CHAPTER 7

Emotional problems

Emotional problems may involve:

- excessive worrying, fear and anxiety: sometimes the fears may be focused on specific objects or situations, sometimes the anxiety may be more general. Refusal to go to school often arises from anxiety;
- excessive misery, unhappiness and depression: usually low mood is linked to a loss or other stress, but sometimes lowering of mood may appear without obvious cause. Particularly worrying features of depression are ideas of self-harming as well as acts of self-harm that may indeed be fatal;
- compulsions and obsessions: these may involve the need to check everything far more often than is necessary or carry out time-consuming rituals.

7.1 Introduction to anxiety problems

7.1.1 Information about anxiety problems

Anxiety is a normal human emotion. It occurs when we are faced with a real or imagined danger. It is an unpleasant sensation which we want to stop. We make it stop by dealing with the danger or by removing ourselves from the scene. We may also realise that the danger is only imaginary and there is nothing to worry about. Anxiety is necessary for us to survive as it warns us about danger and thus protects us from it.

Anxiety may present with physical symptoms such as tiredness or headaches, and mental symptoms such as irritability, inability to relax and 'feeling on edge'. It may also present with physical or mental signs of a panic attack (see Section 7.2).

Sometimes children and adolescents experience too much anxiety which stops them from leading a normal life. When this happens they are in need of help. There are various types of excessive anxiety:

- panic attacks (see Section 7.2)
- phobias (see Section 7.3)
- school refusal (see Section 7.4)
- separation problems (see Section 7.5)
- excessive shyness (see Section 7.6).

In addition, sometimes children and adolescents feel anxious generally. Examples include:

- worries about how good they are at school or at a particular sport, about examinations or sporting competitions
- excessive self-consciousness and the need for reassurance

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- restlessness, nervousness, inability to relax
- physical symptoms, such as tension, light-headedness, heart beating fast, stomach discomfort and dizziness when there is no physical reason why these should be present
- difficulty concentrating
- irritability.

Usually general anxiety occurs because children have an inborn tendency to be more worried and anxious. Often, but not always, they have anxious, worrying parents. Such parents have inherited a tendency to be anxious from their parents. In addition, because their parents worry about them, they worry about themselves. However, it is not always parents who make children anxious. It must be remembered that children who worry can make their parents anxious.

Ways of finding out more about generally anxious children and helping them can be found by consulting the other sections in this chapter which deal with specific anxiety problems. Helpful interventions include yoga and breathing and relaxation exercises (see below) and anxiety management strategies including cognitive–behavioural therapy (CBT) (see p. 7). The most common ways of helping children with anxiety are:

- listening and talking to them and their parents
- trying to find ways of giving them the skills to deal with their excessive fears
- changing the situations that appear to make them anxious
- breathing exercises and relaxation techniques.

Breathing exercises

Teach the child to breathe in slowly through the nose, and out through the mouth. Children should breathe in and count up to 5 while holding the air in and then breathe out while counting up to 5 (breathing in, two, three, four, five, and out, two, three, four, five – at a rate of about one count per second). Adolescents could count up to 10 while breathing in and out. Similarly, for abdominal breathing exercises the child is asked to notice that the abdominal wall goes out when taking air in and goes in when breathing out.

Muscle relaxation

Young children may find it easier to start with a visual imagery. Have the child close their eyes and imagine a relaxing place of their choice such as a garden, beach, park, playing with a favourite person or pet. Once the child has chosen a place and while the child is imagining this, describe the place to them, including what they might see, hear, feel and smell. Younger children may use a picture or drawing to help them in the beginning. The child is then taught to tense and relax major groups of muscles in a fixed order. Train the child to tense or tighten a group of muscles, feel the tension by holding it tight and then gradually relax. This training usually starts with the muscles of the forehead, then the shoulders and upper limbs, then the chest and abdomen, and finally the legs and toes. Audiotapes and CDs are also available to help children learn and practice relaxation techniques.

Medication

Medication – in particular, where they are available, low doses of selective serotonin reuptake inhibitors – can be helpful in some children and adolescents. Short courses of anxiolytic medication may also be useful. But medication, especially anxiolytic medication, should be used with caution as there is always a risk that children may become drug-dependent. It may be very difficult to stop medication for anxiety once it has been started. See Appendix 2 for medication that may be used in anxiety disorders.

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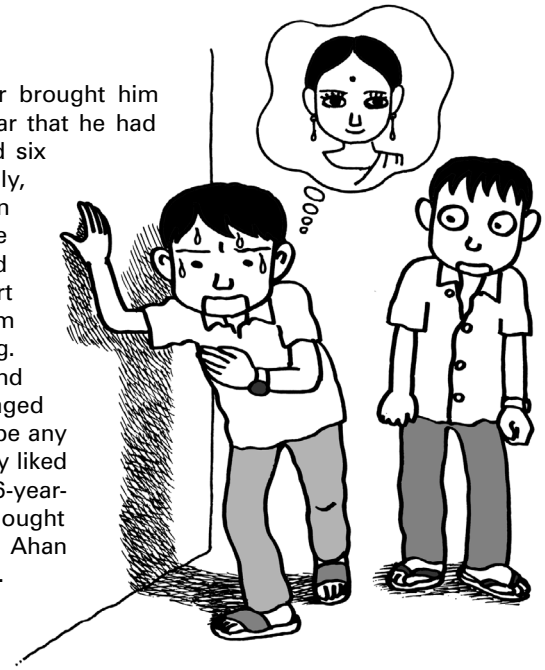
7.2 Panic attacks

Case 7.1

Ahan is a 15-year-old boy whose father brought him to a health professional because of a fear that he had something wrong with his heart. He had six panic attacks which occurred suddenly, without warning. They all occurred when he was leaving the house to spend the evening with his friend, Alok. He would walk a few steps and then find his heart beating very fast. Someone had told him how to feel his pulse and it was really racing. He felt panic-stricken. His legs felt weak and he thought he would collapse but he managed to stagger home. There did not seem to be any reason for these attacks. His parents really liked Alok, who had an older, very beautiful 16-year-old sister. Sometimes his parents even thought they might arrange a marriage between Ahan and this girl, whose family they respected.



7.2.1 Information about panic attacks

These are attacks of extreme anxiety, sometimes coming on without warning. At other times they occur before a situation of which the child or adolescent is very frightened. The physical signs of a panic attack are:

- rapid beating of the heart, with palpitations
- breathlessness and tightness in the chest
- dizziness
- 'butterflies' or even pain in the stomach
- a weak feeling in the legs.

The mental signs of a panic attack are:

- intolerable anxiety or tension
- fear of dying
- fear of going mad
- fear of losing control.

The child or adolescent may not be aware of the reasons why he is getting such attacks. By talking about when the attacks occur it may become possible to understand what the child or adolescent is so anxious about.

7.2.2 Finding out more about a child or adolescent with panic attacks

- Find out how long these attacks have been going on.
- Has the child had panic attacks before?
- What seems to bring them on – situations which he is worried about (examinations, arguments with a friend, parents getting ill or going away), relationship difficulties, etc.?
- Possible toxic effects of coffee, caffeine-containing fizzy drinks?
- Examine the child to make sure that there is no underlying physical cause.

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- Carry out any relevant physical tests: blood pressure and pulse – rate and regularity. An electrocardiogram might be indicated if the equipment is available.

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

7.2.3 Helping children and adolescents with panic attacks

Deal with any physical problems. If physical problems have been ruled out, then you should:

- sit the child or adolescent down calmly
- reassure him that he does not have a physical illness
- tell him that he is not going to die or go mad
- if relevant, tell him that he is not under a spell or been bewitched
- tell him that he will feel better shortly
- if he is breathing too fast, help him to breathe more slowly in a steady manner.

Once the panic attack has stopped:

- try to deal with any stresses that may have precipitated the attack
- work out with the child or adolescent how he can avoid having a panic attack if the same situation arises in the future. For example, if acutely stressed, it can be suggested that he calls a friend or a parent, use relaxation exercises, listens to some music, etc., until he is feeling better.
- practice deep breathing and relaxation exercises (see p. 53). Cognitive–behavioural therapy (see p. 7) can also be useful.

Medication may be helpful occasionally in severe cases (see Appendix 2).

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

7.3 Fears and phobias

Case 7.2

Yoko is a 4-year-old girl who has always been a bit fearful. About a week ago she was shopping with her mother in the market buying fruit and vegetables when a large black dog snarled at her and then started to bark. The dog was held by a strong lead, but the stall-holder who owned the dog pretended to untie the lead to frighten Yoko more. He laughed at her. Yoko was petrified. Now she has been brought to the health professional by her mother because she will not go out of the house in case she meets the dog again. She is sleeping poorly and has nightmares of being bitten by the dog. Her mother is at her wits end and does not know what to do.

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7.3.1 Information about specific fears (animals, strangers, the dark, thunderstorms)

In the early years, between 2 and 5 years, children are likely to be frightened by the unusual or the unexpected. Phobias (disabling fears) of animals (e.g. spiders, dogs, mice), of the dark, and of strangers are very common. It is only when the phobia lasts more than a few days and stops the child carrying out everyday activities that there is a need for help. The phobia is usually triggered by a single unpleasant experience, but there may be repeated unpleasant experiences. Specific phobias nearly always disappear over a few days or weeks without treatment but they are very unpleasant while they last, so if one can do anything to shorten them this is well worth doing. Boys and girls are equally affected, although children who have anxious personalities are more likely to be affected.

Some children when they enter school are too frightened to speak there even though they speak normally at home. These are said to have selective mutism – a phobia of speaking.

7.3.2 Finding out more about children with specific fears

The health professional should listen to the parent's story, asking questions about when the phobia began, what started it, how it is affecting the child's life, whether it is getting better by itself, whether the child's sleep is affected and what the parent has done to make the child better. Usually the diagnosis of a specific phobia is a straightforward matter. There is usually no need to do a physical examination unless there are indicators in the story to suggest this might be helpful.

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

7.3.3 Helping children with specific fears

If the phobia is already reducing in intensity, there is no need to take any action other than to reassure the mother that it will get better. If it has persisted for more than a month, then the health professional should give active advice to the mother and suggest an approach called desensitisation. This involves very gradual introduction to the feared object or situation until the child can be exposed to it with confidence. The mother should be able to manage this by herself if the health professional can give clear instructions along the following lines. The mother (or father, but usually it will be the mother) should:

- make a list of all the things the child is afraid of, starting with the least frightening and continuing to the most frightening – she should do this with the child;
- she should then work out with the child how she is going to manage the task of overcoming the least frightening situation;
- the child should get a lot of praise, kisses, cuddles and perhaps a small reward such as a sweet for having managed this least frightening task;
- once the child is able to perform this least frightening task with confidence, the next most frightening task should be tackled in the same way;
- this process should continue until the child is able to lead a normal life.

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

In fact, this is what happened. As suggested, the mother talked to the child about the problem and together they composed a list from the least frightening to the most frightening situation.

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1 Looking out of a closed window and being able to look at a dog without drawing back
2 Doing the same through an open window
3 Standing at the front door (porch) for 5 minutes with her mother
4 Going for a walk of about 100 yards up the road with her mother, on the understanding that if a dog appeared they would cross the road
5 As above but on the understanding that if a dog came the other way they would walk past the dog
6 Going for longer walks along the same lines
7 Revisiting the market but keeping clear of the dog that had frightened Yoko
8 Going towards the frightening dog but keeping a few feet away

The mother then took Yoko slowly through the above steps, making sure she felt secure before going on to the next step. When Yoko had successfully completed the last step, the treatment was seen as finished.

7.4 Refusal to go to school

Case 7.3

Bindar is a 10-year-old boy who is brought to the health professional because he will not go to school. This began about 6 months ago. He was at first reluctant to go to school and kept making excuses why he should not go. He complained of headaches, and also said that boys were picking on him on his way to school. Three months ago he refused to go at all. He has been spending the time at home playing, going with his mother to her workplace and watching television. His mother and father (a rather quiet man, not very forceful), have tried to get him back to school, but without success. Because of the headaches, the health professional examined Bindar but found no physical problem with him. She talked a bit more to his mother. It turned out that when the problem with school began, his mother was depressed because her own mother had died. Also at this time, a male teacher of whom Bindar was rather frightened had shouted at him for talking when he should have been paying attention. Bindar has always been a rather sensitive boy and was very upset, saying that he thought this teacher might beat him.

7.4.1 Information about children who refuse to go to school

There are three main reasons why children will not go to school.

1 Separation anxiety (see Section 7.5). In these situations children refuse to go because of fear of separation. They may be worried about something bad happening to their parent when they are away at school or of being abandoned by them.
2 A fear of something happening in school (e.g. bullying) or of a person (e.g. teacher). If a child will not go to school for either of these reasons, the parents know about it from their own observations or from the school.
3 A dislike of school, with a wish to get involved in other, often antisocial, activities. This reason for not attending school is truancy. In this situation the parents do not know about their child's non-attendance at school (see Section 8.7).

Sometimes children will not go to school because of a combination of the first two points, for example they may hate to leave their parents and also are frightened of being bullied in school.

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7.4.2 Finding out more about a child who will not go to school

- Obtain an account of how the problem has developed and what it consists of from the mother.
- It is likely that the mother will have brought the child to the clinic with a physical complaint such as a headache, stomach ache or joint pains. Examine the child to rule out any physical problem causing these physical symptoms.
- Talk, if possible, to both parents about the problem. Try to understand how they see it. Ask questions such as 'Why do you think X is having such difficulty getting to school?' Your approach will be very different depending on whether they think he has a physical illness or understand that he is too anxious to attend.
- If there are two parents in the home, see whether they view the problem in the same way. This will be easier if the health professional can manage to see them both: if this is not possible the health professional can ask the mother what her husband thinks about the problem.
- Find out from the parents about how the child is spending the time when he is not at school. Do they give him jobs or schoolwork to do or is he left to please himself?
- Find out what they have already done to get their child back to school. Have they spoken to his teacher about it?
- Find out about the possible reasons why the child will not go to school. His fearfulness may be related to his home life or with school or with both.
- Ask especially about the mother's physical and mental health. Might the child be worried about her because she has a physical illness? Or is she, like Bindar's mother, unusually depressed or anxious?
- Remember that anxiety about separation involves two people: the child and the person the child is anxious about separating from. It is much more difficult for a child to separate from a mother who is worried about separating from him than from a mother who really wants her child to become as independent as other children of the same age. You can ask questions such as 'How do you feel when X is at home. Some mothers feel more settled when they have their children at home and they can see what they are up to. Do you feel like that?' or 'Some mothers feel so low they find it easier if they have someone with them during the day. Do you feel like that with X?'
- Listen and talk to the child. If possible, it is better to see the child separately, but because of time constraints or because the child refuses to be separated from his parent this may not be possible. If this is the case it is still possible to listen and talk to the child with his parent(s) present.
- This may be difficult, but if at all possible, talk to the child's teacher or head teacher about the problem. The amount of interest schools take in this sort of problem varies greatly. In some schools the teachers will have noticed that the child is absent and be very keen to help in any way they can. In other schools, the teachers may be so overwhelmed with the numbers of children they have to teach that they may not notice the absence or may even be quite relieved to have one less student, even if this is a child not causing any problems, like Bindar. It is important to try to find out how the school sees the problem and what time and effort they might be able to put into resolving it.

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

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7.4.3 Helping a child who refuses to go to school

Once a health professional has obtained information as described above, it should be a relatively straightforward matter to work out an action plan. This will involve:

- reducing the stresses preventing the child getting back to school, and
- insisting that he starts to attend school again on a regular basis as soon as possible.

This might mean talking to the school, parents and child.

Talking to the school

Is the school willing to have the child back in school? If he goes back to school, would the school be prepared to try to make life as easy as possible for him in the first few days until he is used to attending again. How does the school suggest this might be done: spending time with the school secretary, making sure that all teachers know how hard it has been for Bindar to attend school? Would a local teacher have time to pick Bindar up from his home? Or are there other students in the neighbourhood that Bindar can go to school with?

Talking to the parents

Explain to the mother how her need to have the child at home with her is preventing him from going back. Does she think she could manage if he was not at home but attending school regularly? Could she try not to take the child to work with her but make some other arrangements that would be less attractive for him? Could she make sure that he is not rewarded for not attending school by not making life so easy for him when he is absent, for example by insisting he has no television or computer games during school hours? She could try to ensure he does continue to see his friends after school hours. Is she depressed? If so, could she be treated for her depressive disorder? Could she get a course of antidepressants for herself?

Talk to the father about how he might help to get the child back to school. Could he be involved in taking him? Would this be helpful?

Talking to the child

Make sure he understands how important it is for him and his future that he goes back to school. Tell him there is really no alternative – and that everyone is in agreement that he has to return to school. It is important to give him the opportunity to confide what is upsetting him. Ask him what he thinks would be helpful.

Then with both parents and the child present, work out when the child will go back to school. Try to do this with confidence, not even allowing the suggestion that he is not going to make it, although admitting it is not going to be easy for him or his parents. Hopefully it will have been possible to enlist the help of the school. The child being greeted at the gate by a friend or a helpful member of the school staff can help reduce the anxiety.

Severe cases

A step-by-step approach may be needed in severe cases where the child spends gradually increasing periods of time at school. If he feels overwhelmed or panicky while at school, he should be supported and allowed to spend time away from the classroom in a quiet place such as the library until he calms down. In most cases this approach will be successful in getting a child back into school. But it is important for the parents to keep the pressure up because if the child starts taking the occasional day off, this can rapidly result in a recurrence of school refusal.

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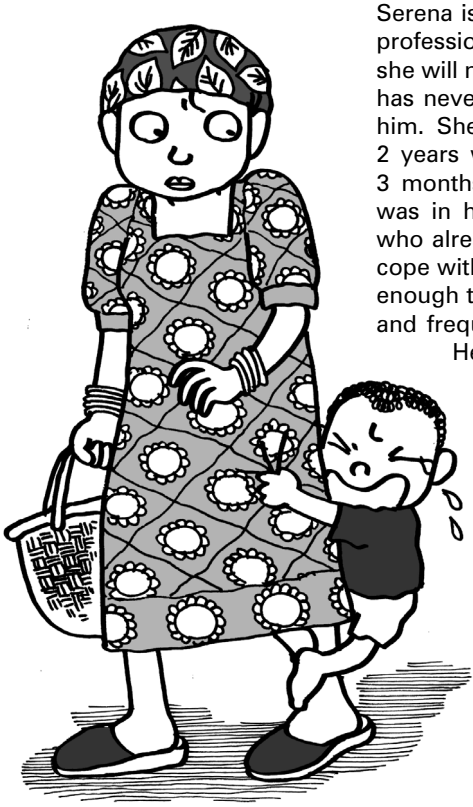
In cases where there is significant anxiety or panic symptoms, this will need to be addressed and managed appropriately (see Section 7.2).

It is likely that the child will remain an anxious boy. His parents will need to remain firm with him when he shows signs of falling back into bad habits, but he should be able to lead a normal life in the future.

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

7.5 Separation anxiety



Case 7.4

Serena is a 4-year-old girl who is brought to the health professional in a city clinic because for the past 2 years she will not go anywhere without her mother. Her father has never lived with her mother and she does not see him. She developed normally until about the age of 2 years when her mother had to go into hospital for 3 months because of tuberculosis. While her mother was in hospital, Serena was looked after by an aunt who already had six children and who could not really cope with another child. Serena was ignored, not given enough to eat, teased and bullied by the older children, and frequently punished for very minor disobedience.

Her mother responded well to treatment and when she came out of hospital she was able to look after Serena again. But as soon as she was reunited with her, Serena would not allow her mother to leave her sight. She insisted on sleeping with her. Her mother needed to go to work but Serena would scream and scream if she attempted to leave her with a babysitter. The health professional examined Serena but found nothing physically the matter with her.

7.5.1 Information about children who cannot separate from parents, especially the mother

Children normally go through a period of anxiety when they are separated from their mother. This period of separation begins in the first year of life, but is at its height between 18 months and 4 years (see Chapter 15). It may persist throughout life.

The way children show separation anxiety varies depending on their family lives. Some children are brought up by their mother only; others have many people responsible for their care, including grandparents, aunts, uncles, older brothers and sisters. A child is more likely to have separation anxiety problems if brought up by just one or two people. This is less likely to happen in LAMI countries than in high-income countries.

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In some children, this period of normal separation anxiety may become so acute that the child is seriously troubled. If the child is over 4 years old there will be a need for the health professional to help. The mother and child may need assistance if there is presence of:

- unrealistic and persistent worry about harm happening to attachment figures, especially parents, of whom the child is very fond, leading to a fear that they will leave and not return
- persistent reluctance or refusal to leave the home, for example, to go to school so as to not be separated from attachment figures (see Chapter 15)
- persistent reluctance or refusal to go to sleep without being near an attachment figure or to go to sleep away from home – this is not relevant if the child and parent(s) normally sleep in the same room
- repeated nightmares involving the theme of separation
- excessive distress (anxiety, crying, tantrums, apathy, withdrawal) regarding separation
- presence of physical symptoms such as frequent headache, stomach ache, nausea or vomiting arising from fear of separation.

The child may have unusual problems in separating because:

- the mother is communicating her anxiety about being apart.
- the child has been ill treated (see Sections 14.3–14.6) and is frightened of this happening again if parted from his mother
- the child is threatened with the mother or father leaving home if he is naughty – children are sometimes told they will be given away if they are naughty.
- the child is temperamentally very anxious – he has inherited a tendency to be anxious
- a mixture of the above.

The child's problem in separating is likely to link with the mother's anxiety about being apart from her child. This may show itself by:

- the mother being a generally anxious person
- the mother finding it very hard to be apart because, for example:
  - this child is very special to her because she had difficulty becoming pregnant or because the child was very ill at birth or is the youngest
  - she knows the child has been ill-treated and feels guilty about it
  - she is frightened of her mother or mother-in-law who thinks she is no good at looking after her child, so she has to be especially protective and not let the child out of her sight.

7.5.2 Finding out more about children who have unusual difficulty separating

Find out whether the child's degree of anxiety is greater than one would normally expect in a child of this age in the community in which the family is living. To do this, obtain a story from the mother or both parents about the nature of the child's problem in separating. Check for the presence of any of the problems described above. All these are reasons the child and mother may need help.

If the child is unusually anxious in situations of separation, check for possible reasons the child may have a tendency to be anxious (see above). Also, check for possible reasons the mother may find it difficult to be apart from her child (see above). But remember, the mother may not be anxious about separating; she may just have a very anxious child. Remember too that some children are so anxious that they make their mothers anxious. Check for any signs of the child being ill-treated or whether he has been ill treated in the past (see Sections 14.3–14.6). Find out how the mother is dealing with the situation at the present time. Is she using threats or providing reassurance?

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Observe how the child responds to his mother while they are both in front of you. Can the child even go to another part of the room to do a drawing? Or is the child unusually clingy? Remember though, many children are unusually anxious when a stranger approaches them. The child's behaviour with you may not be typical of how he usually behaves.

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

7.5.3 Helping children who have unusual difficulty separating

- If a child is having unusual difficulty separating, discuss with the mother how she sees the problem. Does she think the child's behaviour is unusual?
- What does she think the cause of the problem might be?
- What has she already done about it? Is she reassuring and does she cuddle the child if he is anxious? Or does she threaten him that she will leave or that she will give him away?
- You can take various steps to help a child and mother when a child has unusual difficulty separating. You can:
  - encourage the mother to use reassurance rather than threats of punishment
  - talk with the child about what he is frightened of during a period of separation
  - try and work out ways in which the mother can get other people involved in looking after the child with her; this will result in the child depending less on her and more on other people
  - gradually increase the time she can be away from her child; she can start with a separation of just a few seconds and gradually lengthen this by a few minutes at a time
  - make sure the child has interesting things to do when she is separated from him.

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

7.6 Excessive shyness

Case 7.5

Amrita is a 14-year-old girl brought by her mother to the health professional because she has a mole on her face. The mole is really quite small and the health professional cannot see what the fuss is all about. Is there any other problem? It turns out that Amrita has dizzy spells. It is clear that these occur because she does not want to go out to mix with other girls in their homes. She can see one girl at a time, and indeed she has one good friend, but when it comes to little groups of girls she says she does not want to go and then says she feels dizzy and cannot stand up. She gives the mole as an excuse for not socialising. She says she thinks other girls see her as ugly and do not want to have anything to do with her. Recently she has even stopped wanting to see her only friend. Her mother is worried that Amrita will get a bad reputation. She and her husband will be looking for a husband for Amrita soon and she does not want the news to get around that her daughter has problems mixing.

7.6.1 Information about children who are excessively shy

These problems can show themselves in a number of different ways.

- Excessively shy children experience a fear of being looked at or of being ridiculed, embarrassed or humiliated.

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- Some children are fearful of all social situations outside the home; others are just shy of particular social situations such as going to the temple or mosque.
- Most children with this problem will have been shy from a very early age. They may well be 'temperamentally' shy or have inherited a tendency to be shy.
- Most children who are excessively shy would like to be more sociable. Children with the social problems linked to language difficulties in ASD (see p. 26) do not mind not having any friends. These children need to be assessed and treated differently.
- The problem of excessive shyness may show itself when a child first goes to school. Some 5- or 6-year-olds will not say a word in school for the first few weeks or months, although they may chatter away at home. These children are selectively mute. Nearly always they begin talking at school, at least in a limited way, by the end of their first year in school.
- The problem of shyness may surface again in adolescence when in many, but not all, communities young people are expected to broaden their horizons and socialise in a much greater variety of settings.

Shyness is only likely to be a significant problem in communities where children and adolescents are allowed to mix freely with others of their own age. In communities in which they live a very sheltered life and are expected to remain at home when they are not at school, shyness is not likely to be a problem.

7.6.2 Finding out more about children who are excessively shy

- Obtain an account both from the parent and from the child about the nature of the problem and how long it has lasted.
- Try to find out the circumstances in which the shyness shows itself.
- What makes the shyness better or worse?
- To what degree is it interfering with the child leading a normal life?
- How would the child think life would be changed if he was less shy?
- See whether the child really wants to change, or whether he is happy with the way things are.

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

7.6.3 Helping children who are excessively shy

If the child does not really want to change, then the health professional's ability to help is likely to be limited. Her most useful role may be to help the mother come to terms with the fact that she has a shy child who can nevertheless lead a reasonably normal life. The child may have a version of ASD (see Section 4.6).

If, however, the child wishes to receive some advice on how to overcome shyness, then try desensitisation. This involves helping children or adolescents to gradually overcome their fears, little by little. Help the child to first cope with the social situations he finds least upsetting. Then gradually move towards more and more stressful situations. For example, the following desensitisation programme might be suitable for a 14-year-old living in a Westernised community when he is given freedom to visit the homes of his friends:

- going with a friend to another friend's house to listen to some music – do this two or three times
- going without a friend to another friend's house to do the same
- going out to a café with two or three friends – do this two or three times

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- going to a friend's house where there are six or seven friends having a party
- going to a stranger's house where there are some friends but also quite a lot of people he has not met before.

Another technique that can be used is imagining the worst situation. The child or adolescent could be asked to imagine what would happen if he went to a friend's house and the worst possible thing happened to him. What would that be? For example, would it be that no one would talk to him or that he might overhear someone say he was ugly or 'stuck-up'? What would he do in those circumstances? Could he work out how he could start a conversation with someone he had not met before by saying 'I don't know many people here, do you?', or 'How do you know (the host)?' or 'How do you feel about this sort of music? What is your favourite sort of music?'

If the child really does have, for example, a facial disfigurement, then one would need to help him develop a somewhat different set of skills. The child could ask a friend to introduce him to some strangers, who have been told about him beforehand. Maybe she would then be seen as a person who attends school X, has a favourite pop group, etc., instead of a boy with a facial disfigurement.

In motivated children these simple techniques may be very helpful.

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

7.7 Depression, misery and unhappiness

Case 7.6

Benazir is a 14-year-old girl brought to a health clinic in the city by her mother because she is having headaches. It turns out the headaches are not much of a problem. But her mother says that for the past 6 months Benazir has been very moody and unhappy. This is not like her at all. Normally she is a bubbly girl with lots of friends who loves playing with her 4-year-old brother. Now she does not want to see her friends and shows no interest in her brother. She often tries to get out of going to school by saying she has a headache. She refuses to go to the mosque. She gets angry and irritable very easily. Her mother thinks that maybe she is being bullied at school or that she has lost her friends there. Maybe they are picking on her. Her schoolwork remains good. Nothing the mother can think of has upset her at home. What should the health professional do?

Case 7.7

Leo is an 8-year-old boy who was brought to a health professional with stomach pains. But his mother said to the health professional that these were not at all serious and that the real problem was his difficult and disobedient behaviour for the past year. He gets extremely angry if he cannot get his own way. He sometimes cries for no good reason and will not go out to play with his friends when they come to call. This all started shortly after a set of losses that clearly upset him. His father went to another town some distance away to get work and only comes home about once every 3 months. His grandmother, of whom he was fond and who lived with the family, became ill and suddenly died. Before these unhappy events he was not at all a difficult boy. When the health professional first spoke to him he seemed quite happy talking about what he liked doing in school, but when she asked 'Tell me about your father' he immediately began to cry and said how much he missed him.

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7.7.1 Information about depression, misery and unhappiness

Short periods of misery and unhappiness are common throughout childhood and adolescence. When such feelings are prolonged and intense it is appropriate to think of clinical depression. There is no sharp dividing line between ordinary misery and unhappiness and clinical depression.

Children show clinical depression in many different ways, partly depending on their age. As children get older they are better able to describe their moods and what is upsetting them. But even very young children have clinical depression, even if they cannot describe it themselves. They may show their depression by their appearance and behaviour. Definite signs of clinical depression are:

- feeling miserable, unhappy or sad
- lack of energy
- not wanting to do things that are normally enjoyed, such as seeing friends
- saying life is not worth living or wishing to be dead
- making a suicidal attempt.

Indicators to possible clinical depression (but may be normal or signs of other problems) include:

- losing appetite
- poor sleep
- boredom
- tiredness
- unexplained physical symptoms such as headache or stomach ache
- irritability and being easily roused to anger
- reluctance to go to school
- quality of schoolwork deteriorating
- drinking alcohol or taking drugs
- running away from home.

7.7.2 Causes of depression

These include physical causes (e.g. chronic infection, malnutrition, anaemia, viral illnesses, hormonal problems such as low levels of thyroid hormones) and losses (e.g. death of a loved family member or close friend, separation from a loved family member or close friend, loss of a pet, loss of self-esteem or confidence because of failure at school, or some other disappointment). Some children become depressed more easily than others. This may be because they have:

- a strong inherited genetic tendency to depression
- a sensitive temperament and are easily 'put out'
- suffered losses earlier in their lives.

Some children are resilient and do not get depressed even after multiple setbacks.

7.7.3 Finding out more about children who might be depressed

Mothers bringing children who are depressed to a health professional are unlikely to say that they think their child is depressed. They may not have noticed the signs or they may be too guilty or embarrassed to mention it. It is up to you to ask the right questions and to observe the child to see whether there are any signs of clinical depression. Probe further if:

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- a child looks miserable or unhappy
- there is no physical cause for the problem with which the child has presented.

Good questions to ask mothers if you think a child may be depressed are:

- 'Do you think X has been low or "under the weather" recently?'
- 'Has X still been wanting to do things he usually enjoys?'
- 'Have you had the idea that X really feels life is not worth living?'

Children who might be clinically depressed should, if possible, be seen separately from their parents. Good questions to ask children over the age of 7 or 8 years (after setting them at ease by talking about neutral topics) might include:

- 'What sort of things do you like doing with your friends? Do you still enjoy those things?'
- 'What is it you've been most upset about recently?' NOT 'Have you been upset about anything recently?', as this allows them to avoid talking about painful subjects.
- 'Do you sometimes think that people don't like you very much? What makes you think that?'
- 'Do you feel you've done something bad?' and 'What might that be?'
- 'How do you feel about the future?' and 'Do you feel hopeless about what is going to happen to you?'

This may lead to questions probing suicidal thoughts and actions (see Section 9.4 on self-harm for suggested further questions).

Note that most children who are depressed also often show severe anxiety. Some may also show antisocial behaviour.

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

7.7.4 Helping children who may be depressed

In deciding whether to intervene in children who are depressed, you need to ask yourself these questions:

- Is the child's life being affected by their sadness, misery or depression?
- Does the child's thinking reveal guilt about the past, unrealistic ideas about not being liked or being worthless, or hopelessness about the future?
- Is there any risk of the child harming himself?

If the child is unhappy but low mood is not affecting his life – he can still go to school, participate in lessons, play with his friends and cope at home – and if, in addition, there is no evidence of distorted thinking, then there is no need for any active treatment. This does not mean you should not take his problems seriously. In particular, you should give him the opportunity to talk about what is upsetting him and try to reduce any stresses affecting him, as well as continue to monitor him.

If depression is affecting the life of the child but he is not, as far as you can see from the answers to the above questions, in any danger of harming himself, then you should try to work out what is upsetting him. In doing this you should always work in partnership with the child and parents. Can you help, for example, to:

- put a stop to any bullying
- reduce stress caused by schoolwork or examinations
- help parents to argue less

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- help parents with their own mental health problems such as depression or anxiety
- reduce alcohol consumption in one or both of the parents.

Remember that depression following a loss does gradually improve as time goes on. A loss may make a child (or indeed any of us) feel that life will never be the same again after such a dreadful thing has happened. Yet we know that usually within a few weeks or months, deep, unhappy feelings will nearly always have reduced. This does not mean that a child is exactly the same person as beforehand. Losses do affect us, so a child may become better able to cope with loss when it happens again or, in contrast, more vulnerable to depression.

As well as reducing stress there are special forms of listening and talking treatments that can help to shorten the episodes. If there is a psychologist available to provide CBT, a referral should be made. If there is no such help, the health professional may benefit from knowing the principles of CBT:

- develop a positive relationship with the child
- explain that sometimes depressed feelings come about because of negative or unrealistic thinking
- discuss any ideas of guilt, worthlessness and feelings of not being liked
- discuss the evidence that the child is using to confirm these distorted thoughts
- ask the child to keep a record of when these thoughts occur, in what circumstances they arise and what he does about them
- look at the record the child has kept and discuss whether it does really confirm or refute the thoughts he is experiencing.

In many cases this approach will result in the child realising that the thoughts experienced are unrealistic. This may be followed by a lifting of mood.

Note that sometimes depressive feelings and thoughts come apparently without cause or following an illness, especially a viral infection. Post-viral depression is not uncommon and can be very severe. Suspect this if the child was normal before the depression, there is a history of a viral illness, and no stresses have occurred that are severe enough to account for the depressive feelings.

Case 7.8

Abhik is a 14-year-old boy brought to the health professional by his mother because he is completely lacking in energy and unable to go to school. He was fine and doing well in school until about 2 months ago when he developed a temperature, aches and pains in his limbs, and feelings of exhaustion. He did not have any treatment and gradually the temperature went down and the aches and pains disappeared. However, he remained extremely tired and lethargic, did not want to eat, felt miserable and unhappy, and just wanted to lie in bed all day. He has been in this state for about 6 weeks and the health professional was unable to find any physical illness. He no longer had a temperature.

In cases where attempts at stress reduction and a psychological approach are ineffective or do not appear appropriate because of the absence of relevant stresses, the use of antidepressant medication, if it is available, should be considered (see Appendix 2).

For children who have suicidal thoughts or who are actively suicidal, further information is provided in Section 9.4.

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7.8 Obsessions and compulsions

Case 7.9

Amr is a 13-year-old boy brought to the clinic by his very anxious mother. For the past year or so, according to his mother, Amr has been developing a number of funny habits. The worst is that he will not sit down in a chair at home. To begin with it was just one chair he would not sit in, but now he will not sit in any chair. He has also become extremely preoccupied with cleanliness, spending ages in the bathroom, especially after he has been to the toilet. In the morning he seems to need an hour in the bathroom. This is a Hindu household and each of the family members worship in front of the household deity for about 10 minutes a day. Amr kneels in front of the image, chanting mantras for longer and longer periods, in the evening for up to an hour. He also takes ages to get to bed, needing to check that his sheet is clean and all his clothes are in exactly the right place before he is happy to settle to sleep. Things seem to be getting worse, with longer and longer periods of praying and checking everything is in order before he will do anything at all. What should the health professional do?

7.8.1 Information about obsessions and compulsions

Obsessions are ideas that keep coming into the mind and will not go away even when you try to stop thinking about them. Compulsions are behaviours one has to repeat over and over again despite trying to stop, usually because of an idea that something bad will happen if one does not do them. It is normal for young children to show rituals or do things in a particular way. For example, children may avoid the cracks along the pavement or may need to line up their possessions in a special way. These types of behaviour are only a problem if they take a great deal of time and prevent the child from living a normal life. Children who have a problem of this type commonly have a fear of germs, which drives them to wash their hands repeatedly, over and over again, until the skin of their hands becomes dry and cracked.

Affected children often involve their parents or other people in their rituals. For example, they may constantly ask their parents for reassurance that they are clean and not contaminated by germs. They might have a recurring worry that their parents are going to die and repeatedly ask their parents if they are feeling well. They may show compulsive religious observance, praying for much longer periods than is usual in their community.

The problem may start in children as young as 6, but usually starts later in childhood or adolescence and occasionally may begin after an unpleasant or stressful experience.

Other members of the family, especially a parent, may have the problem and there may be a strong genetic influence. Adults who have this problem experience a great deal of inner resistance. One part of their mind struggles to stop the obsession or compulsion but another will not allow this to happen. Children seem to show less inner resistance than adults.

Children with these problems may also have tics (rapid repeated movements of the face or body such as eye-blinking – see Section 6.6). They are quite likely to be shy, inhibited children and very likely to be anxious and may also be depressed.

Children and adolescents who have this problem often deny that it exists, even though it is obviously affecting their lives. If the child and parents are keen for help, appropriate treatment can often be very effective. Without treatment these problems come and go, but can last for years and seriously affect the child's life.

7.8.2 Finding out more about children with obsessions/compulsions

- Find out when the problems began, whether anything seemed to trigger them off, how often they occur now, how they affect the child's life, and what seems to make them better or worse.

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- Check for other problems such as tics, anxiety or depression, which are often present as well.
- It is important to try to see and talk to the child separately from the parents, but remember that the child may deny such problems even though they are seriously affecting his life.
- Find out to what degree the lives of other members of the family are affected by the child's problems. In order to carry out his compulsive behaviours the child may have succeeded in manipulating other members of the family to change quite considerably what they normally do.
- Find out how much the child wants to change the obsessions and/or compulsions that are affecting his life. There may be surprisingly little desire to change.

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

7.8.3 Helping children with obsessions/compulsions

Before any specific form of treatment is started, health professionals should try to help children to talk about their fears. They should explain that such fears are quite common and often occur because children are frightened of losing control of what happens to them. They are not a sign of madness. As they gain control of their behaviour, so they will become less frightened. There are three approaches to helping:

1 behavioural methods
2 medication
3 a combination of behavioural methods and medication. This is the most effective approach, but if, for some reason, only one of these is available, a reasonably good outcome can be achieved.

Both behavioural methods and medication are best carried out in specialist centres, but if such centres are not available, as will usually be the case, the health professional is likely to be able to help at least to some extent.

The most effective behavioural approach is known as response prevention. This can be carried out in two steps.

1 Exposure to the feared situation. For example, the child frightened of contamination by germs may be exposed to soil or dirty dishes, first just by looking at them and then by holding or touching them for longer and longer periods of time. The parents or health professional can model this behaviour, doing it herself and showing the child that no harm follows.
2 Prevention of the ritual. This might involve parents and others encouraging the child not to carry out her rituals for longer and longer periods of time. Gradually, the child will be able to control herself and will not need encouragement from others.

Regarding medication, useful agents include a selective serotonin reuptake inhibitor such as fluoxetine, starting with 20 mg (maximum dose of 80 mg in an older adolescent), or a tricyclic antidepressant such as clomipramine, at a dose of 3 mg/kg, up to a maximum of 100 mg in two divided doses (see Appendix 2 for a list of medications). There may also be a need for the treatment of tics, anxiety and/or depression (see Sections 6.6, 7.3 and 7.7).

Both children and parents should be encouraged to continue to talk about their fears as to what will happen if the obsessions or compulsive behaviour stops.

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

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