The Decision Tree

Child Outcome Seeds for Success

Why Culture Matters: Expectations for Toilet Training

Toilet training is a developmental rite of passage and an emotional issue for both parents and children of all cultures. As providers, we often struggle with what is considered age expected toileting for a child under age three, what advice to give parents and how to score children's toileting progress in the Child Outcome area of Uses Appropriate Behaviors to Meet Needs. Many may remember Zoe's story from a couple of years ago. Three year old Zoe was expelled for one month from a Montessori Program for having too many toileting accidents. Upon her return to school, Zoe's mother was cautioned that Zoe would be expelled again after 5 toileting accidents. Questions were raised regarding not only the emotional and ethical issues of the schools actions (based on the cultural expectations of the school) but also regarding the developmental appropriateness of the expectations.

Different cultures have different expectations about when bladder and bowel control should be achieved. One thing that stands out as you research toilet training around the world is that the actual definition of "toilet trained" is quite broad. Does it simply mean a diaperless baby who goes in a socially acceptable location? Or does it mean the stage at which parental involvement is minimal and the child toilets more or less independently? The real question seems to be, is potty training truly driven by child development, or is it by and large cultural?

Throughout much of the non-Western world, infant toilet training is the norm. In India, China, Southeast Asia, Eastern Europe, the arctic, and parts of Africa and Latin America, parents leave baby bottoms uncovered (Boucke 2003; Sonna 2006; deVries and deVries 1977). Diapers are considered unnecessary, even disgusting. In these "bare-bottom" cultures, babies spend much of their days being carried around. Parents learn to read their baby's cues, and babies learn to wait until their parents give them the signal—usually a special vocalization (Boucke 2003; deVries and deVries 1977). When babies have to eliminate, parents hold them over a preferred target (e.g., a toilet, an outdoor latrine, or simply open ground). It is culturally acceptable for the young one to relieve themselves in public, including on public transportation and the sidewalk.

The expectations for toileting in the United States have changed significantly over time. In the early 1900's, diapers were folded pieces of triangle cloth secured with a safety pin. They were hand washed so parents were motivated to toilet train as early as possible. The goal was to have the child go in a potty or chamber pot, so that there wasn't a dirty diaper to clean. This was achieved in a number of ways. The mothers tried to force the child to relieve him/herself at a particular time. They did this by using a variety of methods including using enemas and suppositories. The approach was strictly "parent-centered". The notion that the child would learn at his/her own pace was not part of the picture. This changed however, in the 1940's and 50's thanks in part to several child development experts and technological advances.

In the early 1940's, Sigmund Freud cautioned that early infant training shapes adult personality in predictable and permanent ways. And that "trauma" experienced as a baby such as stressful toilet training gives rise to mental illness in adulthood. Freud placed great stock in potty training, a critical event in what he called the "anal phase" of childhood. If a baby is toilet trained too early or too harshly, Freud warned, then he will be stuck in the anal stage of development.

By 1946, Dr. Benjamin Spock, a renowned pediatrician, was encouraging parents to "leave bowel training almost entirely up to your baby….who will probably take himself to the toilet before he is two years old." Soon, the stringent potty training techniques were replaced by the "readiness approach," which contended that parents should hold off on any training until a child was physiologically ready -- generally agreed to be around 18 months. Mothers would observe their child's schedule and habits and patiently work with him until they made a connection between the feeling of having to go and the action itself.

It was in the 1950's when Marion Donovan, a New York housewife, invented disposable diapers (although they were incredibly pricey and most parents continued using cloth diapers over the next 20 years). In 1957, GE introduced a washing machine equipped with 5 push buttons to control wash, temperature, rinse temperature, agitation speed and spin speed making diaper washing less of a chore.

Throughout the 1970s, companies began the affordable production of disposable diapers. Pampers became the popular choice, and disposable diapers increasingly replaced cloth diapers. Consequently, the motivation to train children at an early age began to decrease. Potty training pioneers T. Berry Brazelton (who incidentally was being paid by Proctor and Gamble, makers of Pampers) recommended that toilet training should be child-led and later in toddlerhood. The American Academy of Pediatrics also began recommending a "100% child-centered approach" which advocated letting the child dictate her own level of readiness instead of forcing them into it prematurely. The age at which initiation and completion of potty training has steadily increased since then. Makers of diapers have also increased the size of their product in response, thus allowing a child to stay in diapers as they get bigger and bigger.

What does current research tell us? The availability of scientific research around toilet training is actually quite limited and often influenced by a sponsor's agenda. There are studies out there that say it's better for a child's urological system to train early and studies that support later training from an emotional, child readiness perspective. So where does that leave us as providers in guiding parents?

Current guidelines from the American Academy of Pediatrics (AAP) have essentially remained unchanged in the last 30 years. Recommendations state there is no set age at which toilet training should begin. The right time depends on your child's physical and psychological development. Children younger than 12 months have no control over bladder or bowel movements and little control for 6 months or so after that. Between 18 and 24 months, children often start to show signs of being ready, but some children may not be ready until 30 months or older. The child must also be emotionally ready. He needs to be willing, not fighting or showing signs of fear. If the child resists strongly, recommendations are to wait for a while.

AAP's recommended child readiness signs include:

- Stays dry at least 2 hours at a time during the day or is dry after naps.
- Bowel movements become regular and predictable.
- Facial expressions, posture, or words reveal that child is about to urinate or have a bowel movement.
- Can follow simple instructions.
- Can walk to and from the bathroom and help undress.
- The child seems uncomfortable with soiled diapers and wants to be changed.
- The child asks to use the toilet or potty chair.
- Child asks to wear grown-up underwear.

The AAP reports most children achieve bowel control and daytime urine control by 3 to 4 years of age. Even after a child is able to stay dry during the day, it may take months or years before he achieves the same success at night. Most girls and more than 75% of boys will be able to stay dry at night after age 5.

Test Your Inter-rater Reliability

Our state's focus on child outcome ratings has led many to wonder,
"Are we all rating children similarly?"

As part of our efforts to improve results for children, we are focusing each month on increasing our statewide inter-rater reliability. We are using examples of narratives from around the state that ideally will include observations of functional behaviors, parent/caregiver input, results from assessment tools and informed clinical opinion. Below is an example of a narrative from a recent Assessment for Service Planning. Using the limited information provided in the narrative and the process outlined in the Child Indicator Booklet talk thru the scenario with your colleagues to determine a rating. The ratings given by the assessment team can be found at the end.

Disclaimer: This activity is for learning purposes only and is not intended to be an endorsement of any particular narrative. It is intended to help you reflect on the questions that follow.

Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family?
3. Was the child's functioning across settings in each outcome clear?
4. Were functional skills listed under the correct outcome?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Emily's Age: 28 months Adjusted Age: NA

Referral Information, Medical History, Health Status: Emily is an absolutely adorable, vivacious, two-year-old little girl who was originally referred to early intervention a little more than a year ago by her pediatrician following her 15-month--old well-baby check-up. Emily was referred to early intervention services for concerns related to speech and language development. At the time of Emily's referral she was babbling "mama," "dada," and "buhbuh" without meaning. She was not using words to name objects or request items, she was not pointing to things to either show or to request, and she was not consistently responding to her name. Following a developmental screening and assessment Emily was found eligible for El services due to developmental delays noted in her speech and language development, social-emotional development, and cognitive development (note: Emily's cognitive developmental scores were considered less accurate due to dear speech and language delays).

Emily has been receiving service coordination and developmental El services for a year now. In that time Emily has made steady progress related to talking and social-communication skills and behaviors. Over the past year Emily has gone from essentially saying no words to saying many words and even some set phrases. Emily is also more socially aware and socially motivated as evidenced by increased eye contact, increased looking and smiling, and an increase in the frequency with which she initiates social interactions.

Emily was born at full term with no prenatal or birth related complications. She weighed 6 pounds at birth. Emily had an audiological evaluation around the time of her original referral to El services (around 15-16 months of age). Emily's mom reports that the audiological results indicated that Emily has adequate hearing. With the exception of typical infant and toddler respiratory and gastro-intestinal illnesses Emily has been healthy since birth. She currently enjoys good health.

Emily has been diagnosed with Autism Spectrum Disorder (ASD). Emily has two older brothers who also have ASD and receive Part B special education and related services. Emily remains eligible for El services because her communication skills and social- communication skills are delayed and/or inconsistent as compared to same aged peers - and because she has a diagnosed condition associated with high probability of developmental delays = ASD.

Daily Activities and Routines: Emily lives at home with her mom and dad and brothers. Father works outside the home during the week and mother stays home to care for the children. She enjoys watching her favorite TV programs and playing with her brothers when they come home. Emily naps some days but not every day. She loves to dance and will dance to music and her favorite kiddie shows on TV. Emily enjoys looking at books, playing with small toy figurines, and playing with bubbles. Emily also enjoys eating her favorite snacks ice cream and graham crackers.

Family Concerns: Related to Emily's development her parents are concerned about Emily's speech and language development - they would like to see her talking more and following directions. Related to Emily's ASD diagnosis Emily's parents report that she more social motivation and skills than her brothers did when they were Emily's age. They are hopeful Emily will be on the mild end of the autism spectrum and that as Emily's speech and language development gets closer to her same-aged peers she will participate in educational and other age-appropriate activities with typically developing children.

Family Priorities: The kids' health, well-being and happiness. Getting them the services they need to become as independent as possible

Developmental Levels: Cognitive- 16-24 months Gross Motor- 25-30 months
Fine Motor- 25 months Receptive Language- 13-14 months Expressive Language- 13-18 months
Social/Emotional- 18-24 months Adaptive/Self Help- 18-24 months

Social/Emotional Skills including Positive Social Relationships: Emily loves, loves, to have fun! She enjoys being around her family. She likes to hang out with her brothers in their room and she will play beside them. Joseph will run and chase after Emily and she loves this. Emily enjoys playing with herparents too. Emily is mostly a happy child during the day – unless she's being told "no" and/or is not getting what she wants. She is a very typical two year-old in this way. Emily generally acknowledges people when they come into her home by looking toward them (family and visitors alike). She often says "Hi!" especially to familiar faces. She sometimes says "Bye."

Emily enjoys being praised when she completes a play task. For example, when she plays with a shape sorter toy and she gets the shape into the correct hole – if her play partner claps and says "Yayl" Emily will look up at her play partner, smile, and some of the time she will join in saying "Yay" and clap for herself. Emily also does a nice job looking up at her play partner periodically when she's being successful with a toy, For example, she likes to stack toys, whether they be blocks, nesting cups, or interlocking pegs, and as she balances one toy on top of another she will often look to her play partner to share her success and her excitement. Emily imitates actions with toys, and sometimes words, that her play partner models for her.

Emily demonstrates nice social referencing and joint attention skills during play, especially for a child newly diagnosed with ASD. However, one of the concerns that contributed to Emily's diagnosis with ASD is that her social and joint attention skills, while having improved greatly over the past year, remain inconsistent and not fully developed for her age. Emily's joint attention skills and behaviors are strongest when she initiates. The joint or shared attention are not as strong, comparably, when a play partner attempts to initiate joint attention with Emily. For example, if a play partner says "Look at this" during play while holding up a toy or pointing to a toy or picture Emily does not consistently refer to the play-partner and/or the object or picture that the play-partner is pointing to or showing her. Sometimes when Emily is playing independently it is difficult to get Emily to engage in more two-way or interactive play with her play partner. Emily does not typically respond to her name being called. When her name is called Emily keeps doing what she's doing without pausingor looking up or turning. Every now and then she will respond when her mom calls her name by looking up at, or toward her mom.

Like many typical two year olds Emily does not communicate her feelings or moods with words – however Emily does express her feelings and/or mood clearly with non-verbal behavior including facial expression, vocalizations (squeals, crying, yelling), and/or actions (throwing something down when she's frustrated or

engaging in a typical two year-old tantrum or playing cooperatively and reciprocally when she's in a happy and playful mood).

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Emily learns new skills and concepts through observation, self exploration, trial and error, and imitation. Emily has good fine motor (hand) skills and she enjoys learning through manipulative toys such as stacking toys, shape sorting toys, and toys that she has to load smaller toy pieces into a larger piece. If toys have a sound effect, it's even better. She will repeat a toy action to make the sound effect occur again and again, Emily shows sorting skills when she plays with a bunch of small toy figurines - she will go through a pile to find matching ones. Emily will also match a picture on a puzzle piece to an identical picture on the puzzle board when she is attentive to the pictures (she's not always 100% attentive). You'll see her put the puzzle piece onto the matching picture initially though she generally does not have the patience to spend time trying to fit the puzzle piece into the correct puzzle slot and she'll quickly move it and try to fine another slot it fits into more easily (which she won't find but you can't tell her that!). As noted above Emily imitates a play-partner's action with toys. For example, she easily imitates making small toy animals walk or jump echoing· "walk, walk, walk" or "jump!" and she's imitated a play partner making car, train, and airplane puzzle piece move along the floor or fly in the air, and again echoing the "beep beep," "choo-choo." and "Aaahhhh" sounds. And on several occasions Emily has been observed to spontaneously repeat an action or sound with a toy that was modeled for her previously. Emily has a couple favorite books. She will sit with her mom and look at them. Emily will sometimes point to a few favorite pictures and name them including pictures of an apple, banana, ball, and cow. She tends to call many four legged animals cows and she frequently refers to a cat by ''meow.'' Emily has imitated many animal sounds and colors following a model. Emily has a beginning understanding of numbers. If a play partner starts with "one. _ ." Emily will almost always say "two" and sometimes "three." She will often echo "three... four… five…." as they are modeled. Emily will play with her baby doll sometimes - she will feed it and put it in a toy stroller to push. She'll stay with this play longer with an adult modeling and facilitating it. She has said "baby" numerous time with and without modeling.

Emily has a growing vocabulary. Emily has been calling her dad ''Daddy'' for a while though it is not something she says every day. She recently said "Mommy" for the first time - Emily was upstairs and her mom was downstairs and Emily called out "Mommy!" Some of Emily's other words include: bubbles, baby, cat/meow, dog/woof-woof, apple, banana, Hi, Bye, ball, ice-cream, go, no, and she tries to say Julius Jr. She also says "What's that?" and 'What's happening?" She says these phrases spontaneously - sometimes they are appropriate to what she's doing and sometimes they seem to be just babbling or self-talk. There are times when Emily is very engaged with her play or communication partner and she will imitate numerous words or actions that are modeled for her. She tends to be quite vocal during these times and will spontaneous say and repeat sounds and jargon with clear communication intent. Then there are other times when Emily is less engaged and interactive with her play partner and more interested in playing by herself - she is less imitative and verbal during these times.

As noted earlier Emily will point to a few familiar pictures and label them with words - when she wants to. She will not point to a picture, or toy, or object, when asked 'Where's the ?" She will not do this even with toys or pictures that she labels consistently such as the cat or apple or banana. Emily recently started identifying "feet" by looking at and/or touching her feet or a toys feet when her mom says "Where are your (or a toy's) feet." Her mom goes over the other basic body parts like eyes, nose, mouth, tummy, and hands but Emily has not shown interest in these yet. Attending to and following directions, is something Emily is still working on.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Emily has very strong motor skills and she uses these skills to get to where she wants to go and/or to get what she wants whenever possible. Emily walks and runs and climbs and dances. She likes to play in a squatting position. She loves to be helped upside down or through a somersault (she may be a budding gymnast!}. Emily and her family just recently moved to a townhome with an upstairs – they used to live in a one-floor house. Emily is a little cautious of the stairs. She can walk up and down the stairs with an adult holding her hand but she prefers to crawl up and scoot down on her bottom.

Emily can throw a ball (or almost any other toy or object) overhand - perhaps a little too good – she recently aimed for and hit the tv. That is one motor skill her family is trying to discourage!

Emily will ask for a few things with words spontaneously and without modeling such as ice cream, bubbles, and banana. This is usually triggered first by her seeing the desired item out of reach. The things she requests upon seeing most consistently include bubbles, ice-cream, juice, and lollypop. Emily's mom typically knows the things Emily likes and typically wants so she often provides it for Emily. IF Emily sees what she wants and can't reach it and it's not something she typically asks for with a word she will go get as close as she can to it (desired item) and reach for it, When she wants something out of the refrigerator she will go stand In front of it (refrigerator) and her mom will open the door and see what Emily reaches for. Emily sometimes takes her mom's hand to lead her to what she wants. Emily will go find her mom or dad when she wants their attention and/or help.

Emily has been a good eater. She was eating a variety of foods and was not considered a picky eater by her parents until recently. Emily has recently started resisting foods she's always eaten in the past and holds out for more snack foods. Emily eats independently with her hands and/or spoon or fork as needed. She drinks from a sippy cup most of the time. She can take sips from her parents open cups (or glasses). She continues to take a bottle as part of her bedtime routine though her mom wants to fade that out soon. Emily understands getting dressed and undressed. She can take most of her clothing Items off if they are relatively simple (no complicated buttons or zippers). She is just starting to dress herself – just starting! Just this week when she was still in her pajamas she pulled a shirt off the hanger in her closet and put it on (after taking her pajama top off) she then went downstairs and tried to open the front door so she could go outside. She will admire herself in the mirror when she has a cool outfit on {and most of her outfits are cool!).

Up until last week when the family moved to their new townhome Emily was a good sleeper once she fell asleep. She was sleeping through the night. Since the move Emily has been waking up in the middle of the night around 2 a.m. and staying awake for an hour or two. Her mom is hoping it's just an adjustment thing to Emily's new room and surroundings. On the positive side Emily is going to bed easier and earlier. Where she was resisting bedtime in the old house and pushing it to 9 or even 10 p.m. she's now going down about 8 p.m. consistently. Over the past couple months Emily has given up her afternoon nap – she doesn't take naps most days now but every now and then she'll fall asleep, especially if she's in the car in the later afternoon.

She is still in diapers (she's not quite 2.5 years yet) though she is showing more awareness when her diaper is soiled her wet. She recently said "pee pee" to her mom after she had a bowel movement in her diaper.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:

Social/Emotional Skills including Positive Social Relationships: Rating 4: Emily shows use of some age expected skills. Emily has more skills of a younger child in this area.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 4: Emily shows use of some age expected skills. Emily has more skills of a younger child in this area.
Use of Appropriate Behaviors to Meet Needs: Rating 4: Emily shows use of some age expected skills. Emily has more skills of a younger child in this area.

Determining the outcome ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three outcome areas.

Things to consider:

- ✓ While we started out talking about toilet training, Emily is only 28 months of age. Some assessment tools including the ELAP, which is commonly used across Virginia, begin scoring toileting at 18 months of age (ELAP: 18 months- uses toilet when taken by an adult). As mentioned earlier, the American Academy of Pediatrics suggests children may begin showing readiness skills between 18 and 24 months but some children may not be ready until 30 months or older. Based on this guidance, when interpreting assessment results in relation to age anchoring tools, the Infant and Toddler Connection of Virginia has made the decision **NOT** to include toileting skills when determining the child outcome ratings.
- ✓ Cultural expectations worldwide vary greatly regarding the age at which children should be toilet trained. Even within the United States there is variability. According to a recent study, African-American parents believe that toilet training should begin around 18 months. Caucasian-American parents believe that training should start even later--after 25 months, on average (Horn et al 2006). - See more at: http://www.parentingscience.com/potty-training-age.html#sthash.EJzhHPdB.dpuf
- ✓ While the research on toilet training young children is limited, there is extensive scientific research and recommendations related to toilet training children with special needs including autism available in journal articles and on the internet.
- ✓ In regards to Zoe, while the AAP may consider Zoe's accidents a part of typical child development, the Montessori school she attends has different cultural expectations. How would you and your team working with Zoe advice her mother, the school and the swarm of media this case has attracted in regards to what is developmentally appropriate and culturally acceptable for Zoe?

Resources:

- Stadtler AC, Gorski PA, Brazelton TB. Toilet training methods, clinical interventions, and recommendations. American Academy of Pediatrics. *Pediatrics*. 1999; 103(6 pt 2):1359–1368.
- Sequential Acquisition of Toilet-Training Skills: A Descriptive Study of Gender and Age Differences in Normal Children American Academy of Pediatrics
- Toilet Training American Family Physician