Case Report

Caregiver induced Alcohol Dependence in a young child with ADHD – a case report

Sayantani Mukherjee

Department of Psychiatry, Chaitanya Institute for Mental Health, survey no. 31/A, Kondhwa, near Khadi Machine Chowk, Bhagat Puram, Pune.
Corresponding author: Sayantani Mukherjee
Email – drsayantani25@gmail.com

ABSTRACT

A four and a half year old young boy with ADHD (attention-deficit hyperactivity disorder) was brought by social worker as a case of child abuse, as he was being sedated by his infirm grandfather, using alcohol, to control hyperactivity. The child underwent deaddiction, treated for hyperactivity and enrolled into various activities. Grandfather was also extended therapeutic services. Caregiver was changed and case was monitored by social worker. Family was extensively given psycho education, especially regarding child abuse. Discussion of this unusual case is chiefly on ADHD, caregiver burnout, substance abuse and of course child abuse – its current state of under-recognition in India, detection and management.

Key words: ADHD; alcohol dependence; caregiver burnout; child abuse.

(Paper received – 17th August 2018, Peer review completed – 20th September 2018)
(Accepted – 24th October 2018)

INTRODUCTION

Substance abuse in ADHD (Attention-deficit hyperactivity disorder) is common [1], but an induced case of substance abuse in a case of very young hyperactive-impulsive child as a result of caregiver burnout is singular and leaves ample scope for discussion, particularly regarding the perhaps reluctant but unquestionably wilful chemical abuse of the child, its recognition and remedy.

CASE REPORT

Master B, a four and half year old boy was brought to out-patient department along with mother, maternal grandparents and a social worker as a case of child abuse. He had unremarkable birth and developmental history and lived with his divorced mother (parents divorced when he was 3 months old and since then not in contact with father) and maternal grandparents. The mother and grandmother were working (both spending 10-12 hours outside home) while the grandfather (GF) was retired and thus B's chief caregiver.
He presented with the chief complaints of being regularly administered alcohol (15 ml/ day) since 4 months. On enquiry, Master B had always been an overactive and disruptive child, running and climbing continuously, breaking objects, shouting/ talking non-stop, distractible and forgetful, not listening to instructions and having very poor response to disciplining. Mother, erstwhile the primary caregiver, resumed work 5 months back. Master B was not attending kindergarten as previous attempts to enrol him had failed due to his overactive/ disruptive nature. GF had agreed to look after him as they could not afford hired help. GF was a rheumatoid arthritis (RA) patient, regularly consuming 180 ml whisky at home in the evening

daily since 25 years. He did not have history of behavioural or medical issues due to alcohol consumption. Unable to cope with his hyperactive grandson, GF started giving him 5 ml alcohol (whisky) mixed with fruit juice since 4 months in attempt to calm him down. Over a month, GF increased the amount to 15 ml (5 ml mixed with fruit juice thrice daily). According to him, B was less hyperactive after alcohol administration. Though GF knew alcohol would be harmful for a young child, he surmised that 'such a small amount wouldn't hurt'. B was aware that GF gives him alcohol (though, except that it was a 'grown-up drink', did not know what exactly alcohol is or does), called it 'sharbat' (meaning sweet drink in local language) and started enjoying the drink, often pestering GF for more and growing restless if a drink got delayed. B said the 'sharbat' made him feel happy. GF had made him promise not to tell his mother or grandmother. However, B told his neighbours, who alerted the social worker and mother; after verifying details from GF, they brought the child in for treatment and deaddiction. No psychiatric intervention had been done prior to this visit.

B, at presentation, was alert, fidgety, friendly but slightly irritable, had slept poorly and missing his 'sharbat' as his last drink had been 1 day back; no other signs of physical withdrawal were noted. He was clinically hyperactive but had adequate attention and interacted well. He was given an ICD-10 diagnosis of 'Alcohol dependence with uncomplicated withdrawal' (F10.230) along with 'Attention-deficit hyperactivity disorder, combined type' (F90.2) (ADHD Rating Scale-IV total raw score 40, total percentile 99%)[2]. He clinically seemed of average intelligence and a Paediatrics reference showed him to be otherwise healthy. He was started on 0.25 mg lorazepam along with 0.5 mg risperidone and supplemental vitamins. B was explained that his old 'sharbat' was harmful for his growth and he was being given a new healthy 'sharbat' (flavoured risperidone syrup). Lorazepam was tapered off while risperidone was increased and maintained at 1 mg/day. B initially did ask for his old 'sharbat' but stopped soon. The mother and grandmother took turns in caregiver duties.

GF, already having been berated by his family and made to live separately to keep away from grandson, was initially defensive citing that the boy has not come to any permanent harm, but later expressed guilt over his actions and explained it had been a desperate resort as he felt hopelessly inadequate in taking care of the child. He seemed to have genuine affection for his grandson. He had been shocked when the social worker explained that he could be legally prosecuted for child abuse. On further assessment, he was found to have depressive features (secondary to RA and discontentment post-retirement) for which he opted for psychotherapy. He also attended AA meets regularly and reduced his alcohol consumption by half. Later, family therapy sessions were done to reconcile him with his family, after which he moved back home. The whole family attended extensive psychoeducation sessions, especially regarding child abuse. The social worker kept an independent follow-up and helped to enrol the child in a playschool-cum-daycare (where he spent 8 hours 6 days /week) and swimming classes.

At last follow-up, the child has completed six months of treatment, is taking his new 'sharbat' regularly, his ADHD symptoms are reduced (ADHD Rating Scale-IV: total raw score 18, total percentile 75), is attending playschool regularly and still receiving weekly visits from the social worker. The grandmother, recently retired and otherwise emotionally/ physically healthy, acts as the chief caretaker for the child at home. GF is now a secondary caregiver, continues to attend AA meets, has taken up a part-time job at his local library and maintains a good rapport with all family members.

DISCUSSION

This case merits reflection on multiple interwoven psychiatric issues - ADHD, alcohol dependence, and caregiver burnout and child abuse. Whether ADHD is an independent risk factor for child abuse has been debated before. A previous study [3] has confirmed that ADHD indeed may be an independent risk factor, especially in those with more hyperactive-impulsive features than inattentive. Lack of its recognition as a child psychiatry issue is common in India [4, 5], leading to frequent mismanagement by caregivers – harsh punishment, chemically sedating the child, neglect; these mishandlings, especially by those in parental/ authority roles have a lasting negative impact on the child [6].

Caregiver burnout adds to this, being higher reported among caregivers of ADHD children [7]. Selection of an able caregiver here is hence of crucial importance, especially as parents are separated [8]. Age, physical

and psychological health are deciding factors of caregiver's quality of life [9], more so in ADHD [10]. The grandfather, with his advanced age, RA, alcohol dependence and depressive features therefore made a very poor choice of primary caregiver for B. Being inconversant about treatability of alcohol dependence and depression [4]) furthers the psychiatric burden [11].

Finally, a case has to be made here for child abuse – though to cause the child harm may not have been the intention, he was the recipient of chemical abuse with alcohol which would be detrimental to his physical and psychological development and build up potential for him to become a regular substance abuser, particularly owing to both his young age of onset of consumption of alcohol and having ADHD [12]. Unfortunately, a specific literature search for such abusive chemical sedation by caregivers in case of hyperactivity/ behavioural disruption did not yield credible results; so the epidemiologic standing of this case is indefinite at present.

In India, however, conventional concept of child abuse is extreme physical punishment, sexual assault or gross neglect. However, it can be 'redefined, within egalitarian value premises, as inflicted gaps in children's circumstances that prevent actualization of inherent potential' [13]. By this definition, it has limited recognition as here, often measures like corporal punishment are culturally accepted as acceptable forms of disciplining. Awareness regarding how less physically severe offences like this case also come under its umbrella, along with its psychiatric, social and legal ramifications, is sorely lacking, which usually leads to underreporting of such cases [14, 15].

This case is an example of a focal intervention which may spread awareness about child abuse but only locally. Though legislation is in place, broader, updated approach with emphasis on implementation is required with formal initiative coming from policy-makers, so that the message permeates both wide and deep into the populace, rather than only reach those who are placed in positions of better access [14, 15]. Adequate social and mental health support must be provided to families who are dealing with the pain of recognizing their role (whether active or complicit) in their child's maltreatment, and looking for resolutions. An effort has to be continued to be made by every stakeholder to recognize, report and treat all mental health issues - which can prevent cases of child abuse such as this one.

REFERENCES

1. Zulauf CA, Sprich SE, Safren SA, Wilens TE. The Complicated Relationship between Attention Deficit/ Hyperactivity Disorder and Substance Use Disorders. Curr Psychiatry Rep 2014; 16(3): 436-53.
2. Du Paul GJ, Power TJ, Anastopoulos AD, Reid R. ADHD Rating Scale-IV: Checklists, Norms, and Clinical Interpretation. 1st ed. New York: Guilford Press; 1998.
3. Briscoe-Smith AM, Hinshaw SP. Linkages between child abuse and attention-deficit/hyperactivity disorder in girls: Behavioral and social correlates. Child Abuse Negl 2006;30(11):1239-55.
4. Bhola P, Kapur M. Child and adolescent psychiatric epidemiology in India. Indian J Psychiatry 2003;45(4): 208-17.
5. Patel V. Mental health in low- and middle-income countries. Br Med Bull 2007;81-82(1):81–96.
6. Shah H, Rupani K, Mukherjee S, Kamat R. A comparative study of family impact in children with attention deficit hyperactivity disorder (ADHD) and learning disability. Indian J Mental Health 2016;3(1):70-8.
7. Bussing R, Zima BT, Gary FA, Mason DM, Leon CE, Sinha K, Garvan CW. Social networks, caregiver strain, and utilization of mental health services among elementary school students at high risk for ADHD. J Am Acad Child Adolesc Psychiatry 2003;42(7):842-50.
8. Stein M, Diller L, Resnikoff R. ADHD, divorce and parental disagreement about diagnosis and treatment. Pediatrics 2001;107(4):867-72.
9. Meyers JL, Gray LN. The relationships between family primary caregiver characteristics and satisfaction with hospice care, quality of life, and burden. Oncol Nurs Forum 2001;28(1):73-82.
10. Baldwin K, Brown RT, Milan MA. Predictors of stress in caregivers of attention deficit hyperactivity disordered children. Am J Fam Ther 1995;23(2):149-60.
11. Chatterjee S, Chowdhary N, Pednekar S, Cohen A, Andrew G, Araya R, Simon G, King M, Telles S, Verdeli H, Clougherty K, Kirkwood B, Patel V. Integrating evidence-based treatments for common mental disorders in routine primary care: feasibility and acceptability of the MANAS intervention in Goa, India. World Psychiatry 2008;7(1):39-46.
12. Groman SM, James AS, Jentsch JD. Poor response inhibition: At the nexus between substance abuse and attention deficit/ hyperactivity disorder. Neurosci Biobehav Rev 2009;33(5):690-8.
13. Gil, DG. Unraveling child abuse. Am J Orthopsychiatry 1975;45(3):346-56.
14. Kacker L, Varadan S, Kumar P. Study on Child Abuse: INDIA 2007. New Delhi: Kriti; 2007.

15. Arya Y, Chaturvedi A. Analysis of underreporting of cases of child sexual abuse in India. The World Journal of Juristic Policy 2017;1(1):1-12.

****

Acknowledgements – Nil
Conflict of Interest – Nil
Funding – Nil