CHAPTER 8

Behaviour and related problems

Behaviour problems include:

- physically aggressive behaviour such as bullying, constantly getting into fights and hitting other people for no good reason
- disobedience and temper tantrums
- non-physical aggression such as teasing, name-calling and humiliating other people
- lying to cover up behaviour for which the child is worried he may get into trouble or for some other reason
- stealing from home, school or in the neighbourhood; it may be carried out in isolation or with other young people
- fire-setting that can be very minor or extremely destructive
- truancy, not because of anxiety but because the child really does not like school and thinks he can do more things he enjoys outside of school.

8.1 Temper tantrums and disobedience

8.1.1 Information about temper tantrums and disobedience

A temper tantrum is an outburst, usually occurring when a young child is frustrated and cannot get what he wants. It involves shouting, screaming and sometimes aggressive behaviour towards the person who is not giving the child what he wants. It can last anything from a minute or two to an hour. Sometimes the tantrum progresses to a breath-holding attack. In the worst of these, a child may actually go blue from lack of air.

Most children under the age of 5 or 6 years have an occasional temper outburst and this is quite normal. Children who have frequent temper outbursts (several a day) are often very disobedient and aggressive. Disobedient children may also be unusually active with difficulties in concentration (see Section 8.2). Young disobedient children with frequent temper tantrums are often also anxious, not liking to be left with strangers and generally easily upset.

There are usually several reasons why young children are disobedient and have frequent temper tantrums.

- The core of the problem usually lies in inconsistent parental control of a young child who is temperamentally 'difficult'.
- The mother may find it difficult to be firm and consistent because she is depressed and/or has an impulsive personality.
- The parental relationship may be unhappy, so that the parents cannot agree on how to handle the problem.

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- Parents may react to the child's problems by becoming impatient, aggressive and/or rejecting, or these attitudes may have been there from the start.

Discipline may be difficult to enforce because the family is living in overcrowded circumstances. There may be nowhere for the child to play, with worries about disturbing the neighbours.

Some severely disobedient children go on to develop severe aggressive behaviour in middle childhood and adolescence. On the other hand, others whose parents get 'on top' of the problem, calm down and show no unusual difficulties later on.

Case 8.1

Rishi was brought by his mother to the clinic at the age of 4.5 years because of frequent temper outbursts. She said that he had always been a 'difficult' child and seemed more irritable than other babies even shortly after his birth. But over the past year things have become worse. She cannot take him anywhere because if he cannot get what he wants, he often shouts, screams and tries to hit her. She usually gives in to him and then eventually he calms down. She has tried smacking him really hard but that does not seem to work – he just carries on screaming. All this happens several times a day. She feels so guilty and ashamed in the village store when he has an outburst because she feels everyone is looking at her, thinking what a terrible mother she is. As well as the tantrums he is generally disobedient and naughty. He is aggressive to his 2-year-old brother, hitting him at every opportunity when his mother is not looking. He makes a fuss at meals and will not go to bed when he is told to. His concentration is poor, although he seems to be quite a bright child. The mother said she felt like she is at the end of her tether. Her husband is a quiet, gentle man who is always giving in to Rishi. Her mother-in-law is very critical of her, saying she is not bringing up Rishi properly. She did not have this sort of problem with her children. What should the health professional do?

8.1.2 Finding out more about disobedient children with temper tantrums

- Obtain a clear account of the nature of the problem. Find out how often the temper tantrums occur, what brings them on, how long they last, what actually happens during the outbursts, how they are brought to an end and what happens afterwards.
- Do the same type of history-taking for disobedient behaviour, which is often present as well.
- What, if any, other problems are there: aggressive behaviour; hyperactivity and short attention span; anxiety at separation?
- What have the parents done about the problems so far? How do they behave when the child is clearly building up to a tantrum?
- How do the parents get on? Can they agree on how to handle the tantrums and disobedience?

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- Are there any mental or physical health problems in the family? In particular, is the mother depressed?
- What is the child's level of development (see Section 4.1)? In particular, is there a delay in speech? If the child is going to school, are there any problems at school? Do the teachers see his behaviour as a problem?
- What are the home circumstances? Is the family pressed financially?

Now, given the information you have obtained, try to understand why this particular child has temper tantrums and is so disobedient. Then go on to work out a plan to help.

8.1.3 Helping a disobedient child with temper tantrums

Check which of the behaviour problems the parents would like to tackle first and possible barriers to successful intervention – for example, parents unlikely to agree together, the mother is too depressed to cooperate. If these are present, try to tackle these first (see Sections 1.4 and 14.1 on depression in parents and marriage problems respectively).

If possible, ask the mother to describe exactly how the behaviour problems start. What triggers them? Usually this will be the child not getting his own way. Can the mother tell when the child is 'building up' to a tantrum? What does she do when the child refuses to do what he is told or is about to have a tantrum? Has she tried distracting the child by giving him something to do that will take his mind off what he wants to happen? Does she reward the child when he is disobedient or has a tantrum by eventually giving in and letting him have his way? Suggest that the parents follow the rules below.

- Always try to avoid situations that bring about disobedience or tantrums by diverting the child's attention.
- If the child is clearly going to have a tantrum because diversion has not worked, then try to remove the child from the situation as soon as possible by, for example, taking him out of the village store.
- Talk to the child calmly and explain that, no matter how long his tantrum lasts, he is not going to get what he wants.
- When the tantrum is over, explain to the child that when he has another one he still will not get what he wants.
- Remember to reward the child for good behaviour, for example for not having a temper tantrum for a whole half-day. A star chart (Appendix 1) can be used for doing this.
- Tackle other problems such as disobedience at meals in a similar way.

Suggest that the parents try to build into the day some 'quality time', perhaps half an hour, which they will spend entirely with their child, doing things he really wants to do. Using this approach, it is likely that the problems will improve, although the child may well remain more difficult than most.

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

8.2 Hyperactivity and attention problems (ADHD)

Case 8.2

Atif is 8 years old. His mother brought him to the clinic at the request of his teacher, who thought he might have some brain damage. The teacher told his mother that they have never had such a hyperactive boy in the school. He just cannot sit still or concentrate on anything. This was affecting his learning, which was falling behind. His mother, who was a cheerful, tolerant, rather restless woman herself, said she did

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not find him too much of a problem. He was indeed very active and always had been from a baby. She just let him play in the street to let off steam if he could not settle in the home. He could not concentrate on books for more than a moment or two, but neither could her husband who had also been hyperactive when he was a boy. Atif was at an average level in his school subjects but did not have many friends as he was always interfering in what other children were doing. While he was being talked about, Atif was quite well behaved, but when the health professional gave him some paper and coloured pencils, he was only able to concentrate on drawing for a few seconds.

Case 8.3

Mohammed's mother brought her 7-year-old son to the clinic because she thought he had ADHD, which she had read about in the newspaper. She thought there might be a tablet to cut down his hyperactivity. He wanted to be outside playing football all the time. He did not seem able to concentrate on looking at a book for more than 15 minutes. His older sister had been able to read a book for an hour at his age. The school did not think there was a problem but the mother thought that maybe the school was covering things up. The health professional noticed that while she was talking to his mother, Mohammed was quite happy, sitting quietly looking at a magazine she had in the room.

Although Atif clearly had a problem that required attention, Mohammed was just an active boy whose mother needed help to realise that her child's pattern of behaviour was quite normal for a boy of his age.

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8.2.1 Information about hyperactivity and attention problems

Normal children vary widely in their level of activity and attention span. Genes play a major part in how active children are. However, children of parents who are not very good at setting limits are likely to be more active, especially if they have inherited 'overactive' genes. Often, though, the child's behaviour is a result of an interaction between genetic influences and one or more of the factors mentioned below, and as the child gets older, aggressive antisocial behaviour may begin to show itself. Generally, boys are affected three or four times as often as girls.

Children who are hyperactive will show a number of the following problems.

- The child will sometimes have been a restless infant, showing difficulties with feeding and sleeping. Speech and language delay may also be present.
- Inability to sit still for more than a few moments even in situations like school where children are expected to sit quietly for longer periods.
- A short attention span which means that they cannot concentrate on any task that requires some effort for more than a minute or two. They can, however, often sit still in front of a television for a longer period of time, especially if the programme is fast-moving, as this is such a passive activity requiring no effort. Many children can stay focused on a task for longer periods of time if it is their favourite activity, for example a computer game.
- Distractibility. The child's attention is easily distracted so that he cannot keep his mind on one thing at a time.
- Impulsive. The child behaves without thinking. Combined with clumsiness, this may mean the child is accident-prone.

Causes of hyperactivity/attention problems include:

- genetic factors: these are particularly strong in this condition
- brain dysfunction: children with epilepsy and cerebral palsy are especially likely to show hyperactivity
- prematurity and low birth weight
- chemical abnormalities in the brain
- poor social conditions with poverty and overcrowding
- unsettled early childhood experiences
- parents who are unresponsive to their child's demands
- diet: some children respond badly to sweet fizzy drinks as well as food additives such as colourings and preservatives
- other physical conditions such as ear problems, including recurrent infections or middle-ear effusion (see Section 12.3) and obstructive sleep apnoea (see p. 43), may also be relevant.

8.2.2 Finding out more about children with hyperactivity/attention problems

- There is no blood or urine test for ADHD. Even if investigations of brain function are available (and in most places they are not), these will not help in deciding whether the child is showing abnormal behaviour. Instead, you have to rely on the account given by the parents and teachers and on your own observations.
- Ask the parent questions about how long the child can concentrate on looking at a book, sit at the table for a meal, remain involved in a sitting-down activity that really interests him.
- Find out from the teachers how well the child is able to concentrate at school, compared with other children of the same age.

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- Observe yourself how well the child can concentrate when you give him a task. The task might be to draw a picture or do a jigsaw appropriate for his age. Note, though, that some children with ADHD can focus remarkably well on the first visit.
- Especially where the problems are predominantly of poor attention, consider or check whether the child has hearing problems (see Section 12.3), iron deficiency, or behaviours suggesting the underlying problem may be more due to ASD (see Section 4.6), underlying specific developmental delay (see Chapter 4) or intellectual disability (see Chapter 5)
- Is the child reported to be clumsy? This may be due to poor attention or impulsiveness but some children with underlying coordination difficulties can cause concern because of their fidgetiness and poor behaviour (see Section 4.5)
- Has the child got other symptoms such as tics (see Section 6.6) or does he show antisocial behaviour (see Section 8.3 on aggressive behaviour and conduct disorder)? You then need to decide whether the child really does have a problem with attention and concentration.

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

8.2.3 Ways of helping children with attention problems

Some parents, like Mohammed's mother (Case 8.3), think their children have an abnormal level of activity when their behaviour is well within the normal range. They have a mistaken view of normal activity levels. In these cases the mother needs reassurance but no further action is needed.

When the child's behaviour interferes with learning at school or is leading to the child being unable to sit still or to concentrate on a book, puzzle or drawing at home for more than a minute or two, there is a need to intervene, but always remember to ask what the parents have already tried.

Various simple measures should be suggested. First, explain about normal levels of activity and how this child falls outside those limits. The child will probably always show high levels of activity but it will be possible to make an improvement. Second, parents may be advised to:

- try to keep to a regular routine with the child, always doing things in the same order;
- tell the child about any changes of plan beforehand;
- give praise when there is any improvement in the child's behaviour;
- avoid punishment – the child is not to blame for being overactive;
- keep things simple: only make one request at a time so that the child does not have to keep too many things in his mind at once. Follow up on instructions, ensuring that the child complies with the request or instruction. Praise and or reward compliance;
- avoid overstimulation: play with one friend at a time, take part in one activity at a time. Avoid background television and radio. Do not go to crowded places such as markets or the village store at a busy time unless this is unavoidable;
- allow plenty of outdoor play in the street or fields to 'blow off steam';
- avoid fizzy drinks and foods with additives (e.g. heavily coloured sweets, fish fingers) if they seem to make things worse.

Third, suggest to teachers that they:

- give praise and reward even for small improvements in the child's ability to sit still and concentrate
- avoid punishment or humiliating the child – it is not the child's fault he is hyperactive
- give him one thing to do at a time

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- make sure tasks given to the child are short, and if he stays on a task for more than a brief period, that he is praised
- make sure your instructions are simple and clear
- sit the child in the front of the class so that you can keep an eye on him
- make sure he is sitting next to 'good' children who will not encourage him to get into trouble.

If the child's behaviour is still causing significant problems, then, if it is available locally, a trial of medication may be helpful. The drugs usually given are methylphenidate or atomoxetine (see Appendix 2). However, these drugs have a number of side-effects and should only be prescribed by a specialist children's doctor.

Star charts (Appendix 1) can be used both at home and at school to reward desirable behaviours. The child may be encouraged to stay focused on a specific activity for gradually increasing periods of time, and rewarded for doing so. If, with your help, parents and teachers can help to keep the child from being discouraged and angry because he feels nobody likes him, the outcome may be good.

Hyperactive children who develop antisocial behaviour because they have been unsympathetically treated or have drifted towards other children who have a bad influence on them will often have serious problems later on.

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

8.3 Aggressive behaviour and bullying

Case 8.4

Ajit is a 10-year-old boy brought to the clinic by his mother because the school has complained about his behaviour and has told the mother she must take him to the clinic or he will not be allowed in school again. Yesterday he really hurt another boy, whose mother complained about him and said something must be done. Ajit always seems to be in a fight. His mother says that he complains about other boys picking on him and that he never starts a fight, but the teachers say this is not true. He has an older brother who has also been in trouble for fighting. Ajit is behind in his schoolwork compared with the other children in his class because he can hardly read. His father is a labourer who is in regular work, but he drinks heavily and when he comes home at night he is sometimes violent. Ajit is frightened of him. His father beats him with a stick when he is in trouble at school but it does not seem to make any difference. What should the health professional do?

8.3.1 Information about aggressive behaviour and bullying

Aggressive behaviour takes two main forms.

1 Physical force against other people, especially other children. Fighting is the use of force against others of the same size; hitting smaller children is bullying.
2 Hurtful teasing and humiliation of other people, especially other children. Calling names and spreading malicious stories are two common ways in which this occurs. Such behaviour may be face to face or behind the victim's back. Nowadays, it may take the form of cyberbullying on the internet or by texting on mobile telephones.

Being a victim of bullying at school is a major source of stress for a significant number of schoolchildren.

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Aggressive behaviour may occur at home, within the family, at school or in the neighbourhood. Physical aggression is more commonly shown by boys; teasing and humiliation more by girls. Fighting and bullying may be undertaken alone or in groups or by neighbourhood gangs. There are two main types of aggressive behaviour shown by individual children:

1 impulsive, i.e. triggered by a perceived attack
2 controlled, i.e. planned.

Children who show impulsive physical aggression often have problems with attention, concentration and learning (see Section 8.2). Note also that children with aggressive behaviour may have quite deep depressive feelings and may show their aggression particularly when they are feeling low in mood. They may also show other forms of antisocial behaviour, such as truancy, stealing, lying and fire-setting. When these behaviours occur together, it is called conduct disorder.

There may be feelings of inferiority arising, for example, from being small in height, having a chronic physical problem or being a slow learner.

Impulsive, aggressive behaviour often begins in the early years but frequently persists into later childhood and adolescence, and occasionally into adulthood. The background features of children with aggressive behaviour include:

- difficult, overactive behaviour in infancy and early childhood
- models of aggressive behaviour in the home, especially fathers and older brothers
- being members of large families, living in overcrowded conditions
- the frequent use of physical force rather than reasoning as a form of discipline at home
- discipline at home that is inconsistently enforced
- learning difficulties
- attendance at schools at which fighting between children commonly occurs and is even tolerated
- exposure to violent images in the media.

Most children who show aggressive behaviour do not have evidence of brain damage, but children with epilepsy and other evidence of brain dysfunction do have higher than expected rates of aggressive behaviour.

8.3.2 Finding out more about children with aggressive behaviour

- Some of this information is best obtained from the child seen alone. If it is possible to see the child before the parents, this may reduce the child's level of suspiciousness.
- Obtain an account of the aggressive behaviour to find out when it began, where it shows itself, how often it occurs, and how it is triggered.
- How serious is the behaviour? Has the child inflicted serious injury on anyone? Does he use a weapon?
- What does the child feel about his behaviour? Is he guilty or does he usually think his aggression has been justified by the way he has been treated by other children?
- What is the method of discipline in the home? Is beating a frequent form of punishment?
- Do the parents agree on the form of rewards and punishments that are used in the home?
- Does the child have any underlying depressive feelings? What seems to make him depressed? Does he have a poor self-image because of being small or having a physical illness or being behind at school?
- Does the child have any other antisocial behaviour such as truancy, stealing, fire-setting or problems with attention and concentration?
- How is the child getting on in his schoolwork?

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- What is the school's attitude to aggressive behaviour? Is it tolerated or taken very seriously?
- Does the child watch a lot of violent television programmes or play computer games with violent themes?

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

8.3.4 Helping children with aggressive behaviour

Much of the responsibility for stopping bullying in schools lies with teachers and the school authorities (see Section 16.3 on anti-bullying programmes in schools). Dealing with aggressive behaviour more generally is also the responsibility of the school, the parents and the police (if it involves criminal activity or delinquency). A health professional with limited resources will be able to provide helpful input by bringing greater understanding to the problem, supporting the parents when they are behaving appropriately and identifying children in whom depressive feelings are an important reason why a child is being aggressive. It is unlikely that a health professional will be able to undertake interventions that significantly reduce most aggressive behaviour or bullying. However, useful interventions may include:

- counselling parents about the need for consistent discipline based on reward for good behaviour rather than punishment (see Chapter 15);
- seeing the child alone to discuss his attitude towards the trouble he is in, who he thinks is responsible, what he is going to do about it;
- seeing the child alone to check whether he has significant depressive feelings, and if so, how these may be increasing the likelihood of aggression;
- contacting the school to find out what their attitude is to fighting and bullying: offering advice on anti-bullying programmes (see Section 16.3);
- identifying whether there are any practical measures that can be taken to reduce feelings of inferiority, and to improve self-worth and self-confidence, such as extra help for reading or a club with facilities for vigorous activities such as football or boxing.

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

8.4 Fire-setting

8.4.1 Information about fire-setting

Setting fires is an unusual form of antisocial behaviour almost always involving boys. It may be carried out alone or with a group. If carried out with a group there is often a great deal of other antisocial behaviour such as breaking into property and fighting. Individual boys who set fires alone may do so because:

- they have a fascination with fire and matches, going back many years
- they feel a strong sense of anger because they think they have been rejected and want revenge
- they have delusions and hallucinations, with fire-setting arising as a result of psychotic symptomatology
- they are bored and crave excitement.

They often come from very disturbed homes that are disorganised and chaotic. There may be a history of psychosis in the family. Note that all children who play with fire need not have

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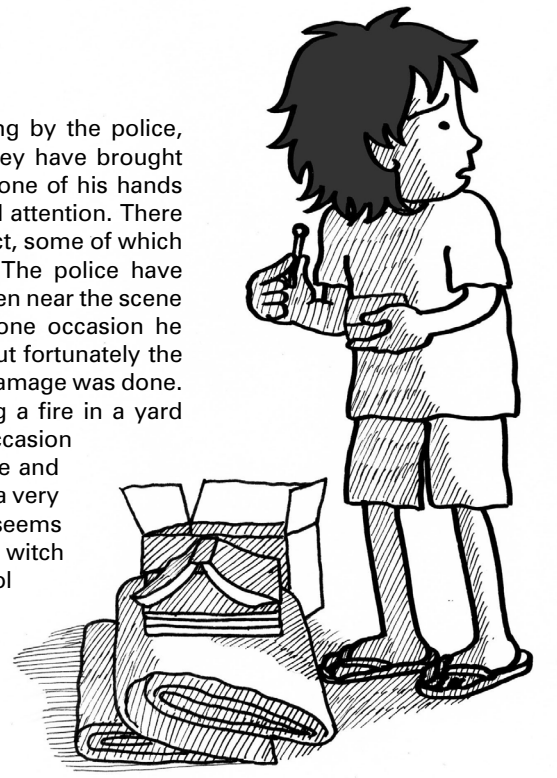
serious problems like Ahan (see below). However, they need to be supervised carefully and also be provided with distractions and opportunities to engage in other activities.

Case 8.5

Ahan is a 12-year-old boy brought along by the police, who have caught him setting a fire. They have brought him to the clinic because he has burnt one of his hands trying to avoid arrest and needs medical attention. There have been a number of fires in the district, some of which have caused a great deal of damage. The police have suspected Ahan because he has been seen near the scene of the other fires. They think that on one occasion he tried to set fire to his school building, but fortunately the smoke was spotted before any serious damage was done. This time they have caught him lighting a fire in a yard used for dumping rubbish. On one occasion the police tried to interview him at home and discovered that he lives with his mother, a very odd woman who talks to herself and seems to have visions. She is regarded as a witch by many of her neighbours. The school say that Ahan is an isolated boy and has no friends. After she has put a dressing on his hand, the health professional wonders whether there is more she can do.



8.4.2 Finding out more about a child who is thought to be fire-setting

If possible, the child should be seen alone as well as with his parents. Fire-setting may be part of a general pattern of antisocial behaviour carried out with other boys who are showing similar problems. If so, then proceed as with other types of antisocial behaviour such as aggression and stealing.

- Find out when the fire-setting began, how often it has happened, where it has occurred and what seems to trigger it.
- What is going through the boy's mind when he decides to start a fire?
- Does the boy have any signs of a psychotic illness (see Chapter 11)?
- What are the parents' attitudes to this behaviour? Do they show signs of mental illness?
- What is the quality of care in the home? Are there signs of neglect or other forms of abuse?
- How is the boy getting on in school? Information from his teachers about his educational progress and friendships or lack of them will be useful.

Now, given the information you have obtained, try to understand how the fire-setting and aggressive behaviour have arisen in this particular child. Then go on to work out a plan to help.

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8.4.3 Helping children who have been responsible for fire-setting

If fire-setting is part of a general pattern of antisocial behaviour carried out with other boys who are showing similar problems, then proceed as with other types of antisocial behaviour such as aggression and stealing. Otherwise tailor the approach to the motivation shown by the boy. If the boy is showing signs of psychotic behaviour, then treat as per Chapter 11.

- If he is showing signs of rejection, then talk to his parents and the school about how he can be helped to make friends and engage in other activities. This is not likely to be easy as he may well show features of mild ASD (see Section 4.6) or intellectual disability.
- If the behaviour is repetitive and there seem to be triggers that set it off, then work out with the parents and the child as to how an alternative response can be developed.

Identify any stresses in the home, especially mental illness in parents, so that appropriate treatment can be provided. If the boy has feelings about his parents or other members of the family that he cannot communicate, try to work out ways in which he can be helped to express himself.

Fire-setting tends to be a repetitive form of behaviour and can cause a great deal of damage to property. If necessary (and it usually will be), try to arrange for the boy to be closely supervised in situations in which he has previously set fires.

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

8.5 Lying

8.5.1 Information about lying

There are various reasons why children and adolescents do not tell the truth. They may be:

- too young (under the age of 4 years) or not yet intelligent enough to know the difference between truth and untruth: note that children with intellectual disability, although of a chronologically higher age, may be functioning at a lower age level;
- spinning fantasies in imaginative play, for example a 4-year-old who says her doll really can talk may be unable to tell the difference between truth and fantasy;
- telling lies to cover something up, like Shreya (see p. 81);
- trying to impress other children by boasting, for example that their father owns a car when, in fact, he only owns a bicycle;
- getting out of trouble: for example when, after skipping school to play football with friends, a boy tells the teacher he has been sick in bed and may even forge a note he pretends has been written by his mother.

Possible underlying reasons for lying in older children who are capable of understanding the difference between truth and fiction include:

- parents who are involved in telling lies to each other or to those in authority, so that the child has poor role models
- an underlying sadness, as with Shreya
- lying being part of a widespread pattern of antisocial behaviour, including aggression, truanting and stealing
- fear of severe punishment if they are caught out in some form of disobedience or ‘naughty’ behaviour.

Case 8.6

Shreya is a 5-year-old girl brought to the health clinic by her mother, who had been told to bring her daughter by the teacher who thought something should be done about Shreya's weight. Shreya is now the weight of an average 9-year-old girl. But what is upsetting the mother is that Shreya is always telling lies. Her mother knows that Shreya constantly steals food. She even gets up at night to take food. Her mother has tried to put the food high up in places Shreya cannot reach. At about 1 o'clock in the morning the other night there was a thump and the mother walked into the kitchen to find that Shreya had fallen off a chair while trying to reach some food that her mother had put on a high shelf to stop her getting it. Shreya had hurt herself but even then denied that she had been on the chair trying to reach food. The health professional spent some time with the mother, trying to work out with her why Shreya had this compulsive need to eat. It started when her father left home about a year ago. Basically, Shreya is a very unhappy girl who eats to comfort herself. This is the real problem and the health professional tried to work out with the mother ways to deal with Shreya's sadness.

8.5.2 Finding out more about children who are lying

Lying is nearly always either a sign of immaturity or a symptom of some other problem. If the child is too young or immature to know the difference between fact and fiction, the parents can be reassured that as the child develops so the telling of lies will stop. They should, however, explain to the child the importance of telling the truth.

8.5.3 Helping children who are lying

If the lying is a symptom of some other problem, then it is important to try to tackle the underlying problem, such as misery, unhappiness or widespread antisocial behaviour. Guidance on helping children who have depression or antisocial behaviour is given in other sections.

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

8.6 Stealing

8.6.1 Information about stealing

The idea of personal property (what is mine is mine and what is yours is yours) does not really develop properly until the age of 5 years. Before this age when children take something that does not belong to them, they do not realise this is wrong and it cannot be regarded

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as stealing. All the same, when they do take something belonging to someone else it is important for parents to make clear that this is a wrong thing to do. There is no need for punishment; just a clear explanation.

Between 6 and 8 years, children may not have a very well-developed sense of property, so if they do take someone else's property, a telling off with an explanation is all that is required. After this age, a single episode of stealing can be seen just as a child seeing what he can get away with. But repeated stealing is a reason for concern.

Children of normal intelligence and over 8 years know that it is wrong to take other people's property, but they may not have sufficient control of their impulses to resist taking something they really want from another child or from home. Children may steal outside the home because they:

- are hungry and there is insufficient food at home to meet their needs
- have a sense of deprivation, perhaps because other children have prized possessions – new trainers, a mobile telephone, a games console – that they badly want for themselves
- are depressed and find it comforting to take something they really want from the cupboard at home, a shop or from another child
- comfort stealing – in cases of neglect, deprivation and lack of love, the child may engage in stealing as a way of compensating for deprivation or for psychological comfort
- crave attention – being noticed, even getting into trouble for stealing, may seem preferable to being ignored
- want to prove themselves as brave and risk-takers in front of other children.

Case 8.7

Maya was a 10-year-old girl brought to the clinic because she had a skin infection, impetigo. She was clearly undernourished, small for her age and very miserable. What struck the health professional was that her mother was very angry with her. The health professional asked the mother why she was so angry. The mother replied that Maya kept on stealing money from her purse and she had done so only this morning. Maya was a very naughty girl; she knew her mother had very little money and yet she kept taking money that was meant for food. The health professional managed to see Maya by herself. She asked Maya what she did with the money she stole. Maya said she gave it to other girls in school. She had no friends, but if she gave money or little presents to the other girls they let her play with them. Maya had no pocket money like the other girls. She knew what she did was wrong but she could not stop herself.

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Adolescents who steal in groups are likely to belong to delinquent gangs engaged in various forms of other antisocial activity, such as truancy (see pp. 84–86) and aggressive behaviour (see pp. 76–78). Adolescents who steal alone usually do so for the purpose of buying cigarettes, alcohol or illegal drugs. The child has acquired a drug habit that is too expensive for him to fund without stealing. If the drug intake has become addictive (see Section 10.2), then the stealing may involve quite large sums of money. Background features of children who steal include:

- material and/or emotional deprivation – lack of love and affection
- neglect with inadequate parental supervision
- other family members have been in trouble with the law
- educational retardation, especially difficulties in reading
- other antisocial behaviour, such as truancy and aggressive behaviour
- poor attention and concentration.

8.6.2 Finding out about a child who steals

The health professional will inevitably be seen by the child or teenager as an authority figure. This means that the child will see the health professional as someone who disapproves of him, and perhaps has the power to punish him or take him away from home. Consequently, it is especially important for the health professional to avoid making any judgements about the child's behaviour or to appear critical in any way. In order to reduce suspiciousness, it may be helpful to first see the child alone, before seeing a parent.

- Obtain some idea from the mother and child of the child's life at home and school. How does the child get on with any brothers and sisters? Does he have friends? What sort of things does he like to do? How is he getting on with schoolwork?
- Find out about the home circumstances – how many children are there, is there enough money to buy essentials?
- Assess the quality of care given to the child. Does he look clean or neglected compared with other children in the locality? Does the mother talk warmly about him or do you feel she thinks of him as a nuisance?
- Find out when the stealing began, where and how often it has occurred, what has been stolen, how any money that has been stolen has been used, how the parents or others have reacted?
- Are there any other behaviour or emotional problems? Is the child depressed? Alternatively, or perhaps in addition, the child may be showing other behaviour problems such as lying and fighting. School attendance needs checking as this may well be poor.
- Does he have problems with attention and concentration?
- What is the child's level of intelligence? Does he understand the difference between right and wrong?
- How does the child feel about having been caught stealing? Is he ashamed and guilty or rather proud of himself?
- What does the parent(s) think is the reason for the stealing? What action have they taken already?

Now, given the information you have obtained, try to understand why this particular child is stealing. Then go on to work out a plan to help.

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8.6.3 Ways of helping children who steal

Dealing with stealing is the responsibility of the school, the parents and the police (if it involves criminal activity or delinquency). A health professional with limited resources will be able to provide helpful input by bringing greater understanding to the problem, supporting the parents in dealing with the problem appropriately, and identifying children in whom depressive feelings are an important reason as to why they are stealing.

The family may be in serious poverty, with the stealing arising from financial hardship. The health professional is not going to be able to inject more money into the home, but advice on household management or on how to spend the little money there is more effectively, may be helpful. Otherwise counsel the parents along the following lines (see also Chapter 15):

- It is important for them to give the child a clear message that stealing from other people is wrong and that they do not approve of it.
- Explain the possible consequences of continued stealing.
- If they are sure the child has stolen, do not ask the child to own up. This may just result in the child lying to cover up. Then the child has committed two offences instead of one.
- Can the child be given more attention, hugs and kisses? Is it possible for the mother or older brothers and sisters to spend more time with him?
- Can the parents try to make sure that any money in the home is made more secure so that it is not so easy to steal?
- The health professional might contact the school to see whether the child's teachers can do anything to help him make friends, to ensure he is included in games without having to buy friendship.
- Make sure the child is rewarded for good behaviour. Rewards need not be material; a hug and warm words may work better anyway.
- If it can be afforded, a small amount of regular pocket money will at least give the child the feeling that he has at least some money to spend as he likes.

Deal with any associated depressive feelings (see Section 7.7) or problems with attention and concentration (see Section 8.2).

If the stealing is seen as part of a widespread pattern of antisocial behaviour (including bullying, fighting, truancy and lying), usually undertaken with others, then this should be managed as described under Section 8.3.4.). It is very likely that the police will become involved at some point if the stealing has arisen to fund a drug habit (see Section 10.2).

If the child is slow to learn, contact the school to make sure the teachers are aware of any learning difficulties and are doing their best to help the child improve. Of course, many teachers will have too many children in their classes to give individual attention, but it may be possible for other children who are more advanced to give help if the child is accepting of this.

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

8.7 Truancy

Case 8.8

Alaa is an 11-year-old boy brought by his mother to the clinic because he has fallen from a wall and hurt his ankle. He is limping quite badly but the health professional is able to rule out a fracture with an X-ray very quickly. While the health professional was bandaging the sprained ankle, she realised that the accident had happened at 11:00 on a mid-week morning when he should have been in school. She asked his mother why he had not been in school. His mother replied that she wished she knew. She suspected he had been skipping quite a lot of school. In fact, she had been to

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the school the previous week to ask about his progress and the teacher had said he was hardly ever in school. His mother had not known what to do about it and had told Alaa that he must go to school. But clearly Alaa had not obeyed her. There was no father in the home. An older brother had left school at 13 years and was working as a labourer's assistant, carrying bricks and making the tea. What should the health professional do?

8.7.1 Information about truancy

Truancy is frequent among boys who are in their last years of schooling and who do not find school a rewarding experience. It is different from school refusal. In truancy:

- parents do not know their children (usually boys) are missing school
- children are often in groups with other truants, involved in other forms of antisocial behaviour.
- children often have learning difficulties.

In contrast, children who are refusing to go to school:

- have difficulty separating from their parents
- are isolated and have few friends
- are anxious, often rather obsessional children
- do not cover up school absences from parents
- are usually intelligent and making good progress at school.

Background features of children who skip school (truants) include:

- educational retardation, especially backwardness in reading
- other antisocial behaviour, such as stealing, lying and aggressive behaviour
- poor attention and concentration
- neglect with inadequate parental supervision
- material and/or emotional deprivation – lack of love and affection
- other family members have been in trouble with the law.

Schools vary greatly in their attitude to children missing school for no good reason. Some do not have the resources to ensure unwilling children do attend; others have attendance officers who visit the home when a child is absent.

Children who skip school often find the curriculum unrewarding. Schools with few resources are unable to deliver the individual tuition necessary to ensure a child is receiving relevant education. Unless this can be provided, even if a successful attempt is made to get a truanting child back to school, the problem is likely to recur.

8.7.2 Finding out more about a child who is truanting

- As with other forms of antisocial behaviour, the child is likely to see the health professional as an authority figure who will be critical of him. If the health professional is to establish trust, she should not make judgements or be critical. If possible, it is a good idea to see the child first as this will reduce the child's level of suspiciousness.
- Find out when the child began to miss school. Was this related to any particular event, such as a change of teacher? What does the child do when out of school? What efforts has the school made to check on the child's attendance and get the child back to school? (Note that often the school will just not have the resources for this.)
- What is the child's educational level? Are there school subjects such as sport that he is good at?

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- Does the child show attention and concentration problems (see Section 8.2)?
- What is the parents' attitude to the child missing school? Do they take it seriously or has their own experience perhaps led them to believe that school is a waste of time?
- What resources does the school have for dealing with children who are skipping school? The health professional's local knowledge will be very helpful here.

Now, given the information you have obtained, try to understand why this particular child is skipping school. Then go on to work out a plan to help.

8.7.3 Helping children who are truanting

Traunting is mainly a matter for the school and the school authorities. The health professional may, however, have a limited part to play.

- Treat any depression (see Section 7.7), anxiety (see Section 7.1), or attention and concentration problems (see Section 8.2).
- Inform the school of your concerns regarding school attendance.
- Be prepared to listen to parents who wish to talk about their child's problems.

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

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