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84 – Helping Family Physicians in Managing Families With a Difficult Child

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Prevention is one important task of family physicians. In the context of child and family difficulties, he is the closest professional in detecting primary signs of dysfunction. However, he needs to acquire abilities to recognize and manage parents' difficulties with their children. It may not be a frequent consultation complaint but when it does occur, the physician often does not have much idea on how to deal with the situation.

Opposition, temper, violence, school difficulties; what distinguishes a difficult child? How can one identify a family or a child at risk?

Aggressive or oppositional behaviour are not necessarily pathological. They might have different significance depending on the context, the environment or the age of the children. Symptoms displayed by the difficult child are variable: lies, stealing, aggressive or disrespectful behaviour which are not pathological if occasional. All children lie and it is between 6 and 8 years old that they can differentiate between real and false. After 8 years old, lies become intentional. Stealing is the most frequent conduct disorder but consistent with lying, it is not intentional prior to 8 years of age. Aggressiveness or temper may be the expression of unhappiness since infancy. Around 2 or 3 years old, a child may become opponent to affirm himself (Marcelli, 2009).

Dealing with a difficult child

First, we have to pay attention to the normal development and particularly to the period of the opposition phase (between 18 months and 2 years and a half). It is a period of self-affirmation but it is also a phase where the parents need to establish clear rules and boundaries. They must set limits for the child within a climate of love and respect. If this period has been difficult, the child may become an "enfant-roi" "child king" (French concept in sociology, Houssonloge, 2008).

Secondly, we need to evaluate the acute or chronic aspect of the difficulties. Usually, acute conduct disorders might be related to life events such as divorce or separation, disease of a parent or a grandparent, death or placement outside the family, boarding school,...

Chronic aspects of behavioural difficulties might be linked to the child's history. He might be unwanted, unloved or involved in couple problems. His parents could be mentally ill or violent. He could be neglected or abused.

He may be suffering from hyperkinesis (ADHD) or other psychopathological symptoms such as depression.

The management of the consultation

We need to pay attention to 4 aspects:

1. The child history: the conception (desire or not), the pregnancy (with eventual pre-term birth or hypoxaemia), childbirth and psycho-developmental aspects such as food, sleep, exercise, speech, school, toilet-trained…

2. The family history: history of the parents, history of the couple, brothers and sisters

3. Recent life events

4. Psychosocial aspects

We introduced workshops for family doctors, with the aim of increasing their understanding of “difficult children”. Group sessions of 30 to 35 Belgian family doctors were organized. As in any workshop, the participants had to find their own answers. They were noted on a flip-chart, synthesized and, if needed, enriched with backup literature by the expert.

During these workshops, they had to first focus on normal child development and particular difficulties at different ages. Next, they had to propose, through case reports and videotapes, practitioner-specific solutions to help the child and his family.

Child difficulties often arise in families with relationship problems. Throughout 2 video sessions, FDs were trained to recognize normal child development and to assess acute or chronic difficulties.

The first videotaped situation concerns Mehdi, a young Moroccan boy. He is 2 1/2 years old. We see him at home during a meal with his brothers and sisters. He is the youngest of 5 children. He pushes his plate away. He can speak but is difficult to understand. He stamps his feet, ask for an orange and has a fit of temper. His sister tries to show him a book: he doesn't want this book; he wants another, precisely the one he may not have.
His mother says that it was not the same with the others; she doesn't understand, she brought him up the same way...

The second situation concerns Jérôme, 11 years old. He attends the consultation with his father. His mother is at the hospital for an operation. He remains silent. The practitioner tries to talk to him: nothing. We learn that the father had a hectic adolescence which he acknowledges in front of his son but he wishes a different one for him. We feel his pride when he recounts his adventures. Since their marriage, the parents have moved many times throughout the country and have practised several professions. The father no longer sees a first son he has from a previous marriage. We don't understand why. When he was very young, Jerome went to live with his grandmother for long periods during which his parents came to visit once a week.
The father doesn't understand: "Jerome has everything to be happy: a bicycle, a TV set in his bedroom... In spite of all that, he has fits of temper and sometimes pees on the carpet." At school he gets bad grades and the parents were told to consult a physician. “Nothing works any more. I hit him, I encourage him, it is just the same" says the father.
The boy has no activities, no hobbies with his father: he goes alone to holiday camps.

Participants have then to work in small groups. They share their experiences.

The questions are: “What difficulties does the child present?” – “How do you explain this behaviour?” – “What conclusions can you draw from this?” - “What would you suggest to the mother or to the father?” - “What would you say to him or her?”

In conclusion, FD’s are in the front line and in the best position to detect such issues regarding the ‘difficult child’. Providing them with the tools and skills to assist them in dealing with such situations can improve primary and secondary prevention of child and adolescent psychopathology.

Take home messages

- The FD is the closest professional in detecting primary signs of dysfunction in child development.
- He knows many details of family history and he has the confidence of the parents.
- He needs to acquire abilities to recognize and manage parents' difficulties with their children.
- He has a major role in primary and secondary prevention of child psychopathology.

Original abstract

http://www.woncaeurope.org/content/14-helping-family-physicians-managing-families-difficult-child

References

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