sets up a fear–pain cycle and results in learned abnormal defecation patterns. **Psychogenic encopresis**, in which the soiling is caused by emotional problems, is often related to a disturbed mother–child relationship.

Normally, children and adolescents have one or two soft-formed stools per day. Children with soiling problems tend to form large-bore stools, which are painful to excrete. Therefore they tend to avoid defecation and withhold stooling. Stool held in the rectum and sigmoid colon loses water and progressively hardens, which causes successively more painful bowel movements and a stretched rectal vault. Over time, the child will lose the urge to defecate on his or her own (Mosca and Schatz, 2013). A pain–retention–pain cycle is established. Many children have diarrhea or loose leakage in their clothing and pass small amounts of hard stool, which suggests leakage around an impaction.

Children may experience exacerbations with transitions in the school setting. Some reasons for developing retentive tendencies at this time are fear of using school bathrooms, a busy schedule, and the interruption of an established time schedule for bowel evacuation. Children may also react to stress with bowel dysfunction.

Therapeutic management consists of determining the cause of the soiling and using appropriate interventions to correct the problem. To determine the cause, a detailed history including risk factors (negative toilet training, child abuse or neglect, fear of bathrooms), comorbid conditions (such as attention deficit disorder, cognitive delays, oppositional disorders), and associated symptoms of bowel movements (retention, overflow soiling, incontinence) are obtained (Mosca and Schatz, 2013). Next, a thorough physical examination including a rectal examination is completed. Abdominal radiography may be done to determine the severity of impaction.

Many children require an extensive and invasive bowel cleansing to remove the bowel impaction before starting treatment (Mosca and Schatz, 2013). Fecal impaction is relieved by lubricants (such as mineral oil), osmotic laxatives (such as lactulose, sorbitol, or polyethylene glycol [PEG or MiraLax]), and magnesium hydroxide. Customary dosages are usually insufficient to produce a therapeutic response. Mineral oil should be avoided in children who have dysphagia or vomiting to prevent aspiration.