Texas School for the Blind & Visually Impaired

Outreach Programs

www.tsbvi.edu | 512-454-8631 | 1100 W. 45th St. | Austin, TX 78756

Toilet Training Children with Deafblindness: Issues and Strategies

By Craig Axelrod, Teacher Trainer, TSBVI, Texas Deafblind Outreach

Originally published in the Summer 2000 edition of PS News.

A version of this article first appeared in the October 1992 edition of P.S. NEWS!!!

Independence in toilet training is a milestone celebrated by the children who achieve it and their grateful parents. Families and educators often experience frustration, disappointment and resignation when faced with the challenges of toilet training a child who is deafblind. Many factors can influence toilet training efforts; such as physical maturity, awareness of self and the environment, positive relationships with other people and the ability to communicate with them. All factors must be considered when toilet training a child who is deafblind. A team approach is also essential for success. People who can contribute important knowledge and experience to a team include the child's parents and siblings, classroom teacher, intervener, VI teacher, communication specialist, OT, PT, school administrators and a medical doctor.

Comparison of Toilet Training Practices

Toilet training approaches for children with disabilities often differ drastically from those used with nondisabled children. It's suggested that a "normal" child be taught in a low-key manner, with social praise and reinforcement. Books, verbal explanation, modeling and observation are used to teach language concepts, responsibility, competence and independence. The child sits on the toilet for short periods of time. If there is resistance to toileting, training efforts are postponed. Use of punishment is not recommended, and can be considered harmful. In contrast, the best known programs developed for children with disabilities recommend rigid training procedures to be followed intensively for several hours every day. Sessions on the toilet may last up to 25 minutes of every half hour. Motivators might include food, toys and other primary reinforcers, or secondary reinforcers such as tokens, adhesive stickers and checkmarks. Overcorrection (for example, cleaning the entire floor of a room where a toileting accident occurs) and positive practice (repeating the steps of a toileting sequence multiple times) are procedures often used to end toileting accidents. Resistance to toilet training is met with stronger rewards or punishers. Why are our educational strategies with disabled children so much more "heavy-handed" than the ways we teach children without disabilities?

Problems with Traditional Programs

There are drawbacks to many of the toilet training programs developed for children with disabilities.

- Many of these programs have intensive time requirements.

- The most popular of these programs requires an intensive commitment of time and attention from those working with a child. In a school setting this is sometimes possible because several adults share the responsibilities of managing a classroom and its students, or a single adult is responsible for providing one-on-one instruction to the student who is deafblind. At home, however, a family often has fewer people and limited time to devote toward this kind of effort.
- Toileting programs have a low success rate.

In acquiring any new skill, a learner must consistently experience a 70% success rate (7 correct responses to every 3 mistakes). The obvious toileting mistake is an accident. A less obvious mistake is sitting on the toilet without "results." Toileting programs that incorporate long, unproductive commode sittings increase the percentage of errors, and ultimately make learning more difficult.

Children don't make the connection between their behavior and the resulting consequences

Children with deafblindness often have limited communication skills. They may not independently distinguish important from unimportant information or see relationships between their behaviors and the resulting consequences. They might not understand that overcorrection or positive practice are responses to a toileting accident. While an adult is responding to wet or dirty pants, the child might think the consequence is related to something else that coincidentally occurred at the same time, such as engaging in a self-stimulation behavior, patting the cat, or playing with a light switch. If independent and consistent toileting is the team's goal, requiring a child to repeatedly "practice" the toileting sequence or clean up the floor will not achieve this result. These activities don't teach the desired behavior, which is successfully voiding in the toilet. It is good for children to develop a sense of responsibility about caring for themselves and their environments. There are also many naturally occurring opportunities to practice removing and putting on clothes, such as before bath time or during morning dressing. Implementing overcorrection or positive practice procedures as consequences of accidents, however, will not teach a child to use the toilet appropriately.

Overcorrection and positive practice feel like punishment

Another problem with consequences such as overcorrection and positive practice is a person's understandable attempts to escape and/or avoid the people, places and activities associated with what is seen as punishment. By making toileting an unpleasant experience, a team may be sabotaging its goal. An additional consideration about punishment is the message it sends: that these are acceptable ways to interact. Children often imitate other people's behaviors. It's important that we behave towards them as we want them to behave toward others.

Developing a Toilet Training Routine

Toilet training follows this general sequence. First, a child's bodily maturity and regularity indicate readiness for toilet training. Then, other people begin anticipating the child's need to go at predictable times, and schedule train. Finally, the child learns to recognize the voiding urge, and responds appropriately by going to the toilet or asking to go.

Determine readiness

"Is my child ready to be toilet trained?" Readiness can be assessed in several ways. A child's body must be mature enough for toilet training. Physical maturity for training readiness typically occurs in nondisabled children between 18 and 30 months. Determine maturity by observing the child's behavior. Behavioral indicators for bowel training include regularity in bowel movements and no accidents while the child sleeps. Readiness for bladder training is indicated when the child remains dry during naps and regularly stays dry for 1.5-2 hours. Initial training with a nondisabled child may take from 5-10 months. These and other toileting norms such as a child's awareness of the need to go, the motivation to become toilet trained, and so forth; can only be suggested by age ranges. The order in which some norms are demonstrated (Chart 1) may also vary from one child to another. Children mature at different rates. In addition, a child may experience setbacks due to circumstances such as an illness, changes in daily routines or a new sibling at home.

Chart 1 - General Toileting Norms

Sphincter and bladder control generally follow this sequence: control of bowels while asleep, control of bowels during waking hours, control of bladder while awake, and finally, bladder control at night.

- A child who has regularity with bowel movements and no accidents while asleep may be ready for bowel training.
- A child who remains dry during naps and regularly stays dry for 1.5-2 hours may be ready for bladder training.
- A child's age of training readiness may range from 18-30 months.
- Initial training may take from 5-10 months depending upon the child's physical maturation and motivation.
- It is not uncommon for children to experience setback or regression during illness, major changes in their daily routines, when starting school or getting a new sibling.
- Some children may not become completely trained in the daytime until age 5, or at night before age 7.
- Girls learn faster and earlier than boys.
- Children become aware first of having eliminated, then that they are in the process of voiding, and finally recognizing the voiding urge before going.

Another indicator of readiness is the willingness and ability of parents and school staff to invest time and energy into toilet training their child. Since successful implementation of a toilet training program requires consistency and cooperation between home and school, everyone on the team must be committed to this effort.

Also, remember that the toileting "experts" don't always agree about a child's readiness. Find out about past toilet training efforts. What was successful and where were the problems? After soliciting and considering the input of all its members, your child's educational team can make an "expert" decision about whether to begin.

Even if the team decides to postpone toilet training, many of the skills needed during toileting, can start to be worked on in a diaper changing routine. Every activity in which your child

participates should be seen as a teaching and learning opportunity for building useful concepts and important skills related to toileting. Learning concepts such as "wet" or "dry," participating in dressing activities, asking for assistance, learning routes and independent travel skills, and so forth can be worked on throughout the day in a variety of activities.

Gather data

After deciding to begin toilet training, find out when your child is wet and/or dirty and dry. A frequent diaper or training pants check (every half hour, or more often if needed) for at least 14 days will be necessary to identify a pattern of elimination. Factors such as amount of liquid intake, illness, sleep and routines can affect regularity. Look for special behaviors your child might demonstrate immediately before urinating or having a bowel movement. Share this information with other team members. Collecting information requires time and effort, but it will save time in the long run. Since a 70% success rate is necessary for learning, it's important to identify times in a day when a child most likely needs to "go," and target those times for toilet training. While children often have bowel control before bladder control, bladder training is usually worked on first because there are more opportunities in a day to be successful.

Using a data collection method such as the one shown in Chart 2 can be very helpful. This baseline information will also help your team determine how well its toilet training program is working. Compare it with data that's regularly collected after toilet training has begun.

Assess your child's toileting abilities

Clarify the sequence of steps a nondisabled person follows when using the toilet. Informally assess your child's ability to complete each of those steps. Identify steps that are completed independently, then distinguish between steps that can be taught without additional changes and those requiring adaptations.

Select objectives

Every child has unique learning needs, specified in an IEP as goals and objectives. Although they are artificially separated in the IEP, many skills are often used together to complete an activity. When developing a toilet training program, it's important to remember that voiding in the toilet is only one of several interrelated skills needed to complete this activity. Knowing where the bathroom is and how to get there, undressing and dressing, getting on and off the commode, and requesting assistance are examples of orientation and mobility, self-help, motor and communication skills that contribute to successful toileting. Select 2 or 3 objective-based skills from the IEP that are necessary or helpful in teaching those steps, and can be naturally incorporated into the routine sequence.

Chart 2 - Toileting Data Collection Chart

Key:

UT- urinated in toilet

BT - b.m. in toilet

N - on toilet, did nothing

UO - urinated off toilet

BO - b.m. off toilet

Week of _____ Week of _____

Time A/P	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
12														
12:30														
1														
1:30														
2														
2:30														
3														
3:30														
4														
4:30														
5														
5:30														
6														
6:30														
7														
7:30														
8														
8:30														
9														
10														
10:30														
11														
11:30														

Identify adaptations

Identify the adaptations that will be needed to support your child's completion of steps in the sequence more independently, such as a calendar system to schedule and communicate toileting time, or pants with an elastic waistband for an older student who cannot zip or snap. Since it's not possible for a small child to struggle at maintaining balance on the commode while at the same time relaxing to use the toilet, consult with your OT or PT to see if adaptive seating is needed. Consider your child's size and dimensions when deciding the specific seating requirements (Chart 3).

Chart 3 - Seating Guidelines

Goals

- Child should be comfortable, balanced and secure.
- Child should use a minimum of conscious effort and physical energy to stay seated.

Principles

- Pelvis should be stable and in a neutral position, with body weight evenly distributed across buttocks and thighs (hips and knees flexed at 90 degrees).
- Trunk should be symmetrical and in midline.
- Feet should be supported on floor or stool (ankles at 90 degrees).
- Head should be in line with trunk and in a neutral position.
- Forearms can rest at elbow height.
- Proper Measurements for Chair or "Potty Seat"
- Seat depth - length of child's thighs (distance from above knees to buttocks).
- Height of chair seat - length of child's shins (distance from just below knees to heels/soles of feet).
- Chair back - length of child's back (tailbone to shoulder girdle).
- Consider appropriate teaching strategies

Because your child may have acquired some skills and not others, the support that is needed could change from one routine step to the next. We often, however, give our children the same level of support throughout an activity, regardless of their ability to complete some steps with more independence. Consequently, they may become prompt dependent by learning to wait for our prompts before beginning or continuing a sequence. To prevent this from happening, keep an array of teaching strategies in mind when designing a toileting routine. Incorporate the approaches that are most helpful into the routine you use for instructing your child. Examples of strategies include:

The hierarchy of prompts - from least intrusive (object needed in routine, picture, point, sign, etc.) to most intrusive (hand-over-hand, hand-under-hand, physical prompt, etc.);

The progression with which prompts are given - independent attempts followed by increasing adult support (least intrusive to most intrusive), or intensive support provided initially, then faded (most to least);

The timing with which prompts are given - immediate redirection to minimize potential distractions and maintain focus on the sequence, or "wait time" to encourage self-initiation and acknowledge the need for processing.

Since our children (like us) have "good days" and "bad days," additional support may sometimes be needed to help them successfully complete steps that are completed independently at other times. We must be attentive to their changing abilities and needs, and provide the support that is necessary at each moment.

Put it all together

Write a toileting sequence for your child that incorporates any necessary adaptations the team has identified. Teaching strategies should also be reflected in the sequence steps and/or noted somewhere on the plan. Be sure the team agrees to a procedure that can be followed at both school and home. Consistency is essential. Plan with your child's safety, security, self-respect and eventual independence as overall goals.

To begin, choose the two times each day, at home and school, that you have found your child to be most regular. Don't be discouraged by the lack of immediate results. After the toileting routine is consistently followed for a while, your child will begin to anticipate the sequence steps. Expectation leads to participation. (If, however, your child still isn't having success, review the routine sequence and consider making changes.) Be prepared to give immediate reward and praise for successful toileting. Select a reinforcement that is truly rewarding yet can be gradually faded over time. One child might enjoy flushing the toilet while another appreciates the overhead light flashing on and off. Do not punish for accidents, though participation in cleanup is okay. Continue collecting data to monitor your child's progress and the program's effectiveness. Gradually increase the number of daily toileting sessions, and generalize the routine into other places.

While developing a toilet training procedure that works on current needs, you should keep long-range expectations in mind. For example, if requesting to use the bathroom is an eventual objective, identify a way the toileting routine can be communicated by adults, with a sign, picture, gesture, physical prompt, or toilet paper roll. After learning that going to the toilet always follows this communication, the student can then be given opportunities to request the activity.

Problem Solving

For solutions to some common problems experienced in toilet training, try the tips suggested below.

Problem: My child refuses to enter the bathroom, sit or stay long enough on the toilet (5-10 minutes).

Tips: Familiarize your child with the bathroom and toilet. Getting into the bathroom or briefly sitting on the toilet should be the first toilet training goal. Reward the smallest step toward that goal. Try to increase your child's performance each successive trip. Provide plenty of

opportunities for practice every day. Be sure your child is well positioned, comfortable and secure on the toilet.

Problem: My child does not urinate often or becomes constipated.

Tips: Give your child plenty of fluids. Salty snacks, exercise and other physical activity sometimes help encourage fluid intake. Swimming is another good choice, as some children manage to drink quite a bit while getting a workout. Motor therapy programs and exercise can also increase your child's ability to push during a bowel movement.

For constipation problems, increase fluids and add more fiber to the child's diet. Fruits, except for bananas and apples, have a laxative effect. The following recipe was recommended by a family in Exceptional Parent magazine: combine 1/4 cup bran, 1 cup prune juice and 1 cup apple sauce. Mix well. Keep refrigerated. They gave their daughter 3 tablespoons of the mixture with breakfast and dinner, and also used an over-the-counter stool softener. Consult a doctor if the condition is chronic, or the child has frequent diarrhea. Doctors can rule out structural problems or blockages, and prescribe stool softeners or diet modifications.

Some children intentionally hold bowel movements because elimination is painful (i.e. a crack or fissure around the anus). Increasing fluid intake and using stool softeners may help. If your child is obviously experiencing pain, consult a doctor. Some medications have side effects that include constipation and the frequent urge to urinate. Consult with a doctor to determine if your child's toileting is affected by medication. Finally, some children withhold urine or bowel movements in reaction to trauma, or in response to punishing toilet training programs, behavior programs or environments. They may try to oppose control through counter control efforts such as refusing to do what is expected. Even though an adult can force a child to sit on the toilet, it is impossible to make him or her use it. The long-term solution is to establish or reestablish an interactional bond. A positive relationship between the adult and child encourages cooperation. Giving the child positive ways to exercise control through choice making also builds trust and reduce power struggles. Adults who are warm, accepting and gentle will provide the type of atmosphere that motivates a child to learn.

Problem: My child does not relax on the toilet.

Tips: First make sure your child is positioned correctly on the toilet. (See Chart 3.) Interrupt and redirect a very active child to an alternative, more calming form of play or activity. There is disagreement about whether children should be allowed to "play" in the bathroom. The "no play" advice is to keep a child focused on the bathroom's primary purpose. Some children, however, may need a positive way to structure their "activity" of sitting on the toilet. Remove temptations like toilet paper rolls. Have pre-planned activities available for times when the child might "get into trouble." Prevent problems. Provide close supervision and instruction, to teach the child what is permitted.

Problem: My child does not initiate toileting, but uses the toilet when taken by an adult.

Tips: Your child's awareness of a full bladder or bowel is the best cue for self-initiated toileting. Some children become too engrossed in activities to notice. Others may lack the cognitive ability to recognize the voiding urge. Sometimes, when adults provide faulty instruction by not fading the use of prompts, their children become dependant on them to initiate the toileting activity. Encourage self-initiated toileting by gradually fading any necessary prompts. By teaching a child

to use the bathroom after specific activities, those activities can become the reminders to go. Putting communicative reminders, such as pictures or object cues, in a child's daily schedule or environment may also help.

Problem: My child is making no progress, doesn't seem to understand the toilet's purpose, is not bothered by being wet and has frequent accidents.

Tips: Take a break. Perseverance is necessary for teaching, but so is our responsiveness to feedback. The teaching sequence may not be appropriate or your child may not be motivated enough to succeed. Reassess the program and make adjustments. Whether you decide to continue toilet training or postpone it for now, always try to use an age-appropriate alternative to diapers, such as "Pull-Ups" or "Depends".

Children at a sufficiently high cognitive and communicative level might understand picture, photograph or book explanations. Direct experience is the only option for children with more basic communication and cognition. They might, however, be able to observe other children or family members model appropriate toileting behavior. Always change clothes in the bathroom after an accident. Deposit any "products" in the toilet.

A child may be making too many toileting mistakes, both accidents and instances when nothing happens on the toilet. Reduce the frequency of toileting visits, and determine if there is some pattern by keeping track of all eliminations. Watch for recognizable indications that the child is urinating or having a bowel movement.

As much as possible, maintain a regular routine or schedule with your child, especially with meals and snack times. Regulate and monitor what is given to eat and drink.

Book and Journal Resources

Azrin, Nathan & Foxx, R. Toilet Train in Less than a Day, Pocket Books, New York, 1976.

Bettison, S. (1986). "Behavioral Approaches to Toilet Training for Retarded Persons," International Review of Research in Mental Retardation, 14, 319 - 350.

Cole, Joanna. Parents Book of Toilet Training, Parents Magazine Press, New York, 1983.

Fredericks, H.D. Bud, et al. Toilet Training the Child with Handicaps, 5th Edition, Teaching Research, Monmouth, Oregon, 1985.

Finnie, Nancy R. Handling the Young Cerebral Palsied Child at Home, E.P. Dutton, 1974.

Toileting Equipment Resources

Flaghouse, Inc.
150 N. MacQuestion Pkwy.
Mt. Vernon, NY 10550
(800) 221-5185

Gunnell
221 N. Water Street
Vassar, Ml 48768
(800) 551-0055

J.A. Preston
60 Page Road
Clifton, NJ 07012
(800) 631-7277

Rifton Equipment for the Handicapped
Route 213
Rifton, NY 12471
(914) 658-3141