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Toilet Training Methods, Clinical Interventions, and Recommendations

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ABBREVIATION. AAP, American Academy of Pediatrics.

One area of pediatric care that strongly presents an opportunity for anticipatory guidance and clinical intervention is that of toilet training. Because most toilet training problems presenting to the health care practitioner reflect inappropriate training efforts and parental pressure, providers can, by consulting with parents, elucidate and address misconceptions parents have about the toilet training process, help parents to develop appropriate expectations about toilet training, and provide information, guidance, and support to parents for managing this potentially frustrating process. And although there already exists a plethora of information on child development in toilet training that parents can access and refer to, parents often solicit the support of health care providers at this particular stage in their child's development.

The health care provider's role in toilet training is really a combination of needs assessment, information-gathering, education, counseling and support, short-term strategizing, and follow-up measures. This article focuses on approaches to and strategies for advising and guiding parents through supporting their child during the toilet training process.

TOILET TRAINING: A DEVELOPMENTAL MILESTONE

Toilet mastery is truly a developmental milestone in a child's life; it is a time when children are discovering and enhancing their physical abilities, understanding and responding to relationship dynamics, and confronting and reacting to external pressures. Meanwhile, as each step is achieved, their self-esteem also is developed. Toilet training also can be one of the most difficult developmental phases that both children and parents experience together, because pressures for the child to conform to parental and social expectations occur simultaneously with a child's burgeoning need for self-actualization and independence. Parental control over the child to train, concurrent with the child's will to be in control,

leads to conflict and anxiety. Power struggles ensue that impact negatively the parent-child relationship and may lead to physical complications such as enuresis, encopresis, and child abuse.

A CHILD-ORIENTED APPROACH

The American Academy of Pediatrics (AAP) strongly recommends that parents avoid pushing their child into toilet training, and suggests instead that the process begin only when the child is developmentally ready or shows signs of readiness.¹ These signs identify when the *child* is prepared or motivated to move to the next phase of independent toileting. Such a child-oriented approach was developed by Dr T. Berry Brazelton, which helps health care providers understand and communicate the toilet training process according to a child's development. This model of toilet training comprises three variant forces in child development: physiologic maturation (eg, ability to sit, walk, dress and undress); external feedback (ie, understands and responds to instruction); and internal feedback (eg, self-esteem and motivation, desire to imitate and identify with mentors, self-determination and independence).² Dr Brazelton identifies developmental stages at which parents and providers can anticipate progress and plan next steps. More specifically, at 18 months, children may show signs of readiness; at 24 months, a step-by-step approach for teaching the child his/her role in the process should be initiated; at 30 to 36 months, most children will have achieved daytime continence; and finally, at 36 to 48 months, most children will have completed nighttime training.

HEALTH CARE PROVIDER VISITS

Based on the stages of a child's development, health care providers can schedule visits to address issues specific to toilet training. For example, a visit to a health care professional when the child is 12 to 18 months old is an opportune time to discuss with parents plans for toilet training their child. Targeted issues could focus on strategy or methods of training; time frame (ie, when to begin and how long it might take to train); expectations (eg, obstacles, bed-wetting concerns, and progress); pressures (eg, from family members or social influences); and any unresolved or particularly negative childhood memories parents may have that could impact any of these strategies.

A visit to the health care provider when the child is 2 years of age, before initiating independent toileting, enables the provider to assess both the child's

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and the parents' readiness. At this visit, the provider should be alert to and inquire about the child's physical, emotional, and language development, including the ability to walk, remove clothing, follow directions, communicate, and control bladder and sphincter muscles. The practitioner also should assess the child's temperament, which includes, but is not exclusive to, motivation to learn, moodiness, ability to cope with frustration or pressure, and cooperativeness, because these characteristics can greatly impact design and timing of training. Once these factors have been evaluated, the health care professional and the parents can collaborate on devising an appropriate toilet teaching plan.

The practitioner also should assess the parents' perceptions, expectations, and time limitations or considerations. For example, some parents might wrongfully equate toilet training success with intelligence or attribute the child's lack of interest in toilet training to the child's character (ie, the child may be perceived as stubborn, lazy, uncooperative, hostile, or perhaps jealous of a new sibling). Moreover, parents might interpret unsuccessful toilet training attempts as a direct assault on their competence and authority.³⁻⁵ It is important for parents to understand that learning independent toileting is a gradual process that is driven by the child's motivation and interest. Initially, the parents explain what needs to be done, perhaps by demonstration, but then it is the child's willingness that will determine when to attempt the next step. During this process, the parents should encourage, reinforce, and praise the child for each accomplishment of toilet training.

The time required for complete understanding and use of toilet facilities varies from child to child. Health care providers can assist parents in recognizing when their child is ready to learn and prepare them for the process, including investing the emotional energy required to work with their child patiently, systematically, and consistently for a period of at least 3 months.⁶

STAGED TOILET TRAINING: PRACTICAL METHODS

The Potty Chair

The potty chair is a useful diagnostic tool for assessing both readiness and desire to train. Parents should introduce the potty chair as the child's own property. It can be colored attractively and placed in a convenient location (not necessarily in the bathroom) to entice the child to use it. The child should be taught to observe, touch, and become familiar with the potty chair well in advance of its encouraged use. Parents should offer the child routine opportunities to use the potty chair, but should in no way pressure the child to use or stay on the potty chair. When the child begins to show interest in using the potty chair, parents should let the child sit on it fully clothed, before trying it while undressed to become comfortable with the look and feel of the chair. To help the child conceptualize and understand the process, parents can be taught to demonstrate the purpose of the potty chair by taking the

stool from the diaper and putting it into the child's potty chair.⁶ Additionally, parents can use imitation as a powerful way to introduce the idea of using the potty chair.

Reminders and Reinforcement

Based on cues or specified times of the day when urination and/or a bowel movement are most probable (eg, on awakening or after meals), parents can synchronize practice runs to the potty chair, while explaining to the child what is expected. Once the child understands the function of the potty chair, the child may alert the parents when he or she feels the need to eliminate.

Certain elements of toilet learning can prompt fears, such as flushing or the disappearance of feces or urine, and may even discourage further development in toileting. Allowing the child to flush a piece of toilet paper or joining the child in saying "bye-bye" to excrement may alleviate some of the anxiety a child might feel as it disappears.

Parents should praise successful toileting and provide the child with more than one acceptable choice for each range of toilet behaviors. As the child develops each step of toileting, he or she gains a sense of accomplishment, which should be reinforced by the parents. The child's self-esteem is delicate during this time; therefore, it is imperative that parents support the child throughout all phases of toilet teaching.

When parent-child relationships are strained, both parent and child may need a moratorium from toilet training to focus on enjoyable activities together and establish a stronger mutual trust and cooperation. The child can use this time to regain a positive self-esteem, which might have been compromised if a wetting accident occurred. For example, several perspectives suggest that a 3-month break from training can prompt spontaneous resolution of bowel and bladder accidents.^{7,8} If, however, a child continues to regress or have wetting accidents, the parents should remain understanding and supportive and discourage the child from feeling like a failure, keeping his or her confidence and self-image high.

Diapers

When the child begins to show regular daytime dryness, parents may start to experiment with allowing the child to roam the house without any bottom covering or putting the child in underwear for part of the day and returning to diapers at night. Toddlers' skin is susceptible to rash as much as infants' skin, but they may suffer more when exposed to urine and feces because of friction caused by increased movement and activity. Therefore, diapers should be changed frequently.⁹

Nighttime Bladder Control

Although nighttime or naptime dryness may be achieved simultaneously with daytime dryness, nighttime bladder control normally takes several months to years after daytime training. This is because the sleep cycle needs to mature so the child can

awaken in time to urinate. If the child is willing to cooperate, parents can encourage a child to stay dry at night by making regular trips to the bathroom before bedtime or providing a potty chair near the bed for easy access. Persistent bed-wetting into school age suggests a problem requiring a health care professional's assistance.

Regression

Setbacks during the toilet learning process (eg, the child starts to withhold stools or insists on wearing diapers after learning to use the toilet) tend to occur or escalate if the child is pushed too hard or too fast, or if a significant, stressful family event (eg, new sibling, new home, or new child care provider) transpires. Regression is a normal part of the toilet training process, does not constitute failure, and should be viewed as a temporary step back to a more comfortable place. Often regression confuses and upsets parents, who in turn may express anxiety toward and exert pressure on the child. Instead, the parents need to be accepting of the setback and reinforce toileting behavior.

GUIDELINES

Both the AAP guidelines and the Pampers Parenting Institute Pediatric Roundtable guidelines published in this article recommend that parents should not force a child to begin toilet training.¹ Both guidelines suggest that a parent should prepare for toilet training by looking for signs of readiness for mature toileting behavior, although the AAP guidelines do not identify types of signs. These guidelines reflect

the belief that toilet training is a process comprising many stages and requiring the right combination of behavioral, developmental, and emotional elements,^{2,6} which can be influenced by parents, caretakers, or day care providers. These guidelines suggest seeking the advice of a health care professional before starting the process to get assistance in planning the various stages of training. Also mentioned herein, but not in the AAP guidelines, are the complications that may arise because of stool withholding, regression, and the connection between toilet training and other developmental steps in a child's growth. Finally, the Roundtable advises that there is no one universal right age to begin toilet training and no absolute deadline to complete training.

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