CANADIAN PAEDIATRIC SOCIETY STATEMENT

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Toilet learning: Anticipatory guidance with a child-oriented approach

Paediatricians are asked frequently about the timing and method for toilet learning. As with many behavioural issues, there are no concrete answers to such questions. Reaching this developmental milestone can be difficult for both the child and parents. To help facilitate the toilet learning process, physicians should inform parents about the 'child-oriented' approach before the process starts, and they should be prepared to offer anticipatory guidance to parents as the child learns toileting skills.

TIMING

The age at which parents initiate a child's toilet learning and the age at which it is considered appropriate for a child to be toilet trained have changed over the years. The relatively 'laissez-faire' approach to toilet learning taken at the beginning of the 1900s was replaced by the the more rigid 'parent-centred' approach of the 1920s and 1930s (1). These approaches were subsequently rejected in favour of the child-oriented approach advocated by Spock (2) and Brazelton (3), which has become the mainstay of advice provided by physicians (4-12). This shift in approach has made it acceptable for children to achieve this developmental milestone at a later age.

Important cultural differences exist between the methods used to toilet train a child (13,14). Most children in western countries achieve bladder and bowel control between 24 and 48 months of age (3,8,15-24). Girls tend to achieve this control at a slightly younger age than boys (17-19,25,26). The average time from the initiation of toilet learning to the attainment of independent toileting varies from three to six months (22). The attainment of bladder control does not always coincide with the achievement of bowel control, and night time urinary continence may coincide with daytime continence or occur several months or years later (3,8,16,17,19,20,25,26). The toileting process encompasses a great deal of heterogeneity, and there is no specific age at which toilet learning should begin.

ASSESSING A CHILD'S READINESS FOR TOILET LEARNING

Toilet learning readiness should not be dictated by a child's chronological age. Rather, as the child-oriented approach advocates, a child must be physiologically and psychologically ready to begin the process. Parents should be prepared to devote attention and patience to the task on a daily basis for several months.

For the child, physiological readiness precedes psychological readiness. By the time a child reaches 18 months of age, reflex sphincter control has matured and myelination of extrapyramidal tracts has occurred; both processes are necessary for bowel and bladder control. These processes cannot be accelerated (25,26). Psychological maturation, however, is not necessarily achieved in concordance with physiological maturation.

When assessing a child's readiness for toilet learning, the physician must consider motor, language and social milestones, as well as the child's demeanour and relationship with his or her parents (2,3,7-11,27). A checklist of a child's toilet learning readiness is in Table 1.

CHILD-ORIENTED TOILET LEARNING TECHNIQUES

Parental expectations about toilet learning should be assessed by the physician at the child's first-year visit. This is an opportunity to provide anticipatory guidance because most parents underestimate the time required to complete the process (18). The child-oriented approach (ex-

TABLE 1: Signs of a child's toilet learning readiness

- Able to walk to the potty chair (or adapted toilet seat)
- Stable while sitting on the potty (or adapted toilet seat)
- Able to remain dry for several hours
- Receptive language skills allow the child to follow simple (one- and two-step) commands
- Expressive language skills permit the child to communicate the need to use the potty (or adapted toilet seat) with words or reproducible gestures
- Desire to please based on positive relationship with caregivers
- Desire for independence, and control of bladder and bowel function

TABLE 2: How parents can facilitate a child's toilet learning

- Decide on the vocabulary to use.
- Ensure the potty chair and position are easily accessible. Allow the child to watch his or her parents use the toilet.
- If a regular toilet is used, use a toilet seat adapter and a foot stool.
- Encourage the child to tell a parent when he or she needs to void. Give praise upon success, even if the child tells the parent after the fact. Learn the child's behavioural cues when he or she is about to void.
- Encourage the child with praise. Do not expect immediate results; expect accidents. Avoid punishment and/or negative reinforcement.
- Ensure the cooperation of all caregivers to provide a consistent approach.
- After repeated successes, suggest the use of cotton underwear or training pants. Make this a special moment.

plained below) should be discussed at subsequent visits, with the physician emphasizing that the age for toilet learning should be flexible. When the child is about 18 months of age, the toilet learning readiness of the child and parents can be assessed, keeping in mind cultural differences. Parents and all caregivers should be ready to initiate toilet learning by ensuring that time is set aside for the process and that the arrangements are suitable for the entire family. The toilet learning process should not be initiated at a stressful time in the child's life (eg, after a move or after the birth of a new sibling), and parents should be prepared emotionally for the inevitable accidents that will occur before the process is completed. Parents should be encouraged to follow their child's cues to progress from one stage to the next, as outlined in Table 2 (2,3,6-11,27). Further visits to the doctor can be used to assess progress while providing a forum to discuss issues that may arise.

A potty chair is recommended rather than a toilet during the early stages because children feel more secure and stable on the potty. The potty also provides the best biomechanical position for the child.

Initially, the child is encouraged to sit fully dressed on the potty. Next, the toddler is encouraged to sit on the potty after a wet or soiled diaper has been removed. It may be helpful to place the soiled diaper in the potty to demonstrate its function. At a later date, the child can be led to the potty several times a day and encouraged to sit on it for a few minutes without wearing a diaper. Finally, the child is encouraged to develop a routine of sitting on the potty at specific times in the day (eg, after waking in the morning, after meals or snacks, and before naps and bedtime). Using this method, the child may gain control of bladder and bowel function in a few weeks.

The child needs to be praised whenever he or she expresses an interest in sitting on the potty. Positive reinforcement may be used with this approach, but material rewards should be discouraged. Encouragement and support are more appropriate reinforcement techniques.

Once the child has used the potty successfully for one week or more, he or she may be ready to try training pants or cotton underpants. Accidents are inevitable however, and parents need to be supportive and patient. A child who has experienced a series of accidents soon after trying training pants or cotton underpants should be allowed to return to diapers without shame or punishment.

At times, children may be reluctant to pass stool in a potty or the toilet, particularly if they do not have good support for their feet. At this time, it is imperative that they be allowed to continue having bowel movements in a diaper to prevent the development of constipation and, consequently, painful bowel movements, which will further delay the toilet learning process.

TOILETING REFUSAL

Organic causes of failure in toilet learning are not common. The most likely explanation for failure is that the child is not ready. If the child is not ready, parents' attempts to toilet train him or her will be futile. Parents should be advised not to engage in 'toileting battles', which damage the parent-child relationship and the child's self-image, and may hinder progress in acquiring toileting skills (5,28,29).

If a child expresses toileting refusal, a one- to three-month break from training is suggested. This allows trust and cooperation to be re-established between parent and child. After this break, most children are ready to begin training. However, if repeated attempts are unsuccessful or if the child is older than four years, a referral to a general paediatrician or to a developmental paediatrician may be required. The referral may be necessary to explore aspects

of the parent-child relationship and to rule out physical and/or neurodevelopmental abnormalities (28-31).

Constipation may complicate toilet learning readiness. A child may associate bowel movements with pain and, therefore, try to avoid the experience as much as possible. Dietary changes are the first step in alleviating this problem, and the use of stool softeners or laxatives may also be considered. A more complete review of the treatment of constipation is beyond the scope of this statement.

CHILDREN WITH SPECIAL NEEDS

Identifying the best time for toilet learning for the child with special needs is as important as it is for his or her peers. Although the stages of toilet readiness are identical for all children, the demands of the child with special needs require the paediatrician to ascertain the degree to which the child is hampered in toileting (eg, by social and adaptive delays and/or by medications) and when the parents are prepared to begin the toilet learning process (32,33). A comprehensive study of this important topic is recommended for physicians involved in the care of children with special needs.

CONCLUSIONS

The process of toilet learning has changed significantly over the years and within different cultures. In western culture, a child-centred approach, where the timing and methodology of toilet learning is individualized as much as possible, is recommended.

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