

Child Health

The World Health Organisation (WHO) defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. A more useful definition of health includes three other very important aspects of health: emotional, environmental and spiritual.

Children have rights to health as well, and are entitled to basic rights such as food, health care, a safe home and protection from abuse.

From the moment they are born, all children depend completely on an adult to meet all their needs, but the way in which these needs are met will vary considerably according to family circumstances, culture and the personalities of the child and the caring adult.

All those who care for young children need a thorough knowledge of child development, so that provision of care can be planned to match each child's needs at each stage of development.

This article does not attempt to cover all aspects of child health but will discuss issues some parents and carers may be concerned about.

Some Conditions Affecting Children 1-8 Years Old

Emotional and behavioural problems

Children often show emotional and behavioural problems at certain times. Usually these problems disappear quite quickly without treatment and may be the result of temporary stress or upset. Other specific conditions cause long-term difficulties for children and their families. The conditions stated below are the ones you are most likely to encounter within an early years education setting. This article will discuss ADHD and ASD in more detail.

Attention deficit hyperactivity disorder (ADHD) • Autism or autistic spectrum disorder (ASD) • Developmental dyspraxia • Eating disorders: Anorexia nervosa – Obesity – Food refusal • Enuresis (Bedwetting) • Soiling or encopresis

Attention deficit hyperactivity disorder (ADHD)

What is it? ADHD is a condition which affects between 1 and 2 per cent of children in the UK. In general, children with ADHD are impulsive and restless, and have difficulty in maintaining attention and concentrating on the task in hand.

Cause: The cause of ADHD is not known, but some believe it is caused by insufficient levels of dopamine in the brain. This hormone causes the electrical impulses which control all that we do to misfire, and results in uncontrolled, impulsive behaviour and often poor coordination (dyspraxia) and other learning difficulties (which may include dyslexia). It is thought that the condition is hereditary, and many families can look back and recall that a family member showed the features of ADHD before the condition was 'discovered'. Sometimes these symptoms go unnoticed until the child starts school and is compared with other children.

What to do: Consult a doctor if you suspect the child has ADHD. He or she may refer you to a consultant paediatrician, a psychologist or psychotherapist for advice and treatment.

Depending upon the needs of the individual child and the severity of the condition, a combination of medical, teaching and behavioural help can be given:

- Ritalin is a drug which, although a stimulant, seems to have a calming effect on two-thirds of children with ADHD; it enables the child to concentrate better and to behave in a calmer way.
- Effective teaching techniques include establishing clear boundaries and creating predictable routines; a child with ADHD benefits from having the school day organised into a recognisable structure.
- Dealing with the child's unwanted behaviour at once; choose one or two particularly difficult behaviour traits to work on first and remember to praise the child when improvements occur.

Possible complications: Children with ADHD are more likely to:

- Be depressed or anxious.
- To behave in a confrontational and antisocial way — for example arguing with and defying adults.
- Have speech and language problems.
- Have co-ordination problems.
- Have poor self-esteem and difficulty with developing social skills.

Support for the child with ADHD and the family

1) Behaviour management approaches often start by teaching parents and carers the A-B-C approach.

- A = Antecedents. Identify the events or circumstances which seem to lead to difficult behaviour or trigger specific problems. These are known as *antecedents*.
- B = Behaviour. Describe the actual *behaviour* in detail (what does the child do, for how long, what don't they do).
- C = Consequences. Observe the *consequences* of this behaviour (what happens to the child, how other people react, what sort of attention is given).

Carers are then shown how to gradually change the child's behaviour, concentrating on small changes at a time and giving praise for any

small step in the right direction.

2) Children taking stimulant medication need to take their tablets regularly, as the effects of medication only last for four to five hours. As a parent or carer you need to ensure that anyone looking after the child is aware of this. Children should also be seen regularly by a specialist to monitor their progress and check for any side-effects. For example, some children develop sleep problems, lose weight, or may even become depressed.

Further information:

Most children with ADHD improve with treatment as they get older. A few go on to display more anti-social behaviour later in childhood.

Signs and symptoms

A child with ADHD may show some or most of the following signs and symptoms:

⇒ Fidgeting with hands and feet and squirming in their seat; the child acts as if 'driven by a motor' and seem to be on the go the whole time.	⇒ Difficulty in awaiting their turn in games or group situations; the child finds it hard to socialise from an early age.
⇒ Difficulty in playing quietly.	⇒ Talking incessantly and unable to listen without interruption; the child might appear to want to take over and be the centre of attention.
⇒ Inability to finish tasks.	⇒ Often blurts out answers to questions.
⇒ Difficulty following instructions.	⇒ Difficulty sustaining attention.
⇒ Often shifts from one incomplete activity to another.	⇒ Often interrupts or intrudes on others.
⇒ Often does not seem to listen.	⇒ Often has difficulty organising things; the child may lose things or be oblivious to mess.
⇒ Often engages in physically dangerous activities without considering the consequences, e.g. running into the road without looking for traffic.	

Sometimes these symptoms go unnoticed until the child starts school and is compared with other children.

Autism or autistic spectrum disorder (ASD)

What is it?

Autism is a life-long developmental disability affecting social and communication skills. Children with autism often have accompanying learning disabilities but, whatever their general level of intelligence, they will share a common difficulty in making sense of the world in the

way most people do. In most children with autism some types of skills will be better than others so that their development will not only be slower than usual but will also be uneven and different from most children with other learning disabilities.

Causes of autism: There is no known cause but because about one-quarter of children with autism have neurological symptoms, many specialists now believe there may be a physical and/ or genetic factor. One theory is that autism may be related to abnormal levels of essential fatty acids in the blood, or to an abnormal blood flow through the brain. It is not due to emotional problems or emotional deprivation. Onset of autism is almost always before the age of three years.

It affects four times as many boys as girls, and has no class or racial barriers.

Features of autism:

The degree to which children with an autistic spectrum disorder are affected varies, all those affected have what is known as a *triad of impairments*. This triad affects:

- Social interaction (difficulty with social relationships).
 - Social communication (difficulty with verbal and non-verbal communication).
 - Imagination (difficulty in the development of play and imagination).
- In addition to this triad, repetitive behaviour patterns are a notable feature and a resistance to change in routine.

A child with autism may show some or many of the following characteristics:

- Lack awareness of other people.
- Avoid eye-to eye contact.
- Prefer to play alone.
- Over-sensitive to certain sounds.
- Extremely resistant to change and become obsessed with one particular topic or idea.
- Have difficulty in understanding and using normal speech patterns. Echolalia — an automatic repetition of what is said to him or her — is common.
- Develop obsessions, with attachment to or collections of one particular type of thing.
- Have delay in speaking, which may be 'robot-like' when it does happen.
- Show repetitive behaviour, rocking, walking on tip toe, etc.
- Show abnormal body movements, for example arm flapping, flicking fingers for hours on end, grimacing, rocking and charging in different directions at great speed.
- Have sudden screaming fits; may injure themselves.
- Show an isolated special skill, for example drawing, music or an outstanding rote memory. Extreme examples of such skills include an 18-month-old who could sing a whole opera, and a two-year-old who can read. Such individuals are known as idiot-savants.

Diagnosis:

A diagnosis of autism is not usually made until the child is two years old, although parents may have noticed a general lack of curiosity in their child with poor sleeping and feeding patterns and general unresponsiveness in the first year.

Support and education for the child with autism:

There is no known effective treatment apart from medication to control the associated problems of epilepsy and hyperactivity. Many therapies are being tried, for example:

- Holding therapy, in which parents group together for long periods of time and try to foster emotional responsiveness by firm holding techniques.
- Behaviour therapy, with reward and discouragement for acceptable and unacceptable behaviour.
- Daily Life Therapy — developed by Dr Kitahara in the Boston Higashi school in the USA — offers a programme of physical education and age-appropriate lessons in a residential setting.
- Lovaas method — developed by Professor Lovaas in California, USA — offers an intensive programme of therapy using behaviour modification techniques.

The child with severe autism will need constant one-to-one care, requiring considerable patience and skill on the part of all family members. Any changes to the person's routine must be carefully planned.

Education:

Early childhood education, for example at a nursery or playgroup, will help the family integrate into the community. Most children with severe autism attend local schools for children with severe learning difficulties. The teaching of self-help skills is an essential aspect of education for any child with autism, as these can help them to achieve maximum independence and make life easier for everyone. Because the child with autism *looks* 'normal', parents often have difficulty alerting others to the fact that he or she has special needs. To an extent, parents may often have to take on the role of educator, sometimes even with professionals, for example GPs, teachers and health visitors. There are other ways in which parents may choose to help their pre-school child, such as:

- using *picture symbols* to develop communication
- trying a gluten and/ or casein-free diet, or
- using educational software on a home computer.

Asperger syndrome:

Most children with Asperger syndrome represent the other end of the autistic spectrum. Language delay is not as common as in autism, but there are often problems with communication and the child with Asperger syndrome is usually aware of his disability.

Features of the syndrome are:

- Social naiveté or simplicity.
- Good grammatical language, using language only for own interests.
- Very specialised interests, often highly academic, for example movement of the planets, railway timetables.
- Lack of common sense arising from unawareness of their environment.

Food refusal

What is it?

Food refusal is a consistent and repeated refusal to attempt to eat, chew or swallow food.

Cause:

Food refusal is fairly common amongst toddlers — often because they are too busy playing and exploring their world to make time for meals.

Frequent refusal to eat can result in mealtimes becoming a battleground, with parent and child testing each other's patience to the limit.

Signs and symptoms:

- The child refuses to eat at family mealtimes.
- The child may eat snacks and 'junk food' at other times.

What to do:

- First, check the child's weight against the growth charts to exclude any cause for concern; consult the doctor to exclude any medical disorder.
- If the child is obviously well and growing normally, offer regular meals in small, attractively presented portions.

General care:

- Allow the child to eat according to appetite.
- Offer small snacks (or mini-meals) of nutritious food, such as fruit, cheese cubes or milk drinks; active toddlers *need* to eat between the normal three meals a day to keep up their energy levels.
- Try not to let family mealtimes become a battleground. Encourage the child to take control and to learn that eating is an active, rather than a passive process.

- Allow the child to eat by any method or combination of methods — fingers and fists as well as with spoons. Tolerate any mess!
- Don't scoop the food into the child's mouth; if the child asks for help, load the spoon with food and encourage them to take the spoon to feed themselves.
- Let him or her eat in any order or combination — for example, don't insist that they eat all their main course before having any dessert.
- Keep the meals simple and offer food you know they are likely to eat; any leftovers should be removed without fuss.
- Try to keep mealtimes enjoyable and a sociable experience; serve treats as part of mealtimes rather than as snacks between.
- Don't ever use food as a reward, punishment, bribe or threat. Keep the child's eating separate from issues of discipline.

Possible complications:

Serious eating disorders may develop in later childhood if the problem of food refusal is not successfully managed.

Enuresis (Bedwetting)

What is it?

Enuresis — the medical name for bedwetting — is the involuntary passing of urine and the most common form of bedwetting among children is nocturnal enuresis (wetting the bed at night).

Cause:

Most children who wet the bed have done it all their life, and in many cases no reason can be found. Often it is passed on through the family. Bedwetting also happens, or has happened, to a close relative in up to 85 per cent of cases. Fifty-seven per cent of children who wet their beds either have a brother, sister or a parent who has experienced the same problem. One explanation could be that these children are heavy sleepers who do not wake up when their bladder is full. Also, some children develop bladder control later than others.

At night, some children produce too little of the anti-diuretic hormone (ADH) which controls the production of urine. Enuresis may also have a *medical* or *psychological* cause such as cystitis, diabetes, problems at school, at home, the arrival of a new baby in the home or the divorce of the child's parents.

Signs and symptoms:

- A child younger than six years old regularly wets the bed.
- NOTE:** Frequent bedwetting is common in children up to the age of six. Approximately 15—20 per cent of all five-year-olds and six-year-olds wet the bed and most of those are boys.

What to do:

Consult the doctor if:

- the child still wets the bed after the age of six
 - the child suddenly starts wetting the bed without having done so earlier
 - the child's urine has a strong smell, or if the child says that it hurts during or after urination
 - the child starts to wet her or himself during the day
 - the child urinates more than usual, day or night
 - the child has constipation or defecates in his or her pants.
- The doctor will start by asking questions about the child, such as when they learnt to go to the toilet in the daytime. They will probably also ask if someone else in the family has had the same problem. After this, the doctor will examine the child, feeling their stomach and abdomen. Often, the doctor will ask for a urine sample in order to rule out a bacterial infection or cystitis. The doctor may also take a blood sample.

General care:

- Protect the bed by using a waterproof mattress, or a fitted waterproof mattress cover under the bottom sheet. This must be fastened securely to prevent any danger of suffocation. Place clean night clothes and sheets next to the bed so the child can change if she or he wakes up.
- Don't make the bedwetting a big issue in the family. Most children are embarrassed about wetting the bed, so it will help if the family support the child and show a positive attitude.
- Don't get angry with the child or punish them if they wet their bed. This could only make matters worse.
- Let the child know that many other children do it too. If someone in the family has had the same problem, tell the child about it. Knowing that others have been affected in the same way will help a child deal with the problem.
- If the child is in agreement, keep a calendar or diary and mark Dry Nights with a star.
- Praise the child when he or she wakes up in the morning without having wet the bed. Encouragement is often the most helpful way of dealing with the problem.
- Don't put a nappy on the child at night as this will make the child less aware of the problem and not teach them to notice when they need to urinate.

If methods using praise and encouragement don't work:

- Try using a bedwetting alarm that makes a ringing or buzzing sound or vibrates if the child wets the bed. (These are successful in curing the condition in 70 per cent of cases.)

- The alarm is often very effective because it makes the child wake up as soon as the first drop of urine hits the underwear or the sheet. The child is thus made aware that he or she is urinating and what it feels like when their bladder is full. (NOTE: Don't use a bedwetting alarm if the child objects to it.)
- Don't be embarrassed to discuss further options with the GP or health visitor if none of the above suggestions appear to be effective.

Further information: • Many parents have been told to wake the child in the middle of the night and make them go to the bathroom. Studies show that the positive effect of this is almost non-existent, since the child does not wake up by him or herself because of the need to urinate.

- It may take weeks or months before there is any change. Training a child will take time, so patience is required from all involved. Most children naturally stop wetting the bed eventually.



This article is an excerpt from the book

Baby and Child Health

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This article discusses several issues related to child health. It is taken from the book, which covers all aspects of the health of babies and young children and how to care for them. Although the book's focus is on physical health, it also recognises the needs of children to be healthy in other equally important ways: emotionally, mentally and socially. The book includes a systematic and up-to-date summary of the main conditions affecting babies and children, how to recognise symptoms and what action to take. It also provides guidance for early years carers on how to influence the health of children in their care by providing a safe and hygienic environment, and good nutrition.

