CHAPTER 14

Stressful situations

14.1 Parental marriage relationships and children

Case 14.1

Odra, a 7-year-old girl, was brought to the clinic by her mother with a number of problems that had been going on for several months. These included bed-wetting, fears of going to school (although she had previously liked school), and not wanting to play with her friends. Her mother said that these problems had started at a time when there had been difficulties in her relationship with her husband. He was a clerk in a government office. They had always got on well together, but 6 months ago he had started to be irritable and angry with her. He would not talk about why he had changed. She had not known what the problem was until a female friend had told her that he had started a relationship with a younger woman he had met at work. Odra's mother said she had been really upset and had confided in Odra's 14-year-old sister, but she could not talk to Odra about it. Now she was worried that her husband was going to leave her. He had started to spend nights away from the home, saying he had extra work to do, but she knew this was not true. She was sure that Odra's problems were caused by all the unhappiness in the home. What should the health professional do?

14.1.1 Information about parents' marriages and children

Most health professionals will know about the behaviour norms for marriage in their locality. In many places, however, the nature of the relationship has changed over recent years because of increasing Western influence. In all societies, no matter what the type of marriage, children have a need for continuing warmth and affection from their parents. The following are ways in which marriage varies across cultures.

Ages of marriage

In some societies, marriage at 16 years is common; in others it is regarded as highly undesirable.

Pre-marital relationships

In cultures where marriages are arranged, the bride and bridegroom may not have met or have met only a few times before marriage. In others, the couple may have lived together for several years and had children before they marry.

Residence after marriage

In some cultures it is expected that the bride will go to live with her husband's family. In others it is normal for the couple to set up a home on their own.

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One or more wives

In some societies it is expected that a man will have more than one wife. In others this is totally unacceptable.

Separate or shared roles

In some societies, married men and women live almost entirely separate lives apart from their sexual relationship. In other societies they share virtually all family tasks.

Communication

This may be free and open or the couple may hardly communicate important factual information such as the state of their finances, let alone their feelings for each other.

Child care

This may be shared almost equally or the mother may take responsibility for all aspects of childcare. In some societies the mother takes responsibility for boys and girls up to a certain age, after which, in the case of boys, the father takes over.

Sources of tension

All types of marriage experience tension, nearly always centring on money, sex, the upbringing of children and other relationships. In traditional societies, the relationship between the wife and her mother-in-law is a common source of tension. In Western societies, marriage strain often arises from the isolation of the couple in cramped living conditions.

Parental separation, divorce and death

In some societies, separation and divorce are extremely uncommon. In many Western societies, as many as 1 in 2 marriages break down before children have reached age 16 years.

Children whose parents separate have a higher rate of emotional and behaviour problems than children whose parents do not separate. If parents separate amicably and remain friendly, the risk of their children developing behaviour and emotional problems is much less than if their separation is accompanied by violent and bitter arguments. All children are affected by parental separation but the majority do not develop significant emotional and behaviour problems. It is important for children that they remain in touch with both parents unless there is a risk of abusive behaviour from one of them.

When parents separate, children often feel that they are kept in the dark and that decisions that affect them are being made without asking them what their preferences are. Children are less confused if they are kept informed but should not be burdened with having to make decisions on behalf of their parents.

Children whose parents do not separate but have frequent, violent arguments have about the same level of behaviour and emotional problems as children of parents who do separate. In thinking about whether to separate or not (and, if they do separate, what the arrangements for the children should be), parents need to ensure that their children's needs are paramount.

In societies with high adult mortality, especially those with a high prevalence of HIV infection, many children will have lost a parent through death before reaching adulthood. In others, very few children lose a parent through death before this age. Children who lose a parent by death are also affected by the loss (see Section 14.2), but the majority do not show significant behaviour and emotional problems.

14.1.2 Finding out about the parental marriage

When children are brought to a clinic for a behaviour, emotional or developmental problem, it is always useful to have some information about the quality of the parental marriage.

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Some parents will spontaneously link their child's problem with marriage difficulties. Other parents will be more defensive and upset if it is even hinted that their marriage problems are affecting their children. To avoid upsetting and angering defensive parents, questioning along the following lines may be helpful.

'Sometimes children are upset by what is happening at home or at school. What are the sorts of things that might be upsetting your child?'

'Is there anything at home that you think might be upsetting your child?'

'All parents have their ups and downs. Does that happen to you?'

'It sounds as if you sometimes get quite angry with each other. How often does that happen?' and 'How does that affect the children when it happens?'

'It really does sound as if you get quite angry with each other. Have you ever spent some time apart?'

'Have you ever thought it would be better if you spent some time apart?'

When talking to children about their parents' marriage, one needs to be very careful not to alienate the child or the parents. If you wish to approach the subject, you might begin with one of the following.

'Sometimes things happen at home that are very difficult to talk about. I don't want you to talk about anything that might upset your mum and dad if they knew you had been talking to me about it.'

'So are there things at home that you find upsetting?'

'What sorts of things?'

'Can you talk to your mum and dad about these things?'

'How do you feel about that?'

'Would you like me to talk to your mum and dad about how you are feeling?'

Some health professionals may neither have the time nor feel they have the expertise to question along these lines. In this situation and if there is nowhere to refer such problems, a health professional could merely say something like:

'Well, it has been difficult for me to work out why your child has this problem. I am sure you know that sometimes when things are not going well at home this can be upsetting for children. You may wish to think about that when you work out what is best for your child.'

Now, given the information you have obtained, try to work out if this child's behaviour and emotional problems may be a reaction to parental marital problems. Then go on to work out a plan to help.

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14.1.3 Helping with parental marriage problems

Health professionals may feel able to explore the quality of the parental marriage and the way this might be affecting a child who has a behaviour and emotional problem. But they are unlikely to feel able to provide expert counselling for parents whose marriages are in trouble. They should nevertheless keep in mind the following principles when talking to parents who might be thinking of separating.

- It is better for children over the age of 6 years to be kept informed of any proposed changes that might affect their lives. If possible, although they should not be inappropriately burdened with making decisions, it is always a good idea to ask their views on what should happen. This is especially the case with older children.
- Parents who are thinking of separating should be clearly told that their children will be less upset if they are able to separate in a friendly way. Their children will not do so well if the separation involves violent arguments and recriminations.
- Children whose parents separate almost always suffer from the fact that there is less money to go round. They need to have this explained to them.

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

14.2 Grief and loss

Case 14.2

Anga is a 9-year-old girl who is brought to the clinic by her mother because she is crying, wetting the bed and does not want to go to school. This has been going on since Anga's father was killed in an accident at work 4 months ago. He fell off scaffolding at a building site and died immediately. The other two children, an older boy and a younger girl, were both very upset initially, but they seem to have adjusted to the idea that they are not going to see their father again. Anga remains very upset. She will not talk about her feelings to her mother, who herself is finding it difficult to cope. The mother's family is trying to help, but even so, the money coming into the home is much reduced. There is enough money to eat but nothing left over for extra things such as new clothes. What should the health professional do?

14.2.1 Information about grief and loss in children

Loss is a common experience in childhood. Even in high-income countries, 3 in 4 children will have experienced the death of a close relative, often a grandparent, by the age of 16. In LAMI countries with high death rates, many children will lose one or both parents by the time they reach adulthood. This is particularly likely in places where HIV/AIDS is endemic.

Loss of a parent through separation or divorce is an increasingly common experience for children in Westernised countries than the loss of a parent through death. Parental separation is also increasingly common in LAMI countries and is discussed in the previous section.

Children's ideas of death change as they get older (Clinical Center, 2006).

- Pre-school children see death as reversible and temporary – they watch cartoon characters get killed, then get up again and carry on as if nothing has happened.

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- Between 5 and 9 years, children begin to realise that death is final but retain the belief that a person can come back to life. They may form an image of death in their minds, for example as an angel of death or a skeleton.
- From age 10 upwards, children increasingly understand that death is irreversible and that all living things die.

Children's ideas of death will vary greatly depending on their previous experience of death. Their ideas will also depend on the religious ideas in their society. For example, in societies that believe in reincarnation, children will have very different ideas from those living in societies in which death is regarded as final and irreversible.

Reactions to death (bereavement reactions) differ widely from society to society. Individuals within societies also differ greatly in how they react to the death of a family member. The following bereavement reactions are common features shown by children under the age of 10 years and may last from a few days to several months and include:

- Confusion over why adults are so upset, constantly questioning them
- Magical thinking – the child believes that the dead person will come back
- Sense of guilt and feeling of responsibility for the death
- Sleep disturbance, perhaps with nightmares and bed-wetting.

Over the age of 10 years, reactions may last from several days to a few months and include:

- immediate disbelief and a sense of numbness
- outbursts of weeping
- outbursts of anger, perhaps towards doctors or nurses who could not keep the dead person alive
- disturbed sleep, possibly with nightmares
- difficulties in concentrating and decline in schoolwork.

The following factors influence bereavement reactions.

- Age of the child.
- Previous experience of loss by death, for example of a pet or a friend at school.
- The reactions of others around them. If others are openly crying, children will feel better able to cry themselves. If others are holding in their emotions, children may feel they should do this too.
- Whether the death was expected, for example following chronic illness, or sudden and unexpected. People, including children, take longer to adjust to an unexpected death because they have not been able to begin to mourn before the death.
- The relationship of the child to the person who has died. Reactions will be stronger if there was a close bond between the child and the person who has died.
- The length of time since the death. Crying, sleep disturbance and inability to concentrate usually fade by 3 months and disappear by 6 months. However, this varies widely.

Children who have suffered bereavement in childhood are slightly more likely to show psychological problems, especially depression, in adulthood than those who have not been bereaved, but the differences are not great. In contrast, children whose parents have separated or divorced have a distinctly increased rate of psychological problems later on.

14.2.2 Finding out about bereavement reactions

- What signs of bereavement is the child showing? Note that these may involve any combination of a range of behaviours and feelings. The child may show depressive features, anxiety, irritability with outbursts of temper, anger and disobedience, aggressive behaviour, sleeping or eating problems, and decline in schoolwork.

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- How long have these been present? Did they start when the person died or after a period in which the child showed little reaction?
- Was the death sudden and unexpected or did it occur after a chronic illness? Has the child been told the truth about the reasons for death? This may have been especially difficult if the person ended their own life or died of HIV/AIDS.
- What was the relationship of the child to the dead person? Was it close and positive, indifferent, or perhaps tense and hostile?
- Did the child participate in the rituals following death? Or was he excluded?
- What is the current reaction of others in the family to the bereavement? Are they still showing signs of upset? Can they talk about the dead person?
- What ideas has the child expressed about what has happened to the person after death? Are these the sorts of ideas that adults have in the society in which the child is living?
- Has the child expressed his feelings about the death? Are there people around who feel comfortable talking about the death? Is the child being shunned by friends because they do not know what to say to her?
- Are there other stresses present that the child may be reacting to? Remember that there may be factors other than the bereavement that may be affecting the child's feelings and behaviour.
- Some of this information will only emerge if it is possible to talk to the child alone. The health professional should try to talk alone to all bereaved children over the age of 8 years.

Now, given the information you have obtained, try to understand this child's grief and feeling of bereavement. Then go on to work out a plan to help.

14.2.3 Helping bereavement reactions in children and adolescents

This will depend very greatly on the findings made in the assessment. It is important to communicate to parents the wide range of normal bereavement reactions, and active steps to provide help will be needed if, after a few weeks, the child:

- is refusing to go to sleep
- is refusing to see her friends
- has continuing anxiety, panic attacks or phobias
- is showing a persistent decline in schoolwork
- refuses to talk about the person who has died
- is showing aggressive or very disobedient behaviour
- has taken to drinking alcohol.

The health professional should try to see the child by himself. The conversation with a child aged 8 years or over might begin:

'I know that your …… died a few weeks ago. Could you tell me a bit about him please?'

If the child only says positive things, one might go on:

'Well, those are a lot of good things. Were there any things that were not so good? After all, no one is perfect.'

After the child has talked about the person's good and bad points, one might go on to ask: 'How did you and he get on?' and then 'What do you miss most about him?'

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The conversation might then go on to deal with why the person died when they did. With parental permission, the child may need to be told the truth of what happened later on, but the health professional should not divulge such information without getting permission from the parents. How is the child currently feeling about the death? Are those feelings changing as time goes on?

It is important to find out whether the child feels responsible for the death in any way. Younger children especially may have fantasies along these lines that they find difficulty in expressing. If such fantasies exist, the child may be asked whether there is anything that might make him feel he was not to blame in some way. In addition, the parents or, if a parent has died, the surviving parent may need the opportunity to talk about their own feelings of loss.

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

14.3 Physical abuse

Case 14.3

Khalifa was brought by her mother to the health clinic in a poor part of the city one morning because, her mother said, she was not moving her left arm. The 4-year-old was crying bitterly and it was obvious that she was in pain. She screamed when her arm was touched or when the health professional tried to move it. There was a bruise on the forearm. The health professional suspected a fracture and an X-ray confirmed this. The X-ray also showed that Khalifa had old rib fractures. The mother was asked how the arm fracture had occurred and said she did not really know. She also did not know how the rib fractures had come about. Khalifa must have fallen. The mother looked uncomfortable when she gave her explanation. The bruise stretched right round the arm and it looked as if someone had gripped the arm very tightly. Neither the fracture nor the bruise looked as if they could have been caused by a fall. The health professional noticed that Khalifa was very thin and looked dirty and uncared for. She had no difficulty in deciding that Khalifa was both neglected and the victim of physical abuse. What should the health professional do?

14.3.1 Information about physical abuse

Physical abuse occurs when an adult inflicts a physical injury on a child to a degree that is unacceptable in the society in which the family lives.

What is regarded as acceptable physical punishment varies between societies. In some societies it is acceptable for parents and teachers to beat children extremely hard when they see them as being naughty or disobedient. Indeed in some places it is thought that to be a good parent it is necessary to beat your child for bad behaviour. On the other hand, some places it is against the law for parents (or teachers) to hit children when they are naughty.

Physical abuse occurs across the social spectrum, even in very rich families, where it may be inflicted by parents or servants. However, it is far more common in poor families, living on the edge, where parents are experiencing multiple stresses. Such practices can cause both physical and psychological harm to the child.

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Even in societies where physical punishment, even severe physical punishment, is 'normal', children who are beaten are more likely to be aggressive and anxious later on in life than those who are disciplined in other ways.

Unless the injury is very minor (scratches or small, single bruises), health professionals should regard the presence of all physical injury for which the parents cannot provide a convincing explanation as evidence of physical abuse. The following injuries are likely to be signs of physical abuse:

- bruising on the face, ear lobes, buttocks or back, especially if multiple
- crescent shape discolouration in the shape of a human bite
- burns, cigarette butt marks or scalds
- retinal haemorrhages, usually caused by head-shaking
- bone fractures for which no convincing explanation can be provided
- torn upper lip.

Conversely, bruises over the shins of toddlers and young children are common 'play bruises' and usually not associated with maltreatment. Accidental bruises are found most over bony prominences and the front of the body.

Parents who abuse their children tend to be:

- young
- unemployed
- violent and impulsive
- drinking alcohol excessively or using drugs
- the result of a violent upbringing themselves.

Characteristics of children who are abused include:

- hyperactivity
- oppositional
- have a difficult temperament
- frightened
- distrustful of adults.

Parental attitudes to the child may reveal an abusive relationship. The parents may:

- blame or belittle the child
- treat the child as a scapegoat, for example holding him responsible for all that goes wrong in the family
- be unconcerned about the child's welfare
- fail to keep appointments made for the child.

The young child may react in several ways. He may:

- become sad and withdrawn
- be suspicious of all adults
- cry and refuse food
- lose weight or fail to gain weight.

Older children may:

- become miserable and depressed
- become aggressive and violent
- fail in schoolwork
- run away from home, perhaps to the city or to other relatives.

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14.3.2 Finding out more about a child who may have been physically abused

Information may be forthcoming from teachers, neighbours or health professionals who may notice injuries to the child, or from the child himself who may report to teachers or others that he is being physically abused.

Absolute certainty is never possible but health professionals, in making this judgement, need to be convinced that it is highly probable that the child has been physically abused.

There are a few physical conditions which, on rare occasions, may provide explanations of physical injuries that look as if they are the result of abuse but are in fact caused by something else.

- Multiple bruising may be caused by blood clotting disorders. In this case the child will probably have experienced abnormal bleeding in other circumstances such as with accidental cuts or a tooth extraction.
- Multiple fractures may be caused by very rare bone disorders, especially brittle bone disease or osteogenesis imperfecta. In this case the child will almost certainly have been brought to the clinic previously by the parents because of fractures caused by very minor injury.

A child whose injuries suggest that he has been physically abused should be examined unclothed from head to toe for signs of physical injury other than those with which the child has presented. If facilities exist, an X-ray of the whole body should also be taken. All this information should be carefully recorded, with drawings of all injuries that are visible.

The health professional who learns that a child has probably been abused, should pass this information on to the local child protection agency, usually a social worker or the police.

If there is no such agency available, then the health professional will need to take the responsibility herself. She will begin by interviewing the child. It will sometimes be a difficult task to decide whether to inform the parents before interviewing the child, because if it is the case that the abuse has taken place in the home, the parents may threaten the child and prevent him from telling the truth. In these circumstances, the health professional may be at risk of injury from family members who are angry at what they believe is an accusation against them. Health professionals therefore need to be cautious in what they say and make sure, if at all possible, that they do not act without discussion with whoever is in charge of the clinic.

If, as happens occasionally, it seems likely that abuse has occurred outside the family or that no family member has been involved, then the health professional should tell the parents that she needs to talk to the child with a parent present as the possibility exists that the child has been abused. If a family member has been involved, then tell the parents that you need to talk to the child. Someone known to the child but who is not family, such as a teacher, should be present.

Many children who have been physically abused will, in fact, be too young to interview. Children over the age of 4 years should, however, be interviewed. When interviewing children at risk of abuse with or without a parent present:

- make sure that you put the child at ease before asking difficult questions – you can use toys or drawing or talk about neutral subjects such as things the child enjoys doing or subjects the child enjoys at school;
- speak calmly and ask questions without putting any ideas into the child's head;
- do not accuse anyone in the child's presence;

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- ask questions such as 'Sometimes children can get hurt by a grown-up. Has that happened to you?' If the child answers positively, go on to ask 'Please could you let me know who has been hurting you?', then go on to ask what happened and if the child has told anyone else about this;
- when the extent of the child's injuries is known, the parent(s) may be asked questions such as: 'X has got these [describe injuries]. How do you think this happened?';
- assuming an inadequate or unconvincing explanation is given: 'It doesn't seem to me that that could explain the injury. Have you any other ideas how it could have occurred?' or 'Is there anyone else in the home who would be able to tell me more?' or 'I'm afraid it looks to me as if X has been hit by someone. Have you any idea who that could be?'

The health professional may then go on to try to give the parent or the person who has brought the child the opportunity to express their feelings. You can say things such as: 'This must be very upsetting for you. How do you feel about the fact that X is hurt and you don't seem to be able to explain this?' Given this opportunity, the adult responsible is more likely to be open and honest about what has really occurred.

Always make sure that you write down exactly what both parents and children have said as soon as they have talked to you.

14.3.3 Helping children who have been physically abused

Once it is clear that a child has been physically abused, what the health professional should do depends on whether there is a child protection service in the area. If such a service exists, then the health professional should immediately alert the service to the problem. In most places the presence of a child protection service will also mean that the police will have to be involved. In these circumstances the role of the health professional is to make sure that the problem is being dealt with by the child protection service and that this service has all the information it needs to make the best decisions on behalf of the child. If a child protection service is available, the health professional has two tasks:

1 to establish that the child's injuries have been caused by unexplained trauma
2 to keep the child safe until the child protection service can take over.

If a child protection service does not exist, then the health professional will need to take responsibility for ensuring that the child is as well protected and receives the best possible care.

14.3.4 Principles of good care for a child who has been abused

- The child needs to be safe from further abuse. This is the number one priority but remember it is never possible to guarantee absolute safety.
- The child should remain in as familiar a place as possible, preferably the home, as long as it is safe to do so. In Western countries, children who had been abused were, until quite recently, removed from their homes. It is now realised that the removal from loved ones is often more harmful than keeping children at home.
- All family members should be involved in taking responsibility for the child's welfare. Grandparents may have a particularly important part to play, especially as the parents are likely to be young.
- The family should be treated with respect; horror at what has occurred should not result in rudeness to or rejection of family members.
- If the family is prepared to accept help from them, local resources such as voluntary organisations that help families should be involved.

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- The fact that the child has been abused and requires to be kept safe should not draw attention away from all the other needs the child is likely to have, such as for adequate nutrition, healthcare, clothes, stimulation and education.

14.3.5 Helping the abused child

Helping the abused child can take a number of forms (Box 14.1). However, remember it is not just the child who will need help. Other family members may also be under stress. They should be given the opportunity to talk and help should be provided depending on their needs. If a family member has been involved, it may be necessary for this member to leave the family at least for a period of time.

Once the abuse has been made known, the person responsible may stop it, but this does not always happen. The child should be given the opportunity over the following weeks and months to say whether he is still being hurt, physically, sexually or otherwise.

Continuing abuse may mean that the child will need to be found an alternative home. If at all possible this should be with a relative (e.g. aunt, grandparent), but where no family member is prepared to take on the responsibility, then the child may need to be placed in a children's home or orphanage. If at all possible, contact with the family should be maintained.

Now write down the ways in which you think a health professional could help Khalifa.

Box 14.1 Helping the abused child

1 Help the child feel positive about himself
   - Reassure the child that he is not responsible for the abuse
   - Give positive messages to the child about his behaviour and emotions
   - Suggest activities that the child enjoys, such as playing with friends
2 Help the child to trust
   - Be someone who the child can talk to in confidence
   - Spend time alone with the child
   - Show love and affection, but remember to be careful about physical touching
3 Help the child to identify and express emotions
   - Play games that involve feelings and emotions
   - Read books that involve emotions
   - Talk about what emotions the child is experiencing and why
   - Teach the child ways of dealing with anger, such as playing with toys until he calms down
4 Help the child make a safety plan
   - If there is a local police number, write it down somewhere where the child will find it easily
   - Choose a friend or neighbour where the child can go for help
   - Help the child to say 'no' to the adult
5 Healing messages for children
   - I care about you
   - I respect you
   - You are lovable
   - You have strengths
   - It is a good thing you have told me; now we can try hard to make sure you will not be hurt again
   - Most adults would never hurt children
   - You can say 'no' if you do not like the way someone touches you.

Patel (2003)

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14.4 Sexual abuse

Case 14.4

Soraya is a 5-year-old girl who is brought to the clinic by her mother with a stomach ache in the lower part of her abdomen. On examining her, the health professional notices that there is bruising around the vulva. When she gently parts the vulva she notices also that there is a tear inside the vulva and that the girl has a vaginal discharge. What should the health professional do?

14.4.1 Information about sexual abuse

Sexual abuse has occurred when children and young adolescents are involved in sexual activities with adults or older adolescents with or without their consent. Such activities may involve sexual contact such as penetration of the vagina or anus, or lesser forms of sexual activity such as fondling of the genitalia. Another form of sexual abuse involves the making of films or videos of children participating in sexual activities. Non-contact abuse occurs when, for example, a man 'exhibits' his penis to a child while masturbating. Penetrative abuse is often preceded by a period of 'grooming' when the older man begins by befriending and then stroking and fondling other parts of the child's body before moving on to the genitalia. Both boys and girls can be victims of sexual abuse.

Sexual abuse has certainly or almost certainly occurred when:

- a child under the age of consent (14 or 16 years in most countries) has physical signs of sexual contact – perforated hymen, bruising or cuts in or around the vulva, damage to the anus or a sexually transmitted infection such as chlamydia or gonorrhoea. It is important to remember though that many forms of sexual abuse can occur without any abnormalities being found on physical examination;
- a child of this age reports that he is being sexually molested. It is very unusual for children of this age to make up such stories and they should be assumed to be telling the truth unless there is very good evidence to the contrary.

Sexual abuse should be suspected if there is:

- precocious sexualised behaviour, but remember that this type of behaviour may be shown by many other children who are influenced by media portrayal of sexually aware children
- touching and playing with sexual parts in public.

Sexual abuse should be borne in mind as a possibility when a child shows any of a range of behaviour and emotional problems for which there is no convincing explanation. The health professional should, however, be very reluctant to assume abuse has occurred without the presence of more positive evidence.

If the perpetrator is a child or adolescent, it is important to remember that they too may be a victim. Overwhelmingly, sexual abuse is perpetrated by older boys and men on younger boys and girls. However, women are also sometimes perpetrators. The perpetrator has often been abused himself as a child and in adulthood he often has problems with excessive alcohol consumption or is using illegal drugs.

Most sexual abuse is carried out by family members. Fathers or stepfathers are often involved. If the father is the perpetrator, the mother may sometimes know about what is going on but may say nothing because of fear. In addition, there are often other forms of family violence occurring at the same time. For example, the mother may herself be the victim of domestic violence. Sexual abuse by strangers outside the family is much less common, although when it occurs it is much more widely publicised.

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Children who are victims of sexual abuse may become sad and withdrawn, show aggressive behaviour problems, fail in their schoolwork or run away from home. These problems may, however, arise from any severe stress and it should not be assumed that the child has been the victim of abuse without strong confirming evidence.

14.4.2 Finding out more about a child when sexual abuse is suspected

When sexual abuse is suspected, the assessment will depend on the availability of specialist resources. In some areas there will be a Social Services department to carry out the assessment. In many places there will not even be a social worker to advise. The health professional will then have to depend on his own skills and on the limited local resources that are available.

First, it should be explained to the parents that there is reason to think that their child has been sexually 'interfered with'. If the parents have brought the possibility of sexual abuse to attention, this will, of course, not be necessary.

After an explanation to the child at a level appropriate to the child's understanding, there should be a general physical examination with the mother present (if this is not appropriate, then with another familiar person), followed by examination of the external genitalia for signs of injury. If there is a discharge and if facilities exist, a specimen should be taken for culture. All observations should be carefully recorded, with drawings of any injuries noted. Examination of the genitals for signs of sexual abuse can be difficult, especially if the damage is relatively slight. If possible this should be done by someone who is experienced in this type of work.

In most places there will be no child protection team available to deal with child abuse cases. In these cases the health professional needs to begin by interviewing the parent(s). She will begin by explaining that there is a concern that someone has been hurting the child's 'private parts'. She will explain that this is a very serious matter and that she will have to ask some difficult questions. She can then find out from the parent what the family names for the genitalia are. She may ask:

'What do you call the part of X's body where she does her wee?' and 'What does X call that part of her body?'

This will give the health professional a shared vocabulary with family members, including the child. She may then go on to ask the mother:

'It looks as if there has been some interference with X's private parts [or whatever word the mother has used]. I wonder how you think this could have happened?' and 'Who do you think could have done this?'

If the mother reveals she has been aware of what has been going on, she will need to be asked what she has done about it and who else she has told. The mother's response should be carefully recorded.

If at all possible and if the child is over the age of 4 years, the health professional should ask permission from the mother to talk to the child separately, explaining that some children find it easier to talk when they are alone. The child should be put at ease before moving on to ask for details of the abuse. At this point the health professional can begin by asking the child to make a drawing of the body. Alternatively, the health professional can draw a body and then point to the genital area and ask:

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'What do you call that part of you, down there?'

'Has anyone touched your [term the child has used]?'

'Did you like that, or not very much?'

'Did it hurt?'

'Who did that?'

'Did you ask them to stop?'

(In specialist facilities there will probably be a number of anatomically correct dolls to make communication easier, but these are unlikely to be available to most health professionals).

The child's answers may make clear what has been going on and who has been responsible. On the other hand, many children who have been sexually abused will deny this has happened because they know it is wrong and do not want to get the perpetrator into trouble. Whatever the child has said the health professional will need to record.

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

14.4.3 How to help children who have probably or definitely been sexually abused

Once it is clear that a child has probably or definitely been sexually abused, what the health professional should do depends on whether there is a child protection service in the area. If such a service exists, then the health professional should immediately alert the service to the problem. In most places the presence of a child protection service will also mean that the police will have to be involved. In these circumstances the role of the health professional is to make sure that the problem is being dealt with by the child protection service and that this service has all the information it needs to make the best decisions on behalf of the child.

If a child protection service is available, the health professional has two tasks:

1 to establish that the child has been probably or definitely sexually abused
2 to keep the child safe until the child protection service can take over.

If a child protection service does not exist, then the health professional will need to take responsibility for ensuring that the child is well protected and receives as good care as is possible.

The same principles apply to the care of children who have been sexually abused as with those who have been physically abused (see Section 14.3).

Health professionals who identify sexual abuse may be at risk of injury from family members who are angry at what they think is an accusation against them. Health professionals therefore need to be cautious in what they say and make sure, if at all possible, that they do not act without discussion with whoever is in charge of the clinic.

Now write down ways in which a health professional could help Soraya.

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14.5 Emotional abuse

Case 14.5

Nikhil is a 7-year-old boy brought to the clinic because he is wetting the bed. In fact he only wets the bed about once a month and the health professional does not think this needs any special treatment. But she notices that while the mother is talking about Nikhil she seems to be extremely angry with him. She says the bed-wetting is just one of the ways in which Nikhil tries to hurt her. He never does anything to help in the home. Compared with his 10-year-old sister, he is 'useless'. When Nikhil tries to speak she shuts him up immediately. The health professional asks what are the good things about Nikhil, and the mother says 'Well, there isn't much good about him. Oh yes, he does once in a while give some sweets to his sister, but he only does that because he wants something from her.' The health professional feels this mother really dislikes her son. What should the health professional do?

14.5.1 Information about emotional abuse

In this type of abuse the child is damaged not by physical injury but by a combination of rejection and lack of affection. Emotional abuse is nearly always accompanied by neglect (see Section 14.6). It may be shown in a number of ways. The child may be:

- exposed to relentless criticism and hostility from one or both parents
- deprived of affection – there will be no warmth shown to the child in the way of praise or cuddles or hugs
- ignored – when the child tries to draw attention to something he has done, he is ignored or told off
- exposed to threats – the child is, for example, frequently told he will be sent away from home
- exposed to stressful situations he is in no position to influence – for example, the child may witness his father beating up his mother without anyone caring to think about what he must feel.

Emotional abuse is often linked to:

- poor social circumstances (although many children living in poverty are in no way emotionally abused; on the other hand, some children living in affluent homes may be emotionally abused by servants, relatives living in the home or parents who are absorbed with their own lives and have little time for their children)
- living in a disadvantaged neighbourhood, with high rates of violence and unemployment
- parental problems, when parents:
  - have often had a harsh upbringing themselves
  - are violent and impulsive
  - show excessive alcohol consumption
  - use illegal drugs
  - punish harshly
- behaviour problems – the child may:
  - have a difficult temperament
  - be excessively demanding
  - be frequently disobedient.

A child may be singled out or made a scapegoat, while other siblings are appropriately loved and emotionally supported. This may be due to parental attitudes relating to the past. For example, the child may be:

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- not of the gender the parent wanted
- conceived by a partner from a different relationship – often a secret held by the mother
- born at the wrong time, disrupting parental plans
- have an intellectual disability or a physical disability
- have a personality that conflicts with that of one parent.

14.5.2 Finding out more about a child who is being emotionally abused

The health professional should look out for:

- the possibility that the child has undiagnosed developmental problems (intellectual disability, a specific delay, hyperactivity, ASD) that may make parenting more difficult (note that some of these problems may have arisen as a result of emotional abuse and not be the cause of it);
- constant belittling of the child, who cannot do anything right; if the child does something positive the parent may say, for example, that she cannot remember the last time he did this;
- a lack of warmth in the parent's tone of voice when talking to or about the child;
- parents giving the impression that the child is always trying to irritate or annoy them.

All these behaviours are likely to be even more damaging if the child is singled out for hostile or rejecting behaviour, while other children receive more favourable treatment.

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

14.5.3 How to help a child who is being emotionally abused

Action to reduce emotional abuse could involve:

- talking to the parents about the child's need for love and affection
- showing caring behaviour to the parents and trying to find out at least the small, positive ways they are behaving towards their child
- if the child does have a developmental problem, discussing this with the parents in such a way to help them to both promote development and rebuild affection towards the child
- a discussion with teachers or other relatives
- working out ways of helping the child to spend time away from the family, with neighbours, friends or other relatives
- giving the child the opportunity to talk about his feelings at being rejected and sympathising with him, making it clear he is not alone in the world.

Now write down ways the health professional could help Nikhil.

14.6 Neglect

Case 14.6

Maya is an 18-month-old girl in an orphanage. She has been in the orphanage since the age of 3 months when her mother became unable to look after her because she had AIDS. Her mother died 2 months later. Her father died of AIDS while her mother was pregnant with her. There were no grandparents or other relatives available to take over her care. No one from the family came to visit Maya. A health professional who visited the orphanage on a regular basis was asked to see Maya because the staff were worried about her and wondered whether she had a physical illness. She

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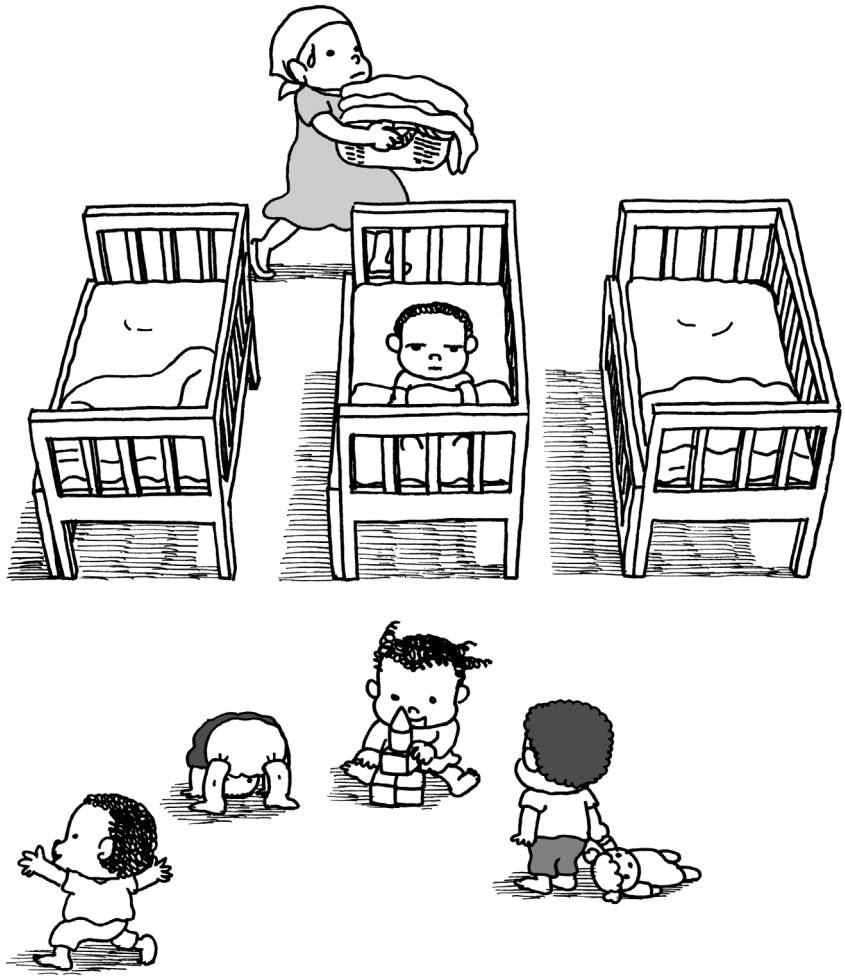
found Maya lying in a cot with the sides up in the middle of the afternoon. The staff of the orphanage said they were so short of staff that no one was available to take her out into the garden. They told the health professional that there was no one who took a particular interest in Maya. One member of staff had spent a lot of time with Maya after she was admitted to the orphanage but this person had left about a month ago. Shortly afterwards Maya had started to refuse most foods. She seemed lacking in energy and was listless. When the health professional spoke to her she did not respond, but just lay in her cot. There did not seem to be anything physically the matter with her. What should the health professional do?



Case 14.7

Maliki is a 6-year-old girl who has been sent to a health clinic by the school because her teachers think she is very small for her age and they are worried about her. She comes with her mother. When she is weighed and measured, Maliki is below the third centile for height. Her mother is also small and very quiet. It is difficult to hear her speak. It turns out she has six children and Maliki is the youngest. Her mother has no complaints about Maliki. She says she is such a good girl that she often forgets she is there. The girl looks unwashed and is wearing clothes with holes in them. The health professional has seen other children in this family and knows they are better looked after.

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14.6.1 Information about children who are neglected

In this form of maltreatment no actions are taken that harm the child. Instead, the child is denied essential care that all children should receive. This can be just as, if not more, harmful than more active forms of abuse. There are several types of neglect, which may occur together.

- Lack of physical care. The child is likely to appear dirty, undernourished and has inadequate clothing. Poor parents will not be able to provide their children with new, smart clothes, but most will manage to ensure that their children are dressed in clean clothes, even if they are shabby.
- Lack of warm, affectionate care. Children do not receive hugs and cuddles and are rarely, if ever, praised when they have performed well.
- Lack of supervision to ensure safety. Children are allowed to play in dangerous areas, for example around busy roads where they are at risk of being victims of road traffic accidents. Parents often do not know where their children are playing and there are no rules about the time they are expected to come in from playing outside in the evening or when they are expected to be in bed.
- Lack of stimulation to promote learning and development of intelligence. The parents show no interest in helping their children to learn. They do not make sure they attend school regularly. They do not read to their children or listen to them reading.
- Lack of healthcare. Parents neglect the presence of major or minor illness, not taking their children to health professionals when clearly they are in need of medical or nursing attention.

Causes of neglect include:

- lack of money
- unemployment
- large numbers of children
- poor household organisation
- young parents
- parents with mild intellectual disability
- parents who have been neglected in their own childhood
- parental, especially maternal, depression or other mental disorders
- issues relating to emotional abuse (see Section 14.5).

The impact it has on the child includes:

- failure to thrive, physically or emotionally
- small stature
- mild intellectual disability
- failure in schoolwork
- lack of close attachment to parents
- overfriendly relationships with strangers.

14.6.2 Finding out more about a child who may be neglected

The identification of child neglect does not usually present many problems provided the possibility that it is present is borne in mind. Observation of the mother and child will usually prove quite sufficient to establish whether a child is being neglected.

The child should be physically examined and all the findings, especially the height and weight of the child, should be recorded.

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Some assessment of the child's level of mental function should also be made in terms of the child's mental age. Are the child's replies to questions like that of a child of his actual age or are the replies more like that of a child 1, 2 or even 3 years younger?

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

14.6.3 How to help a child who is neglected

The parents should be given as much help as possible to improve their care of the child. If the parents are experiencing stress themselves, providing help may give them more ability to care for their child. Relatives, neighbours, friends or local community support might be recruited to support the parents, perhaps take over some of the childcare and thus improve the child's quality of life. Advice to parents and relatives might include:

- advice on the child's diet
- help to obtain more food for the child
- advice on how to show physical affection to the child
- advice on how to keep the child safe
- encouragement to send the child to school regularly, monitoring the child's school attendance
- explanation of how to bring the child to a clinic for check-ups and for medical or nursing care if the child is ill.

If health professionals are involved with children in orphanages who are neglected, they should use their influence to improve the conditions in the institution. This might involve encouragement to ensure:

- a better staff to child ratio, with more adults looking after each child
- more personalised care, with children being allocated special caregivers who will be responsible for their care
- stimulation appropriate for the developmental level of the child
- good healthcare and nutrition
- an active programme to transfer the children to good family care, with either an adoption or long-term fostering arrangement.

Now describe how a health professional might be able to help Maya and Maliki.

14.7 Children in disasters

Case 14.8

A health professional is contacted and asked to go to a large village in a rural area 50 miles away from where she works. The village, with a population of a 1000 people of whom 300 were children, was devastated by a landslide a week ago. In the car on the way she is told that most of the houses in the village were destroyed and the rest have been deemed unsafe. About 100 people were killed and a number of others injured. The surviving members of the village have been housed in tents in a camp that has been set up 5 miles from the landslide area. The camp is being supplied with clean water and a sufficient supply of food. The injured, another 100 people, have been taken to a hospital in a city 100 miles away. The health professional is told that she is to take responsibility for the welfare of the children in the camp. What should be going through her mind about what she is going to do as she nears the village?

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14.7.1 Information about the needs of children who are victims of disasters

When disasters occur, individuals experience feelings of helplessness and hopelessness. Feelings of confusion about what has happened are mixed with feelings of loss. The sooner the community regains a sense of empowerment over its own future, the more rapidly will its members come to terms with what has happened, so it is important that decision-making becomes the responsibility of the community leaders and the rest of the population as soon as possible.

The paramount need of children who have become victims of disaster is to be reunited with their parents if they are still alive and with substitute parents who will take responsibility for them if the parents have died. Similarly, the paramount need of parents is to be reunited with their children. In most disasters involving loss of life and serious injury, separation of children from parents occurs because the injured child/parent is removed from the scene for emergency, life-saving treatment.

The most common mental health consequence of both natural and man-made disasters is PTSD (see Section 14.8). However, reactions to sudden overwhelming stress may include the whole range of emotional and behaviour disorders.

14.7.2 Assessment of children's needs in a disaster area

The first requirement is to identify and obtain names for all the children under 16 years in the affected area and in hospital or emergency treatment centres. This should be done by the leading aid organisation together with the community leaders. The second requirement is to identify those children who are separated from their parents. Attempts should also be made to keep all family members, especially brothers and sisters, together. Questions that should be asked are:

- Are the physical needs (e.g. food and water, clothing and shelter) of the children being met?
- Have all physical injuries been attended to?
- Have all children had the opportunity, if they wish to take it, of describing what happened to them and what their main worries and anxieties are at the present time?
- What practical steps are necessary to re-establish normal life, including attendance at school classes?

Now, using the information you have obtained about the disaster and the way the child and family have been involved, try to understand how they are feeling. Then decide what is the best course of action.

14.7.3 Treatment of children who have been exposed to disaster

Assuming that all the physical needs of the child population have been met, and that family members have been reunited as best as possible, the next step is to ensure that the mental health needs of the children are considered.

Engaging children in activities aimed at restoring normal life will give them a sense of responsibility and self-esteem. Children should be involved in tasks such as helping adults to obtain and carry food and water, putting up tents, looking after younger children, etc., as much as possible. In addition, give all children with PTSD or other emotional reactions appropriate intervention (see Section 14.8), using activities such as drawing, colouring and group work.

Now make a list of the ways in which health professionals called to disaster areas can most helpfully meet the mental health needs of children.

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14.8 Post-traumatic stress

Case 14.9

Shakiri is a 7-year-old girl brought by her mother to the clinic. About a year ago, a heater in their home caught fire and the shack in which the family lived was burned down. Shakiri, her parents and her 9-year-old brother were able to get out but her baby sister, aged 9 months, who was sleeping near the heater, was badly burned and died shortly afterwards. The family went to live with a relative but have now found another shack to live in. Although Shakiri's parents and brother were very upset for some months, they are now able to get on with their lives, but since that time Shakiri tells her mother that she cannot stop thinking about the fire and about her baby sister. She wakes several times during the night, crying out for her mother. Previously, she could happily play outside with other children, but now she cannot bear to let her mother out of her sight. When she plays at home, her mother can see she is constantly going over the events of the fire. She will not go anywhere near to where the shack was burned down. She is too frightened to go to school. What can the health professional do?

14.8.1 Information about post-traumatic stress

Post-traumatic stress (stress following trauma) can occur after any natural or man-made disaster affecting large groups of people. Natural disasters include earthquakes, volcanic eruptions, floods, tsunamis and bush fires. Man-made disasters include wars, civil disturbances and train crashes. Children may also experience post-traumatic stress reactions following sexual or physical abuse, or sudden, unexpected separation from their parents.

Stress reactions following trauma can take the following forms.

- Flashbacks or sudden acutely frightening feelings that the traumatic event is happening again and that one is reliving it – this is unusual in young children but more common in adolescents
- Sleep disturbances such as difficulty in getting to sleep, waking during the night, nightmares and sleep-walking
- Difficulties in separating from parents
- Difficulties in concentration and memory
- Avoidance of the place where the trauma occurred
- In teenagers, aggressive and risk-taking behaviour.

These reactions are very common after an acutely traumatic event, occurring in as many as a third of disaster victims. These reactions usually reduce in intensity over time. In about a third of those who experience such symptoms, they disappear by the end of a year. In some children, however, they persist well beyond this time.

Children who are not separated from their parents and are well supported by them after the trauma, have friends to talk to, and do not regard themselves as in any way responsible for the traumatic event are much less likely to develop a stress reaction of this sort. Children who have suffered trauma at the hands of a family member are more likely to have persistent, disabling symptoms.

14.8.2 Finding out more about children with post-traumatic stress

- Find out the details of the trauma to which the child has been exposed. In what way was the child involved?
- What symptoms is the child is showing? How severe are they and in what way are they interfering with the child's life?

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- How soon after the trauma did the child first show these symptoms?
- Has the child had an opportunity to talk about the trauma and how he was involved?
- Has the child been separated from parents and other familiar figures?
- What was the child's personality before exposure to the trauma?
- Are there stresses other than the traumatic event to which the child has been exposed? For example, has he been exposed to quarrelling between his parents or bullying at school?
- How have the parents responded to the symptoms the child is showing?
- How does the child think of the traumatic event? Does he think of himself as responsible in any way? Who does the child think is responsible?
- Identify any mistaken beliefs the child may have about the likely recurrence of the trauma.
- Identify any stimuli that may bring back the fears of the child, for example the presence of a well-controlled bonfire making the child think his house is going to get burned down again or a low-flying aeroplane making the child think there is going to be another plane crash.
- Do any other members of the family have post-traumatic stress symptoms? How are these being handled?
- Has the child been involved in any way in restoring any damage caused by the traumatic event?
- Is the stress reaction getting worse or better?

Now, using the information you have obtained about the post-traumatic stress and the reactions of the child and family since that time, try to understand why the child has problems at this time. Then decide what is the best course of action.

14.8.3 Helping children with post-traumatic stress

- Give the child and parents an opportunity to talk about the traumatic experience, separately and together. Do not try to force children to talk about their experiences if they do not want to. The child can be given drawing or painting materials. Given this opportunity, the child may choose to draw or paint the stressful event.
- Explain to the parents and to the child (if of a suitable age) that it is very common for children who have been exposed to trauma to have these types of symptoms. This aims to make the child and parents less ashamed.
- Discuss any mistaken beliefs the child may have about the likely recurrence of the traumatic experience.
- Help the child to think of stimuli that seem to bring back the traumatic event in a more normal way. For example, help the child to think of the sound of a low-flying plane in a different way than in terms of another crash. You might, for example, get the child to keep a record of when he hears a plane and what happens afterwards.
- With young children suggest they play out the traumatic event with a non-traumatic conclusion. For example, the child may be helped to play out a scene in which there is a flood and people are able to get away.
- Involve parents in all procedures of this type.
- If there are several children experiencing post-traumatic stress, you can see them all together in a group to apply these techniques.
- Do not use medication for this type of problem as there is a lack of evidence for its effectiveness and the child may become habituated to such medication or experience unpleasant side-effects.

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- Try to make sure children and adolescents are involved in actions to repair damage after an event or to prevent a recurrence.

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

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