# November 19th 2024 Webinar: Toilet Training and Elimination Problems

*Oregon Pediatric Improvement Partnership (OPIP) Learning Collaborative for Integrated Behavioral Health in Primary Care: Strategies and Tools to Provide Issue Focused Interventions Addressing* ***Social Emotional Health in Young Children (Birth to Five)***

**While We Wait to Let Everyone In**

**PLEASE UPDATE YOUR NAME IN ZOOM TO INCLUDE:**

- **FIRST AND LAST NAME**
- **INITIALS of the PRIMARY CARE PRACTICE IN WHICH YOU WORK**

*NOTICE OF RECORDING*

- *We will be recording this overview webinar for those attendees who registered but could not attend*

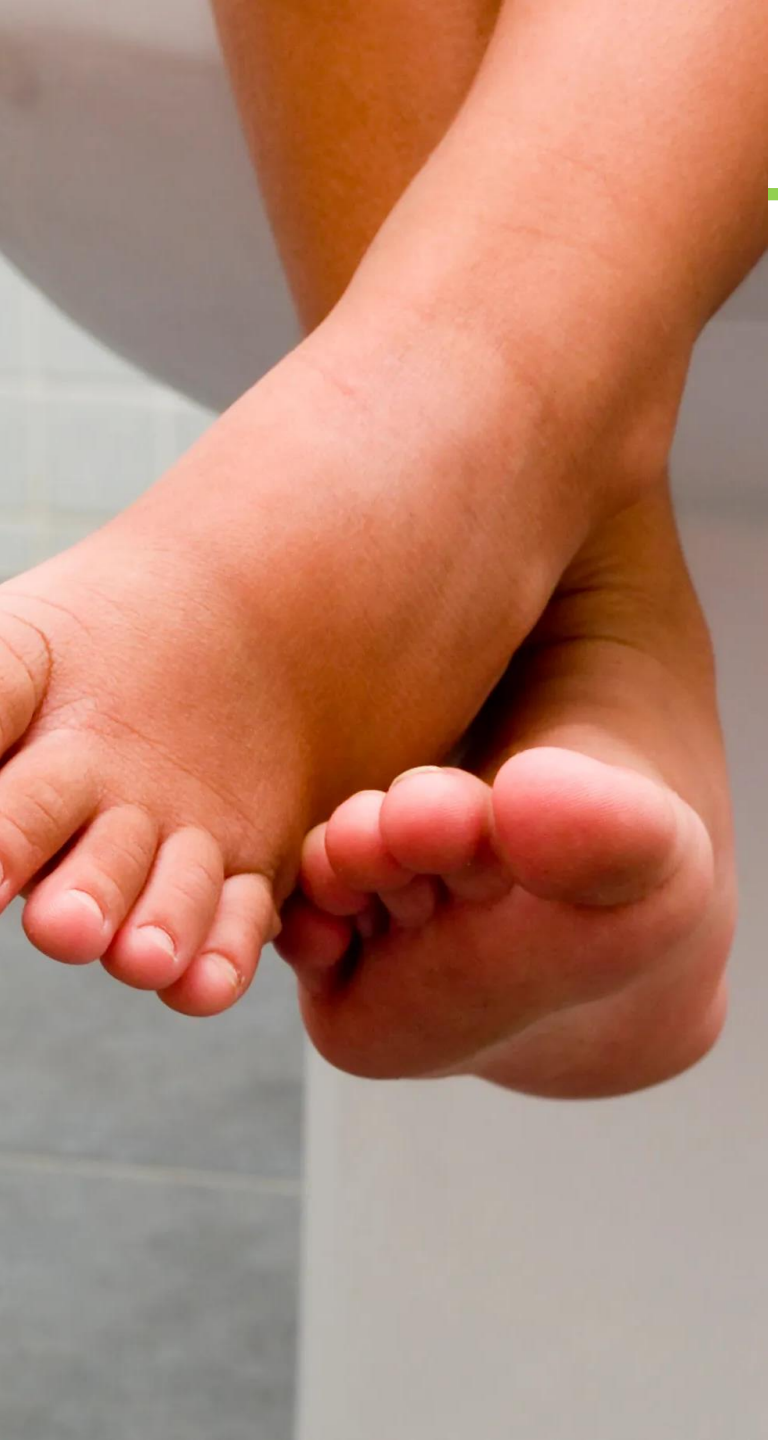
*This 2024 Learning Collaborative is financially supported by* ***Health Share of Oregon.***

# Agenda

- Topic Specific Focus for Today: Toilet Training & Elimination Problems
- Case Consultation on Implementing These Strategies:
- **Participant Ask Questions, Share Examples, and Obtain Feedback**
- Looking forward:
  - December 3rd 12-12:30: Optional Case Consultation will include an option to practice with cases identified by Dr. Riley
  - FINAL Webinar: December 17th: Guest Speaker Dr. Kimberly Burkhart Incorporating Trauma-Informed Principles into IBH
  - Coming Soon: Virtual Resource Library

# Learning Objectives

- Review prominent methods of toilet training
- Describe possible variations and methods to enhance success
- Identify some common pitfalls and possible solutions
- Describe approach to diagnosis and billing
- Case examples and questions



# Toilet Training

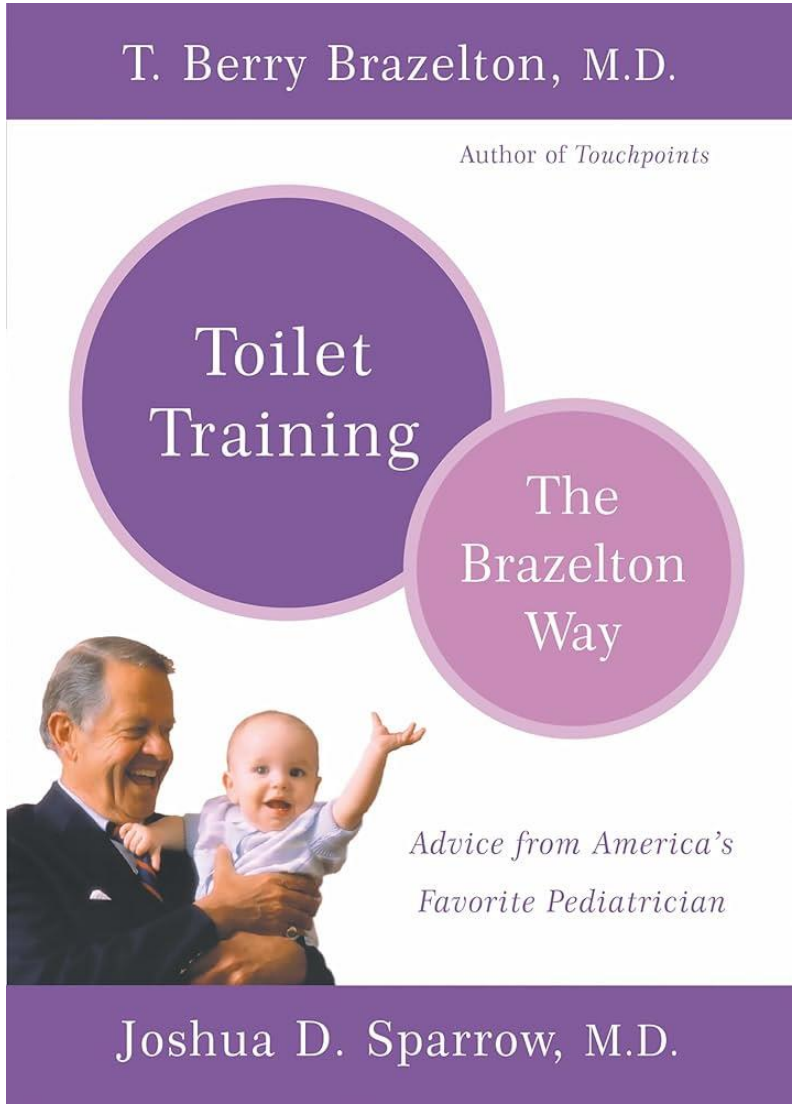
- Despite universal importance, toilet training is under studied.
- No single accepted definition of “toilet trained”
  - How long must a child be continent? What tasks (undressing, wiping, flushing, washing hands) must happen independently
  - In Western cultures, tends to mean an absence of accidents, voiding in socially acceptable places, and proper hygiene
- Significant cultural differences
  - Some cultures in Asia, South America, Central America, Africa, and Europe begin toilet training from birth.
  - In most Western nations, 18-24 months is the most common window to initiate training, though this has changed over time.
    - In 1932, US government suggested 6-8 months of age.

# Assisted Infant Training/Elimination Communication

- May start from birth or 2-3 weeks of age
- Parents learn infant's elimination signals
- When infant is expected to eliminate, placed in particular position over sink or toilet
- When infant eliminates, parent makes a specific noise (classical conditioning)
- Voiding may be reinforced via feeding or affection (operant conditioning)
- Not well studied but has been used for hundreds of years

# Child-Oriented Approach

- Developed by Brazelton (1962)
- Reaction to rigid, parent-oriented approach of the 1920-30s
- Emphasizes physiological development and “neurologic maturity” to engage in toilet training
- Wait for at least age of 18 months and developmental readiness
  - Voluntary control over bowel/bladder
    - Can be dry for extended periods
    - Some indicators of awareness of need to void
    - Reacts to wetting/soiling
  - Ability to cooperate with training
    - Follows simple instructions/imitate others
    - Receptive and expressive vocabulary
  - Sufficient motor abilities
    - Walking
    - Remove/replace clothes
    - Sit down/stand up from potty



# Child-Oriented Approach (cont.)

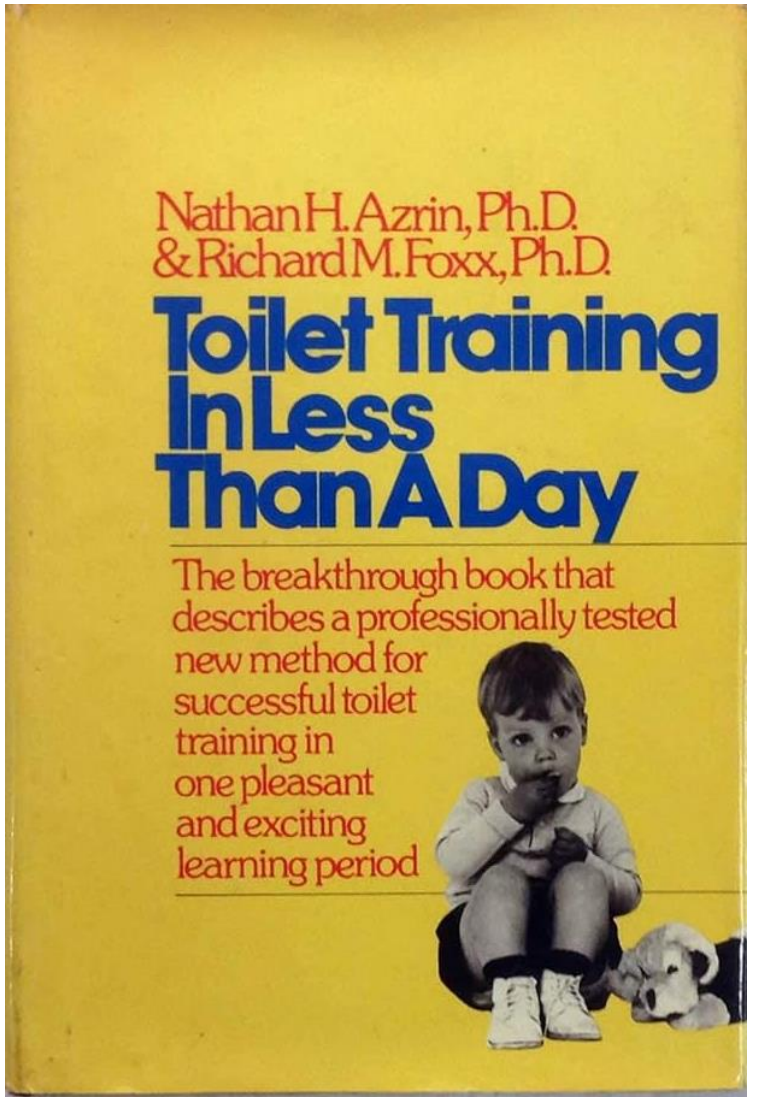
- Once a child shows readiness, a potty is introduced
  1. Sit on potty with clothes on and read or give a treat
  2. Sit on potty without clothes
  3. Sit on potty to change diapers
     - Dump stool into potty and point out this is where it goes
     - Draw connection between potty and adult toilet
  4. With cooperation, start making multiple trips per day to "catch" poop or pee
     - Occasional reminders, but not demanding

- *Pros:*
  - Generally well-accepted by caregivers
  - Minimizes potential for conflict
  - Less time and resource intensive

- *Cons:*
  - Some kids may not ever show interest
  - Parents may get frustrated with lack of progress
  - "Deadlines" for getting trained (e.g., preschool)

# Intensive Behavioral Training (Dry Pants Training)

- Developed by Azrin and Foxx (1971)
- Grounded in behavior analysis
- Initially developed for institutionalized adults with intellectual disability
- Designed to produce continence as quickly as possible
- Similar readiness signs as the child-oriented approach, but much more structured and proactive procedures



# Intensive Behavioral Training (cont.)

- Components of “Dry Pants” training
  - Modeling/rehearsal with doll
  - Fluid loading – access to preferred liquids and prompts to drink every 5 min
  - Potty sits – About every 10 min. 5 min duration at first, then 1 min after some success.
  - Positive reinforcement – Edible treat for successful voiding, praise for other components
  - Dry pants check – Checking about every 5 min, rewarding dryness with preferred liquid
  - Response to wet pants
    - “No wet pants.”
    - Positive practice – Child is instructed to practice going to the potty 10 times, sitting for just a few seconds each time.
  - Fading of prompts/reinforcers

# Intensive Behavioral Training (cont.)

- *Pros:*
  - Rapid acquisition of continence (mean 3.9 hours in Foxx & Azrin, 1973)
  - Has been adapted successfully for children with developmental disabilities (LeBlanc et al., 2005)
- *Cons:*
  - Takes more time to appropriately teach procedures
  - Much more demanding of caregivers
  - More potential for frustration and conflict

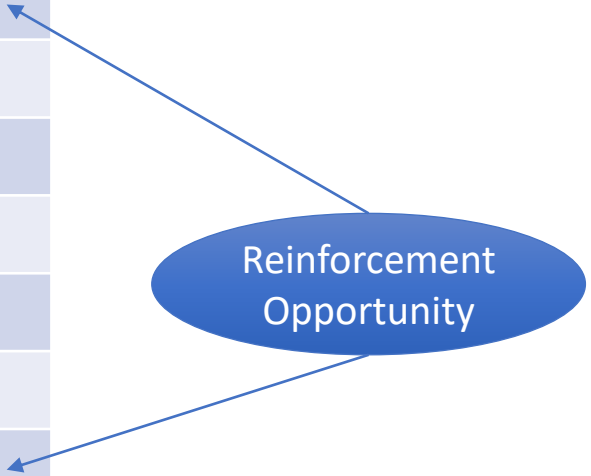
# Finding the Right Level of Intervention


- Many families may benefit from a middle-ground blend of these contrasting strategies
- Factors that impact the approach
  - Child readiness/age
  - Motivation of child and family
  - Cultural and individual expectations
  - Caregiver bandwidth and resources

# Scheduled Sits + Positive Reinforcement

- Overall goal is to reinforce:
  - The right behavior (voiding)
  - In the presence of the right signals (toilet, bathroom, etc)
  - Under the right physical condition (full bladder/bowel)
- Make sits comfortable and fun
- Rewards/Praise for successful voids
- *Pros*: Relatively easy to implement, gets child used to sitting
- *Cons*: Imprecise, active holding during sits

| Time | Sit | Void | Time | Sit | Void |
|---|---|---|---|---|---|
| 6:00 | X | | 12:00 | **X** | **X** |
| 6:30 | | X | 12:30 | | |
| 7:00 | X | | 1:00 | X | |
| 7:30 | | | 1:30 | | X |
| 8:00 | X | | 2:00 | X | |
| 8:30 | | X | 2:30 | | |
| 9:00 | X | | 3:00 | **X** | **X** |
| 9:30 | | | 3:30 | | |
| 10:00 | X | | 4:00 | X | |
| 10:30 | | | 4:30 | | |
| 11:00 | X | | 5:00 | X | |
| 11:30 | | X | 5:30 | | X |

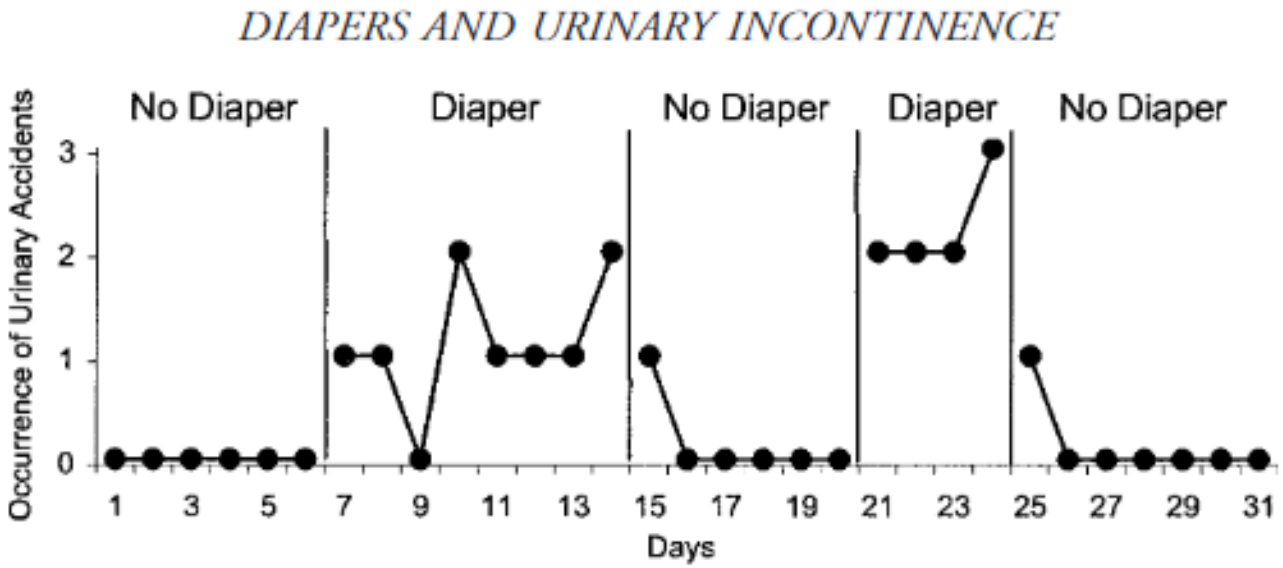


# Encouraging the Stars to Align

- Reinforcement is a consequence-based process, so you want to increase odds of “success by accident”
  - Fluid loading
  - Behavioral indicators
  - Strategic timing of sits
    - After meals, physical activity, and baths
    - Tracking of voiding to identify patterns
  - Water prompt
  - Ditching diapers

# The Modern Marvel of Disposable Diapers!

- Diapers present a number of challenges for toilet training
  - Decreased sensory feedback
  - Delayed response from caregivers
  - Desensitization




Tarbox et al., 2004

# Walking Toilets

- For some kids, voiding becomes strongly associated with diapers/pull-ups
- Some children will wear underwear most of the time, but request pull-ups to void
- Scheduled Sits + Positive Reinforcement is less likely to effective because of active holding
- Diaper Fading is a good alternative

# Diaper Fading

- Preparation
  - Store diapers in bathroom and make sure the child can't otherwise access
  - Make sure everyone is on the same page
  - Rule out any physical issues (e.g., constipation)
  - Identify effective rewards
- Implementation
  - Identify an initial goal. Start one step further than  baseline.
  - Reward and praise any instance of meeting the goal.
  - After 3-5 days of success, move to the next step.
    - Don't go backward.
    - Modify steps/rewards if needed
  - Monitor for holding if child is prone to constipation

**Examples steps:**

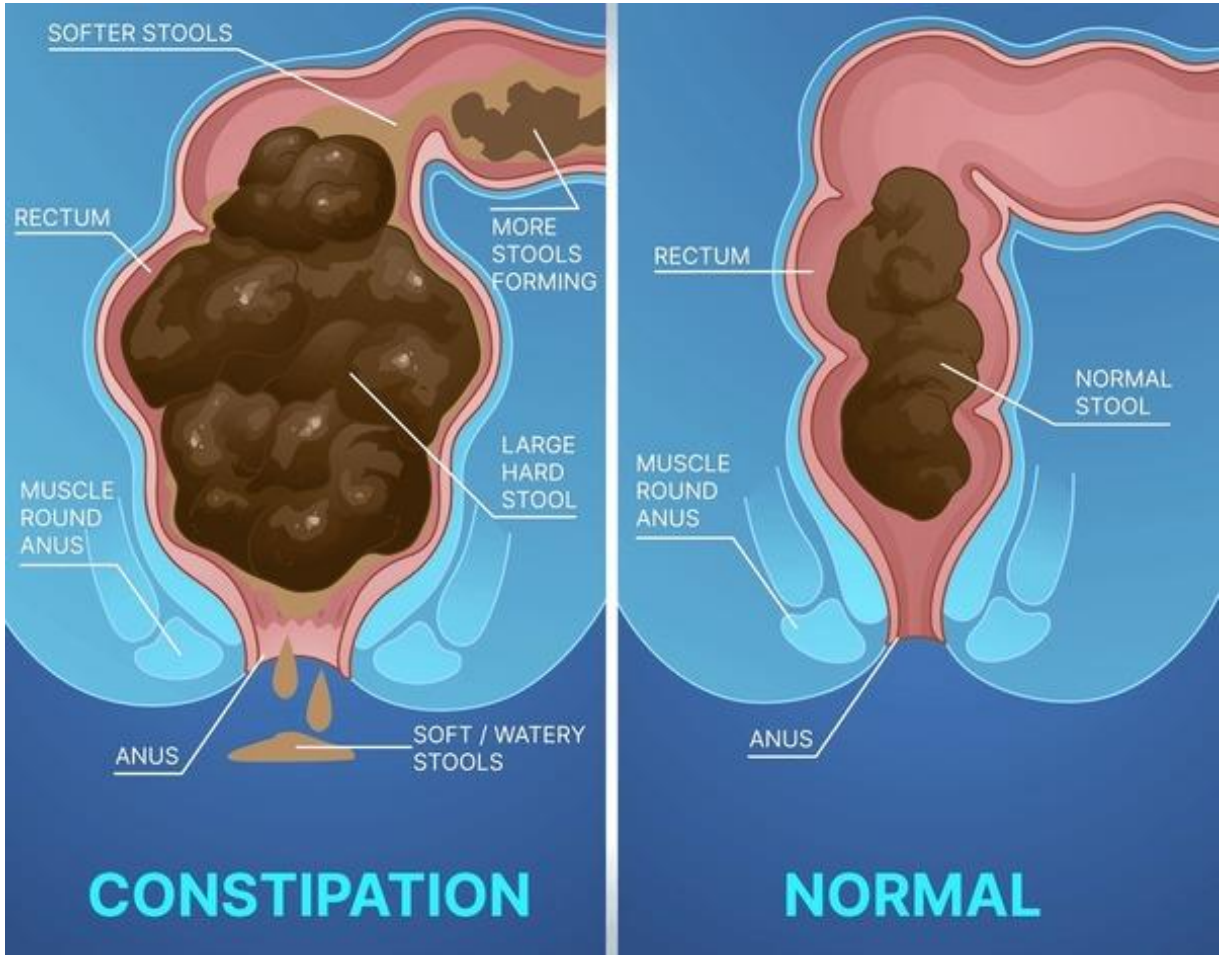
1. Poop in a diaper anywhere in the house
2. Poop in a diaper in the bathroom
3. Poop in a diaper in the bathroom while touching the toilet
4. Poop in a diaper while sitting on the toilet with clothes on and lid down
5. Poop in a diaper while sitting on the toilet without clothes and lid down
6. Poop in a diaper while sitting on the toilet without clothes on and lid open
7. Poop in a diaper while sitting on the toilet without clothes on and small hole cut in diaper
8. Poop in a diaper while sitting on the toilet without clothes on and large hole cut in diaper


Austin & Begotka (2024)

# Constipation

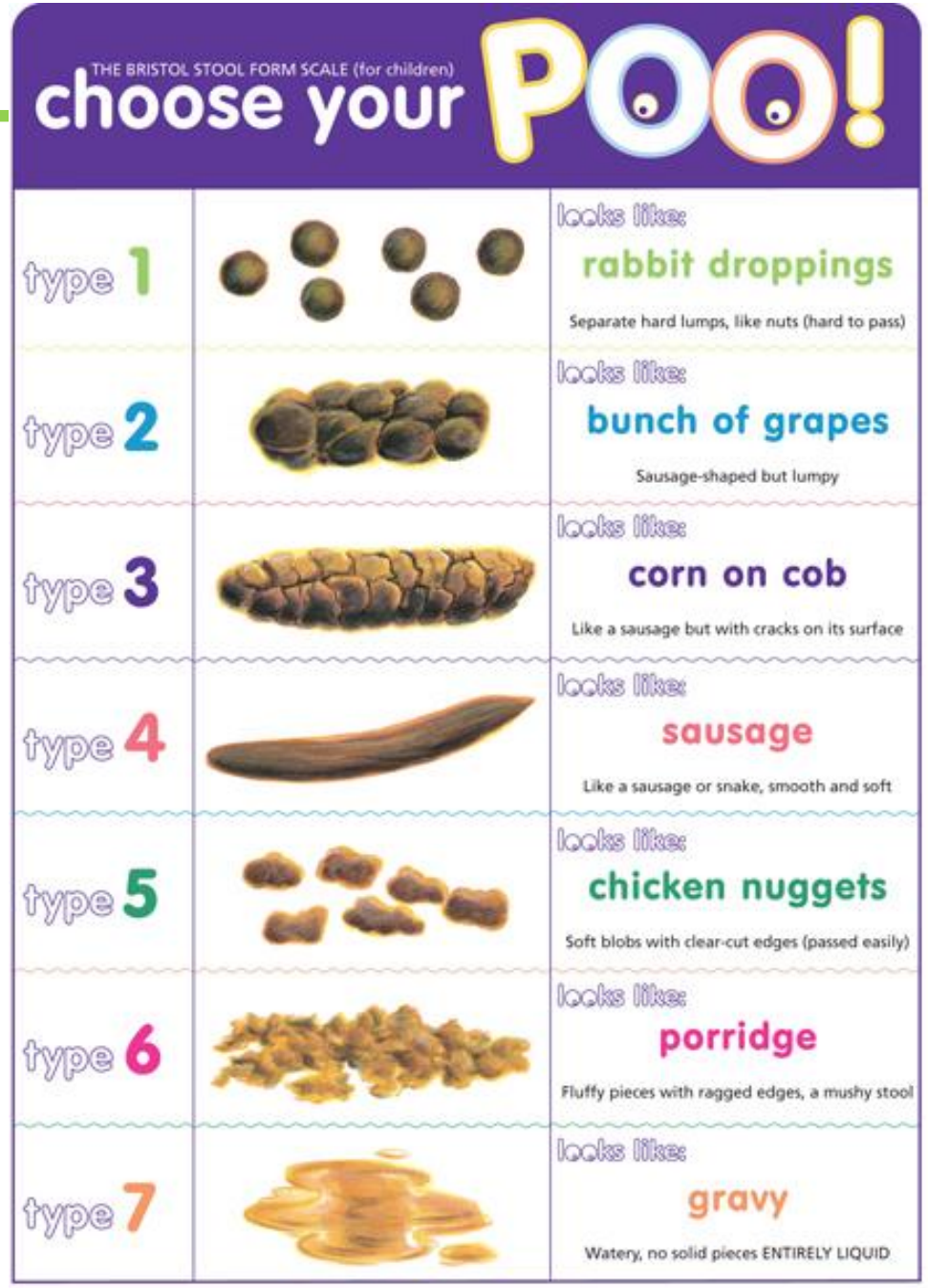
- Common
  - Estimated 10-20% of children in US
  - 3-5% of pediatric healthcare visits
  - Up to 35% of pediatric gastroenterology visits
  - Functional/non-specific in 95% of cases

- Can lead to:
  - Painful, large, hard stools
  - Stool withholding
  - Toileting refusal
  - Worse colon functioning
  - Loss of sensation
  - Fecal incontinence
  - Urinary incontinence/bedwetting



# Assessing for Constipation

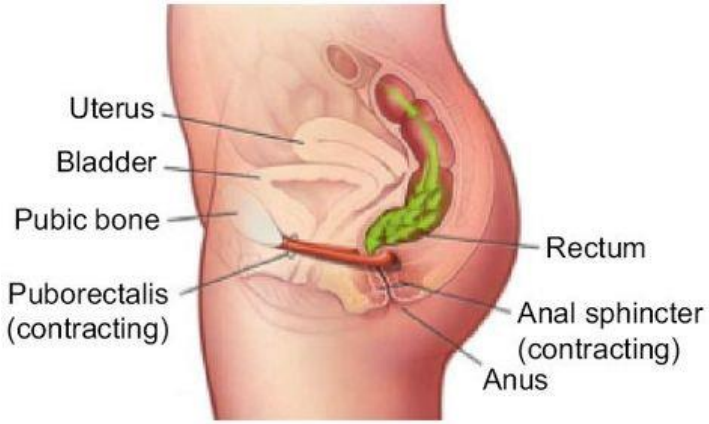
- Frequency
  - 1-2 BMs per day is typical for most preschoolers
  - < 3 per week is concerning
- Texture
  - Cracked, hard, dry, or sticky textures suggest constipation
- Size
- Odor
- Difficulty passing

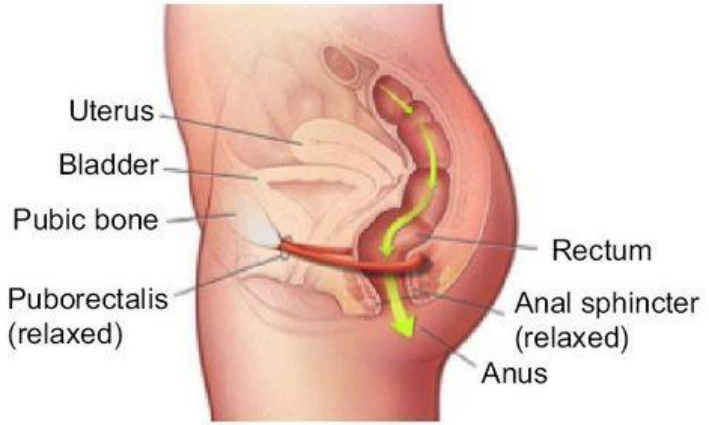


# Treating Encopresis with Constipation

- Constipation must be resolved first
  - Clean out
  - Maintenance laxatives (up to a year)
  - Dietary changes (water insoluble fiber)
  - Water intake
  - Goal of daily, soft stool
- Behavioral methods
  - Psychoeducation on biobehavioral effects of constipation
  - Scheduled sits
  - Proper poster and defecation dynamics
  - Rewards
  - Responsibility for accidents

# Posture and Defecation Dynamics


# Bedwetting

- Recommend deferring treatment at preschool ages
- Prevalence rates range 10-33% at age 5 (more common for boys)
- About 15% will spontaneously improve each year; nearly all will eventually
- Effective treatments are cumbersome
- Best viewed as maturational lag

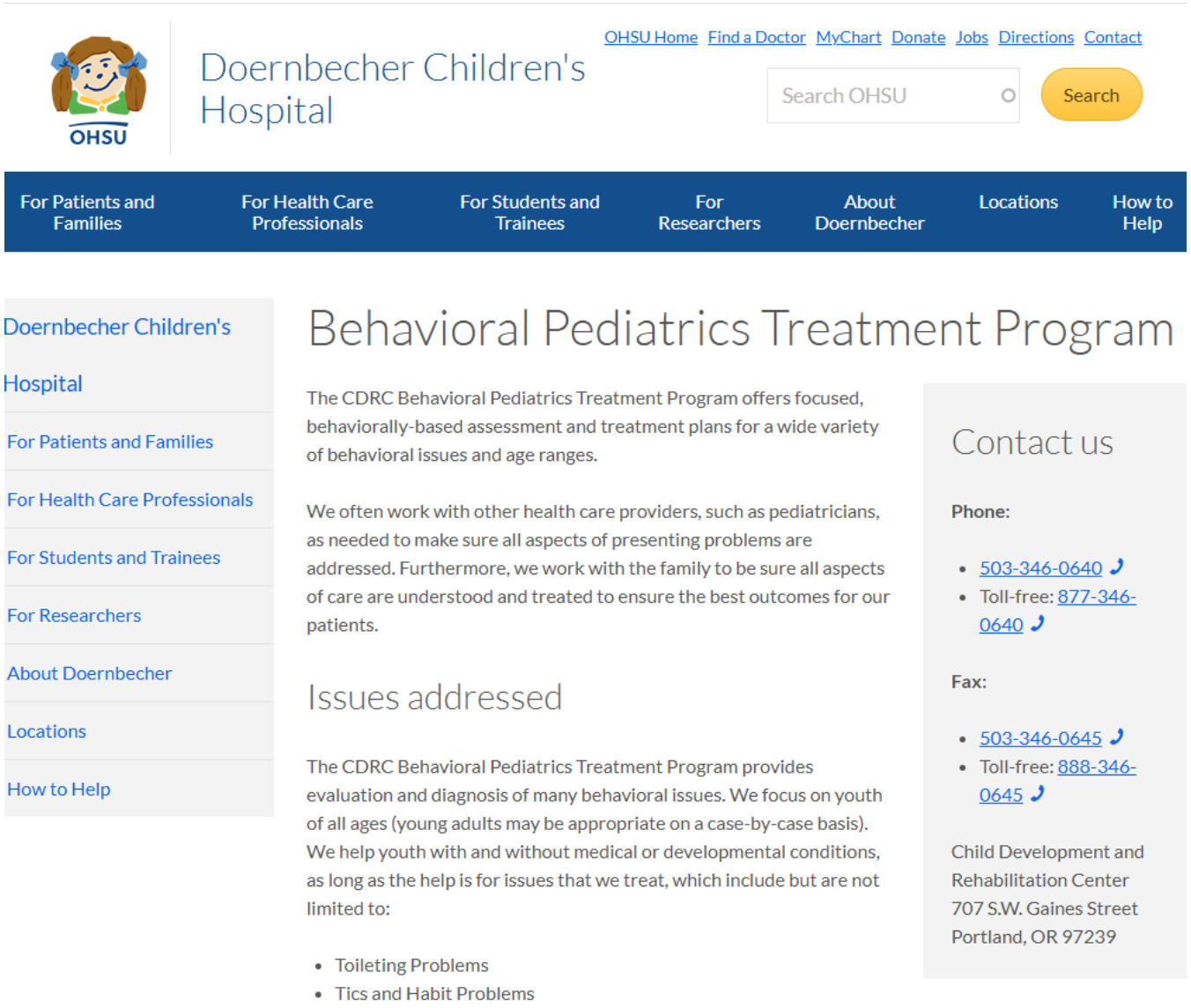
# Diagnosis and Billing

| Diagnosis | Preventive Counseling | Health Behavior Assessment | Health Behavior Intervention | Psychiatric Diagnostic Evaluation | Psychotherapy |
|---|---|---|---|---|---|
| Z62.89 Other Specified Problems of Upbringing | X | | X | | X |
| R62.0 Delayed Milestone | | X | X | | |
| R15.9 Encopresis (≥ 4 yo) | | X | X | | |
| F98.1 Encopresis (≥ 4 yo) | | | | X | X |
| R32 Enuresis (≥ 5 yo) | | X | X | | |
| F98.0 Enuresis (≥ 5 yo) | | | | X | X |

*Based on OPIP's "Billing Considerations for Oregon Integrated Behavioral Health in Primary Care."*

*Note: Billing and payment may be affected by several factors and the above are meant as possible options rather than definitive recommendations.*

# Referrals




- Behavioral Pediatrics Treatment Program @ OHSU for specialized behavioral intervention
- Pediatric GI for complex constipation
- Pediatric Urology for intractable enuresis or other complications

# Questions and Case Examples!

*This 2024 Learning Collaborative is financially supported by **Health Share of Oregon.***

# Case Example #1

- You are consulted during an 18-month well-child visit to answer a parent's questions about how to handle tantrums. As you are wrapping up, the parent remarks that grandparents have started to pressure them to toilet train, but she isn't sure if they're ready.

- What questions would you ask?
- What advice might you give?

# Case Example #2

- You are scheduled to see a 5 yo girl who is trained for urine but struggling with fecal accidents. She usually wears underwear, but only defecates in a pull-up, which she will request from parents. According to her parent's report, this happens once every 3-4 days. She denies pain but seems to actively fight bowel movements.

- What questions would you ask?
- What approach might you consider?

# Looking Forward

| Month | Topic-Focused Webinars & Person-Specific Registration Links (Third Tuesday of the Month) | OPTIONAL Office Hours & Zoom Links (First Tuesday of the Month) |
|---|---|---|
| December | 12/17/24: 12-1pm \| Incorporating Trauma-Informed Principles into IBH with Dr. Kim Burkhart \| Registration Link: https://us06web.zoom.us/meeting/register/tZcuceGoqjwpH9Iiz8bWB91uBhtxGIIA1I0A | 12/3/24: 12-12:30pm \| Zoom Link: https://us06web.zoom.us/j/89365465702 |

- Last webinar of this funded Learning Collaborative: **12/17, 12-1pm**
- Last Optional Case Consultation Call: **12/3 12-12:30 pm**
  - Will prioritize questions and cases from attendees & have prepared practice cases related to topics covered in this month's webinar
  - Remember: You do not need to register

# Next Month's Guest Speaker: Dr. Kimberly Burkhart

- Dr. Kimberly Burkhart is a clinical child psychologist at Rainbow Babies and Children's Hospital and Associate Professor of Pediatrics at Case Western Reserve University School of Medicine in Cleveland, Ohio.
- She leads trauma-informed initiatives within the hospital's ED and pediatric primary care centers.
- She is the Behavioral Health Education Subdomain Lead for the Pediatric Pandemic Network and the Behavioral Health Co-Lead for ASPR Region V for Kids.
- She serves as hospital lead for the HealthySteps program.
- Dr. Burkhart presents at national conferences and has numerous publications in the areas of parent training, autism spectrum disorder, disaster mental health, child maltreatment, and screening practices within primary care.

# Online Resource Library:
# Integrated Behavioral Health Learning Community Webinars & Materials

- As we close out our contract with Health Share of Oregon, OPIP will be creating a password-protected online repository on our website with:
  - Monthly webinar recordings, slides & resources shared
  - Slides from 10/15 in-person training & resources shared
  - **You will receive access via email by January 2025**