Beyond the Toilet

Toilet Use, Non-Toilet Use and Bodily Freedom

Abstract

Modern society treats toilet use as the natural and inevitable endpoint of human development. Children are expected to be trained into it; adults are expected to maintain it; and those who do not are commonly regarded as delayed, disabled, regressed or unfortunate. Yet the foundations of this certainty are weaker than they appear.

Research shows that toilet-training methods can produce continence, but does not establish one universally superior method, adequately document long-term psychological effects, or prove that toilet use is the only rational form of bodily management. Training can involve refusal, withholding, constipation, anxiety, conflict and shame. Research among young people and adults also shows that continence problems become harmful partly because of secrecy, inaccessible toilets, bullying and stigma. Meanwhile, absorbent products can improve quality of life, confidence, independence and daily functioning even when the person's underlying continence does not change.

This paper argues that toilet use should be understood as one body-management system rather than the compulsory destination of every human life. Human beings are born without voluntary continence. That is not a defect but the original condition of every person. Remaining outside the toilet system, delaying entry into it or returning to an alternative later in life should not automatically be understood as failure. In suitable circumstances, non-toilet use may offer less stress, greater comfort, more portability, less bodily vigilance and a more honest form of freedom.

> **Toilets are useful. They should remain available. But they should not rule.**

1. A system mistaken for nature

Most people do not meaningfully choose toilet use. They are introduced to it before they are old enough to examine the choice.

The process is usually presented as an unavoidable part of growing up. Babies wear nappies; toddlers are trained; children become "clean and dry"; adults use toilets. The sequence appears so ordinary that it becomes almost invisible.

But toilet use is not merely a bodily capacity. It is a social system supported by plumbing, architecture, schedules, schools, workplace rules, family expectations and ideas about maturity. It depends on access to private rooms, clean facilities, permission to leave an activity and the ability to interrupt one's life when the body demands it.

Children are not only taught how to use a toilet. They are taught that using it is what a proper person does. They learn that the nappy which was previously ordinary is now embarrassing, that one outcome is a "success" and another an "accident," and that maturity is demonstrated through bodily control.

This is a powerful lesson: this is what you will do with your body for the rest of your life, and there is no serious alternative.

The lesson may be socially familiar, but familiarity is not proof.

2. What the research establishes

The research does establish that toilet training can work. It does not establish the much larger claim society builds around that fact.

A major evidence review commissioned by the US Agency for Healthcare Research and Quality found that established child-oriented and behaviourally directed methods could successfully teach toilet use. However, the studies were heterogeneous, the methods had not been adequately compared, information about whether results were sustained was limited, and a lack of data prevented firm conclusions about adverse outcomes. The review concluded that there was insufficient evidence to identify an optimal method and called for more long-term research into withholding, refusal, enuresis, encopresis and psychological consequences (Klassen et al., 2006).

This is not evidence that training is always harmful. It is evidence that the confidence surrounding it exceeds the evidence beneath it.

Recognised difficulties are not rare curiosities. In one prospective study of 482 children, 22 per cent experienced at least a month of refusing to defecate in the toilet. Stool withholding was strongly associated with refusal. When training was interrupted and children were allowed to return to nappies, 24 of 27 subsequently began using the toilet for bowel movements within three months (Taubman, 1997). Another study found that avoiding negative language about faeces and praising children for using their nappies did not prevent refusal, but shortened its duration and reduced some of its negative consequences (Taubman, Blum and Nemeth, 2003).

The implication is not that returning to nappies is a clever technique for achieving the same predetermined goal. The more important point is that removing pressure can improve the situation. The nappy is not always the problem. Sometimes it is the relief from the problem.

Cross-cultural research also challenges the idea of a single natural timetable. Expectations, ages, methods and ideas of readiness have varied significantly between societies. DeVries and deVries concluded that sociocultural factors were more important in determining supposed readiness than was generally recognised (1977). Toilet practices respond to cultural values, labour, housing, expert fashion and available technology. They do not simply unfold from biology.

Research concerning adults makes another important distinction. Absorbent products can have beneficial effects even when a person's underlying symptoms do not change. Getliffe and colleagues described these as product "treatment effects": effective containment can improve comfort, confidence, psychological

wellbeing and social functioning (2007). The ICIQ-PadPROM questionnaire was later developed specifically to measure how absorbent products affect quality of life in the absence of any improvement in continence itself (Yearwood Martin et al., 2018).

In a study of people with chronic urinary or faecal incontinence in Thailand, providing adult diapers significantly improved health-related quality of life and independence in activities of daily living (Teerawattananon et al., 2015).

This distinction is fundamental. A person's life can improve because their way of managing elimination improves, not because they become more continent.

None of this proves that elective non-toilet use is medically superior for every child or adult. Direct research into choosing it as an ordinary way of life is almost nonexistent. But absence of

research is not evidence that the choice is irrational. Existing research is sufficient to reject three common assumptions:

1. Toilet training is not a perfectly understood or risk-free intervention.

2. Continence is not the only route to independence or quality of life.

3. Absorbent products are not merely failed substitutes for toilets.

3. Human beings begin without voluntary continence

Every human being enters life without voluntary bladder or bowel control.

> **This is not a pathology. It is the original bodily condition of every person.**

It is normally described as a temporary stage because society expects it to be replaced. Yet describing something as a stage does not prove that everyone must leave it, nor that leaving it is an improvement in every respect.

“Developmental milestone” is often used as though it settles the question. It does not. A milestone marks an event or acquired capacity. It does not establish a moral duty to use that capacity permanently.

A person may learn to drive without being obliged to drive. They may learn to cook while sometimes choosing prepared food. They may be capable of climbing stairs while preferring a lift. Acquiring an ability does not make every alternative inferior.

The relevant question is therefore not simply whether a person can learn toilet use. It is whether toilet use gives that person the best life.

4. Toilet use does not eliminate dependence

Toilet use is routinely described as independence. In reality, it exchanges one system of dependence for another.

A person using absorbent protection depends on products, appropriate changing, cleaning, skin care and disposal. A toilet user depends on plumbing, bathrooms, physical access, privacy, schedules and proximity.

Neither system is independent of technology or infrastructure.

The toilet has one considerable cultural advantage: its dependencies have been built into the environment and made invisible. Buildings, workplaces, schools, restaurants and transport systems are arranged around it. Society then mistakes the convenience created by this investment for proof that the system itself is natural.

A toilet is fixed sanitation infrastructure. An absorbent product is wearable sanitation infrastructure.

One requires the person to find and move to a particular room. The other moves with the person. One interrupts the activity. The other can postpone the interruption. One depends upon public availability. The other creates a degree of private availability wherever the person goes.

This does not make wearable management better in every circumstance. It does make the hierarchy much less obvious than people assume.

5. The hidden costs of the toilet norm

The benefits of toilet use are easy to see. Its costs are rarely counted.

For children, training can turn ordinary bodily processes into a field of observation and judgement. Adults watch for signs, prompt, reward, question, inspect, praise success and respond to failure. Even a patient method can communicate that the child's current body is a problem to be corrected.

For some families the transition is easy. For others it brings conflict, withholding, anxiety, constipation, fear, hiding and repeated disappointment. These harms are often treated as unfortunate difficulties on the road to an unquestionably desirable destination. The destination itself is rarely examined.

The system also introduces shame at an unusually early point in life. A child learns that urination and defecation are not merely private but potentially humiliating. A product which was once acceptable becomes evidence of being "little." An ordinary bodily event becomes an "accident."

The lesson lasts. Young people with continence problems describe secrecy, restricted drinking, interrupted education, anxiety about disclosure, inadequate toilets, fear of bullying and social isolation (Whale, Cramer and Joinson, 2018). Qualitative research among adults likewise finds shame, concealment, fear of judgement and reluctance to seek help (Toye and Barker, 2020).

The physical condition is only part of the harm. The social meaning attached to it creates another layer.

Standard toilet use can also impose continual low-level vigilance:

Do I need to go?

Where is the nearest toilet?

Can I wait?

Is it accessible?

Is it clean?

May I leave?

Should I avoid drinking?

Will I wake during the night?

For many people these calculations are minor. For others they influence journeys, work, education, sleep, social life and fluid intake. Toilet use is presented as freedom from management, but it remains a management system. Its work has simply become normalised.

6. Non-toilet use is not failure

It is useful at this point to introduce more neutral language.

“Non-toilet use” means managing urination or defecation through an absorbent product or another deliberate alternative rather than using a toilet on that occasion. It can be occasional, combined with toilet use or used as a person’s principal system.

Non-toilet use is not inherently an accident. An accident is an unintended event or a failure of the intended system. When a product is used deliberately and performs as intended, no accident has occurred.

> **A nappy is not a failed toilet. It is a different tool.**

For children, choosing not to conduct a formal programme of toilet training need not mean ignoring health, communication or development. Parents can make toilets available, explain their purpose and allow a child to explore them without creating a campaign of rewards, disappointment and pressure. The child can choose toilet use later. Declining to impose training is not the same as preventing learning.

For adults, choosing absorbent protection need not be understood as regression. Regression is movement backwards only if toilet use is first accepted as a higher state. That is precisely the assumption being questioned.

An adult may prefer non-toilet use for comfort, convenience, sleep, travel, concentration, anxiety reduction, sensory reasons or simply because it suits their life. Adults routinely choose tools and routines that reduce inconvenience without having to prove medical necessity. Bodily management should not be an exception.

The proper test is practical and human: is the choice informed, hygienically managed, freely made and compatible with the person’s wellbeing?

> **When the answer is yes, non-toilet use requires no apology.**

7. Why the alternative can be better

The case for the alternative is not limited to tolerance. On ordinary measures of human wellbeing, it can be the better system.

It can produce a calmer childhood

Not training removes a potential struggle over the child's body. It avoids making elimination into a test of obedience, maturity or parental competence. A child can remain cared for without being told that their current way of living is embarrassing or overdue for correction.

A calmer childhood is not a minor benefit. Where training produces conflict and non-training does not, non- training is better.

It can reduce bodily vigilance

A reliable absorbent product can reduce the urgency of locating a toilet, interrupting work, restricting drinks or planning every journey around facilities. It can provide security during sleep, transport, long events or periods of intense concentration.

Where it reduces anxiety and interruption without producing greater harms, it is better.

It can provide portable freedom

Toilet use ties bodily management to particular rooms. Non-toilet use makes part of that infrastructure wearable.

This is not absolute freedom: changing is still required. But the timing of the interruption may become more flexible, and immediate toilet access becomes less important.

Where portability creates more mobility and participation, it is better.

It can legitimise comfort

Comfort is often dismissed as an inadequate reason because non-toilet use is considered acceptable only when medically necessary. But comfort is a serious component of a good life.

People design their clothing, homes, beds, furniture, schedules and technology around comfort. They are not normally required to prove that the less comfortable alternative is medically impossible.

If a person feels calmer, safer and more at ease using protection, those benefits are real. A choice does not become frivolous merely because it makes life gentler.

It can separate dignity from bodily performance

Dignity should not depend on the ability or willingness to manage elimination through one approved fixture.

Research on dignity-protective continence care locates dignity in privacy, autonomy, respect, communication and control over one's own care—not simply in successful toilet use (Ostaszkiewicz et al., 2020).

A freely chosen product may therefore be more dignified than coerced toilet use. A cared-for child who is not ashamed may be better placed than a toilet-using child who has been frightened or humiliated. An adult confidently using protection may be freer than an adult organising life around the fear of leakage or unavailable toilets.

It can make society more inclusive

So long as absorbent products are treated as proof of disability, decline or failure, those who need them will remain marked as exceptions.

Normalising them as an option available to anyone would weaken that hierarchy. A disabled person would no longer be using the humiliating substitute reserved for those who could not achieve the real goal. They would be using one recognised form of human body management.

The alternative is therefore not only capable of helping individual users. Its acceptance could reduce the shame imposed on millions of people.

It can produce a more honest relationship with the body

Human bodies are not perfectly sealed or permanently controlled. They leak, sweat, bleed, discharge, become ill, sleep, age and change.

A culture which recognises this and develops comfortable ways to manage it may be more mature than one which equates dignity with appearing invulnerable.

The alternative says that the body requires care, not moral judgement.

8. The language which protects the system

The current vocabulary does not merely describe toilet use. It reinforces its status.

“Still in nappies” contains both a timetable and a verdict. The person should already have left them.

“Accident” defines non-toilet elimination as a mistake before anyone considers whether it was intended.

“Clean and dry” wrongly merges hygiene with continence. A toilet user also requires cleaning, while a person using an absorbent product can be clean, healthy and properly cared for.

“Big boy” and “big girl” attach maturity and approval to toilet use.

“Regression” assumes that returning to protection is a descent.

“Toilet refusal” may describe behaviour, but it can also turn fear, discomfort, preference or resistance to pressure into a problem located entirely inside the child.

“Training” assumes in advance that the desired destination has been decided by someone else.

This is not necessarily propaganda in the sense of a centrally organised campaign. But it performs a propaganda-like social function. The language is repeated by parents, teachers, advertising, healthcare, children and institutions until one system appears natural and the other becomes almost unspeakable.

More neutral language makes the choice visible:

• toilet use and non-toilet use; • toilet-based and product-based management; • uses absorbent protection; • chose or returned to protection; • unintended leakage, where something was genuinely unintended; • learning toilet use, where learning is actually taking place.

Changing the language does not force anyone to abandon toilets. It merely stops embedding a moral verdict in every description.

9. Limits, care and choice

A serious argument for non-toilet use must acknowledge its responsibilities.

Absorbent products can cause skin problems when they are poorly fitted, unsuitable or left unchanged for too long. Faecal and urinary symptoms can indicate constipation, infection, pain or another condition requiring attention. Products cost money, create waste and require reliable supply, cleaning and disposal.

Non-toilet use is therefore not freedom from care. It is a different form of care.

For children, not training must never become inverse coercion. A child should not be prevented from learning or using a toilet because an adult prefers the alternative. Toilets can be offered without pressure, and the child's wishes should carry increasing weight as they become able to express them. Pain, withholding, distress and skin problems must be taken seriously.

The strongest position is neither compulsory toilet use nor compulsory non-toilet use. It is genuine bodily choice supported by good care, honest information and better technology.

Hybrid arrangements should also be ordinary. A person may use toilets at some times and protection at others. They may change their approach across childhood, adulthood, illness, travel, work or old age. No single decision needs to become a permanent identity.

10. Conclusion

Toilet use is useful. It is not sacred.

The evidence shows that training can work, but the research base is less complete than cultural certainty suggests. Adverse effects have been inadequately studied. Refusal, withholding, conflict, stigma and anxiety are real. Absorbent products can independently improve quality of life and daily functioning without restoring continence.

History and anthropology show that toilet expectations are culturally variable. Philosophy shows that acquiring bodily control does not create a duty to exercise it in one socially approved way. Practical analysis shows that toilet use and non-toilet use are both technological systems, with different advantages, costs and dependencies.

Human beings are born without voluntary continence. This is not merely a defect waiting for correction. It is an ordinary human condition which can be managed in more than one way.

A child who is not toilet trained has not failed.

An adult who chooses protection has not regressed.

A nappy is not a failed toilet.

Where non-toilet use creates less stress, greater comfort, more security, more mobility and an equally acceptable standard of hygiene and health, it is not merely permissible. It is better.

The aim should not be to replace one compulsory system with another. It should be to end the monopoly of one system over dignity, adulthood and respectability.

Toilet use should be an option.

Non-toilet use should be an option.

The measure of success should not be conformity to the fixture society prefers. It should be whether the person is healthy, comfortable, respected and free.

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