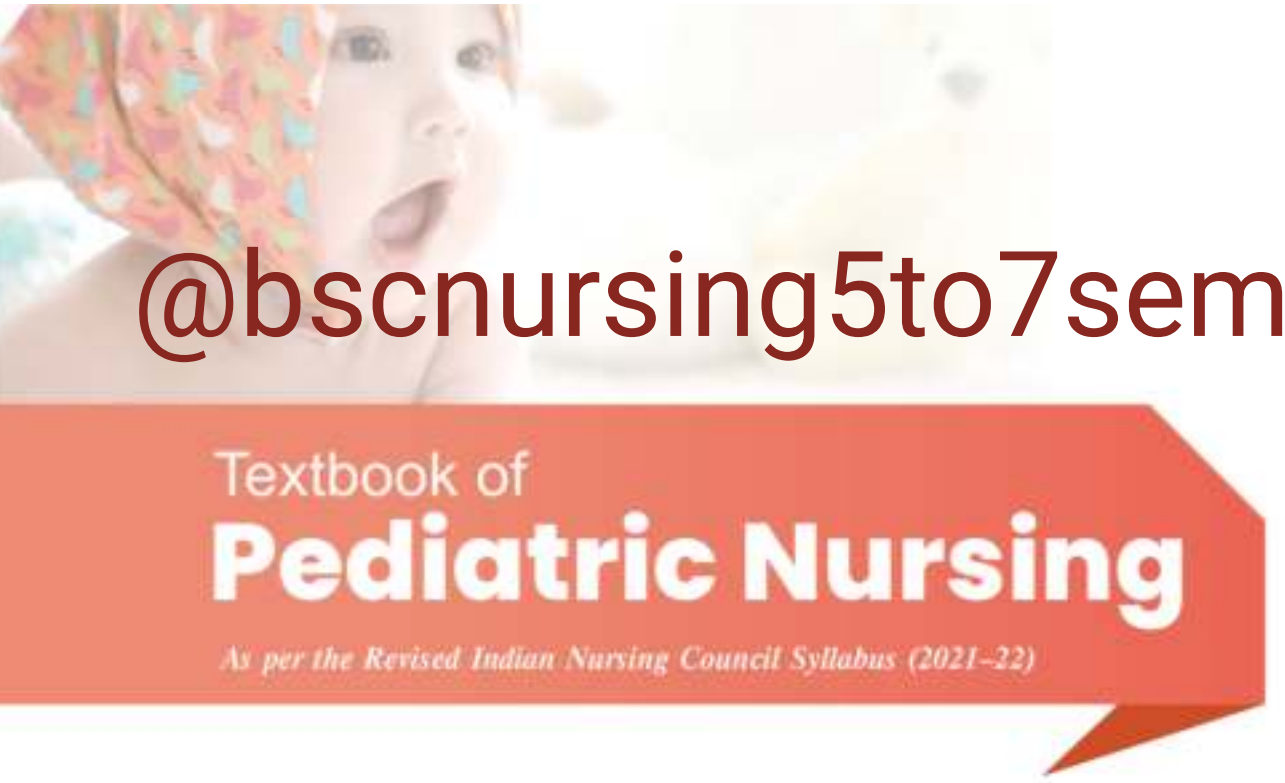

Textbook of Pediatric Nursing

As per the Revised Indian Nursing Council Syllabus (2021–22)

Unit IX

Behavioral and Social Problems in Children

Learning Objectives

At the end of this unit, the students will be able to:

- Describe the management of children with behavioral and social problems.
- Identify the social and welfare services for challenged children.

Unit Outline

Chapter 26

Child with Behavioral Problems

Chapter Outline

INTRODUCTION

Definition: Behavioral disorders are defined as a pathological state of mind producing clinically significant including but not limited to, affective, cognitive, and behavioral or physiological symptoms together with impairment in one or more major areas of functioning wherein behavioral health services can reasonably be anticipated to result in improvement.

CAUSES OF BEHAVIORAL DISORDERS

Behavioral problems are caused due to multiple factors. A few of them are listed here:

- **Faulty parental attitude:** Strained parent child relationships, overprotection, dominance, broken family, comparison with siblings, etc.
- **Inadequate family environment:** Poor economic status, child rearing practices, parental illiteracy, cultural values, parents psychosocial health, etc.
- **Mentally and physically sick or handicapped conditions:** Child with history of chronic illness, disability, etc.
- **Strained social relationships:** Maladjustment at home, school, neighbors, school teachers, schoolmates, peers, etc.
- **Influence of mass media:** Internet, television, radio, newspapers, high-tech communication devices, affect the school children and adolescents leading to conflict and tension leading to behavioral disorders.
- **Factors related to social change:** Abnormal behavior may be evidenced in children who are exposed to social unrest, violence, unemployment, change in value systems, economic insecurity, etc.

TYPES OF BEHAVIORAL DISORDERS

Some of the most commonly types of behavioral disorders, such as habit disorders/stereotypic movement disorders, elimination disorders, speech disorders, learning disorder, eating disorders, psychiatric disorders, and miscellaneous disorders have been described here (Table 26.1).

Habit Disorders/Stereotypic Movement Disorders

Childhood habits appear in many different forms, for example, nail biting or foot tapping, teeth grinding (bruxism) and hair pulling (trichotillomania). Habit disorders, now called stereotypic movement disorders, consist of repetitive, seemingly driven, and nonfunctional motor behaviors that interfere with normal activities or that may result in bodily injury.

Table 26.1: Types of behavioral disorders

Sl. no.	Type	Behavioral disorders
1.	Habit disorders/ stereotypic movement disorders	Nose picking, bruxism, breath-holding spells, head banging, thumb sucking, nail biting, trichotillomania, tourette syndrome
2.	Elimination disorders	Enuresis, encopresis
3.	Speech disorders	Stuttering, stammering
4.	Learning disorder	Dyscalculia
5.	Eating disorders	Pica, anorexia nervosa, bulimia nervosa
6.	Psychiatric disorders	Disruptive behavioral disorder, attention-deficit/ hyperactivity disorder (ADHD), school phobia, childhood schizophrenia, autism
7.	Miscellaneous disorders	Infantile or evening colic, temper tantrums, masturbation

Nose Picking

It refers to inserting the finger into a nostril and may involve the removal of nasal discharge.

Bruxism

It is the forcible gnashing, grinding, clicking, or clenching of teeth. Nocturnal bruxism occurs during sleep, and the child is usually unaware of the problem. Episodes are typically brief, lasting 8–9 seconds, with audible grinding noises. Diurnal bruxism involves clenching of the teeth and may not produce audible noises. It may be associated with other oral habits, such as nail biting or lip chewing.

Breath-Holding Spells

A breath-holding spell is a paroxysmal event in which a child stops breathing at the end of expiration after crying, generally because of pain or anger. The crying may be brief or prolonged. Breath-holding spells are classified as simple, cyanotic, or pallid.

- **Simple breath-holding spell:** It results when the child becomes apneic (cyanotic or pale) and then takes a deep breath.
- Spells with loss of consciousness and muscle tone are classified by the child's color during the event.
- **Cyanotic spells:** These have an emotional precipitant, (e.g., anger, frustration). The spell is initiated subconsciously by young children often as a component of a temper tantrum. With breath-holding, the child progresses from cyanotic to apneic. The child may then become limp and lose consciousness. The spell typically lasts less than 1 minute. If a seizure occurs, the results from an EEG obtained during rest or sleep are normal.
- **Pallid spells:** These are generally observed in response to pain, and the child quickly becomes apneic and pale. An enhanced vagal response has been assumed to be a precursor to bradycardia or asystole. Seizures rarely result.

Head Banging

It refers to the rhythmic hitting of the head (generally the frontal or parietal region) against a solid surface. It usually lasts less than 15 minutes but can also last for hours. A frequency of up to 60–80 hits/min is common. It may also be associated with temper tantrums, or stress.

Body Rocking or Rhythmic Movements

These involve a forward and backward rhythmic swaying of the trunk at the hips, generally from a sitting or quadruped position. The intensity may be gentle, or forceful enough to move the child. This behavior typically occurs when child is alone in the crib. Generally, episodes last less than 15 minutes but may continue up to 30 minutes. Rhythmic or stereotypic behaviors include repetitive nonfunctional motor movements, such as hand flapping or shaking, self-biting, or hitting one's own body.

Thumb Sucking

Thumb sucking is normal in babies and young children. It is common in 0–1 year of age as the babies have the natural urge to suck. This usually decreases after the age of 6 months. Many babies continue to suck their thumbs and fingers to soothe themselves. Thumb sucking in children younger than 4 years is usually not a problem. Children who suck their thumbs often or with great intensity around the age of 4 or 5 are in response to an emotional problem or other disorders such as anxiety. They also pose the risk for developing dental and speech problems. Thumb sucking can become a habit in babies and young children to comfort themselves when they feel hungry, afraid, restless, quiet, sleepy or bored.

Causes

It can be due to feeling of insecurity and tension reducing activities, e.g., separation from parents, siblings, disharmony between parents, overprotection or neglect of parents, etc. It may develop due to inadequate oral satisfaction during early infancy as a result of poor breastfeeding. In older children, this habit may develop when they are tired, bored, frustrated or at bed and want to sleep, but feel lonely.

Effects of Thumb Sucking

If thumb sucking continues beyond 4 years of age then complications may arise as malocclusion and malalignment of teeth, difficulty in mastication and swallowing. It may cause deformity of thumb, facial distortion and speech difficulties

with consonants (D and T) and gastrointestinal (GI) tract infections. If the child develops thumb sucking at the age of 7 or 8 years, it indicates a sign of stress leading to the development of emotional problems.

Management

Management of children with thumb sucking can be done at home with the active involvement of the parents and the family members. It has been suggested by experts that this habit gradually disappears if the parents ignore and does not pay much attention to it.

- Advise parents not to become irritable, anxious, and tense. Do not scold the child.
- Praising and encouraging child for breaking the habit are very useful.
- Provide positive reinforcement by offering rewards for not sucking the thumb.
- Offer distraction during bored time and divert child's attention.
- Engage the thumb or finger, practice to keep the hand busy in play activities.
- Encourage the child to socialize and play with elder children.
- Hygienic measures to be followed and infections to be treated promptly.
- Application of nontoxic bitter taste substances on the thumb has been useful.
- If the cause of the sucking thumb is due to anxiety or distress, address the issue promptly. Talk to the children to understand about the cause for thumb sucking.
- Consultation with dentists and speech therapist may be required to correct the complications.

Nail Biting

Nail biting, also known as onychophagia, is an oral compulsive habit commonly observed in children and adults. Nail biting is oral habit especially in school age children beyond 4 years of age (5–7 years). It may continue up to adolescence. The child may bite all the fingers or any specific one. The bite may include the cuticle or skin margins of nail bed or surrounding tissue.

Causes

The causes for nail biting may be due to variety of reasons:

- As a sign of tension and self-punishment or to cope with the hostile feelings
- Out of boredom or curiosity
- Due to nervousness and insecurity
- Feeling of hostility and conflict or shy
- Fear or jitteriness due to family situations
- Due to constant nagging, tiredness as well as to cope with pressure to study at school or home
- Habit formation—seeing parent who is a nail biter

Management

- Address the anxiety issues if any. Encourage the child to speak about this or her worries. Do not nag or punish the child for this habit. This creates additional stress and tension.
- The child should be praised for well-kept hand by trimming the nails periodically so as to break the habit of nail biting. This will boost their self-confidence.
- Reassure the child with love and affection.
- Help the child to become aware of this habit and discuss about the ways and means to break the habit.
- The child's hand to be kept busy with creative activities or play.
- The causes for nail biting to be identified by the parents with the help of clinical psychologist and steps to be taken to remove the habit.
- Parents need reassurance and assistance to accept the situation and to help the child to overcome the problem.
- In case if all these measures are ineffective, then behavioral therapy is helpful. Habit reversal training, which seeks to unlearn habit of nail biting and possibly replace it with more constructive habit, has proven to be effective. In addition to this, stimulus control therapy is used to both identify and then eliminate the stimulus that triggers biting urge can be recommended.

Tourette Syndrome

Tourette syndrome is a common genetic neurological disorder characterized by chronic motor and vocal tics beginning before adulthood. Affected individuals typically have repetitive, stereotyped movements or vocalizations, such as blinking, sniffing, facial movements, or tensing of the abdominal musculature.

Signs and Symptoms

Tics, i.e., sudden, rapid, recurrent, nonrhythmic, stereotyped abnormal movements or vocalizations that are diverse, can be classified as either motor or vocal/phonic and simple or complex (Table 26.2).

Diagnosis

The specific DSM-5 criteria for Tourette's disorder are as follows:

Both multiple motor and one or more vocal tics have been present at some time during the illness, though not necessarily concurrently.

- The tics may increase or decrease in frequency but have persisted for more than 1 year since first tic onset
- The onset is before age 18 years
- The disturbance is not due to the direct physiologic effects of a substance (e.g., cocaine) or a general medical condition (e.g., Huntington disease or postviral encephalitis)

Table 26.2: Simple and complex tics

Simple tics	Complex tics
Simple motor tics involve a single muscle or group of muscles. e.g., Eye blinking, nose sniffing, coughing, neck twitching or jerking, eye rolling, and jerking or postured movements of the extremities.	Complex motor tics involve movements that often involve multiple muscle groups and may appear as semipurposeful movements or behaviors. e.g., Touching oneself or others, hitting, jumping, or shaking.
Simple phonic tics are simple vocalizations or sounds. Examples include grunting, coughing, throat clearing, swallowing, blowing, or sucking sounds.	Complex phonic tics are vocalizations of words and/or complex phrases. These verbalizations can be complex and sometimes socially inappropriate.

Management

Treatments for tics include:

- Dopamine D2 receptor antagonist therapy
- Dopamine agonist therapy
- Habit reversal therapy

Patient education is very important for individuals with Tourette syndrome. Counseling and support including cognitive behavioral therapy and social skills training should also be considered.

Elimination Disorders

Enuresis

Generally, the children can be trained for toilet training by 18 months of age slowly and calmly. Before the toilet training, the child should be assessed for readiness, especially motor and cognitive development, i.e., ability to walk independently, pick up the small objects by pincer grasp, take off the clothes and ability to follow the instructions. The children develop full bladder control by 4–5 years.

Definition

The bedwetting or urinary incontinence occurring beyond the age of 4 years at daytime and 6 years at night-time or loss of continence after at least 3 months of dryness is called enuresis. It is common in 3–10% of school children. Bedwetting at night is known as nocturnal enuresis.

Etiology

- **Physiological causes:** Anatomical defect of urinary tract and bladder, urinary tract infection, diabetes insipidus, small bladder capacity, spina bifida, neurogenic bladder, juvenile diabetes mellitus, seizure disorders, etc.
- **Neurological causes:** Delay in the nervous system ability to receive the signals from distended bladder to empty it especially in deep sleep.
- **Genetic causes:** Bedwetting is associated with strong genetic component of chromosomes 13q and 12q.
- **Emotional factors:** Sibling rivalry, emotional deprivation due to insecurity, parental death and emotional conflict
- **Environmental factors:** Cool climate, dark passage to toilet, fear of toilets or toilet at a distance from bedroom.
- **Improper toilet training:** The age at which toilet training is started has an important impact on child. If toilet training is started very early, it produces stress to the child.

Types

Primary enuresis: It is characterized by repeated (twice a week for at least three consecutive months) passage of urine into clothes/bed or who has never been dry in night more than 5 years of child. It is mainly due to organic causes.
Secondary enuresis: The child is dry for several months and again starts bedwetting at night. In such cases, look for underlying causes of emotional deprivation, parent-child maladjustment and too early toilet training, etc.

Management

Management of enuresis depends upon the specific cause. Assessment of exact cause is very essential through history, clinical examination and other investigations.
Nonpharmacological management: It consists of behavior modification, bladder strengthening exercises and alarm systems.

- **Behavior modification:** The child should not be given liquids in late night and asked to urinate before going to sleep. The child should be fully aroused after 2–3 hours of sleep and instruct to void fully.
- **Bladder exercises:** (1) Hold urine as long as possible during the day. (2) Practice repeated starting and stopping the stream of urine. (3) Practice getting up from bed and going to the bath room at bedtime before sleep. The practice during daytime increase holding time of the urine and delaying voiding for some time.
- **Condition therapy:** The electric alarm bell mattress is an effective and safest method, where the child wakes up as soon as the bed is wet.

Medications: Drug therapy with tricyclic antidepressants (imipramine/amitriptyline/nortriptyline) is given orally at night for 2 months.

Parental Counseling

- Reassure the parents that condition is self-limiting.
- Ask them to maintain a diary record of dry nights, reward the child for such nights.
- Ensure the child emotions support, not to criticize and changing the bedsheets without the child's notice.
- The parents should be explained about the factors related to bedwetting. They should not scold, threaten or punish the child. Punishment and criticism may lead to embarrassment and frustration in the child.

- The child needs reassurance and support from the parents
  - Restrict fluid intake after dinner for the child.
  - Motivate the child to void before bedtime.
  - The child should be fully wakened up by the parent and made aware of passing of urine at night once or twice, 3–4 hours later.
  - Make environmental modification like having a dim light in the passage to toilet to alleviate the fear of darkness in the child, etc.

Encopresis

Encopresis, also known as paradoxical diarrhea, is voluntary or involuntary fecal soiling in children in inappropriate places after the age of 5 years, after the bowel control is normally achieved. The age at which a child achieves bowel control varies between 3 and 4 years of age. The estimated prevalence of encopresis is 4 years children between 1% and 3% and common in males than females.

Causes

In majority of cases, it develops as a result of chronic constipation. In most children, with encopresis, the problem begins with painful passage of large, hard constipated stool. Over the time, the child becomes reluctant to pass stool or holds stool to avoid pain. This holding in of stool becomes a habit. As more stool collects in the child's lower intestine, the colon stretches gradually. As the colon stretches more and more, the child loses the natural urge to pass stool. Eventually, the partly formed soft stool from high up in the intestine, leaks around the large collection of hard stools at the bottom of the rectum and then leaks out of the anus. As time goes on, the child is less and less able to hold the stool in, more and more stool leaks and then the child starts passing entire stool in his/her underwear. Often the child is not aware that he or she has passed a bowel movement.

Associated Factors

It is more serious form of emotional disturbances due to unconscious anger, stress, and anxiety. It can be primary or secondary like bedwetting. Associated problems are chronic constipation, parental overconcern, overaggressive toilet training, toilet fear, attention deficit disorders; poor school attendance and learning difficulties may be found with encopresis.

Management

- Assessment includes history of bowel training, use of toilets and associated problems.
- The child needs help in establishment of regular bowel habit, bowel training, dietary intake of roughage and intake of adequate fluid.
- The child should be made to sit into toilet for 5–10 minutes after breakfast as well as after dinner every day.
- Provide appropriate positive reinforcement for developing regular toilet habits.
- Parental support, reassurance and help from psychologist for counseling of child and parents may be essential in persistent problems.
- The behavior therapy of encopresis focuses on:
  - Empty the colon of stool
  - Establish regular, soft, and painless bowel movement
  - Promote regular habits
  - Behavior therapy for modification of child's behavior

Speech Disorders

Stuttering (Disfluency)

It is characterized by difficulty in pronouncing the initial consonants or spasmodic repetition of same syllables. The common age of occurrence is 2–5 years.

Causes

The causes can be genetic factors, stress, tension or altered family dynamics.

Management

Reassure the parents for the self-regression of the problem if not caused by genetics. The child should not be teased or reproached when he is stuttering. They should be asked to recite a poem and ask to read loudly. The fluency of speech improves if they are made to practice. In younger children, stuttering disappears by about 6 years but older children need emotional support and referral to speech therapist.

Learning Disorder

Learning disability is a neurological disorder. It includes several areas of functioning in which a person has difficulty learning in a typical manner, usually caused by unknown factors that affect the brain ability to receive and process information. These problems interfere with learning basic skills such as reading, writing or calculating. They can also interfere with higher level skills such as organization, time planning, abstract reasoning, long- and short-term memory and attention. Learning disabilities can affect an individual's life beyond academics and can have an impact on relationships with family, friends and at workplace.

Definition

Learning disability refers to a group of disorders that affect a broad range of academic and functional skills including the ability to speak, listen, read, write, spell, reason and organize information.

Causes

The causes for learning disabilities are not well understood, and sometimes there is no apparent cause for a learning disability. However, some causes of neurological impairment include:

- Hereditary and genes: Parents with similar disorders
- Problems during pregnancy and child birth: Anomalies in brain, illness or injury, exposure to drugs or alcohol, low birth weight, oxygen deprivation, premature or prolonged labor.
- Accidents after birth: Head injuries, malnutrition, toxic exposure to heavy metals.

Types

Learning disabilities can be categorized based on the specific difficulties caused by a processing deficit. These include:

- **Dyslexia:** It is a language-based disability in which a person has difficulty in understanding written words. It is also known as reading disability or reading disorder.
- **Dyscalculia:** It is a mathematical disability in which a child has difficulty in solving arithmetic problems and grasping concepts in mathematics.
- **Dysgraphia:** It is a writing disability in which child finds it hard to form letters or write within a defined space resulting in illegibility.
- **Auditory and visual processing disorders:** It includes sensory disabilities in which a person has difficulty in understanding language despite normal hearing and vision.
- **Nonverbal learning disabilities:** It refers to a neurological disorder which originates in the right hemisphere of the brain causing problems with visual-spatial, intuitive, organizational, evaluative and holistic processing functions.

Management

Interventions for learning disorders include:

- Assess the exact nature of the problem by using specific psychological tests.
- Address the emotional and self-esteem issues of the child.
- **Mastery model:** The learners work at their own level of mastery. They practice till they gain fundamental skill before moving to the next level. This approach has to be adopted outside the school system.
- **Direct instruction:** Rapid paced interaction between the teacher and student, the students should be grouped based on their achievement level, frequent assessment need to be done.
- **Classroom modification:** Special seating arrangements, modified form of assignments to be given, quiet environment without distractions.
- **Special education:** Enrollment in special schools for learning disabled children, individual educational plan, and educational therapy.
- Teachers may allow students to demonstrate learning through alternate forms of assessment.
- Use of technology like internet, video, etc., to assist them in achieving academic success.

Eating Disorders

Common eating disorders include pica, anorexia nervosa and bulimia nervosa.

Pica

Pica is a pattern of eating nonfood materials (such as dirt or paper), seen in young children between 1 and 6 years of age. Children with pica may eat animal feces, clay, dirt, hairballs, ice, paint, sand. This pattern of eating should last at least 1 month to fit the diagnosis of pica.

Pica can occur in people with malnutrition, the health care provider should test blood levels of iron and zinc. Blood tests can also be done to test for anemia. Lead levels should always be checked in children who may have eaten paint or objects covered in lead-paint dust to screen for lead poisoning.

Treatment

Assess and manage malnutrition if any, or other medical problems, such as lead exposure. Treatment involves behavioral, environmental, and family educational approaches. Other therapies can be mild aversion therapy which includes punishing for eating nonedible items followed by positive reinforcement for eating the right foods.

Prognosis

The disorder may last several months, then disappears on its own. In some cases, it may continue into the teen years or adulthood, especially when it occurs with developmental disorders.

Complications

Pica may lead to bezoar (a mass of undigestible material trapped inside the body, usually in the stomach), infection, intestinal obstruction, lead poisoning, and malnutrition.

Anorexia Nervosa

Anorexia nervosa is a severe eating disorder related to distorted body image that leads to restricted eating or excessive exercise that prevents a person from maintaining a healthy weight.

Causes

Anorexia nervosa usually begins as dieting or increased exercising for health or fitness, but then progresses to extreme and unhealthy weight loss. Genetic factors may play a role in increasing the risk for anorexia nervosa. It may also be related to other mental health problems, such as anxiety disorders or affective disorders.

Types

There are two subgroups of anorexic behavior:

1. **Restrictor type:** An individual severely limits the intake of food, especially carbohydrates and fat-containing foods.
2. **Bulimia (also called binge-eating or purging type):** An individual eats in binges and then induces vomiting and/or takes large amounts of laxatives or other cathartics.

Symptoms

The following are the most common physical symptoms associated with anorexia nervosa that result from starvation and malnutrition:

- Pale, dry skin, dehydration
- Abdominal pain
- Constipation
- Lethargy, dizziness, fatigue
- Intolerance to cold temperatures
- Amenorrhea

People with anorexia may also be socially withdrawn, irritable, moody, and depressed.

Diagnosis

Diagnosis of anorexia nervosa involves history taking and physical examination. Blood work needs to be done to assess malnutrition. Other tests may include X-rays and evaluation for any underlying psychological disorder.

Complications

- **Cardiovascular:** Arrhythmias, hypotension, electrolyte abnormalities.
- **Hematological:** Anemia, leukopenia.
- **Gastrointestinal:** Reduced gastric motility.
- **Renal:** Limited fluid intake can cause dehydration and highly concentrated urine.
- **Endocrine:** In females, amenorrhea is one of the hallmark symptoms of anorexia.
- **Skeletal:** Anorexic person has a greater likelihood of decreased bone mineral density and increased fracture risk exists.

Management

Eating disorders can be effectively treated, if they are detected at initial stages itself. If treatment is initiated, majority of the clients recover, although it takes months and years for complete recovery.

The management or treatment of anorexia nervosa follows a multidisciplinary team approach including psychiatrists, clinical psychologists, physicians, dieticians or nutritional advisors, psychiatric social workers, occupational therapist and nurses work together and formulate the line of treatment.

Goals of management for anorexia nervosa are as follows:

- Restoring the child to a healthy weight
- Treating the psychological disorders related to the illness
- Reducing or eliminating behaviors or thoughts that originally led to the disordered eating.

Hence, the treatment focuses on dietary education and nutritional advice, psychological interventions and treatment of concurrent mental ailments like depression and anxiety disorders, and restrictions on dieting and over exercise.

Nursing Management of Child with Behavioral Disorder

Assessment

- Assess the child for various signs and symptoms like bedwetting, encopresis, short attention span, speech problems, etc.
- Elicit history from parents/caregivers about duration, any aggravating factors, any family history.
- Perform physical examination to assess for any physical anomalies, malnutrition or infection.

Nursing Diagnoses

- Risk for injury
- Ineffective role performance
- Impaired social interaction
- Compromised family coping

Nursing Interventions

- Assess the need for health education among caregivers.
- Teach parents problem-solving techniques involving—identifying the problem, exploring all possible solutions, choosing and implementing one of the alternatives, and evaluating the results.
- Identify the factors that aggravate and alleviate the child's performance.
- Focus on child's strengths as well as problems.
- Teach age-appropriate social skills.
- Provide a safe environment.
- Give the child a positive feedback for accomplishing the task successfully.
- Set limits for unacceptable behavior.
- Provide consistency with client's treatment plan.
- Teach accurate administration of medication and possible side effects.
- Counsel the parents.
- Refer parents to specialists, support groups.

Psychiatric Disorders

Common psychiatric disorders in children include disruptive behavioral disorders, attention-deficit/hyperactivity disorder (ADHD), school phobia, childhood schizophrenia, and autism.

Disruptive Behavioral Disorders

Disruptive behavior disorders in children include two types: (1) oppositional defiant disorder (ODD) and (2) conduct disorder (CD). They are often first noticed when they begin to interfere with school activities or family and friend relationships.

Causes

Risk factors for disruptive behavioral disorders may include a family member with ADHD/ODD, depression or an anxiety disorder and environmental factors like stress in the home (divorce, abuse, or conflicts within the family). The disorders may occur along with other conditions such as ADHD.

Symptoms

Children with ODD are short tempered, have temper tantrums, are physically aggressive, argumentative, defiant, disobedient, steal and behave in other ways to show their hostility to authority figures. They tend to struggle in school and may have legal problems later in life. If symptoms worsen and become more extreme, the child is defined as having a Conduct disorder.

Children with CD have a repetitive and persistent pattern of behavior which violates the rights of others. They are seriously aggressive, destroy property, steal, run away from home, miss school, and behave as a delinquent.

Treatment

Treatment involves parent training at home and behavioral support in the school.

Parents specialized strategies including positive attending, ignoring, the effective use of rewards and punishments, token economies, and time out to address clinically significant behavior problems. School interventions include (1) clear, consistent consequences for inappropriate behaviors; (2) positive contingencies for appropriate behaviors; and (3) effectively managing anger or aggressive behavior.

Juvenile Delinquency

The Children Act, 1960 in India defines delinquent as "a child who has committed an offense". The Juvenile refers to a boy who has not attained the age of 16 years and a girl who has not attained the age of 18 years. It is increasing in India, during the past 2 or 3 decades due to changes in the cultural pattern of the people, urbanization, and industrialization. The highest incidence is found in children aged 15 years and above. The incidence among boys is 4–5 times more than among girls.

Definition

Delinquency is criminal and other deviant behavior committed by children and adolescents who are not yet considered adults.

Etiology

The causes for juvenile delinquency are:

- **Biological causes:** Children with minimal brain dysfunction, physical defects (mental retardation), glandular imbalance and chromosomal anomalies.
- **Psychosocial causes:** Family dispute, broken homes, death of parents, separation of parents, poverty, peer influence, problem in schools and education system, alcoholism, parental neglect, ignorance about child care, too many children result in lack of development of emotions and attachment.
- **Others:** absence of recreation facilities, urbanization, industrialization, cinemas and TV, slum dwelling.

Management

- **Team approach:** The family members have the primary responsibilities. The other members are social workers, psychologists, psychiatrists, pediatricians and police should be educated for adjustment in society and rehabilitation.
- **Improvement of family life:** A well-adjusted family can stem the tide of delinquency. Parents should be prepared for parenthood; the needs of children should be appreciated and met.
- **Schooling:** The school comes next to home in the community in ordering the behavior of children. There should be a healthy teacher-pupil relationship and teacher can play an important part by detecting early signs of maladjustment and conflict resolution.
- **Social welfare services:** These comprise recreation facilities, parent counseling, child guidance, educational facilities, and adequate general health services.

Juvenile Justice Act (2000) provides a comprehensive scheme for care, protection, treatment, development and rehabilitation of delinquent juveniles.

Attention-Deficit/Hyperactivity Disorder

Definition

Attention-deficit/hyperactivity disorder is one of the common behavioral disorders of school age children. ADHD includes the combination of problems such as difficulty in sustaining attention, hyperactivity and impulsive behaviors.

Etiology

The exact cause is unknown. Multiple factors may trigger the ADHD like genetic predisposition, problems with central nervous system at key moments in development. The risk factors are:

- Exposure to environmental toxins—such as lead, found mainly in paint and pipes in older buildings.
- Maternal drug, alcohol use or smoking during pregnancy.
- Maternal exposure to environmental poisons—polychlorinated biphenyls (PCBs)—during pregnancy.
- Premature birth.

Signs and Symptoms

It is noticeable as early as 2–3 years of age. ADHD occurs more often in males than in females and behaviors can be different in boys and girls. For example, boys may be more hyperactive and girls may tend to be quietly inattentive.

Diagnostic Criteria

Diagnosis can be confirmed by the history collection and interview with family members or class teachers to know evidence of clinically significant impairment in social, academic or occupational functioning in last 6 months. The child must meet criteria according to the DSM-5 to diagnose of ADHD, the child must have *six or more* core signs and symptoms from one or both of the two categories as given in Table 26.3.

Management

The management of ADHD requires different modalities of treatment including medications, educational interventions and psychotherapy. The management requires a team approach of parents, school teacher, psychologist, nurse and pediatrician for positive outcome.

Table 26.3: Diagnostic criteria for attention-deficit/hyperactivity disorder

Category 1: Inattention	Category 2: Hyperactivity/ Impulsivity
1. Often fails to give close attention to detail or makes careless mistakes in school work or other activities. 2. Often has difficulty sustaining attention in tasks or play activities. 3. Often does not seem to listen when spoken to directly. 4. Often does not follow instructions, and fails to finish school work, chores or duties in the work place (not because of oppositional behavior or failure to understand the instructions). 5. Often has difficulty organizing tasks and activities. 6. Often avoids, dislikes, or is reluctant of engage in task that require sustained mental effort (such as school work or homework). 7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools). 8. Often easily distracted by extraneous stimuli. 9. Often forgetful in daily activities.	**Hyperactivity** 1. Often fidgets with hand or feet or squirms in seat. 2. Often leaves seat in classroom or in other situations in which remained seated is expected. 3. Often runs about or climbs excessively in situations in which it is inappropriate 4. Often has difficulty playing or engaging in leisure activity quickly. 5. Often "on the go" or often acts as if "driven by a motor". 6. Often talks excessively. **Impulsivity** 7. Often blurts out answers before question have been complete. 8. Often has difficulty awaiting turn. 9. Often interrupts or intrudes on others (e.g., butts into conversations or games)

Medications: The psychostimulant drugs are the most commonly prescribed medications for ADHD. Examples: Methylphenidate (Ritalin) and dextroamphetamine (Dexedrine).

Psychotherapy and counseling: The psychotherapy may be provided by a psychiatrist, psychologist, social worker or other mental health care professional. Some children with ADHD may also have other conditions such as anxiety disorder or depression. In these cases, counseling may help both ADHD and the coexisting problem. The examples of therapy include:

- **Psychological therapy:** It is aimed to letting the ADHD children learn to use and accept themselves despite their disorder, understand their strengths and weakness.
- **Behavior therapy:** This form of therapy helps the child or caregiver to increase the appropriate behavior and decrease the inappropriate behavior.
- **Cognitive behavioral therapy:** It is designed to make a child rethink and resume the thoughts and feeling on initiating behavior change.
- **Biofeedback:** Children are taught how to control emotions, decrease the tension, anxiety and stress.
- **Parenting skills training:** It can help parents to develop ways to understand and guide their child's behavior. The family therapy helps to relieve the stress and promoting the appropriate behavior.
- **Social skills training:** This can help children learn appropriate social behavior. Inform and work with the class teacher to support their efforts in the classroom.

Interventions for caregivers to reduce problems and complications of ADHD:

- Be consistent, set limits and have clear consequences for the child behavior.
- Put together a daily routine for the child with clear expectations that includes bedtime, morning time, mealtime, simple chores and TV.
- Avoid multitasking the self when talking with the child, make eye contact when giving instructions and set aside a few minutes every day to praise the child.
- Work with teachers and caregivers to identify the problems early, to decrease the impact of the conditions on the child's life.

School Phobia or School Refusal

School phobia is persistent and abnormal fear of going to school. The child refuses to attend the school due to emotional distress. It is common in all social groups. It is an emotional disorder in children who are afraid to leave the parents, especially mother, and prefer to remain at home and refuse to go to school absolutely. It is a symptom of crisis situation

of developmental stages and cry for help which needs special attention.

Causes

- Separation anxiety—maternal separation
- Familial relationships—overindulgent, overprotective and dominant mother, disinterested father
- Uncongenial school environment—poor teacher-student relationship, response to bullying and peer rejection
- Seeking attention from significant people outside the school
- Anxiety about academic achievement—fear of examinations, presentations
- Learning difficulties
- Shyness or social phobia

The child may complain of recurrent physical complaints like abdominal pain, headaches, etc., which subside, if the child is allowed to remain at home.

Management

- The most important aspect to manage this problem is family counseling to resolve the anxiety related to maternal separation.
- The problem can be managed by habit formation for regular school attendance by positive reinforcement through rewards.
- Encourage the child to actively take part in play session.
- Motivate the child to involve with peer groups during recreational activities at school.
- Promoting or improvement of school environment.
- Assessment of health status of the child to detect any health problems.

Childhood Schizophrenia

In adults, schizophrenia is characterized by an acute psychotic episode. In children, it appears gradually. Diagnosis is the same as for adults except that symptoms appear before the age of 12 instead of the late teens/early 20s. Approximately 50% of children suffering from childhood-onset schizophrenia have at least one first-degree relative with schizophrenia.

Definition

Childhood schizophrenia is a severe brain disorder in which children interpret reality abnormally. Schizophrenia involves a range of problems with thinking (cognitive), behavior or emotions.

Causes

- Unknown—still under investigation
- Neurobiological disorder
- Genetic predisposition
- Environmental factors
- Problems with neurotransmitters
- Difference in brain structure—significant loss of gray matter over time

Risk Factors

- Family history of schizophrenia
- Exposure to viruses, toxins or malnutrition while in the womb
- Prenatal injury to the brain, viral infections, starvation, lack of oxygen at birth, and untreated blood type incompatibility
- Abnormal activation of the immune system
- Older age of the father
- Taking psychoactive drugs during teen years

Clinical Features

Childhood-onset schizophrenia is often confused with autism because many symptoms overlap. It is distinguished from autism by presence of delusions and hallucinations for at least 6 months and a later age of onset, 7 years or older (Autism is usually diagnosed by age 3). Teens may be less likely to have delusions and more likely to have visual hallucinations. The symptoms are listed in Table 26.4.

Diagnosis

- Child's medical and psychiatric history
- Conduct a physical examination
- Medical and psychological screenings
- Review school records
- Blood tests, imaging studies, such as MRI or CT scan
- Electroencephalogram (EEG)

Psychological evaluation or assessment:

- Done by a professional specifically trained and skilled at evaluating, treating, and diagnosing children and adolescence with mental disorders. Observe appearance and demeanor. Ask about thoughts, feelings, and behavior patterns. Talk to child about any thoughts of self-harm or harming others. Evaluate the ability to think and function

Table 26.4: Symptoms of schizophrenia

Early signs and symptoms	Late signs and symptoms	Signs and symptoms in teens
• Language delays • Late or unusual crawling • Late walking • Other abnormal motor behavior	• Hallucinations • Delusions • Disorganized thinking or speech • Disorganized or abnormal motor behavior • Negative symptoms	• Withdrawal from friends and family • A drop in performance at school • Trouble sleeping • Irritability or depressed mood • Lack of motivation • Strange behavior

at an age-appropriate level. Assessing mood, anxiety and possible psychotic symptoms.
- It is important for parents/guardians to keep a record of their child's behavior, symptoms, and reports from school personnel.

Diagnostic criteria:

DSM-5 diagnostic criteria for schizophrenia require at least *two* of the following five symptoms to be present for a month. At least one of these must be (1), (2), or (3):

1. Delusions
2. Hallucinations
3. Disorganized speech
4. Grossly disorganized or catatonic behavior
5. Negative symptoms

Treatment

- The child with schizophrenia requires multimodal care. This includes social skills training, a supportive environment, and a structured individualized special education program.
- There is no cure for schizophrenia; however, symptoms are manageable with treatment. Two common antipsychotic medications prescribed are: (1) olanzapine (Zyprexa) and (2) clozapine (Clozaril).
- Individual and family therapy: It is important to talk to the child as well as the siblings after the diagnosis is made. It is important for the parent/guardian to have a good understanding of the disease before they can openly address their children's questions and fears.
- Social and academic skills training
- Hospitalization in acute conditions
- Lifestyle and home remedies

Complications

- Poor performance or inability to attend school or work
- Inability to perform daily activities, such as bathing or dressing
- Withdrawal from friends and family, suicide, self-injury
- Anxiety and phobias, depression
- Abuse of alcohol, drugs or prescription medications
- Poverty
- Homelessness
- Family conflicts
- Inability to live independently
- Health problems
- Being a victim of aggressive behavior
- Aggressive behavior

Autism

Autism spectrum disorder (ASD) manifests in early childhood and is characterized by qualitative abnormalities in social interactions, markedly aberrant communication skills, and restricted repetitive behaviors, interests, and activities. ASD is the broad current designation for a group of conditions characterized by autism. It includes:

- Autism: It refers to problems with social interactions, communication, and imaginative play in children younger than 3 years.
- Pervasive developmental disorder had been used to describe disorders including ASD and conditions with some traits characteristic of autism.
- Asperger syndrome refers to high-functioning individuals with ASD; these are people who have normal or superior intellectual abilities. People with Asperger syndrome may lack the communication abnormalities characteristic of ASD.
- Childhood disintegrative disorder. These children develop normally for at least 2 years and then lose some or most of their communication and social skills.

Signs and Symptoms (Fig. 26.1)

- Developmental regression
- Absence of protodeclarative pointing, i.e., use of the index finger to indicate an item of interest to another person
- Abnormal reactions to environmental stimuli
- Abnormal social interactions
- Absence of smiling when greeted by parents and other familiar people
- Absence of typical responses to pain and physical injury
- Language delays and deviations
- Susceptibility to infections and febrile illnesses
- Absence of symbolic play
- Repetitive and stereotyped behavior

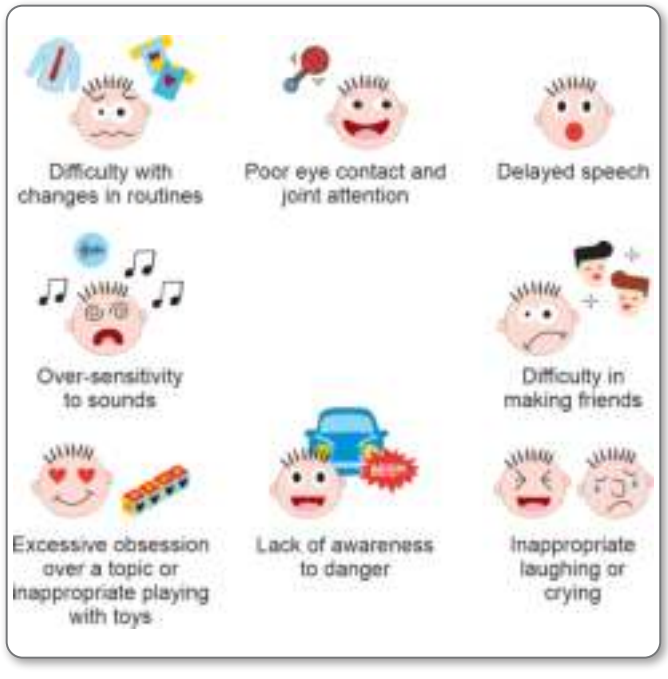

Figure 26.1: Early signs of autism

It is important to do regular screening of infants and toddlers for sign and symptoms of autistic disorder so that early referral of patients for further evaluation and treatment can be done. Siblings of children with autism are also at risk for developing autism. Therefore, they should also undergo screening for autism-related symptoms, language delays, learning difficulties, social problems, and anxiety or depressive symptoms.

Diagnosis

Examination of children with suspected ASD may include the following findings:

- Abnormal motor movements (clumsiness, hand flapping, tics)
- Dermatologic anomalies (aberrant palmar creases)
- Abnormal head circumference (small at birth, increased from age 6 months to 2 years, normal in adolescence)
- Orofacial, extremity, and head/trunk stereotypies (purposeless, repetitive, patterned motions, postures, and sounds)
- Self-injurious behaviors (picking at the skin, self-biting, head punching/slapping)
- Physical abuse inflicted by others (parents, teachers)
- Sexual abuse: bruises in genitals

Diagnostic criteria:

Autism spectrum disorder is characterized by the following:

- Deficits in social communication and social interaction
- Restricted repetitive behaviors, interests, and activities.

These symptoms are present from early childhood and limit or impair everyday functioning. Both components are required for diagnosis of ASD.

Studies that may be helpful in the evaluation of autistic disorder include the following:

- **EEG:** To exclude seizure disorder.
- **Psychophysiologic assessment:** To show lack of response habituation to repeatedly presented stimuli (in respiratory period, electrodermal activity, vasoconstrictive peripheral pulse amplitude response); auditory overselectivity may be seen.
- **Polysomnography:** To identify sleep disorders and to demonstrate seizure discharges.

Management

Nonpharmacologic therapy: It includes:

- Intensive individual special education
- Speech, behavioral, occupational, and physical therapies (e.g., assisted communication, auditory integration training, sensory integration therapy, exercise/physical therapy).
- **Social skills training:** A specialist teaches children with autism how to be effective in communicating and better at socializing. Some examples of skills targeted in social skill training programs include:
  - Initiating conversations, greetings
  - Appropriate eye contact
  - How to behave in specific social and community settings
  - Understanding emotions and facial expressions
  - Gestures and body language
  - Assertiveness
  - Empathy

Medical management: Drugs may be effective in treating associated behavioral problems and comorbid disorders (e.g., self-injurious behaviors, movement disorders). Example:

- Second-generation antipsychotics (e.g., risperidone, aripiprazole, ziprasidone)
- SSRI antidepressants (e.g., fluoxetine, citalopram, escitalopram)
- Stimulants (e.g., methylphenidate)

Miscellaneous Disorders

Infantile or Evening Colic

It is characterized by intermittent episodes of abdominal pain and accompanied with severe cries for more than 3 hours/day; for more than 3 days/week; and for more than 3 weeks. It commonly occurs in the afternoon and evening in infants younger than 3 months of age.

Etiology

The exact cause is not known. It may be because of cow's milk intolerance, overfeeding, immaturity of intestine, and aerophagia.

Signs and Symptoms

- The sudden loud cry and may last for more than 3 hours mostly in late afternoon and evening.
- Stereotypically, the paroxysms of colic start within few weeks of after birth, reach peak by 4–6 weeks and subside by 3–4 months.
- Face becomes red and legs drawn up on the abdomen.
- Colic ends after the passage of flatus or feces.

Management

During the episode, hold the child erect or prone in the lap of the parents. There is not much use of carminatives, suppositories or enema. Avoid drugs to reduce intestinal motility. If the cry persists, give mild sedation.

Calm the parents and counsel for exclusive breastfeeding. Explain about correct feeding techniques, practice of proper burping and place the child for about half an hour on right lateral position after feeding. Avoid bottle feeding and allergic foods.

The nurse should try to reassure the anxious parents and clear their doubts regarding child rearing. The infants should

be nurtured in emotionally stable environment and avoid undue attention. Reduce the parental anxiety, encourage the parents to attend counseling regarding nature of problem, lack of soothing and self-remission by about 4–6 months.

Temper Tantrum

Temper tantrum is a behavioral problem, where the child asserts their independence by violently objecting to discipline through display of anger at uncontrollable level. Temper tantrums are seen mainly in toddlers. The toddlers express their behavior by a sudden outburst or violent display of anger, frustration and bad temper as physical aggression or resistance such as rigid body, biting, kicking, throwing objects, hitting, crying, rolling on floor, screaming loudly, banging head, limbs, etc.

Temper tantrum occurs in children who are maladjusted. Their behavior is not directed toward the environment or any person or anything. It is normal in toddler age group children, but sometimes may continue to preschool period. It is found usually in boys, single child and pampered child.

Temper tantrum occurs when the child cannot integrate the internal impulses and the demands of reality. The child become frustrated and reacts in the only way he/she knows, i.e., by violent bodily activity and crying, using great deal of muscular activity and striking out against environment.

Causes

- Emotional insecurity
- Lack of sleep and fatigue
- Frustration
- Unmet needs
- Attention seeking

Management

- Educate the parents that temper tantrums are the way of child expressing frustration or an unmet need.
- Parent should be made aware about the cues or signs of temper tantrum and when the child loses control.
- Parent should divert the attention or provide alternate activity at that time.
- Do not make fun or tease the child about the unacceptable behavior.
- Parents should explain the child that the feeling angry is normal but controlling anger is an important aspect of growing up.
- The child should be protected from self-injury or from injuring others.
- Overindulgence should be avoided.
- After the temper tantrum is over the child's face and hands should be washed and play materials to be provided for diversion.
- The child's tension can be released by teaching the child to do exercise and physical activities.
- If temper tantrum continues, the child needs professional help from child guidance clinic.

Masturbation

It is characterized as stimulation of one's own genitals for derivation of pleasure. It is commonly seen in age groups of infants, toddlers, and adulthood. By 8 years, 10% of girls and 1/3rd of boys are reported to engage in this activity, increasing to 90% by adolescence.

Definition

It is self-stimulation of the genitals for pleasure and self-comfort. The children may rub themselves with a hand or object.

The compulsive, intense masturbation that interrupts other activities, and is an objectionable act that is publicly not acceptable as normal behavior and usually signals a disturbance in some aspect of the child's emotional life. The masturbation may also be the result of an experience of sexual abuse or an exposure to explicit sexual materials or events.

Management

- Preschoolers and children should be provided with nongenital tactile input such as rocking and holding. Try to change the environment where such activity occurs. Any underlying cause such as sexual exploitation should be identified.
- Children need counseling and suggestions that this behavior should be private. Punishment only solidifies this behavior.
- Parents should not worry until masturbation is compulsive or results in isolation of the child from healthy interpersonal relationships. In such situation, they need to take help from child psychiatrist.
- Parents should be counseled regarding normal nature of this type of behavior and it does not cause any physical or mental disturbance. Adolescents should be counseled that such activities do not cause physical or mental harm and they should not feel guilty about it.

Roles of Parents in Sex Education

The children are very curious by nature and very much observant about the change occurring in them. By 3 years, children are able to identify their gender and have various questions related to the sexuality. These questions may sometimes put parents in a difficult situation. It is utmost important for the parents to provide them with an accurate answer like accurate name for the various body parts, etc.

It is also very important to discuss about physical difference between the male and female and difference between the appropriate and inappropriate adult touch (good and bad touch). As the children grow, the parents should be cautious about their various activities and their peer group.

When the children reach adolescence, they are immature emotionally, but physically they are advanced for the age and are selfish and idealistic. Now parents should impact them appropriate knowledge about various pubertal changes. While discussing this issue they can also give knowledge about reproduction, pregnancy, sexually transmitted disease and prevention. Children who are involved in risky sexual behavior are also more likely to be involved in substance abuse and delinquent behavior. Parents are the first and most important teacher of children, children who are provided with warm, loving, satisfying role by the parent are shown to do better in academics and social life and are less likely to get involved in risky sexual behavior than their peers.

BASIC APPROACH TO CHILD WITH ANY BEHAVIORAL DISORDER

- **Background history:** Child's early development of the personality and behavior depends upon the environment in which he is raised. Children raised in emotionally supportive, caring and responsive environment are well adjusted. The type of family, school, community, and society has a lot of influence on the overall development of behavior. Hence, it is important to take a detailed history about the place, family, and society when dealing with children having behavior problem.
- **Assess severity:** It is important to find out day-to-day activity of the child and influence on day-to-day activity by this problem, it is also important to access severity of the problem.
- **Identify triggers:** In order to classify the severity of the problem, it is important to find out the events, nature, duration, frequency and situations that trigger the problem.
- **Increase appropriate behavior:** Interventions that are intended to increase the appropriate behavior use principles of reinforcement and intervention. The reinforcement techniques are social reinforcement (attention, praise), tangible reinforcement (material objects of personal value), and token economy.
- **Decrease inappropriate behavior:** Those used to decrease inappropriate behavior use the principle of punishment. The punishment techniques are extension, time out for positive reinforcement, response cost and overcorrection.
- **Skill development:** Children are helped to develop particular skills. The skill training is encouraged in prosocial activities of children such as sharing toys, waiting for turn, asking for helps. This helps the children for joining in group activities and resolving conflicts. The area of skill training is problem-solving skill, social skills and anger-coping skills.
- **Loving attitude:** Overall, children of growing age with behavior problems should be dealt with supportive, tender, and loving care. Caregiver or nurses should also be great listeners to understand to exact nature of their problems. Nurses should try to solve this problem and counsel the parents and family members, appropriately.
- **Parent management training:** Parents are taught to deal with the children having behavior problems using different techniques such as positive reinforcement for appropriate behavior, how to give effective commands and request and reinforce children compliance. They are also taught how to use response cost and time out techniques following noncompliance or inappropriate behavior.

NURSING RESPONSIBILITIES IN MANAGEMENT OF BEHAVIORAL PROBLEMS OF CHILDREN

Nurses play an important role in prevention, early identification, and management of behavioral problems in children.

- History taking to assess the specific problem and find out the cause of the problem.
- Informing the parents about the causes of problems of the particular child.
- Assisting the parents, teachers, and family members regarding environment modification at home, school, and community.
- Encouraging the child for behavior modification as needed.
- Promoting healthy emotional development of the child by adequate physical, psychological, and social support.
- Counseling children and the parents to solve the problems, whenever necessary and for tender loving care of the children.
- Collaborating with other members of health team along with pediatricians, psychologist, and social workers to manage problems of child.
- Referring the children to experts and support agencies like child guidance clinics.

Assess Yourself

1. Define bruxism, trichotillomania, pica, enuresis, and encopresis.
2. Explain the causes of behavioral disorders.
3. Write a short note on Conduct disorders.
4. Discuss the nursing management of a child with learning disability.

Chapter 27

Challenged Child

Chapter Outline

- Challenged (Handicapped) Children
- Child Abuse/Maltreatment/Battered Child Syndrome
- Welfare Services for Challenged Children in India
- Child Guidance Clinic

CHALLENGED (HANDICAPPED) CHILDREN

Handicapped child refers to any child who has a physical or mental impairment which substantially limits one or more of the major life activities of the child and reduces his capacity to fulfill a social role.

According to the WHO, the sequence of events leading to disability and handicap is as follows:

Disease → Impairment → Disability → Handicapped

Impairment refers to any loss or abnormality of psychological, physiological, or anatomical structure or function due to injury.

Disability is any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being.

A **handicap** is a disadvantage for a given individual, resulting from an impairment or a disability that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.

A handicap may result from impairment without the mediation of a state of disability (e.g., a disfigurement). On the other hand, someone with a serious disability may live a fairly normal life without being handicapped.

Etiology

Many of the causes of disability are preventable by providing expectant mothers with better prenatal and postnatal care as well as proper nutrition for infants and mothers. The main causes for disability in children are:

- Genetic factors and consanguineous marriages
- Communicable diseases
- Infections in the early childhood
- Early motherhood
- Nutritional deficiencies
- Insufficient or inaccessible health care services
- Inadequate sanitation

Classification

The handicapped children are classified as follows:

- Physical handicapped
- Mentally handicapped
- Socially handicapped

Physically Handicapped or Challenged Children

It can be grouped according to the affected parts of the body. They are orthopedically handicapped, sensory handicapped, neurologically handicapped and handicapped due to chronic systemic diseases. The Orthopedically handicapped children are those having congenital bony defect (clubfoot), bony defects following rickets, fracture, amputation due to accidental injury, arthritis, leprosy, etc. The Sensory handicapped children are having visual problems:

Partial or complete blindness, Auditory problems: Partial hearing loss, Deaf and dumb, Speech problems of Stammering and Dysphonia.

- **Blindness:** WHO has defined blindness as "visual acuity less than 3/60 (Snellen) or its equivalent" or "inability to count fingers in daylight at a distance of 3 meters". The causes fall in to three broad causative groups: (1) birth defects, (2) infections, and (3) accidents. The problems of the blind children are: unable to use hand as an organ for perception, difficulty in locomotion, behavioral problems, less physical activities, less social interaction and dependence on parents or caregivers. The management of blindness lies in use of mobility guides and aids and use of braille technology. Blindness can be prevented to a large extent through adequate prenatal, natal, postnatal services, screening, vitamin A prophylaxis, health education, precautions related to eye safety and genetic counseling.
- **Deafness:** Hearing loss, also known as hearing impairment, is a partial or total inability to hear. Disabling hearing loss refers to hearing loss greater than 30 dB in the better hearing ear in children. It may be congenital or acquired. The causes are: (1) congenital causes: Genetic factors, intrauterine infections like cytomegalovirus, herpes simplex, prematurity, maternal diabetes, toxemia during pregnancy, etc. and (2) acquired causes: Ear infections—otitis media, meningitis, measles, mumps, head injury and exposure to noise. Hearing loss impacts functional, social, economic, emotional loss and poor academic performance in children. The management focuses on helping the children to use hearing aids/devices—assistive listening devices, cochlear implants, lip reading, learning sign language, speech therapy, and use of written or printed text for communication.
- **Dumbness:** Mute is a term used to identify a person who cannot speak an oral language or have some degree of speaking disability. It also refers to an impairment of speech or sound production, fluency, voice or language which significantly affects child's educational performance or their social, emotional or vocational development. The cause of dumbness is similar to that of deafness. The speech impairment leads to lack or inadequate communication skill, less social interactions and relationships, behavioral problems in children as well as poor performance in academics. The management focuses on early identification of the problem, medical or surgical interventions for underlying causes, psychological counseling, speech therapy, and cognitive rehabilitation.
- **Orthopedically handicapped:** It includes impairments caused by disorders like clubfoot, poliomyelitis, bone tuberculosis, cerebral palsy, amputations, and fractures or burns which cause contractures. The locomotor disability leads to substantial restriction of the movement of the limbs. The management focuses on correction of deformities, physical therapy, occupational therapy, use of prosthetics, and devices for positioning and mobility like cane, walkers, crutches, wheel chairs or specialized equipment (Fig. 27.1).

Figure 27.1: Assistive devices for children

Management of Physically Handicapped Children

The required multidisciplinary approach mainly focuses on early diagnosis and treatment. The aim of management is to safeguard against or halt the progression of the disease process from impairment to disability and handicapped. Hence, the following approaches are used:

- Careful history, through physical examination and necessary investigations for detection.
- Regular medical supervision and earlier stage assessment help to identify the conditions.
- Treatment of particular conditions by medical or surgical management, e.g., cataract, otitis media, leprosy, accidental injury, rickets, and congenital anomalies.
- Correction of deformity, e.g., visual or hearing problems by spectacles or hearing aids.
- Physiotherapy and exercise to improve physical conditions.
- Occupational therapy according to child's ability.
- Speech therapy to improve communication.
- Use of prosthetics: provision of artificial limb in a child with amputated leg.
- Guidance and counseling to the parents and family members for continuation of care of the children with emotional, educational, and social support.
- Provide special training and education to children and their parents.
- Rehabilitation and support services, like pension, scholarship, and special allowances.
- Referral services (Government, NGOs) for assistance of aids and appliances.

Mentally Handicapped or Challenged Children

A mental handicap is an impairment in the individual's ability to function cognitively, emotionally or physically due to significantly impaired intellectual and adaptive functioning. The intellectual disability affects 2–3% of the general population and 75–90% of mentally challenged children have mild intellectual disability. It usually includes mental retardation, Down syndrome, and cerebral palsy.

Intellectual Disability (Mental Retardation)

There are four levels of intellectual disability (ID): (1) mild, (2) moderate, (3) severe, and (4) profound. Sometimes ID may be classified as "other" or "unspecified". ID involves both a low IQ and problems adjusting to everyday life. There may also be learning, speech, social, and physical disabilities. Almost all cases of ID are diagnosed by the time a child reaches 18 years of age.

Causes

The causes of ID include:

- Trauma before birth, such as an infection or exposure to alcohol, drugs, or other toxins
- Trauma during birth, such as oxygen deprivation or premature delivery
- Inherited disorders, such as phenylketonuria or Tay-Sachs disease
- Chromosome abnormalities—Down syndrome
- Lead or mercury poisoning
- Severe malnutrition or other dietary issues
- Early childhood illness, such as whooping cough, measles, or meningitis
- Severe brain injury.

Classification

The classification provides an idea of mentally retarded person functions in relation to his education, appropriate behavior and the degree of his independence. The level of MR can be calculated based on their intelligence quotient. The formula for IQ is:

$$IQ = (\text{Mental age}/\text{Chronological age}) \times 100.$$

Levels of ID: ID can be classified as mild, moderate, severe, and profound (Table 27.1).

Diagnosis

The detailed information from the parents is needed before making the diagnosis which includes:

- History collection of antenatal, intranatal, and postnatal period
- Assessment of developmental milestones
- Physical and neurological examination
- Administration of psychological test—Stanford-Binet Intelligence scale and Wechsler intelligence scale for children
- Biochemical tests to rule out the metabolic disorder
- Hearing and speech evaluation if needed.

Management

The assessment and management are undertaken by a team consisting of psychiatrist or physical medicine expert, psychologist and a special educationalist. The other team members are speech therapist, physiotherapist, occupational therapist, social worker, and vocational counselor. Broad areas of intervention are needed that allow for active participation from caregivers, community members, clinicians and children with ID. They are are as follows:

- **Psychosocial treatments:** They are intended primarily for children before and during the preschool years which is the optimum time for intervention. This early intervention includes encouragement of exploration, mentoring in basic skills, celebration of developmental advances, guided rehearsal and extension of newly acquired skills, etc.
- **Behavioral treatments:** They include language and social skills acquisition. One-to-one training is offered in which a therapist uses a shaping procedure in combination with positive reinforcements and to help the child pronounce syllables until words are completed.
- **Cognitive behavioral treatment:** It is a combination of the previous two treatment types, involve a learning technique that teaches children regarding language and other basic skills pertaining to memory and learning. The goal of the training is to teach the child to be a strategic thinker through making cognitive connections and plans.

Table 27.1: Levels of intellectual disability

Mild ID	Moderate ID	Severe ID	Profound ID
• Taking longer to learn to talk, but communicating well once they know how • Being fully independent in self-care when they get older • Having problems with reading and writing • Social immaturity • Inability to deal with the responsibilities of marriage or parenting • Benefiting from specialized education plans • Having an IQ range of 50–69	• Slow in understanding and using language • May have some difficulties with communication • Can learn basic reading, writing, and counting skills • Generally unable to live alone • Can often get around on their own to familiar places • Can take part in various types of social activities • Generally have an IQ range of 35–49	• Noticeable motor impairment • Severe damage to, or abnormal development of, their central nervous system • Generally have an IQ range of 20–34	• Inability to understand or comply with requests or instructions • Possible immobility • Incontinence • Very basic nonverbal communication • Inability to care for their own needs independently • The need of constant help and supervision • Having an IQ of <20

- **Family-oriented strategies:** They involve empowering the family with the skill set to support and encourage their children with an intellectual disability. Children are encouraged in home-based training and vocational training.
- **Drug therapy:** No specific drugs available. If required, neuroleptic drugs can be given to reduce aggressive and antisocial behavior, e.g., phenothiazone. If needed, antipsychotic and antidepressant drugs can be given.
- **At school:** Sensory training and perceptual knowledge is emphasized. Children are taught utilitarian tasks that will help them to be more independent. Child gains proficiency through drill and repetition over a period of years.

Role of Parents in Management of Mentally Challenged Children

- Early identification and seeking prompt treatment.
- Approach child guidance centers and special schools to provide perfect environment to help in development of the child.
- Accept the presence of deficits and help him/her to grow to the full potential that he or she is capable of.
- Parents and family members must provide a secure environment for the development of the abilities and interests of the child.
- Help child to socialize with family members, relatives, and friends.
- Provide love, care, and strength.

Socially Handicapped or Challenged Children

A "socially handicapped child" may be defined as "a child whose opportunities for a healthy personality development and a full unfolding of potentialities are hampered by certain elements in his/her social environment such as parental inadequacy, environmental deprivation (i.e., lack of stimulation of learning process), and emotional disturbances. The child who is physically or mentally handicapped also meets with social handicaps to the extent to which he is subjected to social rejection or misunderstanding and cannot make use of the normal value of social fulfillment. It includes orphans, neglected children, children of divorce/step parents, delinquent children, street children, and abused children.

Role of Nurse in Care of Challenged Children

- **Assessment:** Complete assessment of a handicapped child includes detailed history of the condition, thorough physical and neurological examination, specific investigations, review of developmental screening, assessment of parent-child interaction and family coping, socioeconomic status and available support facilities.
- Planning and providing care to the handicapped children especially physically and mentally handicapped in health care institutions and community.
- Assisting the family to strengthen effective relationship and bondage to prevent children from becoming socially handicapped.
- Creating awareness in the society about the prevention of handicaps, the abilities of the child with handicap conditions and the potentialities.
- Referring parents/caregivers to support groups and welfare agencies.
- Educating caregivers about their special needs like assistive devices or psychological needs and empowering them to manage their children successfully.
- Teaching about preventive aspects like genetic screening and counseling of at risk parents, immunization, appropriate antenatal and postnatal care, prevention of maternal and neonatal infections, birth injuries, asphyxia, hyperbilirubinemia, etc.

CHILD ABUSE/MALTREATMENT/BATTERED CHILD SYNDROME

According to World Report on Violence and Health, child abuse refers to all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust, or power (WHO). The risk factors are depicted in Figure 27.2.

Causes

- Caregiver's angry and uncontrolled disciplinary response to actual or perceived misconduct of the child

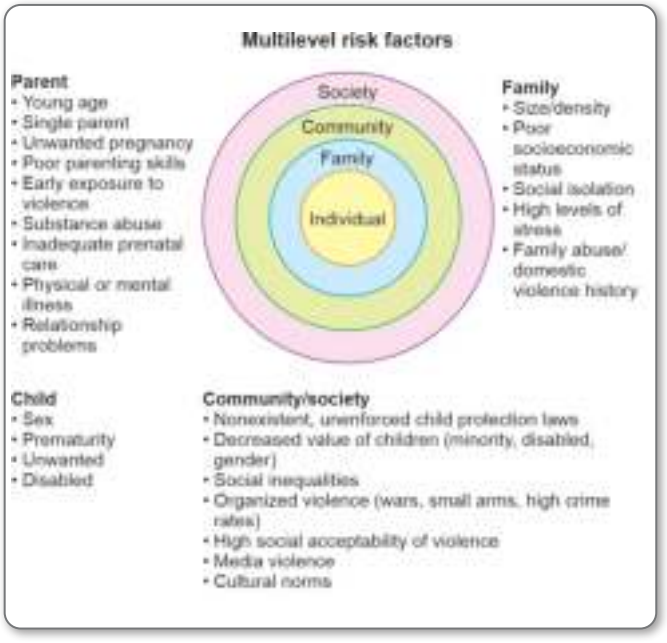

Figure 27.2: Risk factors of child abuse

- Caregiver's psychological impairment, which causes resentment and rejection of the child by the caregiver and a perception of the child as different and provocative.
- Child left in care of a baby-sitter who is abusive.
- Caregiver's use of substances that disinhibit behavior.
- Caregiver's entanglement in a domestic violence situation.

Categories of Child Abuse

Within the broad definition of child maltreatment, five subtypes are distinguished:

1. Physical abuse
2. Sexual abuse
3. Neglect and negligent treatment
4. Emotional abuse
5. Exploitation

Physical Abuse

Physical abuse of a child is that which results in actual or potential physical harm from an interaction or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power, or trust. There may be single or repeated incidents (WHO, 1999).

Types of Physical Abuse

- **Battered child syndrome:** A form of child abuse in which children are physically abused.
- **Shaken baby syndrome or "whiplash" syndrome:** A clinical constellation of findings classically described as subdural hematoma (SDH), retinal hemorrhage and skeletal fractures (metaphyseal fractures, posterior rib fractures) sustained while the child is shaken violently in a to-and-fro fashion. Shaking-impact syndrome is a syndrome where the child's head is impacted against a surface, either soft or hard. This can cause serious injuries such as blindness or eye damage, delay in normal development, seizures, damage to the spinal cord (paralysis), brain damage or death.
- **Munchausen syndrome by proxy:** It refers to illness that one person fabricates or induces in another person to gain attention from the medical staff. Characteristics are as follows:
  - Unexplained, prolonged, recurrent or rare illness in child
  - Discrepancies between clinical findings and history, illness unresponsive to treatment
  - Signs and symptoms occurring only in parent's presence
  - Parent has knowledgeable about illness, procedures, and treatment. Parent very interested in interacting with health team members. Parent is very attentive toward child and refuses to leave hospital
  - Family members with similar symptoms.

Signs and Symptoms of Physical Abuse

- Unusual and unexplained bone fractures. Any fracture in an infant who is too young to walk or crawl, evidence of fractures at the tip of long bones or spiral-type fractures that result from twisting, fractured ribs, especially in the back, Evidence of skull fracture (multiple fractures of different ages may be present).
- Bruise marks shaped like hands, fingers, or objects such as a belt, or unexplained bruises in areas where normal childhood activities would not usually result in bruising (Fig. 27.3). Multiple bruises of different ages, especially in unusual areas of the body (e.g., not the shins) or in patterns suggesting choking, twisting, or severe beating with objects or hands.
- Lash marks
- Burn marks from cigarettes electric stove, heater or other hot objects on hands, arms, buttocks, or genitals (Fig. 27.3).
- Specific patterns of scalding, seen when a child is immersed in hot water as a punishment—particularly "glove" or "sock" burn patterns.
- Black eyes in an infant or a similar, unexplained injury in a child. Bleeding in the back of the eye, seen with shaken baby syndrome or a direct blow to the head.
- Human bite marks, choke marks around neck.
- Unexplained abdominal injuries may be due to punching.
- Unexplained unconsciousness in infant, circular marks around wrists or ankles indicating twisting or tying up.

Child Sexual Abuse

- It is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed

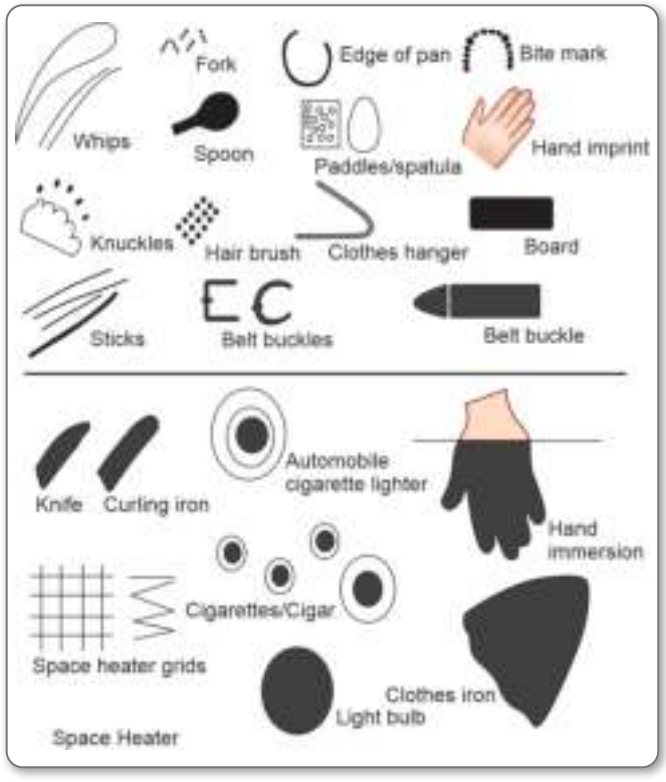

Figure 27.3: Marks from instruments and heated objects

consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by an activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person.

- This may include but not is limited to the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials (WHO, 1999).

Types of Sexual Abuse

Types: Rape, molestation, incest, and sexual exploitation.

Sexual abuse includes fondling the child's genitals, getting the child to fondle an adult's genitals, mouth to genital contact, rubbing an adult's genitals on the child, actually penetrating the child's vagina or anus, showing an adult's genitals to a child, showing the child pornographic or "dirty" pictures or videotapes, using the child as a model to make pornographic materials.

Signs of Sexual Abuse

- Changes in behavior, extreme mood swings, withdrawal, fearfulness, and excessive crying
- Nightmares, sleep disturbances
- Inappropriate sexual activity, unusual interest in sexual matters
- A sudden acting out of feelings or aggressive or rebellious behavior
- Regression to infantile behavior; clinging
- Change in toilet-training habits
- A fear of certain places, people, or activities
- Bruises, rashes, cuts, limping, multiple or poorly explained injuries
- Pain, itching, bleeding, fluid, or rawness in the private areas.

Guidelines for Parents According to American Academy of Pediatrics

- **Teach** your child about the privacy of body parts.
- **Listen** when your child tries to tell you something, especially when it seems hard for her to talk about it.
- **Give** your child enough of your time and attention.
- **Know** who your child is spending time with. Be careful about allowing your child to spend time in out-of-the-way places with other adults or older children. Make visits to your child's caregiver without notice. Ask your child about his visits to the caregiver or with child sitters.
- **Check** to see if your child's school has an abuse prevention program for the teachers and children. If it does not, get one started.

Table 27.2: Prevention plan for child abuse

Age	Prevention plan
18 months	Teach child the proper names of body parts.
3–5 years	Teach child about "private parts" of the body and how to say "no" to sexual advances. Give straightforward answers about sex.
5–8 years	Discuss safety away from home and the difference between being touched in private parts of the body (parts covered by a bathing suit) and other touching. Encourage child to talk about scary experiences.
8–12 years	Stress personal safety and give examples of possible problem areas, such a video arcades, malls, locker rooms, and out-of-the-way places outdoors. Start to discuss rules of sexual conduct that are accepted by the family.
13–18 years	Restress personal safety and potential problem areas. Discuss rape, "date rape," sexually transmitted diseases, and unintended pregnancy.

- **Talk** to your child about sexual abuse. A good time to do this is when your child's school is sponsoring a sexual abuse program.
- **Tell** someone in authority if you suspect that your child or someone else's child is being abused.

The prevention plan for child abuse according to age is given in Table 27.2.

Neglect and Negligent Treatment

It is the inattention or omission on the part of the caregiver to provide for the development of the child in all spheres: Health, education, emotional development, nutrition, shelter and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes, or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible (WHO, 1999).

Neglect: The failure of a parent or other person legally responsible for the child's welfare to provide for the child's basic needs and an adequate level of care.

Types of Neglect

- **Physical:** Deprivation of necessities such as food, clothing, shelter, supervision, medical care, and education
- **Emotional:** Failure to meet the child's needs for affection, attention, and emotional nurturance

Signs of Emotional Neglect

- Failure to gain weight (especially in infants)
- Desperately affectionate behavior
- Voracious appetite and stealing of food

Emotional Abuse

It includes the failure to provide a developmentally appropriate, supportive environment including the availability of a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies matching with her or his personal potential, and in the context of the society in which the child lives. It involves acts toward the child that causes or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. These acts must be reasonably within the control of the parent or person in a relationship of responsibility, trust or power. These acts include:

- Restriction of movement, patterns of belittling, denigrating
- Scapegoating, threatening, scaring, discriminating
- Ridiculing, or other nonphysical forms of hostile or rejecting treatment (WHO, 1999).

Signs of Emotional Abuse in Children

- Sudden change in self-confidence
- Headaches or stomach aches with no medical cause
- Abnormal fears, increased nightmares
- Attempts to run away

Commercial or Other Exploitation of a Child

It refers to the use of child in work or other activities for the benefit of others. This includes, but is not limited to, child labor and child prostitution. These activities are to the detriment of the child's physical or mental health, education, moral or social-emotional development (WHO, 1999).

Long-Term Consequences of Abuse and Neglect

In most cases, children who are abused or neglected suffer greater emotional than physical damage. They exhibit depressed, suicidal, withdrawn or violent behavior. Child may use drugs or alcohol, try to run away, refuse discipline or abuse others. As an adult, he may develop marital and sexual difficulties.

Complications of sexual abuse:

- Post-traumatic stress disorder (PTSD)
- Depression
- Eating disorders
- Sleep disorders
- Anxiety disorders
- Participation in unsafe sexual activities.

Those who have been abused as children have an increased risk of becoming abusers themselves when they reach adulthood.

WELFARE SERVICES FOR CHALLENGED CHILDREN IN INDIA

The National Policy states that for Persons with Disabilities, the basic goal is to create an atmosphere for them in conjunction with the basic constitutional rights, i.e., equality, freedom, justice, and dignity. This policy also ensures the protection of their rights and enabling their full participation in the society. The primary objectives of the National Policy are as follows:

- Physical rehabilitation which includes medical treatment, counseling, providing aids and appliances.
- Educational rehabilitation which offers vocational and on-hand training
- Economic rehabilitation ensuring a better and dignified life in society.

Some of the initiatives taken at the national level are as follows:

- **Assistance to disabled persons for purchase/fitting of aids/appliances** involving physical rehabilitation by providing them with aids and appliances.
- **Deendayal Disabled Rehabilitation Scheme (DDRS)**—a multifaceted scheme that addressing all the possible aspects of rehabilitation.
- **Scheme for Implementation of Persons with Disabilities Act** aimed at providing funds for projects involving construction of public buildings; support the regional institutions that provide service to the PWD and creating awareness.
- **Scheme of Integrated Education for the Disabled Children:** The handicapped children are sought to be integrated in normal school system. The Hearing Handicapped (mild and moderate impaired only) are provided with financial allowance and facilities for books, transport, uniform and boarding and lodging services.
- **The Integrated Program for Street Children:** The Ministry of Social Justice and Empowerment seeks to prevent destitution of children who are without homes/family ties/vulnerable to abuse and exploitation. This program rehabilitates these children and facilitates their withdrawal from life on the streets.
- **The Integrated Program for Juvenile Justice:** It seeks to provide care and protection to the children in difficult circumstances/conflict with laws through Government Institutions and NGOs. The special features are: Establishment of a National Advisory Board on Juvenile Justice, creation of a Juvenile Justice Fund, training, orientation and sensitization of judicial, administrative police and NGOs responsible for implementation of Juvenile Justice Act.
- **Child helpline:** The child helpline is a toll-free telephone service (1098) which anyone can call for assistance in the interest of children. Being run with the support of Women and Child Welfare Ministry is working in 72 cities across the country.
- **Elimination of child labor:** Through the Ministry of Labour, the projects for rehabilitation of working children and for elimination of child labor was implemented. Based on Action Plan of the Policy, **National Child Labour**

Project (NCLP) has been established in different areas to rehabilitate child labor. The NCLP undertaken the major activities are withdrawn children from employment, provide nonformal education for special schools, vocational training, supplementary nutrition, etc.

- **National awards for people with disabilities:** The Ministry of Social Justice and Empowerment has been awarding National Awards since 1969 on the International Day of Disabled Persons on 3rd December every year. The awards are classified in different categories, namely best employer of disabled, outstanding employee, creative disabled person and National Technology Awards for the rehabilitation and welfare of persons with disabilities.
- **Scholarships for the disabled:** The Union Ministry of Social Justice and Empowerment awarded the scholarship for all kinds of handicapped students subject to their obtaining of at least 40% marks at the last annual examination from the 9th class onward for general technical or professional education.
- **Children's educational allowance:** As per the office memorandum issued by the Ministry of Personnel, Public Grievances and Pensions (Department of Personnel and Training) reimbursement of tuition fee in respect of physically handicapped and mentally retarded children of the Central Government employee is permissible.
- **Railway travel concession:** The Ministry of Railway allows the disabled persons/patients to travel at concessional fares in Indian railways. Deaf persons are allowed 50% concession in single and return journey rail fares on production of Medical Certificate issued by the Government Medical Officer. 50% concessions are also allowed in monthly seasonal (first and second class) ticket fares to the deaf.
- **Reservation of jobs:** The Government of India has reserved 3% vacancies against identified posts in Group "C" and "D" for the disabled. The handicapped persons benefited by this scheme are the blind, the deaf and the orthopedically handicapped on 1% reservation for each category in the Central Government Services, Public Sector Banks and Government Undertakings.
- **Income tax concessions:** The **section 80D** provides for a deduction in respect of the expenditure incurred by an individual in India on the medical treatment and rehabilitation of handicapped dependents. For officiating the increased cost of such maintenance, the limit of the deduction has been raised from ₹12,000/- to ₹15,000/- **Section 80V:** It has been introduced to ensure that the parent income of a disabled minor has been clubbed under Section 64, is allowed to claim a deduction up to ₹20,000/- in terms of Section 80U, even the individual suffering from a permanent disability (including blindness) or subject to mental retardation.
- **Assistance to voluntary organizations for the disabled:**
  - Assistance is given to NGOs for education, training and rehabilitation of the disabled; for rehabilitation of people recovering from mental illness; emphasis on vocational guidance and training; liaison with nearest psychiatrist center or hospitals.
  - **Assistance for purchase of aids and appliances** for people with disabilities.
  - **Development in the field of cerebral palsy and mental retardation:** For manpower training of professionals and developing organizational infrastructure such as classroom/library/hostel in the field of cerebral palsy and mental retardation.
  - **Assistance to voluntary organization for establishment of special schools:** The preference is given for opening schools in new districts and upgradation of existing schools.
- **Establishment of institutions and organizations to providing services for the disabled:**
  The Government of India has set up the following premier institutes in their respective fields to cater the needs of the handicapped in the area of education, development of manpower training, vocational guidance, counseling, research, development of suitable service models and low-cost aids and appliances.
  - National Institute for the Orthopedically Handicapped (NIOH), Kolkata.
  - National Institute for the Mentally Handicapped, Hyderabad.
  - Ali Yavar Jung National Institute for the Hearing Handicapped, Mumbai
  - National Institute for the Visually Handicapped, Dehradun
  - Institute for the Physically Handicapped (IPH), New Delhi
  - National Institute of Rehabilitation Training and Research, Cuttack.
  - National Institute for Empowerment of Persons with Multiple Disabilities, Chennai.
  - Pt. Deendayal Upadhyaya Institute for the Physically Handicapped
  - District Rehabilitation Center (DRC) Project started in 1985.
  - Four Regional Rehabilitation Training Centers (RRTC) operative in Mumbai, Chennai, Cuttack, and Lucknow under the supervision of the DRCs since 1985.
  - National Information Center on Disability and Rehabilitation.
  - National Council for Handicapped Welfare
  - National Level Institutes—NIMH, NIHH, NIVH, NIOH, and IPH

List of few centers that treat mental disorders in India:

- National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru.
- All India Institute of Mental Health and Neurosciences (AIIMS), New Delhi
- Ram Manohar Lohia Hospital, New Delhi.

- Central Institute on Mental Retardation (CIMR), Trivandrum
- Central Institute of Psychiatry (CIP), Ranchi
- Ranchi Institute of Neuro-Psychiatry and Allied Science (RINPAS)
- National Institute for the Mentally Handicapped, Secunderabad
- Rehabilitation Council of India, New Delhi.

CHILD GUIDANCE CLINIC

Introduction

The Child Guidance Clinic (CGC) was initiated with the aim of treating a group of children affected with mild behavioral and emotional problems. It is focused on understanding as well as relieving psychological distress in the children and adolescents to make suitable adjustments to their environment.

History

The first CGC began in Chicago (1922) as a result of common wealth fund's program for prevention of juvenile delinquency. This led to the development of community-based facilities specially for treating the maladjusted child of school going children. In India, the first CGC was established at Bombay, in the Tata Institute of Social Sciences, in 1937. Around 1955, the Ministry of Health and Family Welfare (MoHFW) started the full time "Child Guidance Center" at Rajkumari Amrit Kaur (RAK) College of Nursing, New Delhi for providing services and strengthening the pediatric and public health nursing training programs. The National Institute of Mental Health and Neurosciences (NIMHANS) Bengaluru has established special guidance unit in 1957, which provides the expertise service from team members around the clock to take care of these children. Currently all children and psychiatric hospitals have developed CGC in order to promote child health service for 3–18 years.

Definition

The CGC is a specialized health clinic which has medicosocial amenities to deal with the problem child. The problem child refers to, "maladjusted child of school going age with normal intelligence exhibiting slight behavior or psychological problems". For example: thumb sucking, enuresis, temper tantrums, etc.

Objectives

- To promote subjective well-being and personal development in children.
- To offer care and guidance for children with learning difficulties.
- To educate, counsel, guide, and inform the parents regarding care and treatment.
- To provide training to the health care professionals and referral services if needed.
- To conduct research related activities of problem child.

Functions

It deals with concept of whole child; psychological, emotional and perception changes that occur from infants to school age. The physical and social environment plays vital role in making the child to develop a balanced personality. The CGC functions as specialized center for diagnosing mental distress and offers appropriate management for children with psychological problems. It also examines the broad range of activities like motor skills, psychophysiological processes, problem solving, language acquisition, conceptual understanding, social, personality and emotional development of the child.

The psychiatrist plays the pivotal role to formulate the line of treatment. The team members like clinical and educational psychologist, psychiatric social workers, nurses, speech therapist, occupational therapist, neurologist, pediatrician and special educators are crucial for the successful outcome of the child. The services provided at CGC are shown in Figure 27.4. It works with individuals or groups in a variety of settings, including of private practice, hospitals and schools to help the children to lead a normal and productive life.

The following are the services provided by CGC:

- **Screening and assessment services:**
  - Conduct interview with the child/parent and establish interpersonal relationship to aid in further management.
  - Administer screening and assessment tools/tests to diagnose possible problems in development, speech, hearing, social, learning, emotional/behavioral skills.
  - Evaluate complete physical assessment followed by developmental and neuropsychological assessment.
  - Identify the nature of the problem and the factors contributing to it.

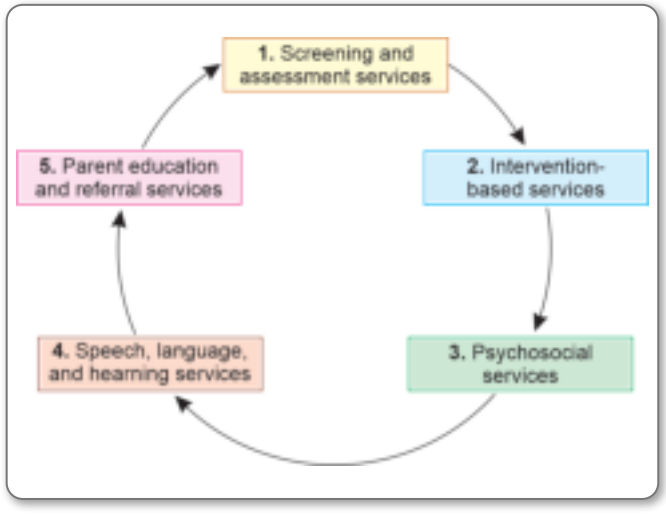

Figure 27.4: Services offered at child guidance clinic

- **Intervention-based services:**
  - Offer guidance, continues monitoring, family and relationship counseling to the children as well as parents based on their need.
  - Provide supportive medical and physical rehabilitation services if needed, remedial training to correct specific learning disability.
  - Plan for behavior modification therapy if needed.
  - Conduct periodical personal interviews with the family members to identify factors in the family or in the environment affecting the child and offer assistance in modification of the same.
  - Provide peer support groups and information to parents regarding availability of appropriate schools/vocational training centers.
- **Psychosocial services:**
  - Assess, diagnose and treat the mental health problems and promote healthy interactions in prevention of mental disorders in children.
  - The teams offer services that promote, maintain and restore mental health of the children and the families in coordination with developmental health services.
- **Speech, language, and hearing services:**
  - Allied therapist conduct/evaluate the children's speech/language, hearing abilities.
  - Parents are offered counseling regarding the child's development in the areas of language, articulation, fluency, and voice.
  - Parents are often involved in the treatment plan and counseling sessions to encourage positive parent-child interaction and to improve the language stimulation.
- **Patient education and referral services:**
  - Educate the parents regarding parenting skills and strengthen family interaction.
  - Adolescents, children or their parents who are in need of services, are provided with appropriate referral.

The CGC provides the following specialty clinics:

- **Neurobehavioral Clinic (NBC):** It offers specialized multidisciplinary assessment and therapy for children with autism, ADHD, and mental health comorbidities. Through the parent and caregiver's education, the team member seeks to work collaboratively in supporting children needs.
- **Mood and Anxiety Clinic (MAC):** It provides comprehensive assessment, treatment, planning and intervention for children with mood and anxiety and other related emotional conditions require attention.
- **Forensic, Rehabilitation, Intervention, Evaluation and Network Development Services (FRIENDS):** It provides comprehensive and integrated multidisciplinary assessment and intervention services integrated at the following groups facing mental health issues:
  - Young offenders
  - Youth at risk of committing offenses
  - Victims of child abuse
  - Children and parent involved in complex custody and access disputes
- The other common therapeutic interventions used in this clinic are psychotherapy, drug therapy, play therapy, speech therapy, family therapy, transactional analysis, and Gestalt therapy. Relaxation methods and hypnosis are also used in selected cases.

Role of the Nurse in Child Guidance Clinic

The child health nurse plays a significant role in taking care of the physical and psychological aspects of the child.

- Assists in physical and psychological assessment of child during screening tests.
- Provides guidance and counseling related to the needs of the child and their parents.
- Educates and informs the parents regarding the ongoing management and importance of follow-up.
- Provides holistic nursing care and advocates for the rights of the children.
- Supports the health care providers, child and the family as and when need arises.
- Participates or conducts research activities related to problems of the children.
- Educating the public in the community about problem child and its management.

Summary

Every child with a disability has strengths. These may be in doing artwork, in their personality, or in their motor skills. It is more important to focus on what children can do, their abilities, rather than their disability. The children's abilities can be used to assist the areas that they have most challenges with.

Assess Yourself

1. Elaborate the facilities available for challenged children.
2. Discuss the causes, types, and management of different types of child abuse.

Note