting and strengthened demands for using the toilet instead of diapers. By contrast, increased pressure to give up diapers in children with contentious diaper dependency exacerbates parent-child conflict and may impede progress towards more mature toileting.

INTRODUCTION

Toileting skills are acquired by two simultaneous processes: *toilet training*, i.e. what parents do to help their children towards socially-appropriate, self-sufficient toileting; and *toilet learning*, i.e. what children think and do while learning the mores of eliminative behavior, how to recognize sensory signals, and how to control anal and urethral sphincters when choosing whether or not to void.[1,2] The age at which children acquire "readiness skills" (e.g., showing interest in using the potty, indicating a need to void) ranges between 24 and 29 months, although some may not be fully ready until their 4th or 5th year.[3] This interactive learning process often entails children's negative and oppositional responses to parents' limits and requests.[4-6] Failure to make the expected progress from diapers to underwear becomes a clinical problem when parents develop concerns about the possibility of an organic etiology for prolonged use of diapers and the stress it causes in their relationship with their child.

METHODS

The author is a pediatric gastroenterologist trained in the biopsychosocial model of practice.[7,8] The time allotted for each consultation was 2 to 3 hours, during which the History of Present Illness and other elements of the medical interview (including psychosocial and developmental data) were elicited in a manner that fostered rapport

and the development of working relationships with the parents and the child.[9, 10] The consultations began with greetings and getting acquainted. Then the child was invited to go back into the waiting room where he or she was entertained by a relative so as not to be exposed to discussions of adult-level concerns. The clinical interviews included many open-ended questions and freedom for the participants to pursue associations to the historical data [9]. At the end of the visit, just prior to their departure, the physician had a private chat with the child [11] to demonstrate respect, empathic understanding and to enlist him or her as a responsible participant in the ongoing process of recovery . [12]

Three hundred ninety five charts of patients referred for fecal soiling or other toileting difficulties between 1980 and 1991 were reviewed retrospectively. Thirty (8%) were between 3-1/12 and 6-2/12 years of age who were referred because of persistent use of diapers or pull-ups and failure to use the potty or toilet in a manner considered age-appropriate by their parents.

RESULTS

The children could be categorized into two main groups: The first group, those with *permitted diaper dependency*, was comprised of 3 boys and 2 girls. Three defecated and urinated in diapers, one defecated but did not urinate in diapers and for one, data were insufficient to determine the frequency at which diapers were used for urination as compared with defecation. Characteristically, their parents were, on some level, accepting of immature toileting behavior and as a result, the children were confused as to what their parents and others expected of them. There was comparatively little conflict between

these parents and their children regarding immature toileting, although they were concerned enough to seek a medical consultation.

The second group, those with *contentious diaper dependency*, was comprised of twenty-five children, ten with features of early functional fecal retention syndrome [13] (6 boys and 4 girls) and fifteen with no features of that disorder (13 boys and 2 girls). Twenty of these 25 children wore underwear, used the toilet well for urination, but insisted on wearing a diaper for defecation.. They were clear about what was expected of them because their parents had been emphatic about the unacceptability of soiling and use of diapers or pull-ups. Their inability to give up the use of diapers had created alarming conflict between them and their parents.

Permitted diaper dependency

CASE 1 A 3-6/12 year-old boy began toilet training at 24 months. He was given a potty and complied with requests that he sit on it, but he never passed stool or urine into it. One month later, his parents adopted a three-day old infant. Whenever his mother attempted to talk with him about his refusal to use the potty, "he changed the subject." He nevertheless put his doll on the potty. He had been put into underwear at 3-2/12 years but continued to urinate and defecate into them, so his parents reverted to putting him into diapers. "We don't try to force him. When I tell him I have to change him because I can't bear the smell anymore, he tells me, 'I don't want to change, Mom!'" He was the only child in his nursery school class who wore diapers. His teachers changed him and didn't seem to mind. "They say I am over-reacting and that it was ridiculous for me to take him to a doctor for this. Everyone says he is a perfect child, except for this one

thing… When my husband tells him to use the potty, he says he should, but he doesn't want to. We haven't exploded at him. It's just not in our nature… My husband's family are screamers, so he's not willing to be loud with him." Physical examination showed a healthy-appearing, articulate boy who hastened to assure me that he “goes” in his potty. He wore a wet diaper. The perianal skin was erythematous, but not soiled. The remainder of the examination was negative. I discussed the importance of making it clear to her child that eliminating into diapers is offensive and that everyone expects children to use the toilet. I recommended that they get rid of diapers and offer him attractive underwear. I explained to his nursery school teacher that their kindly acceptance of his diaper dependency obscured the goal necessary for toilet learning and recommended that they require him to wear underwear and make clear that soiling was not acceptable because it was offensive. Six weeks later, the patient wore underwear at school and at home and used the toilet for urination. He still insisted on wearing a diaper at night and continued to defecate into it while in bed.

CASE 2 A 3-6/12 year old girl was given a potty seat at 2-6/12 years of age. She sat on it, but never passed urine or stool into it. She entered nursery school at 2-9/12, separated from her mother easily and enjoyed school from the start. At three years, her mother asked that she tell when she had to void and told her to wear panties instead of diapers. However, she continued to ask for diapers or pull-ups and her mother continued to comply. Her brother was born after an easy pregnancy when the patient was 3-3/12 years old. At the time of the consultation, the patient's manner of voiding was as follows: she announced to her mother, "I want to pee-pee." Her mother removed the diaper, the child

sat on the potty, but passed no urine. She then got off, wiped herself, washed her hands, got her diaper or pull-up on, and urinated into it shortly thereafter. Her stools were soft and passed without discomfort into diapers. Her mother and nursery school teacher avoided pressuring her in any way towards more age-appropriate toileting. Physical examination was entirely negative. The parents were advised to make it clear, in a non-punitive, but firm tone, that excrement passed anywhere other than in the potty is offensive. Her mother and teacher were asked to advise the patient of the very real risk of embarrassment should her soilage be discovered by her classmates. I suggested that she be allowed to wear diapers, if necessary, or underwear, but not pull-ups, because pull-ups are underwear-like in form and application, but diaper-like in function. Pull-ups in this case, blurred the distinction between baby-like versus age-appropriate underclothing. Follow-up six weeks later revealed that the patient had begun wearing underwear during the day and used the toilet for urination. She still put on a diaper at bedtime and defecated while it was on.

CASE 3 A 5-9/12 year-old boy had never used the toilet on his own initiative and continued to urinate and defecate into pull-ups. He was born prematurely weighing 1847g. He suffered necrotizing enterocolitis and underwent five abdominal surgeries during the 2-1/2 months he was in a Neonatal Intensive Care Unit. During his second year, he had repeated middle ear infections and Stevens-Johnson syndrome. Toilet training was begun at 18 months, but he didn't seem interested and further efforts were suspended. At 2-6/12 years of age, he urinated into the toilet prior to his bath at the request of his parents. As he sat on the toilet, his older brother went up to him and said,

"Just go poo!" "It's broken," the patient replied. He continued urinating and stooling into diapers and occasionally stooled on the toilet at his mother's request, provided she accompanied him. Otherwise, she did not insist that he use the toilet. If she noticed a malodor, she didn't mention it, hoping that he would ask to be changed. He never seemed bothered by his soilage, so she continued to change his diaper after every bowel movement. The patient entered pre-school at 4-10/12 years of age. His parent's warned him beforehand that soiling would not be acceptable there, but he didn't seem to care. It turned out that his teachers were "very understanding" and quite willing to change his soiled pull-ups. They told his mother not to express displeasure at his infantile eliminative behavior. His mother had never been sure that there wasn't a "medical reason" for it. When I asked the mother what it was that concerned her most about her son, she said, "We were told throughout the pregnancy that he could have deformities… I felt that it was my fault as a mother… I probably do dwell on the surgeries of the past." Physical examination showed a verbally articulate boy with a well-healed incision on his upper abdomen, mild perianal erythema and no other abnormalities. I began by saying that, not withstanding his series of intestinal catastrophes as a newborn, his GI function was now normal and that there was no organic cause for his diaper dependency. I recommended that they tell him that he was the boss of his own eliminative functions and that they stop reminding him because it made them responsible for getting him to use the toilet. At the same time, the parents were to make it clear that soiling is offensive. They were to place non-punitive, but firm limits that would prevent him from imposing his soilage on others' awareness. The use of pull-ups would cease. Instead, "big-boy" underwear was to be worn day and night, at home and at school. They were to expect

him to do for himself with age-appropriate self-sufficiency, as though he were a perfectly healthy, intelligent five year-old - which indeed he was! Within two months of the consultation, the patient no longer soiled or wore pull-ups. He used the toilet appropriately. "I toughened-up," his mother said. "If he made a mess, I told him to clean it up… I learned that I could do a lot less for him and still be a good mother."

CASE 4 A 4-11/12 year-old boy, the survivor of a twin pregnancy, was found to have congenital absence of the cerebellum at 25 months of age. He had persistent cerebellar signs, but no intellectual handicap. Toilet training was begun at 3 years. The patient refused to stool when placed on a potty, although he used it for urination while awake. Diapers were put on during afternoon naps and at bedtime and he defecated into them.. He was described as a pleasant, engaging, determined child who pushed himself to achieve despite his handicap. Two weeks prior to the consultation, he stopped napping and began to refuse diapers. He also began to insist on dressing himself. Nevertheless, his mother insisted that he wear a diaper and explained that she was afraid to begin toilet training because his poor coordination might cause him to have "an accident" and suffer humiliation. A few days prior to the consultation, while napping at his grandmother's home, he awoke mistakenly thinking that he had stooled in his diaper. His grandmother invited him to try the potty. He did so and passed a normal bowel movement; this was the first time this nearly 5 year-old boy had stooled in a potty. When he returned home, however, he reverted to stooling in his diaper or underwear. Physical examination revealed a child who appeared well except for ataxia. His mother said that she doubted he could ever wipe his own bottom. I decided to test this assumption. After establishing

rapport, I introduced the patient to diaper lotion by putting some on my hand, then on his hand, and asking him to touch it with his other hand. He touched both dabs of lotion without hesitancy. I then put some on his thigh, gave him a tissue, and asked him to wipe it away. He did so quite well. I put some on his buttock and he wiped it off without difficulty. I then put some lotion on a tissue and asked him to squat on the examining table and wipe his anus. To his mother's surprise, he did so, somewhat clumsily, but quite thoroughly. This patient's diaper dependency resulted from his parents' obfuscation of the importance of autonomous toileting because they felt that his ataxia would prevent him from managing his own toileting and that he would embarrass himself. They hadn't been able to appreciate his readiness for mastering toileting skills and avoided presenting self-care as an important goal. Then, with the patient out of the room, I explored with his mother the origins of her fearful reluctance to expect her son to use the toilet. In a separate chat with the child, I told him that the worries about passing bowel movements were unnecessary because his stomach would take care of that for him. What he had to figure out was how to get the BM into the right place when he felt it was ready to come out.

Contentious Diaper Dependency

The 25 children in the contentious diaper dependency category could be sub-categorized into two groups: 10 in whom diaper dependency was associated with early functional fecal retention syndrome; and 15 with no history of stool withholding (except when their parents refused to provide diapers or pull-ups) and no memorable or recurrent physical discomfort during defecation. The sub-group of contentious diaper dependent children

with fecal retention was comprised of 6 boys and 4 girls who were 3-1/12 to 5 years of age at the time of presentation; nine used the toilet for urination but defecated only in diapers and one used a diaper for both urination and defecation.

The sub-group of contentious diaper dependent children *without* symptoms of fecal retention was comprised of 13 boys and 2 girls, 3-3/12 to 6-2/12 years of age; 11 used a diaper only for defecation and had otherwise worn underwear and urinated in a toilet for a year or more prior to presentation; 3 urinated as well as defecated in diapers. (The manner of urination was not recorded in one child.)

Contentious diaper dependency *with* early functional fecal retention syndrome.

CASE 5 A 4-5/12 year-old boy toilet-trained for urinary control between 2-9/12 and 3-2/12 years of age. Thereafter, he wore underwear and used the toilet autonomously for urination. He defecated on the toilet on two occasions, three weeks apart, at 4-4/12 years. Otherwise, he had only defecated in pull-ups. He routinely was provided a pull-up at bedtime. He put it on, defecated, went to the toilet, removed his soiled pull-up, dumped its contents, flushed, wiped himself, put on a clean pull-up and went to sleep. He withheld stool for three days during which he displayed retentive posturing and soiling which culminated in the painful passage of a large blood-streaked stool. At 3-4/12 years old, his maternal grandmother was baby sitting for him and his younger brother when she suddenly fell to the floor, paralyzed. She instructed the patient to telephone an uncle for help, which he did. During the ensuing four months, the patient's mother was pre-occupied with caring for her mother who then died at the age of 58. The patient's mother

described him as happy, affectionate, but stubborn, especially when asked to give up his bottle or diapers. "He has a strong need to be in control, just like me." In a separate chat with the patient, he explained that he was "afraid of going to the potty."

Contentious diaper dependency *without* a history of fecal retention . This subcategory consisted of 13 boys and 2 girls. They did not withhold stool (except when their parents refused their demands for diapers or pull-ups) and had no memorable or recurrent physical discomfort during defecation. In contrast to their insistence on diapers for defecation, they all used the toilet for urination. They wore underwear, only asked for a diaper when they felt the urge to stool, and they all asked to have their soiled diapers removed when they were finished. Anxiety, emotional regression and/or oppositional defiance were prominent features of their clinical presentations. As with other contentious diaper dependent children, mounting parental pressure for them to use the toilet for defecation, in the same way they used it for urination, was met with increasingly obstinate refusals.

CASE 6 A 4-6/12 year-old boy was born soon after his parents emigrated from Croatia. The mother returned to work six weeks later and he was cared for at home by his maternal grandmother. At 12 months, his grandmother returned to Croatia and he was put into daycare where toilet training was begun. He was placed on a potty repeatedly during the day despite his resistance each time. He began urinating in the toilet standing up at 2 years and wore underwear during the day, but diapers at night. At 3 years, his parents realized that he mostly stooled in his diapers while in bed. "I asked him to sit on

the toilet. He looked scared, his pupils dilated and his heart raced… so, if he gets the urge, he just asks for a diaper and we give it to him and he goes," his mother said. Whenever they refused his requests for a diaper, he withheld bowel movements. His parents never persisted longer than three days without acquiescing and he never developed symptoms of fecal retention.[13] "Both my mother and I have anxiety and I don't want my son to get that way," his mother said. Past history included five hospitalizations for pneumonia and ENT procedures, including an emergency helicopter transport for acute laryngitis at 4 years of age. The patient's mother suffered a "nervous breakdown" at 22 years of age and subsequent phobic anxiety which was incapacitating at times. The paternal grandmother had died of cancer when the father was 13 years old. The patient was described as being fearful of new things of any kind, such as a new toy he'd never seen before. He hated loud noises and insisted on being forewarned so that he could leave the room before a vacuum cleaner or blender was turned on. Physical examination revealed no palpable fecal mass or soilage and was otherwise negative. The salient feature in this boy's diaper dependency seemed to be severe anxiety which interfered with his ability to try new things, including defecating on the toilet. The parents were advised to stop pressuring their child to give up diapers (without implying that his immature toileting was unimportant to them or to him) and pursue treatment for his anxiety.

CASE 7 A 4 year-old boy learned self-initiated use of the toilet at 2-8/12 years of age, around the time his sister was born. He wore underwear and was dry day and night. He never stooled on a toilet except for one isolated instance at 3-9/12 while visiting his

grandparents in a distant city. Otherwise, he asked his mother for a diaper when he felt the urge to stool. She asked him to remove his pants and underwear. She then put a diaper on him and obliged him to stay in the bathroom with the door shut for privacy. He played in the bathroom and eventually defecated in his diaper during play. He immediately asked his mother to remove the soiled diaper. He lay on his back like an infant while his mother cleaned him. When she obliged him to sit on the toilet, he said he was scared and she relented. When his parents asked him to pick a date when he would no longer use diapers, he responded by withholding stool for four days. "He tries to eat as little as possible, because he knows that eating will cause him to grow up and when he's a grown-up, he'll have to use the potty." Psychosocial history revealed that there had been marital difficulties from the time the patient was born until he was 3 years old. When he was 2-3/12, his mother was confined to bed during much of her second pregnancy. His sister was born when he was 2-10/12; he then deliberately urinated on the carpet several times. When he entered pre-school a month later, he was angry and isolated himself from his peers. Although he often had "horrible tantrums," he could also be very sweet. On physical examination, the patient was petulant and used baby talk. Again, (as in the previous case) applying more pressure for age-appropriate toileting didn't help the patient and only exacerbated his regressive behaviors and tantrums. The parents were counseled to call off the control struggle around his use of the diapers and allow him to manage defecation his own way. I urged them to involve him in diapering and cleaning up (to avoid giving him the impression that they accepted his infantile behavior) and make clear to him that using diapers for bowel movements might evoke derision from peers and others. I advised his parents to tell him of their concerns and

objections to what amounted to an offensive imposition of his bodily function on others. Nevertheless, how he defecated was his choice. Beyond that, I suggested that the immediate focus of management should be the causes of his regressive, angry behavior rather than his immature toileting.

CASE 8 A 4-10/12 year-old adopted boy began toilet training at 2 years and mastered control of urination 6 months later. He wore underwear during the day and a diaper during naps and at night. He always urinated into the toilet, but defecated only while in a diaper, except on two isolated occasions. He never withheld stool, except during a one-week interval at 3-3/2 years when his parents left him with his grandparents during their vacation. At the time of his 4 year-old well-child visit, his pediatrician recommended that his mother stop supplying diapers. The patient reacted by "stooling in his pants and all over" for two days and his mother relented. Punishments "didn't seem to faze him." Although he was well liked at school, he had frequent tantrums at home, disobeyed, and procrastinated on school mornings. "He never seems to worry about anything," his mother said. Psychosocial history revealed that his mother's childhood was marred by abuse and neglect. “I over-identify with him. I set limits… but I always question if it's too much. I don’t want to make his life crazy." She was manifestly anxious and fidgety during the consultation. Physical examination of the child was negative, except for well-developed sucking calluses on both thumbs. (In this case, there was a mixture of maternal ambivalence suggestive of permitted diaper dependency. However, conflict only worsened when parents became more insistent and this seemed more typical of contentious diaper dependency.)

DISCUSSION

In order for toilet training to progress in a timely and untroubled manner, at least three conditions must prevail: 1) The child has to have achieved the developmental level that enables toilet learning.[1, 3, 14] 2) The child must comprehend what his parents and society consider normal eliminative practices. 3) The child needs to be free of physical, cognitive and emotional impediments to toilet learning. The absence of any of these three conditions predisposes to the development of functional disorders of defecation, such as diaper dependency.

It is important to distinguish the two types of diaper dependency because their clinical management differs. Measures appropriate for children with permitted diaper dependency, e.g. clarification of expectations and strengthening of demands for more mature toileting practices, only intensify the contentious diaper dependent children's resistance to giving up diapers.

In most cases of permitted diaper dependency, the parents' mixed feelings (insofar as wanting their child to use the toilet and not wanting to pressure them to do so) were not appreciated early in the clinical interviews. It only became apparent as growing rapport prompted more disclosure of the psychosocial elements relevant to the onset of their child's toileting problem. It is not surprising, therefore, that several elegant prospective studies of populations of children with stool toileting refusal investigated by means of standard psychological tests and behavioral observations,[15-17] rather than a more searching anamnesis of emotionally significant events in the lives of individual

patients, could miss the subtle differences between the types of delays in toileting skills proposed herein.

Considerations in the management of permitted diaper dependency.

In 1964, Benjamin Spock and Mary Bergen published an essay describing children in their third and fourth years that had not succeeded in toilet training despite their parents' desire for success[18]. The “Spock-Bergen Syndrome” mentioned in the Rome II Criteria for Functional Gastrointestinal Disorders [19] seems to be what is herein referred to as “permitted diaper dependency.” Characteristically, these children had no history of painful defecation, excessive anxiety or intense parent-child conflict over toileting. The delay in getting rid of diapers and mastering use of the potty or toilet was caused by the parents' hesitancy in their attitude towards training. Fearful of conflict with their children and the possible emotional trauma it might cause, they relented in toilet training for weeks or months at a time and missed their child’s signals of readiness for toilet learning. As a result, these children failed to progress and continued to use diapers because *the goal of mature toileting remained unclear*.[18] Cases 3 and 4 suggest an additional psychodynamic in the development of permissive diaper dependency: the vulnerable child syndrome. [20] Unwanted behaviors, such as infantile toileting, occur as a reaction to parenting difficulties caused by an unrealistic fear that their child is abnormally susceptible to illness or death. The fear originates in an earlier experience in which the child suffered (or was perceived to have suffered) a life-threatening injury or disease or a life-altering handicap.

Effective management of permissive diaper dependency involves more than merely recognizing the pattern and advising parents to change. The clinician’s task is to

help parents discover and re-evaluate the sources of feelings and behaviors that perpetuate their child's toileting problem. [9] The clinician must then remain accessible so that what was learned during the consultation can be "worked through"[21] until the problem has been overcome

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Considerations in the management of contentious diaper dependency. What causes children with *contentious diaper dependency* to remain in conflict with their parents, the people they are closest to and dependent upon for protection, sustenance, love and approval? By the end of the second year, the toddler is struggling for independence and autonomy. Secure in his or her parents' presence and love, the child feels free to be assertive and aggressive. The parents' attitudes shift from being totally accepting of their infant to placing limits and expectations on their toddler .[5] They can help their child gain control over elimination, but they can't force their child to learn the necessary perceptual-motor skills. Toilet training is impaired when toilet learning is impaired. Anxiousness is a major factor in children with both retentive and non-retentive types of contentious diaper dependency. There are at least three potential sources of anxiety: a) fear of anticipated pain on defecation; b) conflict with one's parents over toileting; and c) emotionally traumatic experiences in general. Anxiety may cause pelvic floor dysfunction. [22, 23] Normally, defecation requires relaxation of the pelvic floor to open the anal canal while expulsive pressure is produced by contraction of the muscles surrounding the abdominal cavity. Fear of pain or generalized anxiety heightens the muscle tone of the pelvic floor and an "up-tight" pelvic floor can impede the muscular synergy needed for efficient elimination. Fear of painful defecation and parent-child

conflict over toileting should be amenable to pediatric management.; the relief of pathologic anxiety may require the assistance of a mental health professional.

Another factor pre-disposing to toileting anxiety, especially in children who respond to the defecatory urge by withholding, is *the animism of early childhood*.[11, 24, 25] Young children believe that inanimate objects are alive and capable of willful action. For example, when a 2-1/2 year-old accidentally bumps his forehead on a doorknob, he may retaliate by "spanking" the door. It is common for 2 year-olds to wave "bye-bye" before flushing their toilet. If a young child engaged in toilet learning has never experienced anal pain or fright [26] related to defecation, he and his bowel movements "get along". He doesn't feel threatened, and toilet learning can be easy. By contrast, if a child passes a hard bowel movement that causes an otherwise insignificant anal fissure, he may suddenly feel pain in an area of his body he cannot see, during a bodily function that he feels is not entirely under his control. From the child's point of view, "poo-poos" have a will of their own and can be nice or scary. If he is afraid that his bowel movements are hurtful, he may feel threatened by the defecatory urge and respond by keeping stool from coming out at all costs, including loss of his parents' good will. [27]

The first step in treating contentious diaper dependency is to call off the power struggle.[15] Acknowledge to the child that he is the only person that can manage his bowel movements and that he must do it in his own way, even if that means using diapers. At the same time, the goals must be kept clear by reminding the child (without being irksome) that everyone expects everyone else to use the toilet appropriately and that use of diapers is potentially embarrassing. Although parents owe their child love, peers and other adults do not, and if the child wants to be accepted socially, he must

prevent soiling or at least be vigilant and get the help he needs to keep it from becoming known. Cleaning up bowel movements of children who are old enough to do it for themselves is an odious burden; parents should make this clear in a non-punitive, non-derisive manner and should not allow their child to presume otherwise. "Testing behaviors," such as messiness or demands made at particularly inopportune times, might be best responded to with non-punitive expressions of displeasure. More severe punishments evoke a desire for retaliation and therefore are counter-productive. Withholding expressions of esteem and loving approval would be a more effective, reality-based sanction. If there is an element of fecal retention and dyschezia, stools must be softened so that they are narrow and non-abrasive. Perhaps the most effective method that is least likely to create a control struggle over medicine-taking or eating consists of the ongoing administration of polyethylene glycol, a tasteless, safe, osmotic laxative that is quite acceptable when well dissolved in the child's favorite beverage. [28]

Functional disorders of defecation in children, including abnormal diaper dependency, should not be viewed as simple problems of tubes and sphincters, amenable to actively-applied, passively-received “cures.” Children’s eliminative functions are their own and cannot be “fixed” by coercion or manipulations that don’t involve the child’s participation in the process of recovery. Children with permitted diaper dependency need clear leadership in order to accomplish age-appropriate toileting; the clinical goal is to help parents recognize and overcome the conflicting feelings that impair their ability to lead in this aspect of their child’s development. In children with fecal retention, anal pain caused by wide, abrasive stools can be abolished through regular administration of an acceptable osmotic laxative in doses sufficient to soften rectal accumulations, prevent re-

accumulations from hardening, [27] and by avoidance of treatments, such as the coercive administration of enemas, that cause pain and fear.[29] Anxiety caused by the defecatory urge will subside as the child continues to experience defecation that is invariably more comfortable than expected. Emotional disturbances caused by family dysfunction or other psychological traumas severe enough to prevent progress should be recognized and treated as a priority during the management of children with contentious, non-retentive diaper dependency and other functional disorders of defecation.

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