A CHILD-ORIENTED APPROACH TO TOILET TRAINING
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*Pediatrics* 1962;29;121-128

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A CHILD-ORIENTED APPROACH TO TOILET TRAINING

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Pediatricians have a unique opportunity to prevent problems for the child in the area of bowel and bladder control. Since the advent of streamlined diaper care has liberated mothers in our culture from the real need to "train" their children early, this step may be viewed more honestly as a major developmental task for the child. Proper timing of this may enable him to achieve mastery for himself. The ultimate value of such self-achievement can be easily weighed against the adverse effects of inopportune training by an adult society. The pediatric and psychiatric literature reports complications resulting from adverse toilet training.1-12 This paper will present the results of a program for training in which utilizing the child's developmental capacities and interest was the primary goal.

Parents and pediatricians are aware that the child's autonomous achievement in any developmental area frees him to progress to more advanced areas. Faulty mastery may leave him with a deficit that results in regression under stress. The relationship of coercive toilet training to chronic constipation has been pointed out.7 Garrard and associates6,11 presented six cases of functional megacolon with psychogenic etiology, in which the environmental pressure expressed in training practices were a primary factor. Glicklich6 summarized psychogenic factors in enuresis. Encopresis7,6,9,11 and urinary incontinence6,13,14 can be traced to adverse or punitive training practices. Such pathologic symptoms usually reflect a fundamental psychologic disturbance in the child's adjustment. But in healthful situations, parents can be encouraged to produce a positive reaction in the child to his control of bowel and bladder.

This paper will outline a child-oriented approach to "toilet training" at around 2 years, geared to each child's developmental capacities. The results from 1,170 children in 10 years of pediatric practice, for whom this program was suggested, are summarized.

THEORY

The method suggested was constructed on several assumptions based on observations of physical and emotional maturation in children.

Voluntary Control of Sphincters

Local conditioning of reflex sphincter control can be effectively elicited as early as 9 months and has been the basis for an early introduction of training.7,8 Voluntary co-operation may be elicited as early as 12 to 15 months, and this period has been suggested7,9,12,15 as optimal for training. However, myelinization of pyramidal tracts to these areas is not completed until the twelfth to eighteenth month.16 Associated with the transition from reflex compliance to a more voluntary type of developmental accomplishment, there is usually a perceptible time lag. In this period there is a kind of subtle inner resistance to outside pressure on the part of the child. This may be seen in many other developmental areas, such as reflex standing at 5 months to voluntary standing at 10 months, and vocalizations in the first year to verbal expressions in the latter half of the second year. This period is probably an important period of incorporation and of gathering inner forces for the child. In a complex area such as toilet training, it would be even more likely that any training based on early reflex compliance would go through a subsequent period.
of lag and breakdown before voluntary compliance on the part of the child could ensue.

Postponed breakdown in a control achieved before 12 to 18 months is much more frequent than that seen when control is accomplished after 18 months.\textsuperscript{7, 8, 20} That this breakdown in control can be circumvented by pressure from the environment is easy to see in some European cultures, where the incidence of postponed breakdown is much lower than in our own less rigid culture.\textsuperscript{13, 14, 19} However the severity and intractability of the symptoms produced in the deviant cases in these countries is good evidence for the strength of the child's inner resistances, which bring about such breakdowns. The incidence of failure in England is reported as varying from 10 to 15\%.\textsuperscript{5, 13}

**Motor Adjuncts to Training**

Other aspects of motor development participate in the ease with which a child achieves training. He must be able to sit and to walk in order to maintain some degree of autonomy about leaving the potty chair, and some understanding of verbal communication is a help.

The developmental energy invested in learning to walk on his own is freed after 15 to 18 months and can be transferred to the more complex mastery of sphincter control and toilet training.

**Impulse Control**

There must be a psychologic readiness associated with a desire to control the impulses to defecate and urinate. These impulses are associated with a kind of primitive pleasure and an immediacy. The realization of and wish to control them is dependent on influences from the environment. Chief among them are 1) security and gratification in the relationship with parent figures, resulting in a desire to please them; 2) the wish to identify with and imitate his parents and other important figures in his environment; and 3) the wish to develop autonomy and mastery of himself and his primitive impulses.\textsuperscript{8, 17, 21, 22}

These psychologic processes come to the fore in the latter half of the second year and appear to reach a peak of readiness in most children beginning at 18 months and increasing to 30 months.

**Other Psychologic Processes**

At about 2 years of age there is a period in most children in our culture that is characterized by organizing and setting things in their proper places. Even a trend toward personal cleanliness may develop. These trends are useful in understanding a readiness for toilet training.

There is an ebb and flow of negativism in this period of development, and it must be accounted for in urging new accomplishments. As it is difficult for a parent or physician to evaluate the degree of negativism that is active at any particular time, it is necessary to pace any such program slowly and with enough elasticity to allow for these subtle variations.

**PARENTAL INVOLVEMENT**

Sears et al.\textsuperscript{18} pointed to many of the complexities of parental feelings about toilet training in our culture. The child's ability to learn by imitation is complicated by taboos centered around modesty and the sexual feelings of the parents. For parents who wanted to train their children early in order to avoid such complex areas as 1) sexuality, 2) cultural pressure from older generations, or 3) strong compulsive feelings about cleanliness, pressure to delay training increased the parents' anxieties. They found, however, that many of their group of young parents were "in transit between old and new theories" (p. 109) and were in conflict about the age at which training might best be instituted. The "new" theories\textsuperscript{15, 20} suggested waiting for the child's readiness. In the group who were able to postpone training, less time was required to complete it. But Sears et al. wondered whether parents who were pushed to delay against their wishes might not increase the tension around this area for the child.

We have found that a "child-oriented"
approach in the group of parents in our study could divert some of their own anxiety, provided there was the "guiding ear" of a third person, such as the pediatrician. The conviction that this was "better for the child" undoubtedly acted as a counterbalance to the older cultural influences, as well as to their own sexualized taboos in this area. Since the child's autonomous achievement was constantly the focus, there was the implication that there was less parental responsibility for failure in the child's lack of accomplishment. Tension could be reduced by airing parental conflicts and by assurance that the child would achieve control in his own time.

PROCEDURE

Advice was geared to each individual situation. At the 9-month visit the question of future toilet training was raised with the parents. Because the grandparents' generation usually began to press them at this time, it has proven to be an optimal period for the discussion of future plans in this area. With a program planned, the parents were better able to withstand outside pressure to institute an early attempt at training the child.

Before suggestions were introduced, the parents' own feelings in this highly-charged area were explored. A repeated opportunity for them to express their own resistances and anxieties about toilet training was important in preventing their expressing them unconsciously to the child. The importance of a relaxed, unpressured approach to training for the child was constantly stressed. This method was presented as an adjunct to helping the child meet society's demands in this area. Because there is little innate in the child that leads him to want to be clean and dry, it must be understood as a kind of compliance to external pressure. The act of giving up the instinctual method of wetting and soiling to comply is evidence of 1) healthy maturation in the child, coupled with 2) a wish to identify with an adult society.17 Hence the optimal timing for such pressure must be geared to each child's physical and psychological readiness to cooperate. With his autonomous achievement of this major task, the reward for him is equivalent to that seen with his mastery of standing and walking and becomes a valuable step in his developmental progress. The danger of residual symptoms is then at a minimum.

The importance of timing the introduction of this method to the child's readiness, and of allowing him freedom to master each step at his own pace, was reiterated at each subsequent visit. Problems with the child and resistances or questions from the parent were discussed at each opportunity. Since this was not necessarily an attempt to prejudice parents for this particular approach to toilet training, every effort was made to help them with their own method. However, when problems arose, the child's interests were placed foremost in the discussion.

Method of Training

At some time after the child is 18 months of age, a "potty chair" on the floor is introduced as the child's "own chair." During the period of getting familiar with it, association between it and the parents' toilet seat is made verbally. At some routine time, the mother takes him each day to sit on his chair in all his clothes. Otherwise, the unfamiliar feeling of a cold seat can interfere with any further cooperation. At this time, she sits with him, reads to him or gives him a cookie. Since he is sitting on a chair on the floor, he is free to leave at will. There should never be any coercion or pressure to remain.

After a week or more of his co-operation in this part of the venture, he can be taken for another period with his diapers off, to sit on the chair as the routine. Still no attempt to "catch" his stool or urine is made. "Catching" his stool at this point can frighten him and result in his "holding back" for a longer period thereafter. This gradual introduction of the routine is made to avoid setting up fears of strangeness and of loss of "part of himself." When his interest in these steps is achieved, he can be taken to his pot a sec-

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TOILET TRAINING

...and time during the day. This can be after his diapers are soiled, to change him on the seat, dropping his dirty diaper under him into the pot, and pointing out to him that this is the eventual function of his chair.

When some understanding and wish to comply coincide, there will be verbal or active compliance on the first routine trip. Then he can be taken several times a day to "catch" his urine or stool, provided he remains willing.

As interest in performance grows, the next major step becomes feasible. All diapers and pants are removed for short periods, the toilet chair is placed in his room or play area, and his ability to perform by himself is pointed out. He is encouraged to go to his own pot when he wishes and by himself. He may be reminded periodically that this is indicated. When he is ready to perform alone, this becomes an exciting accomplishment, and many children take over the function entirely at this point. Training pants can be introduced, the child instructed as to their removal, and they become an adjunct to his autonomous control. The excitement which accompanies mastering these steps by himself is well worth the postponing until he can accept them.

Teaching a boy to stand for urination is an added incentive. It becomes a part of identifying with his father, with other boys, and is often an outlet for a normal amount of exhibitionism. It is most easily learned by watching and imitating other male figures. It is better introduced after bowel training is complete. Otherwise, the excitement of standing for all functions supersedes.

Nap and night training are left until well after the child shows an interest in staying clean and dry during the day. This may be 1 to 2 years later, but it often becomes coincident with daytime achievement. When the child evidences an interest in night training, the parent can offer to help him by rousing him in the early evening and offering him a chance to go to the toilet. A pot painted with luminous paint by his bedside is often a useful "gimmick." He is reminded that this is there for early morning use also. Some children who are eager and ready to remain dry at night have needed further help from the parents to awaken in the early morning for an interval. When this is not forthcoming, they fail in their efforts at night, lose interest and feel guilty in their failure. Then, enuresis and "giving up" may follow.

These steps are stressed as the child's achievement, and when there is a breakdown the parent is urged to stop the process and to reassure the child. He needs the reassurance that he is not "bad" in his failure to achieve, and that someday he will co-operate when he is "ready."

RESULTS

The results are compiled from unselected records of 1,170 patients over 10 years of pediatric practice (1951-1961) in Cambridge, Massachusetts. Upper-middle-class well-educated parents comprised the major portion of patients in this group. They lived under economic pressure, and mothers were washing their own diapers, so there was some practical pressure to achieve training. But their desire to give their children a thoughtful environment freed them in most cases to want to follow the suggested method.

The sample consisted of 672 (57.4%) male and 498 (42.6%) female children, of whom 660 (56.4%) were first children and 450 (43.6%) were second or later. It was found that the position in the family was a factor in determining the kind of environmental pressure which existed. With the first child there was usually more anxiety shown by the parents about waiting to train the child, more ambivalence about this "delayed" method, but surprise and relief when training was accomplished. The later children were given more freedom to train themselves at their own speed. However some pressure on these later children to conform came from the older siblings. Imitation of the older children often facilitated training in the younger ones.

The daytime training of first children...
was effected 1 to 2 months later than in their younger siblings. Night training was delayed 1 to 7 months longer in first children than in subsequent siblings. Figure 1 summarizes the ages at which training was started. The preponderance of patients who started around 24 months reflects these parents' willingness to accept this advice, and, with second children, their own choice about such timing. Figure 2 summarizes the ages at which parents reported the child's initial success, which was maintained. One hundred forty-four (12.3%) achieved bowel training first, 96 (8.2%) were trained for urination first, and 930 (79.5%) were reported as training themselves simultaneously for bowel and bladder control. Of the 930, some 839 (90.3%) were between 24 and 30 months of age. The average age of the total group who accomplished initial success was 27.7 months.

Initial success reflects an understanding
of the use of the toilet rather than a mastery of the process. Figure 3 summarizes the ages of completion of daytime training. Nine hundred forty-four (80.7%) accomplished this between the ages of 2 and 2½ years. The average was 28.5 months. No significant difference was noted between males and females. Day training means an absence of accidents under the usual stresses. When a breakover occurs under stress, it is of temporary duration only (less than 1 month).

Night training implies 1) that subsequent failure was reduced to less than once a week and 2) that enuresis returned under unusual stress only, e.g., a new baby, moving, absence of a parent, etc., and resolved itself again in a short time (less than 2 months). Figure 4 summarizes the ages of night training. Sixteen (1.4%) children are included who had residual problems of enuresis, encopresis and constipation beyond the age of 5 years. In the total group 940 (80.3%) were completely trained by the age of 3 years. The average age of all training was 33.3 months. Females were completely trained 2.46 months before males.

There were 150 children in this group whose training was not completed until 3½ years. Forty-eight, or approximately one-
third of these, were started to be trained before 18 months. One hundred and eight (9.2%) were untrained by 4 years. Of these 70 or two-thirds had started training before 18 months. Of the 16 problem children only two had started early, and the time of training them seemed to have little influence in creating their more severe difficulties.

Of these 16 children, 12 were enuretic after 5 years of age, 4 soiled in stress situations, and 8 had chronic constipation. There were environmental problems in all of these cases, and it was obvious that in each of these children the above symptoms reflected deeper disturbances of a psychogenic nature. But of the other 1,154 in the group, there were often similar environmental stresses present, and it is encouraging that these did not produce problems in the training area. This suggests that by allowing the child more freedom to develop his controls at his own speed, problems in such an area may be prevented, provided parental anxiety in this area can be averted also. It is not possible in this paper to present the details of techniques available to pediatricians which can facilitate the handling of incipient problems, but these results lead one to believe that such a child-oriented approach does divert environment tension from this area and may reduce the incidence of subsequent difficulties.

SUMMARY

Results of toilet training obtained from the records of 1,170 children in pediatric practice over a 10-year period are summarized. The suggested method stressed the child’s interest and compliance in developing autonomous control. This was instituted at about 2 years of age and depended on his physiologic and psychologic readiness.

Initial success was achieved simultaneously in both bowel and urinary control in 79.5% of the cases, 12.3% in bowel control alone, and 8.2% in urinary control. This first accomplishment was reached at an average age of 27.7 months. Daytime training was completed between 2 and 24 years of age in 80.7% of this group. The average age for day training was 28.5 months; males and females showed no significant difference; first children were 1.2 months slower than their siblings. Night training was accomplished by 3 years in 80.3% of cases. The average age for completion of all training was 33.3 months. Males took 2.46 months longer for complete training. First children were delayed 1.7 months in complete training in relation to their siblings.

Of the children who had chronic difficulties in this area, 76 (6.5%) were untrained at 4 years, and 16 (1.4%) were failures by the age of 5 years. The value of such a child-oriented program in preventing residual symptoms is stressed.

REFERENCES


BOOK REVIEW


This booklet of 64 pages is as simple, practical, and prosaic as the reminders inside its front and back cover for the medical man when (A) returning from meetings ("Answer accumulated mail. Report interesting and new information to staff. Outline plans for new projects.") and when (B) preparing for visitors ("Plan coffee breaks. Special honorarium must be arranged well in advance."). Between these covers there is a wealth of useful detail, some of it also a little self evident, but well worth the time of any speaker or writer, and required reading for most.

The eight pages devoted to medical writing are scarcely enough for their purpose, but the rest of the booklet, with its brief sections on the various sorts of self-made slides and of those requiring technical assistance, is excellent. Perhaps most welcome of all is the section on projection screens, with its diagrams of proper relationships between screen size, room size, wattage of bulb, and focal length projector.

The Director of the Department of Visual Education of the Children's Hospital Medical Center tells us: "This booklet is well done, authentic. I approve heartily." Coming from F. B. Harding, this approval is impressive.

C.A.S.
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