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Case Report

THE MANAGEMENT OF AN ADOLESCENT WITH CONDUCT PROBLEMS IN A PRIMARY CARE CLINIC – A CASE REPORT

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ABSTRACT
Purpose: To describe the management of mild conduct problems in an adolescent at the primary care level.
Case report: A 16 year old girl presented with conduct problems with impending school suspension. The cause of her behavioural problems was mainly related to poor parenting skills of her parents and anger in herself. She was successfully managed with counselling and improvement of parenting styles in her parents.
Conclusion: This case report illustrates the opportunity for family physicians to manage simple conduct problems at primary care level.
Key words: Conduct problems, adolescents, parenting skills, anger management.
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INTRODUCTION

Conduct disorder in children is diagnosed by the presence of three (or more) characteristic symptoms which include aggression to people and/or animals, destruction of property, deceitfulness or theft and serious violation of rules. These symptoms are present over the past 12 months, with at least one characteristic symptom present in the last 6 months.[1] The conduct problems usually present as a child approaches adolescence.[2] The reported prevalence among American adolescents was around 10% to 15%.[3] Unfortunately there is no local data available. Several risk factors associated with the conduct problems include male gender, poor family financial status and ineffective parenting.[3,4,5] In untreated cases, these conduct problem children may not only be harmful to themselves but also to the others. They are among the early school leavers with poor academic attainment.[5] They tend to have poor socio-economic status in adulthood life later.[3,5] In general, it is not unusual to see adolescents with conduct problems in our community and many of them are left unassisted. If some do receive treatment, they are mainly being managed by the child psychiatrists. However, as the prevalence is expected to be increasing, the primary care physician should be able to diagnose and manage mild conduct problems of adolescents. Family and individual or group interventions to the affected adolescents have been shown to be effective in the management of conduct disorder.[6]

CASE ILLUSTRATION

NH, a 16 year-old girl, was brought by her parents due to school absenteeism for almost a month with impending suspension from the school authority. She was the only child in the family. Her mother was paraplegic and her father was a driving instructor who worked at long hours. NH was brought up in a very protective environment; all her activities were closely supervised by the parents. NH was an obedient child and showed good academic performance during her primary school. Her father practised authoritarian parenting and used physical punishment for any NH's misbehaviour. These had actually accumulated anger in NH. She became rebellious after she entered secondary school. In response to NH's change in behaviour, NH's father had imposed more rules and the physical punishment became more frequent. Both daughter and father frequently ended with physical fighting. In contrast, NH's mother was a permissive parent that made NH took advantage over the mother especially for monetary gains. Subsequently NH involved herself in activities such as smoking, alcohol drinking and motor racing. She spent time with her friends almost every night and would only come home early in the morning especially over the last one month. These events resulted in her being late for school and frequent absence from school. There were times that she stayed overnight at her friend's place without her parental consent and would lie to her parents whenever she was in trouble. As NH's

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discipline and activities became uninhibited, the father had reduced his contact with NH. He had stopped punishing her completely and left NH's mother to control NH alone. Due to her mother's handicapped condition, there were several times NH hurt her mother physically and emotionally. NH was tested negative for illegal drug usage and she was found not to have depression. She had no mental retardation and other co morbid illnesses.

DISCUSSION

In NH case, it is clear that the diagnosis was conduct disorder. NH was an adolescent of less than 18 years old presented with three important symptoms which include aggression to people including her parents, deceitfulness to her parents and violation of rules either at home or school for more than 12 months duration. These behaviours had affected her school attendance, academic performance as well as family interactions. The conduct problems in NH are categorised as mild in which her behaviours mainly affecting herself rather than others.[1] Other important differential diagnoses such as substance abuse, attention deficit hyperactivity disorder, mental retardation and major depression[3] were not apparent in NH. However the challenge lies in managing her conduct problems.

The first step into the management was to understand the reasons behind her socially unacceptable behaviours. This involves good counselling skills. Through self exploration, it was discovered that her over protective parents and early childhood physical punishment had actually accumulated anger in her. A good parenting especially during the first five years of life is important for the child's secure attachment.[7] In contrast, early use of extensive physical punishment in children are associated with aggressive and angry adolescents.[4] NH presented her anger by being rebellious, aggressive especially towards her handicapped mother and displaying the conduct problems. The recommended management of conduct disorder include family therapy, behaviour modification and pharmacotherapy.[3,6] There was no pharmacological treatment used in NH. The use of pharmacotherapy such as stimulants or antidepressants would be effective when there is specific co-morbid illness.[3] Ideally, the management would involve a multidisciplinary team such as family therapist, psychologist, social worker, counsellor and teachers. However in our Malaysian context to have all of them involved are not always possible. The following management describes what has been done for NH by a family physician.

Parenting skills

In NH case, the three basic emotional children needs which include love, care and commitment from her parents need to be instilled in this family.[7] NH's parents learned about the ill effects of over controlling as well as over permissive parenting styles. NH parents were taught about good parent-child interaction, immediate rewards for positive behaviour, clear consistent limit setting and non-aversive management as oppose to the use of physical punishment for non-compliance or problem behaviour.[2,3] The consequences for NH negative behaviours include withdrawal of her daily financial allowance, time for television viewing or doing the house chores for a week. As NH likes cooking, this was used as her family activity which had improved the family relationship. The fact that her parents started to praise her cooking and enjoyed the meals prepared by NH had actually motivated NH to be at home and to prepare the dinner meals for the family. Family activity even as short as 15 minutes would improve the emotional climate in the adolescent's family and ensure a regular reinforcing contact.[3]

Anger management

In NH, the anger management which focuses on physiological responses, cognitive processes and behavioural responses was used.[4] NH was taught about the recognition of the early signs of physiological responses such as flushed feeling and quickened heart rate based on her daily anger diary. The diary also helped her in determining the triggering factors of her anger outburst. The relaxation technique which includes the imagery together with deep breathing exercise was helpful in controlling NH physiological responses. These arousal management skills are helpful in reducing the adolescents' emotional tension, improving their cognition and hence rationalizing their behaviour.[4] NH was also assigned with homework which focused on positive self talk. In the assignments, NH had to understand the circumstances that led people to be aggressive, feelings related to anger, feelings of victims of aggression, other people's views on aggression, self talk to control anger and learn alternatives to aggression.[8] NH managed to receive a total of 10 sessions over 3 months period. Study had shown that even a minimum of 4 sessions are still beneficial.[9]

Behavioural change

Another important part of the management in NH was helping NH to change her socially unacceptable behaviour and hence resume her function as student and child. Behavioural change is rarely a discrete event and often takes place gradually.[10] In NH, this was done over the three months, concurrently with counselling sessions. As she was supposed to sit for her secondary school exit examination in the same year, getting her to attend school class was the main focus. In order to ensure she had enough rest in the morning, the parents and NH had agreed to allow her outing time to 12 midnight at the most. Initially it was difficult but phone calls from the mother and the pro-activeness

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from the father to look for NH in her favourite places for loitering had helped NH. This parental monitoring of children's activities and enforcement of curfews are important in the management.[3] With NH's permission, the school counsellor as well as the school principal was contacted and NH problems were discussed. This also had helped NH to feel welcome and less disparage in school. With time, steadily once NH's anger had been controlled together with the improvement in her family interaction, her conduct problems had slowly reduced. As she was not nicotine and alcohol dependent, these were easily discontinued in her.

Progress

On the last visit of the tenth counselling session, NH had shown a remarkable improvement. She only met her friends over the weekend and her night outing time had reduced to 10 o'clock at night. She attended her school class regularly and had started preparing herself for the important secondary school exit examination. Both parents were happy with her progress and they were reminded on the needs for them to be consistent in their parenting.

CONCLUSION AND RECOMMENDATIONS

The success of this conduct problems management depends on the adolescents' motivation in the clinic attendance, practising the skills that they have learned in their daily practice as well as the set up of the service in the clinic. In this case, there were times when the adolescent lost focus and motivation. However, good commitment from both parents had actually resulted in a promising outcome. This adolescent definitely requires the continuity of care and reinforcement of anger management to prevent relapse. In short as primary care physician, our role is to be able to detect conduct problems in the community, assess its severity, to treat the uncomplicated cases and refer difficult cases for specialized treatment. The decision to treat these children with conduct problems especially the mild one is very much related to our clinical exposure and experience. In doubtful cases, the referral to clinical psychologist and child psychiatrist is very much desired and cannot be denied. It is unfortunate if these adolescents are left unassisted as evidence had shown that many of them will have poor socioeconomic status in adulthood life later.

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Research Digest

Chinese adolescent girls are more dissatisfied than Chinese adolescent boys about their body image

Mellor D, McCabe M, Ricciardelli L, *et al.* Sociocultural influences on body dissatisfaction and body change behaviors among Malaysian adolescents. *Body Image*. 2009;6(2):121-8.

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529 Malaysian high school students (103 Malays, 344 Chinese and 82 Indians) completed Body Dissatisfaction Scale in classroom settings. Chinese adolescent girls are more dissatisfied than Chinese adolescent boys about their body, but no gender difference was found for Malay and Indian participants. The unexpected findings among the Malays and Indians were attributed to the relativelh high level of dissatisfaction reported by boys in all ethnic groups (which dilute the gender difference).