THE ADOLESCENT BEHAVIOR DISORDERS ALERT

TREATMENTS THAT HARM ADOLESCENTS, PT. II
P.T.S.D., EATING DISORDERS, & GRIEF

FALL, 2011

In the last issue, Winter 2011, I opened this series with a discussion of how I became interested in the problem of treatments that can actually do harm to children and adolescents. It began with a study by Harvard that found that adolescents who went through hospital based drug rehab. programs actually increased their drug use compared to those who did not go into rehab. For many years, research studies which found that a particular treatment for a mental or emotional disorder did not yield positive results (or even resulted in a worsening of symptoms) were simply not published. These studies were considered of no value to scientists. But there has been a new interest in this data because it may give us clues as to what treatments *may* work. This has been paralleled by new interest in publishing drug treatment studies which found that a particular drug for a mental or emotional disorder was ineffective or worse.

I found so much material in this area I divided it into two issues. The first dealt with treatments for teens who are "acting out"—those with failing grades, drug or alcohol abuse, and juvenile delinquency. In this second issue I will focus on what we call "internalizing" problems—eating disorders, post traumatic stress disorder, and bereavement.

Are Group Programs on Eating Disorders Good for Teen Girls?

Eating disorders began to rise in high school and college age girls in the 1970's. There has been a good deal of media coverage about the impact of our cultural ideal of thinness in young women and its association with beauty, wealth, popularity, and celebrity status. *Primary programs* are those which seek to prevent eating disorders by selecting a large group of girls randomly, and putting them through a series of educational sessions which focus on proper nutrition, body image, and the negative consequences of binging, purging, and self starvation. *Secondary programs* are aimed at those who are in the early stages of an eating and seek to restore them to a more normal condition.

Do these programs work? We assume that providing teens with factual information about a problem will make them informed, and thus informed, they will choose not to engage in a dangerous behavior. Right? The answer is "not necessarily." We saw in the first issue that congregating teens to discuss acting out behavior seemed to normalize it, even make it interesting to some who had not previously considered engaging in that behavior. I became interested in treatments for eating disordered girls while listening to a radio interview in December of 2010 on NPR while traveling. The speaker said, "Well, we all know, when treating anorexic girls, not to bring in a celebrity who will give a testimonial about when she was anorexic. All the girls will want to be like her." (Unfortunately, I could not track down the author of the statement.)

Garner (1985) wrote about treatments for eating disorders which he called "iatrogenic." This is a medical word which means that the treatment itself can cause a disorder. He reviewed the use of prevention programs such as group lectures to high school girls, public service announcements, and television programs. He concluded that these programs may unwittingly inspire girls to become anorexic because of the association with "ultra-thinness, upper class status, intelligence, perfectionism, and physical fitness." Some of his patients said they liked the "identity" of being anorexic. Those in support groups liked the sense of belonging to an anorexic group because it made them feel "special." He used the term "social contagion" to explain how eating disorders spread in the community to high school girls

through hearing about how to binge, purge, use laxatives, over-exercise, etc. from other girls who talked about it.

Only a few studies of these groups have included measures of whether those in the prevention program actually engaged in fewer abnormal behaviors regarding eating habits. Joel Killen and others (1993) did a study of 931 6th and 7th grade girls who were divided into a prevention program or a control group. The prevention group went through a program that emphasized (1) the harmful effects of abnormal eating behaviors, (2) an emphasis on good nutrition and healthy exercise, and (3) skills you can use to cope with social pressures for thinness and dieting. They found no differences in attitude measures, body mass index, or abnormal behaviors. In a similar study by Paxton (1993) the students went through 5 classes that addressed similar issues. Again, no differences were found.

Traci Mann and others (1997) looked at this phenomenon when developing an eating disorders program for young women at Stanford University. They gave a questionnaire on eating habits, body image, and self esteem to 509 students. Half of them came back one month later and sat through a 90 minute program on eating disorders (in small groups). The program consisted of an educational presentation followed by three young women who told their personal stories. The participants were surveyed 4 weeks and 12 weeks later. When the authors looked at the data on each group of young women who were re-assessed (not just the ones who had completed all 3 surveys), they found that those in the intervention group had *more* eating disorder symptoms than those in the control group. The authors suggested that the message might have gotten lost because of how healthy and attractive the speakers looked, despite their recovery from an eating disorder.

What About Critical Incident Stress Debriefing for Trauma?

In the 1970's and 1980's, as psychologists began to study post traumatic stress disorder, new treatments were devised to help people cope with the symptoms they experience following natural disasters, violent crime, and human tragedy. One new approach, developed in the military for soldiers in combat zones, was to provide a group intervention immediately after the event to prepare people for what they may experience and explain how to cope with it. Called "psychological debriefing" or PD in Britain, it is called "critical incident stress debriefing" in the U.S. When school shootings began in the 1990's, it was commonplace for counselors to go the school en masse and do CISD with the students. Is this a good thing?

Mayou and others (2000) noted that few studies had been done on the effectiveness of CISD. They found that one study, done in 1998 in England, had found that brief interventions or "debriefings" had been ineffective in preventing the symptoms of PTSD, and that it could exacerbate some symptoms. Mayou then began to collect data on a sample of people who came to the emergency room in Oxford, England, following a traffic accident. Half were given a one hour debriefing and half were not. They were followed up four months later and then three years later to see how they were doing. The participants ranged in age from 16 to 65. A total of 30 in each group were located and interviewed at the three year mark.

For those who had low initial scores on a survey of psychiatric symptoms, the ones who received debriefing were no better but no worse than those who did not. However, for those with initially high scores, those who went through the debriefing had more symptoms of PTSD three years later than those who did not. They were still symptomatic, but the controls, who had had no counseling, had returned to normalcy. A systematic review of CISD was done by Rose and others in 2004. The Cochrane Review, as it is called, concluded that there is no evidence for the benefits of CISD in the short term and possible harm at long term follow-up.

Stallard and others did a similar study in 2006 of the use of CISD with children and teens, age 7 to 18, following a traffic accident. The findings were similar. Not only did the CISD group not improve, compared to the control group, but their PTSD symptoms were 11% *higher* than those of the control group.

What about CISD in the school setting for children who are held hostage or who learn of the sudden death of a classmate or teacher? Wei, and others, (2010), searched the literature and found no

systematic studies using control groups that investigated the merits of having children and adolescents go through CISD after a traumatic event. Based on the negative outcomes of adults and children who underwent CISD following other traumas, the authors concluded "there is no compelling reason to support [CISD] to individuals after trauma, including children and adolescents in school settings."

The studies by these researchers have caused many clinicians to re-evaluate our thoughts about response to trauma and how we should treat it. In the aftermath of the terrorist attacks on the World Trade Center on Sept. 11, 2001, more than 9,000 counselors went to New York City to offer CISD to rescue workers, families, and victims of the tragedy. There were predictions in the media that a high percentage of New Yorkers would suffer from PTSD which is characterized by experiencing flashbacks, having nightmares, feeling numb and confused, avoiding reminders of the event, and being tense and easily startled. In October of 2001 researchers reported that 7.5% of adults living in Manhattan in the area of the devastation were suffering from PTSD. By February of 2002, however, the proportion reporting PTSD had fallen to only 1.7%. These low numbers surprised many in the trauma field.

Psychologists have now concluded that the vast majority of people, even children, will go through some sort of life altering trauma in their lives and that most of them will cope successfully on their own without any intervention. It is common for many children to simply "not think about it," and this appears to be a healthy response to trauma. Sitting through group sessions where other people talk about their traumatic responses, or re-telling one's story to the group, may act to *re-traumatize* children who might otherwise have few symptoms. This process may cause them to focus on their symptoms, to expect to have certain symptoms, and to worry about how they are coping.

In my practice, I often get requests for treatment for children and adolescents who have gone through a recent trauma—a severe car accident, a house fire in which a sibling died, a sexual assault, being mauled by a vicious dog, etc. The parents assume that psychotherapy is in order and is part of the child's recovery process. I have learned to proceed carefully in these cases, warning the parent that immediate treatment may not be the best approach. Parents are surprised at this. In some cases I have seen the child or adolescent, determined that they were coping well, and suggested to the parent we hold off on treatment for the time being, with the offer to see the teen at a later time, if they are having problems.

Grief Therapy for Children and Teens

By now we all know the five stages of grief—shock, denial, anger, bargaining, acceptance—first put forth by Elizabeth Kubler Ross, in her book *On Death and Dying*, in1969. Except that there is no evidence that people go through these stages when suffering the death of someone close to them. In fact, Kubler-Ross was writing about people's acceptance of the imminence of their own death, not the death of another. The theory was not tested until 2007 when researchers at Yale recruited 233 people who were recently bereaved and interviewed them soon after their loss and several months later. The study, published in the *Journal of the American Medical Association*, found that most respondents accepted the death of the significant person right from the beginning. They reported more yearning for the loved one than anything else.

We have also come to accept the premise that it is good for bereaved children and adults to talk about their sad and painful emotions. Yet George Bonanno, a professor at Columbia, did a study in 2007 which compared those bereaved people who expressed their grief and unhappy feelings with those who did not. He found that those who avoided their feelings were less depressed and less anxious and had fewer health complication than those who did. This, and many subsequent studies, shocked many in the grief therapy community.

And what about the idea that we must do "grief work" to recover from the death of a family member? Isn't it important that everyone, children and adults, go through grief therapy and do grief work? The answer, simply, is no. Grief is not work. Most people recover from significant loss with the simple passage of time. Only abut 15% of adults go on to have serious symptoms one year after an important loss. Niemeyer and Currier (2009) reviewed over 61 controlled studies (those in which half of

the participants had grief therapy and half did not, but made up the control group) in a meta-analysis of the effectiveness of grief therapy. The age of the participants ranged from childhood through old age. They found that those who had grief therapy mostly recovered in time, but so did those who had no treatment at all. Those who had grief therapy showed no benefits over no treatment at all. When they narrowed the data to those people who already were experiencing complicated grief (symptom scores in the clinical range), they found that those people actually did benefit from intervention. Bonanno and Kaltman (1999) reported on a series of studies which found that those adults who went through grief therapy were actually having *more* symptoms (such as increased depression and lower morale) than those who didn't.

Children experience symptoms of grief at the loss of an important person, and their symptoms are similar to those of adults—feelings of fear and unhappiness, physical complaints, difficulties learning and concentrating in school, and feelings of being inadequate and/or different from other children. As with adults, most recover in time and only about 15% to 20% go on to have significant symptoms of grief after one year.

Currier, et al., (2007), did a similar meta-analysis of studies of grief therapy for children and teens. They found only 13 studies which included both a treatment group and a control group. In all of the studies the treatment consisted of a psychoeducational group offered by the school or a community center. On average the treated child fared no better than the child who had no treatment. The researchers also found that only those children who already showed signs of significant difficulty benefited from treatment.

Fringe Treatments

Emory professor Scott Lilienfeld (2007), did a comprehensive review of potentially harmful treatments which include those listed previously but also a group that are "on the fringe" of the mental health field and which have been soundly rejected by the scientific community. These will be briefly summarized here.

Attachment Therapies. Attachment therapists work with children who, after multiple disruptions of caretakers, have never formed a deep attachment to an adult. They determined that holding therapy, or holding the child tightly until he/she looks into the adult's eyes, would correct this problem. A variant of this is rebirthing therapy, where the child is confined in a small space, wrapped in a blanket, compressed, then gradually released or "re-born." No studies have been done on whether it works, but several children have been suffocated to death.

Recovered Memory Techniques. During the height of the sexual abuse allegation hysteria of the 1980's, many therapists concluded that children and teens repress memories of sexual abuse, but that they can be recalled through prompting, hypnosis, and guided imagery. This was called the "recovered memory technique." Large number of children, teens, and adults began to suddenly recall memories of sexual abuse by parents, sexual abuse in daycare centers, satanic ritual sexual abuse, and even alien abduction abuse. Thousands of parents and daycare center operators were subject to false claims of abuse as a result of this technique which served to plant false memories in people. Many families were disrupted and innocent parents and daycare staff went to prison for many years. Those who made the false allegations deteriorated psychologically in hospital programs and several committed suicide.

Dissociative Identity Disorder-Oriented Psychotherapy. DID is the psychiatric term for multiple identity disorder, a condition in which people seem to have multiple personalities. In the 1980's and 90's a treatment arose in which the therapist uses prompting and hypnosis to contact and bring out the different "alters," or personalities so that they can come to awareness and fuse into one whole personality. This method became very popular and was sensationalized in television shows. Unfortunately, research studies found that the therapists were actually suggesting alters to people who didn't have any, and that the number of alters actually increased over the course of treatment as people got worse. In fact, only about 20% of those with DID actually have clearly defined alters. By the late 1990's, researchers concluded that DID treatment was not only bogus but harmful.

What Treatments Are Successful for These Disorders?

Some children and teens do suffer from P.T.S.D. after a life-threatening event and from complex and protracted grief after the loss of an important family member. Experts would estimate that perhaps 10% to 20% of them would need professional help. For those children, the best mental health treatment is a combination of : (1) individual psychotherapy with a focus on understanding what happened to them, being able to express emotions about the event, cognitive behavior therapy to challenge distorted thinking, and learning new coping skills: (2) family therapy to strengthen bonds with parents and siblings; and (3) medication, if needed. For those teens with an eating disorder, group programs should be avoided. The same combination of individual and family therapy, along with medication in some cases, is the best intervention.

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