BROADER HORIZONS

Therapies for children and adolescents

Part II: family and group therapy, parent training, medication (pharmacotherapy) and diet therapies

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This is the second part of an article outlining the main therapies in use with children and adolescents today. Part I appeared in the last issue (Forrest 2008a).

Family therapy

For 50 years now it has been recognised that some children's difficulties are a reflection of problems within the family, rather than within the individual child. This has led to the development of various forms of family therapy, where the whole family is engaged in the treatment process and the focus in on understanding the family as a system in which some imbalance has produced symptoms in one of its members.

The therapist uses various techniques to achieve this, eg a genogram (family tree), with the aim of improving communication between family members and finding ways of correcting the imbalances in the family system. Barbara Gale's previous article in this series (2007) expands on this. Sessions are usually conducted by two therapists and other colleagues may observe, possibly through a one-way mirror, and provide feedback and suggestions for interventions.

Family therapy is used for a wide variety of presenting problems but has been shown to help grief reactions after the death of a parent, eating disorders (anorexia nervosa) and asthma. Recently multi-family therapy has been introduced where several families meet to share their experiences of the same problem. It is worth remembering that sometimes young children feel unable to express themselves in a family session, and need to be seen on their own to reveal bullying, abuse or emotional difficulties.

Group therapy

Group therapy usually involves small groups of children or adolescents of similar ages, and suffering from similar difficulties, eg social anxiety, sexual abuse, bereavement. The main therapeutic aspects of a group are: acceptance by the other group members; the realisation that one's problems are not unique; the sharing of experiences and feelings in a safe and contained setting; and the opportunity to give and receive feedback and develop new coping strategies and skills. In schools, therapeutic groups are used for children with a range of social, psychiatric or learning difficulties. 'Dinosaur School', for example, aims to help young children with anger management problems, and provides social skills programmes to help children who are experiencing bullying and rejection.

Parent training

Parent training programmes teach the principles of behaviour management in a structured series of weekly sessions (usually 10-12). In addition, they aim to help parents improve their effectiveness by exploring any issues that may be blocking this, eg poor self-confidence, depression, lack of a supportive partner, social isolation. Many research studies have shown that parent training is very effective in improving parent-child relationships, and reducing antisocial or oppositional behaviour, particularly when combined with social skills training for the children.

Medication (pharmacotherpy)

Alongside other therapies, children are being increasingly prescribed medication for a variety of symptoms and behaviour problems, from hyperactivity and depression, to major mental illness. There is a marked difference between the UK and the USA in the use of medication, particularly for young children and those with mood disorders and attentional difficulties, and this reflects differences in diagnosis as well as prescribing practice. It is particularly important to discuss these treatments in full with the patient and family so that they can give informed consent. The main drugs in current use are briefly described here.

Stimulants

These are the first line medications for attention deficit hyperactivity disorder (ADHD). They work by increasing attention and decreasing impulsivity. The most commonly prescribed drug in this group is methylphenidate which should not be used with children under six years old and works for only about four hours. Several longer-acting versions have now been developed to prolong the effect and avoid having to take medication at school. Atomoxetine is a non-stimulant treatment for ADHD. Children on these medications require regular medical review and there is recent debate over their effectiveness in the long term.

Antidepressants

The prescription of antidepressants should only be considered for severe depression, panic anxiety disorder or obsessive compulsive disorders, and should be preceded by, or combined with, individual therapy such as CBT (see Part 1). The older antidepressants, the tricyclics, are no longer used for treating severe clinical depression in children and adolescents, and have been replaced by the SSRIs (selective serotonin uptake inhibitors) which alter the levels of chemicals in the brain and take several weeks to work. There is continuing controversy about the effectiveness of SSRIs in depression. Fluoxetine (Prozac) is used for severe depression in adolescents, as it has a good safety profile and has not been shown to release suicidal ideation. (For a discussion the use of these drugs with adults, see p33.)

Minor tranquillisers

These include diazepam (valium) and are occasionally prescribed for children who have to face upsetting medical interventions, such as bone marrow aspirations. Otherwise they are used rarely, if at all, in children and others for the very short-term treatment of anxiety, because of their potential for dependence.

Antipsychotics and major tranquillisers

These include haloperidol, risperidone and olanzepine, and are used to treat children with psychotic symptoms, schizophrenia and bipolar (manic-depressive) disorder and Tourette's syndrome. They are powerful drugs with significant side effects, and must be monitored carefully. Low doses of risperidone, one of the antipsychotics, can be used to treat severe aggressive behaviour in conduct disorder, though their use is disputed.

Mood stabilisers

These are used to help children with very severe mood swings, eg lithium, valproate and carbamezepine are used to prevent mood swings in bipolar illness. Lithium may be toxic and requires careful monitoring of blood levels.

Diet

Diets are used successfully in the treatment of many physical conditions like eczema and migraine. Their usefulness is less clear with childhood behaviour problems, however.

The Feingold diet was introduced for children with hyperactivity, autism and learning difficulties and involves avoiding food additives and caffeine. There are many variations and there is some evidence that dairy products, wheat, chocolate, oranges and tomatoes can affect some hyperactive children. In an individual child, it needs careful investigation, and the skills of a paediatric dietician to identify the exact culprit and ensure that the child continues to receive a balanced and healthy diet.

Omega 3 and fish oil supplements have recently become popular for children with learning difficulties, but the scientific evidence for their effectiveness is not strong at present. ●

Further reading

BARKER P (2007). *Basic Family Therapy*, 5th edn. Oxford, UK. Blackwell.

BLACK D, URBANOWICZ M (1987). Family interventions with bereaved children. *Journal of Child Psychiatry and Psychology*; **23**:467-476.

FORREST G (2008a). Therapies for children and adolescents. Part I: individual therapies. *Bereavement Care*; **27**(1): 14-15.

GALE B (2007). Family therapy. *Bereavement Care*; **26**(3): 58-59.

BOOK REVIEWS

Group work with adolescents after violent death

Alison Salloum

Hove, Sussex, UK
Brunner Routledge
2004, 184pp
13.99 pb
ISBN 0 415 94861 6

This excellent book provides a rich and solid introduction to working with groups of adolescents bereaved by a traumatic death. It achieves a good balance of theory and practice, giving clear indications of exactly what to do, and also an overview of the models of bereavement and group processes on which the instruction is based. As with so many other such books, this one recommends involving the parents but, unlike others, it actually goes about telling the reader how to do so. Furthermore it suggests how to involve teachers and other important adults as well.

Evaluation is often overlooked, particularly in child bereavement work, but this manual stands out because of its approach to this. Not only does the author describe some of the existing outcome studies that lead us to believe that such an intervention is likely to be effective, she also emphasises the importance of evaluating the intervention and using measures which have been standardised. Although Salloum stops short of making specific recommendations, she does direct the reader to websites where various measures can be considered.

I do have some criticisms, but these are things that I would suggest the reader take into account rather than reasons not to buy. Only minimal guidance is provided on avoiding being traumatised by other people's accounts. One reference is incorrect and an internet reference, quoted as support for the effectiveness of play therapy and medication, in fact says the opposite, that there is no research showing the effectiveness of medication (of course 'no evidence of effectiveness' could just mean that we cannot prove it yet). European readers should find that tolerance, rather than translation, is sufficient to cope with the US English. For example, while it is a challenge to have to keep describing the sometimes quite extreme waxing and waning of grief reactions, to expect the reader to recognise them as STUGs (Subsequent Temporary Upsurges of Grief) is a bit annoying.

Chapters are long enough to impart sufficient information, but short enough to be manageable. The style is quite prescriptive but this is, after all, a manual and sometimes when running such groups with young people who feel that the world is distressingly out of control, it can be a blessed relief to them (and us) to have at least something that appears to be well controlled. In the end, practitioners can choose for themselves whether to use this as a prescription or a guide. ●

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EMDR (eye movement desensitisation and reprocessing) is a cognitive behavioural therapy for treating post-traumatic stress disorder that has proved effective with both young people and adults. A comment by David Trickey on this technique was published in a previous issue (*Bereavement Care*; 22[2]: 23) and EMDR will be the subject of the next Broader Horizons article.

EVENTS IN 2008

Grief research and bereavement care. Anglo-Dutch conference with Margaret Stroebe, Henk Schut, Colin Murray Parkes, Marilyn Relf, Liz Rolls, Paul Boelen. 17 October. **Bereavement care for people with learning disabilities and autistic spectrum disorders.** 15-19 Sept. Course with Noelle Blackman, Linda McEnhill. London. Tel 020 8768 4694; email: education@stchristophers.org.uk