CASE REPORT

A social casework report of adolescent adjustment disorder with borderline intelligence

Upasana Baruah, Ameer Hamza[1]

PhD Scholar, [1]Associate Professor, Department of Psychiatric Social Work,
National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, Karnataka, India

Abstract

Adjustment disorder (AD) is common in adolescents but very few treatment studies exist. This study reports the use of behavioural model of 'social casework' for an adolescent girl with AD. It describes how an adolescent girl with borderline intelligence might react to different types of demand that is imposed on her and highlights how the demands might be the possible sources of maladjustment. It demonstrates how helping people in transition require an identification of the source, or combination of sources, that have led to the adjustment problem first, followed by the implementation of an adequate helping approach. Social casework based on behaviour modification approach which included family psychoeducation, anger management techniques, social skills, and supportive work with the family members, consisted of a thirteen sessions intervention with telephonic follow-up. This resulted in parent and self-reported improvements in the client's social interaction and adjustment. Family's understanding about the illness and acceptance of the client also improved.

Baruah U, Hamza A. A social casework report of adolescent adjustment disorder with borderline intelligence. Dysphrenia. 2013;4:148-57.

Keywords: Psychotherapy. Family. Temperament.

Correspondence: upasana.baruah@gmail.com

Received on 1 March 2013. Accepted on 24 March 2013.

Theoretical and research basis for treatment

Adjustment disorder (AD) is a stress-related, short-term, non-psychotic disturbance. Persons with AD are often viewed as disproportionately overwhelmed or overly intense in their responses to given stimuli. These responses manifest as emotional or behavioural reactions to an identifiable stressful event or change in the person's life; for instance, in the paediatric population, these events could be parental separation or divorce, a new birth in the family, or loss of an attachment figure or object, e.g., pets. The disorder is time-limited, usually beginning within three months of the stressful event, and symptoms lessen within six months upon removal of the stressor or when new adaptation occurs.[1]

The diagnosis of AD in children and adolescents is shaped by a combination of factors similar to those found in adults. Tomb[2] identified four areas that may contribute to the development of AD. These included the nature of the stressor, the vulnerabilities of the child, intrinsic factors and extrinsic factors. Intrinsic factors included age; sex; intellectual, emotional and ego development; coping skills; temperament; and past experiences. Extrinsic factors included the child's parents and support systems, expectations, understanding, skills, maturity and available support of the child's larger environment [2].

The most important factor in the development of AD in a child is the vulnerability of the child. Vulnerability depends on the characteristics of both the child and the child's environment. Adults often develop AD due to marital or financial problems. In adolescents, common stressors include: family conflict, school problems, sexuality issues. Other stressors for people of any age include: death of a loved one, general life changes, unexpected catastrophes.[3]

There is no way to predict which people among those affected by the same stress are likely to develop AD. Financial conditions, social support, and career and recreational opportunities can influence how well a person reacts to stress. A person's susceptibility to stress may be influenced by factors such as: coping strategies, intelligence, flexibility, genetic factors and social skills.[3] Form and presentation of the stressor also contribute to the individual's reaction. Depending on the coping skills and resources available for a person, a stressor might be perceived differently by different individuals. In a retrospective study of 72 adolescents with AD, al-Ansari and Matar[4] found that disappointment in relationships with a family member or friend of the opposite sex was the primary stressor.

The ADs constitute a diagnostic category that lies between health and pathology. Prompt treatment of persons with AD is critical to prevent worsening of

symptoms and social, relational, academic and occupational impairment. However, there has been little systematic research regarding the best way to manage individuals with an AD. Because natural recovery is the norm, it has been argued that there is no need to intervene unless levels of risk or distress are high.[5] However, for some individuals treatment may be beneficial. In some cases, if the illness goes untreated, the potential sequelae might lead to some serious consequences.

Because AD originates from a psychological reaction to a stressor, the stressor must be identified and communicated by the client. The non adaptive response to the stressor may be diminished if the stress can be "eliminated, reduced or accommodated".[6] Clients and their families should comprehend that AD occurs when a psychological stressor challenges an individual's capacity for coping. The stressor can be anything that is important to the client. Everyone reacts differently to a situation depending on the importance and intensity of the event, the personality and temperament of the person, and the person's age and well-being. Thus, only one event may cause AD, or, a string of events may wear down individual resources. The client should be encouraged to acknowledge the personal significance of the stressful event.

Clients and families should be reassured that stressful events often have emotional and physical effects. The acute state experienced by a newly diagnosed client is a natural reaction to events. Stress-related symptoms usually last only days or weeks. AD is time-limited, and clients can generally expect a return to prior levels of functioning. It is important to encourage the client to identify relatives, friends and community resources that can provide support during the acute period. The treatment of ADs entails psychotherapeutic counselling aimed at reducing the stressor, improving coping ability with stressors that cannot be reduced or removed, and formatting an emotional state and support systems to enhance adaptation and coping.

Strain [6] suggests that the goals of psychotherapy should include the following: analyse the stressors that are affecting the client, and determine whether they can be eliminated or minimised; clarify and interpret the meaning of the stressor for the client; reframe the meaning of the stressor; illuminate the concerns and conflicts the client experiences; identify means to reduce the stressor; maximise the client's coping skills; assist clients to gain perspective on the stressor, establish relationships, attend support groups, and manage themselves and the stressor.

Psychotherapy, crisis intervention, family and group therapies, cognitive behavioural therapy, and interpersonal psychotherapy are effective for eliciting the expressions of affects, anxiety, helplessness and hopelessness in relation to the identified stressor(s). Sifneos[7] stated that brief psychotherapy can be most beneficial to persons with AD. One study found that AD sufferers received similar interventions to those with other psychiatric diagnoses, including psychological therapy and medication.[8] Another study found that AD responded better than major depression to antidepressants.[9] Treatments that are effective with other stress-related disorders may be constructive interventions for AD. According to Strain and colleagues,[8] treatment relies on the specificity of the diagnosis, the construct of stressor-related disorders, and whether the stressors are involved as "aetiological precipitants, concomitants or essentially unrelated factors".

Behavioural casework practice can be an effective way to intervene in such cases as it encompasses the range of activities designed to help in such cases. Behaviour theory can fortify social casework by providing practical links between the identification of the client in distress, the delineation of clinical goals, the formulation of plans of intervention, and the measurement of outcome. These basic assumptions in the behavioural approach are implicit in the structure treatment: (1) all social behaviour is learned and can be modified, (2) all psychotherapies involve a teaching and learning experience, and (3) a more deliberate application of learning principles to psychotherapy would yield more effective results.[10] A family-based behavioural casework strengthens family functioning and also addresses challenges that may threaten family stability. These activities include family-centred assessment and case planning; case management; specific interventions with the client and families including counselling, education and skill building; and connecting families with the supportive services and resources they need to improve their parenting abilities and achieve a nurturing and stable family environment.

Case introduction

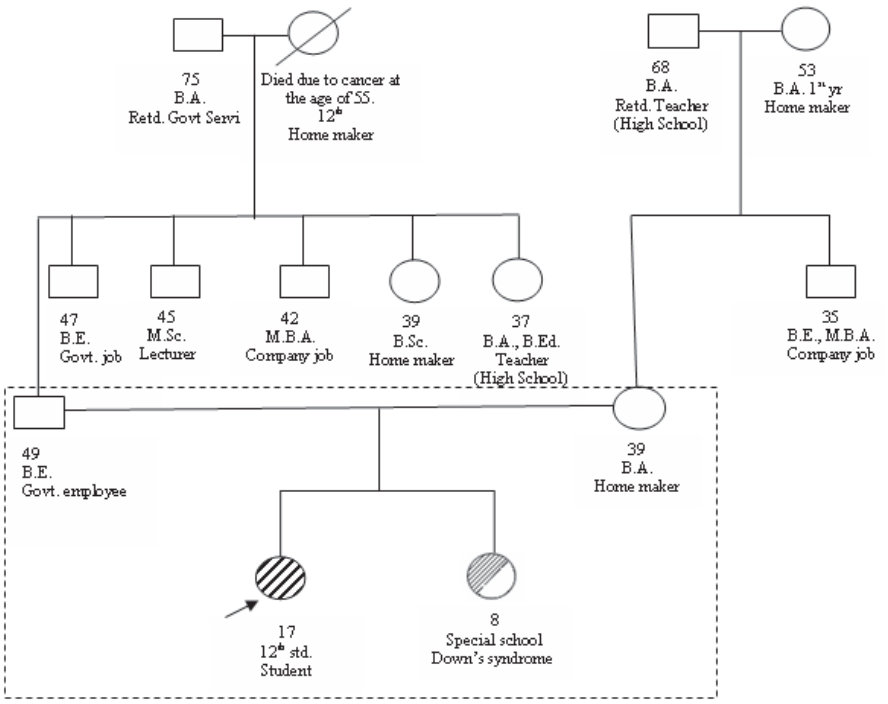
Ms S was a 17-year-old unmarried girl, who was studying in 12th standard hailed from a middle socioeconomic status family of urban background settled in the Eastern part of India. She was temperamentally a slow to warm up child[11] with personal history of borderline intelligence with poor academic performance in school. She had irregular menstrual cycles associated with dysmenorrhoea and poor understanding of concepts. She had family history of Down's syndrome with attention-deficit/hyperactivity disorder (ADHD) in younger sister.

Presenting complaints

She was presented with two years history of collecting discarded materials, decreased social interactions, watching same television (TV) serials repeatedly, and saying that people are talking about her appearance with insidious onset and continuous course.

She also had frequent anger outbursts especially towards her father. A diagnosis of adolescent AD with borderline intelligence was made.

Fig. 1: Genogram of the Family of Origin



Sources of information and reason for referral

The information about the case was collected from the client and her parents. The information was found to be reliable and adequate. The case was referred to the social worker for psychosocial assessment, psychoeducation to family members, and specific intervention for the client and family.

Brief clinical history

The client was apparently doing well till 2006 when she was in tenth standard, after which mother noticed changes in her behaviour, like becoming withdrawn from others and having decreased interactions with friends. They reported an incident when her friend had told her that her eyes looked like 'Chinese eyes'. Subsequent to that whenever she went out she started getting doubts that others are noticing her and were talking about her appearance. Mother also reported that she used to mutter something in the bathroom like talking to someone, but the client explained that she would rehearse what things to tell her family and friends since she might forget them. She was also unable to carry out more than one task at a time and had to be reminded again and again. She had a habit of repeatedly watching a particular TV serial and collecting newspaper cuttings which had information about TV serial timings. She would become very much agitated whenever she was prevented from watching the serial. She also had an attraction towards the actor in the serial and reported that she wanted to marry him and had fights with parents on this matter. She would also get materials like combs, cosmetic items etc., from neighbours' houses without their knowledge, as she felt that it might be useful for her and according to her it was not wrong to do so. She also had the habit of collecting discarded materials like *bindi*s, glossy paper, egg shells, wrapper etc. and keeping it with her. The client had increased irritability, especially towards the father and had frequent anger outbursts. Her biological functions were adequate but socio-occupational functioning was impaired. Her family members were disturbed by these behaviours; however, she was not taken for any treatment for the same before coming to the National Institute of Mental Health and Neurosciences (NIMHANS).

Past history

The client had five to six episodes of generalised tonic clonic seizures (GTCS) at two years of age and three episodes of cluster seizures of GTCS at nine years of age. She had undergone treatment for that and had no episodes of seizures from then onwards.

Family history

The client was the eldest of two siblings born of a non-consanguineous union. The client hailed from a middle class nuclear family. There was family history of Down's syndrome with ADHD in younger sister, and history of hypertension in mother, and diabetes mellitus in maternal grandfather.

Family composition

Father: Client's father was 49 years old, educated up to Bachelor of Engineering (BE). He was an engineer in a public sector company and was described as a person who is very strict and autocratic. He had his own beliefs about things and did not pay much heed to what others had to

say. He believed that the client had some major mental illness and was very critical towards all her actions and behaviour.

Mother: Client's mother was 39 years old, educated up to degree. She was a homemaker and was as a person who was submissive in nature and afraid of her husband. She also had medical complications like high blood pressure and cardiac problem and was physically weak. She was very close to the client and the client confided in her. However, the mother was over burdened as she had to devote a lot of time to her second child too and so she had a lot of stress.

First sibling: Index client.

Second sibling: Client's younger sister was eight years old. She was diagnosed with Down's syndrome with ADHD and was also undergoing treatment in NIMHANS. She was however very fond of the client, and the client was also very protective and caring about her sister.

Family interaction patterns

The family interaction pattern was assessed by the social worker to develop an understanding of the communication style and pattern of the family, and also to understand the relationship existing between the client, her parents and sibling.

Interactions between parents: The interactions between client's father and mother were restricted and they did not share a very cordial relationship. Father took care of the financial aspects and mother was involved in household activities and taking care of the children. Father did not involve the mother in decision making and also did not allow her to mingle with other people. He blamed her for the second child's illness as he believed that it was because of the mother's ill health that the child was born with the disability.

Interactions between parents and children: The interactions between the parents and the children were also restricted to a great extent. Father would not spend much time at home because of his job and even when he was at home he was very critical about the client. Mother was close to the client but she had to devote most of her time for the second child as she required constant attention and supervision due to her illness.

Interactions between siblings: The interactions between the siblings were very cordial. The client liked spending time and taking care of her sister. The sister also responded to the client though she would create some problems like breaking things, not sitting in the same place, throwing tantrums, and even beating the client, which were part of her disorder. The client would spend a lot of time singing to her sister and it was one of their favourite pastimes.

Family dynamics

Boundaries: The family's external boundaries were closed and rigid as the father did not allow much interaction with friends and relatives. Even the internal boundaries were rigid and closed between the parental subsystem and also the parental-child subsystem. An alliance was observed between the client and the mother.

Subsystems: Three types of subsystems were found in the family. The parental subsystem which was not very well formed, the sibling subsystem which was well formed, and a parent-child subsystem between the mother and client.

Family developmental stage: Family with teenagers.

Leadership pattern: Father was the nominal and functional leader. Leadership pattern was autocratic but his leadership was accepted by all the family members as they were scared of him. Decision making pattern was authoritative in nature, where the father usually dominated the other members with firmness and self-assurance, and the others members were not included in the decision making process.

Role structure and functioning: The father played the instrumental role by being the leader, decision maker and manager of the household. The mother played the 'expressive role' by being the 'comfortee' or 'consoler' with whom the client shared all her problems. No multiplicity and complementarities of roles was evident. Both the client and mother reported that over expectation from the father in many aspects such as running of the household and taking care of the children in case of mother and high performance in school in case of the client, hindered their relationship with the father. There was no role strain present in the family.

Communication: There was direct communication existing between the father and the mother, but the noise level was high at times. There was minimal communication between the client and father, and client used switchboard communication to communicate with father, mother being the communicator so as to avoid confrontation with father. The noise level in the family had risen even more after the client's illness.

Reinforcement patterns: Some amount of positive reinforcement was present in the family like framing the client's drawings and paintings etc. However, verbal appreciation like praising or giving encouragement was minimal. Negative reinforcement in the form of criticising and scolding the client for her activities and behaviour was observed. No differential reinforcement pattern was used by the parents.

Cohesiveness: Cohesiveness was present in the family to some extent but the 'we' feeling was lacking. Emotions, social and personal activities were not shared

among the family members. Going for trips were present but they were not regular. The family members did not share meals together or involve in other activities as a family. Over involvement in the client's matters were evident after the start of her illness behaviour.

Family rituals: There were not any particular rituals found in the family.

Adaptive patterns: The family possessed inadequate problem solving ability. The father tried to blame the mother for most of the problems and assumed a non-participative role in solving the problem. The client also had difficulty in conflict resolution which might possibly have been due to her low intelligence quotient (IQ) level, and adopted unhealthy ways of dealing with stress like denial and escape. Father too had inadequate coping patterns, while the mother had coped well with the stress and burden she had been encountering.

Social support

Primary support: Family had adequate financial resources but primary emotional support was inadequate especially not extended to the client.

Secondary support: Secondary support in terms of help from relatives and friends was adequate but not utilised.

Tertiary support: Family had started receiving tertiary support from NIMHANS in the form of consultations and psychosocial interventions. They were encouraged to take help from other such organisations also.

Personal history

Birth and development: Client was born of full term caesarean delivery at the hospital. Mother had preeclampsia while she was pregnant. There were no post natal complications. Her developmental milestones were reported to be slightly delayed as compared to other children.

Behaviour during childhood: Client had few friends during childhood and her interactions with others were less. She was more interested in solitary activities like playing with dolls etc. and usually kept to herself. She was shy and withdrawn but would talk and respond to others when spoken to.

Physical illness during childhood: Client had developed GTCS when she was one and half years old and was treated. She had measles at four years of age which was managed conservatively that is through traditional methods. She also had cluster seizures and three episodes of GTCS at nine years of age.

Schooling: Client started schooling at the age of three years. She was poor in studies and parents had to appoint a special tutor for her at home. However, she would manage to pass the examinations with low scores. She had poor concept of mathematics and frequent spelling mistakes in Bengali and English which got corrected over a period of time. She had few friends but her interactions with them were adequate. She had secured 45% marks in her tenth standard examination. She was in the 12th standard when she came to NIMHANS for treatment.

Menstrual history: Client had attained menarche at the age of 14 years. Her menstrual cycles had been irregular (once every two to three months) since the beginning, and the cycles were associated with dysmenorrhoea. The client was undergoing treatment for the same.

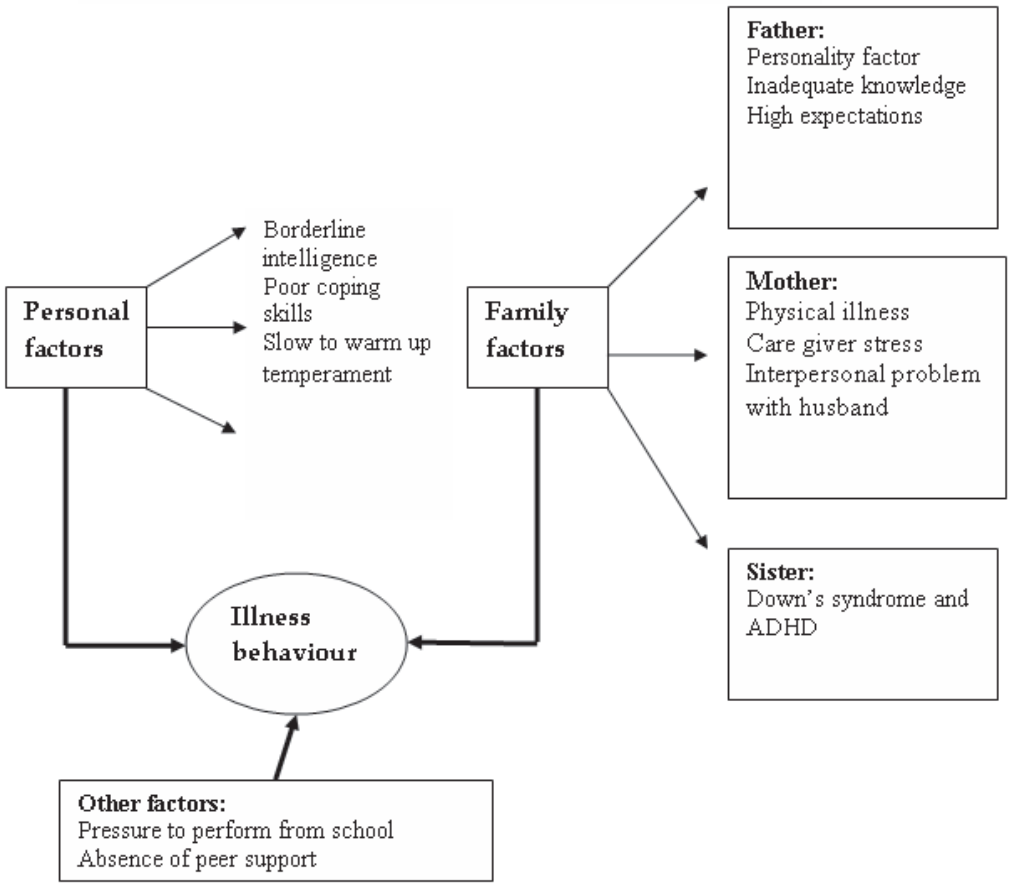
Personality temperamental: The activity level of the client during childhood was adequate but she preferred solitary activities. She had low distractibility and her attention span in terms of studies was suboptimal but was adequate for other activities. Client would take a lot of time to get adjusted to new situations and her energy level was generally low. She used to respond to new situations by withdrawal. The quality of her mood was predominantly normal. She had regular biological functions. Her hobbies were singing, drawing and watching TV. It can be inferred that she was a slow to warm up child.

Social analysis and diagnosis

Ms S was a 17-year-old unmarried girl studying in 12th standard hailing from a middle socioeconomic status family of urban background settled in the Eastern part of India. She was temperamentally a slow to warm up child with personal history of borderline intelligence with poor academic performance in school. She had irregular menstrual cycles associated with dysmenorrhoea and poor understanding of concepts. She had family history of Down's syndrome with ADHD in younger sister. She was presented with two years history of collecting discarded materials, decreased social interactions, watching same TV serials repeatedly and saying that people are talking about her appearance. She also had frequent anger outbursts especially towards her father. A diagnosis of adolescent AD with borderline intelligence was made.

Social analysis revealed that both external and internal boundaries in the family were closed and rigid, associated with autocratic decision making pattern. The father had high expectations from the client in terms of academic performance which she was not able to fulfill due to her borderline intelligence level. Client was doing well when academic pressures were less. As she got promoted to higher classes, the academic load increased. This coupled with the various adolescent issues and conflicts resulted in overwhelming the client. She became overly intense in her reactions which resulted in her anger

Fig. 2: Diagrammatic Representation of Social Analysis and Diagnosis



outbursts and stubborn behaviour at times. Some of the major adolescent issues that bothered the client were interacting with people from opposite sex, preoccupation with her appearance, and various infatuations.

Client's borderline intelligence and her temperament played a major role in her maladaptive coping pattern. Client did not receive emotional support from her father and mother. The main reason being father was not sensitive to her emotional needs nor attended to it. Though mother attended to her emotional needs, it was inadequate as she devoted most of her time in attending to her younger child. Client's father was inclined to catastrophise client's behavior, and tried to label her as suffering from some major mental disorder, and thus treated her in some afflicted manner.

Faulty interaction pattern of parents made the client not to seek help from them. The noise level was very high, which resulted in her withdrawn behaviour getting reinforced. Absence of a role model at this period of her life also made her more vulnerable. Negative reinforcement from the parents also acted as a maintaining factor for client's problem behaviour. Blaming attitudes and faulty decisions of father worsened the family climate which resulted in increased burden for the mother. The client did not have much creative outlet and not knowing how to engage in constructive activities, started hoarding behaviour, and also engaging in watching TV soap operas/serials in which she could actualise her imagination. Her behaviour was not understood by her parents, and they interpreted it as abnormal and sought psychiatric consultation.

The social analysis thus indicated that the case required a holistic outlook and called for a family based behaviour modification approach of social case work. The social worker needed to formulate a management to work with the client and family, to model empowerment and enable the family to meet the needs of its own member (i.e., building a natural social support network). There was also a need to increase skill levels and resources among client and family so that they would function better after the intervention.

Interventions

Goal of interventions

Individual level: Analyse the stressors that are affecting the client and determine whether they can be eliminated or

minimised; teach anger management techniques; modify client's maladaptive coping patterns and teach coping strategies, assist client to gain perspective on the stressor, establish relationships, attend support groups, and manage herself and the stressor.

Family level: Improve their knowledge regarding client's illness through psychoeducation, bring down their expectations of the client; to focus on developing healthy communication between parents; define the role structure and functioning; to teach healthy coping skills.

Course of treatment and assessment of progress

The intervention was done in individual level and family level. The interventions done at the individual level were: supportive work with the client, teaching anger management techniques, social skills training. The interventions done at the family level were: psychoeducation, supportive work with client's mother, dealing with expressed emotions and high expectations, information regarding alternative career options, improving interactions between parents and the client and their social support.

Individual level

The individual sessions with the client initially concentrated on establishing rapport and reassuring the client about help and finally moving towards more directive intervention. A total of six individual sessions were held.

Supportive work with the client: Client was encouraged to talk about the various issues bothering her. Her concerns were validated through active and empathetic listening. She was encouraged to discuss issues which she avoided and also about her interpersonal relationships. Client was also provided reassurance about her personal and social interactions and academic difficulties. She was encouraged to engage in activities which interested her. She was encouraged to engage in creative work like drawing, painting which she did, along with singing and even think about it as career options. She was encouraged to verbalise her anger.

Teaching anger management techniques: Client was helped to understand and analyse the stressors that were affecting her and clarify and interpret the meaning of the stressor. Client was also taught various anger management techniques by which she would be able to control or minimise her anger outbursts. She was taught to apply the following techniques and was monitored from time to time during the course of intervention:

• As soon as she was in control, to withdraw herself from the situation to avoid irreparable or irreversible damage to self, others, relationships and the environment.

• When she recognised that she was angry, just to stop doing what she had been doing. To walk around or sit calmly for a few minutes.

• To release the stress (stored due to anger) in a way in which there was least possible harm to self, others and the environment.

• To breathe deeply, inhale deeply and hold for a second or two. Then exhale deeply and repeat the same for few times. To become aware that she was angry. If possible to get involved in some creative work that could pacify her.

• If possible, to divert her attention to something else that could relax her; like humorous films, calming music, watering flowers and plants, going out to some park etc.

• To postpone the expression of anger again and again.

• Get into the company of persons she liked or who liked her and understand her and speak out to them, if possible.

Behaviour therapy approach was used to treat client's emotional and behavioural disorders as maladaptive learned responses that can be replaced by healthier one with appropriate training. Behaviour therapy focused on observable behaviour like client's hoarding behaviour and preoccupation with TV serials, and concentrates on its modification in the present. A behavioural assessment was done by asking the client to make a list of all the situations when she behaved in a manner not acceptable to her family members. She was then helped to list down her reactions to those situations and the final outcome of it. Each of the situations was tackled individually, and the client was helped to modify her behaviour accordingly through assignments and homework tasks. Successful completion of the task was reinforced though encouragement and praise.

Social skills training: Client was explained about the concept of social skills, those being communication, problem solving, decision making, coping with stress, self-management, and peer relation abilities that allowed one to initiate and maintain positive social relationships with others. Client was taught how to establish and maintain friendships, understanding the feelings of others, dealing with bullies etc. It was helpful to break down the skills into smaller pieces and demonstrate each part individually. In addition, she was given an explanation for why a particular skill is necessary. She was advised to be vocal about her feelings and come forward to seek emotional support from family members. She was also encouraged to be assertive at times when it was necessary.

Family level

The sessions with the family were mainly focused on psychoeducation and improving family interaction patterns. A total of seven family intervention sessions were required for the same.

Psychoeducation: The client's family was given information about the client's disorder. They were explained about both the diagnosis with emphasis on adolescent AD. Parents were also given information about intelligence level with respect to client's IQ level. The queries regarding borderline intelligence were clarified. Parents were also oriented to the various conflicts and issues that are part of the adolescent stage, and were encouraged to identify such issues with respect to the client.

Client's father was also given information about the major mental disorders in order to help him distinguish client's behaviour from psychotic disorders. The need for family support and psychosocial intervention was focused upon. Father was also psychoeducated about his younger daughter's problem (Down's syndrome with ADHD) and the need for medication was impressed upon him.

Supportive work with client's mother: Client's mother had a lot of caregiver burden as she had to take care of both the daughters who needed special care. She herself was physically unwell which added on to the stress. She was encouraged to talk about her problems and ventilate her frustration. She was provided support by active listening and empathetic reaction. She was motivated to do some relaxing activity whenever she found time and engage in recreational activities along with her daughters. She was also taught some effective copings skills like when stressed, to practice taking long, deep breaths; taking regular breaks from her work; getting regular exercise and eating a balanced diet; learning time management and organisation skills; seeking to find the positive in every situation; viewing adversity as an opportunity for learning and growth; learning to really listen to what others were saying rather than getting upset because she disagreed, and to seek to find areas of common ground and work for a compromise.

Dealing with expressed emotions and high expectations: Family interventions, i.e., family psychoeducation and components of behavioural family therapy approach were effective for reducing family's expressed emotions, especially criticality towards the client. Focus on improving interactions between the parents was also made, along with changing decision making pattern in the family. Parents were helped to identify their expectations from the client and how those expectations affect their interactions with her. Parents were guided in exploring their appropriate expectations taking into consideration client's intelligence level and poor coping skills. In subsequent sessions, problem solving techniques were exercised, and parents were helped to improve their own adaptive and coping skills.

Information regarding alternative career options: Client's parents were encouraged to defocus from client's academic decline and concentrate on her creative skills. They were provided information about alternative career options for the client like singing, painting etc. Various resource institutions' addresses were also provided. Positive reinforcement patterns were explained to the parents in order to encourage client's creative abilities. Mother was taught how to channelise client's energy in constructive activities.

Improving interactions between parents and the client and their social support: Parents were guided to realise that primary social support is very important for the client at this stage. Parents needed to encourage the client to identify relatives, friends and community resources that could provide support to her. Tertiary social support for the family was also strengthened by providing information about various resource organisations near client's hometown.

Specific modules/approaches and tools-techniques followed

The social worker had employed the framework of behaviour modification model of social casework in dealing with the case. At the outset of intervention, a contract is formed and goals selected. The social worker developed a treatment plan, explained its rationale, and managed the highly structured therapeutic interchange. Behaviour assessment of stimuli and responses was made of directly relevant and observable behaviour of the client. The social worker used learning principles and behavioural management techniques to alter the environment and/or client's and family member's responses to stimuli. Family was understood as intertwined part of 'person-situation configuration'. In this case, problems were viewed as arising out of role conflicts and poor knowledge of the parents about their daughter's condition.

Techniques of behaviour therapy such as anger management techniques, social skills training were used by the worker with the client while psychoeducation and communication enhancement techniques were used with the family members.

Outcome of interventions

Individual level: Client started verbalising more and her withdrawn attitude diminished. Client's preoccupation with TV serials decreased and there was reduction in her anger outbursts. She was able to manage her anger in a better way. Client could identify the stressors and was better equipped to deal with her adolescent crisis.

Family level: Family's understanding about client's problem improved. Father became amenable towards accepting a psychosocial viewpoint regarding client's illness. Family's concern regarding client's future was addressed. Interaction between father and mother

improved to some extent. Mother-daughter relationship was enhanced and a therapeutic alliance established.

Complicating factors

There were some challenges throughout the course of the intervention. The primary challenge in this case was the client's father's insistence on medical management of the case. It was quite difficult to engage him in the non-pharmacological intervention as he wanted some 'medicines' to be prescribed. However, this aspect became manageable after few sessions of family psychoeducation. The other challenge for the social worker was the fact that the client had borderline intelligence, and hence a lot of the interventions had to be simplified or modelled by the social worker, and the sessions had to be continued for longer duration of time than usual.

Follow-up

As the client's family was from a state very far from the institute, regular follow-ups were not possible. However, the therapeutic relationship was continued through telephonic conversations and e-mails. The client's family had been coming for follow up to NIMHANS every six months. The client was maintaining well, though the irritability towards father was still present. They were planning for the client to take up a course in music from a music college after completion of her 12th standard examination.

Treatment implications of the case

The case provided a very vivid picture of psychosocial management of any AD, especially in the case of adolescents. The treating team had prescribed no medications and the case was given to the social worker for exclusive psychosocial management. This case also demonstrated the effectiveness of social case work using a behaviour modification approach in dealing with adolescent AD. The client and her family reported satisfaction with the outcome of the sessions during the follow-up and reported that the most of the elements of the intervention were helpful.

In summary, the case also shed light on the fact that AD can be manifested in different ways, like in case of the client, it was in terms of withdrawn behaviour, hoarding behaviour, anger outbursts etc. So there is a need for careful screening of the adolescent population if they come for psychiatric evaluation. Behavioural intervention appeared to be a potentially helpful treatment option for clinicians and students who work with adolescents presenting with significant adjustment problems. The techniques used in the intervention, mainly anger management, social skills training, psychoeducation, communication enhancement techniques might be able to help student trainees, teachers, and parents to create a more optimal environment for adolescents with AD.

Recommendations to clinicians and students

AD is a common disorder among adolescents but it is most of the time under reported. Psychiatric assessment and treatment for AD should be individually targeted by taking into account gender-specific stressors and distress symptoms among young people with AD.[12] Therapy is the most common and effective intervention for a child or adolescent with an AD. Individual counselling can be helpful to assist the child in identifying and understanding their reaction to a stressor. Therapy can restore self-esteem, build emotional coping strategies, and help return the child or teenager to their previous level of functioning.

However, as has been observed by the social worker, the therapy of an adolescent with an AD should usually involve the family. The intervention was also found to be easily modifiable by the social worker, as the main changes involved introducing treatment as an family based process, rather than a individualised process; shortening the duration of the sessions and, in our case, including the family in the sessions as it had been suggested that including both parents and children in treatment is more effective than working with either in isolation.[13]

Adolescents in conflict usually actively ask for help, although their pleas may be misunderstood because of their aggressive behaviour. As was in the case of the client, her anger outbursts and odd behaviour were misunderstood, and she was thought to be suffering from some major mental disorder by the father. But, in reality the client was trying to seek help by drawing attention to herself through these behaviours. Social workers and other clinicians can keep this information in mind while evaluating and working with adolescent clients.

Preventive measures to reduce the incidence of AD in children are not known at this time. However, early detection and intervention can reduce the severity of symptoms, enhance the child's normal growth and development, and improve the quality of life experienced by children or adolescents with AD.

References

1. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Text rev. Washington, DC: American Psychiatric Association; 2000:345-92.

2. Tomb DA. Child psychiatry emergencies. In: Lewis M, editor. Child and adolescent psychiatry: a comprehensive textbook. 2nd. Baltimore: Williams & Wilkins; 1996:929-34.

3. Powell AD. Grief, bereavement, and adjustment disorders. In: Stern TA, Rosenbaum JF, Fava M, Biederman J, Rauch SL, editors. Massachusetts General Hospital comprehensive clinical psychiatry. Philadelphia, Pa: Mosby Elsevier; 2008.

4. al-Ansari A, Matar AM. Recent stressful life events among Bahraini adolescents with adjustment disorder. Adolescence. 1993;28:339-46.

5. Casey P. Adult adjustment disorder: a review of its current diagnostic status. J Psychiatr Pract. 2001;7:32-40.

6. Strain JJ. Adjustment disorders. In: Gabbard GO, editor. Treatments of psychiatric disorders. 2nd ed. Washington, DC: APA Press; 1995. p. 1656-65.

7. Sifneos PE. Brief dynamic and crisis therapy. In: Kaplan HI, Sadock BJ, editors. Comprehensive textbook of psychiatry. 5th ed. Baltimore, Md: Williams & Wilkins; 1989. p. 1562-7.

8. Strain JJ, Smith GC, Hammer JS, McKenzie DP, Blumenfield M, Muskin P, *et al*. Adjustment disorder: a multisite study of its utilization and interventions in the consultation-liaison psychiatry setting. Gen Hosp Psychiatry. 1998;20:139-49.

9. Hameed U, Schwartz TL, Malhotra K, West RL, Bertone F. Antidepressant treatment in the primary care office: outcomes for adjustment disorder versus major depression. Ann Clin Psychiatry. 2005;17:77-81.

10. Stuart RB. Applications of behavior theory to social casework. Greensboro, NC: ERIC Clearinghouse on Counseling and Student Services; 1968.

11. Dogra R, Kumar K, Gupta A. Mental health in children: an overview. Dysphrenia. 2013;4:113-22.

12. Pelkonen M, Marttunen M, Henriksson M, Lönnqvist J. Adolescent adjustment disorder: precipitant stressors and distress symptoms of 89 outpatients. Eur Psychiatry. 2007;22:288-95.

13. Stormshak EA, Connell AM, Véronneau MH, Myers MW, Dishion TJ, Kavanagh K, *et al*. An ecological approach to promoting early adolescent mental health and social adaptation: family-centered intervention in public middle schools. Child Dev. 2011;82:209-25.