



Hypno-behavioral Therapy, Systemic, and Institutional Management of Encopresis in Childhood and Adolescence

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Abstract

Introduction: Encopresis is the appearance of involuntary stool emissions more than once a month for 6 months after the age of 4 years outside of any place of cleanliness. It decreases with age and is more common in boys than in girls. There are two different classifications: primary and secondary encopresis, non-retentive and retentive encopresis. This disorder can be caused by several factors: educational, psychological, pathophysiological, psychopathological, etc. We used the various knowledge and techniques accumulated over the history of the development of hypnosis, cognitive and behavioral therapy (CBT) and the systemic approach as therapeutic means in the pragmatic sense to help this young patient.

Method: To confirm our hypotheses, we used several tools, in particular: a tape recorder and audio cassettes, note-taking on paper, sheets for collecting data after the exercise. For this study, four different phases were listed during this treatment. These are: the creation of a good relationship and the therapeutic framework, the learning of hypnosis and self-hypnosis associated with behavioral exercises, the stabilization phase, the phase of consolidation and generalization of acquired knowledge educationally, academically, socially and emotionally.

Results: At the 2nd session, 2 weeks after admission: A summary meeting with the therapeutic team and the family was held. The results were presented, namely: the cognitive psychological assessment (WISC-III), the emotional test and the psychometric assessment: HAS = 12 points (mild intensity for generalized anxiety) and BDI = 6 points (no depression).

From the 5th session, 8 weeks after admission, the HAS = 1 point (no generalized anxiety) and the BDI = 0 point (absence of depression). We can notice that the positive results were fast with the complete absence of encopresis from the 5th session of the HBT.

Discussion: In our study, the metaphors corresponding to the reality of the patient, his problem and the therapeutic context, were like catalysts in the psychocorporal cure. This HBT led our patient to increase his mastery and his internal self-control and to manage his anxiety towards other ways adapted to reality other than encopresis. The use of the double link made it possible to transform

the discomfort caused by encopresis into a playful pleasure with the mastery of the anal erogenous region according to Freud [10], a necessary step to stabilize its healing. Thereafter, the consolidation was possible by the technique of the affective bridge of Walkins quoted by Araoz [31].

Conclusion: The long-term therapeutic efficacy of encopresis treatment methods, whether psychoanalytically inspired, cognitive-behavioural, based on biofeedback, whether medical or mixed, tends to be the same. HBT is not used here as a miracle recipe, it is associated with institutional care requiring understanding, cognitive and behavioral science techniques of the psychodynamic, family, systemic context and the network of stakeholders.

Keywords: Encopresis; Hypnosis; Behavioral Therapy; Systemic; Institution

Introduction

Definition

Encopresis is the occurrence of involuntary upper stool emissions at least once a month for 6 months after the age of 4 years outside of any place of cleanliness. ICD-10 defines encopresis as a disorder characterized by repeated (for 6 months with at least one fecal emission per month), voluntary or involuntary, of normal or near-normal consistency, in inappropriate places given the child's socio-cultural context [1]. Non-organic encopresis may present in three forms: abnormal persistence of physiological childhood incontinence, loss of sphincter control after the period of fecal continence, and deliberate fecal emission in inappropriate places despite normal sphincter control. It is rarer than enuresis and always indicates the presence of an important and sometimes complex general disorder whose causes, in most cases, remain difficult to formalize. Child psychiatric care is always necessary and implies considering the disturbed and disruptive family dynamics.

Although it is rarer in outpatient clinics, encopresis seems to be more frequent in institutions for children and adolescents where the population of children from the economically disadvantaged social class is higher on the one hand, and on the other hand, the children are admitted there most often for reasons of family conflicts that are emotionally and educationally destabilizing.

Epidemiology

Bellman's study in Stockholm indicates that incontinence and encopresis decrease with age. At the age of three, the frequency is 8.1%, at four years it is 2.8%, then it decreases slowly, at five years it is 2.2% and at six years it is 1.9% [2]. Based on these data, the author as well as other clinicians believe that the cut-off age at which incontinence can be classified as abnormal is four years. The diagnosis of encopresis is therefore only meaningful after 4

years of age. Epidemiological data from Bellman (1996), based on a population of 8683 children aged seven years, indicate a prevalence rate of 1.5% in the general population, and Levine estimates a prevalence rate of 3% in children attending medical clinics [3]. According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders [4], the prevalence is approximately 1% in five-year-olds [4]. The disorder is more common in boys than in girls, three boys to one girl [2,5,6] and more present in the lower socioeconomic class [6].

Classification and clinical forms of encopresis

Different classifications and clinical forms of encopresis have been proposed.

Primary and secondary encopresis

The criterion most often used is the presence or absence of a period of cleanliness before the onset of incontinence. Encopresis is said to be primary when the child has never acquired sphincter control. There is thus a continuity of defecation in the pants from infancy until the moment when incontinence becomes embarrassing, after the age of four. Encopresis is said to be secondary when the child has acquired cleanliness but has become incontinent (DSM-5). Epidemiological studies show an almost equal distribution between these two forms [2,7,6]. However, in a study by Levine [3], secondary encopresis is more frequent (62 cases against 40).

Non-retentive encopresis and retentive encopresis

In some clinical pictures, inappropriate fecal emissions may be preceded by voluntary retention or constipation, possibly caused by this retention. From this point on, a distinction is made between a non-retentive form, a simple retentive form and a complicated retentive form with functional megacolon on chronic constipation.

Child psychiatric comorbidities of encopresis

Encopresis is associated with other disorders in 59.3% of cases [8]. According to some studies, 30 to 40% of encopresis children also suffer from enuresis [2,7,4]. Walha, *et al.* found that encopretic children also suffer from enuresis (57.4%), conduct disorder (66.6%), depressive disorder (6.6%), phobic disorder (5.5%), and oppositional defiant disorder (4.4%). Johnson and Wright [9] used the child behaviour check list (CBCL) and found that 23.4% (39 of 167) of the encopretic children had ADHD. It is possible that this psychological comorbidity is more a consequence of the encopresis in most cases.

The shameful symptom leads to high anxiety, social withdrawal and even social phobia with loss of contact with peers and low self-esteem. Landman [10] and colleagues cited by Habimana, *et al.* (1999) conclude that the symptom is not unconsciously intended by the child, as some psychoanalysts once assumed, but is experienced as a particularly embarrassing phenomenon, the source of disturbances from which the child longs to be relieved, which explains the cooperation of encopretic children in treatment [11].

Etiopathogenic hypotheses

Psychodynamic factors

The psychoanalytical theory of the anal stage was developed by Freud [12] on his famous case of Sergei Pankejeff, the wolf man who had been encopretic during his childhood, thus going back even before the term “encopresis” appeared. Freud interprets this symptom as an unconscious identification of Sergei with his mother who was suffering from metrorrhagia. Incontinence would thus have successively two very different meanings, one of active opposition, the other of expression of an identification which reveals itself as a desire of homosexual passivity towards the father.

The theory of “intestinal negativism” of Pinkerton [13] is another way of translating the opposition, therefore the passive resistance of the anal stage according to Freud.

The theory of regulation of the passive and sadistic impulses, advanced by another Freudian psychoanalyst Easson [14], considers that encopresis has powerful unconscious motivations which is the return of the anal and sadistic impulses.

These various theories are no longer cited in current studies, even by some psychoanalysts, who instead emphasize that certain types of toilet training constitute serious risk factors for encopresis.

Encopresis and sphincter training

It is now accepted and increasingly demonstrated that the type of severe or coercive education is a factor in the occurrence of encopresis (Huscka, 1942; Pinkerton, 1958) [13,15] and Bellman [2] found that 31% of encopresis children had a coercive education in either the primary or secondary form.

Triggering factors for encopresis

According to Bellman’s [2] study, psychological stressors or “stressful” events are the cause of 70% of encopresis cases. These include events such as starting school, parental divorce or separation, separation of the child from the family, birth of a child, hospitalization, or various traumas. These facts have been confirmed by other recent studies in the occurrence of secondary encopresis [6,16].

Another trigger for encopresis is sexual abuse. In their study, Boon and Singh [16] found five cases of anal sexual assault (three boys and two girls) among 21 children with non-retentive secondary encopresis. Feehan [17] reports from his school of 8 girls with secondary encopresis, he states that 6 of them had a history of sexual abuse. For the other two, he considers sexual abuse likely, but not proven.

After this general overview, we will present the clinical case in which hypnotherapeutic treatment was successfully performed. The case concerns a 12-year-old boy who has suffered from encopresis since the age of 6. He comes from a multiproblematic family and was admitted to our Pedagogical and Therapeutic Center of Dombresson (PTCD) in a situation of educational deficiency and academic delay.

Cognitive-behavioral theories of hypnosis

Modern hypnotherapy research has focused increasingly on the integration of hypnotherapy and CBT since the publication of the meta-analysis by Kirsch, *et al.* [18]. This work brought together extensive data from 18 different controlled studies (577 participants) comparing the efficacy of cognitive behavioral hypnotherapy to CBT alone. He was able to conclude that for 70-90% of clients, CBT was more effective when integrated with hypnosis, i.e., for the vast majority of patients, cognitive-behavioral hypnotherapy is superior to CBT alone.

However, hypnotism has a long and complex historical relationship with other theories, particularly cognitive-behavioral

psychological therapies. Hypnotherapy was born in 1841 and James Braid is considered the founder [19]. He developed his model, which he called “psychophysiological” in opposition to the “animal magnetism” of the Mesmerism by Doctor Franz Anton Mesmer (1779) [20]. After, the “ideomotor reflex” of his ally Laycock (1845) and William B. Carpenter (1852) to provide a neuropsychological theory and mechanism of suggestion [21]. This association between research and clinical practice continued to suffer in the 20th century, hypnotism was widely studied by social and behavioral psychologists. Their studies led to the development of “influential theories of hypnosis as “suggestion” on the one hand, and others by “behavioral” theories of hypnosis are also attributed to Pavlov’s physiological research in the late 19th century and his recommendations for the development of what he considered hypno-psychotherapy based on “cortical inhibition” and conditioned verbal reflexes. In the 1920s, behavioral psychologist Clark L. Hull began his program including behavioral research on hypnosis published as *Hypnosis and Suggestion* [22], an experimental approach described in 1933. From this research, Hull concluded that he could find no essential characteristics of the “hypnotic state” except an increase in suggestibility. Hull’s inability to delineate the actual difference between “hypnotic trance” and normal suggestibility led social psychologists to re-conceptualize hypnosis as an interpersonal construct combining cognitive and behavioral factors.

On the other hand, Robert White’s article entitled “A Preface to the Theory of Hypnotism” from 1941 is generally cited as the origin of the social psychological and cognitive-behavioral tradition in hypnosis that gradually obscured the popular concept of “hypnotic trance” [23]. As for White, he argued that research suggests that hypnotic responses can be explained by the conscious attitudes and voluntary efforts of the subject. He rejected the mechanical allusions or connotations that mark traditional descriptions of hypnosis. He radically redefined trance as “meaningful hypnotic behavior, the struggle with which is goal-oriented, its most general objective being to behave as a hypnotized person,” that is, permanently defined by the operator and understood by the client. From White’s point of view, “hypnosis” essentially becomes a rather active verb rather than a noun, a status rather than a passive state, something in which the subject actively “contributes” rather than something that “happens automatically” to him or her because of “mechanical” induction rituals and suggestions.

For White, hypnosis should be “restored to a chapter of social psychology”. This was accomplished in the 1950s in the research program led by the social theorist, Theodore Sarbin who clearly rejected “hypnotic trance” in favor of what he called a “cognitive model of action”, i.e. behavior [24]. As for Sarbin, he proposes that behavioral responses are mediated by cognitive factors, mainly identification with social roles, contrary to Beck’s “core beliefs” and “schemas”. Thus, Sarbin replaces the Victorian concept of “depth of trance” with levels of imaginative involvement of the patient and was the first researcher to combine social psychological cognitive factors with behavior and to formulate a fully developed “non-state” theory of hypnosis. As Nicholas Spanos, after Sarbin, later explained, social psychological accounts of hypnotic response are not alternatives to cognitive accounts; they are cognitive accounts. Specifically, social psychological accounts are interpreted by hypnotized subjects as continually altering their cognitive activities and behavior in response to the changing social context that constitutes the current hypnotic situation.

In 1974, *Hypnotism: Imagination & Human Potentialities*, which has become one of the leading texts in the history of hypnotic research, was published by Theodore Barber, Nicholas Spanos and John Chaves. Their detailed review of experimental hypnosis research led them to adopt Sarbin’s point of view by rejecting the concept of “hypnotic trance” [24].

Another point of view, which is elaborated in the present text, could be called the cognitive-behavioral point of view that this approach takes into account.

For us in using the term Hypno-Behavioral and Cognitive in this management of encopresis in this adolescent, we have sought to integrate the differences in knowledge and techniques accumulated over the history of development of hypnosis, CBT and the systemic approach, in a more early eclectic perspective as useful placed on our technical tray, as child psychiatrists, psychologist and psychotherapists. These tools must be associated and used as therapeutic means in the pragmatic sense to help when possible.

The clinic case of our study

Anamnesis

Aldo was 12 years old at the time of his admission in August 1999 to the Pedagogical and Pedagogic and Therapeutic Center of Dombresson (PTCD). He comes from a family of Italian origin.

His parents are 56 years old for the father and 49 years old for the mother. He has an older sister, 23 years old, who works in La Chaux-de-Fonds and regularly returns to Neuchâtel to visit her family. They all work as kitchen staff. Both parents are regularly absent from home and Aldo is left to fend for himself. The social investigation made by the curatorial social assistance reports that the family is of the fourth world type with few financial [25]. A family with poor financial, social, educational, and even cognitive resources.

Aldo was born at full term with an unremarkable delivery. From 0 to 6 years old he was extremely lively, eating quite well and without restriction. From 3 to 6 years of age, he had acquired sphincter cleanliness. There was no family history of enuresis or encopresis, according to the parents' statement. The onset of difficulties with bowel movements dates to the age of 6 years, marked by abdominal pain, constipation, and leakage of stools into underwear at school, at home or elsewhere. The parents attribute this to their son's very sweet diet from school age. Despite leaking stools 3 to 4 times a week at first, Aldo was unable to complain or change his clothes. Faced with this behavior, the father concludes that his son does not feel the unpleasant odor of his stool that remains in his pants for a long time. He is very surprised to see him acting this way. Moreover, he complains about his son's "late weight" and adds: "I think he is afraid to eat because of the leakage of poo"; his wife agrees.

It was around 7 years that Aldo started his follow-up with the family doctor who, following various clinical and paraclinical examinations concluded that he had functional disorders, with colonic dilatation and sensitivity disorders of the solid rectum. Treatments with laxatives were often insufficient and enemas had to be performed at times. However, there was no change despite enemas, a trial of behavioral therapy and appropriate laxative medication.

Beginning of institutional care at PTCD

The 1st session for admission

Aldo was admitted to our center on September 15, 1999 (i.e. in mid-September) because of a lack of family supervision due to his parents' exceptional work schedules, serious academic deficiencies and anti-social behavior. In fact, before his admission in May, Aldo and two other teenagers had set fire to a building in town. It was at this point that the father admitted that his son needed to be in a proper educational setting. The admission was

made under the legal responsibility of Aldo's curator appointed by the juvenile office, who agreed to a two-week observation period during a network admission interview with the parents, educators, teachers, and specialists of the therapeutic team.

The 2nd session, which takes place two weeks after admission, is a medical-psycho-educational assessment in the institution

This assessment is often done after two weeks with a multidisciplinary team composed of specialized educators, psychologists, teachers, occupational therapists, speech therapists and child psychiatrists.

After this observation period, a synthesis meeting of all members of the therapeutic and pedagogical team meets with the family and the child to assess the stay in an institutional environment before making the final decision of a placement or not.

At the child psychiatric interview, the contact with Aldo is immediately good. He is pleasant and makes the interviewer want to protect him from the aggressions of life, so fragile does he look with his wide-open eyes contrasting with his inhibition on the physical level. One has the impression that he is frozen and stuck in his place. Verbally, he has little expression to describe what he is experiencing and feeling. He acknowledges that he is better since he has been in an institution, but nothing more, because at home he explains that he no longer goes to school and stays alone to watch television. He is also relieved because he no longer has nightmares about his father threatening him when he wakes up. He is not very expressive in verbal, motor and facial terms. Very discreet, he seems a bit depressed. He sighs from time to time and has to make a huge effort to maintain a body tone that is useful for the interview and the relationship.

The structured evaluation with psychometric scales such as the HAS (Hamilton Anxiety Scale) reveals a 12-point anxiety (slightly high score) with symptoms such as fear of the dark and of being left alone, nightmares and sleep disturbance, difficulty concentrating and especially muscle tension. No symptoms of somatization in the digestive tract are mentioned; it is as if he avoids talking about this area of his body. The BDI (Beck Depression Inventory) 6 excludes a depressive picture. The Child and Adolescent Adaptive Belief Inventory (CABI) shows a negative self-image and excludes a suspicion of sexual abuse.

Cognitive assessment indicated limited intellectual resources (WISC-III total IQ of 77; IPQ of 78 and IVQ of 82). A standard score of 7 on the cube's subtest and a score of 4 on information show a defect in the stimulation of the external environment. In the affective tests, we notice a tendency to withdraw and distrust, Aldo seems to have no control over his destiny and adopts a passive position in relation to the environment and what surrounds him. At the relational level, Aldo also withdraws, which may suggest that he may be the object of abuse.

The speech and language assessment reveals the presence of a particularly persistent schlatting and semantic difficulties. Aldo's cultural level is very low for his age, but he remains open and eager to learn.

The social assessment done by the curator shows a very unstimulating and limited family. Aldo has almost no relationship with his father and he shows him few affectionate gestures. The father can sometimes be very violent with Aldo, for example when Aldo buys something without his permission, he does not know how to set limits and is inappropriate and impulsive. The curator still notes a lot of vagueness regarding the health problems of the mother, who is apparently going through very depressive phases, and the father is quite helpless to give her effective support.

The school report also indicates that the delay is real. For Aldo, the prospect of being able to follow a normal schooling remains a very difficult objective to reach.

Methodology and phases of hypnotherapeutic and institutional care

Methodology: Data collection material

Different tools allowed us to collect the data of the patient's management. These include the following:

- Tape recorder and audio cassettes
- Note taking on paper
- Cards for the collection of data after the exercise used by the patient

At our request, he gives himself a mark of 1 when after the hypnotherapeutic exercise he has a bowel movement in the toilet and not in his pants during the day.

When he presents this note to his reference educator, he has points that he accumulates for later rewards for his efforts and progress.

He also brings the results of his efforts to clean himself at each session to show the level of his therapeutic evolution to the child psychiatrist, who takes advantage of this to reinforce him positively.

Procedure of the hypnotherapeutic therapy (HBT)

At the end of his two-week observation period at the Pedagogic and therapeutic de Center of Dombresson (PTCD), a global treatment of Aldo was decided in a network during a synthesis in collaboration with the therapeutic, educational and school team under the mandate of the titular authority. From that moment on, the practical modalities were put in place by the therapeutic, psycho-educational team to start the care of the young resident. Four different phases were listed during this care. They are:

- The creation of a good relationship (alliance) and the therapeutic framework.
- The phase of learning hypnosis and self-hypnosis associated with behavioral exercises.
- The phase stabilization
- The phase of consolidation and generalization of educational, academic, social, and emotional gains.

Alliance phase and therapeutic framework

3rd session 4 weeks after admission

During this first session of hypnotherapeutic therapy (HBT) proper, the trust relationship was essential to help Aldo express his problem in his own words, despite his great shame related to this encopresis. In this first session, the child psychiatrist introduced the discussion in an indirect way about the life at the Therapeutic and Pedagogical Center where the young resident now lived.

He replied that it is better here than at home, that he is starting to have fewer nightmares and that he is sleeping better and better. Besides, the school is not far from the house like in the city.

Aldo was reassured that it was a therapeutic setting with a guarantee of secrecy and if anything had to be reported to the educators or to his parents, it would be with his agreement.

The interview with the parents confirms that the mother is very limited cognitively. It is rather the father who describes Aldo's early childhood in detail. The deficiency of the mother-child relationship is confirmed and felt. In this care, I understood that it will be necessary to rely more on the child with his personal resources, on the educational team and not on the parents.

To conclude the session, I decentralize the atmosphere and reactivate Aldo’s resources by focusing on his pleasures (soccer and swimming). Aldo is asked to draw a picture of his choice about these two activities. He drew the pool with someone in the water. The induction was made from his drawing.

It is suggested to Aldo to be in front of the pool, then in the pool, to touch the bottom of the pool and come out on the other side and then to start swimming again, etc.

The voice is heavy, the head does not hold on his neck anymore. The mouth is open, and the slightly closed eyelids begin to beat rapidly and underneath one observes the eye movements to the left and right. He liked this sequence.

We asked Aldo to open his eyes now by tapping on his shoulder. In response to our suggestion, he stood up, put himself on the sofa. Then he yawned widely while stretching. We suggested that he continue swimming with his buddies and that he sees that he swims better than most of them.

Afterwards, it was suggested to Aldo to see a slide, to do the hide-and-peek with the other children.



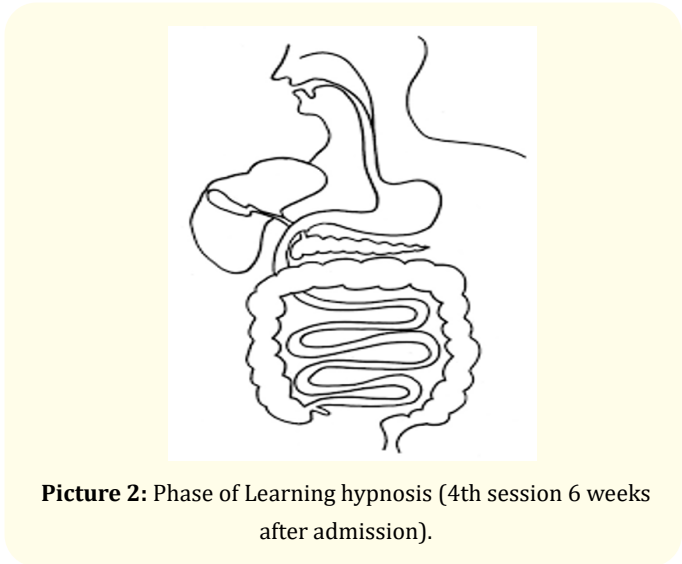
He took this suggestion well and stayed in the slide for a few moments, instead of sliding straight down. We reinforced this “feat” of getting stuck in the slide. It was suggested to play between the pool and the slide for more than 5 minutes, which he enjoyed. When he returned (woke up), he felt good, calm and rested. This first session ended with the handing over of the diagram of the

digestive tract, specifying that it looks like a small slide in the belly of each person. You will tell me what you think next time, won’t you?

A small smile lights up his face, he stands up, takes the diagram and thanks me. This is a home task to better involve Aldo in the care.

Hypnosis learning phase

4th session 6 weeks after admission



Aldo returns to the 2nd HBT session with the digestive tract diagram with many questions and curiosity. Taking his usual place, he takes out the diagram and tells us straight away that he has a question. After some discussion, Aldo realized that the digestive system looks like a slide. During this session, the hypnotic induction using the images of the pool, the slide, and the digestive tract, in a system of two television screens that are presented to him on another diagram. These screens are named: blue screen (B) and grey screen (G) on the left and right respectively.

On the blue screen (B), he sees himself in the pool and then in the slide with the other children. On the grey screen (G), he imagines himself with his eyes closed and a remote control in his right hand. He turns on screen G and sees the diagram of the digestive tract alone and then under suggestion. He “visualizes the digestive tract in his own stomach” on the screen.

The induction by small successive trances, divided by small awakenings helps him to doze off in deeper and deeper trances.

We kindly ask him to choose the position that suits him best for this Exercise of Relaxation and Mental magery(ERMI).He chooses to lie down on the couch with his right hand still in the air with the remote control. He clicks on the screen B, he sees himself in the pool and then in the slide with the other children.

It was suggested to Aldo to feel inside the slide and try to block the exit to prevent the other buddies from getting out even though they were pushing him hard and screaming, which he did for a while until the weight of his buddies dragged him out. Then it was suggested that he turn on the other G-screen on the right and see his stomach and intestines.

After some back and forth, we offered to teach Aldo a little technique. "You are going to try to push to open the exit. While pushing, you must make the contraction of the stomach muscles which will make the intestines contract and you will see them move from your G screen. Now you can start to push by contracting your stomach from the stomach to the intestines".

Silence and Aldo takes these words literally. Under trance, he starts to push and contract his belly. After this technique accompanied by relaxation, Aldo asks to go to the toilet, which we accept and tell him not to draw the water afterwards.

Aldo rushes to the toilet which is right in front of the medical office of the institution (TPCD). After 15 to 20 minutes he came back smiling and very happy to have voluntarily made the stool out of his pants and without undergoing the ordeal of the enema or suppository. After verification, Aldo did indeed have a bowel movement in the toilet. We congratulated him and this behavior was reinforced.

We prescribed two home tasks for Aldo:

"Every night you do your relaxation with screen B... After the pool and slide exercise you go to bed and sleep".

In the morning before getting out of bed you think about your exercise, you relax with your eyes closed and you see your couch and you turn on the screen G. Is it clear? You go to the toilet even if you don't feel the poop coming after looking at the screen (G) moving your bowels. Even if you don't feel the poo, sit on the toilet and push the urine out at the same time as the poo. A word of advice: in the morning, never pee standing up, always sit on the toilet and push the poo, okay? Aldo understood these instructions.

Aldo was given a motivational and behavioral value sheet. The instruction is that each time he does his exercise he scores a point in the column on the left and if he forgets, he scores zero. And after the toilet, if he poops, he scores a point in the other column on the right and if he doesn't, he gives a zero mark, and so on. This form counts 20 days. After this period, Aldo is asked to bring the completed form or to hand it in to the secretariat.

5th session 8 weeks after admission

After 14 days the assessment is positive, Aldo has a bowel movement every time he has practiced ERMI except on Saturday and Sunday when he spent the weekend with his family. He totally forgot to do his exercise and to go to the toilet in the morning. He didn't have a bowel movement in his pants. Once, he forgot to do the V.D.R., but he still had a bowel movement in the toilet.

Stabilization phase

For Aldo this phase consists in practicing to keep the positive behavior of sphincter cleanliness by a routine of life supported by the V.D.R. followed by the passage in the toilet in the morning and in the evening even in the absence of desire to make the stool and the urine.

6th session 10 weeks after admission

Two weeks after the 3rd session of HBT, Aldo has not forgotten his evening and morning ERMI exercises and he still does the stool and urine at the same time and sitting in the toilet. An interview was done with Aldo.

Through this interview we can see that Aldo has no pleasure in having a bowel movement. I am worried about the laughter on his lips when he says "it's boring". I am afraid that he will relapse if he has a bowel movement phobia problem. But I also console myself with the idea that pleasure can also be learned and that for a long time he lived with the nightmare of stool in his pants. Perhaps anal eroticization in the psychoanalytical sense would be in the sense of retention as a masturbatory equivalence. I tell myself that novelty stimulates motivation and learning.

Another hypnosis session was proposed and carried out with the use of the two screens, associated with the soccer that Aldo likes to play. Through this session, Aldo proved that he is still in control of his cleanliness and is able to stay clean. As he said, "I don't poop in my pants anymore, not at school and not when I play.

After making sure he didn't poop in his pants, we tell him that the session is over. He can continue to do his ERMI with his images on the screens in the morning and in the evening and then always urinate while sitting in the toilet and have a bowel movement at the same time in the morning. He can also continue to report his results to me on the cards that were given to the reference educator. If the exercise becomes less interesting, to avoid doing the same thing, he can change with other images. If he can't do it, he can ask us to help him create other images on his two screens, the blue one on the left and the grey one on the right.

To avoid forgetting on the weekends, we called the group from time to time to ask them to remind the parents to tell Aldo to do the exercise without any other comment and to always give him the sheet on the weekends to bring back to the family.

7th and 8th sessions, 11 and 12 weeks after admission

After three weeks, Aldo is still hanging in there with his exercises well done and his chart well filled out in group and at home on the weekends. These are short 15-30-minute sessions of positive reinforcement, praise, and bonus group time to work out.

9th session, 15th week after admission

After four weeks, Aldo occasionally forgets to exercise in the evening, but rarely in the morning; he has developed the habit and pleasure of having a bowel movement and urinating in the toilet every morning before washing. Since the beginning of the therapy the linen maid has not found a trace of stool in his underwear.

Consolidation and generalization phase of positive behavior from week 16 to week 18

I ask the group now that we move into the consolidation phase of sphincter control and pleasure. This is the opportunity to move on to the generalization of positive behavior in other educational spheres outside of his intimate sphere, because now that Aldo is clean, we need to help him synchronize with the social life of the group and the school by asserting himself. It is the passage to the

stage of generalization and synchronization of the social life with the development of a behavioral and educational grid in the group managed by his reference educator.

Sessions 10, 11, 12, 13 and 14th at one-month intervals (5 months in total), making a total of 38 weeks since his admission to the institution

After 5 months, Aldo comes to the sessions with amazing regularity for his age. He is on time and always comes with his forms filled in without the intensive intervention of the educators or parents. He is very proud of himself, gets a lot of group bonuses and is constantly allowed to go out to play soccer, ping-pong and swimming.

The 15th closing session after 1 month, i.e. a total of 42 weeks of therapeutic follow-up in an institutional setting at the CPNea in Neuchâtel.

Aldo is exceptionally received as an outpatient at the Medical-Pedagogical Service for Children and Adolescents (CPNea) in Neuchâtel. He tells me that he forgets to fill in the forms more now because I am no longer at the Centre (PTCD). However, he no longer has a bowel movement in his pants and he still does it in the morning in the toilet. He is no longer teased, and he has many friends at the PTCD and outside. "I also get along with the educators in my group and at school it's okay too", he says. I ask him if he still feels comfortable at the Centre or if he would like to go home. He replied that he prefers the Center and the Center's school. "For the house it is interesting to go there on weekends because everyone is at home. We wish him good luck at Dombresson on the school level and best wishes for Christmas and for the new year 2001. I tell him that although I no longer work at the Borel Foundation, he could ask to meet me exceptionally if he wanted to.

Results

Synoptic table of sessions, periods, balance sheet and evolution of encopresis during the HBC's period

Number of sessions	Corresponding periods	Psychological and Psychiatric Assessments at the PTCD	Number of stool losses (encopresis per week)
1 st	Admission in Institution	QI-total/WISC-III -QIP- QIV- HAS-BDI	3 to 4

2 nd	2 weeks after admission: Synthesis meeting: therapeutic team and family	Total IQ at WISC = 77 IPQ (performance) = 78 IVQ (verbal) = 82 HAS = 12 points (mild intensity for generalized anxiety) BDI = 6 points (no depression) Affective tests = Retreat and Distrust	3 to 4
3 rd	4 weeks after admission	Therapeutic alliance phase management of his encopresis	
	Get to know the young patient and his family, the various stakeholders of the therapeutic and educational team	Explain to each other what the intervention consists of and to avoid intrusions and interruptions in the therapeutic space between the child psychiatrist and the young patient during the sessions	3 to 4
4 th		Learning phase of the techniques of Hypno-behavioral Therapy (HBT)	
	6 weeks after admission start of THC with first induction of hypnotic trance and request to do hypnorelaxation exercises with self-hypnosis before going to the toilet every morning.	HAS = 10 points (for mild generalized anxiety) BDI = 3 points (absence of depression)	3 to 4
5 th	8 weeks after admission	HAS = 1 point (no generalized anxiety generalized anxiety) BDI = 0 point (absence of depression)	0
6 th	10 weeks after admission	Stabilization phase of the desired state	
6 th and 8 th	11 - 12 weeks after admission	HAS = 1 point (absence of mild generalized generalized anxiety) BDI = 0 point (absence of depression)	0
9 th to 10 th		Aldo started forgetting to do some exercises in a morning	0
10 th , 11 th , 12 th	15 weeks after admission	Consolidation and generalization phase of the acquired positive behavior (APB)	
13 th and 14 th (at one month interval)	38 weeks after admission	HAS = 0 points (absence of generalized anxiety) BDI = 0 point (absence of depression)	0
15 th session (closing after 1 month), end of treatment	42 weeks of therapeutic follow-up (in an institutional setting at the (TPCD)	HAS = 1 point (absence of mild generalized generalized anxiety) BDI = 0 point (absence of depression)	0

Table 1

Catamnesis

In order to see the evolution of this case and to pronounce on the prognosis on the one hand, on the other hand to have the consent of our former patient who became a young adult we contacted Aldo via the PTCO 16 years later, thanks to the same Director of the institution who gave us the coordinates of the latter now, who was already married and father of 1 child.

Already his correspondence of 22/03/2001 (after about 2 years after his treatment) the deputy director of the PTCO confirms the positive evolution of Aldo in relation to the encopresis, on the educational, scholastic and social level. However, his relationship with his father still lacks an affective note and he maintains his distance from him.

Addo tells us during our catamnestic evaluation meeting mentioned above that since his mother's death, he has become emancipated from his father, who was never present in his emotional and educational life. He was able to feed on his mother's affection and on the educational contribution of the Pedagogical and Therapeutic Centre of Dombresson (PTCD), which assisted him in this respect and in his academic and professional learning. Now that he has become a father himself, he prefers to take care of his child and his professional and family life. Addo expressed his gratitude for this treatment which helped him to regain his anal sphincter control and to generalize this control in his school, professional and family life as a father and husband. It is with pleasure that he gave us his permission to publish this case if it could help other professionals in the care of children and adolescents who live in emotional, educational and psychosocial deficiencies.

Discussion

In the field of hypnotherapy itself, Kroger and Felzer [26] have developed an effective model, based in part on the hypno-operative therapy of Tugender and Ferinden [27]: "the fundamental hypnosis of the hypno-behavioral model states that maladaptive responses are produced by anxiety". To remedy this situation, the authors use hypnorelaxation, the antithesis, according to them and in our opinion, of anxiety and tension. If we return to the case of our young Aldo, we find that the triggering factor is childhood anxiety (ICD-10) [1] linked to the entry into the first year of primary school at the age of 6 years, the beginning of his secondary encopresis. The persistence of this anxiety confirmed at the child psychiatric examination was complicated by the lack of emotional support from the non-reassuring family environment. It is assumed that Aldo would have initially adopted his inappropriate behavior of withholding feces in the face of the phobia of soiling his pants without the help of the adult. This same strategy being also doomed to failure because of the downward hyper pressure, without resistance in spite of the inconvenience it causes him. And also at certain moments this leakage of stool would have intervened as a mechanism of resolution of the intrapsychic conflict that had become uncontrollable. The repetition of these maladaptive responses to anxiety between a disturbance of the autonomic nervous system of the colon had led to the progressive installation of a functional megacolon. Rossi [28] citing Olness and Conroy [29] in their study showed that children (7 to 17 years old) accustomed to self-hypnosis were able to increase the level of oxygen in their body tissues. With this study, they provided evidence for the existence

of voluntary control under self-hypnosis of the functioning of the autonomic nervous system.

In Aldo's case, good oxygenation of his functional megacolon would have been possible by increasing the blood pressure in the mucosa and in the colonic muscle, restoring all the secretory and peristaltic mechanisms in place thanks to the Exercise of Relaxation and mental imagery (ERMI), which is nothing other than self-hypnosis. This hypno-behavioral therapy approach used by Aldo with a lot of improvisation is inspired by Ericksonian hypnotherapy as presented by his disciple Malarewicz [30] in his manual "Strategy in therapy or hypnosis without hypnosis by Milton H. Erickson". The metaphors corresponding to the reality of the patient, his problematic and the therapeutic context such as the slide, both a playful and meaningful instrument for our young encopretic, was a great catalyst in the psycho-corporal healing of our patient. It was dynamic in the almost immediate change and its relevance to the symptom was the therapeutic contribution of our ERMI technique. Hypnosis, as inner focus and self-examination allowed Aldo to have a good perception of his body through the slide metaphor associated with the digestive tract diagram. This hypnobebehavioral technique resulted in Aldo's increased internal control and self-control and management of his anxiety towards other reality-adapted pathways other than encopresis. The use of the double bond allowed our young patient to choose between two unpleasant situations for him. The fact of having a bowel movement in his pants "is boring", but it is still better to shit in the toilet even if "it is also boring" for him. This second choice transforms the discomfort caused by encopresis into a playful pleasure with the mastery of the anal erogenous region according to Freud [12], an obligatory passage to stabilize his recovery. Subsequently, consolidation was possible by the technique of the affective bridge of Watkins cited by Araoz [32]. The affective bridge is a good technique for transferring pleasant or unpleasant affects between two situations or two states of consciousness. In Aldo's case, we used it by transferring the pleasant sensations from the blue screen (B) to the grey screen (G) in the toilet during defecation to transform this embarrassing act for our young patient into a pleasure. The affective bridge is intended to help the patient unconsciously control or suppress the symptom. Here the metaphorical suggestion of the suppression of the disgust of having a bowel movement is done by the transformation of the grey screen into blue. Ericksonian hypnosis according to Hoareau [33] facilitates the natural process of evolution and psychological

maturation. It intervenes on two levels : the therapist trains the patient at the level of unconscious functioning (hypnotic) and, on the other hand, by affecting a psychotherapeutic work where the words used serve to evoke resonances and by setting in motion associative chains that can lead to new psychological or psycho-educational solutions. In this case, the behavioral techniques that accompany hypnosis, as in the case of our patient, must be adapted to the needs and context of the patient.

This secondary encopresis, resistant to integrated medical and child psychiatric treatment, was brought under control after 6 years of therapeutic wandering. The hypno-behavioral therapy approach allowed to settle this chronic condition in a few sessions. A good catamnestic hindsight of about 11 months (from 24.02.2000 to 15.12.2000) confirmed the consolidation of his recovery with learning learned in hypnosis and taken over by the patient as "homework" or tasks at home associated with self-hypnosis with monitoring by the specialist educators and parents in and out of the institution.

Conclusion

The long-term therapeutic efficacy of psychoanalytic, cognitive-behavioral, biofeedback, medical, and mixed methods of treating encopresis tends to be the same. The four-year catamnestic study by Loening-Baucke [34] confirms this with identical recovery rates whatever the treatment method used. We chose the hypnobehavioral therapeutic approach for several reasons:

- It is appropriate for this type of retentive encopresis on functional megacolon in this case with previous failures to medical and behavioral treatments according to the confirmation of the treating physician.
- It allows the child to have immediate control over his shameful symptom without too much intrusion of adults in his intimacy thanks to simple behavioral techniques that are easily reproducible by the child.
- Compared to other treatments, this hypno-behavioral therapeutic approach (HBTA) is more like a game than a treatment when compared to laxatives, suppositories, or enemas. For the child, the choice is easier, and compliance is better.
- The hypno-behavioral therapeutic approach here was, for little Aldo, a field of experimentation on himself thanks to self-hypnosis through the "in vitro" aspect with the kinesthetic video device of the B and G screens and the "in vivo" aspect

with a visit to the toilet every morning to transform the virtual reality according to Béguélin's [34] expression into a living and experienced reality.

- This approach, by demystifying encopresis for Aldo, positively reinforced him on the psycho-educational level by giving him a taste for effort and increasing his self-esteem for an acceptable socio-educational adaptation.

The hypnobehavioral approach is not only used here as a miracle recipe. It is associated with a global institutional care requiring a psychodynamic and systemic understanding of the whole network of intervening parties : patient, family, educators and the therapeutic and pedagogical team of the institution for children and adolescents whose station here is the TPCD affiliated to the CNPea.

Bibliography

1. Organisation Mondiale de la Santé. Classification Internationale des Troubles Mentaux et des Troubles du comportement, Descriptions cliniques et Directives pour le Diagnostic (CIM-10), OMS, Genève, Edt. Masson, Paris (1993).
2. Bellman M. "Studies on encopresis". *Acta Paediatrica Scandinavica* 170 (1966): 7-151.
3. American Psychiatric Association, Mini DSM-IV, Critères diagnostiques (Washington D.C.). Traduction Français, JD., et al. Edt. Masson, Paris (1994).
4. Levine MD. "Children with encopresis: A descriptive analysis". *Pediatrics* 56 (1975): 412-416.
5. Anthony E J. "Un modèle pour le traitement de la psychopathologie de l'enfance: Encopresis". *British Journal of Medical Psychology* 30 (1966): 146-175.
6. Huschka M. "The child's response to coercive bowled training psychosomatic". *Medecines* 4 (1942): 301-308.
7. Cramer B., et al. "Trente-six encoprétiques en thérapie". *Psychiatrie de l'enfant* 26.2 (1983): 309-410.
8. Walha A., et al. "Encopresis in children in child psychiatry consultation: a study of 91 cases". *Archives of Pediatrics* 17.6 (2010): 90.
9. Johnston BR and Wrigh JA. "Attention dysfunction in children with encopresis". *Journal of Development and Behavioral Paediatrics* 14 (1993): 381-385.

10. Landman GB., et al. "Locus of control and self-esteem in children with encopresis". *Journal of Developmental and Behavioral Paediatrics* 7 (1986): 111-113.
11. Bernard-Bonnin AC., et al. "Parental and patient perceptions about encopresis and its treatment". *Journal of Developmental and Behavioral Paediatrics* 14 (1993): 397-400.
12. Freud S. "Extrait de l'histoire d'une névrose infantile (l'homme aux loups)". In S. Freud, cinq psychanalyses. Paris: Presses universitaires de France 1954 (texte original publié en 1918) (1954).
13. Pinkerton P. "Méga colon psychogène chez l'enfant: The implications of bowel negativism". *Archives of Disease in Childhood* 33 (1958): 371-398.
14. Easson RI. "Encoprésie - souillure psychogène". *Journal de l'Association Médicale Canadienne* 82 (1960): 624-628.
15. Boon F and Singh NN. "Un modèle pour le traitement de l'encoprésie". *Behavior Modification* 15 (1991): 355-371.
16. Vidailhet C. "L'encoprésie: étude clinique". *Neuropsychiatrie de l'enfance et de l'adolescence* 31 (1983): 197-200.
17. Feehan CJ. "Enuresis secondary to sexual assault". *Journal of the American Academy of Child Adolescent Psychiatry* 34 (19945): 1404.
18. Kirsch I. "Clinical hypnosis as a nondeceptive placebo: empirically derived techniques". *American Journal of Clinical Hypnosis* 37 (1994): 95-106.
19. Yeates Lindsay B. "James Braid (IV): Braid's Further Boundary-Work, and the Publication of Neurypnology". *Australian Journal of Clinical Hypnotherapy and Hypnosis* 40.2 (2018): 58.
20. Franz Anton Mesmer. Mesmerism: The Discovery of Animal Magnetism: English, in French originally: Franz Anton Mesmer "Mémoire sur la découverte du magnétisme animal", appeared for the 1st time in English with an Introduction Monography by Gilbert Frankau (1948).
21. Armin Stock and Claudia Stock. "A short history of ideo-motor action". *Psychological Research* 68 (2004): 176-188.
22. Hull Clark L. "Les psychologies conflictuelles de l'apprentissage: un moyen de sortir". *Revue Psychologique* 42.6 (1935): 491-516.
23. Blackwell W and White R. "Le manuel d'hypnose clinique contemporaine: Theory and Practice".
24. Sarbin TR and Coe WC. "Hypnose et psychopathologie: remplacer les vieux mythes par de nouvelles métaphores". *Journal of Abnormal Psychology* 88.5 (1979): 506-526.
25. Francine de la Gorce. "Témoin de l'histoire des pauvres". *Revue Quart Monde* (2011).
26. Kroger WS and Fezler WD. "Hypnosis and Behavior Modification: Imagery conditioning". Philadelphia: Lippincott (1976).
27. Tugender HS and Ferinden WE. "An Introduction to Hypno-operand therapy". Orange, N.J.: Power publishers (1972).
28. Rossi EL. "Psychobiologie de la guérison, influence de l'esprit sur le corps". Edt. Hommes et perspectives. Desclée de Brouwer (1994): 231-232.
29. Olness K and Conroy M. "A pilot study of voluntary control of transcutaneous PO2 by children". *International Journal of Clinical and Experimental Hypnosis* 33.1 (1985): 1-5.
30. Malarewicz JA. "La stratégie en thérapie ou hypnose sans hypnose de Milton H". ERICKSON. Edition ESF; (1992).
31. Araoz L Daniel. "Hypnose et sexologie, une thérapie des troubles sexuels". Ed. Albin Michel 34 (1994): 184-215.
32. Hoareau J. "L'hypnothérapie-Quand l'esprit soigne le corps". Edt. Robert Laffont, S.A, Paris (1993).
33. Loening-Bauche V. "Biofeed-back treatment for chronic constipation and encopresis in childhood: Long term outcome". *Pediatrics* 96 (1995): 105-110.
34. Beguelin C. "Sans renard, pas d'oiseau d'or. Une réflexion sur la place de l'hypnose en psychothérapie". CH-hypnose 7.1 (1997).