# Reference Chart of

# Disorders and 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 Disorders

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| **What Works** | Currently no medication or psychological treatments meets these criteria. |
| **What Seems to Work** | |
| Interpersonal Psychotherapy (IPT) | IPT has the most support in that it helps children and adolescents address problems in their relationships so that they can become less depressed. |
| 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. |
| Group Therapy | Group therapy is beneficial in cases of high stress. |
| Family Therapy | Family therapy helps in making 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 (AN)

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| **What Works** | |
| Nutritional Rehabilitation | Developing meal plans and monitoring intake of adequate nutrition to promote healthy weight gain. |
| Family Psychotherapy | Family members are included in the therapeutic 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. |
| Pharmacological Treatments | Used primarily after weight restoration to minimize symptoms associated with psychiatric comorbidities. |
| **What Does Not Work** | |
| Individual Psychotherapy | While effectiveness is uncertain, it may be beneficial during the refeeding process (not starvation) and to minimize comorbid symptoms. |
| 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 and are discouraged as a sole form of treatment. |
| Somatic Treatments | To date, treatments such as vitamin and hormone treatments and electroconvulsive therapy show no therapeutic value. |

## Attention Deficit Hyperactivity Disorder (ADHD)

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| **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. 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) 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<br>Long-acting: Dexedrine Spansule, Adderall XR, Lisdexamfetamine |
| Stimulant: Methylphenidate | Short-acting: Focaline, Methylin, Ritalin<br>Intermediate-acting: Metadate ER, Methylin ER, Ritalin SR, Metadate CD, Ritalin LA<br>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 other medications' risk for addiction. |
| **What Does Not Work** | |
| Cognitive, psychodynamic, 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 environment. |
| Office-based social skills training | Neither once-weekly individual nor group office-based training have demonstrated significant improvement in social skills. (However, intensive group social skills training that use behavioral interventions are considered well-established.) |
| Dietary Interventions | Interventions include elimination of food additives, elimination of allergens/sensitivities, and use of nutritional supplements. |
| Antidepressants | Bupropion (i.e., Wellbutrin), Imipramine (i.e., Tofranil), Nortriptyline (i.e., Pamelor, Aventil), Clonidine (i.e., Catapres) and Guanfacine (i.e., Tenex). |

## Anxiety Disorders

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| **What Works** | |
| Behavior and Cognitive Behavioral Therapy (CBT) | Treatments that involve exposing children to the (non-dangerous) feared stimuli, the goal being that the child learns that anxiety decreases over time. |
| Selective Serotonin Reuptake Inhibitors (SSRIs) | Treatment with certain SSRIs, e.g., Sertraline |
| **What Seems to Work** | |
| Educational support | Psychoeducational information provided to parents, usually in a group setting. |
| **Not Adequately Tested** | |
| Play Therapy | Therapy that utilizes self-guided play to encourage expression of feelings and healing |
| Non-SSRI Medication | Treatment with antihistamines or neuroleptics |
| Psychodynamic Therapy | Therapy designed to uncover unconscious psychological processes to alleviate tension thought to cause distress. |
| Biofeedback | Minimal support |

## Autism Spectrum Disorder

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| **What Works** | |
| Applied Behavior Analysis (ABA) | Behavioral intervention aimed at improving cognitive, language, communication, and socialization skills characterized by on-going and objective measurement of behaviors, implementation of individualized curricula, selection and systematic use of reinforcers, use of functional analysis to identify factors that increase or inhibit behaviors, and emphasis on generalization of learned skills. |
| Discrete Trial Teaching (DTT) | Behavioral intervention based on principles of operant learning; incorporates units of instruction used to teach and assess acquisition of basic skills; discrete trial incorporates same sequential components regardless of skills taught. |
| Pivotal Response Training (PRT) | Focuses on the most disabling areas of a child's autism by teaching children to respond to multiple environmental cues, increasing motivation, increasing capacity for self-management, and increasing self-initiations. |
| Learning Experiences: An Alternative Program (LEAP) | Peer-mediated interventions in an educational setting with children with autism and typical peer; individualized, data driven, and focused on generalizing learning skills across context through saturation of learning opportunities throughout the day; family involvement is a significant part of this intervention. |
| Pharmacological Treatments | May be considered for maladaptive behaviors and when behavioral symptoms cause significant impairment in functioning. |
| **What Seems to Work** | |
| Educational and Communication-focused Interventions, e.g., TEACCH | TEACCH (Treatment and Education of Autistic and Communication related handicapped CHildren) provides strategies that support the individual throughout the lifespan, facilitates autonomy at all levels of functioning, and accommodates individual needs. |
| Natural Language Methods | Speech and language pathologists often integrate communication training with the child's behavior program to provide a coordinated opportunity for structured and naturalistic language learning. Instruction in communication is designed to provide a generative tool that will serve many immediate needs throughout the child's life. |
| Picture Exchange Communication System (PECS) | Helps children with ASD acquire functional communication skills. Children using PECS are taught to give a picture of a desired item to a communication partner in exchange for the item, thus linking an outcome with communication. |
| Other Behavioral Interventions | Joint attention behavior training, which may be especially beneficial in young, pre-verbal children, shows promise for teaching children with autism behavioral skills. Social skills groups, social stories, visual cueing, social games, video modeling, scripts, peer-mediated techniques, and play and leisure curricula are also supported by the literature. |
| Occupational Therapy & Sensory Integration Therapy (SI) | Occupational therapy helps develop self-care skills, e.g., dressing, using utensils, maintaining personal hygiene and academic skills, and shows promise in promoting play skills and establishing routines to improve attention and organization.<br><br>SI therapy often is used alone or as part of a broader program of occupational therapy for children with ASD. Goal is to correct deficits in neurological processing and integration of sensory information to allow the child to interact with the environment in a more adaptive way. |

## Bulimia Nervosa (BN)

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| **What Works** | |
| Cognitive Behavioral Therapy (CBT) | The most effective independent treatment option; it is used to change underlying eating disorder cognitions and behaviors. |
| Pharmacological Treatments | Antidepressants, namely Selective Serotonin Reuptake Inhibitors (SSRIs), have effectively reduced binge/purging behaviors, as well as comorbid psychiatric symptoms. |
| Combined Treatments | A combination of CBT and pharmacotherapy seem to maximize treatment outcomes. |
| **What Does Not Work** | |
| Individual Psychotherapy | Compared to CBT, few individual therapeutic approaches have been effective in reducing symptoms. |
| Behavioral Therapy | Behavioral techniques, such as exposure, have been less effective than CBT techniques. |
| 12-Step Programs | Not yet tested for efficacy and are discouraged as a sole form of treatment. |

## Depression/Dysthymia — Interventions for Children

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|---|---|
| **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. |
| **What Seems to Work** | |
| Penn Prevention Program (PPP) | A CBT-based program that targets pre-adolescents and early adolescents who are at-risk for depression. |
| Self-Control Therapy | 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. |

## Depression/Dysthymia — Interventions for Adolescents

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|---|---|
| **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 adolescent's interpersonal communication skills, interpersonal conflicts, and family relationship problems. |
| **What Seems to Work** | |
| CBT provided 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. |
| Adolescent Coping with Depression (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) | Addresses the adolescent's specific interpersonal relationships and conflicts, and helps the adolescent be more effective in their relationships with others. |
| Selective Serotonin Reuptake Inhibitors (SSRIs) | Fluoxetine is the only pharmacological treatment approved for youth by the FDA. Most effective when combined with CBT, although there is debate about the use of SSRIs to treat depression in youth. |

## Disruptive Behavior Disorders

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| **What Works** | |
| Assertiveness training: Group Assertive Training | School-based group treatment for middle-school youth |
| Parent Management Training (PMT) Programs | Programs which focus on teaching and practicing parenting skills with parents or caregivers include:<br>• Helping the Noncompliant Child<br>• Incredible Years Parent-Child Interaction Therapy<br>• Parent Management Training to Oregon Model<br>• Positive Parenting Program |
| Multisystemic Therapy (MST) | An integrative, family-based treatment for youth with serious antisocial and delinquent behavior. Interventions last 3-5 months and focus on improving psychosocial functioning for youth and families. |
| Cognitive Behavioral Therapy (CBT) | CBT emphasizes problem solving skills and anger control/coping strategies and includes:<br>• Problem-Solving Skills Training<br>• Anger Control Training |
| CBT & Parent Management Training (PMT) | Combines CBT and PMT |
| **What Seems to Work** | |
| Multidimensional Treatment Foster Care (MTFC) | 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 setting. |
| **What Does Not Work** | |
| Atypical Antipsychotics Medications | Risperidone (risperdal), quetiapine (seroquel), olanzapine (zyprexa), and Abilify (aripiprazole). Limited evidence for effectiveness in youth with intellectual disability or pervasive developmental disorder. |
| 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. |
| 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. |

## Early-onset Schizophrenia

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| **What Works** | Currently, no medication or psychological treatments meets these criteria. |
| **What Seems to Work** | |
| Traditional Neuroleptics/First-generation Antipsychotics | Molindone, Haloperidol |
| Second-generation (atypical) Antipsychotics | Clozapine risperidone, olanzapine, ziprasidone |
| Family Pychoeducation 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. |
| **What Does Not Work** | |
| Psychodynamic Therapy | May be harmful for this population. |

## Habit Disorders

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| **What Works** | |
| Habit Reversal Therapy for Tic Disorder | Treatment increases awareness to the feelings and context associated with the urges and implements a competing and inconspicuous habit in place of the tic. |
| **What Seems to Work** | |
| Cognitive Behavioral Therapy (CBT) for recurrent hair-pulling (trichotillomania [TTM]) | Treatment involves exposing children to the stimuli associated with the urge while challenging thoughts associated with high-risk situations. |
| Not Adequately Tested | |
| Massed Negative Practice | Treatment involves children over-rehearsal of target tic in high-risk ticking situations. |
| Pharmacotherapy | Prescription medications to treat habit disorders in children. |
| **What Does Not Work** | |
| Plasma Exchange or Intravenous Immunoglobulin Treatment (IVIG) | Blood transfusions to alter levels of plasma or immunoglobulin. |

## Juvenile Firesetting

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| **What Works** | Currently no medication or psychological treatments meets these criteria. |
| **What Seems to Work** | |
| Cognitive Behavioral Therapy (CBT) | Structured treatments designed to intervene with children who set fires. |
| Fire Safety 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. |
| **What Does Not Work** | |
| Ignoring the problem | Leaving the youth untreated is not beneficial because they typically do not outgrow this behavior and ignoring these behaviors may even increase dysfunctional behavior patterns. |
| Satiation | The practice of repetitively lighting and extinguishing fire. Satiation may cause youth to feel more competent around fire and actually increase the behavior. |

## Juvenile Offenders

| **What Works** | |
|---|---|
| Multisystemic Therapy (MST) | Integrative, family-based treatment with a focus on improving psychosocial functioning for youth and families. |
| Functional Family Therapy (FFT) | Family-based program that focuses on delinquency, treating maladaptive and acting out behaviors, and identifying obtainable changes. |
| Multidimensional Treatment Foster Care (MTFC) | As an alternative to corrections, MTFC places juvenile offenders who require residential treatment with carefully trained foster families who provide youth with close supervision, fair and consistent limits, consequences and a supportive relationship with an adult. |
| Cognitive Behavioral Therapy (CBT) | 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 (DBT) | 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. |
| **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 in youth. |
| 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 |

## Non-Suicidal Self-Injurious Behavior (NSIB)

| **What Works** | Currently no medication or psychological treatments meets these criteria. |
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| **What Seems to Work** | |
| Cognitive Behavioral Therapy (CBT) | Involves providing skills designed to assist youth with affect regulation and problem solving |
| Dialectical Behavior Therapy (DBT) | Similar to CBT, but additionally involves an emphasis on acceptance strategies. |

## Obsessive-compulsive Disorder (OCD)

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|---|---|
| **What Works** | |
| Exposure and Response Prevention (ERP) | Individual child (probably efficacious); family-focused individual and family-focused group treatments (possibly efficacious). ERP meets well-established criteria for adult OCD. |
| Selective reuptake inhibitors (SRIs) | Clomipramine: Approved for children age 10 years and older. Recommend periodic ECG monitoring. |
| Selective Serotonin Reuptake Inhibitors (SSRIs) | Newer than SRIs, SSRIs primarily affect the serotonin neurotransmitters:<br>Fluoxetine (Prozac): Approved for children 8 yrs +<br>Sertraline (Zoloft): Approved for children 6 yrs +<br>Fluvoxamine (Luvox): Approved for children 8 years + |
| **Not Adequately Tested** | |
| Cognitive Therapy only<br>Psychodynamic Therapy<br>Client-centered Therapy | Systematic controlled studies have not been conducted using these approaches. |
| **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 OCD 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. |

## Pediatric Bipolar Disorder (PBD)

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|---|---|
| **What Works** | Currently no medication or psychological treatments meets these criteria. |
| **What Seems to Work** | |
| Mood stabilizers/ Anticonvulsants | Lithium, divalproex sodium |
| Second-generation Antipsychotics | Clozapine, risperidone, olanzapine, quetiapine |
| Family-focused Psychoeducational Therapy (FFT) | Family therapy format. Helps adolescents make sense of their illness and accept it, along with their medications. 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 children and parents, parent training and support, and family therapy |
| Multifamily Psychoeducation Groups (MFPG) | Child and parent group therapy has 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 | No current evidence of its usefulness for youth. |

## Sexual Offending

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|---|---|
| **What Works** | Currently no medication or psychological treatments meets these criteria. |
| **What Seems to Work** | |
| Multisystemic Therapy (MST) | Intensive family and community-based treatment addressing the multiple factors of serious antisocial behavior in juvenile sexual abusers. |
| Residential Sexual Offender Treatment | May be necessary for public safety. For offenders, addresses both sexual and non-sexual behaviors and provides milieu treatment that is delivered by trained staff in a highly structured setting. Length of stay varies. |
| Community-based Programming | Effective element to treatment continuum; offers advantage of shortening residential lengths of stay, and improving post-residential transitioning. |
| **Not Adequately Tested** | |
| Selective Serotonin Reuptake Inhibitors (SSRIs) | Impacts sexual preoccupations, sex drive, and arousal. |

## Substance Use Disorders

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|---|---|
| **What Works** | |
| Cognitive Behavioral Therapy (CBT) | A structured therapeutic approach to teaching youth about the thought-behavior link and working with them to modify their thinking patterns in a way that leads to more adaptive behavior in challenging situations. |
| Family Therapy | Aimed at providing education, improving communication and functioning among family members, and reestablishing parental influence through parent management training. *NOTE: Only specific family therapies have been tested; not ALL family therapies are considered effective.* |
| Multisystemic Therapy (MST) | An integrative, family-based treatment focusing on improving psychosocial functioning for youth and families. |
| **What Seems to Work** | |
| Behavioral Therapies | Treatment which focuses on identifying specific problems and areas of deficit and working on improving these behaviors. |
| Motivational Interviewing Approaches | A brief treatment approach to increase motivation for behavior change. It focuses on expressing empathy, discrepancies, avoiding argumentation, rolling with resistance, and supporting self-efficacy. |
| Some Medications | Psychopharmological medication can be used for detoxification purposes, as directed by a doctor. Medication may also be used to treat comorbid mental health disorders. |
| **What Does Not Work** | |
| Interpersonal and Psychodynamic Therapies | Methods of individual counseling often incorporated into the treatment plan and focusing on unconscious psychological conflicts, distortions, and faulty learning. |
| Client-centered Therapies | Creates a non-judgmental environment, such that the therapist provides empathy and unconditional positive regard. This facilitates change and solution-making on behalf of the client. |
| Psychoeducation | Educates youth on substance use and may cover topics like peer pressure and consequences of substance use. |
| Project CARE | Raises awareness about chemical dependency through education and training. |
| Twelve-Step Programs | Uses steps as principles for treating addictive behaviors. |
| Process Groups | A type of psychotherapy that is conducted in small groups which can be specialized for specific purposes; therapy utilizes the group as a mechanism of change. |

## Trauma

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| **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 reenter into the present. |
| Pharmacological Treatments | Treatment with selective serotonin reuptake inhibitors (SSRIs). |
| **What Does Not Work** | |
| Restrictive rebirthing or holding techniques | Restrictive rebirthing or holding techniques may forcibly bind, restrict, coerce, or withhold food or water from children and have resulted in some cases of death and are not recommended. |

## Youth Suicide

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|---|---|
| **What Works** | Currently no medication or psychological treatments meets these criteria. |
| **What Seems to Work** | |
| Dialectical Behavior Therapy (DBT) | Outperformed the treatment for the control group in reducing suicide attempts. However, it did not help reduce depressive symptoms. |
| Cognitive Behavioral Therapy (CBT)<br>Interpersonal Therapy<br>Psychodynamic Therapy<br>Family Therapy | Psychotherapy, while not by itself an evidence-based practice, is an important component to the treatment of suicidality in youth. A minimum standard of therapy should be adapted to the youth. All are options when choosing a treatment modality. |
| Selective serotonin reuptake inhibitors (SSRIs) for co-occurring disorders | Necessary to closely monitor youth taking SSRIs because of the risk that SSRIs can increase suicidality in youth and young adults under age 24. |
| **What Does Not Work** | |
| No-suicide Contracts | Study findings are diverse; there have been results which find that that using the contract reduces suicidal behavior and others suggesting that they increase suicidal behavior. |
| Tricylic Antidepressants | Not recommended because their effectiveness has not been demonstrated. They can potentially be lethal due to the small difference between therapeutic and toxic doses. |
| Benzopines | Should be used with great caution as they may result in impulsivity. |
| Barbiturates | Should be used with great caution as they may result in impulsivity. |