



# Community Paediatric Review

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### Sibling rivalry

Birth rates have declined throughout the Western world over the last few decades, but 80% of children still grow up with at least one brother or sister. By one year of age younger children spend almost as much time with their older brothers and sisters as with their mothers, and far more time than with their fathers. Four to six year olds spend more than twice as much time in each others company as with their parents. It is no wonder that conflict between siblings is a normal part of day to day life for most families.

In the first 12 months following the birth of a new baby two peaks of conflict are apparent. First, confrontations between older siblings and their new brothers and sisters are commonplace during the first 3 months, particularly when the mother is feeding or interacting with the new baby. Second, confrontations again become the rule when the younger child approaches 12 months of age and the older child tries to deal with an increasingly intrusive and mobile toddler. In general, more problems are observed with siblings of the same sex.

A number of factors influence the nature of sibling relationships and therefore the extent to which conflict rears its head.

**Spacing** The age gap between siblings is of considerable importance. Spacing intervals of at least 2 years have been associated with improved verbal skills and academic achievement for elder children. There is a tendency for closely spaced siblings (less than 18 months apart) to be treated similarly by parents and more at the level of the younger child. The relative infantilisation of the elder child means that the child may have difficulty then in conforming to the expectations of his or her age peers. Narrow spacing also increases the risk of sibling conflict.

**Gender** First born girls are perceived as more nurturing and friendly in their interactions with younger siblings, particularly with their sisters. Both toddler boys and girls preferentially seek out older sisters over older

brothers for comfort and assistance during free play. Mothers tend to engage in more play with their second born child if that child differs in sex from the first born child. Fathers have a tendency to talk more to their first born child than to their later born children and more to their sons than their daughters.

**Temperament** The child's intrinsic behavioural style seems to exert a more powerful effect on the sibling relationship than either age or gender. As expected, shyness in older siblings is associated with less controlling and competitive sibling relationships. A more difficult temperament in either older or younger siblings increases the frequency and intensity of sibling rivalry and aggression.

**Parenting behaviour and family stress** The quality and nature of the relationship between mothers and young children determines how these children behave towards their brothers and sisters. Research indicates that mothers become involved in more than half of all conflicts between 18-24 month old children and their older siblings. If mothers become involved in minor squabbles between their children, this is likely to exacerbate sibling conflict. Differential treatment of siblings by parents is especially likely to exacerbate conflict. Marital discord and overt conflict between mothers and fathers increases the rate of sibling aggression.

**Physical illness and disability** Chronic illnesses impose major stresses on relationships within

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families, including sibling relationships. Chronically ill children and their healthy brothers and sisters are at greater risk of conflict than healthy sibling pairs. Differential parental handling of siblings is the single strongest predictor of conflict. Low socioeconomic status, male gender, close spacing, marital conflict and illnesses that are visible and severe are all likely to worsen the prognosis for relationship difficulties.

**Management** Although family planning decisions made by parents should be supported, wider spacing (more than 2 years) does seem to offer developmental benefits to both older and younger siblings, and decreases the rate of sibling conflict. In general, older siblings should be informed about the forthcoming baby early in the second trimester of pregnancy, and be actively involved in family preparations for delivery. Parents should refer to the forthcoming infant as “our” new baby to facilitate the older child’s positive attachment to and involvement with his or her new sibling. Young children should be prepared for the mother’s hospitalisation and visit regularly during the postpartum period. They should also be allowed to hold and touch the new baby. Children should be encouraged to help out with the new infant and be praised and rewarded for grown up, gentle and cooperative behaviour. Regressive behaviour, a common occurrence in older sibs, is usually transitory and is best ignored.

Parents need to allocate a special time each day to spend with each child alone. Different bedtimes, allowing age appropriate privileges and encouraging special individual interests helps to reinforce these differences.

Finally, parents should try to stay out of minor sibling conflict. Research indicates that parental interference tends to make it worse. Physically violent or aggressive behaviour however cannot be ignored and should meet with an immediate disciplinary consequence such as time out or withdrawal of privileges. Children should be punished for hitting or hurting irrespective of whether or not they have initiated the disagreement. Giving children permission to hit back if someone else hits first provides an ambiguous message to young children about the appropriateness of using violence to solve problems. Thankfully even the most competitive and hostile sibling relationships in early childhood usually become warm and caring connections in later childhood and through the adult years.

AUTHOR

**DR. RICK JARMAN**

CENTRE FOR COMMUNITY CHILD HEALTH & AMBULATORY

PAEDIATRICS

ROYAL CHILDREN’S HOSPITAL,

MELBOURNE.

## Teething

The average child erupts approximately one tooth per month from the age of about six months, with the full complement of 20 deciduous teeth usually present by 30 months. Although terms such as "eruption", "cutting", and "piercing" imply that tooth emergence is a traumatic process, it is actually a natural degeneration of the overlying dental epithelium as each tooth steadily grows and moves upwards.

Teething was dreaded in earlier centuries. In the mid 19th century the British Registrar General ascribed 12% of all deaths in children under 4 years of age to the condition. Non-fatal effects of teething have covered the gamut of almost every possible childhood illness (eg convulsions, diarrhoea, constipation, gonorrhoea, pneumonia, and otitis media). Treatments were diverse and sometimes dangerous; for instance, teething powder containing mercury was the cause of many cases of lifelong intellectual disability, and even at the turn of this century, lancing of the gums to allow the tooth to come forth was still standard practice.

Today, many professionals take the stance that "teething causes nothing but teeth". In the only detailed study to look objectively at teething symptoms, 89 infants were examined daily through 192 tooth eruptions and no relationship was found between teething and fever, infection, and behavioural disturbances. Nonetheless, many professionals and parents believe that teething causes symptoms such as irritability, drooling, nappy rash, eczema, red cheeks, "strong urine", increased risk of infection, sleep

disturbances, and of course local itchiness and irritation of the affected gum itself.

It is important to remember that there are many other causes of these common symptoms. Infants and toddlers have a high rate of illness, particularly respiratory and diarrhoeal. The importance of not ascribing significant illness to teething

was shown in a study of children admitted to hospital for whom parents or GP volunteered a diagnosis of teething; in 96% of children, an organic illness (not teething) was found to be the culprit. Even salivation and mouthing behaviours may be an essential developmental part of the infant's drive to explore his/her environment. So how do we manage "teething" symptoms? It is reasonable to use simple remedies such as firm objects to bite on and/or teething gels if the infant seems to be in discomfort. Any other symptom should be treated on its own merit, regardless of apparent teething. This is particularly important if the child seems unwell, and for symptoms like strong urine, fever and eczema, which need specific treatment and/or investigation in their own right.

AUTHOR

**DR. MELISSA WAKE**

CENTRE FOR COMMUNITY CHILD HEALTH & AMBULATORY  
PAEDIATRICS  
ROYAL CHILDREN'S HOSPITAL,  
MELBOURNE

## O N T H E S H E L F

### **You and Your ADD Child - Practical Strategies for Coping With Everyday Problems.**

Author: Ian Wallace 1996, pp. 244

Price: \$17.95 (plus \$4.00 for mail orders)

You might say - "Not another book on ADD"! Yes but wait, this one is different. First of all it is Australian, written by consultant psychologist Ian Wallace. In the forward Dr. Christopher Green states that "this must be one of the best books ever written on behaviour management".

Many parents want more than a diagnosis and perhaps medication for their child. They need guidance to help them cope with the day to day management of behaviour problems and this is what Ian Wallace offers. The fifteen chapters reinforce a basic and clearly explained four step procedure to deal with, for example,

very impulsive children who have little or no idea of the consequences of their actions. Many suggestions do not just apply to the ADD child but to the family as a whole. Chapters which parents will find particularly useful include classroom strategies, self-esteem, oppositional defiant disorder and conduct disorder. This book is highly recommended by consultants at the The Royal Children's Hospital who work with children with ADD.

**HELEN ROWAN**

CHILD HEALTH INFORMATION CENTRE  
ROYAL CHILDREN'S HOSPITAL, MELBOURNE

*Available from the Child Health Information Centre, a specialist bookshop, information and referral centre for health professionals, parents, teachers and adolescents. A complete booklist is available for mail orders: Phone (03) 9345 6429, 9.30 - 4.00 weekdays.*

## Croup

Croup is a syndrome of acute upper airways obstruction involving larynx, trachea and major bronchi affecting infants and children. The peak incidence is in the first two years of life. The characteristic clinical features are:

- a repetitive, harsh barking cough
- high pitched inspiratory noise (stridor)
- hoarse voice
- varying respiratory difficulty depending on the degree of airways obstruction

**Aetiology** Croup is most commonly caused by one of several respiratory viruses (ie. infectious croup or laryngotracheobronchitis). In this case there is usually an antecedent upper respiratory tract infection (URTI) with fever and rhinorrhoea for a day or so followed by the development of stridor and croupy cough which is worse in the late afternoon and through the night.

A less common form of croup comes on suddenly at night without an antecedent URTI (ie. spasmodic croup). This form tends to occur in children with an atopic background.

**Severity** The severity of croup ranges from mild, which requires no specific therapy, to severe which presents as a medical emergency. Mild Croup is characterised by minimal inspiratory stridor and no obvious respiratory difficulty. In Moderate Croup there is significant stridor at rest with obvious respiratory difficulty. Severe Croup is characterised by loud stridor (which might be both inspiratory and expiratory in timing), and marked respiratory distress (eg. suprasternal recession, sternal recession, shortness of breath affecting speech, pallor or cyanosis, restlessness or exhaustion).

**Treatment** As croup has the potential to be life threatening, all patients should be medically assessed. Of particular concern are the following:

- patients with a history of previous admission for croup
- patients with moderate to severe croup
- patients with high fever who are sick, drooling and not feeding – it is important to exclude life threatening epiglottitis
- children with croup persisting for more than 4 days
- children where stridor is apparent through the day
- patients with a history of foreign body inhalation.

In mild croup no specific therapy is required and symptoms usually resolve after 5 or 4 days. Paracetamol is indicated for mild sore throat and fever. Antibiotics are usually not indicated. The time honoured treatment of mist therapy has not been shown in controlled trials to be beneficial. Decongestants may help symptomatically with nasal congestion.

Moderate croup – nebulised budesonide and oral corti-costeroids are effective in reducing the upper airways obstruction in acute croup and may avoid the need for hospitalisation.

Severe croup requires urgent medical attention and appropriate transport to hospital. Nebulised adrenaline has an immediate, although short lived benefit and may be repeated en route to hospital.

Nebulised and/or oral corticosteroids may be administered prior to transfer. Oxygen by face mask (rate 4-8 litres/min) may be necessary in very distressed patients. Inhaled beta-2 agents (eg. salbutamol and terbutaline) have no effect in croup.

In summary, croup is a very common paediatric respiratory condition. While mild croup is a self limiting condition, recent studies have shown that oral and inhaled corticosteroids are effective in lessening the degree of upper airways obstruction in more severe cases.

AUTHOR

DR. PAUL W.J.FRANCIS

DIRECTOR OF RESPIRATORY MEDICINE

ROYAL CHILDREN'S HOSPITAL

BRISBANE



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AMBULATORY PAEDIATRICS  
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Editors

Professor Frank Oberklaid

Michele Meehan

Hilary Russell

Production Editor

Lyn Dredge

Katherine Wositzky

For further information contact the Centre for Community Child Health & Ambulatory Paediatrics Royal Children's Hospital Melbourne Phone 03 9345 5899 or Fax 03 9345 5900

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