

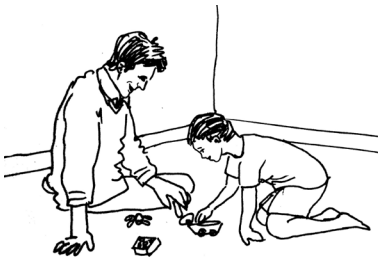
# 11

## Problems in childhood and adolescence<sup>†</sup>

### General approach to children and adolescents

Children and adolescents, whom we can collectively call young people, can be affected by many different types of mental health problems (as can adults), which can range from 'distress' to 'disorders' to 'disabilities'. Distress can be broadly defined as a situation when a young person's emotional stability is disturbed by factors which may be internal (e.g. the onset of puberty) or external (e.g. arrival of a sibling or a problem in the family) or a combination of both. Distress in young people may be reflected in behaviours (e.g. disobedient behaviour or acting as if they are a younger age) and may occur when the challenges the young person faces overwhelm their personal strengths or supports. Disorders, on the other hand, are a more defined group of conditions, which can be recognised by a pattern of emotions, thoughts or behaviours which have an impact on the daily functioning of the young person. Disabilities in children are typically present from birth or develop before the age of 18 and affect the young person's ability to learn and live independently. They may last for most or all of their life.

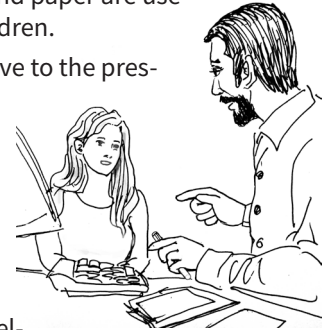
Although the young person may be identified as the one with the problem, it is almost always necessary to consider the family in the assessment



<sup>†</sup>With Gauri Divan.

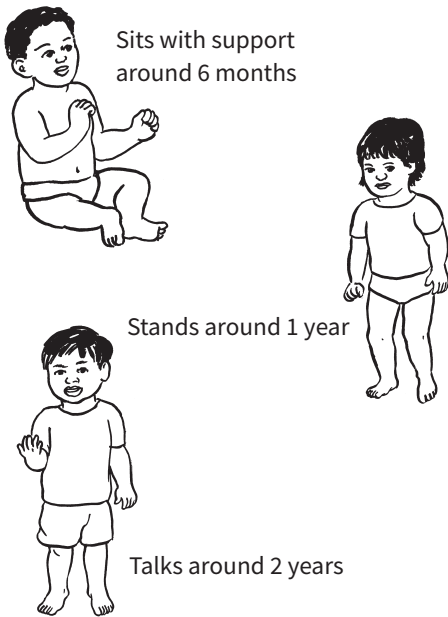
as well as the intervention. Indeed, most young people will be accompanied to the health worker by an adult who may be a parent, a family member or a concerned community member (e.g. a teacher). This need for family (or broader) involvement has to be balanced against the independence and privacy of the young person. Some general guidelines to follow while exploring a young person's problem are as follows.

- Create a place which is comfortable for both the adult and the child. A box of toys to help with the developmental assessment (Box 11.1) along with pen and paper are useful for young children.
- Always be sensitive to the presence of the young person. Be careful of the language being used, even if the child is very young. Avoid labelling the child with negative terms such as 'naughty' even if you don't think that the child is listening.
- There may be situations when you would like to speak to the young person alone; if so, ask the family member if you can have some time alone with the child. When speaking to the child, explain that you will not share any information given to you, unless they give their permission or unless there is an emergency situation.
- When speaking to the child, simplify your language so that it is understandable; however, do not talk 'down' to an adolescent (i.e. as if they are a young child), as this may annoy them.



### BOX 11.1 THE KEY MILESTONES OF DEVELOPMENT

There are many milestones on the road from birth to becoming an adult (⇨ Table 11.1). It is important to remember some important milestones which can be used to check whether a child is developing more slowly than expected. The milestones below can be used as a rough guide for detecting intellectual disability. Any loss of skills already achieved at any age is a cause for concern.



- Similarly, you may need to talk to the family member individually; in this case, explain to the young person that you would like to talk to their parent while they wait outside the room.
- Breaking bad news regarding a child to a family member should be handled sensitively. Remember to make sure you allow enough time for the parents to ask questions; answer these in simple but precise terms; be ready to admit that you may not have all the answers but will try to help the parent to the best of your abilities.

## 11.1 The child who is developing slowly

This section is about a child who is not developing at the rate at which most other children of the same age do; however, keep in mind that there is great variation in physical and mental abilities among children (and adults). Some children are better at sports than others. Some children are better at studies than others. Some children learn to walk later than others. In Part 4 (⇨ 13.3) we describe what all parents should try and do regularly so as to stimulate the development of their baby's brain, for example, through games and play. However, there are situations when a child is much slower in achieving most important 'milestones' in development (Box 11.1, Table 11.1), typically because of problems which occur even before the child is born or are due to genetic defects. In these children you should consider the possibility of an intellectual disability (which used to be called 'mental retardation').

### 11.1.1 What is intellectual disability?

Intellectual disability is when brain development is slower than would be expected for the age of the child. This results in a child having difficulty with learning new things. The child may be slow in learning and understanding the world around them (e.g. understanding their name, understanding instructions), learning how to sit, how to walk and button their shirt, learning to speak and understand new words or learning how to look after themselves (e.g. how to eat by themselves). Intellectual disability is typically present from an early stage of life (usually from birth) and lasts for the rest of the person's life. There is no 'cure'. However, there is much that can be done to improve the quality of life for the child and family. Most children can be helped to develop and learn self-help skills but at a rate slower than their peers, although many will never achieve the expected level of functioning for their age. The disability can be mild, moderate or severe, the most common form being the mild variety.

**TABLE 11.1 THE MILESTONES OF DEVELOPMENT**

<b>Milestone</b>	<b>Age at which a child should achieve this milestone</b>	<b>Suspect a problem if this milestone is delayed beyond</b>
Responds to sounds/voice	2 months	3rd month
Smiles at others	2 months	3rd month
Reacts to peek-a-boo	3 months	6th month
Holds head steady	4 months	6th month
Babbles and laughs	4 months	8th month
Transfers toys between hands	6 months	9th month
Sits without support	8 months	10th month
Pulls self to standing	10 months	12th month
Can feed self, using fingers	12 months	18th month
Says at least one word appropriately	12 months	18th month
Looks for hidden object	12 months	18th month
Takes independent steps	12 months	18th month
Holds a pen and scribbles	18 months	24th month
Points to ask for and show things	18 months	20th month
Follows simple one-step requests	18 months	24th month
Says 8–10 words	18 months	20th month
Tries to wash own hands	24 months	30th month
Says two-word sentences	24 months	24th month
Points to two body parts	24 months	30th month
Knows own name	24 months	30th month
Jumps with both feet	3 years	36th month
Talks in three-word sentences	3 years	36th month
Eats/drinks by self	3 years	4th year
Follows simple requests	3 years	4th year
Avoids simple hazards	3 years	4th year
Draws a circle	3 years	36th month
Is toilet trained	4 years	4th year
Draws a simple face	4 years	5th year
Counts to five	4 years	5th year
Hops on one leg	5 years	5th year
Draws a person with a body	5 years	5th year
Wants to play with others	5 years	5th year

## 11.1.2 Why do some children develop slowly?

The development of the brain can be affected by many factors. The causes of intellectual disability include:

- problems before the child is born, including poor nutrition for the mother, excess alcohol consumption by the mother, certain types of infections in the mother or the mother not having certain important essential salts (e.g. iodine) in her diet;
- problems during childbirth, such as a prolonged labour or traumatic delivery (e.g. the umbilical cord becoming trapped around the baby's neck);
- problems in the first year of life, such as infections of the brain, severe and prolonged jaundice, uncontrolled seizures, accidents and severe malnutrition;
- problems in the way the child is being looked after, such as poor stimulation, child abuse and emotional neglect;
- genetic conditions, such as Down syndrome.



However, in many children with intellectual disability, we may not be able to find out the exact cause.

## 11.1.3 How does intellectual disability affect the child?

Intellectual disability can affect a child in many ways:

- physical functions, for example, the child's ability to walk and use their hands;
- self-care, for example, the ability to feed, bathe and use the toilet independently;

### BOX 11.2 WHEN INTELLECTUAL DISABILITY AND MENTAL HEALTH PROBLEMS OCCUR TOGETHER

Children with intellectual disability are more vulnerable to mental health problems. Children with the mild variety may become very aware of their limited abilities compared with other children and may show emotional and behavioural problems in the classroom (such as hyperactivity ☞ 11.4). As they grow older, their difficulty in making friends may make them depressed and angry. Problems with controlling sexual impulses may arise. Children with more severe intellectual disability are more likely to develop behavioural problems or psychosis. If a child with intellectual disability shows a change in their usual behaviour, you should suspect a mental health problem once physical causes have been ruled out.

- communication with others by talking and understanding what is being said;
- social functioning, such as playing with other children;
- an increased risk of a mental health problem (Box 11.2);
- physical disabilities and diseases (the more severe the intellectual disability, the greater the chance of medical problems such as seizures and physical impairments);
- family problems caused by guilt, unhappiness and anger about the child's condition;
- neglect or abuse because of the stigma within the family or community.

## 11.1.4 When to suspect intellectual disability

If a child:

- has delays in achieving key milestones over time (Box 11.1, Table 11.1);
- has difficulties in schoolwork and playing with other children;
- is not able to carry out simple instructions.

If an adolescent:

- is not able to learn at the same rate as other students in class;
- has inappropriate emotional reactions and sexual behaviours (e.g. masturbation in public).

If an adult:

- has difficulties in everyday functioning (e.g. cooking, cleaning);
- has problems in social adjustment (e.g. making friends, keeping a job).

Moderate to severe intellectual disability is usually detected in a child by the age of 2 years owing to the significant delays in achieving milestones. When intellectual disability is first detected in an adolescent or adult, it is usually mild and only emerges as a problem because the person has to face new and increasing responsibilities as they grow older.

### 11.1.5 How to deal with this problem



#### Special interview suggestions

Just because a young person has intellectual disability, it does not mean they are not able to understand what is being said about them. Do not make the mistake of behaving as if the child is not in the room. Treat all children, no matter how severe the disability, with dignity and respect. See the general advice for assessment in the introduction of this Chapter.



#### Questions to ask the parents

- What are your concerns about your child's development? (*Get a clear story of which aspect of the child's development the parent is most worried about.*)
- Are there similar problems in other children or adults in the family? (*Family history is important, since some disabilities are genetic.*)
- At what age did your child learn to hold their head up? Sit with support? Stand with support? Walk by themselves? Speak their first clear two-word sentence? (*In an older child it*

*is also useful to ask the parent to describe their child's abilities on their first birthday.*)

- When did you first notice that your child was different from other children of their age?
- Do you think your child has any difficulties with their hearing? Seeing things? (*Rule out any sensory problems before you consider the possibility of intellectual disability.*)
- For older children, ask about self-care abilities, school performance and behaviour.
- Does your child have any medical problems, such as seizures?
- Were there any problems during the pregnancy? Were there any problems during childbirth, for example, prolonged labour? Did the child have any problems during the first month or so after they were born? For example, did they have a high fever or fits? Is there any family history of learning problems? (*These questions help to identify the cause of the intellectual disability.*)
- What do you think the cause of the problems is? (*Some parents may think that evil spirits or a curse has caused their child to develop slowly.*)
- Does the child have any difficult behaviours that the family finds difficult to manage? (*Ask about unexplained aggression, or behaviours which embarrass the family.*)
- Are there any challenges the parent or family faces with looking after the child, for example, do they need to discipline them differently from other children, do they need to keep the child restrained because of any behaviours?
- Ask to see any medical records of the child.

#### Things to look for during the interview



The key to understanding the child's level of development during the session is to:

- Observe the child and their behaviour while you are talking with the parent. See the items in Table 11.1 for things to look for depending on the age of the child. Note the child's level of attention and involvement with the interview. Children with intellectual disability often have difficulty following the interview and their attention may shift frequently.

- If possible, allow the child to play with some toys or give them a paper and crayon to scribble with while you are talking to the parents.
- Make the child comfortable by smiling and speaking or gesturing to the child when you are talking to their family member.
- Observe for obvious physical findings which are sometimes seen in children with intellectual disability. These include a small or large head, very small stature and other physical disabilities. However, most children with intellectual disability look like any other typically developing child.
- Observe for unusual facial features which may reflect a specific genetic syndrome. The most common of these syndromes is Down syndrome: where a child has slanting eyes, low ears, short neck and, typically, a single prominent crease across the palms.



A child with Down syndrome will have slanting eyes, low ears, a short neck and a single prominent crease across the palms.

Children with intellectual disability are vulnerable to neglect (since the family may feel it is not worth wasting resources on them) or abuse (both physical and sexual), and it is worth being aware of both these possibilities while talking to the parent or family members but also being alert while examining the individual. Some signs to observe for are:

- a child who is very nervous or flinches when you come near them
- a child who looks obviously undernourished or uncared for
- bruises which do not fit the story of the injury.

If you suspect abuse of any kind, make sure that you examine the child thoroughly in the presence of another health worker and carefully document your findings.

## Questions to ask the child

Asking the child questions and examining their abilities requires some training and practice. Always have the parent present, unless the young person is an adolescent, in which case you may ask the parent whether you can ask them some questions alone. Simple questions to a child will allow you to judge the child's verbal and social skills and get a sense of whether they are appropriate for their age. If the child is old enough, ask them directly about worries (such as relationships with friends, family, studies and school performance).

## What to do immediately

The first, and most important, thing is to be absolutely sure that the child has intellectual disability. This diagnosis has a serious impact because it means that the child has a problem which is not curable. It is a label which can cause great unhappiness and worry, since the young person may need lifelong support; so use it with care. Apart from the history from the parent and examining the child, you should also seek a teacher's report on school performance and refer for an assessment to a child or mental health specialist.

If you are unsure of the diagnosis, support the family by describing the areas where the child appears to be delayed and give simple advice which can help their child. This could be activities around stimulating language development (☞ 13.3) or helping the child to become more independent in daily activities.

The abilities a child has will be an important indicator of how much progress they are likely to make in the years ahead. It is essential to reassure the parents that every child will be able to learn to some extent and to explain that they should

focus on the child's strengths. They should also be informed about what can be realistically expected of their child, although this may be better done by a specialist after a formal evaluation.

- Most children with mild intellectual disability will be able to go to school. Many children may manage in a regular school, especially if the teachers are sensitive to their needs and are able to give them the extra attention and encouragement that they need. Children who need greater support can be helped in schools which have resource rooms with special educators. Most children will be able to care for themselves and will be fairly independent; however, they will need more time to learn the same skills as their peers. These children may have difficulties in making friends as they grow older and in finding and keeping jobs.
- Most children with moderate intellectual disability can be supported in mainstream schools that have resource rooms with special educators so that they can benefit from individualised attention. Others may need to be in special schools. They may need continued prompting and help with daily activities. For example, a child may learn to wash and go to the toilet on their own, but may need prompts on how often they should go and reminders to wash their hands when they are finished. They will be dependent on their families for social interactions. Most will not be able to hold regular employment, although sheltered employment in workshops may be possible (☞ Chapter 15 for your local resources). Inappropriate sexual behaviours may become a problem in adulthood.
- Children with severe intellectual disability are likely to need one-on-one care for the length of their lives. They may have physical disabilities and medical problems. Bladder and bowel control may not be achieved. Such children may not be able to cope, even in special schools, although efforts should be made to allow the parents a break from daily care.

The general principles of care of a child with intellectual disability are as follows.

- If the child has a specific medical problem, such as low thyroid function or seizures, they

should receive the appropriate medication for these. Other than these special (and rare) situations, there are no indications for the use of medications for the treatment of intellectual disability. Occasionally, children with intellectual disability may exhibit disruptive behaviours, which should be managed by trying to identify and deal with environmental causes, not by using medications. 'Brain tonics' or other medications that are supposed to help 'mental function' have no effect on the thinking abilities of the child.

- Be alert to insidious or sudden changes in the young person's behaviour which could be a sign of the onset of a mental health problem.
- Provide information about any special schemes to help families with children with intellectual disability either through financial or educational help (☞ Chapter 15).
- Stay in regular touch with the family. Parents and families may go through cycles of disbelief, denial, anger, loss and sadness when faced with a serious diagnosis such as that of intellectual disability. The daily care of a child with intellectual disability, especially when it is severe, can also add to the stress for a parent. Refer parents to support groups in your area (☞ Chapter 15). Monitor and be aware of the possibility of depression and anxiety in a parent and provide care as described elsewhere in this manual (e.g. ☞ 3.9).
- If you suspect child abuse or neglect, handle as described in ☞ 11.5.

## What parents can do

Explain to the parents that one can never be sure of the potential for a child with an intellectual disability, and hence the child should be given chances to learn at every opportunity, for example, by talking, playing and interacting with others. They may, however, need to use language which is more appropriate for younger children. As the child begins to speak they should keep raising the complexity of their own speech and storytelling.



### BOX 11.3 GENERAL GUIDELINES FOR THE PARENT ON HELPING THEIR CHILD LEARN DAILY ACTIVITIES

- Try to think of your child's various strengths and build on these (e.g. the child may be loving and affectionate, they may like order, they may be good at following simple requests).
- Be realistic and patient in what you expect from your child.
- Start with simple tasks and move to more complex activities only after the simpler ones have been achieved.
- Break down activities into smaller parts, which should be taught separately. For example, putting on a shirt can be divided up into the following steps: lifting the shirt up and aligning it correctly, putting one arm in one sleeve, putting the second arm in the second sleeve, closing the shirt over the chest, fastening the buttons from the bottom to the top. Try to teach one step at a time, and wait for the skill to be learned before adding the next step.
- Praise the child whenever they succeed in any activity, however small. Praise can be in the form of smiles, hugs, positive words and rewards such as a special treat for the child.
- Avoid punishing the child for things they cannot do or mistakes that they make. It is best to ignore behaviours that one doesn't want to see, since attention, even if it is negative, may encourage the child to keep doing it! If appropriate, behaviour charts (Box 11.4) may be used to modify unwanted behaviours and reward positive ones.
- Involve the child in household activities, for example, the child could learn to wash potatoes while you peel them.
- Make a special effort to teach the child social skills – such as learning to greet and say goodbye, to share toys and take turns, and to ask for permission to use things which belong to others. The best way of teaching these skills is to act them out for your child. Explain clearly what you expect your child to do and why, and praise the child when it is done the right way.
- Allow the child to do whatever they can do on their own, even though they may make mistakes (or it may be messy!). This will make the child confident and self-reliant.



Help a child learn a skill by breaking it down into small steps.

☞ Chapter 18 for more details.

Encourage parents to continue to focus on their child's educational needs, since schools are places where children learn social skills and make friends, as well as learn facts. Make the parents

aware that their child with intellectual disability needs education as much as any other child. Refer the family to local schools which support children with special needs (☞ Chapter 15).



**BOX 11.4 THE BEHAVIOUR CONTRACT**

We all work towards gaining a reward or pleasure. This pleasure can be in the form of simple rewards (e.g. praise, hugs, a pat on the back, all of which are given naturally) or more concrete rewards (e.g. stars, points, stickers, tokens or even money for adolescents) when the pre-decided goals are attained. A ‘contract’ of behaviour between the parents (and sometimes with teachers) and child may help by clearly defining what is expected from the child and by getting both sides to agree to the plan. In return for good behaviour, the parents could agree to give a specified reward, while for bad behaviour a specific action would be taken or a privilege denied. This sort of contract can also help establish who has kept to their side of the deal and who has not. The behaviour chart provides a visual, fun way of involving the child in achieving positive behaviours and can be used for a range of mental health problems.



The parent using the chart needs to understand the following guidelines.

1. Keep the goals simple and objective. For example, ‘eating breakfast’ instead of ‘behaving well’.
2. Keep the initial goals within the child’s reach. For example, ‘finishing breakfast three times every week’ instead of every day may give the child a sense of achievement.
3. The chart should be attractive and interactive and could be made with the help of the child (e.g. the child can colour in a star or apply a sticker).
4. The parents must be consistent and not be pressured to give rewards if goals are not achieved.
5. The goals can be positive (e.g. ‘waiting for his turn’) but consequences can be negative (e.g. if the child doesn’t complete breakfast three days each week, he will not get a favourite TV show on the Saturday).
6. Keep the reward collection within a reasonable time span (e.g. for young children it should be at the end of the week; teenagers may be able to wait 2 weeks).
7. Create a reward which will motivate the child (e.g. something that will link into the child’s hobby, an activity he enjoys or a simple treat).
8. Remember that not all charts work with all children. If the parent is not achieving success, take a break and start again.

**ACTIVITY TO BE ACHIEVED:**

.....						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

I will get 1 point/sticker/star for every time I ..... (desired behaviour)

When I collect ..... (number of stars/tokens)

I will ..... (reward)

.....  
Child’s signature

.....  
Parent’s signature



## When to refer

Ideally, refer any child you suspect has an intellectual disability to a child development clinic (or a paediatrician or psychologist if no such clinic is available) where the child can be assessed to confirm this diagnosis. Such a clinic would usually have a number of specialists who would consider possible treatable causes for the problem

(e.g. low thyroid hormone), treat associated problems such as seizures and be able to assess the child's strengths and difficulties. Intellectual disability is a label the child will carry for life; be very careful about using it without a second opinion. Children with Down syndrome can have heart problems and other physical abnormalities, so they should be seen by a specialist to rule out co-existing problems.

### SECTION 11.1 SUMMARY BOX

#### THINGS TO REMEMBER WHEN DEALING WITH A CHILD WITH INTELLECTUAL DISABILITY

- Intellectual disability is characterised by a significant delay in achieving the normal milestones of development, especially around understanding and learning from one's experiences and also in developing language and physical skills.
- Intellectual disability is not a disease, but a condition which lasts the entire lifetime of the person.
- Intellectual disability is not curable but may be preventable. Ensuring healthy pregnancies, childbirth and early appropriate child care can help prevent some cases.
- Early detection is important because parent training can help the child to do better.
- The mild form of intellectual disability may not be detected until adolescence or even adulthood.
- Parents should be supported with information on how to care for their child and where to access special education.
- Be aware of the potential of neglect or abuse of a vulnerable child.
- Medications have very little role in intellectual disability except in the control of seizures and severe mental disorders which may occur in some individuals.

## 11.2 The child who has difficulties in communicating

Children are communicators from the day that they are born. They cry to be fed, when they are cold or soiled, and for affection. Communication itself is made up of understanding language (which comes earlier) and spoken language (which develops later). Different skills of communication are achieved by different ages as

described earlier (Table 11.1). Children who have difficulty communicating are often brought in for help in the pre-school or primary school years.

### 11.2.1 What causes difficulties in communicating in children?

There are a number of reasons for a child to have difficulties in communicating in a way which is appropriate for their age. The causes are:

- hearing impairment or deafness
- specific language delay
- intellectual disability (☞ 11.1)
- stammering or stuttering
- autism
- selective mutism.

Most of these disabilities and disorders do not have a specific underlying cause but are due to a



combination of genetic and environmental factors. Hearing impairment may be related to the exposure of the developing brain to certain medications that the mother took in pregnancy or due to very severe jaundice after birth. Selective mutism may be caused by a stressful event (e.g. starting a new school). There may be a family history of speech problems for a child who stammers.

### 11.2.2 How to deal with this problem

When a parent consults about a child who is not communicating properly, a detailed history will help to differentiate the conditions described in Box 11.5. It is particularly important to try to understand how well the child was developing before the age of 3 years.



#### Questions to ask the parents

- When did you first become worried about way your child is communicating?
- Are you worried that your child is not developing in other areas like other children of his age? (*Children with intellectual disability will have delays in other milestones.*)
- Is there anyone else in the family who has similar kinds of behaviour? (*Stammering and autism may have a positive family history.*)
- Can you tell me about the first 2 years of your child's life? (*Ask particularly about any incidents around pregnancy and childbirth which may cause intellectual disability or deafness.*)
- Does your child have any unusual behaviours? (*Children with autism may show odd behaviours* ⇐ Box 11.5).
- Does your child get upset if you change their routines unexpectedly? How do they show this distress? (*Questions useful to identify autism.*)
- Is your child interested in what other children do? Does your child play with toys appropriately? (*Children with autism rarely 'pretend play', meaning they will not play with dolls or kitchen utensils as if they are imitating grown-up actions; they also are described as being happier 'in their own world' rather than playing with children of their own age.*)
- Has the change in the child's communication come on very suddenly? (*Children with selective mutism often have a history of a sudden change in their communication due to an unpleasant experience such as arrival of a sibling.*)

#### Things to look for during the interview



Interviewing children who have a difficulty in communicating may not yield as much information as observing the child when you are talking to the parents. Give the child a simple toy to play with while you are getting a history from the family. Observe for the following.

- Does the child seem very shy and overwhelmed by the visit to you? Do they seem clingy to their parent and look at them for reassurance? (*This is probably a child with speech delay, mild intellectual disability or selective mutism.*)
  - Does the child play with the toy in an unusual way? (*For example, spins the wheel of a toy car instead of rolling it along, flicking a doll's eyes – unusual play can be a sign of autism.*)
  - Does the child seem uninterested in what is happening around them? Does the child make very little eye contact with the parent during the session? Is the child happy to be on their own while engaging with the toy? (*All signs of autism.*)
  - Does the child use any gestures? Are these gestures appropriate (e.g. a child with hearing impairment instead of speaking may look at the mother and point at something they want)? (*Unusual gestures are typical of autism.*)
  - Does the child exhibit any unusual behaviours such as rocking their whole body back and forth, walking on their toes, flapping their hands? (*Again, these are features associated with autism.*)
- For a child who can speak, call the child and ask simple questions about their friends and what the child likes to do. Listen to the answers.
- Does the child make good eye contact, though they may appear shy? (*Suggestive of intellectual disability, selective mutism, stammering.*)
  - Does the child try to speak, but their speech is not fluent in the way it is produced? (*Stammering.*)

## BOX 11.5 THE DIFFERENCES BETWEEN THE COMMON CAUSES OF A DIFFICULTY IN COMMUNICATION

**Hearing impairment** or **deafness** may be obvious when it is severe. The parent will have noticed that the child does not respond to sounds as an infant and makes no speech sounds as they grow older. Milder forms of hearing impairment may be more 'hidden'. The child may appear inattentive, only respond to loud sounds and have an associated delay or impaired speech. Most children with hearing impairment will use other forms to communicate their needs (e.g. gestures) and their development in other areas will be as expected for their age.

A child with **intellectual disability** will respond to sounds but they will have a delay in all areas of development (⇨ Table 11.1); as a result, their speech may be at the level of a younger child.

**Stammering** is when there is a difficulty in the way the child speaks, which results in their sentences being interrupted by a difficulty in saying specific words. The lack of fluency in the speech may be because of simple hesitations, repetitions of certain sounds or a lengthening of certain sounds. When stammering is severe, there is a 'blockage' so that the child is unable to say a whole word. Stammering may be caused by underlying anxiety. Unclear speech (e.g. lisping) is common below the age of 5 and most children will outgrow it.

**Specific language delay:** a delay in language milestones without any hearing loss or other developmental delays. Children will be late to talk and struggle to have fluent conversations, but they will use the language skills they have in appropriate contexts along with gestures.

**Autism** is a developmental disability. Children with autism show a wide variation in their difficulties. Although all people with autism have difficulties with social communication, at the severe end, the child may have no speech at all or no interest in communicating with others, while at the milder end the child may struggle to start and continue conversations with peers. Children with autism will also have restricted areas of interests and often become extremely focused on repetitive activities (e.g. they may get 'stuck' on a toy or a part of a toy, may be interested in non-play objects such as pieces of string).

Many children with autism will repeat words or phrases they have heard, and use these in a non-meaningful way (e.g. repeating 'Hello, how are you' or a jingle from an advertisement). Other children may make up 'nonsense' words or use words in a way that sounds unusual (e.g. a high-pitched tone). Children with autism will not use gestures to communicate their interests or needs (e.g. they will not point to show a biscuit they want); they also rarely use social gestures such as those for 'bye-bye'. Many children with autism are sensitive to sounds, touch or lights and can find them distressing. Many, but not all, children with autism also have some degree of intellectual disability.

**Selective mutism** occurs when a child who is developing normally stops speaking altogether in front of strangers or at school, but still manages to use gestures which are appropriate and speak normally in front of familiar or selected people.

- Does the child ignore you unless you get their attention by coming in front of them and then they are happy to speak with you? Is the child's speech difficult to understand? (*Hearing impairment.*)
- Does the child ignore you and seem as if they are 'in their own world'? Do they carry on what they are doing even when you try to interact with them? Do they seem to repeat your words back to you without it making sense? Do they use unusual words which do not have any meaning to you? (*Autism.*)

### What to do immediately

The first thing to remember is that there are no medications for any of these conditions; discourage parents from giving their children medications, no matter who has prescribed them.

Each of the specific problems has a distinct approach. Except for stammering, it is a good first step to have a hearing assessment done on any child with a difficulty in communication.

- For **stammering** the first step is to reassure both parents and child that this is no one's



fault. Stammering can be worsened by anxiety and stress. Explain to the parents that allowing the child to complete their sentence without rushing them will build their confidence. Parents should talk to the child slowly and patiently and not rush them for answers or fill in words the child is struggling with. Encourage the parent to create a time every day when they have a slow conversation with their child on something they are interested in, giving opportunities for the child to speak without being pressurised. Ask the parents to speak with the teachers to excuse the child from reading aloud or public speaking activities while the child works at regaining their confidence. More severe stammering with

complete blockages in word production will need the input of a speech therapist.

- **Selective mutism** is often associated with a mild language delay, which should also be addressed. Explain to the parent that the child's reluctance to speak in specific social situations is probably due to them being anxious. In such circumstances, it is better not to pressurise the child to speak. Instead, advise the parent to use positive rewards to encourage their child to speak in specific social situations (Box 11.4). More severe mutism which is affecting a child's academic progress should be referred to a speech therapist.
- In **language delay**, explain to the parent how they should enrich the speaking environment

#### BOX 11.6 WHAT TO DO WHEN SPECIALIST INTERVENTION IS NOT AVAILABLE: ADVICE FOR PARENTS

For any child with a **language difficulty**: enrich the speaking–listening environment in which the child lives. As a parent, you can:

- talk to the child about what you are doing, describe and name the objects that you are using
- describe to the child what they may be doing, feeling or seeing throughout the day
- create fun games with words in them, such as 'I spy', which can teach descriptive words
- read to your child from picture books and describe the illustrations in detail
- use the correct language or grammar without pointing out your child's mistakes
- if your child is watching TV, ask them to tell you about the programme once it is over
- do not force your child to speak
- sing songs with your child and use gestures to reinforce the meanings of what you are saying.

In **autism**, the child's communication difficulties result in parent and child communication being 'out of tune'. As a parent of a child with autism you can try these strategies.

- Observe your child carefully to see what their interests are, what upsets them and what calms them down. Learn the signals the child gives to express their feelings.
- Slow down routines across the day, allowing your child to take their time.
- During your routines give your child opportunities to express themselves, although this may only be through their actions (e.g. the child may choose to walk away to show you that they don't want to do something – recognise this and respond to it appropriately).
- Wait for your child to request your help and allow them to communicate with you. For example, if the child wants a drink they should request it, instead of you anticipating their needs and giving them a glass of water.
- Help your child by decreasing the instructions you give them. Instead, show them by using simple steps or give simple one-word instructions (e.g. 'dinner time').
- Give your child a simple explanation of what will happen next in new situations; this will help them to stay calm in unfamiliar places.





of the child. Anybody involved in caring for the child should make an effort to show and name objects and to talk to the child, preferably in one language. Clarify with the parents that acquiring language is a gradual process. They should not force their child to speak, as this may worsen anxiety.

- **Autism** is a more complex disorder. Explain to the family that the child will not 'grow out' of the current difficulties, although certain strategies can help the child (Box 11.6).

## When to refer

Never label a child with a developmental disability unless you are confident about the diagnosis. Refer the child for assessment to an appropriately trained professional, such as an educational psychologist or a child development specialist (or to a paediatrician if a specialist is not available). The specialist will be able to advise the parents (and yourself) on how to support the child's developmental needs and on resources for any additional therapies in your area (☞ Chapter 15). Box 11.6 explains what to do if there are no specialist facilities to refer to.

### SECTION 11.2 SUMMARY BOX

#### THINGS TO REMEMBER FOR THE CHILD WITH DIFFICULTY IN COMMUNICATING

- There are varied reasons for a child to have communication difficulties, including hearing impairment, intellectual disability and autism.
- Communication difficulties should be evaluated by a specialist if possible, as the approach to each can be quite distinct.
- Early detection is important to help provide the appropriate language-enriched environment for the child.
- Parents may also need information on where to access special education to support the specific needs of their child.

## 11.3 The child who has difficulties with studies

Children may have problems with their studies for many reasons. For example, they may need to help their parents by working or helping out at home. The school may be in poor condition or the teacher may be badly trained; this may make a child feel that education is of no use. There are also important child mental health problems that can make it more difficult to study. Helping children to stay in school is a fundamental part of health promotion, since educated children grow up to be healthier adults. When a child has difficulties with studies or drops out of school, a health worker should try to find out why and offer appropriate advice and support.

studies may be caused by a lack of adequate parental care or neglect (☞ 11.5). Being a first-generation learner means that the child is growing up in a family where the adults have not been to school themselves, and they may be unable to support the child with their studies. Problems within the school may include poor classroom facilities, large class sizes, poorly trained teachers and the language of instruction (which may not be the language the child speaks at home). The child may have one or more of a number of mental health problems which may also lead to difficulties with studies. These could be:

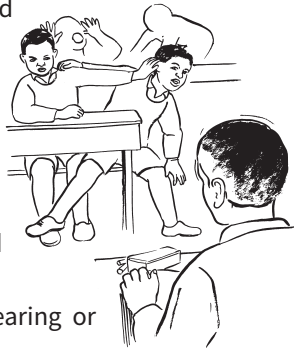


### 11.3.1 What causes children to have difficulties with studies?

The common reasons can be found in the family, school or child. In the family, difficulties with

- intellectual disability, which may cause a difficulty in learning (☞ 11.1);
- hyperactivity, which may be accompanied by a difficulty in concentration and attention (☞ 11.4);

- depression, because of which the child (typically an adolescent) feels unhappy and loses interest in studying and other things (☞ 11.8);
- conduct disorder, which results in the child ‘misbehaving’ and getting into trouble (☞ 11.6);
- child abuse, which may result in the child being unhappy, scared and distracted (☞ 11.5);
- difficulties with hearing or vision;
- drug misuse, especially in adolescents (☞ 9.2);
- intellectual disabilities or dyslexias (☞ 11.1, Box 11.7).



all of the common childhood mental health problems in the following manner.

- When did you realise that your child has difficulties with studies? (*Ask questions about delayed development in childhood. Remember that mild intellectual disability may go undetected until the child reaches school. A careful history of milestones may suggest that the child has an intellectual disability ☞ 11.1.*)

If you are confident that the child does not have an intellectual disability, ask these questions.

- Do you think your child’s vision or hearing is a problem?
- Can you tell me about your child’s activity levels throughout the day? (*Consider hyperactivity and restlessness ☞ 11.4.*)
- Can you tell me about your child’s ability to listen to and follow up on instructions that you give them? (*Enquire about a difficulty in concentration and attention ☞ 11.4.*)
- What difficulty does your child have with studies? Does the child make errors mainly with reading or spelling or writing? Do they have specific problems with mathematics? Do they have difficulty in understanding instructions? (*These may be present on their own or in combination and are typically reported in children with dyslexia ☞ Box 11.7.*)
- Does your child have difficulty in telling right

### 11.3.2 How to deal with this problem

#### Questions to ask the parents

The child is rarely brought to the health worker for problems with studies. Most likely, you will need to be alert to which children in your community are not in school and then actively follow up to find out why. You will need to ask questions about

#### BOX 11.7 WHAT IS DYSLEXIA?

Learning disabilities, which are commonly called **dyslexias**, are conditions in which a child has difficulty to understand and process particular aspects of their studies. For example, a child may have a specific difficulty with reading, spelling, writing or mathematics. These children usually have normal intelligence. Because of low awareness of these difficulties amongst educators, many children with dyslexia are labelled as intellectually disabled or ‘lazy’ by their teachers. Behaviours in a classroom would include a child who loses concentration and becomes bored, frustrated and then misbehaves in the class. This often results in academic failures and an accompanying loss of confidence.

We do not know why some children have learning disabilities or dyslexia; it is possible that there is a problem in the way the brain processes information. We do know, though, that dyslexia is common and that it is not the same as intellectual disability. With special educational help, many children with dyslexia will do as well as other children. Children with dyslexia can have difficulties with:

- copying, spelling and writing
- understanding instructions
- numbers and mathematics
- reading aloud
- understanding what they are reading
- behaviour, because the child gets frustrated with struggling with their studies.



| How dyslexia can affect a child.

from left? Are they clumsy or poorly coordinated, for example, in sports? (*Many children with dyslexia have these difficulties* (⇨ Box 11.7.)

- Finally, consider a family problem. Ask the parents about problems in the home, including violence and child abuse, which may be upsetting the child (⇨ 11.5).



### Questions to ask the child

Interviewing children to identify dyslexia requires experience and skill. Ideally, you should refer the child to a special education facility or clinic for further tests. Explain to the parents why this is being done; they may become very worried about the ‘testing’. If, however, you do not have such a specialist facility near you, you could ask the following questions to help detect dyslexia in the child.

- What do you find difficult in your studies? (*The child’s views are important; remember that the child is probably very worried about their difficulties.*)
- Do you have difficulty with hearing what the teacher is saying? Or seeing what is written on the blackboard? (*This could reflect a hearing or vision problem.*)
- Are there some subjects which you find more enjoyable than others? (*For example, children with specific problems with numbers will not like mathematics but may enjoy languages.*)
- Do you have difficulty with reading or following what the teacher is saying? Do you have

difficulty with spelling? Do you have difficulty with mathematics? (*Ask to see the child’s school notebooks and look for untidy writing or repeated patterns in spelling errors.*)

- How do your teachers and parents react to your difficulties?
- Which aspects of school do you enjoy?

Asking to see a school notebook may allow you to see the difficulties the child is having in their schoolwork (⇨ next section for the kinds of errors to look for).

### Things to look for during the interview



- Examine the child’s hearing and vision, ideally in a quiet room. Both tests described below are only crude screeners if you do not have access to specialists.
- Vision can be assessed by allowing a child to read a normal-sized text or describe a picture in a book and assessing how close they hold the book to their face to explore details or how well they can read letters on a graded wall chart.
- For hearing assessment, you should stand an arm’s length behind the child, ask them to cover one ear at a time and whisper a combination of three distinct numbers and letters (e.g. 4, k, 6), and ask the child to repeat them. If the child responds incorrectly, the test is repeated using a different number/letter combination. The child is considered to have passed this test



if they repeat at least three out of a possible six numbers or letters correctly.

- Specific signs of dyslexia can be of three types: academic, motor and language.
  - **Academic signs.** Ask the child to read a simple text (at the child's class level) and write a few lines on any subject (e.g. their family) and copy a few shapes. While reading, look for errors such as replacement of words by guessing, and understanding the context (e.g. 'litter' for 'letter' or 'home' for 'house'), errors such as dropping letters and omitting words (e.g. saying 'red' for 'read'). Look at the writing for crowding of letters, poor letter formation, reversal of letters or words which look like a mirror image of each other (e.g. 'b' and 'd' or 'no' and 'on'). For spelling difficulties look for mistakes such as omitting letters or putting the wrong letter in the word. Assess number skills by asking the child to sum up simple two-digit numbers. Observe for a difficulty in recognising numbers or explaining number concepts such as 'bigger than' or 'less than'. They may also have a difficulty in recognition of operational signs (plus, minus, times and division) correctly ( e.g. multiplying when the sign is for addition).
  - **Motor signs.** The child may be restless or overactive. They may appear distracted and forgetful. They may be clumsy with an unusual grip on the pencil and with poor handwriting. You can ask the child to point out her right arm or left ear to check for right-left orientation. They child may be unable to tie their shoelaces or button their shirt.
  - **Language signs.** Speech may be delayed or unclear. The child may have difficulty

understanding instructions or telling a simple story.

## What parents can do

- Parents are often frustrated and puzzled because their child appears bright and normal and yet is doing badly in school. They may be worried that their child has intellectual disability. Explain that the difficulty in studies may have a number of causes, of which dyslexia could be one. Explain to the parents that the child may be suffering from a learning problem and is not to be blamed for poor performance in school. Ideally, you should refer the child for further evaluation before making any statement about the problem.
- Remedial education is a special type of teaching method which helps children with dyslexia to learn better. Remedial education usually identifies and then tries to support the specific learning area which the child is struggling with, whether this is breaking down letter and word recognition (reading), understanding and working with numbers, or processing information which is placed in front of them in the written format. With this focused help, most children will be able to complete their schooling and many do quite well. Children with dyslexia do not need 'special' schools, which are mainly geared for children with intellectual disability. However, they can be helped by a special educator in a resource room in a mainstream setting.
- If possible, talk to the teacher about the child's needs. Explain that the child does not have intellectual disability. Many school boards give 'concessions' for children with learning disabilities, so you can encourage the teacher

Tohn has a funny tay boat Look  
how beg it is! He can play with  
st.

| Dyslexic handwriting.

and the parent to investigate these. They could include having a 'reader' (a person to help with reading), allowing the use of a calculator and giving more time for completion of tests. The school may also be encouraged to exempt the child from some subjects or be more lenient in some aspects of marking (e.g. handwriting; ↗ 13.4 for mental health promotion in schools).

- Counsel the child. They will probably feel angry and unhappy. Explain that they have a problem which is making it harder for them to cope with their studies. Reassure them that they are not 'stupid' and that, with proper help, they will be able to do much better.



### When to refer

Never say to a child they have an intellectual disability or dyslexia unless you are confident. This is especially true of mild intellectual disability, which may appear just like dyslexia. Refer the child for assessment to an appropriately trained professional such as an educational psychologist or a child development specialist. They will also be able to give advice on remedial education facilities in your area (↗ Chapter 15). Box 11.8 explains what to do if there are no specialist facilities to refer to.

#### BOX 11.8 WHAT TO DO WHEN SPECIALIST INTERVENTION IS NOT AVAILABLE

- Encourage the parents to make time every day to help and support their child with homework and studies. The parent should split up the content of lessons and try and teach them to the child in different ways. For example, if a child has difficulty in reading, having the lesson read out to them may help them understand the meaning.
- Games like drawing, colouring and copying different shapes (e.g. a clock, a man) are useful exercises to help build fine motor skills to support writing.
- The teaching methods can be adapted to fit the child's needs (e.g. less written work and more oral presentations), or by adapting the curriculum so that the child can learn fewer key concepts.
- Encourage the school to consider concessions for the child (e.g. extra time in exams).
- If mainstream schooling seems impossible, suggest a vocational school where the child can learn skills to improve their future employment opportunities.

#### SECTION 11.3 SUMMARY BOX

##### THINGS TO REMEMBER WHEN DEALING WITH CHILDREN WHO HAVE DIFFICULTIES WITH STUDIES

- A child who has difficulties with their studies may also be experiencing a mental health problem. Intellectual disability, hyperactivity, dyslexia, depression and child abuse can all lead to difficulties with studies.
- Dyslexia can cause a child of normal IQ to do badly in school because of a specific difficulty with reading, writing, spelling or mathematics.
- Dyslexia is an important cause of childhood misbehaviour and depression.
- Diagnosing dyslexia needs specialist evaluation.
- Children with dyslexia should continue in a regular school. Inform their teachers about the dyslexia and advocate for special educational help to be provided. (Advice on promoting mental health in schools ↗ 13.4.)

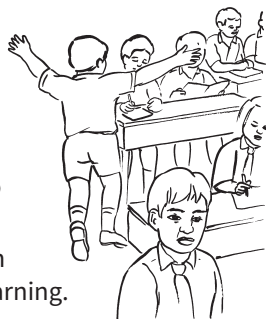
## 11.4 The child who cannot sit still

When they are younger, many children have a short attention span and will move from one activity to another in quick succession. However, as children grow they develop the ability to focus on a given task for longer and longer periods. Being able to sit in one place reflects the ability of the mind and body to pay attention to a particular task, for example, reading a book. If a child cannot pay attention, then they will not follow what is being taught in the classroom. Similarly, if the child is not paying attention to what the parents want them to do, the child is more likely to be considered to be misbehaving. When the inattention is accompanied by restlessness and a lack of thinking through the consequences of one's actions (impulsivity), the child may have a disorder called **attention-deficit hyperactivity disorder (ADHD)**.

### 11.4.1 Why do some children have difficulty being still?

ADHD is a mental health problem which causes difficulty in being still. ADHD is more common in boys. Children with ADHD will:

- be restless, for example, being unable to sit in a chair through a full lesson;
- have difficulty concentrating or paying attention, for example, not being able to complete homework or carrying out an instruction;
- be easily distracted and not finish what they have started;
- be impulsive – doing things before thinking of the consequences, for example, running across a busy road;
- be unable to wait their turn in games or while talking to others;
- be extremely demanding of attention;
- be disorganised, untidy and prone to losing things;
- and as a result often have difficulty in learning.



These behaviours may be so extreme that they affect the child's life in many ways:

- at home, the boy may be difficult to discipline and may exhaust his parents with the levels of his activity, his impulsive behaviour and difficulty concentrating;
- at school, he may do poorly in studies and distract his teacher with his inability to sit still and listen, as well as constantly interrupting the class;
- at play, he may annoy his peers by not waiting his turn, interrupting others, getting into fights and wanting his own way.

### 11.4.2 Why is ADHD an important problem?

Most children with ADHD are labelled as being naughty and irresponsible instead of being recognised as having a mental health problem which can be addressed by specific strategies. By not detecting and treating this problem, the child may fail to do well and drop out of school, and continue to have problems in adjusting to life even when they grow up. Some may develop behaviour problems (☞ 11.6) during their teenage years and start using drugs or alcohol. Recognising this disorder can help parents and teachers understand that the child's behaviour is a symptom of an underlying problem.

### 11.4.3 How to deal with this problem

Children with the symptoms of ADHD will rarely be brought to a health practitioner since the problems are considered to be due to bad behaviour, which is primarily a discipline issue in the school setting.

### Questions to ask the parents

- Can you tell me about your child's levels of activity throughout the day? Since when have you been noticing these behaviours? (*Explore how long the child's behaviours have been causing problems. Get a detailed description of the behaviours that the parents find challenging*)



and for how long these have been happening. Often a child with ADHD will have had a difficult and restless temperament even as an infant.)

- Does your child have difficulty paying attention to things? (For example, they seem to miss parts of the instructions that are given to them.)
- Does your child have difficulty staying in one place? For example, sitting in their seat until they finish their dinner or homework? (Remember that girls with ADHD will often have less restlessness but will have inattention and distractibility and, because of this, parents may miss the problems in schoolwork and finishing tasks.)
- What are your child's relationships with their friends like? How is the child doing in school? (In ADHD, the behaviour problem should be present in several aspects of a child's life, in the learning setting, at home as well as at play with friends. If the problem is limited only to the school setting, it may be due to the school environment, for example, a learning problem which makes it more difficult for the child to follow the teacher, which in turn makes them restless ☞ Box 11.7.)
- What have you tried to do to reduce the problem? (Specifically, ask how the parents try to get their child to behave appropriately. Many hyperactive children get physically beaten or restrained owing to their behaviours.)



### Questions to ask the child

A child with ADHD, especially an older child, may be able to describe their problem quite clearly if asked appropriate questions in an empathic manner. The questions could be phrased as follows.

- Have you been having any problems at home or school? (Encourage the child to talk about what they feel 'drives' them to move and be restless. Many children will be able to describe the 'pressure' they feel to get up and move, say things or rush to the next task.)
- Have you had difficulties following the teacher, or paying attention to what they say or to your studies? (Many children with ADHD may also have a coexisting developmental disability which may add to their problem.)

- How about at home? Do you have problems concentrating on things at home, for example, finishing your food or watching television?
- Do you lose your temper often? What are the things that make you angry?
- Do your parents get angry with you? Why do you think they get angry? What do they do when they are angry?

### Things to look for during the interview



A child with ADHD may be restless, fidgety, constantly trying to get up and walk around the room. They may interrupt what others are saying and talk out of turn. Girls with ADHD may 'daydream' or switch out of a conversation which doesn't directly involve them, without being obviously restless.

### What to do immediately



- Explain to the family what the child's problem is. Describe that it is not the child's 'fault' but that it is a problem with the way they are able to make decisions and plan activities. Understanding that a child has a health problem can help many parents and children feel more hopeful.
- Reassure the parents that creating structure around the child's routines will help to manage many of the difficult behaviours at home (Box 11.9).
- Suggest to the parent that you would be happy to send a note to the child's class teacher explaining the problem, with strategies that could be tried in the school setting (Box 11.10).





- If even after establishing the advice in Box 11.9; the child continues to have significant behaviour problems, it is worth suggesting to the parents that their child may benefit from a medication called methylphenidate (see Table 14.6). This medication is usually prescribed by a child or mental health specialist.
- Do not use sedative medications; these will only make the child drowsy and worsen their ability to concentrate.

## When to refer

ADHD can be a difficult problem to treat without support from the family and school. If you have access to a specialist child or mental health service, then refer all children with this condition, since there are effective medical treatments available which can help transform the child's learning potential.

### BOX 11.9 MANAGING THE HYPERACTIVE CHILD: ADVICE FOR PARENTS

Parents should be advised the following.

- Avoid physical punishments and humiliating the child for the behaviours that they may not be able to control. Physical punishments 'justify' to the child that it is OK to hit others and they may do this in school. Instead, focus on the positive behaviours that they see and actively praise them, for instance, by saying 'Well done for sitting for 2 min'. An alternative to physical punishments is the negative consequence of 'time out' (Box 11.12).
- Use a 'behaviour contract' (Box 11.4) and link it to a system of appropriate and consistent rewards which can be used once the child has been told how they work.
- Give rewards when the child behaves in the right manner. Keep a 'pride' file of the child's achievements; you can file drawings, certificates and other mementoes of the child's abilities.
- Make sure you have the child's attention when speaking to them, and give one instruction at a time. For example, do not say 'Have a bath and finish your studies'. Instead, break this up into two requests; after the child has finished their bath, praise them and then ask them to complete the second request.
- Be specific in what you expect. For example, instead of telling a child who is about to eat 'Be a good boy now', you could say 'Please finish your food, then you can leave the table'.
- Create clear predictable routines for your child in the day. Make visual timetables which they can refer to from time to time. Discuss new activities and outings with your child beforehand; explain what you expect from your child and negotiate a reward for good behaviour in advance.
- Make sure there is regular sport or physical activity every day so that your child can get rid of excess energy.
- Avoid sweetened drinks, sodas and junk foods – they often have additives which overstimulate the child.
- Create calming routines around periods like bedtime. For example, a story and a glass of milk, instead of activities and games.
- Listen to your child's feelings and thoughts. Many children with ADHD feel misunderstood and unhappy. Show the child that you know why they are having difficulties and that you want to help them get more in control of their life.



### BOX 11.10 MANAGING THE HYPERACTIVE STUDENT: ADVICE FOR TEACHERS

Teachers should be advised to do the following.

- Seat the student as close to the teacher's desk as possible. This will allow the teacher to focus on the student as required. They will also be less distracted by other students.
- Place the student away from windows or doors.
- When giving instructions, look at the child. Ask the student to repeat the instructions to make sure they have understood what was said. Give the child a personal written instruction if this helps them – a 'post-it' note on the table can help.
- Make instructions clear and concise. Avoid multiple instructions. Break up tasks into smaller parts and give short rests in between. Monitor the child frequently during tasks to make sure they are on track.
- Try to follow a timetable which is predictable; if changes do occur, inform the child of what to expect.
- Be patient and clarify things for the student if they come back for help.
- Allow the child to get up at regular intervals. For example, they can help clean the blackboard or distribute books.
- Allow the child more time in tests; for example, take their answer paper last.
- Make the student keep a homework book in which you can check whether the homework tasks have been written down before the child goes home. This will also help improve communication between the teacher and parent.
- Reinforce clear classroom and school rules calmly. Do not humiliate the child, but give them pre-agreed consequences (e.g. that they will stay back in class for 5 min at break time).
- A suitably modified 'behaviour contract' may also be used (Box 11.4). Always praise and reward the child for every task successfully completed. Praising the effort is just as important as praising the achievement.

Many of these principles can be applied for all children to promote mental health in schools (☞ 13.4).



### SECTION 11.4 SUMMARY BOX

#### THINGS TO REMEMBER WHEN DEALING WITH A RESTLESS CHILD

- Many children show restless behaviour and have poor attention span, especially when they are toddlers. However, if this remains as they grow and becomes severe, affecting the child at home, at school and with friends, then this may be ADHD.
- ADHD is best managed initially by giving advice to parents and teachers on how to create a structured environment for the child and strategies to manage the restlessness and poor attention.
- As a child grows, the restlessness will improve, although problems with getting distracted may stay.
- It is advisable to refer the child to a specialist when possible. There are medications which can help many children with ADHD, but they should be given only under specialist supervision.

## 11.5 The child who has been abused

Child abuse can be considered as any action, either deliberately or through neglect, which can negatively affect a child's health or development. There are a number of ways in which children can be abused.

- **Emotional abuse.** This is the most common, but least reported, type of abuse. The child can be neglected by not being given sufficient attention, love, care or food. This may include not being brought for vaccinations or not being given medications when the child is sick. Sometimes, just one child in the family is abused while others are treated in a different manner; this may be due to the child's gender, nature or abilities. Verbal abuse, by shouting, mocking or calling the child insulting things, is also a form of emotional abuse. Neglect may also affect a child with parents who have mental health problems.

- **Physical abuse.** Many parents use a slap occasionally to discipline their children, although this is not recommended. When the physical punishment is more severe and more frequent, it can cause great damage to a child's physical and emotional health. Some children can also be hit or shaken so badly that they break bones. In the worst case they can die from the trauma inflicted on them.



- **Sexual abuse.** This is when an adult uses a child for their sexual pleasure. The adult may show their sexual organs to the child, touch the child on their sexual organs, and make the child touch their sexual organs, or even try to have full intercourse with the child.



### 11.5.1 Why do children get abused?

It is important to remember that both boys and girls can be abused. Most commonly, the person involved in child abuse is someone the child knows well – they may be part of the family, the household or environment the child is in (e.g. neighbourhood, school or religious institution). The adult takes advantage of their close relationship and influence over the child. Families in which child abuse is taking place are often also families where there are other forms of violence (such as the father being violent towards the mother).

Less often, a child may be abused by a stranger. In some situations, children who are already vulnerable, such as those living on the streets, can be abused and used as sex workers by adults (≈13.5). Most abusers tend to be men, but this does not rule out women as abusers or facilitators for children being abused. Most abusers look the same as anybody else and do not behave in an unusual manner.

### 11.5.2 How are children affected by abuse?

This depends on the type and severity of abuse. For example, the occasional corrective slap (though not advised) by a parent who is otherwise loving and supportive is unlikely to have any harmful effects. On the other hand, repeated or severe emotional and physical abuse and even single episodes of sexual abuse can lead to severe problems:

- **physical health:** injuries such as bruises, cuts, fractures or burns, recurrent unexplained urinary tract infections in girls
- **sexual health:** injuries to the sexual organs, pregnancy and sexually transmitted diseases
- **mental health:** anxiety, aggression, poor concentration, depression and antisocial behaviour
- **school performance:** a drop in the child's school performance.

### 11.5.3 When to suspect child abuse

Suspect abuse when a child shows a marked change in behaviour, which may include:

- being fearful of specific adults for no understandable reason
- withdrawing from activities which they participated in in the past
- being aggressive or bullying other children
- running away from home or school
- lying or stealing regularly
- performing poorly in school
- losing weight without an obvious medical reason
- being passive and not reacting like other children
- behaving like a younger child (e.g. when a 6-year-old starts behaving like a 3-year-old)
- trying to self-harm.



In addition, signs specific to sexual abuse include:

- showing sexualised play or behaviour, such as touching and playing with their sexual parts in public
- knowing more about sex than you would expect
- starting to bed-wet or soil after having achieved control
- being over-friendly with adults
- having repeated urine infections, pain while passing urine, or other infections or inflammation of the sexual organs.

### 11.5.4 How to deal with this problem



#### Questions to ask the family or friends

Few adults will openly report that they suspect a child they know is being abused. It is essential that, if you suspect child abuse, you ask the adult in a frank and open way.

- Do you suspect or know whether this child is being hurt in any way by someone? *(If there is a possibility, be more specific by asking about all three types of abuse. Do not skip asking about emotional abuse just because it seems less 'serious' than sexual or physical abuse.)*
- Who do you think is hurting the child? When did it start? What action has been taken for this?
- Have you shared this information with anyone else? Who?
- Have you told the person (the abuser) that you are concerned about what is going on? If so, what was their reaction? If the abuser has not been confronted, why?
- Who is the child's guardian? *(If it is the abuser, then ask who else could take responsibility for the child.)*

#### Questions to ask the child



Be very careful while asking these questions, since they can be misinterpreted by the child and their guardians. See the special interview suggestions below.

- Sometimes, children can get hurt by a grown-up person. Has anyone grown-up hurt you recently?
- If so, who was it? *(If the child is reluctant to name a person, do not force it. Move on to the next question.)*
- How did the person hurt you? How often?
- How do you feel about this?
- Have you told anyone else? Who? What did they say to you?

#### Special interview suggestions



- Interviewing children about the possibility of abuse is a very sensitive task. Ideally, get an experienced health worker to talk to the child. If possible, contact a child specialist or other health worker who has worked with abused children. If there is a specialist, immediately refer the child to them, as the child should not be questioned and examined by multiple adults.



- Do not ask questions about abuse until you have established a rapport with the child. If this means spending more time, then do so. Use toys, drawings or story-telling as a way to help the child become comfortable with you.
- Speak to the child calmly, keeping in mind the developmental level of the child so that your questions or suggestions are framed in an appropriate way. Make it clear that the child can ask questions about anything and that you are there to help them. Clarify to them that what they tell you will only be used to keep them safe.
- Interview the child with the mother or with another family member who is definitely not a suspected abuser and whom the child trusts (ask the child which adult they would like to have with them during the assessment). Ask the child to describe what happened in their own words, using open-ended questions.
- A physical examination is likely to be necessary. However, a child who has been abused may be very sensitive to being examined physically. Respect the child's privacy and comfort. A very young child could be examined on their mother's lap.
- Ensure that you are accompanied by an experienced colleague. Explain to the child what you are doing and why before you start, but also describe each step as you proceed. Make

sure that you are gentle and do not hurt the child further. Document the findings in detail. These may be needed in a police investigation. Do not force an examination if the child is uncomfortable.

- Do not make accusations or threats against anyone. You may frighten the child and make the adults suspicious of your intentions.

## Things to look for during the interview and examination



A thorough examination of the child should include:

- an impression of the child's mental health and demeanour
- injuries on any part of the body
- any injuries or inflammation of the sexual organs – always examine the anal region as well, especially for boys.

Do not make any judgement of what you see. Write down instead what you observe in detail.

## What to do immediately



- Talk to the family members who are available, and who can ensure the safety of the child. Explain why you suspect abuse. Many parents are not aware that their actions can be so damaging to the child's health. Just telling them about the dangers of beating a child or neglecting the child's emotional needs may bring about a change in their behaviour. Often, a cycle of violence builds up in the home where parents beat their child who, in turn, misbehaves even more, leading to more beatings.
- If you suspect sexual abuse, it is unlikely that the family will accept it easily, particularly if the abuser is someone close to the family. Do not accuse anyone. Instead, share your concerns openly with the family and stress that if the abuse continues, the child's health will be even more seriously affected.
- Your priority is the health and safety of the child. If you suspect the child's life is in danger, refer them immediately to a place of safety. This could be a family member, a nearby hospital or an organisation working with children.

Sometimes children can get hurt by a grown-up person. Has anyone grown-up hurt you recently?





Removing the child to a place of a safety (such as a relative's house) may provide a temporary solution.

- Teach the child how to ensure their safety. Explain that the abuse is not their fault and that they should not feel guilty for having spoken out about it (also Box 11.11). It is important to make sure this never happens again. Suggest the following to the child regarding how they may prevent abuse from recurring:
  - try to avoid being alone with the abuser;
  - tell the abuser, in a firm loud voice, not to touch you;
  - get away from the abuser – go to another adult who can provide protection.
- Put the family in touch with community supports. This could include child support groups, family violence groups, legal support, child protection agencies, the police or specialist health care workers (⇨ Chapter 15).
- Explain to the adults concerned that child abuse is a serious criminal offence and that the abuser is liable for police action if a complaint is made. Carefully write down what was said during the interview. In some places, health workers are required by law to inform the police of cases of child sexual abuse; familiarise yourself with these requirements. In such places, you must inform the police and let the legal process take its course.

### BOX 11.11 HELPING A CHILD WHO WAS ABUSED

#### Help the child to trust

- Reassure the child that you are an adult they can trust and that you will be available for them to talk to in confidence.
- Make time when the child can speak to you in an uninterrupted way.
- Be warm and affectionate to the child, but remember to be careful about physical touching.

#### Help the child feel positive about themselves

- Reassure the child that they are not responsible for the abuse.
- Help the child identify their strengths and how they can build on them.
- Suggest activities which the child enjoys, such as playing with friends.

#### Help the child to identify and express emotions

- Talk about what emotions the child is experiencing and how they can be managed.
- Use drawings or stories to help the child explore their emotions.
- Teach the child ways of dealing with anger.

#### Help the child make a safety plan

- Choose a friend or neighbour to whom the child can go for help. Make sure this adult is informed that the child will come to them for help.
- Allow the child to practise with you how to say 'no' to the adult who is abusing them.
- If there is a local police number, give it to the child.

#### Healing messages for children

- 'I care about you.'
- 'I respect you.'
- 'You are lovable.'
- 'You have strengths.'
- 'It is a good thing you have told me; now we can make sure you will not be hurt again.'
- 'Most adults would never hurt children.'
- 'You can say no if you don't like the way someone touches you.'



## When to refer

Refer any serious physical abuse to a specialist facility and be sure to inform the police.

## What to do later

Keep in close touch with the child and the family at regular intervals for at least 6 months. Very often, the abuse stops once it has been openly discussed. If it does not, you may need to strongly intervene with the family to take action to stop it. Talk to the child each time; many children do recover from the trauma, but some children may develop mental health problems. Such children may need specialist help.



### SECTION 11.5 SUMMARY BOX

#### THINGS TO REMEMBER WHEN DEALING WITH CHILD ABUSE

- Child abuse is much more common than is actually reported. This is because most children are too scared or embarrassed, or feel they are to blame.
- The most common type of abuser is someone whom the child knows – often a father, other male relative, domestic help or family friend.
- Boys can be abused as well as girls.
- Abuse can be emotional, physical or sexual. All three types of abuse can damage the physical and mental health of children.
- Most abusers will stop the abuse once they are found out. It is important for you to inform the parents and relevant authorities immediately if you suspect abuse. It is essential to follow up on the action taken, especially when the abuser is in a position of authority, for instance, a teacher.
- Never doubt a child's claims that they are being abused. Take it seriously since it will not stop until someone intervenes and addresses the problem.

## 11.6 The child who behaves 'badly'

Most children will be disobedient or refuse to follow family rules at some time or another. Many children, especially those under the age of 4, will lose their temper and have tantrums if they do not get what they want. However, the majority of children will outgrow this behaviour as they learn to handle their emotions and deal with disappointment. Many parents recognise that this behaviour is part of normal childhood and that a combination of the right mixture of love, firmness and consistent discipline will bring the behaviour under control. Some parents, however, may become

worried and may seek help. It is therefore useful to know when a child's misbehaviour becomes a health problem.

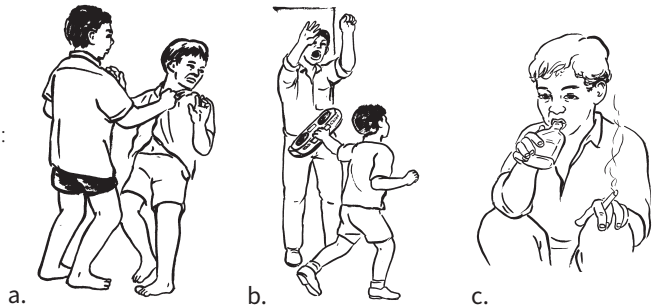
### 11.6.1 When is misbehaviour a health problem?

A child's misbehaviour is a health problem if it:

- results in serious and repeated breaking of family or social rules, such as continuous lying;
- is accompanied by serious aggression against others, such as hitting or abusing;
- is accompanied by potentially criminal acts, such as stealing;

Children can behave badly in a number of ways:

- by getting into fights
- by committing crimes
- by abusing drugs.



- is accompanied by not attending school or by poor school performance;
- is present for a long time (more than 6 months).

When a child's bad behaviour becomes a health problem, it is called a **behavioural disorder**.

### 11.6.2 Why do children behave badly?

There are notable situations which lead to behaviour problems.

- When there is violence in the family (e.g. between parents, or physical beating of the child to impart discipline), a child copies these behaviours to express anger, disappointment and unhappiness.
- When parents are not consistent in the way they discipline their child, the child is no longer sure whether the behaviour is right or wrong.
- When a child is neglected, they may learn that the only way to get attention is to misbehave.
- When a child is using drugs, they may steal to get money to buy drugs.

Sometimes, children have behaviour problems because of a mental health problem, such as ADHD (⇨ 11.4) or dyslexia (⇨ 11.3, Box 11.7).

### 11.6.3 How to deal with this problem

#### Questions to ask the parent

Find out what is meant by the 'bad' behaviour. Where, when and with whom does the 'bad' behaviour occur? If the child is present, do not

allow the parents to 'label' the child as 'bad' but refocus the conversation on the 'unacceptable' behaviour. Get a detailed description of it.

- Can you describe the behaviour in detail? When did this behaviour start? How has it affected the family? How has it affected the child's studies?
- What happens before the behaviour and what happens after the behaviour?
- Why do you think the child is behaving this way? What do you do when the child behaves like this? (*Find out how the parents discipline the child. Ask both parents this question separately, since this may reveal a different attitude to, or method of, discipline. Violent discipline or inconsistency in the disciplinary practices of the parents or other adults is likely to make the behaviour problem worse.*)
- How do you expect your child to behave? (*Find out the parents' expectations; are they unrealistic for the age of the child?*)

#### Questions to ask the child

- Having heard your parents' thoughts on your behaviour, do you think they are right? Why do you feel they are upset by your behaviour? (*The child will have heard their parents' complaints about them. Now they have a chance to respond.*)
- What is the reason for your behaviour? What does it achieve? Do you feel upset with your parents? (*Finding out about difficulties from the child's viewpoint can help identify a solution.*)
- How do you think the situation could be changed? What are you willing to do? What would you like your parents to do? (*These*



questions will indicate how far the child is prepared to go to address the behaviour problem.)



## Special interview suggestions

Most child behaviour problems are related to the child's environment. Interview the child and family members together as well as separately. Observe how they react to one another. You may notice anger between the parents and their child. When a parent is speaking, the child's facial expressions may tell you something about how

they feel about what is being said. The child may be defiant or sad. Always talk to the child so that they know that their account is just as important as that of their parents.

## What to do immediately

- Reassure the family (in the presence of the child) that behaviour problems are common. Make both child and parents understand that it is the behaviour that is 'bad' or 'unacceptable', not the child.



### BOX 11.12 DISCIPLINING CHILDREN: WHAT'S USEFUL AND WHAT'S NOT

As a health worker, you should be able to advise parents on how to discipline their children. Of course, this is also helpful for your own role as a parent! Here are some points regarding positive disciplining practices which should be acceptable to most parents, especially if you explain to the parent how they may help improve the child's behaviour.

- Praise good behaviour and efforts at good behaviour.
- Be consistent. Stick to the rules you have made and make sure that your rules apply each time the child misbehaves.
- Be sure that all adults treat the child the same way. A big challenge is if the two parents treat the child's behaviour in different ways. The child will learn that if they misbehave with one parent, the other will come to their rescue.
- Be clear. Explain why you are upset and why you are disciplining the child. Be specific in your requests. Make one request at a time. Tell the child what to do rather than what not to do. For example, say 'Be home before 10 p.m.' instead of 'Don't come home late'.
- Be calm and speak in a normal tone. Do not lose your temper. If parents lose their temper, this is what the child will copy when they are angry.
- Do not use violence under any circumstances. A slap, even in extreme circumstances, will not help change the problem in the long term and only illustrates to the child that it is sometimes all right to hit.

- Spend time with the child talking about their feelings and hopes and fears, and share your own with the child. Treat your child as a loved and trusted friend. The key to discipline is showing love and respect for your child.

These general principles can be applied to two specific techniques to modify the child's behaviour.

1. Establish a **behaviour contract** with the child (Box 11.4 and next page).
2. Use **'time out'**. This means that when a child misbehaves, they are told to go away (e.g. to another room) and come back after a prescribed amount of time. Using 'time out' like any other method to change behaviour must be explained to the child in age-appropriate terms. It should not be explained as a punishment but as a negative consequence of the child's disruptive behaviour. The place chosen should not be fun or interesting (e.g. a bedroom full of toys) and the time period should, as a simple rule, not be more than the age of the child in minutes (so a 7-year-old should have a 7 min period). It is important to talk to the child after the 'time out' period and discuss why they needed to have 'time out', which behaviour led to them having 'time out' and ways in which they could avoid this in the future. 'Time out' must be coupled with 'time in'. This means playing with or listening to the child for some time every day.

- Encourage the parents to spend time each day with the child doing something together that they enjoy.
- Effective discipline techniques can help set behaviours back on track (Box 11.12). Acceptable behaviours should be praised or rewarded, while unacceptable behaviours should be ignored or face pre-agreed consequences. The discipline must be clear and consistent so that all adults behave in the same way towards the child. 'Time out' (Box 11.12), 'behaviour contracts' (Box 11.4) and denying privileges can be effective ways of disciplining younger children; violence and abuse are the least effective ways. Responses should be carried out immediately after the unacceptable behaviour.
- Positive discipline practices need patience and time to work. Discipline is especially difficult if there are other family problems, such as marital problems. You may need to work on these other problems as well (⇨ 5.15).



- With the parents' permission, share the problems with elders in the family or friends who can support them. If the child's teachers are worried, talk to them about why the child is misbehaving and guide them on classroom tips to manage disruptive behaviours (Box 11.10).
- Do not use medications, even if you feel that the child needs to be 'calmed'.
- If the child has problems with learning or maintaining attention, think of the possibility of dyslexia or ADHD (⇨ 11.3, 11.4).



I Negotiating a behaviour contract.



- See the family every 2 weeks, after asking them to keep a diary in which they record their child's behaviour. At each meeting, review the child's behaviour. If there is no improvement, find out why not. Often, the reason is because the agreement made by the parents and child is not being observed.

## When to refer

Refer to a mental health or child specialist if:

- the child is at risk of harming others (or themselves, such as through drug abuse);
- the child's family has severe problems, for example, severe violence or abuse.

### SECTION 11.6 SUMMARY BOX

#### THINGS TO REMEMBER WHEN DEALING WITH CHILDREN WHO BEHAVE 'BADLY'

- All children will show challenging behaviours at some time or another, especially when they are young. This is normal.
- When the disruptive behaviour is present for many months and is consistently associated with breaking family or school rules by lying, stealing, bullying, fighting or not attending school, then this is a mental health problem.
- Encourage families to regularly spend time on activities which both the child and parent enjoy.
- The most common underlying causes of this problem are domestic violence, which may be directed at the child and be a cause of inconsistent parental discipline. Hyperactivity (ADHD), intellectual disability and dyslexia are other causes.
- Practising simple ways of encouraging positive behaviour and encouraging parent-child contracts on acceptable behaviours are the key methods of dealing with this problem. Medication has no role.

## 11.7 The child who wets the bed

Like other developmental milestones, children vary in the age at which they achieve control for when they pass urine. Urinating in clothing in the daytime (enuresis) is a problem only when a child repeatedly does it after the age of 3, and passing urine during sleep (also called bed-wetting or 'nocturnal enuresis') should be considered a problem only after the age of 7. Children with intellectual disability may take longer to achieve this milestone, in keeping with their overall delay.

### 11.7.1 Why do children wet the bed?

The most common cause is inherited. So, if there is a family history of a parent of the child having had delays in achieving control then the child is more likely to also have this problem. Many children will continue to have occasional accidents as they grow up, especially at times of exhaustion and stress. Some children may start regular

bed-wetting after having learned how to control their urine. This may be due to the child becoming upset about something, such as fights in the family or the arrival of a younger sibling. Other, less common, reasons include urinary infections, child abuse, diabetes, physical problems in the urinary tract and some rare neurological problems. Some children wet themselves in the daytime. If children wet themselves during the day even after starting primary school, then it can cause problems because of shame and guilt. Common reasons for daytime wetting are not wanting to use the school toilets and urinary tract infections (especially in girls).

### 11.7.2 How to deal with this problem

#### Special interview suggestions

Bed-wetting can be a very embarrassing topic for a child to talk about. By the time a child with bed-wetting is brought to see you, they will



probably already believe that they are doing something ‘wrong’. They will likely feel ashamed and unhappy. Be sensitive to the child’s feelings. Examine the child’s lower back and gait (how the child walks) to rule out rare diseases of the spine which may cause bed-wetting. Talk about bed-wetting in private, or with an adult relative who is sensitive. Ask for a urine examination for infections and sugar to check for urinary tract infections and diabetes, especially if the child has complained of a burning sensation or is drinking an unusually large quantity of water in the day.



### Questions to ask the parent

- Has your child achieved other age-appropriate milestones? Has your child ever been dry in the day and/or the night? (*This is important to know whether the bed-wetting is part of a more global delay in development* ☞ Box 11.1.)
- How many nights a week does your child wet his bed, how often every night? Does your child have daytime control or is this a problem as well? Does your child wake up after bed-wetting? (*Lack of daytime control beyond the age of 3 years suggests a medical cause, for example, a urinary tract infection, or developmental delay.*)
- How much does your child drink during the day? (*Consider all fluids, including milk and juices.*)
- Is the child constipated? (*Chronic and severe constipation can cause pressure on the bladder.*)
- If the child had learned to control their urine, when did you notice that they had started bed-wetting again? Was there any significant event in your family around that time? For example, the birth of another child or some family problem? (*This suggests a psychological cause for the bed-wetting.*)
- How do you and other carers react to the bed-wetting? What have you said to your child? (*Angry parents who blame the child may make the problem much worse.*)
- How has the problem been handled so far?
- Does your child seem to pass urine very often in the daytime, complain of it hurting during

passing urine and do they seem unusually thirsty throughout the day? (*Infections cause pain while passing urine, while excessive thirst may signal diabetes.*)

### Questions to ask the child



- Your parent has told me that you have had some occasional accidents while sleeping – can you tell me a little more about when this happened? Why do you think it is happening?
- How have you been feeling recently? Have there been any problems at home? At school? (*Start by asking general questions so as to give time for the child to feel more comfortable.*)
- Have you been worrying about anything of late? (*See if the child brings up the topic themselves.*)
- Does it burn or hurt when you pass urine in the day or at night? (*This is to check for a urinary infection.*)
- Has anyone hurt you recently? For example, by touching you around your private parts? (*Ask these questions if you suspect child abuse.*)

### What to do immediately



Many families become very anxious about bed-wetting. Reassure them and explain that bed-wetting is common and that many children need time to achieve this milestone. Most children will be dry by the age of 7. Explain to the parents that they should not blame the child for the bed-wetting, since this can make the child more anxious, which in turn can cause more frequent accidents. Explain to the parents that children do not bed-wet on purpose and this behaviour is not in their control.

If there is a urinary infection, treat with an antibiotic and advise the child to drink enough water. Remember to be sure that it is an infection before you give this advice, because asking the child to drink more water can make the problem worse if there is no infection!

### Night-time bed-wetting (advice for parents)

- Encourage the child to learn how to ‘hold’ urine in the daytime by increasing the amount of time spent between trips to the toilet. This



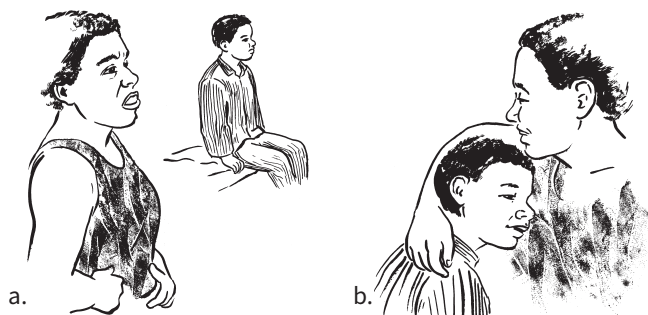
should be done in a way that doesn't cause accidents which would further embarrass the child.

- Ask the parent to restrict liquids (water, milk etc.) after 6 p.m. in the evening, but ensure that children under 8 get at least 1.5 litres of fluid in the day, and 2 litres if older.
  - Create a routine where the child passes urine in the toilet just before bedtime.
  - A behaviour chart (e.g. a star chart) can motivate the child to achieve behaviours which encourage dry nights (e.g. not drinking anything after 6 p.m., passing urine before bedtime). These goals are more motivating and less stigmatising than actual dry nights, which may be harder to achieve for the child.
  - If the child wets their bed, the parent should not get angry but instead tidy the bed up without a fuss. In an older age group, the child can help strip the bed and place the sheets in the laundry, but this should not be used as a punishment.
  - If bed-wetting persists, set the alarm at a fixed time in the night, for example, at midnight, wake the child and take them to the toilet to pass urine. Older children, depending on their maturity, may be able to handle the alarm independently.
  - Aim to have 2 weeks of consecutive dry nights.
  - An exercise which can help the child develop control over urine is encouraging the child to stop urinating before they have finished, then hold the urine for a few seconds, and start urinating again until they finish. The more the child can stop-start urinating in this manner, the more control they will gain.
- Special 'buzzer' alarms are available in some places which can be attached to the bed sheets and make a loud noise the instant the bed is wet. This wakes the child before they complete urinating and the parent can then take the child to the toilet. If such devices are available, the process needs to be explained to the child prior to its use.
  - If there are any worries or stresses in the home, try to correct them.
  - If none of the advice above works, then there are medications that you can try. If available and affordable, the first choice is desmopressin. This can be used if there is a need for rapid control of bed-wetting or need for short-term control. The initial dose is 200 µg for Desmotabs®. If the child is still not dry after 1 to 2 weeks, increase the dose to 400 µg. The usual length of treatment is 3 months, after which the medicine should be withdrawn slowly to prevent rebound bed-wetting.
  - If bed-wetting comes back, an alternative medication is imipramine (☞ Chapter 14) at a dose of 25–50 mg 2 h before bedtime. Imipramine will help many children, but the problem often comes back when it is stopped. Thus, its real advantage is that by helping control the problem, it will boost the child's confidence. The medication must be combined with all the other advice above. It can be used for up to 6 months.

#### Daytime wetting (advice for parents)

- Reward the child with praise or other rewards for each day that passes by without wetting. One way to support children is using a behaviour contract (Box 11.4). By prior agreement,

Never scold a child who has wet their bed – children never wet their beds purposely. Showing them love is an important part of helping stop the problem.



after a certain number of stars are given for 'dry days', the child gets a reward.

- Get the child to go to the toilet regularly, say every 2h. This way, the bladder is always empty. Once this controls daytime wetting, gradually increase the time between trips to the toilet. If the child is in school, it helps to involve the teacher in this plan.



- Review the child and parents until the problem is under control for at least 2 weeks. If the problem persists, you should refer the child.



### When to refer

Refer to a child specialist if:

- there is a physical cause such as infection, diabetes or a neurological problem;

- there is a family disturbance, especially if you suspect abuse;
- the problem persists despite your suggestions and efforts from the family and child;
- the child has the problem beyond the age of 10 years.

### 11.7.3 Soiling clothes

Soiling means passing faeces or stool while dressed or in bed. This is abnormal if it happens beyond the age of 4 years.

There are three main causes of soiling. The first is severe constipation. In this situation the child passes infrequent stool which is dry and hard. Over time, the soft stool builds up behind the constipated stool and forces its way out. Advise the parents to ensure that the child's food has sufficient fluids, fruit, vegetables and fibre. Give stool softeners or laxatives if the stool is so hard that it causes pain on passing. Establish a regular routine for passing stool and praise the child each time a stool is passed in the toilet. A second reason is not learning how to use the toilet. This is may be a behavioural problem and can be part of a general refusal of a child to cooperate with parents over multiple issues. Thirdly, soiling clothes can also be part of an intellectual disability or autism (⇨ 11.1, 11.2).

#### SECTION 11.7 SUMMARY BOX

##### THINGS TO REMEMBER WHEN DEALING WITH BED-WETTING

- Bed-wetting is a concern only if it occurs repeatedly after the age of 7.
- Children with intellectual disability may take longer to learn how to control their urine. However, just because a child wets the bed, it does not mean they have intellectual disability.
- Bed-wetting is most commonly due to delay in the development of the ability to control the bladder, which is often inherited from one's parents.
- Simple advice on how to control the bladder and passing urine at regular intervals can help most children.

## 11.8 The adolescent who is distressed

Adolescence is the period of life which begins around puberty and may continue until the early 20s. It is a unique period for many reasons.

- This is when young people start to see themselves as unique individuals different from their parents.
- Their bodies change physically and they become sexually mature. This means they begin to be attracted, sexually, to others. And, of course, they become more sensitive to the attraction other people have towards them!
- This is also the time when important decisions about education and their career will be made.

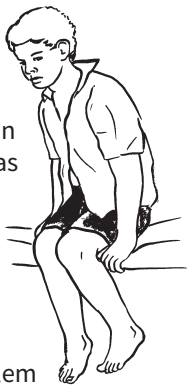
With all these great changes taking place, it is not surprising that some adolescents may find themselves feeling under stress.

It is rare for an adolescent to seek help independently. They will most frequently be accompanied by a parent or have been referred by a teacher or school counsellor.

### 11.8.1 Why do some adolescents feel distressed?

Adolescents may become distressed for many reasons:

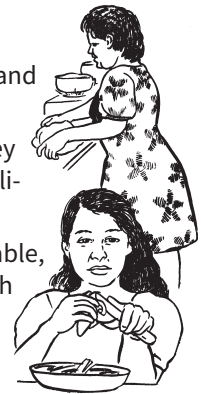
- their family lives are unhappy – violence, abuse and constant fights in the family;
- they are frustrated with their school performance – failing in examinations or not doing as well as was expected;
- they cannot be with someone they love – love affairs which are broken either by the parents or by the loved person;
- they have a chronic problem such as obesity, severe acne or diabetes;
- abuse and violence are directed at them at home, school or in a workplace;
- they are suffering from severe depression or psychosis.



### 11.8.2 Depression in adolescents

Depression is a common problem in adolescents. It often presents with physical symptoms, frequently related to difficulties in schoolwork. Common features are:

- headaches and non-specific aches and pains
- difficulty with concentration
- poor sleep
- loss or increase of appetite
- withdrawing from family and friends
- the adolescent feeling that they are not as attractive or intelligent as others
- becoming moody and irritable, and getting into fights with family and friends
- stopping activities that previously brought pleasure
- seeing life as being pointless
- suicidal feelings.



Depression can affect adolescents in many ways by resulting in:

- poor school performance
- poor relationships with friends and family
- increased risk of harming themselves (suicide is a leading cause of death in adolescents)
- high-risk behaviours such as drug or alcohol misuse.

### 11.8.3 How to deal with this problem

#### Special interview suggestions

Remember to respect the privacy of the adolescent. Ask them if they would like to be in the room when you are speaking to their parents. Similarly, make sure that you give them the opportunity to talk to you on their own. Building a therapeutic alliance with an adolescent can be a difficult experience, especially when they may perceive that they are being 'forced' to come to see you. Take time to build trust and always treat the adolescent as a young adult.





## Questions to ask the parents

- What changes have you noticed in the adolescent's behaviour recently? (*Ask questions around sleep habits, appetite and interactions with friends.*)
- Why do you think this is happening? (*The parents' views may give a clue to the cause of the problem. For example, if a parent says that the adolescent is not studying hard enough, it could be that pressure for examination performance is a stress.*)
- Do you feel there is anything in your child's personal life which is upsetting them? (*The parent may know about their child being in a relationship, or of an approaching exam.*)
- Have you been concerned about any unusual behaviour in your child? (*For example, talking to themselves when no one else is there, or getting suspicious of family and friends; these questions help screen for psychosis.*)
- Is there anything you have tried to help your adolescent?
- What do you think the adolescent should do to change the situation?



## Questions to ask the adolescent

- How have you been feeling recently? (*Specifically, ask about sleep, concentration and emotions.*)
- Have you been worried about anything recently? For example, about problems at home? Or with your studies? Or because of your relationships with friends, in particular, a 'special' person you are fond of? (*Ask girls whether they are worried that they could be pregnant.*)
- Have you shared these worries or concerns with anyone else? Who? What was their advice? (*Find out about the adolescent's social supports and who the adolescent is comfortable talking too.*)
- Have you been in an intimate relationship with anyone? Have there been any difficulties with that relationship?
- Have you felt like harming yourself or ending your life? (*Find out how often and since when.*)

*Thoughts or plans to end their life, or thoughts which have been present for a period of time and are accompanied by depressed mood are cause for particular concern.)*

- Has anyone hurt you recently? For example, hit you, or taken advantage of you sexually?
- Have you been drinking alcohol or taking drugs? (*If so, find out what and how much.*)

## What to do immediately



- Listen to the adolescent's account of their feelings and what they are worried about. Do not be in a hurry. If you do not have time immediately, then tell them to come back later, when you have more time.
- Carry out a mental health assessment to determine whether the adolescent has depression, anxiety or any other mental disorders (☞ 11.9).
- Use counselling strategies to help the adolescent cope with the specific mental health problem. Problem-solving is always a useful general strategy to addressing mental health problems (☞ 5.11).
- Help the adolescent to make the link between their feelings and the stressful situation they are facing. Often, understanding this link helps to make the symptoms less overwhelming and frightening.
- Suggest that you would like to talk to the parents (and teachers, if possible) and share the adolescent's concerns with them. Often, the adolescent will not have been able to share their feelings with their parents, and this will have made the problem even worse. Encourage the adolescent to realise that an open discussion of the problems with the family can help. You can suggest that you would be happy to help support such a dialogue between the adolescent and the parents.
- Make practical suggestions. For example, if an adolescent has become stressed because they are having difficulties with a particular subject, write a note to their teacher explaining this. The teacher may help by giving the adolescent more time after regular school hours to help them make up for their difficulties.



- The adolescent may be worried about an intimate relationship they are in. Give them practical advice on safe sexual practices without being judgemental, but also explain the potential risks.
- Advise them to avoid using alcohol, tobacco or drugs, explaining the risks.
- Ask the adolescent to come back and see you regularly until they are feeling better. Improvement can be judged by the adolescent feeling more positive about their future, sharing their feelings with others, and better performance in school.

### BOX 11.13 COPING WITH STRESS: SUGGESTIONS FOR ADOLESCENTS

People react to stress in different ways. Some people cope with the stress in ways which leads to less harm to their health. Here are hints on how you can do the same.

- Identify those situations or events which make you feel stressed.
- List as many ways you can think of to make these situations less stressful.
- Imagine yourself doing one of these things.
- Rehearse a situation before you face it.
- Share your stress with others, such as friends, family or teachers.
- Imagine how your friends would respond to these situations, especially friends who you feel are able to cope with stress better than you.
- Do some exercise to release tension.
- Do not be embarrassed to see a counsellor.

☞ Part 4 for mental health promotion in adolescents.

### When to refer

- If there is no improvement despite your efforts.
- If the adolescent has severe problems such as drug abuse, violence or psychosis.



### SECTION 11.8 SUMMARY BOX

#### THINGS TO REMEMBER WHEN DEALING WITH AN ADOLESCENT WHO IS SAD

- Vague physical complaints are most commonly related to stress and depression.
- Depression is common in adolescents and suicide is a leading cause of death.
- Most adolescents with depression will get better with counselling.
- Working with families and teachers is an important way of helping adolescents, since stress in the family or in school is a major cause of depression.

## 11.9 Symptom checklists to diagnose mental disorders in childhood

<b>Intellectual disability</b>	<b>Conduct disorder</b>
<p>From early childhood, similar levels of delays observed in all areas of development:</p> <p>In their understanding, reasoning and language abilities compared with other children of the same age <input type="checkbox"/></p> <p>In learning self-help skills (e.g. washing, toileting) <input type="checkbox"/></p> <p>In achieving physical skills (e.g. walking) <input type="checkbox"/></p> <p>In their ability to make friends with children of their age <input type="checkbox"/></p>	<p>From late childhood or adolescence showing disruptive behaviours without feeling sorry or concerned about the consequences of their actions; social or academic performance is affected:</p> <p>Aggression or cruelty to people or animals <input type="checkbox"/></p> <p>Destruction of property <input type="checkbox"/></p> <p>Regularly lying or stealing from others <input type="checkbox"/></p> <p>Regularly breaking rules <input type="checkbox"/></p>
<b>Specific learning disability</b>	<b>ADHD</b>
<p>From middle childhood, difficulties which affect academic performance and are not due to intellectual disability:</p> <p>In reading (e.g. inaccurate, slow and with a lot of effort) <input type="checkbox"/></p> <p>In understanding the meaning of what is read <input type="checkbox"/></p> <p>With written expression (e.g. with grammar, spelling, punctuation, organisation) <input type="checkbox"/></p> <p>With mathematical reasoning (e.g. applying maths concepts or solving maths problems) <input type="checkbox"/></p>	<p>Symptoms from before the age of 12; social or academic performance at home and at school is affected:</p> <p>Careless mistakes in work due to lack of attention <input type="checkbox"/></p> <p>Difficulty in remaining focused on the task at hand (e.g. class assignment) <input type="checkbox"/></p> <p>Seems not to be listening when talked to <input type="checkbox"/></p> <p>Often loses personal things <input type="checkbox"/></p> <p>Easily distracted by other things happening <input type="checkbox"/></p> <p>Constantly forgetful in daily routines <input type="checkbox"/></p> <p>Often fidgets with things, taps hands or feet or is unable to sit still <input type="checkbox"/></p> <p>Is unable to play 'quietly' <input type="checkbox"/></p> <p>Seems to be always 'on-the-go' <input type="checkbox"/></p> <p>Talks excessively <input type="checkbox"/></p> <p>Interrupts or intrudes on others without permission <input type="checkbox"/></p>
<b>Autism</b>	<b>Anxiety disorders<sup>†</sup></b>
<p>Difficulties from early childhood (often variable across the areas of development):</p> <p>Difficulty in interacting and communicating with others (e.g. not talking to or looking at others) <input type="checkbox"/></p> <p>Difficulties in making and maintaining a relationship with others of their age (e.g. showing no interest in interacting with others) <input type="checkbox"/></p> <p>Narrow areas of interest (e.g. being stuck on a single toy) <input type="checkbox"/></p> <p>Ritualised behaviours (e.g. playing only in a certain way with a toy or repeating certain actions or sounds every day) <input type="checkbox"/></p> <p>Sensory difficulties (e.g. over-sensitive to sensations or seeking sensory stimulation in inappropriate or excessive ways) <input type="checkbox"/></p>	<p>If any one of the following are present at any point in childhood or adolescence, and social or academic performance is affected:</p> <p>A severe fear (or phobia) of animals, strangers or situations <input type="checkbox"/></p> <p>Persistent refusal to go to school because of fear that something bad may happen <input type="checkbox"/></p> <p>Persistent refusal to separate from a loved one (often the mother) <input type="checkbox"/></p> <p>Excessive shyness in engaging with normal social interactions <input type="checkbox"/></p>

<sup>†</sup>Depression in adolescents has symptoms similar to adults (☞3.5).

