CHAPTER 6

Habit disorders

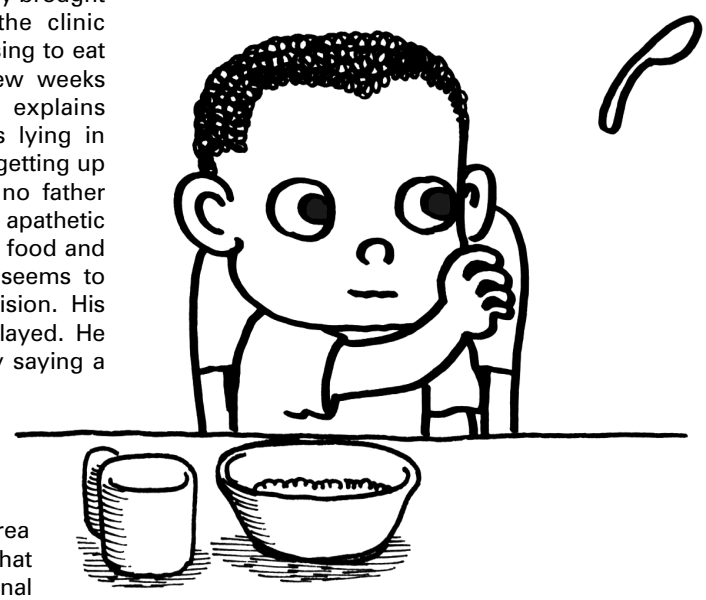
Habit disorders include:

- feeding problems for which there is no physical cause – the baby may refuse the breast or bottle, fail to suck, cry before or after feeds, have constipation or diarrhoea, vomit or appear to have abdominal pain. Later the young child may fail to thrive for non-organic reasons;
- sleep problems – the child may have difficulty settling at bedtime, may wake frequently during the night, or may wake very early in the morning and disturb the household. As a result of being awake some of the night, the child may be tired during the day. Much less commonly the child may sleep excessively during the day. There may be other problems related to sleep in the early years, such as sleep-walking, nightmares and night terrors;
- bladder and bowel problems, especially bed-wetting and soiling;
- tics and other movement disorders.

6.1 Feeding problems

Case 6.1

Benjamin is a 2-year-old boy brought by his grandmother to the clinic because he has been refusing to eat his food from the first few weeks of life. The grandmother explains that Benjamin's mother is lying in bed – she has difficulty in getting up in the morning. There is no father in the home. Benjamin is apathetic when he is presented with food and turns his head away. He seems to prefer to watch the television. His development is a little delayed. He is walking well, but is only saying a few single words. When he is weighed and measured, he is below the second centile in both height and weight. The food supply in the area is more than adequate. What should the health professional do?



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6.1.1 Feeding problems in the first 3 months of life

These are likely to be due to:

- exclusive breastfeeding: poor fixation or breast sepsis or maternal illness, especially HIV infection, tuberculosis, depression and chronic infectious disease
- too early introduction of complementary feeding, leading to infection or inadequate calorie intake
- illness in the child such as neonatal tetanus, pertussis and other congenital abnormalities.

Where there is enough food in a locality, there are other reasons for feeding problems in young infants.

- Problems in the baby such as inability to suck as a result of an anatomical abnormality of the mouth, tongue or other part of the swallowing apparatus, or because of brain damage. The baby may be temperamentally very restless or apathetic or may cry persistently after feeds. There may be a physical illness such as a congenital heart condition, cystic fibrosis, anaemia or narrowing of the gullet or narrowing of the outlet from the stomach (pyloric stenosis).
- Problems in the mother, such as an abnormality of the breast or nipple (uncommon), anxiety leading to clumsy handling of the baby, or depressive feelings with apathy and lack of interest in the baby.
- Problems in the feeding technique with, for example, the baby being held too close or too far away from the breast, or, with bottle feeding, too large or too small an opening in the teat.
- Problems in the mother–baby relationship. Successful early feeding needs the establishment of a rhythm between mother and baby, with both satisfying each other's needs. Too frequent or too infrequent feeds, for example, may lead to a breakdown of the feeding relationship.

6.1.2 Feeding problems from 3 months to 3 years: failure to thrive

In many LAMI countries, although the food supply is adequate, the distribution of food is such that people in poorer areas are malnourished. Where the food supply is adequate the following feeding problems may occur:

- finicky eating habits (unusual in LAMI countries)
- overeating
- putting things that are not food (e.g. dirt, grass) into the mouth
- vomiting.

These feeding problems are only important if they lead to a failure to thrive. Children who fail to thrive have fallen below the second centile in height, thus are very small for their age. Failure to thrive always arises from inadequate calorie intake, which in turn may be due to an inadequate food supply. Where the food supply is adequate the main reasons for failure to thrive are:

- physical causes in the child, including chronic infection and, much less commonly, heart failure, food allergies or failure to absorb food
- temperamental characteristics of the child such as an unusual degree of restlessness that makes the child difficult to feed
- poor social conditions, with lack of sanitation, overcrowding and financial hardship
- inadequate parenting, perhaps due to depression in the mother leading to apathy, irritability and insensitivity to the needs of the child

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- inappropriate feeding practices – the child may be fed too quickly, with too many distractions such as the television on, or with food that is unattractive, too hot or too cold.

6.1.3 Finding out more about children with feeding problems

The health professional should weigh and measure the child, plotting height against weight on a growth chart (www.who.int/childgrowth/standards/en/). There should be a record of the child's height and weight from birth so that a check can be made as to whether the child was growing satisfactorily and then showed growth faltering.

- A physical examination should be carried out to help rule out any form of chronic disease.
- A blood test should be carried out to rule out anaemia.
- Urine should be examined for infection.
- Is there sufficient appropriate food available for the child?
- Is there any evidence of infection, especially chronic infection such as tuberculosis or HIV infection or a combination of these?
- Is the mother physically and mentally fit? In particular, does she have any chronic infectious disease or signs of a depressive disorder?
- If there is appropriate food available and there is no evidence of illness in the child or mother, then:
  - find out when the feeding problem began. Has it been present from birth or developed more recently?
  - what does the feeding problem consist of – rejection of food, overeating, playing with food in the mouth, vomiting, pain with eating?
  - what food is the child being given? Is she being given snacks or food between meals?
  - what is going on during mealtimes? Is the television on? Are other children sitting at table, and if so, are they constantly getting up and down from the table?
  - what has the mother already tried to overcome the feeding difficulty?
  - are there any other problems such as sleeping difficulties?
  - does the mother have a physical or mental health problem? In particular, is she depressed, anxious, worn out by pressures and stress?
  - if a friend or relative is available who knows the mother, ask whether they have any observations about the child's feeding.

The single most useful part of assessment of a feeding problem is direct observation of the mother feeding the child, if at all possible in the home, but if not, in the clinic.

Now, given the information you have obtained, try to understand how the feeding problem has arisen in this particular child. Then go on to work out a plan to help.

6.1.4 Helping children with feeding problems

Mothers who complain that their children have feeding difficulties but whose children are not failing to thrive may be given practical advice and reassured that their child does not have a serious health problem.

- If the child is failing to thrive, intervention should be based on the findings on assessment. In LAMI countries, it is most likely that there is not sufficient appropriate food available, the child has an infection or the mother is unwell or exhausted as a result of financial or other stresses.

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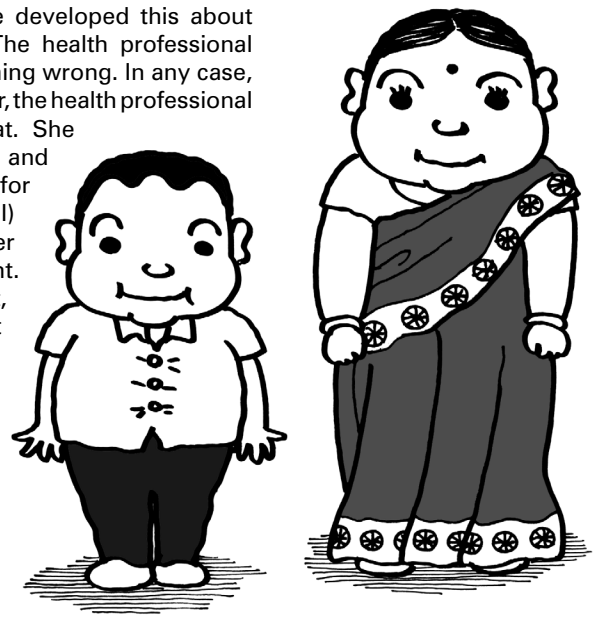
- If the child is failing to thrive despite the availability of appropriate food and absence of evidence for infection, then observation of the feeding situation in the home is likely to reveal the nature of the problem and to suggest what should be done about it. The following interventions may be appropriate depending on the assessment findings:
  - practical advice to the mother on her feeding technique – this should be followed by repeated observation of her feeding to assess the degree to which the advice has been taken and has been effective
  - appropriate counselling for mental health problems such as depression or anxiety in parents.

Now make a list of the ways in which the health professional might be able to help Benjamin and his grandmother.

6.2 Obesity

Case 6.2

Alok is brought by his mother at the age of 9 years to the clinic with a recurrent cough. He developed this about 3 weeks ago after a bad cold. The health professional examines the chest and finds nothing wrong. In any case, the cough is getting better. However, the health professional does notice that Alok is very fat. She measures his height and weight and finds he is above the 97th centile for weight. His body mass index (BMI) is 35. She asks his mother whether she is worried about his weight. The mother smiles and says that, of course, she knows he is a bit fat but there is nothing she can do about it. He just loves eating. She herself is overweight and has type 2 diabetes. Apparently there is nothing else the matter with Alok. He is doing well at school. He does have friends, but prefers to stay at home to watch television and DVDs. What should the health professional do?



6.2.1 Information about obesity

In many middle-income countries, obesity is now a more widespread nutritional problem than malnutrition. Moderate and severe obesity in children are major health problems, predisposing to type 2 diabetes and metabolic syndrome with high BMI, blood pressure and cholesterol levels in adolescence and to the later development of heart disease, respiratory disease, joint problems, varicose veins, poor operative risk and obstructive sleep apnoea.

Hormonal causes of obesity are extremely unusual. If the child is unusually short compared with his parents, this would be worth considering. Sometimes obesity may be part of a chromosomal abnormality (e.g. Prader–Willi syndrome). Most commonly there are just two main causes of obesity and these are usually both present:

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1 excessive calorie intake (too much food), and
2 too little exercise.

Some children are genetically predisposed to develop obesity if they eat too much or take too little exercise. They have genes that make it more likely they will turn food into body fat than are other children. Genes have no or little influence on whether a whole population has a high or low prevalence of obesity. Stress during the pregnancy may also make babies more likely to develop obesity later. In addition, bottle-fed babies are more likely to become obese than those who are breast-fed.

Significant reasons for overeating are:

- a family pattern of overeating.
- parents not liking their children to be hungry
- cheapness and ease of access of unhealthy foods
- friends eating unhealthy foods and advertisements on television
- having depression and being apathetic.

Significant reasons for taking too little exercise are:

- watching television and DVDs, playing computer games or 'surfing' on the internet for large amounts of the day
- lack of interest in sport
- a family pattern of inactivity
- social isolation.

Often, children who are depressed may use food for comfort. Obesity may also be a side-effect of some types of medication, especially antipsychotics. Unfortunately, children who are obese are more likely to be unpopular and teased by others.

Most parents of children who are seriously overweight do not ask for help – the obesity is noticed when the child attends for some other reason. The outcome of treatment for obesity is generally poor, especially if children do not see obesity as a problem. Unfortunately, the management programme described below, although it has a small chance of success in highly motivated children, is unlikely to be widely effective unless the parents are highly motivated to change their own lifestyle.

6.2.2 Finding out more about children who are obese

Note why the obesity has come to notice. Is this because you have noticed it or because the parents or child want help with it?

Weigh and measure the child. Assess the degree of obesity using growth charts (www.who.int/childgrowth/standards/en/) and/or skin thickness and/or BMI. Body mass index is used to estimate the total amount of body fat and it is calculated by dividing the weight in kilograms (kg) by the height in metres squared (m^2). For example, a child who is 35 kg in weight and is 130 cm in height has a BMI of 27 ($35 / 1.3 = 27$). However, it is to be noted that, unlike in adults, BMI is both age- and gender-specific for children and adolescents as the amount of body fat changes with age and also differs between girls and boys. Therefore the BMI must be compared against age and gender percentile charts (e.g. www.cdc.gov/growthcharts/html_charts/bmiagerev.htm). Similarly, BMI may not correspond to the same degree of obesity in different populations due, in part, to different body proportions. Therefore the health risks associated with BMI score may differ for different populations (http://apps.who.int/bmi/index.jsp?introPage=intro_3.html).

Assuming the child is overweight, assess the attitudes of the child and parents to the problem. Are the parents/child worried at all, slightly or seriously? Remember that the

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attitudes of the child and parents are a better guide to action than the degree of obesity as you measure it.

Take a rough dietary history and test the child's urine for sugars. Taking an accurate dietary history is not possible without specialist dietary resources, but you can find out what sort of foods the child prefers and whether the child snacks between meals. In addition, make a rough assessment of the amount of exercise the child is taking. Again, an accurate account will not be possible without specialist advice, but you can find out whether and how often the child walks to school and plays outdoor games. You can also find out how many hours a day the child spends watching television or playing on a computer. Information about the dietary habits and exercise patterns of other family members should also be taken; could the family afford and stick to a healthier diet if this were recommended?

Check also whether the obesity is causing any difficulties for the child such as being teased or causing low self-esteem. Is the child depressed? (See Section 7.7.) Does the child use food as a comfort? Is the child on regular medication?

Now, given the information you have obtained, try to understand how the weight problem has arisen in this particular child. Then go on to work out a plan to help.

6.2.3 Helping a child with obesity

Discuss with the child and family how they view the child's obesity. Then explain the dangers of obesity. If present, assess and treat type 2 diabetes or metabolic syndrome.

If the child and family wish to enter into a weight reduction programme, refer to a centre that has such programmes available. If this resource is not available, counsel along the following lines.

- Recommend a simple diet, containing locally available foods that will produce a calorie deficit. With children under the age of 5 years the parents should be able to control the child's intake relatively easily. With older children, explain that the whole family will need to go on this diet if it has any hope of success.
- Work out how the child can maintain the diet if he is eating away from home.
- Recommend a physical activity programme to take the place of some sedentary activities such as watching television and DVDs.
- Arrange for the child to be weighed regularly, praised and given small (non-food) rewards for any weight loss.
- If weight loss does occur, explain that relapse is likely and that the family need to be prepared to repeat the measures described above.

If the health professional is able to educate the local population on the risk of obesity, the following should be emphasised:

- breastfeeding of infants will lower the rates of later obesity
- from the earliest days children should receive diets that are healthy and have a low risk of producing excessive weight gain
- snacking between meals needs to be discouraged
- local schools should be encouraged to provide cheap, healthy school meals
- parents should be encouraged from the earliest days to limit the amount of time their children watch television and engage in other sedentary activities.

Now make a list of the ways in which the health professional might be able to help Alok.

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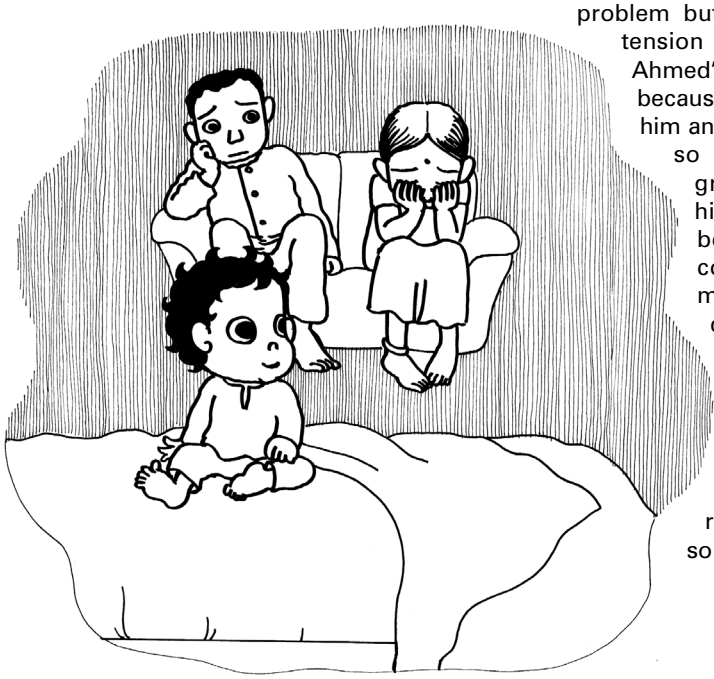
6.3 Sleeping difficulties

Case 6.3

The mother of Ahmed, aged 2 years, an only child, was very embarrassed when she told the health professional what the problem was. Ahmed was a healthy child, developing normally and with nothing physically wrong with him. Nearly every night over the past year Ahmed has woken during the night. He has cried until either his mother or father have come to him in the next room. Then he goes back to sleep but wakes up half an hour later and cries again. It is very exhausting. She and her husband, Ahmed's father, were at their wits end when Ahmed went to a child minder. He spent quite a bit of time at the child minder's house asleep. It seemed a trivial problem but it was causing great tension between the parents. Ahmed's father blamed his wife because he thought she spoiled him and this was why he slept so badly. Both Ahmed's grandmothers thought his mother was useless because she could not control her child. The mother admitted she was quite depressed and getting to the end of her tether. She just did not know what to do and this silly problem was destroying her marriage. She was really guilty that she felt so angry with Ahmed.



6.3.1 Information about sleeping difficulties

Children's sleep needs

Children vary enormously in how much sleep they need. At 1 year of age, they sleep on average for 15 hours a day. By 2 years, they are sleeping an average of 13–14 hours, and by 4 years, an average of 12 hours. But this varies. A 4-year-old might easily manage on 8 hours or need as much as 15 hours. The amount a child needs does not always fit in with what the parents would like.

Types of sleep problems

The most frequent types of sleep problems in infancy and early childhood are unwillingness to go to bed or sleep and waking in the night. These are most common between 18 months and 4 years.

Sleeping arrangements

Sleep problems of this type are less common when there are traditional sleeping arrangements with all the family sleeping in one room. The child is less likely to feel anxious than if sleeping

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separately. If the family are all sleeping in the same room, the parents can comfort the waking child with little inconvenience to themselves. On the other hand, if a child is sleeping in the same room as the parents in a society where it is usual for children to sleep separately, this may indicate undue anxiety in the parents.

Family influences

In most cases, parents of children with sleep problems do not have significant mental health problems. Sometimes, for example, a mother's depression or anxiety or a father's alcohol problem may play a part. A sad, unhappy mother may really want to cling to her child during the night. An anxious mother may need to check that her baby is still breathing normally several times during the night. A father with an alcohol problem may arrive in the middle of the night and unsettle his wife and child by shouting or with violent behaviour.

6.3.2 How to find out more about a child with sleeping difficulties

- Find out what the sleeping arrangements are. Try to find out exactly what happens during the night. When does the child wake? What do the parents do? What happens then? If possible, get the parents to keep a diary for a week or so to establish exactly what is happening. If possible, try to get information from more than one family member.
- Assess family stresses and how they are affecting the situation.
- What have the parents tried so far?
- What do they think would be best to do next?

Now, given the information you have obtained, try to understand how the sleep problem has arisen in this particular child. Then go on to work out a plan to help.

6.3.3 How to help the parents with a child with sleeping difficulties

First, let the parents decide whether they think it is a good idea to take the child into their own bed. If the child is sleeping in a separate room, let the parents decide whether to keep the child in a separate room. Then work out a programme that will remove all reward from the child waking.

Second, establish a behavioural programme. For example, the parents may leave the child to cry. Eventually the child will stop. The child will then wake again but for a shorter period and then go back to sleep. This pattern will recur until the child barely wakes before going back to sleep. However, some parents will not be able to bring themselves to carry out such a programme. This approach is effective, but do not press parents to do something they really do not want to do. An alternative programme would be that when the child wakes, the parent goes into the room for the briefest moment and then leaves, even if the child cries. Either of these approaches can be combined with a star chart (Appendix 1). The child is rewarded with a star for desired behaviour such as going to bed without a fuss, or not calling for his parents when he wakes in the night. When the child has accumulated, for example, five stars, he can be rewarded with a small treat decided in advance. However, strongly discourage any reward for the child in waking, for example by having something to eat or drink. If the child is getting sweet drinks in the night, gradually replace with water and then no drink at all.

Finally, tell the mother that you do understand just how stressed she is. Agree it is not a small problem. Reassure her that the problem will almost certainly have stopped by the time the child is about 4 years old.

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Case 6.3 ***(continued)***

When the health professional talked to Ahmed's mother it became clear that, apart from the sleep problem, there were no other stresses acting on the family. It turned out that she and her husband did not want Ahmed in their bed at night. However, they were rewarding him for waking up by giving him sweet drinks and telling him stories when he woke up. The health professional explained how this was encouraging Ahmed to wake up more. It was explained that the fact that he was getting so much sleep in the day meant he needed less sleep at night. The mother told the child minder to keep him active and not allow him more than 1 hour of sleep while he was with her. The mother agreed to reduce the amount of sweet drinks during the night and to gradually introduce water. She thought it was a good idea not to read him stories but just to go into the room briefly and settle him but not stay in the room even when he cried. Ahmed cried bitterly when he first realised that his parents were not going to stay in the room with him until he went to sleep, but they stayed firm. Gradually, Ahmed woke much less and cried less in the night, so that after 3 weeks the problem only happened very occasionally.

6.3.4 Prevention of sleep and waking problems in infants and young children

Parents should be encouraged:

- to help the child to feel safe and secure when going to bed and preparing for sleep
- to establish a regular bedtime
- to avoid exposing the child to overstimulating activities in the hour or so before bedtime, including watching scary movies or exciting television shows
- to develop a bedtime routine, for example with a regular wash before bed, a song or story for 10–15 minutes and then a firm 'Good-night' and departure from the room
- to establish a regular waking time before which they should be firm about returning the child to bed if he wakes early.

6.3.5 Sleep problems in later childhood and adolescence

As children develop, they need less sleep. The average 10-year-old sleeps for about 10 hours a night and the average 15- to 19-year-old, 7.5–8.5 hours. Adolescents occasionally complain of an inability to sleep (insomnia). They should be advised to follow these rules:

- have a regular waking-up time
- take a steady, daily amount of exercise
- make sure the bedroom is neither too hot nor too cold
- not to drink caffeine late in the evening
- not to smoke late in the evening (or even better, not to smoke at all)
- if not able to get to sleep because they are angry, frustrated or anxious, then they should not try harder and harder to fall asleep but get up and do something different, preferably in another room
- only go to bed when sleepy
- set the alarm and get up at the same time every morning regardless of how much they slept during the night
- not to nap during the day, if they are having difficulty sleeping at night.

In general, health professionals should avoid the use of hypnotic (sleep-inducing) drugs unless all the above measures have failed.

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6.3.6 Other sleep problems

Note that all these sleep problems are likely to improve or disappear before or during adolescence, but just occasionally they do persist into adulthood.

Nightmares

These are frightening dreams usually occurring in light sleep. The child or adolescent wakes in a frightened state and is able to remember the content of the dream. Usually this has to do with a frightening experience the evening or day before, such as a scary television programme, something the child has read or an event in school.

All children have occasional nightmares and, in this case, all that is needed is to give the child comfort and reassurance. Frequent nightmares (a couple of times a week or more) are a cause for concern and may be a sign of post-traumatic stress disorder (PTSD) (see pp. 168–170 for how to assess and what to do).

Night terrors

These typically occur about 2 hours after the child (usually over 3 years but under 7 years old) has gone to sleep. The child sits up, utters a scream or shouts, moans and may walk around the house apparently unaware of the parents' presence. The child does not respond when spoken to or mutters a few muddled words. After a few minutes, but occasionally 20 minutes or more, the child returns to quiet sleep and has no recollection of the episode in the morning. Parents are often very frightened by these attacks but they are harmless and do not, in themselves, indicate emotional disturbance. They do not require any action. The parents should not try to wake the child. If the parents want to stop them and there is a regular pattern, they can try waking the child half hour or so before they occur and then let him go back to sleep.

Sleep-walking and talking in sleep

The child or adolescent may sit up and then get up and walk about with a glazed expression. He may talk while doing this. After a few minutes he returns to his bed. Again he has no recollection of what has happened in the morning. No action needs to be taken. The child or adolescent should not be woken but may be gently guided back into bed. Because, extremely rarely, young people have been known to injure themselves in an episode of sleep-walking, sharp objects should be removed and all doors and windows should be locked at night to prevent them getting out.

Obstructive sleep apnoea

This is a condition in which the child stops breathing for brief periods during sleep. The child snores loudly and has restless sleep. Most commonly this occurs because of the presence of large tonsils and adenoids. As a result of very brief periods when the brain is starved of oxygen, the condition may lead to a variety of behaviour and emotional problems, including irritability and attentional problems. If this condition is suspected, then, if at all possible, the child should be referred for further evaluation by a medically trained professional.

6.4 Bed-wetting

6.4.1 Information about bed-wetting

At birth and for some time afterwards, the bladder, empties automatically. By the age of 2 or 3 years most children can hold their urine in their bladder during the daytime until they

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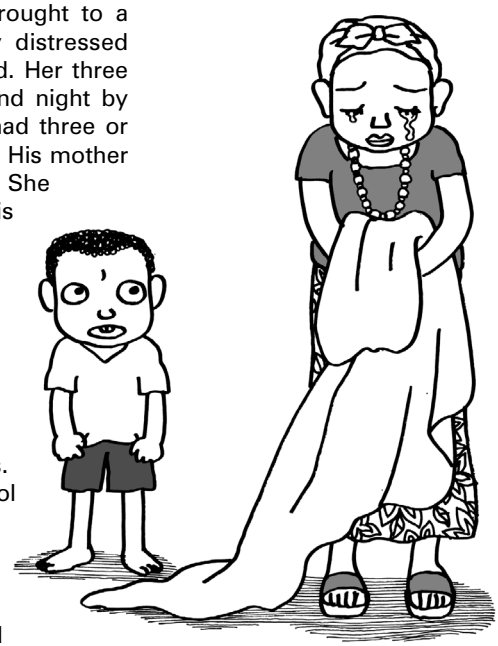
get a feeling of fullness and empty their bladder. It takes longer for children to learn to hold their urine at night until they get up in the morning. Usually they manage this by the age of 3 or 4 years. By the age of 6–7 years, about 9 out of 10 children have stopped wetting the bed. Most who are still bed-wetting at that age will have stopped and be dry at night without treatment by the age of 10 years. Very few go on to wet the bed in adulthood. Most children who wet the bed at 7 years have never been dry. The technical term for wetting the bed is nocturnal enuresis.

Case 6.4

Zoltan is a 7-year-old boy who is brought to a health clinic in the city by his very distressed mother because he is wetting the bed. Her three other children were all dry by day and night by the age of 3 years. Zoltan has only had three or four dry nights in the whole of his life. His mother has 'tried everything' to make him dry. She has shouted at him and told him he is behaving like a baby. She has made him wash his own sheets. Nothing has worked. She finds washing and cleaning the sheets every morning a great burden and expense. The family live in a tiny apartment and drying the sheets is a great problem. She has to go out to work for 9 hours a day and Zoltan just adds to her burdens. He seems to be doing well at school and has no other problems. She sometimes thinks he is sad and cries for no good reason, although he does not seem to care about the bed-wetting. Although his mother said she had no idea why Zoltan wet the bed, it turned out that she knew that both her husband and his brother had wet the bed until they were 10 years old.



Causes of bed-wetting

As with all other areas of development there is wide variation in the age at which children gain bladder control. The age at which children gain bladder control is mainly inherited: some children are built to become dry early, others much later. Often one of the child's parents has been slow to become dry at night.

Children of mothers who punish or neglect their child may also gain bladder control later, although genetic influences are more important. If a child has a genetic tendency to wet the bed, the way mothers behave may tip the balance. In these cases there is an interaction between the genes and the environment.

Occasionally, stress may be an important factor in why a child wets the bed. This is most likely to be the case if the child has been dry for some months or years and then starts to wet the bed again. Bed-wetting may then continue even when the stress is no longer present.

Very occasionally, bed-wetting may be caused by illness, especially urinary infection or diabetes.

Delay in gaining bladder control may be one sign of general slowness of development (e.g. intellectual disability, see Chapter 5).

Effects of bed-wetting

These will depend very much on the social circumstances in which the family is living. A child living in a hut in a poor rural area may be sleeping on the ground or on a mat. If the child wets himself at night, the urine will just seep away into the ground and no one will take much notice. A child who wets the bed while sleeping on a sheet over a mattress will, at the very least, give the mother more washing to do each day, which will be very hard for mothers to do if they are working. If there are servants to do the washing, this will not have as much impact.

Effect on the child

Many children are ashamed of the fact that they wet the bed. They may think that they are the only ones to have this 'bad' habit. The fact that they wet the bed may, for example, mean they or their mothers think they cannot spend a night away from home at a friend's house. They may become sad and miserable, even depressed. If they become dry and their mood lifts, this suggests that the bed-wetting has been the cause of their low mood.

Effect on the mother

Mothers often cannot decide whether they or their children are to blame for the bed-wetting. They may blame their child for not trying hard enough to become dry. The mother may think she has not brought her child up properly and feel guilty. So mothers change between being angry with the child and guilty about their own part in the problem. Some well-informed mothers will know that they have no need to blame themselves or their children – the wetting is just a sign of an isolated delay in development.

Prevention

Healthcare professionals should encourage mothers of babies and infants not to worry too much about when their children become dry at night or stop wetting the bed. Most will gradually become dry first by day and then by night by the age of 5 years.

By day, mothers should praise their child at the first signs they want to use the toilet to pass urine. During the day mothers can remove nappies when the child is showing signs of being able to control his bladder. They should put them back on again if the child is clearly not ready. A dry night should be followed by praise but wet nights should not be punished. The mother should just remove the sheets without comment and replace them with clean ones.

6.4.2 Finding out more about a child who is wetting the bed

If the child is under the age of 5 or 6 years there is no need to enquire further unless there are other reasons for concern.

For older children

- Obtain an account from the mother or both parents about the frequency with which the child wets the bed. Once or twice a night? Once a week or less?
- How does the mother react to the bed-wetting? Does she reward the child when he has a dry or drier night? Or does she punish the child for wetting the bed?
- Is there any evidence that the child has a physical problem causing the bed-wetting? This would be very unusual, but needs checking. Does the child have pain passing urine? Has the child had any blood in the urine? How often does the child pass urine in the daytime? Is the child dry by day?

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- Rule out diabetes or urinary infection by testing the urine.
- Find out what the parents have already tried, including restricting fluids before bedtime, lifting the child during the night, etc.
- What effect is the bed-wetting having on the everyday lives of the child and the mother?

Now, given the information you have obtained, try to understand how the bed-wetting has arisen in this particular child. Then go on to work out a plan to help.

6.4.3 Helping children who are wetting the bed

With children who are wetting the bed under the age of 6 years, the mother should be reassured that this is quite normal and that probably the child will gain control within the next year or two. She should avoid punishing the child.

Children over the age of 6 years

- In children who have been wet from birth, check to find out whether there is evidence of developmental delay or intellectual disability (see Chapters 4 and 5).
- In children who have been dry but have then started to wet the bed again, ask whether there are any stresses acting on the child. If stresses are present, try to work out ways with the mother and child of reducing or eliminating these.
- In children who do not have any physical problem, reassure the parents and child. Explain that this is a very common problem and is extremely likely to get better over the next year or so.
- Encourage the parents not to give too much attention to the problem. Parents should reward success without drawing attention to failure.
- Strongly discourage emotional (insulting, teasing) or physical punishment for bed-wetting.
- Discourage giving the child a lot of drinks during the evening and night both before and after the child goes to bed.
- Encourage the child to go to the toilet before going to bed.
- Suggest to the parents they might try to wake the child up before they go to bed themselves for the night. If they have learned when the bed-wetting takes place in the night, they might try to wake the child just before this time and encourage him to empty his bladder.
- Try the use of a star chart (Appendix 1) to encourage dryness by rewarding the child for dry nights. A star is stuck onto the chart the morning after the child has a dry night. When the child has accumulated an agreed number of stars, the child is given a small treat. No comment is made about nights when the child wets the bed, but the child does not get a star for those nights. Such a chart is used to emphasise achievement. It also provides a baseline for the problem and can form a record of the child's progress. In about a quarter of cases, it will produce some definite improvement.
- Bladder training may be useful if the child is wetting in the daytime. Parents encourage the child to wait slightly longer each time between passing urine. They can do this by encouraging the child to try to wait for at least a few minutes when the bladder is full, before he empties it.
- In high-income countries, a variety of alarms are available to try to deal with this problem when it occurs in older children.
- Wetting the bed at night is, in itself, not an indication for a talking treatment (see p. 7). However, children and parents do benefit when health professionals explain sympathetically why a child is wetting the bed. If the child is anxious or depressed in addition to wetting the bed, then a talking treatment should be used (see Section 2.3.1).

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- Regarding medication, a tricyclic antidepressant may be helpful if it is particularly important for a child to be dry over two or three nights, for example if the child is going away with his class for a trip or is spending a night or two at a friend's home. Imipramine (25 mg) can be used for short-term situations but should not be used long term. In parts of the world where it is available, desmopressin, either as a nasal spray or tablets, may be used.
- With the very small number of children who continue to wet the bed into adolescence and even adulthood, make sure they are not punished. They may need help to be able to explain to boyfriends/girlfriends what the matter with them is.

Now describe how the health professional might be able to help Zoltan.

6.5 Soiling

Case 6.5

Nikhil is a 7-year-old boy brought by his mother to the clinic in the city because he is soiling his underwear. He was clean and dry by the age of 3 years. Then, shortly after he started school at the age of 6 years, he began to come home with faeces in his underwear. To begin with there was just slight soiling and his mother did not say anything about it. But, after a few weeks, he began to pass whole motions into his underwear. Other children complained of the smell and tried to avoid sitting near him but Nikhil did not seem to notice the smell. His mother told him to stop and after she had changed him when he came home from school she punished him by not letting him go out to play. But this did not make any difference. What should the health professional advise?

6.5.1 Information about soiling

Control of the bowels

Normally, children first show interest in passing their motions into a pot between the ages of 18 months and 2 years. On average, bowel control is achieved by the age of about 2.5 or 3 years, but it is not unusual or abnormal for this to be delayed until about 4 years.

Mostly, bowel control comes about because the child is physiologically ready. The process is helped along if the parents encourage and praise steps in the right direction. The process will be delayed or go wrong if parents punish a child for not performing in the right way. Delay beyond the age of 4 years may be linked to intellectual disability. Delay in obtaining bowel control also tends to run in families and thus might be due to genetic influences.

Soiling over the age of 4 years is caused by constipation or difficulty in passing faeces (unusually hard) with overflow – this is easily the most common reason for soiling. Occasionally there is encopresis – the passing of normal faeces in inappropriate places. There may also be a mixture of the above two.

Constipation with overflow of soft/liquid faeces

A constipated child passes hard faeces into the pot or toilet pan but liquid faeces accumulating above the constipated mass may leak out and cause liquid soiling.

Chronic constipation usually starts in infancy but may begin later, for example after an episode of anal fissure when defecation has been painful. After a prolonged period of constipation the bowel becomes stretched and the child can lose the normal sensation of the need to pass faeces.

If the problem has been present from birth and the child has always been badly constipated, with no period without constipation, there may be a serious physical problem affecting the

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nervous supply to the lower part of the bowel and, if possible, the child needs to see a specialist. Usually constipation arises because of:

- excessive attempts by the mother to 'train' the child too early and to administer punishment if he does not 'perform'. In contrast, control of the bowel may also fail to develop because the child is being brought up in neglectful circumstances with no training and nobody minding too much if he soils or not;
- a diet lacking in fibre, with adequate fruit and vegetables and plenty of water to drink;
- stressful family circumstances;
- fear of using the toilet. This may occur after an episode of painful constipation or, in an anxious child, after an upsetting experience or because the child has frightening fantasies, for example, of being bitten by something in the toilet;
- a child who has learned he can 'control' his parents by withholding faeces;
- sexual abuse. The child may have been hurt in this way and be frightened that passing a motion will cause pain. This is an unusual cause.

Passing normal motions in inappropriate places (encopresis)

- This is uncommon.
- This may be present from birth or there may have been a period when the child was clean but soiling recurred after a stressful experience.
- Mild constipation may be present, making things worse.
- It may occur at school or the child may only pass a motion on the way home from school.
- The child may go to some lengths to hide his dirty clothes.
- The child may smear his faeces on the walls or over furniture. This is likely to be a sign that the child feels aggressive towards his parents.
- Children with encopresis often show other behaviour or emotional problems, especially aggressive behaviour at home and elsewhere.
- The child might also have significant learning problems.

6.5.2 Finding out more about a child who is soiling

The health professional first needs to find out from the mother and child the following.

- How and when, if at all, did the child develop bowel continence, become clean and able to go to the toilet to pass motions?
- What sort of training, if any, did the parents use? Is there any suggestion the mother found contact with the child's faeces distasteful or repugnant?
- If the child was clean and then lost bowel control, what was happening at the time that might have been upsetting for the child?
- Is the child frightened of using the toilet?
- Has anyone else in the family, parents or brothers and sisters, been slow to establish bowel control?
- What is the child's diet like? Does it contain enough roughage, i.e. fruit, vegetables, liquids?
- What is the consistency of the motions that are passed? In particular, are they normal in consistency or unusually hard/liquid, or a mixture of hard and liquid?
- What is the child's attitude to the soiling? Is he upset about it or not seem to mind?
- Does the child use the faeces in any way, for example, smear them around?
- What are relationships in the family like? Do family members generally get on well or is there a good deal of shouting and arguments?
- How is the child getting on at school? Is he making progress? Is there any evidence that he is a bully or is bullied himself?

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- Does he have any other behaviour, learning or emotional problems?

After obtaining an account of the problem, the health professional should carry out a physical examination, looking especially for:

- a distended, swollen abdomen
- faecal masses that can be felt in the abdomen or by rectal examination
- any evidence of disease or trauma in the anal region – the scars of a fissure may be present or there may be evidence of trauma suggestive of sexual abuse.

If indicated, an X-ray of the abdomen should be carried out to detect faecal masses. No other radiological investigation is necessary.

Now, given the information you have obtained, try to understand how the soiling has arisen in this particular child. Then go on to work out a plan to help.

6.5.3 Helping a child who is soiling

Where there is any evidence of constipation, the first priority is to empty the bowel using the following procedure.

The child should be given oral laxatives. Most children, but not all, will respond. If the laxative medication fails to have sufficient effect, the child should be given an enema. Once the bowel is cleared out, the child should be put on a maintenance laxative as it may be many months before the bowel regains the capacity to function without such medication.

The child's diet should be considered and the parents encouraged to provide a high-fibre diet with a good fluid intake. At the same time the parents should be strongly encouraged to establish regular visits to the toilet with rewards for going to the toilet, a bigger reward for attempting to pass a motion and an even bigger reward for actually passing a motion. This procedure should be recorded on a star chart (Appendix 1).

Both children and parents should be given clear explanations about how the bowel functions so that they can become more self-reliant in this area.

If the constipation continues after all these measures have been taken, try to refer for a more specialist opinion as there are other rare causes of constipation.

When there is no evidence of constipation but there is soiling, then the physical process of normal defecation should be described to the child and parents so that they understand what is happening.

A routine of regular visits to the toilet should be established. The child should again be rewarded for going to the toilet, given a slightly bigger reward for trying and an even bigger reward if he is successful in passing a motion in the toilet. This should be accompanied by the show of a good deal of positive affection towards the child and a star chart system, recording success (Appendix 1), should be established.

The child should be given the opportunity to express his feelings about his family members. Good questions to ask are: 'A lot of children I see get very cross with their mum or dad. Does that ever happen to you?' and 'What sort of things make you angry?' If the health professional feels confident about such an approach, she can undertake a small number of family interviews in which the child and parents can express to each other their feelings about the soiling and other family matters. It is important that the health professional does not take sides even if she feels very strongly that either the parents or the child are in the right. In most cases this approach will be moderately successful and the child's soiling will be reduced or even disappear altogether. Soiling in adulthood is very unusual but it does occur.

If constipation persists, there may be a number of rare conditions present and, if possible, the child should be referred for further investigation.

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6.6 Tics and other jerky movements

Case 6.6

Aadi is a 7-year-old boy whose mother brought him to the clinic because he keeps blinking his eyes. He also has some twitching of other parts of his face. This started about a year ago but has become worse in the past 2 months. When his mother tells him to stop, it just seems to make him do it more. It is also worse when he has work at school that he finds hard. His mother is very cross with him because she knows he can stop this blinking if he wants to. He is also restless and overactive and has poor attention and concentration. He is an only child. His father would have liked to have come along, but cannot take time off work. He has an office job and often works late in the evening as he is so conscientious. What should the health professional do?

6.6.1 Information about tics and other jerky movements

Tics are rapid, repeated movements such as blinking or twitching of the face. Usually, it is only the face that is affected, but sometimes other parts of the body are involved. Children who are seriously affected may show quite violent, sudden movements of the arms or legs. Involuntary sounds, voices or noises such as throat-clearing, grunts and even brief screams or shouts may occur. When several movement (motor) tics and at least one sound (vocal) tic have been present for more than a year, the condition is known as Tourette syndrome.

Tics of the face usually begin round about the age of 5 or 6 years. They may be made worse by anxiety, stress or boredom. Some types of tics disappear after a few weeks, while other types persist. If people draw attention to them or children are told off or asked to stop, the tics usually get worse. They may be less prominent when the child is occupied or relaxed. One type of movement may get replaced by a new one over time.

The more severe form, Tourette syndrome, is often linked to problems of attention and concentration (see Section 8.2), obsessions and compulsions (see Section 7.8), and sleep difficulties. Very occasionally there may be involuntary swearing (coprolalia). In addition, there may be other family members with tics or obsessions and compulsions. Genetic influences are important.

6.6.2 Finding out more about children with tics and other jerky movements

Find out when the problem began, what parts of the body it affects, what makes it better or worse, and what the parents and child think have caused it. Are there any particular stresses that seem to bring the tics on?

Check for the presence of other problems, such as difficulties in attention or hyperactivity (see Section 8.2) and obsessions and compulsions (see Section 7.8), or self-injurious behaviours. Ask whether other members of the family have had the same sort of problem.

Now, given the information you have obtained, try to understand how the tics have arisen in this particular child. Then go on to work out a plan to help.

6.6.3 Helping children with tics and other jerky movements

Explain to the parents and child that the tics are outside the child's control. He really cannot help these sudden movements.

Having identified any stresses that seem to be making the problem worse, see how far they can be removed. In addition, help the child to be more aware of what brings the tics on. More information on awareness training and other specific behavioural techniques for managing tics can be found at www.cdc.gov/ncbddd/tourette/treatments.html.

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Medication can be effective but is not needed if there are only a few tics and these are not causing any serious problems. For severe tics (Tourette syndrome), it is worthwhile considering medication. Clonidine (see Appendix 2) can be used if tics and hyperactivity are both present. A very small dose of haloperidol or risperidone (see Appendix 2) can also help control the tics. The dose can be increased slowly if side-effects do not occur. Side-effects to look out for are drowsiness and, most alarming, muscle spasms producing a twisted posture (dystonic reactions). Stop the medication immediately if muscle spasms occur. Associated problems such as difficulties with attention, hyperactivity or obsessions and compulsions will need appropriate treatment (see the relevant sections).

Now make a list of the ways in which the health professional might be able to help Aadi.

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