



Medical and Psychiatric Management of Fecal Smearing in Adult Persons with Mental Retardation and Developmental Disabilities (MR/DD)

1. Overview

Fecal smearing or throwing of feces can be a distressing behavioral problem in the person with mental retardation. The frequency of this behavior is not known. Fecal smearing can produce serious health hazards, especially in patients with past exposure to hepatitis or other communicable diseases.

Fecal incontinence is a disturbing occurrence to most patients. For instance, severely psychotic, schizophrenic patients rarely soil themselves. Alzheimer's patients will make significant efforts to prevent self-soiling and episodes of incontinence often produce significant distress in even the most demented patient.

2. Differential Diagnosis

The assessment of fecal smearing depends upon the clinical circumstances of the individual. Fecal smearing is not a typical behavior in persons with mild retardation or borderline intellect (1). Fecal smearing in this intellectual group suggests manipulative behavior, attention-seeking behavior or delirium. Incontinent patients may smear feces in frustration over self-soiling. A successful toileting schedule that includes physical assistance with toilet hygiene may correct this problem.

Fecal smearing may occur in moderate and severely retarded persons and minimal clinical data describes this distressing behavior (2), (3), (4). No specific type of intellectual disability is associated with increased risk for fecal smearing. Fecal smearing can be divided into acute and chronic syndromes. The acute onset of fecal smearing suggests a new, unrecognized health problem referable to the gastro-intestinal or genito-urinary system (5), (6). Fecal obstipation and rectal impactions are common problems in the mentally retarded person. Atonic, floppy colons can become distended with feces, i.e., obstipation. Any patient with new onset fecal smearing should have a careful assessment of their gastro-intestinal and genitor-urinary system. Older males

with prostatic hypertrophy may “dig” at their perineal area in response to discomfort from the genitourinary tract. Females may “dig” in the perineal area in response to vaginitis, vulvitis, and sexually transmitted diseases. Perimenopausal women may “dig” at the perineal area as a result of itching produced by estrogen deficiency, and vulva skin thinning. The clinician should carefully assess for the possibility of pain or medical problems in any patient with a new onset of fecal smearing (**See Table 1**).

Chronic, fecal smearing may result from chronic gastro-intestinal or genito-urinary problems; however, this behavior may represent a response to stress or a learned behavior. Boredom, frustration, loneliness, or lack of stimulation may cause the patient to engage in rectal digging and fecal smearing. The resident who has smeared feces will self-stimulate through the actual fecal smearing and the response of the caregivers to cleaning the patient. The fecal smearing patient requires a careful behavioral intervention and behavioral management strategy. The medical team should strive to prevent fecal loading in the colon or rectum through high fiber diets, stool softeners, adequate hydration and enemas when required.

| Table 1 Medical Diagnosis of “Digging” in Perineal Area in Persons with MR/DD | |
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| 1. GI System | Constipation Hemorrhoids Obstipation |
| 2. GU System | Prostatitis Vaginitis Vulvitis Cystitis |
| 3. Other | Perineal Dermatitis Other painful GU Problems, e.g., endometriosis, fibroids |

Throwing feces by a patient with moderate or severe retardation is a behavioral problem that requires behavioral assessment and intervention. Fecal “flinging” by mildly retarded persons suggests manipulative behavior.

3. Assessment

Fecal smearing requires a comprehensive medical, psychiatric, and behavioral review. The medical examination includes abdominal assessment, rectal examination to assess rectal competence, and a digital exam to exclude impaction and identify hemorrhoids. The perineal area should be carefully examined and a stool specimen sent for occult blood. A flat plate X-ray of the abdomen may identify loops of bowel dilated with feces when fecal obstipation is suspected.

4. Treatment

Treatment begins by correction of all medical problems that may produce abdominal and perineal pain or distress. Treatment focuses on behavioral

assessments and interventions. Staff should adjust diet to reduce constipation. The patient should be placed on a toileting schedule and staff should monitor frequency of bowel movements. Incontinent patients should have rapid changing of adult diapers and cleansing of perineal area.

Psychotropic medications are not effective for fecal smearing or fecal flinging. Patients should not be sedated or tranquilized unless the health consequences are so grave as to warrant the probable side effects produced by the medications. Uncontrollable fecal smearing in a hepatitis C carrier who sheds virus may require the drastic intervention of psychotropic medication. Fecal smearing in a borderline IQ or mildly retarded is strongly suggestive of manipulative behavior.

References

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