Partners in Pediatrics

Naturally Healthy Kids Since 1977

WELL-CHILD CARE

AGE: 18 MONTHS

GROWTH:

Weight: lb. oz. (%)

Height: inches (%)

Head Circumference: inches (%)

SCREENING:

Blood Pressure:

IMMUNIZATIONS:

☐ Hepatitis A

☐ Influenza (today, this fall)

☐ _____

DEVELOPMENT/ASQ

Screening Results:

☐ Passing ☐ Borderline ☐ Referral

GENERAL PARENTING ISSUES:

1. NUTRITION

Once children are well into their second year of life, increased distractibility may cause a significant **decrease** in their food intake. Between 15-18 months we also expect a significant percentage of children to become **"picky eaters."** Many consume one "good meal per day" and may pick at the rest of the meal offerings. While that good meal may be any one of the three, it is most often breakfast. As long as your child eats one good meal a day on average, and is healthy and growing appropriately according to our check-ups, there is no concern. Children between 18-24 months will become adept and insistent on self-feeding with fingers and utensils. Do continue to offer a variety of nutritious foods, spices and textures.

If you have not already done so, wean all bottle use NOW to help reduce the chance of dental problems. Often, as children cut back on the volume of liquids from the bottle they actually consume more soild foods.

In addition to eating smaller amounts of foods, many children will become "picky" in their selection of foods. Some children may refuse foods they once gladly accepted, or others may refuse to eat an entire food group, e.g. meats. This pickiness is normal, and requires no dietary changes except the addition of a **liquid vitamin.**

At 18 months, because of increased communication skills and independence, children may begin to demand more sweet foods (e.g. candies, pastries, cookies, pop.) First, offer children naturally sweet foods which are nutritional (e.g., fruit, dried fruits, etc.). Strict elimination of all highly sweet foods is unnecessary. In fact, this may intensify your child's interest in these foods. these foods should be offered sparingly, preferably no more than once a day. The ideal time of day is between lunch and dinner, not associated with a meal. We strongly discourage the use of sweets as a reward for finishing a meal. Please limit juice intake to no more 4 oz. per day. Excess juice consumption can lead to chronic diarrhea, refusal of other foods, and cavities. Be sure to include 3-4 servings a day of Vitamin D and calcium-rich foods for optimal bone health and growth. Almond milk, yogurt, cheese and calcium rich foods are good alternatives to cow'smilk if needed.

2. SLEEP

Nearly all children will now have gone to a one nap routine. For those still taking two naps, anticipate that all children will soon be down to one nap per day within 6 months. If you have not already done so this is an excellent age to develop a bedtime ritual to enhance your child's ability to go to sleep ("sleep induce") more independently.

The ritual should include a routine of clothes changing, hygienic activity (e.g. tooth brushing, face washing, etc.) and followed by a cuddle time in a comfortable chair with a story, lullaby, etc.

Not only are these precious moments, but they really help a toddler to develop independent sleep induction skills making them more flexible in sleep behavior.

If you have had difficulty weaning the last bottle at bedtime, the following is an effective technique to **eliminate** the **night time bottle** with minimal trauma: A new **bedtime ritual** should now be established. The ritual should include:

— Hold your child in your lap in a quiet room, preferably his own bedroom.

— Focus with them on the book you will read together.

— The child should be offered the cup with WATER, not milk (milk residue on your child's teeth can now lead to cavities).

— A bedtime story or lullaby should be the **primary** focus of attention at this time.

— Also, a soft object (e.g. cloth blanket or teddy bear) should be placed in the lap to encourage comfort with a "transfer object."

3. TOILET LEARNING

It is impossible in the scope of this publication to thoroughly discuss a topic as complicated as toilet training. Rather, it is our intent to provide an overview of this intricate, delicate and often poorly understood skill, which is a required step in the successful process of socialization.

Most of the **folklore** currently handed down about potty training was developed in the **1940's and 1950's.** Parenting has obviously changed greatly since then, as has our understanding of children and their development. Therefore, we should look beyond the folklore and try to educate ourselves fully to enhance this very exciting parenting experience.

The family structure of the 1940's and 1950's necessitated **early potty training.** Mothers often had **several** children close in age and in diapers. Only **cloth** diapers were available with no easy or convenient way to handle them (e.g., diaper services, their own washer/dryer, etc.) These mothers could easily spend 1-2 hours of each day just

doing diapers. Thus, the motivation to have children out of diapers early was not a luxury but a **necessity.**

During those years, toilet training began **very early,** often between nine and 12 months. It was a very **laborious** process which relied on the child's ability to learn through **repetition**, rather than conscious understanding and cooperation. Parents would continuously take the child to the potty at fixed, regular intervals, regardless of what the child's attitude, interest, or response may have been.

This approach was tiresome at best, and often success was achieved only after some struggle in a **majority** of children. Furthermore, it was full of dangerous pitfalls. For example, some children and parents were left feeling like **failures** if they didn't achieve success. **Confusion** for both parent and child was common, leaving the future course of action uncertain. Such experience may have set the tone for other **future** unsuccessful parent-child interactions. Some parents became increasingly insecure in giving normal guidance to their child, while some children became less comfortable in accepting it.

In its most severe form, failed toilet training deteriorated into a **power struggle** filled with tension, animosity, resentment, fear, disrespect, etc. These feelings often went far beyond the potty training relationship to permeate all aspects of parent-child relations, to set up a long-standing disharmony which often was **not** resolved.

In retrospect, it is easy to understand why this technique of toilet learning was adopted then, even with its inherent dangers. It is hopefully equally clear that our family and social structure has changed dramatically, thus allowing this method to gracefully become history.

Many books have been written about toilet training. The majority of their text is directed to the technical procedures with scarcely any information to aid the parent in deciding whether or not the child is ready. These books have only further compounded the problem by misleading their readers into thinking that **technique** is more important than **readiness**.

There are two reasons why we describe the old method in such detail. First, many new parents still naturally turn to other family members for **advice** in the area of toilet learning. This, as we have shown, may **not** be the best resource.

Secondly, many of the pitfalls of the older method largely resulted from a **single, crucial flaw.** This flaw is that the older method only took into account the **parent's readiness** to begin the toilet learning process and ignored when or if **the child was ready.** This fact is the essential difference between today's toilet training style and the method of our parents.

In fact, knowing how to tell **when your child is ready** is the single **most** important ingredient of successful toilet learning. It is nearly impossible to teach an unreceptive student–the **child** who is **not** truly **ready** is **unreceptive.**

In order to be able to learn to be independently responsible for bowel and bladder control, a child needs **two qualities:** A sincere **interest** in cooperating, and the **basic skills** required to perform this function.

These basic skills include the following six items: 1) recognize the need to evacuate, 2) be willing to stop what they are doing to go to the potty, 3) be able to hold it in until they arrive at the potty, 4) disrobe themselves, 5) climb on the potty, and 6) then relax on the potty seat to allow evacuation to take place.

This is a complicated and difficult sequence to perform and requires neurological and emotional maturity, For most children, this capability does not develop until between the **second and third years** of life. **Girls** are generally ready **earlier** than boys.

Intellectually, we may know what our children must be able to do to be considered ready. However, it is difficult to know practically when they actually are ready. Again, this **readiness** is the single most important aspect of toilet training.

Thus, we recommend a simple **trial** of training to **test readiness.** This trial is intended to give the parent a definitive baseline of the child's readiness to undertake the learning process. It is designed specifically to be a gentle, non-threatening test.

The child should be given a **trial** over **24-48 hours.** The parent should give **excited and supportive reminders** on an hourly basis for the child to go potty. The child should be left in diapers during the test as a sign that no definitive commitment has been made.

After the trial is up, the parents can assess the child's responsiveness to it. This assessment provides a direct indication of the

child's interest or cooperation, and the general skill level.

If the child has shown **any resistance** to the trial, it is a reliable sign that he is **not** receptive to learning this new responsibility and, thus, is not ready to be trained.

If the child's success rate, despite hourly reminders, is **not greater than approximately 30%,** it is strongly suggested that they are **not** ready for independent function. Thus, if the child is resistant or relatively unsuccessful, they are considered not ready, and toilet learning is then postponed. **Another trial** should be made again every 2-8 weeks until they are considered ready.

However, if the child is **both receptive** and at least **30% successful,** one may assume that they are ready to begin the process of training. While in training, the child may lose receptivity or plateau in increasing their frequency of successful evacuation. This is a strong sign that readiness has been lost. Lost readiness can happen for many reasons. Reasons may include: illness, a new house, starting a new day care, etc. Regardless of the reason, training should be discontinued and trials should be reevaluated again every 2-8 weeks.

The key to successful toilet learning is a patient, kind, and supportive teacher (i.e., the parents) and a receptive, skillful student (i.e. the child). Most children love to learn and they relish the opportunity to become more independent in their self care as long as the responsibility is offered at the right time. Hopefully, this brief synopsis has demonstrated the importance of picking the right time and has given some guidance in how the right time can be selected.

We wish you luck when you undertake this exciting endeavor.

DEVELOPMENT/STIMULATION:

Now your child is a real toddler. They are all over; up and down the stairs, up and down the furniture, squatting, standing, and walking.

At the same time, play is developing into different levels. As they expand the use of toys previously mentioned, they are now interested in pegs, stacking blocks, and containers (nesting blocks). Additionally, an interest in simple puzzles is emerging as well as a three-shape shape sorter. In and out activities, such as opening a door to place blocks in and to take them out, are becoming of interest. Children of this age also like to carry objects about as they explore the house. Make certain these are of varying shape, size and weight and will not be harmful. Push and pull toys are appropriate as they are something they can take along with them. Once again, riding toys that can be propelled with their feet are enjoyable.

HOMEWORK ASSIGNMENTS:

1. Please reread the toilet learning article above.
2. Mark your calendars to call for your 2 year appointment 3 months ahead of your child's birthday.
3. Make an appointment for your child to see the DENTIST soon.

COMING SOON:

1. The next visit will be at age 2 years.
2. Discussion of television philosophies (until your child reaches the age of 2 years, the AAP recommends no television viewing).
3. Discussion of changing from crib to bed.
4. Discussion of preschools.
5. Influenza vaccine will be available in the fall for your child.

Partners In Pediatrics

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