Benefits of Toilet Training

- The benefits of toilet training are obvious and important.
- Your child will learn an important life skill, benefit from improved self confidence and greater independence, and achieve improved social status. In addition, toilet training saves money that would ordinarily be spent on diapers.


“Wetting and soiling clothing results in significant amounts of time, energy and resources being devoted to an individual’s personal care needs. Wet or soiled clothing or poor toileting hygiene can also significantly interfere with social acceptance.”

When a family member with autism is trained...

- The long-term impact of toilet training on the person realizes independence and social acceptance
- Realize the long-term impact of toilet training on the family’s independence, resources, interactions and social acceptance.
- Set aside specific amounts of dedicated time for other family members who may feel deprived of attention
- Use stress management techniques to decrease the negative effects of extra demands on time and energy

What Method?

- Research suggests that when searching for information regarding toilet training, parents seek advise from friends and family members, while professionals seek advice from books and research (Ganger, 2003).
- According to Timothy R. Schum, “...most advise on this topic is based on theory and common experience rather than on scientific knowledge.”
What Method?

- Over the last 100 years, recommended toilet training methods have varied. Methods differ with respect to goal development, endpoints, and emphasis on the child's self-esteem. In 1962, Brazelton developed the “child readiness” approach, which focused on gradual training.

What Method?

- The Azrin and Foxx method emerged in 1971 as a parent-oriented method that emphasized structured behavioral endpoint training aimed at eliciting a specific chain of independent events by teaching the component skills of toilet training.

Azrin and Foxx (1971) effectively toilet trained 9 profoundly impaired adults who were in residential care. The method used included:

- artificially increasing the frequency of urination
- positive reinforcement of correct toileting but a delay for “accidents”
- use of new automatic apparatus for signaling elimination
- shaping of independent toileting
- cleanliness training
- staff reinforcement procedures.

Results:

- Incontinence was reduced immediately by about 90% and eventually decreased to near-zero.
- These results indicate the procedure was an effective, rapid, enduring, and administratively feasible solution to the problem of incontinence for institutionalized individuals with special needs.

In 1974, Azrin and Foxx published:


What Method?
- Other methods include variations of operant conditioning, assisted infant toilet training, and the Spock method.

EPC Research
In 2006, the Evidence-based Practice Program of the Agency for Healthcare Research awarded contracts to institutions in the United States and Canada to serve as Evidence-based Practice Centers (EPCs). The EPCs develop evidence reports and technology assessments based on rigorous, comprehensive syntheses and analyses of relevant scientific literature, emphasizing explicit and detailed documentation of methods, rationale, and assumptions. One report centered on “The Effectiveness of Different Methods of Toilet Training for Bowel and Bladder Control”

EPC Research
- Twenty-six observational studies and eight controlled trials were included.
- Approximately half of the studies examined healthy children while the remaining studies assessed toilet training of mentally or physically handicapped children.

EPC Research
The objectives of this report are to determine the following: (1) the effectiveness of the toilet training methods, (2) which factors modify the effectiveness of toilet training, (3) if the toilet training methods are risk factors for adverse outcomes, and (4) the optimal toilet training method for achieving bowel and bladder control among patients with special needs.

What toilet training method was most effective in healthy children?
- Both the Azrin and Foxx method and the child-oriented approach resulted in quick, successful toilet training, but there was limited information about the sustainability of the training.
- The two methods were not directly compared; thus, it is difficult to draw definitive conclusions regarding the superiority of one method over the other.
- In general, both programs may be used to teach toilet training to healthy children.

Which factors modify the effectiveness of toilet training?
- Some factors believed to impact toilet training include sex, age at initiation, race, physical or mental handicaps, and constipation.
- No studies that looked specifically at modifying factors
- Common themes were found among the studies:
  - Improved outcomes were reported with older and more tolerant mothers and higher socioeconomic status
  - The presence of younger siblings was correlated with a higher incidence of stool toileting refusal (STR)
What are the risk factors for adverse outcomes with the different toilet training methods? While the majority of children are toilet trained without incident, approximately 2 to 3 percent experience an adverse outcome. Common adverse events are enuresis, encopresis, stool toileting refusal, stool withholding, and hiding while defecating. Only four studies specifically addressed adverse outcomes.

What are the risk factors for adverse outcomes with the different toilet training methods? A lack of data precluded conclusions regarding the development of adverse outcomes. One study of the “child-oriented” method cited stool toileting refusal problems were more frequently associated with the presence of younger siblings, parental difficulty in setting limits, and training at a later age (42 months and older).

What are the risk factors for adverse outcomes with the different toilet training methods? None of the operant conditioning or Azrin and Foxx studies reported these outcomes. The only other adverse effects mentioned in these studies were temper tantrums and child and parental refusals and frustration with the training method itself.

What is the optimal toilet training method for achieving bowel and bladder control among patients with special needs? The Azrin and Foxx method and operant conditioning methods were consistently effective for toilet training mentally handicapped children. Programs that were adapted to physically handicapped children also resulted in successful toilet training.

Kroeger & Sorensen-Burnsworth (2009) In 2009, Kroeger and Sorensen-Burnsworth further reviewed the toilet training practices for individuals with autism and other related disabilities. They noted that most toilet training of individuals with developmental disabilities were modeled after the original Foxx and Azrin (1973) rapid toilet training methods. The goal of this study was to isolate and describe components and their relative efficacy.

Kroeger & Sorensen-Burnsworth (2009) A review of 68 citations resulted in the selection of 28 data based papers. Subjects with IQs greater than 20 and younger subjects were more successful. Components:
- Graduated guidance: highly successful component
Reinforcement-based training: positive reinforcement successful, negative reinforcement more recently also successful

Scheduled sitting: successful

Elimination schedules (Pants checks): either mechanical or manual are successful

Punishment procedures: Positive practice and overcorrection used effectively. More recently, trend is toward “less aversive” punishment in the form of a verbal reprimand (corrective feedback).

Hydration: effective, but use cautiously with children with medical issues

Manipulation of stimulus control: transferring stimulus control from “other” outside antecedents to the toilet. Often used when success with other methods has not been achieved.

Priming and Video modeling: intervention whereby information is provided to a subject in order to prepare the subject for the performance of an activity. Unknown whether this step is necessary due to limited research.

Keen, Brannigan, & Cuskelly (2007) assessed the effectiveness of an animated toilet training video for teaching daytime urinary control to five young boys with autism across several settings. A between and across groups multiple baseline design was used following a 2-week baseline-monitoring period. Children in the treatment condition received video modeling plus operant conditioning strategies, whereas children in the control condition received only operant conditioning strategies.

Frequency of in-toilet urinations was found to be greater for children who watched the toileting video than for children who did not. Gains were maintained for three participants at a 6-week follow-up with generalization to a new setting for two participants. Results indicate that, for young children with autism who are resistant to toilet training, acquisition of urinary control may be facilitated by use of an animated toileting video in conjunction with operant conditioning strategies.

Younger participants with IQs of at least 20 are successful

First time training of shortest duration

Manipulation of stimulation control most lengthy

Tendency for return to prompt dependency

Protocols successful in a variety of settings-training across settings supported

Maintenance of toileting success: communication training, self-initiation, and bowel training

Bowel movement training has limited studies
What Method?

Toilet training children with special needs presents a unique set of challenges as impaired communication skills, reduced ability to process sensory information, and mobility and neurophysiologic deficits add challenges to their toilet training.

The potty training protocol utilized by The Center for Autism Treatment is based on the work of Nathan H. Azrin and Richard M. Foxx as this approach has been demonstrated effective in toilet training children and adults with special needs.

Guidelines for Bowel Training

- Teach concurrently with urine training whenever possible
- Check with the pediatrician to ensure that there are no medical contraindications for bowel training
- Keep a log of dates, times, size, and consistency of bowel movements
- For any child with a history of constipation, work closely with the pediatrician
  - Dietary modifications and laxatives may be needed to gain regularity of bowel movements and obtain softer stools.
  - For kids with chronic constipation, it is advisable to gain 30-90 days of regular bowel movements prior to bowel training.

According to Dr Preston Smith (2004), children should have 2-3 BMs per day and they should be the consistency of overripe bananas.

- Dr. Smith (2004), Dr. Dorrington (2009) and others agree that there are many misconceptions that laxatives are harmful when taken in larger doses for longer periods of time and that this will commonly interfere with successful bowel treatment
- These misconceptions can result in poor bowel habits and make bowel training difficult

Guidelines for Bowel Training

- Use the log to determine if training is appropriate
- Identify times that a BM is probable.
- Shortly after each meal, during high probability times, and anytime that the child demonstrates any precursor behaviors that a BM may occur, initiate scheduled sitting
- Initiate scheduled sittings and clean pants checks as in urine training.

Guide the child to the bathroom
- Make sure that the child’s feet are touching the floor or a stool
- Do not instruct the child to push
- Encourage or prompt the child to lean forward
- Use preferred activities to promote cooperation with staying seated on the potty
Guidelines for Bowel Training

- If the child has a BM on the toilet, deliver the strong reinforcer and praise
- If the child does not have a BM, simply praise the attempt and allow the child to leave the area

Bowel Training

- When a self-initiation occurs, discontinue scheduled sittings, but continue clean pants checks during high probability times.
- When the child has had two self-initiations, discontinue clean pants checks.
- Continue to use reinforcement for success and systematically lean the schedule
- Consequences for Bowel accidents are case specific

References


Guidelines for Bowel Training

- As with the urine training, guide the child to check their pants every five minutes. As long as the pants are not soiled, reinforce clean pants by providing a consumable or easy to deliver reinforce
- Continue until the child has a BM on the toilet.
- Once the child has had a BM, discontinue the dry pants checks and scheduled sittings until the next high probability time or a time when the child shows some precursors of BM.

References


References
