Constipation is a chief complaint in 3 - 5% of paediatric outpatient visits and is a problem for about 1 in 6 children at some time. There is wide variability in what should be considered normal defaecation frequency in children. The first bowel movement generally occurs within 36 hours after birth in term newborns. It may be delayed in premature infants.

**Functional constipation**

Outside the neonatal period constipation is generally a functional disorder (i.e. no evidence of structural, endocrine or metabolic disease). It is defined as the passage of hard and pebble-like stools, or the infrequent (2 or less per week) passage of firm stool for a period of at least 2 weeks.

Possible contributing factors to the development of constipation are:
- genetic predisposition
- diet
- efficient absorption
- transit delay.

Inadequate fibre intake and the ingestion of drugs can be excluded by careful history taking. Physical examination is generally normal and special investigations are only warranted in the presence of poor weight gain, abdominal distention, vomiting, anterior or displaced anus or occult spinal dysraphism (sensory or motor deficits, patulous anus, urinary incontinence, absent cremastic reflex or pigmentary abnormalities and hair tufts in the sacro-coccygeal area). Treatment includes an increase in dietary fibre. Sorbitol and fructose found in fruit juices can cause increased frequency and water content of stool. When dietary intervention is unsuccessful, non-stimulant laxatives like lactulose and sorbitol can be effective.

**Functional faecal retention (often with soiling)**

Functional faecal retention (FFR) is defined as the infrequent passage of large diameter stools with retentive posturing (contracting muscles of the pelvic floor and squeezing buttocks together). Accompanying symptoms include soiling of the underclothes, irritability, abdominal cramps and decreased appetite. FFR begins when there is a painful bowel movement. The child learns to fear the urge to defaecate, with subsequent withholding. There are 3 periods when a child is particularly vulnerable to developing constipation:
- time of weaning from breast milk to formula and introduction of solids to the diet
- toilet training
- start of school.

On physical and rectal examination there may be a palpable lower abdominal mass and a dilated, stool-filled rectum. A thorough history and physical examination generally suffice to establish whether further evaluation is required. A plain abdominal X-ray can confirm the presence of a faecal mass and the extent of faecal loading, especially when the rectal examination is best avoided. Treatment goals in FFR include a combination of parental education, behavioural modification and medical intervention. This is to help the child overcome the emotional distress associated with defaecation. Initial faecal clearance can be achieved by enemas (phosphate enema: 6 ml/kg, up to 135 ml in total — to be avoided in children under 2 years old) and by the oral administration of a balanced polyethylene glycol electrolyte solution (Go-lytely) as an intestinal lavage. Nasogastric administration is often needed, as large volumes are required (25 ml/kg/h).

Only artificial sweeteners can be added to improve palatability, as glucose will facilitate electrolyte and water absorption. A 24-hour hospitalisation period is usually adequate. The Go-lytely must be given until virtually clear fluid is passed. Painless defaecation is best acquired through the use of non-stimulant stool softeners (mineral oil: 1 - 3 ml/kg/day in divided doses — to be avoided in children < 1 year old) or osmotic laxatives (lactulose, sorbitol, magnesium hydroxide: 1 - 3 ml/kg/day in divided doses). Titrate doses to provide soft stools. Continue laxatives daily for at least 3 - 6 months or longer if indicated. Stimulant laxatives (senna, bisacodyl) should be reserved for resistant cases, or as rescue agents when there has been no bowel movement for more than 3 days. Parents must be compulsive about medicating the child, because one painful bowel movement will reinstitute the fear and holding-back cycle. The child should also be
TREATMENT DEFINITELY PREVENTS FURTHER MORBIDITY AND IS ALSO MORE EFFECTIVE WHEN ADMINISTERED SOON AFTER THE TRAUMATIC EVENT.

IN CHILDREN YOUNGER THAN 6 YEARS THE REACTION TO TRAUMA IS REFLECTED IN DEVELOPMENTAL ASPECTS OF THEIR BEHAVIOUR.

POST-TRAUMATIC STRESS DISORDER IN CHILDREN

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‘Closer than the moon, even closer than the depths of the seas, the minds of children seem to most people not only mysterious, but impenetrable.’

In children younger than 6 years the reaction to trauma is reflected in developmental aspects of their behaviour.

References available on request.

Functional non-retentive faecal soiling

Faecal soiling without retention may be secondary to diarrhoeal disease (fatigue of pelvic floor muscles) or defective neuromuscular control, e.g. spinal defects. Encopresis is an uncommon subtype of functional non-retentive faecal soiling. It is a psychiatric term that refers to the repeated, voluntary or involuntary passage of quantitatively normal faeces into inappropriate places. It occurs after the age of 4 years. There is no organic cause. Refer these children to a mental health professional as their soiling is a symptom of emotional upset.

The role of diet and fibre in FFR is controversial. Fibre does not reliably soften stools during childhood and may occasionally worsen symptoms. Dietary restrictions are not really necessary. However, the clinician should provide continuing availability and follow-up visits. The factors leading to stool withholding and the benign nature of the disorder should be explained to the family. Prognosis is good as long as there is compliance with the treatment plan.

Few syndromes of psychopathology evoke as many powerful and diverse reactions in clinicians as trauma-induced syndromes, such as acute stress disorder (ASD) and post-traumatic stress disorder (PTSD), especially when they occur in children and in the youth.

The need for timely diagnosis and intervention is pressing. Treatment definitely prevents further morbidity and is also more effective when administered soon after the traumatic event.

Unfortunately, the recognition of trauma-related pathology is not easy in an age group in which development determines the form that the psychopathology will adopt. Children of all ages are susceptible to the effects of trauma. Many are particularly vulnerable to certain types of trauma because of their dependency on adults for care and safety, their limited ability to influence the events and surroundings in which they live, and their limited cognitive and emotional level of development.

The most prevalent and researched trauma is that which occurs directly to children, e.g. sexual and physical abuse, violent crime, motor vehicle accidents, and threatening illness, with invasive medical procedures. These children are at great risk of developing psychological symptoms. As recently as the 1980s it was widely believed that children only have transient reactions to single traumatic events and soon put the experience ‘behind’ them. This misunderstanding largely resulted from a failure of researchers to interview children about their experiences and subsequent responses. Instead, they relied on reports from parents, teachers, etc. In fact, when questioned, children report a wide range of reactions and feelings after traumatic events. These tend to cluster around signs of re-experiencing the event, attempts to avoid dealing with emotions and a wide range of signs of increased physiological arousal. There may also be considerable co-morbidity, with depression, anxiety and pathological grief reactions.

After a traumatic experience repetitive, intrusive thoughts about the event trouble most children. Sleep disturbances, fear of the dark and nightmares are very common. Tiredness and difficulty with concentration as well as problems with memory are often seen. Separation difficulties are also prevalent in teenagers and it is not unusual for children not to let their parents out of their sight. Heightened alertness to danger is observed commonly. These children feel that life is ‘fragile’. Children may have a loss of confidence in their future or a sense of a foreshortened future. Unsurprisingly, many develop fears associated with specific aspects of their experience and avoid situations which they associate with the event. Survivor guilt may also manifest. High rates of depression and anxiety as well as panic attacks may co-exist. Although not described in the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM –IV) criteria, psychotic symptoms may definitely be a component of PTSD. Unfortunately, many children and adolescents who survive traumatic experiences find it difficult to talk about their feelings with family and peers. Therefore other therapeutic approaches are of the utmost importance.

In children younger than 6 years the reaction to trauma is reflected in developmental aspects of their behaviour. These children can often convey...