UNIT 4 NURSING MANAGEMENT OF MENTAL DISORDERS IN CHILDREN AND ADOLECENTS

Structure

4.0 OBJECTIVES

After studying this unit, the student should be able to:

- define the various neurotic behaviours of children;
- identify the causative factors of such behaviours;
- explain the Psychotic disorders in children;
- describe the clinical features of each behaviour;
- discuss the management of children with mental retardation; and
- explain about the maturational pattern of adolescents.

4.1 INTRODUCTION

Usually the emotional reaction of children differs from adult reactions. Moreover, some maladaptive behaviours are prominent among the children like autism, school phobia, bed wetting, tempertantrums, attention deficit hyperactive disorder (ADHD)

etc. As the child grows to adolescent period s/he goes through many changes such as developmental, cognitive and psychosocial. In this unit the discussion will be on some of the maladaphic behaviour in children and adolescents. In the unit the definition, causative factors, clinical feature of each condition and nursing management will also be discussed.

4.2 NEUROTIC DISORDERS OF CHILDREN

Expression of neurotic behaviours of children differs from adult persons. Let us discuss the different neurotic reactions of the children.

4.2.1 Thumb Sucking and Nail Biting

The habitual manipulation of the body for pleasure in children ranges from thumb sucking to picking the nose, ears, plucking eye lashes and hairs, fondling of genitalia and masturbation. The most common ones are nail-biting and thumb sucking. All these habits were once accorded more importance than they deserved. When these probloems are marked, they may indicate an underlying anxiety or insecurity.

i) **Definition**: Thumb sucking and nail biting represent a learned maladaptive habit that is reinforced and maintained by its tension reducing properties.

ii) **Nail Biting**: It is a phenomenon demonstrated by children beyond 4 years of age. It may be continued up to adolescence. Sometimes it may reappear at the time of stress.

iii) **Etiological Factors**

- Faulty development: Freud described psychosexual development of personality of the individual. The oral stage of one year of the child is divided into two phases.
  - i) First six months is 'Passive receptive oral stage'.
  - ii) The second six months is 'Oral aggressive phase'. The infant begins to explore everything with his mouth and gums. He tries to experiment with chewing and biting whatever comes to his mouth. By this time mother also makes attempt to wean the child and gradually withdraw him/her from breast. The child experiences a feeling of hostility as the child does not want to give up the pleasure and satisfaction of sucking at the breast. The infant develops a feeling of love and hostility towards the mother. The ambivalent feeling may produce anxiety in infant. This unfulfilled primitive need transfers into thumb sucking and nail biting.
- Feeling of insecurity: Security is the greatest emotional need of the child. The child feels insecure when:
  - i) The mother consistently fails to gratify the oral needs due to hostility or some reason.
  - ii) The comfort giver disappears from the child's world.
- Heredity: Frequently, the history reveals that the parents of nail biters were also nail biters.
- Stress: Thumb sucking provides an outlet for discharging tension. As child becomes older, s/he has a tendency to inhibit this behaviour, especially when they are in public, but it may reappear at time of stress.
- Attention getting mechanism: Sometime these dysfunctional behaviours are used as attention getting mechanism and are reinforced by parents.

iv) **Management**

- Assess the duration, frequency and intensity of nail biting and thumb sucking.
- Assess the stress factors affecting the child.
- Decrease parental concern: Counsel the parents, reassure that they need not panic over these benign problems. They must not make excessive demand on child to get rid of this habit.
- Deemphasize the habit: No one should discuss his/her maladaptive behaviour otherwise child will have anxiety and tension for the habit disorders and repeat the maladaptive behaviour.
- Behaviour Therapy:
  - i) Negative reinforcement – punishments, restraints and bitter tastes in finger is not effective.
  - ii) Parents are encouraged to give up any maladaptive behaviour, if they have, for example they themselves are in habit of nail biting, or being too nervous.
  - iii) Child should not be too frustrated.
- Positive reinforcement.

4.2.2 Bed Wetting (Enuresis)

Involuntary micturation is normal in infancy both by night and day. Most of the children achieve control by the age of 3-5 years. Persistence of day and night wetting after the age of 5 is abnormal. It may be nocturnal or diurnal or both. It is most common in children although it can extend to adulthood.

i) **Definition**: In the absence of any diseases, repeated involuntary micturation occurring after the age of 5 is termed as enuresis.

ii) **Psychological Factors**: Psychological factors account for the majority of cases of secondary enuresis:

- Acute stress, birth of a sibling, insecurity, death of a parent, emotional disturbances, etc.
- Family break up, maternal separation, accidents, hospitalization may also cause enuresis in children.
- Enuresis sometimes occurs in very ambitious boys. Strength and quality of the urine stream may become equated with physical process. Micturation can then become conflicted resulting from urination at inappropriate times.
- Nocturnal enuresis is most often caused by emotional conflicts. It can be a conversion reaction and can also be an expression of regression.
- Hostility can be expressed through the symptoms of enuresis. Such expression of hostility is nearly always unconscious. The child does not deliberately void at inappropriate times.
- Some children wet their pants because they are too busy or preoccupied to use the bathroom. Toilet training difficulties can also cause enuresis.

iii) **Management**

- *Assessment*: A careful history and appropriate physical examination is needed to exclude organic pathology. Then psychiatric disorder should be sought. If none is found an assessment should be made to find out any distress experienced by the child. An evaluation is made to find out the attitude of the parents and siblings regarding bed wetting. Finally the parents should be asked how they tried to help the child.

- *Treatment*
  - — Any physical disorder should be treated.
  - — If the enuresis is functional then explanation is given to the child and parents that the condition is common and the child is not be blamed.
  - — Punishment and disapproval are inappropriate and unlikely to be effective.
  - — The parents should be encouraged not to focus attention on the problem but to reward success without drawing attention to failure. Many younger enuretic children improve spontaneously but those over 6 years of age need more active measures. Some effective measures are:

a) Restriction of fluid intake after 8 pm in case of nocturnal enuresis.

b) Bladder training during day time, aimed at increasing holding time of bladder. This is carried out in a step by step manner using positive reinforcements.

c) Interruption of sleep before the expected time of bed wetting. The child should be fully woken up and made aware of passing urine.

d) Conditioning devices which cause an alarm to sound as soon as the voided urine touches the bed sheet. It causes inhibition of further micturation and child awakens.

e) In a group, other children frequently ridicule the enuretic child. Under these circumstances, punishment, rewards, discussion or group pressure from age mates seldom are helpful. The child should be treated for any emotional stress. The parents, child and other family members need emotional support, guidance and counselling.

f) Pharmachotherapy: Antidepressant, usually imipramine 25-75 mg/day may be given according to doctor's advice. It probably acts by its anticholinergic effect as well as by decreasing the sleep period. As enuresis is a self limited condition, therefore the use of antidepressants is discouraged, except in refractory or unusual cases. The other drugs for this purpose include diazepam, anticholinergics, amphetamines, placebos, but none has shown a good therapeutic response.

4.2.3 Masturbation

Masturbation or self-stimulation of genitals occurs at any age for a variety of reasons and, if not excessive, is normal and healthy. For preschoolers it is a part of sexual curiosity and exploration.

i) **Definition**

It is an act of achieving sexual arousal and orgasm through manual or mechanical stimulation of the sex organs.

ii) **Concepts and Principles Regarding Masturbation**

- Masturbation is normal and universal, not physically and psychologically harmful in itself.
- Pleasurable genital sensation is important for increasing self pride, finding gratification for own body, increasing sense of personal value of being lovable, helping to prepare for adult sexual role.
- The negative feelings and reactions of the parents influence children's response which increases masturbation.
- Masturbation may be related to curiosity, experimental, tension reduction and pleasure.

- Excessive masturbation – When it interferes with children's regular activities or causes soreness, pain or tissue damage which create potential for infections, it becomes unhealthy or maladaptive behaviour.

iii) **Management**

- Nurse will assess the parental concern with masturbation.
- Assess the belief of the parents held as doctrine for acceptable normal conduct or view that any form of masturbation as negative and unacceptable.
- The parents with negative reaction needs more help in understanding it as a natural, healthy expression of sexual development.
- Investigate the circumstances associated with masturbation because all genital stimulation is not masturbation, for genital stimulation may be an expression of anxiety, boredom or unresolved conflicts. A boy who repeatedly touches his penis may not be masturbating for pleasure but may be reassuring himself that it is intact. This may be an expression of castration anxiety and should be investigated further.
- For children who masturbate at inappropriate times or in inappropriate places; require special attention when they are not masturbating.
- Teach them that masturbation is a private act that should not be expressed in public.
- Counsel the parents not to punish the child or induce shame or guilt feeling in them.
- The parents must deal with loneliness, boredom, anxiety and insecurity feelings of the children. If exploration of the genital area is compulsive, the behaviour is a signal that the child is insecure.
- Assess the activity: When does it occur and why? Help the child develop other strategies for coping with anxiety.
- Counsel parents that threats and punishments are contraindicated and help parents to deal with their feelings about masturbation.

4.2.4 Temper Tantrums

Anger is an emotional reaction that should be expressed usefully. Toddlers may assert their independence by violently objecting to attempt at restricting their behaviour. They may be down on the floor, kick their feet and scream, and do actions like head-banging, head-rolling and breathe holding. While these mannerisms are very disturbing to observe, they do not usually become behaviour problems. The child is unable to control his/her behaviour like an adult person.

i) **Definition**

Temper tantrums may be defined as a state of explosive breaking out of intense feelings and conflicts, by stamping feet, screaming and throwing himself on the floor or breaking furniture, etc.

ii) **Causative Factors**

- ***Anger***: It is a part of normal development to act out anger, when child loses control, his angry feelings pour out by producing fearful tantrums. These children lose control of their emotions and are unable to listen to reactions.
- ***Frustration***: Children with low tolerance of frustration resort to tempertantrum, often destroying the object of the anger.
- ***Individuals who cease to adapt***: Ceasing to adapt as a response to anxiety has been shown in handicap children in developmental and daily

living tasks. The most frequent form of abnormal behaviour is refusing to learn in secure surrounding place.

- ***Attention seeking behaviour***: When children learn that he will gain the attention of the parents by producing violent tempertantrums, or screaming and throwing himself serve to control his parents and gain their attention.

iii) **Clinical Features**

- Kicking the feet
- Screaming
- Head banging
- Head rolling
- Breath holding and fainting
- Throwing himself on the floor
- Breaking objects

iv) **Management**

- Breath holding and fainting from lack of oxygen cause no physical harm because the accumulation of carbon dioxide stimulate the respiratory center to initiate breathing.
- Head banging results in self inflicted injury and child requires protection, such as a padded cot.
- The best approach toward extinguishing attention seeking behaviours to ignore it provided the behaviour is not inflicting self injury.
- Educate the parents, they must provide love and affection to the child and act as model parents for expression of anger.
- Allow the child to talk before the act and make him confident to communicate his problem to the parents.
- Talk about the behaviour when the child is in good mood and help him/her to see the behaviours which are acceptable.
- Reward the child when s/he is behaving properly.

4.2.5 Attention Deficit Hyperactive Disorder(ADHD)

Both hyperactivity and hyperkinesis are occasionally observed in school children. About 1/3rd of children by their parents and 5 to 20 percent of school children by their teachers are described as overactive. ADHD occurs in different cultures and is difficult to diagnose before 4 years of age.

i) **Definition**

Hyperactivity is defined as an increased motor activity to a level that interferes with the child's functioning either at school or at home.

ii) **Clinical Features of ADHD (ICD-10)**

a) Impaired attention manifested by

- prematurely breaking off from tasks,
- leaving activities unfinished,
- frequent change from one activity to another, and
- loose interest in one task as they become diverted to another.

b) Over-activity manifested by

- excessive restlessness especially in situations requiring relative calm,

- running and jumping around,
- getting up from a seat while he is supposed to remain seated, and
- excessive talkativeness and noisiness, or fidgeting and wriggling.

Both these cardinal features are necessary for the diagnosis and should be evident in more than one situation (e.g. Home, classroom, clinic).

iii) **Management**

- Gratify wishes in reasonable amount of time as the child has impulsive behaviour with low frustration tolerance.
- Reduce anxiety by verbal intervention and redirection of activities.
- Use behaviour modification, can use the nurse for external control of behaviours. Teach techniques that child can use to think before acting (e.g. count to ten).
- Give the child a chance to express feelings without being rejected.
- Modify the environment and staff should provide support to the child, so that child is able to continue his activities under supervision.
- Help the child to connect his feelings to the current situation and acting out behaviour.
- Assess the family's support system. Discuss how to make a safe home environment.
- Teach behaviour modification technique and give parents support as they learn to apply them (education and follow up support is the key to a successful treatment programme for ADHD).
- Give educational information about modification that enables parents to monitor their effectiveness and side effects.
- Facilitate collaboration between parents and school system.
- Refer parent to a local child guidance clinic for consultation and treatment.

4.2.6 Sleep Disorders

Sleep is an essential biological need. The young infant will spend most of the time sleeping between feeds. Sleep disturbances of the child can arise from emotional problems associated with any of the phases of development.

i) **Definition**

A sleep disorder is a chronic disturbance of sleep patterns (amount, quality or timing of sleep and nightmares).

It may be:

— Insomnia
— Night terror
— Nightmares
— Sleep walking (Somnambulism)

ii) **Management**

— Counsel parents about the importance of a consistent bed time ritual.
— Ignore attention seeking behaviour.
— Other measures that may be helpful include keeping a light on, in the room, providing transitional object such as a favourite toy or leaving a glass of water by the bedside.
— One approach is to establish rituals that signal readiness for bed, such as a bath or story telling. Parents can reinforce the pattern by stating "after this story it is time to bed" and consistently carrying out the routine.

4.2.7 Speech Disorders

The most critical period for speech development occurs between 2 to 4 years. During this period children are using their rapidly growing vocabulary faster than they can produce the words. This failure to master sensorimotor integration results in stuttering or stammering as children try to say the word they are already thinking about. This difficulty in speech pattern is a normal characteristic of language development. In fully developed speech there are 3 phases.

- Receptive difficulties: Delayed development of speech can arise from failure to understand speech owing to complete or partial deafness.
- Expressive difficulties: This refers to children in whom the main difficulty is with articulation, which can occur with general spasticity of the muscle in spastic children.
- Formative difficulties: One of the simplest to understand but one of the rarest of these disorders is the aphasia which may be accompanied by severe hemiplegia, whether congenital, from birth injury or acquired in the early year of life through encephalitis or vascular accident. In some of these children the defective interpretation and regrouping of sounds and their associated ideas is further complicated by clumsy articulation. In these cases it is important to rule out mental subnormality.
- Parents may be referred to speech therapist.

4.2.8 School Phobia

A child when separated from those to whom s/he is attached, experiences anxiety beyond that is expected from the child's developmental level. The child may demonstrate sudden and seemingly inexplicable fear of going to school. These children often don't know what it is they fear at school.

Definition

School phobia refers to a persistent refusal to attend school, the child remaining at home with the full knowledge of his/her parents. This is an acute anxiety reaction related to separation from home and not actually a phobia.

Manifestation of Behaviour of School Phobic Children

- Physical dimension: Stomach ache, head ache, nausea and vomiting when separation occurs or is anticipated.
- Emotional dimension: Experiences anxiety to the point of panic, fear of being lost and never being reunited with parents. Child is extremely homesick when away from home.
- Intellectual dimension: Preoccupied with morbid fear, accidents or illnesses about significant persons when separated. Preoccupation with reunion fantasies when away from home.
- Social dimension:
  - Display clinging behaviour, staying close to parents or shadowing the parents.
  - Uncomfortable when alone, away from home or in unfamiliar surrounding.
  - Exhibits recurrent instances of social withdrawal when a major attachment figure is missing.
  - Become violent towards a person who forces separation.

Management

- If the child is allowed to stay at home, the dread of returning to school is usually increased.
- Preparation of child for schooling is important.
  - — Allow the child to mix with children who are going to school.
  - — Make friends with school going children so that child develops confidence to mix with others.
  - — Talk about school, teachers, books, tiffins, school uniforms, sports and games etc. Observe the reaction of the child.
  - — The child should not be forced or punished for not going to school.
  - — Accompany the child and inform school teacher about the problem.
  - — Sometime the child feels confident when teacher welcomes him/her with smile and holds him/her with love and affection.
  - — Sometime teacher allows parents to stay in waiting room.

Check Your Progress 1

List five neurotic behaviours of children.

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4.3 PSYCHOTIC DISORDERS OF CHILDREN

The diagnostic categories for severe childhood disorders have been periodically revised as differential diagnosis have evolved, originally called infantile autism, symbiotic psychosis, a typical psychosis or childhood schizophrenia. Most of these disorders now fall under the classification of Pervasive Development Disorder (PDD).

4.3.1 Autism

Autistic disorder is usually observed at 3 years of age and the prognosis is related to the child's overall intellectual level and the development of social interaction and language. Some children show improvement as they develop, but puberty can be the turning point for either improvement or further deterioration.

i) **Definition**

Autism is a psychotic disorder beginning in infancy characterized by inability of the child to relate to others or to form a normal self concept.

ii) **Clinical Features of Autistic Children**:

- Withdrawal, self absorption, inability to relate to others and lack in emotional contact.
- The autistic child seems indifferent to affection and physical contact.
- Failure to develop speech; either delayed or totally absent.
- Inability to name the objects.
- Failure to develop imaginative play.

- Does not develop friendship or play cooperatively with other children.
- Exclusive interest in object such as buttons or body parts.
- Changes in daily routine or in child's physical environment can cause catastrophic reaction.
- Poor coordination.
- Tiptoe walking.
- Peculiar hand movement – e.g. flapping, clapping.
- Stereotype body movement – e.g. rocking, spinning.
- Self injurious behaviour – e.g. head banging, finger or hand biting, hair pulling.

iii) **Management**

- Engage the child in a therapeutic alliance beginning with non verbal play.
- Help the child to verbalise what is happening and what s/he might be experiencing.
- Encourage vocalization with sound, games and songs.
- Identify desired behaviours and rewards (e.g. hug, treat, points)
- Use name frequently and encourage the use of correct pronouns (e.g. I, me, he)
- Foster ego development by reinforcing self-identity and ego boundaries through drawing, stories and play activities.
- Teach parent how to facilitate speech development in order to continue the behaviour modification.
- Set up play situation with peers. Arrange games, sports, music and cultural programme.
- Provide support in activity of daily living (ADLS). Recognize emotional distress and comfort the child.
- Facilitate superego development by role modeling.
- Empathy and sharing in activities with child's peers.
- Learning occurs through imitation, modeling, feedback and reinforcement.

Check Your Progress 2

Write five characteristics of autistic child.

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4.3.2 Childhood Schizophrenia

The onset of schizophrenia usually occurs in adolescents although it may appear in childhood with common symptoms of inability to relate to others, low frustration tolerance, autistic thinking and disorganized motor activity.

i) **Definition**

Childhood schizophrenia, similar to infantile autistic, manifests impaired behaviour, communication, perception, affect and social relatedness. In addition, schizophrenics demonstrate disordered thought.

ii) **Clinical Features of Childhood Schizophrenia**

- Speaking in incomplete and fragmented sentences.
- Morbid preoccupation with bodily functioning.
- Poor attention span.
- Extreme restlessness.
- Maintaining bizarre postures.
- Sudden kicking and screaming.
- Refusal to talk or to eat.
- Loss of interest in play or continuously plays with one toy.
- Head banging.
- Irregular sleep patterns.
- Delusions bizarre introjections e.g. animal or machines are felt to be within his body.

iii) **Etiology**

- A genetic cause for childhood schizophrenia has been well delineated as it has for adult schizophrenia.
- A grossly chaotic upbringing with constant exposure to aggressive behaviour of parents.
- A failure of repression: A child, who is repeatedly exposed to violence, may be unable to repress sexual and aggressive fantasies which normally occur at the age of 6 years.

iv) **Psychodynamics**

- The early painful experiences of childhood related to mother child relationship. It could be due to extreme frightening or threatening experiences in the early life of the child.

v) **Treatment and Nursing Management**

- Supportive psychotherapy promotes mature defense and adaptive functioning.
- Educate the parents to understand the nature of their child's behaviour.
- Family therapy is indicated when disruption of the family is evident.
- Hospitalization may be needed when aggression and sexualized stimulation can't be minimized at home.
- Antipsychotic agent may be used to treat severe agitation and aggressiveness. Haloperidal 0.5-15 mg/kg/day is usually given. The dose should be as low as possible.
- Prevent acute and chronic side effects such as seizures, a condition that may develop in some childhood schizophrenia.

vi) **Prognosis**

The prognosis is more helpful if the child has high I.Q., intelligible speech, a history of good premorbid functioning. A family history of schizophrenia worsens the prognosis. Schizophrenia with acute onset has better prognosis than insidious onset.

4.4 MENTAL RETARDATION

Mental retardation is a state of arrested development of mind existing from birth or from an early age. Mental Retardation (MR) is currently under study, and advances have been made in the prevention of retardation through genetic counseling, amniocentesis, special diet for children with phenylketonuria and in early detection and management of disorders.

Definition

Mental retardation is a state of arrested or incomplete development of intellectual functions characterized by impairment in cognitive, language, motor and social skills manifested at birth or early childhood.

Epidemiology

The prevalence of MR is 1-2 percent of the population. In India, more than 20 million children are mentally retarded. The ratio of mentally retarded and normal people is 3:1000. The incidence of MR seems to increase sharply at the age of 5 with the number of cases identified at the age of 15.

Etiology

Mental retardation may be largely a genetically determined or may be due to factors operating during pregnancy, at birth or during infancy and childhood.

- Genetic factors (probably in 5 per cent of cases of MR)
  - a) Chromosomal abnormalities: e.g. Down's syndrome, Fragile X-syndrome, Turner's syndrome, etc.
  - b) Inborn errors of metabolism including amino acid (homocystinuria), lipids (Gaucher's disease), carbohydrates (galactosaemia), phenylketonuria, hypothyroidism, Hurler disease, Tay-Sachs.
  - c) Single gene disorders: e.g. tuberous sclerosis, neurofibrinomatosis.
  - d) Eranical anomalies: e.g. microcephaly
- Prenatal causes (probably in 10 per cent of cases of MR)
  - a) Infections: e.g. rubella, syphilis, toxoplasmosis, influenza, etc. in mother.
  - b) Use of drug during first trimester.
  - c) Placental insufficiency.
  - d) Blood type incompatibility.
- Perinatal causes
  - a) Anoxia
  - b) Birth injury
  - c) Prematuriy
  - d) Kernicterus
- Postnatal causes
  - a) Infection – meningitis, encephalitis.
  - b) Postnatal cerebral trauma, convulsive disorder, etc.
- Socio-cultural causes (probably in 1-2 per cent of cases of MR)
  - a) Deprivation of socio-cultural stimulation

- Psychiatric disorders
  a) Autism
  b) Childhood schizophrenia

Diagnosis of MR

Nurse assists in diagnosis which is made by the following steps.

- History of mother – prenatal, natal and postnatal.
- History of child – prenatal, neonatal and 0-5 years of age.
- General physical examination to identify physical defects.
- Mental status examination.
- Clinical assessment of level of intelligence i.e. IQ test.

Classification of MR

A classification of mentally retardation is done on the basis of mental age of the child.

i) **Mild Mental Retardation (IQ level is between 50-70)**

Characteristics:

- Develop like other normal children with very little deficit.
- They often progress up to 6th class in school.
- These children are 'educable'.
- The incidence is 85-90 per cent of all cases.

ii) **Moderate Mental Retardation (IQ level is between 35-50)**

Characteristics:

- These children can speak and communicate.
- Have poor social awareness.
- They drop out from school after the 2nd class.
- These children are 'trainable'.
- The incidence is 10 per cent of all cases.

iii) **Severe Mental Retardation (IQ level is between 20-35)**

Characteristics:

- Identified early in life.
- Poor motor development.
- Absent or markedly delayed development of speech.
- These children are 'dependable'.
- They include 3-4 per cent of all cases.

iv) **Profound Mental Retardation (IQ level is below 20)**

Characteristics:

- Achievement of development milestones is markedly delayed.
- Associated physical disorder is present.
- These children are 'dependent' and need nursing care and life support under a carefully planned and structured environment.
- The incidence is 1-2 per cent of all cases.

Management of Mentally Retarded Children

The management of mentally retarded children includes prevention of primary, secondary and tertiary levels.

i) Primary Prevention

- Awareness program for public and family members.
- Care of antenatal mother. It includes:
  - — Regular antenatal check up.
  - — Rubella immunization.
  - — Genetic counseling.
  - — Avoid smoking and drinking.
  - — Screening for STD and AIDS.
  - — Early diagnosis of ultra sound study for:
    1) retardation
    2) microcephalus
    3) hydrocephalus
    4) multiple birth
  - — Checking weight, BP and foetal condition regularly.
  - — Health education on nutrition, rest and sleep of antenatal mother.
- Care of natal period.
  - — Reducing hypoxia and birth trauma
- Care of post natal period.
  - — Screening for hypothyroidism and phenylketonuria.
  - — Immunization programme.
  - — Control epilepsy.
  - — Control infection and accidents.

ii) Secondary Prevention

- Education of parents to assess the significant developmental milestones.
- Identify isolated handicaps like sensory motor difficulties, dyslexia, dyscalculia, dysgraphia, spasticity, ataxia, etc.
- Counsel the family regarding diagnosis.
- Teach the parents how to care a mentally retarded child at home.
- Assist them in locating suitable community resources for necessary help.
- Treat the child as normal as possible.
- Encourage the family to raise the child in the home environment with mainstreaming in the community.

iii) Tertiary Prevention

It consists of mainly rehabilitation and follow up care.

Parental counseling.

- Explain the parents about the nature and severity of the handicap and also expected outcome.
- Assess the reaction of parents and provide emotional support to remove their grief, helplessness, shame, and guilt feelings.

- Talk about the importance of early training, social and emotional stimulation.
- Make parents understand that the child needs love, affection and support from them.
- Help the parents to develop right attitude towards handicap and not sympathy to the child.
- Teach them that MR is due to poor development of the brain, medicine can't cure it but child needs special guidance to improve his biological and psychological skills.
- Teach them that marriage will not cure MR but they need safety and security.
- Children of school age can receive special education in special schools or special classes.
- Industry workshops are utilized by some institution for vocational training and various forms of employment according to the ability of the handicaps. The parents should take initiative and contact those institutions for rehabilitation of their children.

Check Your Progress 3

Classify mental retardation on the basis of mental age of the child.

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4.5 ALTERED MATURATIONAL PATTERNS OF ADOLESCENTS

Adolescence is a time of transition – an age wl en the person is

not yet an adult but is no longer a child. Adolescence is a unique stage of development that occurs between ages 11 and 20 years.

Major tasks of adolescence:

- Achieving new and more mature relations with age mates of both sexes.
- Achieving masculine or feminine social roles.
- Accepting physical build and using body effectively.
- Achieving emotional independence from parents and other adults.
- Preparing for marriage and family life
- Preparing for a career
- Developing values, an ethical system as a guide for behaviour, self esteem and sense of identity.

4.5.1 Identity Confusion

Adolescence is seen as an adaptation on a continuum of development. There is less emphasis on age and more on the developmental level and timing of biological,

physiological and environmental influences. These variables change rapidly during adolescence and affect their behaviour and viewing of self. The marked physical, physiological and psychological changes of adolescence, the development of sexual awareness and the reaction to these changes by family and society, threaten the continuity of self and ego identity. These conflicts are the base of identity crisis in adolescence, the resolution of which is of paramount importance in successful adjustment.

— The chief characteristics of the normal adolescents are hope, ambition, being appropriate and desire for social contact.

— The adolescent tends to feel emotions like anger, disappointment, frustrations, etc. more acutely

— In some individuals serious maladjustment may develop during adolescence such as delinquency, neurosis, psychosis, marked emotional instability, etc.

— The tendency to maladjustment will be determined by the individual's constitution and personality, his upbringing and the nature of parental influences.

— During adolescence the individual gains a keen appreciation of the needs of the society, develops standards in moral, ethical and religious matters and in short, develops his philosophy of life.

4.5.2 Body Image Distortion

The growth and changes of adolescents may produce view of self. They may overemphasize on defects with compensation; inflated ideas of body, ability, beauty, perfection, preoccupation with body appearance or body processes. Body image is crucial for self concept formation, status achievement and adequate social relation. The body image disturbances of adolescents related to eating disorder is characterized by an intense, pathologic fear of being fat and by denial of current body weight. The female are more concerned than male to see body fatter than it is. The two types of eating disorders are as follows:

1) Anorexia Nervosa

Anorexia nervosa is an eating disorder and body image disturbances usually seen in adolescent girls. The individual is not obese but has an intense self concept of obesity and pathological fear of being fat. The body weight is reduced excessively and looks emaciated due to extreme form of anorexia.

i) ***Definition***

Anorexia nervosa is characterized by distorted body image and prolonged inability to eat, with marked weight loss, amenorrhoea, and other symptoms resulting from emotional conflict, creating a life threatening condition and retarded growth.

ii) ***Clinical Features (Adolescent Female)***

- Amenorrhoea
- Nutritional deficits
- Obsession with need to loss weight and with fear of becoming fat.
- Refusal to eat.
- Electrolyte abnormality.
- Excessive exercise.
- Induced vomiting.
- Cardiac arrythmias related to hypokalemia resulting from starvation.

iii) *Management*

- Monitor physiologic signs and symptoms, e.g. amenorrhea, constipation, hypoproteinemia, hypoglycemia, anaemia, hypothermia, hypotension, leg cramps, etc.
  - — weigh regularly at same time and with same amount of clothing.
  - — water drinking is avoided before weighing.
  - — stay with the person during meals.
  - — give one to one supervision 2 hours after mealtimes to prevent attempt to vomit food.
- Improve self esteem, self image and self concept through cognitive therapy.
- Promote awareness of fear about sexuality and intimacy.
- Try to explore the underlying anxiety.
- Encourage participation in family therapy.
- Health teaching: explain normal sexual growth and development to improve knowledge deficits.

2) **Bulimia**

Bulimia is another type of eating disorder, characterized by atleast two binge-eating episodes of large quantities of high-caloric food over a couple of hours followed by self induced vomiting. The individual suffers from persistent overconcern with body shape and weight. Bulimic episode may occur as part of anorexia nervosa but not all anorexics are bulimic.

i) *Definition*

Bulimia is an eating disorder, characterized by recurrent binge eating episodes coupled with methods to prevent weight gains.

ii) *Management*

- Help to regain self control of binge-purge behaviour through one to one observation by nurse for 2 hours after meals in order to monitor eating related behaviour.
- Minimize compulsive purging by encouraging participation in social activities that discourage secret binge purge episodes.
- Limit weighing to once in a week.
- Give fluids and high fiber food to prevent constipation and reduce temptation to use laxatives.
- Avoid discussion of foods as focal point of family visits.
- Provide a structured eating situation: serve nutritionally balanced meals, rather than soft, sweet high calorie food. e.g. ice cream, pastries, etc. should be avoided.
- Encourage expression of anger and negative feelings to reduce depression related to self contempt (anger turned inward).
- Focus on strengths and capabilities to build self esteem and discourage guilt and self criticism.
- Lessen obsession with food, weight and physical appearance.
- Involve in independent decision making in managing own daily activities, leisure time and social functions.

4.5.3 Antisocial Behaviour

Adolescents with conduct disorders display behaviour that violates the basic rights of others or social norms and rules. The tendency of doing offences against person and property and tendency of violating laws is increasing day by day among the children. Juvenile delinquency is one of such antisocial behaviour of adolescents.

i) ***Definition***

Antisocial behaviour is a lack of socialization with behaviour pattern that bring a person repeatedly into conflict with society.

ii) ***Characteristics of Antisocial Behaviour***

- Verbal and physical aggression toward people, property, animals.
- Stealing, rape, lying, cheating, truancy from school, fire setting.
- Use of drugs.
- Callous, disregard for feelings of others.
- Blaming others for own behaviour.
- Low tolerance for frustration; irritability.
- Lack of empathy, remorse, guilt.
- Never ready to learn by experience and punishment.

iii) ***Management in Counselling Parents and Teachers***

- Counselling parents and teachers:
  - — Observe early symptoms of anti social behaviour.
  - — Evaluate surface behaviour and intervene when the intensity is becoming too great.
  - — Use a word, a gesture or eye contact to remind the child to use self control.
  - — Move closer to the child for a calming effect and put an arm around the child.
  - — Increase involvement in the activity to redirect the child's attention to the prescribed activities and away from a distracting behaviour.
  - — Give the child emotional support for the current problems and ignore the provocative content of the behaviour.
  - — Use of humor to help the child save face and relieve feeling of guilt or fear.
  - — Give early help or extra assistance to the child who 'blows up' and is easily frustrated when trying to achieve a goal. Do not overuse this technique.
  - — Setting limits and giving permission for the behaviour to be expected.
  - — Corporal punishment must be avoided; it should be used as last resort with full explanation.
  - — In case all efforts of treatment and rehabilitation have failed the antisocial child is admitted to certified school meant for education and correction.

4.5.4 Habit Disorder (Substance Use)

The adolescent uses drugs and alcohol for reasons such as experimentation, boredom, curiosity and most frequently peer pressure. Many adolescents use drugs

and alcohol frequently as a form of relaxation. When drugs are used in excess, school performance, social relations and family life are harmed. The adolescent engaging in substance abuse generally appears disinterested, lethargic, easily distracted, irritable and moody. School performance and social relation gradually deteriorate. Addiction to drugs and dependence on alcohol may result in the adolescent's becoming abusive, hostile and difficult to manage. The high risk adolescents need professional help and care to get rid off such problems.

For details, refer to Unit 3 of this block on psychoactive substance use disorder.

Check Your Progress 4

1) Write five clinical features of anorexia nervosa.

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2) Write five antisocial behaviours of adolescents.

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3) Encircle the T (true) or F (false) after going through the following statements.

a) Bulimic episode may occur as part of anorexia nervosa. (T/F)

b) Masturbation may be related to tension reducing behavior (T/F)

c) Childhood schizophrenia is an acute anxiety reaction related to separation from home (T/F)

d) The moderate mentally retarded children are trainable. (T/F)

4.6 LET US SUM UP

Neurotic and psychotic behaviour of children differ from adult's reactions. In this unit you have studied various neurotic disorders of children, like thumb sucking, nail biting, enuresis, masturbation temper tantrum, ADHD, sleep disorders, speech disorders in children like autism and early childhood schizophrenia are also discussed. The nursing management in each condition is also described. Mental retardation, its causative factors, classification and management are also explained as the early diagnosis. Altered maturational patterns of adolescents like identity confusion, body image distortions, antisocial behaviour are also discussed and the management is described as how to help the disturbed adolescent to function adequately in school, at home and in community.

4.7 KEY WORDS

Acting out : Expressing oneself through actions rather than speech.

Aphasia : Abnormal neurological condition in which language function is defective or absent because of an injury to certain areas of the cerebral cortex.

Ataxia : Muscular incoordination, particularly at arms and legs.

Body Image : Person's subjective concept of his physical appearance.

Castration : Literally, the loss or damage of the genital organs. Symbolically, a state of powerlessness or psychologically impotent.

Conflict : Opposition between two drives that are experienced simultaneously in response to some situation.

Desmopressinacetate : A synthetic antidiuretic with greater antidiuretic activity but less pressor activity than vasopressin.

Dyslexia : Impairment of the ability to read.

Fragile X Syndrome : Condition of an X-linked mutation associated with a fragile site near the tip of the long arm of the X chromosome. Most males and 30 per cent of females with this syndrome are mentally retarded.

Genetic Counseling : Counseling prospective parents concerning the probability of their having defective offspring as a result of genetic defects.

Juvenile Delinquency : A legal classification of children's behaviours that violate the law.

Masturbation : Production of orgasm by self manipulation of genitals.

Play therapy : A technique used in child psychiatry to establish interaction between the child and the therapist.

Refractory : Resistant to ordinary treatment.

School phobia : Child's state of anxiety related to separating him from parents by his attending school.

Somnambulism : Dissociative manifestation of sleep walking.

4.8 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) Thumb sucking
2) Bed wetting
3) Temper tantrum
4) Sleep disorders
5) School phobia

Check Your Progress 2

1) Identify to relate to others.
2) Self absorption.
3) Inability to name the object.
4) Failure to develop speech.
5) Dislike any change of environment or daily routine.

Check Your Progress 3

1) Mild mental retardation.
2) Moderate mental retardation

3) Severe mental retardation.
4) Profound mental retardation.

Check Your Progress 4

1) a) Refusal to eat.
   b) Fear of becoming fat.
   c) Exercises excessively.
   d) Induces vomiting.
   e) Malnourished and dehydrated.
2) a) Verbal and physical aggressive behaviour.
   b) Disregard the feeling of others.
   c) Low tolerance of frustration.
   d) Lack of guilt feelings.
   e) Never learn by experiences and punishment.
3) a) T
   b) F
   c) T
   d) F

4.9 FURTHER READING

Kapoor, Bimla (2002), *Text Book of Psychiatric Nursing*, Vol. II, Kumar Publishing House, Delhi.

NOTES