BROADER HORIZONS

Therapies for children and adolescents

Part I: individual therapies

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This article will briefly outline the main therapies in use with children and adolescents today and the clinical indications for their use. 'Child' or 'children' will be used here to denote young people of all ages, unless otherwise specified.

There are several factors distinguishing the treatment of children with mental health difficulties from that of adults:

- Children's needs will vary depending on their stage of development so this must be taken into account when deciding on the optimum treatment for them (eg language skills and thought processes are very different in a young child compared with a teenager so that, rather than talking, play may be the better medium for a young child to communicate feelings and experiences).
- Children's difficulties may reflect problems in their adults carers (eg a depressed mother) and these may need treatment in their own right.
- Similarly, children's difficulties may reflect problems at school or with their peer group, and attention may need to be focused on these areas rather than on the child's symptoms.
- The parents or carers of a child living at home must be engaged in the treatment plans. This can vary from providing information for the parent to help their understanding of their child's difficulties, to the involvement of the whole family in therapy.
- If a child reveals abuse during the treatment, the therapist must make sure that the appropriate steps are taken to protect the child.

The decision to offer treatment for a child will be determined not only by the presence of symptoms (eg anxiety, behaviour problems, depression etc), but also by the impact that these symptoms are having on the child's life, and the likelihood of them persisting unless they are treated. Selecting the best treatment for an individual child's difficulties will be influenced by the child and family's circumstances and preferences and their willingness to engage in treatment, as well as by clinical judgement and evidence of effectiveness.

Individual therapies

Behaviour therapy has been shown to be very effective for treating wetting, soiling, eating and sleeping difficulties, phobias and obsessions, and for anti-social behaviour in younger children. It based on the theory that all behaviours are learned, and are affected by antecedent events and consequent responses. Behaviours will persist if they are rewarded, and tend to stop if there are no rewards or if there are negative consequences. Behaviour programmes first focus on identifying the ABC (Antecedents, Behaviour and Consequences) of an unwanted behaviour and then devising a plan with the child and family which is based on this information and which introduces positive rewards for desired behaviours and sanctions for unacceptable behaviours. For children, parental attention has been shown to be a very powerful reward. The negotiation of rewards and sanctions for an individual child requires skill!

Time Out is the withdrawing of a child from positive reinforcement (attention and distraction) for a short period until they calm down. It can be helpful when used sparingly for more major infringements, and to assist the child in learning to gain control of their behaviour.

Cognitive behaviour therapy (CBT) has been shown to be effective in the treatment of older children and adolescents with anxiety, depression, obsessive compulsive disorder (OCD), aggression, and post-traumatic stress disorder (PTSD). It combines behavioural principles with attention to the cognitions (thoughts) which are associated with the problem pattern of behaviour. The young person is then helped to challenge and change their cognitions and develop more effective problem-solving strategies. Anger management is an example and CBT is becoming widely used to help children with temper control. It helps the child identify the thoughts associated with their loss of temper, and learn strategies for coping with these, eg visualising a cooling volcano.

Dialectic behaviour therapy (DBT) is another form of talking therapy used for adolescents who repeatedly self-harm, and are showing other signs of borderline personality disorder.

Support and counselling are used mainly to relieve symptoms or to come to terms with an event. Both involve the provision of a supportive relationship and sympathetic listening, and may include the giving of advice. In young children non-verbal communication is important, and play materials (eg pencils and crayons, a dolls' house with family figures) are useful to help children communicate and express themselves. Bereavement services often provide this form of therapy.

Short-term psychotherapy, for example, interpersonal therapy (IPT), is used to treat depression in adolescents. The aim is not only to treat the symptoms, but also to explore the problem areas associated with the development of the depression (eg relationship problems such as role disputes at home, transitions such as divorce, or interpersonal deficits such as poor social skills) and to help the young person develop new problem-solving strategies for dealing with these. However, unlike psychoanalysis, it does not aim to explore deep-seated disturbances in the earliest experiences of the child.

Analytical psychotherapy (child psychoanalysis) aims to establish a powerful therapeutic relationship (transference) with the child, within which conflicts and feelings associated with the child's early life and relationships will be re-experienced by the child. To achieve this, the child will have sessions two or three times a week for a year or longer. The child is encouraged to talk, draw or play. This treatment is costly and only available for a small number of troubled children.

Scientific evaluation of its effectiveness is difficult but there are some studies which demonstrate its value for children with deep-seated disturbances relating to their early childhood experiences, such as child abuse and neglect.

Creative therapies (eg play and art therapy). These methods are especially suited to younger children or children with learning difficulties who find it hard to communicate verbally. The child is provided with suitable materials for play or art work, and encouraged to use these to express their feelings or experiences in a safe setting. The therapist does not make interpretations, but instead engages in the child's play or makes comments in such a way that the child feels understood and valued and their feelings contained.

Part II of this article will deal with group therapy and family therapy, medication (pharmacotherapy), diet, and parent training. ●

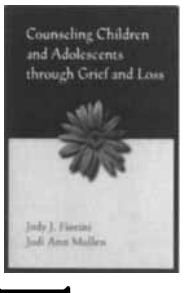
Further reading and resources

GOODMAN R, SCOTT S (2005). *Child Psychiatry* 2nd edn. Oxford, UK: Blackwell.
www.youngminds.org.uk
www.camh.org.uk

REVIEWS

Counselling Children and Adolescents Through Grief and Loss

Jody Forini, Jodi Ann Mullen



Champaign, Il, USA
Research Press, 2006
232pp
$26.95 pb
ISBN 0 87822 553 6

The authors, assistant professors at an American college, say they have written this book in response to the dearth of similar material. This is debatable, to say the least, but is consistent with the lack of reference in the text to notable authors such as Jewett and Grollman, let alone the research of Silverman or Christ.

The 'counsellors' for whom the book is written are able to decide whether and how to work with various family members and other professionals. This is very different to the experience of a supporter in an organisation like Cruse Bereavement Care in the UK, or a youth counselling agency where extensive permissions would have to be negotiated before inviting anyone other than the client to be part of the work.

The authors use multiple case studies to illustrate their approach, though these do not always adhere to the neutral statement of fact I would expect, and then unpick the clients' primary, secondary and intangible losses and their cognitive, behavioural and emotional responses. They list questions for discussion and finally give a guide to working with the case. The impression is rather prescriptive and there is no reflection on the work after its completion, so we are unable to gauge its efficacy for ourselves.

The writing expresses a clear love and feeling for the client group, and this is its redeeming feature, but I do not feel that this book enhances our understanding of how to help children in this situation. Readers looking for a practical, insightful and helpful way to understand working with children experiencing all kinds of losses should seek out Claudia Jewett's *Helping Children Cope with Separation and Loss**, a book I have found invaluable as a social worker, bereavement counsellor and therapist over the past 20 years. ●

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***Available from Cruse. Order from www.cruse.org.uk or tel 020 8939 9530**

Teenage Grief

Leeds Animation Workshop

Leeds, Yorks, UK: Leeds Animation Workshop
2007, 13 mins
£40.00 DVD/VHS
£10.00 hire
www.leedsanimation.org.uk

This 13-minute DVD uses six scenarios of various types of bereavement to illustrate the impact of death on teenagers from a wide range of backgrounds. It is accompanied by a helpful resource booklet. The scenarios present a simplified version of the real thing, understandably, but they do highlight the rollercoaster of emotions that may be experienced by this age group, and the challenges for the adults trying to offer support.

Nasreen has an argument with her dad and later that same day he dies unexpectedly. As a result, she blames herself and starts truanting from school. Laura's friend Jack is depressed. He kills himself while Laura is on holiday and she feels guilty about not being around to help. Nathan and Nicola's mum is murdered by an ex-boyfriend. Brother and sister react very differently. Their gran finds out about a bereavement group which they both eventually enjoy. Very slowly for both, life begins to move on. That is what I like most about this DVD: it gives hope, something of which bereaved young people do not get enough.

There is plenty here that adolescents, bereaved or not, could identify with and it would be an excellent resource to use in schools for PSHE or for adult training. The video *A Death in the Lives of...*# which is real life rather than animated, may be more appropriate for use with older teenagers, who could find the approach in this DVD rather condescending. ●

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#CHILDHOOD BEREAVEMENT NETWORK (2002). *A Death in the Lives of...* London: CBN.

Leeds Animation Workshop also produces and distributes the DVD/VHS *Not Too Young to Grieve* (reviewed *Bereavement Care* 2007: 26[2]: 42)