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REFERENCE CHART OF EVIDENCE-BASED PRACTICES

Findings by Treatment Type for Children and Adolescents

Please refer to individual sections of the Collection for discussion of a particular disorder.

ADJUSTMENT DISORDER

What Works	
There are no evidence-based practices at this time	
What Seems to Work	
Interpersonal psychotherapy (IPT)	IPT helps children address problems to relieve depressive symptoms.
Cognitive behavioral therapy (CBT)	CBT is used to improve age-appropriate problem-solving skills, communication skills, and stress management skills. It also helps the child's emotional state and support systems to enhance adaptation and coping.
Stress management	Stress management is particularly beneficial in cases of high stress and helps the youth learn how to manage stress in a healthy way.
Group therapy	Group therapy among of likeminded/afflicted individuals can help group members cope with various features of adjustment disorders.
Family therapy	Family therapy is helpful for identifying needed changes within the family system. These changes may include improving communication skills and family interactions and increasing support among family members.
What Does Not Work	
Pharmacology alone	Medication is seldom used as a singular treatment because it does not provide assistance to the child in learning how to cope with the stressor.

ANOREXIA NERVOSA

What Works	
Nutritional rehabilitation	Entails developing meal plans and monitoring intake of adequate nutrition to promote healthy weight gain.
Family psychotherapy	Family members are included in the process to assist in reduction of symptoms and modify maladaptive interpersonal patterns.
In-patient behavioral programs	Individuals are rewarded for engaging in healthy eating and weight-related behaviors.
What Seems to Work	
Cognitive behavioral therapy (CBT)	Needs further study to be well established; it is used to change underlying eating disorder cognitions and behaviors.
Pharmacological treatments	Used primarily after weight restoration to minimize symptoms associated with psychiatric comorbidities.

ANOREXIA NERVOSA (CONT.)

Not Adequately Tested	
Individual psychotherapy	Controlled trials have not supported this treatment; however, it may be beneficial during the refeeding process and to minimize comorbid symptoms.
What Does Not Work	
Group psychotherapy	May stimulate the transmission of unhealthy techniques among group members, particularly during acute phase of disorder.
12-step programs	Not yet tested for their efficacy; discouraged as a sole treatment.
Tricyclic antidepressants	Tricyclic antidepressants are contraindicated and should be avoided in underweight individuals and in individuals who are at risk for suicide.
Somatic treatments	To date, treatments such as vitamin and hormone treatments and electroconvulsive therapy show no therapeutic value.

ANXIETY DISORDERS

What Works	
Behavioral & cognitive behavioral therapy (CBT)	Treatment that involves exposing youth to the (non-dangerous) feared stimuli and challenging the cognitions associated with the feared stimuli with the goal of the youth's learning that anxiety decreases over time.
Selective serotonin reuptake inhibitors (SSRI)	Treatment with certain SSRIs have been proven to help with anxiety; however, SSRIs may increase suicidal ideation in some youth.
Benzodiazepines	While proven effective, not a first choice treatment because of an increase in the risk of behavioral disinhibition.
What Seems to Work	
Educational support	Psychoeducational information on anxiety provided to parents, usually in a group setting.
Computer-based behavioral & cognitive behavioral therapy (CBT)	CBT administered electronically to eliminate long waiting periods or lack of clinical experts in a given area.
Not Adequately Tested	
Play therapy	Therapy using self-guided play to encourage expression of feelings.
Antihistamines or herbs	No controlled studies on efficacy.
Psychodynamic therapy	Therapy designed to uncover unconscious psychological processes to alleviate the tension thought to cause distress.
Biofeedback	Minimal support for efficacy.
Antipsychotics/neuroleptics	High level of risk of impaired cognitive functioning and tardive dyskinesia with long-term use; contraindicated in youth who do not also have Tourette's syndrome or psychosis.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

What Works	
Behavioral classroom management (BCM)	BCM uses contingency management strategies, including teacher-implemented reward programs, token systems, time-out procedures, and daily report cards (DRCs). Clinicians or parents may work in consultation with teachers to develop a classroom treatment plan.
Behavioral parent training (BPT)	BPT teaches the parent to implement contingency management strategies similar to BCM techniques at home.
Intensive behavioral peer intervention (BPI)	Intensive BPI is conducted in recreational settings, such as summer treatment programs (STPs). STPs have demonstrated effectiveness and are considered well-established. However, STPs are less feasible to implement than other evidence-based practices.
Stimulant: d-Amphetamine	Short-acting: Adderall, Dexedrine, DextroStat Long-acting: Dexedrine Spansule, Adderall XR, Lisdexamfetamine
Stimulant: Methylphenidate	Short-acting: Focaline, Methylin, Ritalin Intermediate-acting: Metadate ER, Methylin ER, Ritalin SR, Metadate CD, Ritalin LA Long-acting: Concerta, Daytrana patch, Focalin XR
Serotonin and norepinephrine reuptake inhibitor (SNRI): atomoxetine	Atomoxetine is unique in its ability to act on the brain's norepinephrine transporters without carrying the same risk for addiction as other medications.
What Does Not Work	
Cognitive, psychodynamic, and client-centered therapies	Traditional talk therapies and play therapy have been demonstrated to have little to no effect on ADHD symptoms. ADHD is best treated with intensive behavioral interventions in the youth's natural environments.
Office-based social skills training	Once-weekly office-based training, either one-on-one or in a group setting, have not led to significant improvement in social skills. (However, intensive group social skills training that uses behavioral interventions, such as STPs, are considered well-established.)
Dietary interventions	Interventions include elimination of food additives, elimination of allergens/sensitivities, and use of nutritional supplements.
Antidepressants	These include bupropion (Wellbutrin), imipramine (Tofranil), nortriptyline (Pamelor, Aventil), clonidine (Catapres) and guanfacine (Tenex).

AUTISM SPECTRUM DISORDER (ASD)

What Works	
Behavioral interventions	Includes antecedent interventions and consequent interventions.
Discrete trial teaching or training (DTT)	A type of behavioral intervention that uses operant learning techniques to change behavior. Also known as the ABC model (action request, behavior, consequence).
Cognitive behavioral intervention package	CBT modified for ASD youth.
Comprehensive behavioral treatment for young children (CBTYC)	Also known as applied behavior analysis (ABA), early intensive behavioral intervention (EIBI), and behavioral inclusive programs.
Language training (production)	Targets the ability to communicate verbally.

AUTISM SPECTRUM DISORDER (ASD) (CONT.)

Modeling	Involves demonstrating a target behavior to encourage imitation.
Naturalistic teaching strategies (NTS)	Child-directed strategies that use naturally occurring activities to increase adaptive skills.
Parent training package	Involves training parents to act as therapists.
Peer training package	Trains peers on how to behavior during social interactions with a youth with ASD.
Learning experience: An alternative program (LEAP)	A type of peer training program for peers, teachers, parents, and others.
Pivotal response training (PRI)	Involves targeting pivotal behaviors related to motivation to engage in social communication, self-initiation, self-management, and responsiveness to multiple cues.
Schedules	Used to increase independence in youth with ASD.
Scripting	Providing scripted language to be used as a model in specific situations.
Self-management	Strategies that involve teaching youth to track performance while completing an activity.
Social skills package	Aims to provide youth with the skills (such as making eye contact appropriately) necessary to participate in social environments.
Story-based intervention	Use stories to increase perspective taking skills.
What Seems to Work	
Augmentative and alternative communication devices	Communication systems designed to complement speech (pictures, symbols, etc.).
Developmental relationship-based treatment	Programs that emphasize the importance of building social relationships by using the principals of developmental theory.
Exercise	Uses physical exertion to regulate behavior.
Exposure package	Requires youth to face anxiety-provoking situations.
Functional communication training (fct)	Behavioral method that replaces disruptive or inappropriate behavior with more appropriate and effective communication.
Imitation-based intervention	Relies on adults imitating the actions of a child.
Initiation training	Involves directly teaching individuals with ASD to initiate interactions with their peers.
Language training (production and understanding)	Aims to increase both speech production and understanding of communicative acts.
Massage therapy	Involves the provision of deep tissue stimulation.
Multi-component package	Involves a combination of multiple treatment procedures that are derived from different fields of interest or different theoretical orientations.
Music therapy	Aims to teach individual skills or goals through music.
Picture exchange communication system	Involves the application of a specific augmentative and alternative communication system for youth with limited communication skills.
Reductive package	Relies on strategies designed to reduce problem behaviors without increasing alternative appropriate behaviors.
Sign instruction	Teaches sign language as a means of communicating.

AUTISM SPECTRUM DISORDER (ASD) (CONT.)

Social communication intervention	Targets some combination of social communication impairments.
Structured teaching	Relies heavily on the physical organization of setting, predictable schedules, and individualized use of teaching methods.
Technology-based intervention	Presents instructional materials using the medium of computers or related technologies.
Theory of mind training	Aims to teach youth to recognize and identify the mental states of others.
Not Adequately Tested	

- Animal-assisted therapy (e.g., hippotherapy: the use of horseback riding as a therapeutic or rehabilitative treatment)
- Auditory integration training
- Concept mapping
- DIR/Floor time
- Gluten-free and/or casein-free diet
- Facilitated communication
- Movement-based intervention
- Sensory integration
- Shock therapy
- Social-behavioral learning strategy (e.g., SODA)
- Social cognition/social thinking Intervention program
- Holding therapy

BINGE EATING DISORDER

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT)	The most effective independent treatment option; it is used to change underlying eating disorder cognitions and behaviors.
Interpersonal psychotherapy (IPT)	Attempts to reduce the use of binge eating as a coping mechanism by supporting the development of healthy interpersonal skills.
Pharmacological treatments	Antidepressants, namely SSRIs, have effectively reduced binge/purging behaviors, as well as comorbid psychiatric symptoms.
Not Adequately Tested	
Dialectical behavior therapy (DBT) Mindfulness and yoga-based interventions	These treatments are suggested as future areas of research.
What Does Not Work	
Pharmacological treatments	Although may reduce binge eating in high doses, does not necessarily help with weight loss; in addition, very high placebo response rate and relapse rate.
Nutritional rehabilitation and counseling	Although initial weight loss is associated with these treatments, weight is commonly regained.
12-step programs	Discouraged as a sole treatment; does not address nutritional or behavioral concerns.

BIPOLAR AND RELATED DISORDERS

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Psychopharmacological treatment	Mood stablizers/Anticonvulsants; second-generation antipsychotics.
Family-focused psychoeducational therapy (FFT)	Helps youth make sense of their illness and accept it and also to better understand use of medication. Also helps to manage stress, reduce negative life events, and promote a positive family environment.
Child- and family-focused cognitive behavioral therapy (CFF-CBT)	Emphasizes individual psychotherapy with youth and parents, parent training and support, and family therapy.
Multifamily psychoeducation groups (MFPG)	Youth and parent group therapy have been shown to increase parental knowledge, promote greater access to services, and increase parental social support for youth.
Not Adequately Tested	
Interpersonal social rhythm therapy (IPSRT)	Works to minimize the effects of life stressors by helping youth establish regular patterns of sleep, exercise, and social interactions.
Omega-3 fatty acids	Unclear if supplementation helps with depressive symptoms when used in conjunction with other treatments.
Topiramate; Oxcarbazepine	Anticonvulsants; not proven to be effective in youth or adults.
Dialectical behavior therapy (DBT)	Family skills training and individual therapy; not proven to help with mania or interpersonal functioning.

BULIMIA NERVOSA

What Works	
Cognitive behavioral therapy (CBT)	The most effective independent treatment option; it is used to change underlying eating disorder cognitions and behaviors.
Combined treatments	A combination of CBT and pharmacotherapy seems to maximize outcomes.
What Seems to Work	
Pharmacological treatments	Antidepressants, namely SSRIs, have effectively reduced binge/purging behaviors, as well as comorbid psychiatric symptoms.
Not Adequately Tested	
Individual psychotherapy	Compared to CBT, few individual therapeutic approaches have been effective in reducing symptoms.
Family therapy	May be more beneficial than individual psychotherapy, but outcomes should be considered preliminary at this time.
What Does Not Work	
Bupropion	Bupropion has been associated with seizures in purging individuals with BN and is contraindicated.
Monoamine oxidase inhibitors (MAOIs)	MAOIs are potentially dangerous in individuals with chaotic binging and purging and their use is contraindicated.
12-step programs	Discouraged as a sole treatment; do not address nutritional or behavioral concerns.

DEPRESSIVE DISORDERS – CHILDREN

What Works	
Stark's cognitive behavioral therapy (CBT) - child-only group or child group plus parent component	Stark's CBT includes mood monitoring, mood education, increasing positive activities and positive self-statements, and problem solving.
Fluoxetine (SSRI) in combination with CBT	Fluoxetine is the only antidepressant approved by the FDA for use in children. For moderate to severe depression, pharmacological treatment in combination with psychosocial therapy may be warranted. However, because SSRIs can increase suicidal behavior in youth, children taking fluoxetine must be closely monitored.
What Seems to Work	
Penn prevention program (PPP)	PPP is a CBT-based program that targets pre-adolescents and early adolescents who are at-risk for depression.
Self-control therapy	Self-control therapy is a school-based CBT that focuses on self-monitoring, self-evaluating, and causal attributions.
Behavioral therapy	Includes pleasant activity monitoring, social skills training, and relaxation.

DEPRESSIVE DISORDERS – ADOLESCENTS

What Works	
Cognitive behavioral therapy (CBT) provided in a group setting	CBT for depression focuses on identifying thought and behavioral patterns that lead to or maintain the problematic symptoms.
Interpersonal therapy (IPT) provided individually	In IPT, the therapist and patient address the patient's interpersonal communication skills, interpersonal conflicts, and family relationship problems.
Fluoxetine (SSRI) in combination with CBT	Fluoxetine is the only antidepressant approved by the FDA for use in children. For moderate to severe depression, pharmacological treatment in combination with psychosocial therapy may be warranted. However, because SSRIs can increase suicidal behavior in youth, children taking fluoxetine must be closely monitored.
What Seems to Work	
CBT in a group or individual setting with a parent/family component	CBT for depression focuses on identifying thought and behavioral patterns that lead to or maintain the problematic symptoms.
Adolecent coping with depression (CWD-A)	CWD-A includes practicing relaxation and addressing maladaptive patterns in thinking, as well as scheduling pleasant activities, and learning communication and conflict resolution skills.
Interpersonal psychotherapy for depressed adolescents (IPT-A)	IPT-A addresses the adolescent's specific interpersonal relationships and conflicts, and helps the adolescent be more effective in their relationships with others.
Physical exercise	Physical exercise has shown promise in improving symptoms of depression in adolescents. Group-based and supervised light- or moderate-intensity exercise activities 3 times a week for a period of between 6 to 11 or 12 weeks may bring about an improvement in depression. Additional research is need.
Not Adequately Tested	
Dietary supplements	Supplements such as St. John's Wort, SAM-e, and Omega-3 have not been adequately tested and may have harmful side effects or interact with other medications. Parents should discuss supplement use with a mental health care professional.
What Does Not Work	
Tricyclic antidepressants	These antidepressants can have problematic side effects and are not recommended for children or adolescents with depression.

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

What Works	
Assertiveness training	School-based group treatment for middle- school youth.
Parent management training (PMT) • Helping the Noncompliant Child • Incredible Years • Parent-child interaction therapy • Parent MT to Oregon model • Positive parenting program	PMT programs focus on teaching and practicing parenting skills with parents or caregivers.
Multisystemic therapy (MST)	MST is an integrative, family-based treatment for youth with serious antisocial and delinquent behavior. Interventions last 3-5 months and focus on improving psychosocial functioning.
Cognitive behavioral therapy (CBT)	CBTs emphasize problem-solving skills and anger control/coping strategies.
CBT & parent management training	Combines CBT and PMT.
What Seems to Work	
Multidimensional treatment foster care	Community-based program alternative to institutional, residential, and group care placements for use with severe chronic delinquent behavior. Foster parents receive training and provide intensive supported treatment within the foster home.
Not Adequately Tested	
Atypical antipsychotics medications	Risperidone (Risperdal), quetiapine (Seroquel), olanzapine (Zyprexa), and aripiprazole (Abilify); limited evidence for effectiveness in youth with ID or ASD.
Stimulant or atomoxetine	Methylphenidate, d-Amphetamine, atomoxetine; limited evidence when comorbid with primary diagnosis of ADHD.
Mood stabilizers	Divalproex sodium, lithium carbonate; limited evidence when comorbid with primary diagnosis of bipolar disorder.
Selective serotonin reuptake inhibitors (SSRIs)	Limited evidence when comorbid with primary diagnosis of depressive disorder.
What Does Not Work	
Boot camps, shock incarcerations	Ineffective at best; can lead worsening of symptoms.
Dramatic, short-term, or talk therapy	Little to no effect as currently studied.

INTELLECTUAL DISABILITY

What Works	
Behavioral interventions, such as positive behavior support (PBS)	Behavioral interventions analyze the cause of a negative behavior and how it is being reinforced, and then offer techniques targeted to promoting positive behaviors.
What Seems to Work	
Psychotropic medication for co-occurring mental health disorders	Prescribed to treat comorbid disorders. Because these medications have not been studied in ID populations, they should only be used when other therapies do not address symptoms and in conjunction with appropriate behavioral interventions.
Not Adequately Tested	
Psychotropic medications to treat challenging behaviors	Psychotropic medications are sometimes used “off label” to treat challenging behaviors such as aggression. These medications should be used with caution and only when necessary. They should never be used for the convenience of caregivers.

FIRESETTING, JUVENILE

What Works	
There are no evidence-based practices at this time	
What Seems to Work	
Cognitive behavioral therapy	Structured treatments designed to intervene with children who set fires.
Fire safety education	Education includes information about the nature of fire, how rapidly it spreads, and its potential for destructiveness, as well as information about how to maintain a fire-safe environment, utilizing escape plans and practice, and the appropriate use of fire.
Firefighter home visit	Firefighters visit homes and explain the dangers of playing with fire to at-risk juveniles.
What Does Not Work	
Ignoring the problem	Leaving youth untreated is not beneficial because they typically do not outgrow this behavior and ignoring these behaviors may increase dysfunctional behavior patterns.
Satiation	Satiation, the practice of repetitively lighting and extinguishing fire, may cause the youth to feel more competent around fire and may actually increase the behavior.
Burning the juvenile	Burning a juvenile to show the destructive force of fire is illegal/abusive. It will not decrease the likelihood of the juvenile setting fires or actually treat the problem.
Scaring the juvenile	Scare tactics may produce the emotions or stimulate the actions the clinician is trying to prevent, particularly when family or social issues may trigger firesetting. Scare tactics may also trigger defiance, avoidance, or increase the likelihood that firesetting traits continue.

MOTOR DISORDERS

What Works	
Habit reversal therapy (HRT) for tic disorder	Treatment increases awareness to the feelings and context associated with the urge to tic and implements a competing and inconspicuous habit in place of the tic.
Comprehensive behavioral intervention for tics (C-BIT)	Combines habit reversal and other approaches like education, awareness via self-monitoring, relaxation techniques, and sometimes situational changes.
What Seems to Work	
Exposure with response prevention (ERP)	Consists of repeated, prolonged exposures to stimuli that elicit discomfort and instructions to refrain from any behavior that serves to reduce discomfort.
Pharmacotherapy	Medications may be considered for moderate to severe tics causing severe impairment in quality of life or when medication responsive psychiatric comorbidities are present that target both tic symptoms and comorbid condition.
Massed negative practice	Treatment involves children's over-rehearsal of target tic in high-risk situations.
What Does Not Work	
Deep brain stimulation	Surgical intervention; not recommended.
Repetitive transcranial magnetic stimulation (rTMS)	Safety in youth has not been established; not recommended.
Plasma exchange; Intravenous immunoglobulin (IVIG) treatment	Blood transfusions alter levels of plasma or immunoglobulin. While several of these treatments have been shown to be promising, they are not empirically supported and not recommended.
Dietary supplements (magnesium and vitamin B6); special diets	Supplements may have the potential to negatively interact with other pharmacological agents. Not recommended until safety in children is established.

NONSUICIDAL SELF-INJURY

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT)	CBT involves providing skills designed to assist youth with affect regulation and problem solving.
Dialectical behavior therapy (DBT)	DBT emphasizes acceptance strategies and the development of coping skills.
Not Adequately Tested	
Problem solving therapy	Designed to improve an individual's ability to cope with stressful life experiences.
Pharmacological treatment	Evidence of the effectiveness of the use of medications, such as high-dose SSRIs, atypical neuroleptics, and opiate antagonists, is limited. In addition, some medications have been shown to increase suicidal ideation in children and adolescents.
Hospitalization	Because effectiveness is not consistently demonstrated, should be reserved for youth who express intent to die.

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

What Works	
Cognitive behavioral therapy (CBT) with exposure and response prevention (ERP)	Treatment path with a consistent and compelling relationship between the disorder, the treatment, and the specified outcome. Combines training with exposure and preventing the accompanying response.
Family-focused individual CBT	Individual CBT that includes a focus on family involvement. It should be noted that the distinction of family focused here is meant to imply a format for treatment delivery.
SRIs	Clomipramine: Approved for children aged ten and older. Recommend periodic electrocardiographic (ECG) monitoring.
SSRIs	Fluoxetine (Prozac): Approved for children aged eight and older. Sertraline (Zoloft): Approved for children aged six and older. Fluvoxamine (Luvox): Approved for children aged eight and older.
What Seems to Work	
Family focused group CBT	Studies show promising results, but there have only been a small number of studies.
Not Adequately Tested	
CBT without ERP Psychodynamic therapy Client-centered therapy	Systematic controlled studies have not been conducted using these approaches.
Technology-based CBT	Results show preliminary support for telephone CBT and web-camera CBT. Although these results are encouraging, caution must be taken due to the small sample sizes and lack of active control groups.
What Does Not Work	
Antibiotic treatments	Antibiotic treatments are only indicated when the presence of an autoimmune or strep-infection has been confirmed and coincided with onset or increased severity of obsessive-compulsive disorder symptoms.
Herbal therapies	Herbs, such as St. John's Wort, have not been rigorously tested and are not FDA approved. In some instances, herbal remedies may make symptoms worse or interfere with pharmacological treatment.

OFFENDING, JUVENILE

What Works	
Multisystemic therapy (MST)	An integrative, family-based treatment with a focus on improving psychosocial functioning for youth and families.
Functional family therapy (FFT)	A family-based program that focuses on delinquency, treating maladaptive and "acting out" behaviors, and identifying obtainable changes.
Treatment Foster Care Oregon (TFCO)	As an alternative to corrections or residential treatment, TFCO places juvenile offenders with carefully trained foster families who provide youth with close supervision, fair and consistent limits, consequences, and a supportive relationship with an adult. The program includes family therapy for biological parents, skills training and supportive therapy for youth, and school-based behavioral interventions and academic support.
What Seems to Work	
Family centered treatment (FCT)	FCT seeks to address the causes of parental system breakdown while integrating behavioral change. FCT provides intensive in-home services and is structured into four phases: joining and assessment, restructuring, value change, and generalization.
Brief strategic family therapy	A short-term, family-focused therapy that focuses on changing family interactions and contextual factors that lead to behavior problems.
Aggression replacement therapy (ART)	A short-term, educational program that focuses on anger management and provides youth with the skills to demonstrate non-aggressive behaviors, decrease antisocial behaviors, and utilize prosocial behaviors.
Cognitive behavioral therapy (CBT)	A structured, therapeutic approach that involves teaching youth about the thought-behavior link and working with them to modify their thinking patterns in a way that will lead to more adaptive behavior in challenging situations.
Dialectical behavior therapy	A therapeutic approach that includes individual and group therapy components and specifically aims to increase self-esteem and decrease self-injurious behaviors and behaviors that interfere with therapy.

POST-TRAUMATIC STRESS DISORDER

What Works	
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Treatment that involves reducing negative emotional and behavioral responses related to trauma by providing psychoeducation on trauma, addressing distorted beliefs and attributes related to trauma, introducing relaxation and stress management techniques, and developing a trauma narrative in a supportive environment.
What Seems to Work	
School-based Group Cognitive Behavioral Therapy (CBT)	Similar components to TF-CBT, but in a group, school-based format.
Not Adequately Tested	
Child-centered Play Therapy	Therapy that utilizes child-centered play to encourage expression of feelings and healing.
Psychological Debriefing	An approach in which youth talk about the facts of the trauma (and associated thoughts and feelings) and then are encouraged to re-enter into the present.
Pharmacological Treatments	Treatment with selective serotonin reuptake inhibitors (SSRIs).
Peer Treatment	Classroom treatment that pairs withdrawn children with resilient peers with a parent present for assistance.

POST-TRAUMATIC STRESS DISORDER (CONT.)

Eye Movement Desensitization and Reprocessing Therapy (EMDR)	Therapy that utilizes visual and physical memory imagery while the clinician creates visual or auditory stimulus to reduce negative memory and increase positive memory.
What Does Not Work	
Restrictive rebirthing or holding techniques	Restrictive rebirthing or holding techniques that may forcibly bind or restrict, coerce, or withhold food/water from children and have resulted, in some cases, in death; not recommended.

SCHIZOPHRENIA

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Psychopharmacological treatment with second-generation (atypical) antipsychotics	Risperidone Aripiprazole Quetiapine Paliperidone Olanzapine
Psychopharmacological treatment with traditional neuroleptics/first generation antipsychotics	Molindone Haloperidol
Family psychoeducation and support	Helps to improve family functioning, problem solving and communication skills, and decrease relapse rates.
Cognitive behavioral therapy (CBT)	Includes social skills training, problem-solving strategies, and self-help skills.
Cognitive remediation	Pointed tasks to help improve specific deficiencies in cognitive, emotional, or social aspects of a patient's life.
Not Adequately Tested	
Electroconvulsive therapy (ECT)	Small electric currents are passed through the brain, intentionally triggering a brief seizure to reverse symptoms of certain mental illnesses. Unproven as effective in youth. Should only be used as a last effort after all risks are weighted against possible benefits.
What Does Not Work	
Psychodynamic therapies	Talk therapies that focus on a client's self-awareness and understanding of the influence of the past on present behavior. These therapies are considered to be potentially harmful for youth with schizophrenia.

SEXUAL OFFENDING

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Multisystemic therapy for problem sexual behaviors (MST-PSB)	An intensive family- and community-based treatment that addresses the multiple factors of serious antisocial behavior in juvenile sexual abusers.
Cognitive behavioral therapy (CBT) Children with problematic sexual behavior CBT (PBS-CBT)	Treatment modalities that provide cognitive-behavioral, psychoeducational, and supportive services.
Not Adequately Tested	
Pharmacological treatment	There is no research validation for the use of medication targeting sexually deviant behavior in youth and only limited methodologically sound research to guide in the treatment of adults.

SUBSTANCE USE DISORDERS

What Works	
Cognitive behavioral therapy (CBT)	A structured therapeutic approach that involves teaching youth about the thought-behavior link and working with them to modify their thinking patterns in a way that will lead to more adaptive behavior in challenging situations.
Family therapy Multidimensional family therapy (MDFT) Functional family therapy (FFT)	Family-based therapy is aimed at providing education, improving communication and functioning among family members, and reestablishing parental influence through parent management training. MDFT views drug use in terms of networks of influences (individual, family, peer, community) and encourages treatment across settings in multiple ways. FFT is best used in youth with conduct and delinquent behaviors along with substance use disorders combining relationship with CBT interventions to change relationship patterns and improve the family's functioning.
Multisystemic therapy (MST)	An integrative, family-based treatment with a focus on improving psychosocial functioning for youth and families.
What Seems to Work	
Behavioral therapies	Behavioral therapies focus on identifying specific problems and areas of deficit and working on improving these behaviors.
Motivational interviewing (MI) Motivational enhancement therapy (MET)	MI is a brief treatment approach aimed at increasing motivation for behavior change. It is focused on expressing empathy, avoiding argumentation, rolling with resistance, and supporting self-efficacy. MET is an adaptation of MI that includes one or more client feedback sessions in which normative feedback is presented and discussed.
Pharmacological treatments	Some medication can be used for detoxification purposes, as directed by a doctor. Medication may also be used to treat co-existing mental health disorders.

SUBSTANCE USE DISORDERS (CONT.)

Not Adequately Tested	
Multifamily educational intervention (MEI)	MEI combines psycho-educational and family interventions for troubled adolescents and their families.
Adolescent group therapy (AGT)	The AGT intervention incorporates adolescent therapy groups on stress management, developing social skills, and building group social support.
Interpersonal and psychodynamic therapies	Interpersonal and psychodynamic therapies are methods of individual counseling that are often incorporated into the treatment plan and focus on unconscious psychological conflicts, distortions, and faulty learning.
Client-centered therapies	A type of therapy focused on creating a non-judgmental environment, such that the therapist provides empathy and unconditional positive regard. This facilitates change and solution making on behalf of the youth.
Psychoeducation	Programs aimed at educating youth on substance use and may cover topics like peer pressure and consequences of substance use.
Project CARE	A program aimed at raising awareness about chemical dependency among youth through education and training.
Twelve-step programs	A twelve-step program that uses the steps of Alcoholics Anonymous as principles for recovery and treating addictive behaviors.
Process groups	A type of psychotherapy that is conducted in a small group setting. Groups can be specialized for specific purposes and therapy utilizes the group as a mechanism of change.

TRICHOTILLOMANIA (HAIR PULLING DISORDER) AND EXCORIATION (SKIN PICKING DISORDER)

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Habit reversal therapy (HRT)	Treatment increases awareness to the feelings and context associated with the urges and implements a competing and inconspicuous habit in place of the hair pulling and skin picking.
Cognitive behavioral therapy (CBT) for trichotillomania	Treatment involves exposing children to the stimuli associated with the urge, while challenging thoughts associated with high-risk situations.
Not Adequately Tested	
SSRIs N-acetylcysteine Naltrexone	Some demonstrated improvement on certain measures of picking behavior has been demonstrated in some pharmacological studies.

YOUTH SUICIDE

What Works	
Currently no psychopharmacological treatments meet criteria for a treatment that works.	
Currently no psychological treatments meet criteria for a treatment that works.	
What Seems to Work	
Selective serotonin reuptake inhibitors (SSRIs)	These antidepressants may help reduce suicidal ideation; however, in some individuals they may cause suicidal ideation. Youth taking SSRIs must be closely monitored.
Cognitive behavioral therapy (CBT) Dialectical behavior therapy (DBT)	These psychotherapies have both shown promise in reducing suicidal ideation in some youth when paired with appropriate medication therapy. Other psychotherapies, such as interpersonal therapy for adolescents, psychodynamic therapy, and family therapy, may also be effective.
SOS Signs of Suicide Prevention Program	A school-based education and screening program that teaches students to recognize warning signs of depression and suicidality in themselves or their peers.
Not Adequately Tested	
Gatekeeper training	Involves educating youth, parents, and caregivers in warning signs of suicide to encourage early intervention.
What Does Not Work	
Tricyclic antidepressants	Not recommended; effectiveness has not been demonstrated, and older tricyclic antidepressants are lethal in overdose quantities.
No-suicide contracts	Designed as an assessment tool, not a prevention tool. Studies on effectiveness in reducing suicide are inconclusive and their use is discouraged, as they may be interpreted as being coercive or may encourage suicide in some individuals.