REPORT OF THE
VIRGINIA COMMISSION ON YOUTH

Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs, 10th Edition

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH of VIRGINIA

Commission on Youth

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December 17, 2025

Dear Fellow Citizens of the Commonwealth:

As Chair of the General Assembly's Commission on Youth, it is my pleasure to present the 10th Edition of *The Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs.*

The 10th Edition of *The Collection* is designed to be a quick reference guide for those seeking an overview of evidence-based mental health treatments for children and adolescents. This condensed edition describes mental health conditions that affect youth, a discussion of evidence-based treatments, and a compendium of resources for further reading. The 10th Edition includes a newly added section on the impact of social media on children's mental health. This edition, and previous editions, are available on the Commission's website at https://vcoy.virginia.gov.

The 2002 General Assembly, through State Senate Joint Resolution 99, directed the Virginia Commission on Youth to coordinate the collection of treatments that are recognized as effective for children, including juvenile offenders, who have mental health treatment needs, symptoms, and disorders. This reference document is not intended to serve as a means for medical diagnosis, but rather as a basic reference tool for the general public, legislators, and non-medical professionals who work with children and adolescents.

To ensure that this information remains current and reaches the intended audience, the 2003 General Assembly passed Senate Joint Resolution 358, which requires the Commission on Youth to update *The Collection* biennially and to disseminate it via Web technologies. Since 2003, the Commission has updated this resource document and made it available through the Commission on Youth's website and in limited print editions.

For more information about the Virginia Commission on Youth or *The Collection*, I invite you to visit our website at https://vcoy.virginia.gov. Thank you for your support in our mission for healthy youth.

Sincerely,

Barbara Favola

Barbara A. Favola

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INTRODUCTION

Welcome to the 10th Edition of the *Collection of Evidence-Based Practices for Children and Adolescents with Mental Health Treatment Needs*. This update is designed to be a quick reference guide to evidence-based practices—interventions that have been proven through scientific testing to be effective. This short guide includes information that is most relevant to non-clinicians, including:

- A brief discussion of each disorder
- A description of treatments and interventions, with a focus on treatments that are evidence-based
- A list of resources and organizations for further information

HOW TO USE THE 10TH EDITION OF THE *COLLECTION*

The 10th Edition is designed to provide a brief overview of evidence-based treatments and interventions for children and adolescents with mental health disorders. It is intended as an educational tool to help inform non-clinicians about treatment options, and it should not be used as a substitute for consultation with a qualified mental health professional.

For more information about disorders and treatments, a comprehensive discussion can be found in the *Collection, 6th Edition,* published in 2017, which is available on the Commission on Youth's website at **https://vcoy.virginia.gov**.

WHAT ARE EVIDENCE-BASED PRACTICES?

Evidence-based practices (EBP) are treatments and interventions that have been shown through clinical research to produce positive outcomes. In recent years, there has been a shift away from relying on theory-driven treatments (treatments that clinicians believe *should* work, and that *seem to* work) and towards an emphasis on treatments that have been scientifically demonstrated to work in measurable, replicable ways. Identifying EBPs in mental health has significantly aided clinicians in the decision-making process by providing a fair, scientifically rigorous method of evaluating treatment options. In addition, with so many treatment options available, EBPs give parents a way to evaluate those treatments so that they can partner with their child's clinician to determine which intervention offers the best approach.

Although there are no standardized criteria used to determine if a treatment is evidenced-based, in general, EBPs have been tested in at least two randomized controlled trials (a rigorous type of scientific study) and found to be effective. In the *Collection*, these treatments are listed under the heading "What Works." Treatments that fall under the heading "What Seems to Work" have less scientific evidence to support their efficacy but are still considered by the medical community to be effective. Treatments that are designated as "Not Adequately Tested" may be effective, but rigorous scientific testing either has not, or cannot, be done. Treatments under the heading "What Does Not Work" have been shown to either not work or to have the potential for harm, and these are not recommended. Table 1 describes these treatment categories in more detail.

Table 1
Treatment Categories Used in the *Collection, 10th Edition*

Levels of Support	Description
What Works **(Evidence-based Treatment)**	Meets all of the following criteria: 1. Tested and found effective across two or more randomized controlled trials (RCTs). 2. At least two different investigators (i.e., researcher). 3. Use of a treatment manual in the case of psychological treatments. 4. At least one study demonstrates that the treatment is superior to an active treatment or placebo (i.e., not just studies comparing the treatment to a waitlist).
What Seems to Work	Meets all but one of the criteria for "What Works." or Is commonly accepted as a valid practice supported by substantial evidence.
Not Adequately Tested	Meets none of the criteria for any of the above categories. It is possible that such treatments have demonstrated effectiveness in non-RCT studies, but their potency compared to other treatments is unknown. It is also possible that these treatments were tested and tried with another treatment.
What Does Not Work	Meets none of the criteria above but meets either or both of the following criteria: 1. Found to be inferior to another treatment in an RCT. 2. Demonstrated to cause harm in a clinical study.

Limitations of Evidence-based Practices in Children's Mental Health

The trend toward relying on EBPs in children's mental health treatment has significant limitations, some of which are described in Figure 1. It is important to keep in mind that "evidence-based" does not necessarily mean that a treatment is superior to one with less evidence supporting it. For this reason, EBP designation should be viewed as just one tool in the evaluation of mental health interventions.

Figure 1
Limitations of Evidence-Based Practices

- An effective treatment may not be classified as an EBP because it cannot be measured by a randomized controlled trial (RCT). For instance:
  - The treatment may produce results that are difficult to quantify scientifically.
  - It may be unethical to test the intervention in an RCT because it would be harmful to withhold treatment from the control group.
  - The nature of the treatment may make it difficult to create a RCT or to control for the placebo effect.
- Scientific testing may not be the best way to determine a treatment's effectiveness. For example:
  - RCTs cannot measure whether the holistic needs of the individual are met over multiple domains.
  - RCTs are designed to isolate disorders and treatments and are often not the best way to measure the effect of a treatment on an individual with multiple disorders or the effect of combined treatments.
- Evaluation of specific interventions is an evolving process; therefore, effective interventions may not yet have been thoroughly tested or tested on children.
- Because there is no universal set of standards used to determine whether a practice is evidence-based, lists of EBPs often do not agree with each other. For this reason, there should not be an overreliance on any one organization's list of EBPs.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)
http://www.aacap.org/

Facts for Families Guides
https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Layout/FFF_Guide-01.aspx

American Academy of Family Physicians
https://www.aafp.org

American Psychiatric Association (APA)
http://www.psych.org
http://www.parentsmedguide.org

American Psychological Association (APA)
http://www.apa.org/

Centers for Disease Control and Prevention
https://www.cdc.gov/

Familydoctor.org
https://familydoctor.org/

Medscape
https://reference.medscape.com/

National Alliance on Mental Illness (NAMI)
https://www.nami.org/

National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov/index.shtml

Psychology Today
http://www.psychologytoday.com/us

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/children

U.S. Department of Education

Office of Special Education and Rehabilitative Services

https://www2.ed.gov/about/offices/list/osers/index.html?src=mr

U.S. National Library of Medicine and the National Institutes of Health

Medline Plus

https://medlineplus.gov/

VIRGINIA RESOURCES AND ORGANIZATIONS

Mental Health America of Virginia

https://mhav.org/

National Alliance on Mental Illness Virginia (NAMI Virginia)

https://namivirginia.org/

Virginia Department of Behavioral Health and Developmental Services (DBHDS)

http://www.dbhds.virginia.gov/

Virginia Office of Children's Services

http://www.csa.virginia.gov/

Voices for Virginia's Children

https://vakids.org/

EVIDENCE-BASED PRACTICE RESOURCES

Blueprints for Healthy Youth Development

https://www.blueprintsprograms.org/

California Evidence-Based Clearinghouse for Child Welfare

http://www.cebc4cw.org/

Evidence-based Prevention and Intervention Support (EPIS) Center (Pennsylvania)

https://epis.psu.edu/

Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) Model Programs Guide

https://www.ojjdp.gov/mpg/Program

SAMHSA Evidence-Based Practices Resource Center

https://www.samhsa.gov/ebp-resource-center

PRINT RESOURCES

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). American Psychiatric Association. Washington DC: American Psychiatric Publishing, 2013.

The Oxford Handbook of Clinical Child and Adolescent Psychology, by T. H. Ollendick, S. W. White, & B. A. White. Oxford: Oxford University Press, 2018.

REFERENCE CHARTS OF EVIDENCE-BASED PRACTICES

ADJUSTMENT DISORDER

What Works	
There are currently no evidence-based practices.	
What Seems to Work	
Interpersonal psychotherapy (IPT)	IPT helps children and adolescents 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 like-minded/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	
Medication alone	Medication is seldom used as a singular treatment because it does not aid the child in learning how to cope with the stressor. Targeted symptomatic treatment of the anxiety, depression, and insomnia may effectively augment therapy.

ANOREXIA NERVOSA

What Works	
Family-based 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.

Nutritional rehabilitation	Entails developing meal plans and monitoring intake of adequate nutrition to promote healthy weight gain.
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.
Medication	Used primarily after weight restoration to minimize symptoms associated with psychiatric comorbidities.
Not Adequately Tested	
Individual psychotherapy	Controlled trials have not supported this treatment; however, it may be beneficial during the renourishing process and to minimize comorbid symptoms.
Imaginal Exposure therapy	Involves imagining fear-inducing situations and then working through resulting emotions and behaviors. Future randomized control trials still needed.
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 (e.g., exposure) & cognitive behavioral (CBT) therapies	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 (SSRIs)	Treatment with certain SSRIs have been proven to help with anxiety; however, SSRIs may increase suicidal ideation in some youth.
What Seems to Work	
Educational support	Psychoeducational information on anxiety provided to parents, usually in a group setting.
Benzodiazepines	While proven effective, not a first choice treatment because of an increase in the risk of behavioral disinhibition.
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 and healing.
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.
Neurofeedback	A type of non-invasive brain training that enables an individual to learn how to change mental and/or physiological activity.
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: Focalin, 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	SNRIs do not carry the same risk for addiction as some other medications.
Non-stimulant: Alpha-agonists: guanfacine and clonidine	Can be an alternative for children who do not tolerate stimulants well; both are available in short and long-acting forms.

What Seems to Work	
Non-stimulant: Serotonin and norepinephrine reuptake inhibitor (SNRI)-viloxazine	FDA-approved in April 2021 for ADHD in youth ages 6 to 17.
Not Adequately Tested	
Dietary interventions	Interventions include elimination of food additives, elimination of allergens/sensitivities, and use of nutritional supplements. Best viewed as a potential complementary intervention.
Interactive metronome training	Involves synchronizing of hand and foot exercises to audible tones.
Neurofeedback	Involves monitoring brain waves and rewarding focused attention through computerized games and exercises.
Antidepressants	These include bupropion (Wellbutrin), imipramine (Tofranil), nortriptyline (Pamelor, Aventil).
What Does Not Work	
Cognitive, psychodynamic, and client-centered therapies	Some talk therapies and some forms of 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 environment.
Office-based social skills training	Once-weekly, office-based training, either one-on-one or in a group setting, has not led to significant improvement in social skills. However, intensive group social skills training that uses behavioral interventions is considered well-established.

AUTISM SPECTRUM DISORDER (ASD)

What Works	
Applied behavior analysis (ABA)	Uses principles of learning theory to bring about meaningful and positive change in behavior, build a variety of skills (e.g., communication, social skills, self-control, and self-monitoring), and help generalize these skills to other situations; also known as early intensive behavioral intervention and comprehensive behavioral treatment for young children (CBTYC).
Discrete trial teaching or training (DTT)	A behavioral intervention that uses operant learning techniques to change behavior. Also known as the ABC model (action request, behavior, consequence).
Pivotal response training (PRT)	Involves targeting pivotal behaviors related to motivation to engage in social communication, self-initiation, self-management, and responsiveness to multiple cues.

Positive behavioral interventions	Behavioral interventions analyze the cause of a negative behavior and how it is being reinforced, and then offer techniques targeted to promoting positive behaviors.
Modeling	Involves demonstrating a target behavior to encourage imitation.
Story-based intervention	Uses stories to increase perspective-taking skills.
Self-management	Strategies that involve teaching youth to track performance while completing an activity.
Cognitive behavioral intervention package	CBT modified for ASD youth.
Language training	Targets the ability to communicate verbally.
Scripting	Provides scripted language to be used as a model in specific situations.
Naturalistic teaching strategies (NTS)	Child-directed strategies that use naturally occurring activities to increase adaptive skills.
Peer training package	Involves training peers on how to behave during social interactions with a youth with ASD.
Schedules	Used to increase independence in youth with ASD.
Learning experience: An alternative program (LEAP)	A type of peer training program for peers, teachers, parents, and others.
Social skills package	Aims to provide youth with the skills (such as making eye contact appropriately) necessary to participate in social environments.
Parent training package	Involves training parents to act as therapists.
What Seems to Work	
Augmentative and alternative communication devices	Communication systems designed to complement speech (pictures, symbols, communication boards, or other assistive technology, like tablets, text-to-speech programs, 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 and help with social, communication, and motor skills. The value of exercise is not that stereotypic behaviors stop, but that stress, dysregulation, or feelings of being overwhelmed decrease as a result of physical activity.
Exposure package	Involves gradually exposing youth to the non-dangerous situations that they fear, with a focus on having them learn that their anxiety will decrease over time; at the same time, the use of maladaptive strategies used in the past is prevented.

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; promotes a "back-and forth" dynamic and the use of spontaneous language/vocalizations.
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	Uses deep tissue stimulation to induce physiological reactions in the body that have preventive, therapeutic, and relaxing effects.
Medication	Risperidone and aripiprazole are FDA-approved to target behavioral symptoms of ASD like aggression, self-injury, and irritability.
Multi-component package	Involves a combination of multiple treatment procedures that are derived from different fields of interest or different theoretical orientations.
Music therapy	Uses music to practice communication and social skills or behavioral goals.
Picture exchange communication system	Involves an alternative communication system designed to teach functional communication to youth with limited skills.
Reductive package	Relies on strategies designed to reduce problem behaviors without increasing alternative appropriate behaviors.
Sign language instruction	Teaches sign language as a means of communicating.
Social communication intervention	Targets some combination of social communication impairments.
Structured teaching	Relies heavily on the visual organization, predictable schedules, and individualized use of teaching methods; can be used in educational, community, and home settings.
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/Floortime
- Gluten-free and/or casein-free diet
- Movement-based intervention
- SENSE theatre intervention
- Sensory intervention package
- Social-behavioral learning strategy
- Social cognition intervention
- Social thinking intervention

What Does Not Work	
Facilitated communication	A person with a disability is assisted by a facilitator in typing letters, words, phrases, or sentences on a keyboard.

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.
Medication	Antidepressants, namely SSRIs, have effectively reduced binge/purging behaviors, as well as comorbid psychiatric symptoms.
Not Adequately Tested	
Dialectical behavior therapy (DBT)	Combines parts of CBT with principles of mindfulness.
Mindfulness and yoga-based interventions	Use of yoga as a therapeutic model to incorporate concentration, meditation, and physical and emotional awareness practices.
What Does Not Work	
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 because they do 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	
Medication	Mood stabilizers (lithium)/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.

BODY DYSMORPHIC DISORDER

What Works	
There are no evidence-based practices at this time.	
Not Adequately Tested	
Selective serotonin reuptake inhibitors (SSRIs)	Possibly effective because of effectiveness with similar disorders.
Cognitive behavioral therapy (CBT)	Shows promise because of its effectiveness with similar disorders.

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 medication seems to maximize outcomes.
What Seems to Work	
Medication	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 because they do not address nutritional or behavioral concerns.

DEPRESSIVE DISORDERS – CHILDREN

What Works	
Stark's cognitive behavioral therapy (CBT)	Stark's CBT (child only or child plus parent) includes mood monitoring, mood education, increasing positive activities and positive self-statements, and problem solving. CBT is based on the premise that patients with depression have thinking that is characterized by dysfunctional negative views of oneself, experiences, and the future. CBT helps individuals identify and modify maladaptive thinking and behavior patterns.
Fluoxetine in combination with CBT	Fluoxetine, a selective serotonin reuptake inhibitor (SSRI), is the only antidepressant approved by the FDA for use in children (eight years old or older) for depression. For moderate to severe depression, fluoxetine in combination with psychosocial therapy may be warranted. However, because SSRIs can increase suicidal behavior in youth, children taking fluoxetine must be closely monitored by a mental health professional.
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	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 behavior patterns that lead to or maintain the problematic symptoms.
Interpersonal therapy (IPT)	In IPT, the therapist and patient address the patient's interpersonal communication skills, interpersonal conflicts, and family relationship problems.
Fluoxetine in combination with CBT	Fluoxetine, a selective serotonin reuptake inhibitor (SSRI), is the only antidepressant approved by the FDA for use in children (eight years old or older) for depression. For moderate to severe depression, fluoxetine in combination with psychosocial therapy may be warranted. However, because SSRIs can increase suicidal behavior in youth, children taking fluoxetine must be closely monitored by a mental health professional.
What Seems to Work	
CBT in a group or individual setting with a parent/family component	CBT for depression focuses on identifying thought and behavior patterns that lead to or maintain the problematic symptoms.
Adolescent 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 three times a week for a period of between 6 to 11 or 12 weeks may bring about an improvement in depression.
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.

DEVELOPMENTAL COORDINATION DISORDER

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive motor intervention	Therapists design a set of exercises into steps for children to practice at home. Emotional, motivational, and cognitive aspects are emphasized, as children are taught how to plan a movement, how to execute it, and how to evaluate their success. Building self-confidence through positive reinforcement is a critical goal, as success depends upon the patient's motivation to practice outside of therapy.
Physical and occupational therapy	Tailored to a child's specific needs.

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

What Works	
Parent management training (PMT)	PMT programs focus on teaching and practicing parenting skills with parents or caregivers. Program models include: • Helping the Noncompliant Child • Incredible Years • Parent-child interaction therapy • Parent MT to Oregon model
Multisystemic therapy (MST)	MST is an intensive family- and community- based treatment that addresses the multiple determinants of serious antisocial behavior. MST clinicians use empirically validated approaches, such as cognitive-behavioral therapy and pragmatic family therapies, and typically provide individual and family counseling and 24-hour crisis management.
Cognitive behavioral therapy (CBT)	CBT emphasizes 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 home.
Not Adequately Tested	
Brief Strategic Family Therapy	Counselors establish relationships with the family, then coach to reshape patterns of interpersonal interactions.

Atypical antipsychotics medications	Risperidone (Risperdal), quetiapine (Seroquel), olanzapine (Zyprexa), and aripiprazole (Abilify); limited evidence for effectiveness in youth with ID or ASD; primarily short-term use recommended.
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; may also address aggression.
What Does Not Work	
Boot camps, shock, incarcerations	Ineffective at best; can lead to worsening of symptoms.
Dramatic, short-term, or talk therapy	Little to no effect as currently studied.

FIRESETTING, JUVENILE

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT)	Structured treatments designed to intervene with children who set fires. Because firesetting is a maladaptive behavior, CBT is a reasonable intervention to consider for behavior modification.
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.
What Does Not Work	
Ignoring the problem	Leaving youth untreated is not beneficial because they typically do not outgrow this behavior. Behavior may increase.
Satiation	Satiation, repetitively lighting and extinguishing fires, 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 and abusive. It will not decrease the likelihood of the juvenile setting fires or 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 may even increase the likelihood that firesetting traits continue.

HOARDING DISORDER

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT) for hoarding	A multi-component, cognitive behavioral treatment designed specifically for hoarding has shown promising results in adults.
Not Adequately Tested	
Selective serotonin reuptake inhibitors (SSRIs)	Possibly effective because of their effectiveness with similar disorders.

INTELLECTUAL DISABILITY (ID)

What Works	
Behavioral interventions	Behavioral interventions analyze the cause of a negative behavior and how it is being reinforced and then offer techniques targeted to promoting positive behaviors. They may also involve modified teaching approaches to assist in the development of social skills, emotion regulation, and functional skills.
Applied behavioral analysis (ABA)	A type of behavioral intervention that uses principles of learning theory to bring about meaningful and positive change in behavior. ABA techniques have been used to help build a variety of skills (e.g., communication, social skills, self-control, and self-monitoring) and help generalize these skills to other situations.
Functional communication training (FCT)	An example of a behavioral intervention program that combines the assessment of the communicative functions of problem behavior with ABA procedures to teach alternative responses. Problem behaviors can be eliminated through extinction and replaced with alternate, more appropriate forms of communicating needs or wants.
What Seems to Work	
Psychotropic medications for co-occurring mental health disorders	Prescribed to treat co-occurring disorders such as anxiety disorders and ADHD. Because these medications have not been studied in ID populations, they should only be used when therapeutic and social measures do not properly 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.

JUVENILE OFFENDING

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 (DBT)	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.

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.
Medication	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.
What Does Not Work	
Benzodiazepines or trazodone	May potentially increase incidence of NSSIs in depressed or anxious individuals.

OBSESSIVE-COMPULSIVE DISORDER (OCD)

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.
Serotonin reuptake inhibitors (SRIs)	Clomipramine: Approved for children aged ten and older; recommend periodic electrocardiographic (ECG) monitoring.
Selective serotonin reuptake inhibitors (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. However, each study addresses complex comorbidity and issues impacting community-based treatment.
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.
Deep Brain Stimulation (DBS)	Involves implanting electrodes in the brain to monitor abnormal impulses. There is strong evidence for success in young adults, but not enough adolescent studies.
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 (PANDAS).
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 medications.

POST-TRAUMATIC STRESS DISORDER (PTSD)

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	
Family centered treatment (FCT) trauma treatment	FCT trauma treatment provides intensive in-home services and seeks to address the causes of trauma, including parental system breakdown, while integrating behavioral change.
School-based group 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.
Medication	Includes treatment with selective serotonin reuptake inhibitors (SSRIs).
Resilient peer treatment	Classroom treatment that pairs withdrawn children with resilient peers with a parent present for assistance.

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.
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. Recent research suggests this approach is ineffective and potentially harmful.

SCHIZOPHRENIA

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Medication treatment with second-generation (atypical) antipsychotics	Risperidone Aripiprazole Quetiapine Paliperidone Olanzapine
Medication treatment with traditional neuroleptics/first generation antipsychotics	Molindone Haloperidol
Family psychoeducation and support	Helps to improve family functioning, problem solving, and communication skills, and decreases 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	
Medication	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.

STEREOTYPIC MOVEMENT DISORDER

What Works	
Habit reversal therapy (HRT)	Increases awareness to the feelings and context associated with the stereotypies and implements competing and inconspicuous habits in their place. HRT can be modified to include rewards, relaxation, education, self-awareness, and situational changes. It is sometimes combined with other therapies.
What Seems to Work	
Medication	Medications may be considered for moderate to severe stereotypies causing severe impairment in quality of life or when co-occurring conditions that would also benefit from the medication are present.

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 co-occurring conduct and delinquent behaviors. It combines a focus on family relationships with CBT interventions to change 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.
Medication	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.
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; 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.

Neurofeedback	A type of non-invasive brain training that enables an individual to learn how to change mental and/or physiological activity.

SUICIDE, YOUTH

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT) Dialectical behavior therapy (DBT)	Both of these psychotherapies have 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. Suicide focused treatment can be effective without medication therapy in some cases.
Selective serotonin reuptake inhibitors (SSRIs)	These antidepressants may help reduce suicidal ideation in teens with diagnosed depression; however, in some individuals they may cause suicidal ideation. Youth taking SSRIs must be closely monitored. Limitations: SSRIs must be taken consistently, require a therapeutic dose per individual, and can take up to 3 months to show effectiveness.
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. Includes a screening component.
Safety Planning	Clinicians help patients identify effective coping techniques to use during crisis events (American Academy of Pediatrics).
Sources of Strength	Peer leaders model and encourage friends to name and engage trusted adults; reinforce and create an expectancy that friends ask adults for help for suicidal friends; and identify and use interpersonal and formal coping resources.
Attachment-Based Family Therapy	Most effective for youth aged 12-24; based on the idea that the quality of familial relationships has the potential to exacerbate or mitigate depression, suicide, and suicidal ideation; the only treatment adapted specifically for LGBTQ+ youth.
Not Adequately Tested	
Collaborative Assessment and Management of Suicidality (CAMS)	Centered on building a relationship between the physician and individual that allows the individual to identify and manage suicidal thoughts, feelings, and behaviors.
Gatekeeper training	Involves educating youth, parents, and caregivers about warning signs of suicide to encourage early intervention.
What Does Not Work	
Group counseling	Multiple randomized control trials fail to demonstrate efficacy.

Tricyclic antidepressants	Not recommended; effectiveness has not been demonstrated. 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.

TIC DISORDERS

What Works	
Habit reversal therapy (HRT) for tic disorder	A type of cognitive behavioral therapy, HRT increases awareness to the feelings and context associated with the urge to tic, then replaces it with competing, inconspicuous habits.
Comprehensive behavioral intervention for tics (C-BIT)	Combines HRT 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.
Medication	Medications may be considered for moderate to severe tics causing severe impairment in quality of life or when co-occurring conditions that would also benefit from the medication are present.
Massed negative practice (MNP)	Treatment involves developing reactive inhibition through the child's over-rehearsal of target tic in high-risk situations.
Not Adequately Tested	
Web-based exposure with response prevention (ERP)	ERP virtual treatment is considered generally effective, but there are limited studies on how it compares with in-person treatment.
What Does Not Work	
Deep brain stimulation	A neurostimulator is surgically implanted into the brain; not proven to be effective and not recommended.
Repetitive transcranial magnetic stimulation (rTMS)	Uses magnetic fields and electrical pulses to affect neurons in the brain; 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 medications; not recommended until safety in children is established.

TRICHOTILLOMANIA (HAIR PULLING) 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)	Treatment involves exposing children to the stimuli associated with the urge, while challenging thoughts associated with high-risk situations.
Not Adequately Tested	
Selective serotonin reuptake inhibitors (SSRIs) N-acetylcysteine Naltrexone	Some demonstrated improvement on certain measures of picking behavior has been shown in some pharmacological studies of adults.

INTRODUCTION TO NEURODEVELOPMENTAL DISORDERS

In the 2013, the American Psychiatric Association (APA) released the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). In the DSM-5, the section, "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" was replaced with a new section, "Neurodevelopmental Disorders."

According to the APA, neurodevelopmental disorders are a group of conditions with onset in the developmental period. The disorders typically manifest early in development, often before the child enters grade school, and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning. The range of developmental deficits varies from very specific limitations of learning or control of executive functions to global impairments of social skills or intelligence.

Neurodevelopmental disorders included in the *Collection* are:

- Intellectual Disability
- Autism Spectrum Disorder
- Attention-Deficit/Hyperactivity Disorder
- Motor Disorders

Co-Occurring Disorders (Dual Diagnosis)

Neurodevelopmental disorders frequently co-occur. For example, individuals with autism spectrum disorder (ASD) may have intellectual disability, and children with attention-deficit/hyperactivity disorder (ADHD) may also have a specific learning disorder.

In addition, youth with a neurodevelopmental disorder may also have a diagnosable mental health disorder. Unfortunately, symptoms of mental health disorders are sometimes attributed to the primary neurodevelopmental disorder. Clinicians who do not recognize the possibility of dual diagnosis may leave mental health issues untreated and exacerbate symptoms. A dual diagnosis may cause significant clinical impairment, placing additional challenges on youth with developmental disorders and their families and greatly reduce quality of life. For this reason, it is important that accurate diagnosis and appropriate treatment be obtained.

Service providers may use structured or semi-structured tools developed for individuals with neurodevelopmental disorders to improve the accuracy of the mental health diagnosis. A full psychiatric/ behavioral assessment is a critical step to help accurately diagnose a co-occurring mental health disorder.

INTELLECTUAL DISABILITY

OVERVIEW

KEY POINTS

- **Characterized by early onset of symptoms in developmental period, below average IQ, and deficits in adaptive functioning.**
- **About one-third of children with ID also have a co-occurring mental health disorder (known as dual diagnosis).**
- **Effective intervention has the goal of improving adaptive functioning and the quality of life.**
- **Behavioral interventions have the most evidence-based support.**

Intellectual disability (ID) is a neurodevelopmental disorder characterized by significant limitations in both intellectual and adaptive functioning. Intellectual functioning—also called intelligence—refers to general mental capacity, including, but not limited to, such abilities as learning, reasoning, and problem solving. Adaptive behaviors are conceptual, social, and practical skills, such as, but not limited to, using concepts like numbers and time, developing interpersonal skills, and managing day-to-day activities. For a youth to be diagnosed with ID, he or she must have an onset of symptoms during the developmental period, have an IQ significantly below average (usually around 70 or below), and have significant deficits in adaptive functioning.

A multidisciplinary team, which may include psychologists, psychiatrists, pediatricians, and clinical geneticists, should conduct the assessment for ID. Assessments should include standardized testing of intellectual ability (generally called an IQ test), adaptive behavior and function, and a detailed family and medical history evaluation. In addition, the team should evaluate a youth's overall physical and intellectual strengths and weaknesses and create a tailored person-centered plan to help the child be fully included in all facets of community life.

Intellectual Disability and Co-occurring Mental Health Disorders (Dual Diagnosis)

It is estimated that one-third of all individuals with ID also have a diagnosable mental health disorder.[1] This is known as a dual diagnosis. While most professionals understand dual diagnosis to describe those who are living with mental health disorders and substance abuse, the term is also used for individuals who have a diagnosis of ID and a mental health disorder. A dual diagnosis may cause significant clinical impairment in youth with ID and result in additional challenges for these youth and their families. Unfortunately, it is frequently assumed that behaviors associated with co-occurring disorders are related to the ID. Holding to this assumption can leave

[1] Aggarwal, R., Guanci, N., & Appareddy, V. L. (2013). Issues in treating patients with intellectual disabilities. *Psychiatric Times.* Retrieved from https://www.psychiatrictimes.com/view/issues-treating-patients-intellectual-disabilities.

mental health issues untreated and exacerbate symptoms. Table 1 lists mental health disorders that commonly co-occur with ID and their prevalence rates.

Table 1
Prevalence of Co-occurring Mental Health/Neurodevelopmental Disorders Among Children and Adolescents with and without Intellectual Disability

Co-occurring Disorder	Prevalence Rates by Percentage	
	With Intellectual Disability	Without Intellectual Disability
Any anxiety disorder	11.4	3.2
Any depressive disorder	1.4	0.9
Attention-deficit/hyperactivity disorder (ADHD)	8.3	0.9
Any conduct disorder	20.5	4.3
Autism spectrum disorder	8.0	0.3
Tic disorder	0.8	0.2
Eating disorder	0.2	0.1
Emotional disorder & conduct disorder	4.4	0.8
Conduct disorder & ADHD	5.8	0.6
Emotional disorder & ADHD	1.3	0.1
Emotional disorder & conduct disorder & ADHD	0.8	0.1

Source: Emerson, E., & Hatton, C. (2007). Mental health of children and adolescents with intellectual disabilities in Britain. *The British Journal of Psychiatry, 191*, 493-499.

CAUSES AND RISK FACTORS

Knowledge of the causes of ID in a particular case is important because the cause may be associated with a particular "behavioral phenotype," the cognitive and behavioral characteristics associated with a genetic syndrome. Understanding the cause can lead to a better understanding of expected difficulties, life course, risk factors, and helpful interventions. Doctors can find a specific reason for an ID in 25 percent of cases. The following are risk factors associated with the development of ID:

- Infections (present before or shortly after birth)
- Chromosomal abnormalities (e.g., Down syndrome) and other genetic causes
- Environmental factors
- Nutritional (e.g., malnutrition)
- Toxic exposure (e.g., exposure to alcohol, cocaine, amphetamines, or other drugs)
- Trauma (present before or shortly after birth)

INTERVENTIONS

Children with ID have the ability to lead meaningful lives if they are provided the education and supports needed to be successful. Effective interventions should contribute to improving day-to day adaptive functioning and overall quality of life. The most widely utilized and investigated interventions are behavioral interventions, psychopharmacological interventions, and environmentally mediated interventions, which include developmental and educational services. Individual, group, and/or family psychotherapy may also be included in the intervention plan. Verbal psychotherapies are most appropriate for persons with mild to moderate ID. Table 2 summarizes interventions for youth with ID.

Table 2
Summary of Interventions for Youth with Intellectual Disability

What Works	
Behavioral interventions	Behavioral interventions analyze the cause of a negative behavior and how it is being reinforced and then offer techniques targeted to promoting positive behaviors. They may also involve modified teaching approaches to assist in the development of social skills, emotion regulation, and functional skills.
Applied behavioral analysis (ABA)	A type of behavioral intervention that uses principles of learning theory to bring about meaningful and positive change in behavior. ABA techniques have been used to help build a variety of skills (e.g., communication, social skills, self-control, and self-monitoring) and help generalize these skills to other situations.
Functional communication training (FCT)	An example of a behavioral intervention program that combines the assessment of the communicative functions of problem behavior with ABA procedures to teach alternative responses. Problem behaviors can be eliminated through extinction and replaced with alternate, more appropriate forms of communicating needs or wants.
What Seems to Work	
Psychotropic medications for co-occurring mental health disorders	Prescribed to treat co-occurring disorders such as anxiety disorders and ADHD. Because these medications have not been studied in ID populations, they should only be used when therapeutic and social measures do not properly 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.

Behavioral Interventions

Behavioral interventions are designed to provide alternatives to unwanted behaviors. These interventions analyze the cause of the behavior and how it is being reinforced. Techniques such as functional communication training (e.g., learning how to request breaks), noncontingent reinforcement (i.e., reinforcement delivered on a fixed time schedule), and extinction are used to reduce challenging behaviors (e.g., aggression, self-injury, task-avoidance) and to promote positive behaviors. Behavioral techniques target skills, deficits, and modifications to the environment and are most effective if applied across multiple settings to promote generalization of skills.

There are many simple behavioral techniques that can be helpful in attempting to ease the transition of an individual with ID into the general public, such as setting boundaries, creating positive reinforcement of desired behaviors, and creating activity schedules. The overall goal of behavioral intervention is to increase the quality of life.

Applied Behavioral Analysis (ABA)

Also known as *early intensive behavioral intervention* and *comprehensive behavioral treatment for young children*, applied behavioral analysis is a type of behavioral intervention that uses principles of learning theory to bring about meaningful and positive change in behavior. ABA techniques have been used to help build a variety of skills (e.g., communication, social skills, self-control, and self-monitoring) and help generalize these skills to other situations. The techniques can be used in structured (e.g., classroom), everyday (e.g., family dinner time), and in one-on-one or group instruction settings. ABA is also used for individuals with ID who have autism spectrum disorder. Intervention is customized based on the individual's needs, interests, and family situation. ABA techniques are often used in intensive, early intervention programs to address a full range of life skills.

Functional Communication Training (FCT)

FCT is one example of a behavioral intervention program that combines the assessment of the communicative functions of problem behavior with ABA procedures to teach alternative responses. Problem behaviors can be eliminated through extinction and replaced with alternate, more appropriate forms of communicating needs or wants. FCT can be used across a range of ages and regardless of cognitive level or expressive communication abilities.

Pharmacological Interventions

There are no pharmacological treatments available for ID. For this reason, psychotropic drugs (chemical drugs that alter perception, mood, consciousness, or behavior in the nervous system) should only be used to target co-occurring mental health disorders, and only when therapeutic and social measures do not properly address symptoms.

Reports of the prevalence of psychotropic medication use in both adults and children with ID show that over one-third of this population served in residential settings is receiving at least one psychotropic drug. Psychotropic medications are also used "off-label" for the treatment of challenging behaviors, such as

aggression and behavioral disturbance. The literature repeatedly advises that medication should not be used for the convenience of caregivers or as a substitute for appropriate services.

Pharmacological Interventions in Dual Diagnosis

For people with intellectual disabilities, medication is appropriate when there is a dual diagnosis of a psychiatric disorder, such as a mood disorder or a psychotic disorder. Medication treatment should not be a total treatment approach but rather be part of a comprehensive bio-psycho-socio-developmental treatment approach. In addition, treating ADHD with medication is not recommended in youth with IQs less than 50, as pharmacological treatment can cause serious side effects such as tics, social withdrawal, irritability, and anxiety. Table 3 outlines some of the different pharmacological approaches and the different comorbid symptoms that each drug treats for individuals with ID.

Table 3
Pharmacological Treatments and Their Side Effects

Drug	Targeted Symptoms	Potential Side Effects
Risperidone	Hyperactivity, irritability, aggression, and impulsivity	Hyperprolactinemia, weight gain, somnolence, and headaches
Quetiapine	Aggression and hyperactivity	Sedation, weight gain, and paradoxical agitation
Ziprasidone	Aggression and irritability	Dizziness, fever, and fast/uneven heartbeat
Stimulants and nonstimulant atomoxetine	Symptoms of ADHD	In persons with an IQ less than 50, can cause tics, social withdrawal, irritability, anxiety, and anorexia
Fluoxetine	Stereotypic and self-injurious behaviors	Restlessness, hyperactivity, agitation, decreased appetite, insomnia
Valproic acid	Aggression and self-injurious behavior	Hepatic failure, pancreatitis, thrombocytopenia, development of ovarian cysts, obesity, irregular menses, increased hair growth, sedation, GI upset, tremor, alopecia

Source: Aggarwal, R., Guanci, N., & Appareddy, V. L. (2013). Issues in treating patients with intellectual disabilities. *Psychiatric Times.* Retrieved from https://www.psychiatrictimes.com/view/issues-treating-patients-intellectual-disabilities.

SPECIAL EDUCATION SERVICES IN VIRGINIA

The Individuals with Disabilities in Education Act (IDEA), Part B, requires that eligible children with disabilities receive a free and appropriate education (FAPE) from ages 2-22.

Pursuant to IDEA, special education is defined as specially designed instruction, offered at no cost to the parent(s), that meets the unique needs of a child with a disability, including instruction conducted in a classroom, in the home, in hospitals, in institutions, and in other settings, and instruction in physical education. According to IDEA, “specially designed instruction” means adapting as appropriate to the needs of an eligible child the content, methodology, or delivery of instruction to a) address the unique needs of the child that result

from the child's disability; and b) ensure the child's access to the general curriculum, so the child can meet the educational standards that apply to all children within the jurisdiction of the public school division.

In Virginia, IDEA Part B preschool services are available to eligible children with disabilities from age two to age five. Virginia parents also have the option of IDEA Part C early intervention services for their child before age three. A separate eligibility determination is required for Part B services and Part C services.

Early intervention services under Part C are based on a multi-disciplinary evaluation and each state develops its own definition of eligibility. In Virginia, children from birth to age three are eligible for Part C early intervention services if the child:

- Has a 25 percent developmental delay in one or more areas of development,
- Has atypical development, or
- Is diagnosed with a physical or mental condition that has a high probability of resulting in a developmental delay.

In Virginia, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) is the lead agency that administers Part C of IDEA. Virginia's statewide early intervention system is called the Infant & Toddler Connection of Virginia. Infant and toddler services can be home-based, center-based, or a combination. To the maximum extent possible, services are to be provided in the child's natural environment.

The nature of the services is based on two components: an assessment of the child and the priorities of the family. The services that are provided in response to this plan are the identification of appropriate assistive technology, intervention for sensory impairments, family counseling, parent training, health services and intervention, language services, occupational therapy, physical therapy, speech therapy, case management, and transportation to services. Part C services are provided on a sliding fee scale (adjusted for income).

Other Accommodations

There are numerous students with disabilities who do not require special education services through an Individualized Education Program (IEP), but who may need accommodations to be successful. Examples of accommodations include: giving a student preferential seating, allowing more time for tests, having certain tests read aloud, allowing the use of a calculator, and so forth.

These students may be eligible for a 504 plan under Section 4 of the amended Rehabilitation Act of 1973. The 504 plan is developed by a committee generally consisting of the student with the disability (if appropriate), at least one of the student's parents or guardians, at least one of the student's teachers, and the school's 504 coordinator. A 504 plan, which must be updated annually, documents the student's disability, their need for accommodations, and the set of specific accommodations that will be provided by the school.

VIRGINIA'S HOME AND COMMUNITY-BASED MEDICAID WAIVERS

In Virginia, individuals with an ID may be eligible to receive services from Virginia's Home and Community-Based (HCBS) Medicaid Waivers. Medicaid HCBS waivers provide opportunities for individuals eligible for an institutional level of care to receive services in their own home or community rather than in an institutional setting. Eligible individuals are screened for the waiver by their local community services board. If the child is

found eligible for the waiver, the parent would "waive" the child's right to receive services in an institution and choose instead to receive services in the community. Virginia's four HCBS Waiver programs are described in Table 4. More information about Developmental Disability (DD) Waivers can be found on the DBHDS website.

Table 4
Medicaid Waiver Program in Virginia

Waiver		Description
Developmental Disability (DD) Waivers		
	Community Living Waiver (formerly ID Waiver)	Includes residential supports and a full array of medical, behavioral, and non-medical supports; available to adults and children; may include 24/7 supports for individuals with complex medical and/or behavioral support needs through licensed services.
	Family & Individual Supports Waiver (formerly DD Waiver)	Provides supports for individuals living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs; available to both children and adults.
	Building Independence Waiver (formerly Day Support Waiver)	Supports adults (18+) to live independently in the community; individuals own, lease, or control their own living arrangements and supports are complemented by nonwaiver-funded rent subsidies.
CCC Plus Waiver (formerly EDCD Waiver/Tech Waiver) Is transitioning to Cardinal Care		CCC Plus is a new statewide Medicaid managed care program. The CCC Plus Waiver is the community alternative to a nursing facility placement. Individuals on a DD Waiver receive their acute and primary care medical services through CCC Plus. CCC Plus Waiver service may be used while on a wait list for a DD Waiver.

Source: Virginia Department of Behavioral Health and Developmental Services.

RESOURCES AND ORGANIZATIONS

American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter
https://www.jaacap.org/article/S0890-8567(19)32223-3/pdf

American Association of Intellectual and Development Disabilities
http://aaidd.org/

Behavioral Supports
https://aaidd.org/news-policy/policy/position-statements/behavioral-supports

American Psychiatric Association
https://www.psychiatry.org/patients-families/intellectual-disability/what-is-intellectual-disability

American Speech-Language-Hearing Association

Intellectual Disability
https://www.asha.org/Practice-Portal/Clinical-Topics/Intellectual-Disability/

Center for Excellence in Developmental Disabilities
https://health.ucdavis.edu/mindinstitute/centers/cedd.html

Center for Parent Information and Resources
http://www.parentcenterhub.org/

Council for Exceptional Children

Division on Autism and Developmental Disabilities
http://www.daddcec.org/

Individuals with Disabilities Education Act (IDEA)
https://sites.ed.gov/idea/

National Down Syndrome Society (NDSS)
http://www.ndss.org/

National Fragile X Foundation
https://fragilex.org/

National Organization on Fetal Alcohol Syndrome
https://fasdunited.org/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

U.S. Department of Education

Office of Special Education and Rehabilitative Services (OSERS)
https://www2.ed.gov/about/offices/list/osers/index.html?exp=5

U.S. Department of Health and Human Services

Administration for Children and Families
https://www.acf.hhs.gov/

U.S. Department of Health and Human Services

Administration for Community Living
https://www.acl.gov

The Arc of the United States
http://www.thearc.org/

Webinar: Effective Behavior Strategies for Children with Intellectual/Developmental Disabilities
https://www.aucd.org/docs/webinars/Aug22MHWebinar.pdf

VIRGINIA RESOURCES AND ORGANIZATIONS

The Arc of Virginia
https://thearc.org/chapter/the-arc-of-virginia/
Infant and Toddler Connection of VA
https://www.itcva.online/
Partnership for People with Disabilities at Virginia Commonwealth University
https://partnership.vcu.edu/
Virginia Board for People with Disabilities
https://www.vbpd.virginia.gov/
Virginia Department of Behavioral Health and Developmental Services (DBHDS)
http://www.dbhds.virginia.gov/
Covered services by waiver type:
https://drive.google.com/file/d/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/view
Virginia Department of Education
Office of Special Education Programs
https://www.doe.virginia.gov/programs-services/special-education
Virginia Department of Medical Assistance Services (DMAS)
https://www.dmas.virginia.gov/
Cardinal Care Virginia Medicaid Program
https://www.dmas.virginia.gov/for-providers/cardinal-care-transition/
Disability Law Center of Virginia (DLCV)
http://dlcv.org/

AUTISM SPECTRUM DISORDER

KEY POINTS

- **Main characteristics include:**
  - **Difficulty relating to and communicating with others and**
  - **Restricted, repetitive behaviors, interests, and activities.**
- **Children with ASD have great range of abilities and traits.**
- **Seventy percent of children with ASD also have a co-occurring mental health disorder.**
- **Early detection and intervention is critical.**
- **Behavioral and cognitive-behavioral interventions provide the best outcomes.**

OVERVIEW

Autism Spectrum Disorder (ASD) is a complex neurodevelopmental disability that is typically diagnosed during childhood. According to the American Psychiatric Association (APA), the disorder is marked by two main characteristics: 1) persistent deficits in social communication and social interaction, and 2) restricted, repetitive, behaviors, interests, and activities. Symptoms and characteristics of ASD are varied, both in scope and severity. For instance, social communication and interaction deficits can include limited verbal (e.g., functional speech) and non-verbal (e.g., gestures) communication, responding inappropriately in conversations, misreading nonverbal interactions, or having difficulty building age-appropriate friendships. Behavioral characteristics can include an overdependence on routines, high sensitivity to changes in environment, or inappropriate focus. In addition, for an individual to be diagnosed with ASD, symptoms must be present in some form in the early developmental period, must cause clinically significant impairment in the individual's daily life, and cannot be explained by another disorder.

ASD is characterized as a spectrum because there is a great range of abilities and traits found in youth diagnosed with this disorder. Some children are very bright and do well in school, although they may have problems with school adjustment or require special education or related services. Other children may have more significant challenges, including cognitive, psychological, and behavioral challenges. The severity of ASD also varies widely from mild to severe. Many people with mild forms of the disorder can live independently when they are adults, have careers, get married, and have children, while individuals with more severe specifiers of the disorder may need lifelong supportive interventions.

Figure 1
Some Characteristics of Youth with ASD

Youth with ASD might:
• Not point at objects to show interest • Not look at objects when another person points at them • Have trouble relating to others or not have an interest in other people at all • Find eye contact uncomfortable and seek to avoid it • Have trouble understanding other people's feelings or talking about their own feelings • Prefer not to be held or cuddled, or might cuddle only when they want to, or even recoil at close physical contact • Appear to be unaware when people talk to them but respond to other sounds • Be very interested in people but not know how to talk, play, or relate to them • Repeat or echo words or phrases said to them, or repeat words or phrases in place of normal language • Have trouble expressing their needs using typical words or motions • Not play "pretend" games (for example, not pretend to "feed" a doll) • Not engage in typical back-and forth activities (e.g., pat-a-cake, peekaboo) • Repeat actions over and over again (e.g., hand-flapping, rocking) • Have trouble adapting or become distressed when a routine changes • Have unusual reactions to the way things smell, taste, look, feel, or sound • Lose skills they once had (for example, stop saying words they were using)

Source: Centers for Disease Control and Prevention, https://www.cdc.gov/ncbddd/autism/signs.html.

Signs, Screening, and Assessment

ASD is often discovered when parents become concerned that their child is not developing in the manner expected or achieving typical developmental milestones.[1] Challenges with social interaction, processing, sensory disturbances, communication, and behavior may be among the characteristics noticed by parents that would indicate the need for further evaluation.

Table 1
Some "Signs" That Indicate That a Child Should Be Screened for ASD

Domain	Signs and Symptoms Commonly Noted by Caregivers
Social Differences	• Doesn't smile when smiled at • Has poor eye contact • Seems to prefer to play alone • Gets things for themselves only • Is very independent for their age • Seems to be in their "own world"

[1] For more information about typical developmental milestones, refer to the Centers for Disease Control and Prevention website at https://www.cdc.gov/ncbddd/actearly/milestones-app.html.

	• Seems to tune people out • Is not interested in other children • Doesn't point out interesting objects by 14 months of age • Doesn't like to play "peek-a-boo" • Doesn't try to attract their parent's attention
Communication Differences	• Does not respond to their name by 12 months of age • Cannot explain what they want • Doesn't follow directions • Seems to hear sometimes but not other times • Doesn't point or wave "bye-bye" • Used to say a few words or babble, but now does not
Behavioral Differences	• Gets "stuck" doing the same things over and over and can't move on to other things • Shows unusual attachments to toys, objects, or routines (for example, always holding a string or having to put on socks before pants) • Spends a lot of time lining things up or putting things in a certain order • Repeats words or phrases over and over

Source: National Institutes of Health, https://www.nichd.nih.gov/health/topics/autism/conditioninfo/symptoms.

The American Academy of Pediatrics (AAP) recommends that all children be screened for ASD during regular well-child doctor visits at 18 and 24 months, but additional screenings may occur if symptoms are detected prior to 18 months or if the child is at high-risk (e.g., has a sibling with ASD). A diagnosis may be made by an individual clinician or, more preferably, by a multi-disciplinary team that may include a developmental pediatrician, a neurologist, a neuropsychologist, a speech/language therapist, a learning consultant, an occupational therapist, and/or other knowledgeable professionals.

Co-Occurring Disorders and Conditions

Approximately 70 percent of individuals with ASD may have at least one co-occurring mental disorder, and 40 percent may have two or more co-occurring disorders. Unfortunately, it is frequently assumed that behaviors associated with co-occurring mental health disorders are related to the ASD diagnosis. The assumption that all behaviors are related to ASD can leave underlying mental health concerns untreated and exacerbate symptoms. For this reason, accurate, reliable diagnosis of co-occurring mental health disorders is critical.

Table 2
Disorders and Conditions that Commonly Co-Occur with ASD

Category	Co-occurring Disorder or Condition
Neurodevelopmental disorders	• Intellectual Disability • Language Disorder • Attention-Deficit/Hyperactivity Disorder (ADHD) • Motor Disorders

	• Stereotypies (repetitive or ritualistic movements, postures, or utterances) and tics
Psychological disorders	• Obsessive-Compulsive and Related Disorders (OCRD) • Anxiety Disorders (including social phobia and specific fears or phobias) • Depressive Disorders • Trauma- and Stressor-Related Disorders
Medical conditions	• Epilepsy • Sleep Disorders • Constipation or other digestive disorders • Immune/metabolic conditions
Other conditions	• Self-injury • Aggression • Extreme and limited food preferences

Causes and Risk Factors

Although the causes of ASD are not yet known, it has been established that ASD is not caused by any psychological factors. The high recurrence risk for ASD in siblings and identical twins has provided strong support for the importance of genetic factors. In recent years, there has been a focus on searching for environmental and biological causal factors. A variety of risk factors, such as advanced parental age, low birth weight, or fetal exposure to valproate (an anticonvulsant and mood stabilizer used to treat seizures and bipolar disorder and to help prevent migraine headaches), may contribute to the risk of ASD. Pre- and peri-natal maternal infections and birth complications associated with ASD have also been reported.

There have been concerns among caregivers on a possible association between childhood immunizations and ASD. However, numerous scientific studies have shown that vaccines do not cause or contribute to the development of ASD.

GENERAL PRINCIPLES FOR INTERVENTION

Serving a child with ASD is determined by the child's individual needs. In order to improve outcomes for youth with ASD, lessen challenging behavior, and provide the child with maximum independence, a combination of three principles is required: early intervention, a family-centered approach, and educational intervention.

Early Intervention

Evidence from various diagnosis and intervention research suggests that early detection of ASD is key to improving developmental outcomes. Early detection leads to early intervention, and for youth with ASD, early

participation in specialized intervention programs can optimize long-term outcomes. Evidence has shown that both younger age and more intervention hours are associated with positive developmental outcomes.

Family Centered Approach

A multi-disciplinary and family focused approach, in which the service providers and the parents work in a collaborative manner to develop appropriate interventions for the child, is considered the most effective method of service delivery for children with ASD and their families. A family centered approach employs the expertise of the family regarding the strengths and needs of the child.

Educational Intervention

Children with ASD often have behavioral and communication challenges that interfere with learning. Therefore, many benefit from an Individualized Education Program (IEP), as provided for under Part B of the Individuals with Disabilities Education Act (IDEA). Children with a disability from birth through age three are also eligible for early intervention services under Part C of IDEA. In Virginia, parents with children between ages two and three can choose for their child to stay in Part C, early intervention services, or transition to Part B special education services.

Infant/toddler services under Part C of IDEA can be home-based, center-based, or a combination. The nature of the services is determined based on an assessment of the child and the family's priorities. The services provided in response to this plan may include the identification of appropriate assistive technology, intervention for sensory impairments, family counseling, parent training, health services, language services, health intervention, occupational therapy, physical therapy, case management, and transportation to services.

In Virginia, the Department of Behavioral Health and Developmental Services (DBHDS) is the lead agency that administers Part C of IDEA. Virginia's statewide early intervention system is called the Infant & Toddler Connection of Virginia. In Virginia, children from birth to age three are eligible for Part C services:

- If they have a 25 percent developmental delay in one or more areas of development
- If they have atypical development or
- If they are diagnosed with a physical or mental condition that has a high probability of resulting in a developmental delay

Once the child reaches the age of two, special education programs established by Part B of IDEA are available to eligible children. An IEP is developed based on team evaluation and parental input. This plan provides for academic, communication, social, and other learning objectives for the child to obtain within the school year. Extended year services may be available to students who require year-round services to prevent skill regression. Students with disabilities, including ASD, are required to be educated in the least restrictive environment, which often is in the general education classroom with appropriate supports. However, there is a continuum of placements that also includes special classes, special schools, home instruction, and instruction in hospitals and institutions.

VIRGINIA'S MEDICAID HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS

In Virginia, individuals with ASD may be eligible to receive services via Medicaid HCBS waivers. Medicaid HCBS waivers provide opportunities for individuals eligible for an institutional level of care to receive services in their own home or community rather than in an institutional setting. Eligible individuals are screened for the waiver by their local Community Services Board or Behavioral Health Authority. If the child is found eligible for the waiver, the parent would "waive" the child's right to receive services in an institution and choose instead to receive services in the community. Virginia's four HCBS waiver programs are described in Table 3. More information about Virginia's Medicaid waivers can be found on the DBHDS website.

Table 3
Medicaid Waiver Program in Virginia

Waiver		Description
Developmental Disability (DD) Waivers		
	Community Living Waiver (formerly ID Waiver)	Includes residential supports and a full array of medical, behavioral, and non-medical supports; available to adults and children; may include 24/7 supports for individuals with complex medical and/or behavioral support needs through licensed services.
	Family & Individual Supports Waiver (formerly DD Waiver)	Provides supports for individuals living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs; available to both children and adults.
	Building Independence Waiver (formerly Day Support Waiver)	Supports adults (18+) to live independently in the community; individuals own, lease, or control their own living arrangements and supports are complemented by nonwaiver-funded rent subsidies.
CCC Plus Waiver (formerly EDCD Waiver/Tech Waiver) Is transitioning to Cardinal Care		CCC Plus is a new statewide Medicaid managed care program. The CCC Plus Waiver is the community alternative to a nursing facility placement. Individuals on a DD Waiver receive their acute and primary care medical services through CCC Plus. CCC Plus Waiver service may be used while on a wait list for a DD Waiver.

Source: Virginia Department of Behavioral Health and Developmental Services.

ABOUT EVIDENCE-BASED INTERVENTIONS

There are two important resources that detail evidence-based practices and resources for children and adolescents diagnosed with ASD. Both initiatives were undertaken to provide information to clinicians, family members, and others because treatments for ASD are diverse and interventions with no scientific evidence were being recommended for children and adolescents with ASD. The consistent theme that emerges from both projects is the importance of selecting interventions that are sufficient in their intensity and that are individualized to meet the needs of the child and the family.

The National Professional Development Center on Autism Spectrum Disorders (NPDC) conducted an extensive review of the autism intervention literature published between 1997 and 2007 and identified evidence-based practices for children and youth with ASD.[2] The project utilized strict criteria relating to evidence-based practices. In 2014, the NPDC released findings from a follow-up review of studies from 1990-2011 and identified 27 practices that meet the criteria for evidence-based practice. The NPDC is currently developing online modules for each of the 27 identified practices.

The National Autism Center's National Standards Project has published two reports that detail evidence-based interventions for ASD based on behavioral and educational studies.[3] The second phase of the Project was launched in 2011 in order to provide up-to-date information on the effectiveness of a broad range of interventions for ASD. The Phase 2 findings were published in 2015 and identified 14 interventions for children and adolescents that have sufficient evidence of effectiveness.

Analysis of both resources conducted by the California Autism Professional Training and Information Network (CAPTAIN) has noted very little difference between the reviews conducted by these two initiatives. The NPDC lists interventions separately, whereas the National Standards Project discusses treatments as intervention strategies, or classes, that are clustered into packages. There is considerable overlap between the NPDC and the National Standards Project, with a majority of the interventions being included in both resources.

EVIDENCE-BASED INTERVENTIONS

The interventions outlined in the following paragraphs have been identified as established interventions (evidence-based) by the National Autism Center's National Standards Project, with the exception of Learning Experience: an Alternative Program. A summary of all interventions noted by the project is provided in Table 4. Please see the *Collection, 6th Edition* for more information about interventions listed under the "What Seems to Work" and "Not Adequately Tested" headings.

With many evidence-based interventions to choose from, it is important to select the most appropriate practice. Before beginning any new practice or intervention with a learner, parents/guardians should follow four general planning steps: identify the behavior, establish an observable goal, identify potential interventions based on research, and choose based on individual and family characteristics.

Behavioral Approaches:

Applied Behavioral Analysis (ABA)

Also known as *early intensive behavioral intervention* and *comprehensive behavioral treatment for young children*, applied behavioral analysis is a type of behavioral intervention that uses principles of learning theory to bring about meaningful and positive change in behavior. ABA techniques have been used to help build a variety

[2] NPDC evidence-based practices for children and youth with ASD are available at https://autismpdc.fpg.unc.edu/evidence-based-practices.
[3] National Autism Center's National Standards Project reports are available at http://www.autismdiagnostics.com/assets/Resources/NSP2.pdf.

of skills (e.g., communication, social skills, self-control, and self-monitoring) and help generalize these skills to other situations. These techniques can be used in structured (e.g., classroom), everyday (e.g., family dinnertime), and one-on-one or group instruction settings. ABA has also been used for individuals with ASD who also have an intellectual disability. Intervention is customized based on the individual's needs, interests, and family situation. ABA techniques are often used in intensive, early intervention (before age four) programs to address a full range of life skills.

A. Discrete Trial Teaching or Training (DTT)

DTT is just one example of a behavioral intervention that focuses on the principles of operant learning. In DTT, children learn appropriate responses to the presence of specific words and environmental stimuli. DTT involves using a basic process to teach a new skill or behavior and repeating it. Tasks are broken down into small components. DTT may also be called the ABC model, whereby every trial or task given to the child to perform consists of an antecedent (directive or request to the child to perform an action), behavior (response from the child), and consequence (reaction from therapist). Timing and pacing of teaching sessions, practice opportunities, and consequence delivery are designed precisely for each child's learning pace and style to help ensure success.

B. Pivotal Response Training (PRT)

PRT focuses on targeting pivotal behaviors related to motivation to engage in social communication, self-initiation, self-management, and responsiveness to multiple cues. Key to the delivery of PRT is parent involvement and implementation in the natural environment such as the home, community, and school setting. PRT is based on the theory that if improvements in functioning can be achieved in the areas that are most disabling to children (i.e., pivotal areas), then effects should extend to other areas. PRT is now considered one of the more effective and proven interventions for children with ASD.

Positive Behavioral Interventions

Positive behavioral interventions are the most effective type of intervention for children and adolescents with ASD. They are designed to provide alternatives to unwanted behaviors by first analyzing the cause of the behavior and how it is being reinforced, and then either modifying a triggering factor in the environment before a behavior occurs (antecedent interventions) or modifying a factor in the environment after a behavior occurs (consequent interventions). Antecedent interventions attempt to increase the likelihood of success or reduce the likelihood of problems occurring. Consequent interventions are designed to reduce challenging behavior and teach functional alternative skills through the application of basic principles of behavior change. Behavior intervention techniques are most effective if applied across multiple settings to promote generalization of skills.

Functional communication training (e.g., learning how to request breaks), noncontingent reinforcement (e.g., reinforcement delivered on a fixed time schedule), and extinction are types of positive behavioral interventions that can be used to reduce challenging behaviors (e.g., aggression, self-injury, task-avoidance) and to promote positive behaviors. Other examples of some simple behavioral interventions include:

- Setting boundaries

- Positive reinforcement of desired behaviors
- Activity schedules
- Task correspondence training

In order to effect an appropriate intervention, a functional behavioral assessment should be performed to determine when and why the behavior is occurring. Once this is determined, a positive behavioral intervention plan can be developed and implemented.

Modeling

The goal of modeling is to correctly demonstrate a target behavior to encourage imitation. Children can learn a great deal from observing the behavior of parents, siblings, peers, and teachers, but they often need to be taught which behaviors should be imitated. There are two types of modeling: live and video modeling. Live modeling occurs when a person demonstrates the target behavior in the presence of the child. Video modeling occurs when the target behavior is pre-recorded. Video modeling can be a great option for children and adolescents who have an affinity for television shows and movies, or who have an interest in seeing themselves on a monitor. Some children and adolescents may enjoy assisting in the production of the video.

Story-based Intervention

Story-based interventions identify a target behavior and involve a written description of the situations under which specific behaviors are expected to occur. Most stories aim to increase perspective taking skills and are written from an "I" or "some people" perspective. Stories can include pictures, words, and videos and should be used in addition to other treatments. One most well-known story-based intervention is Social Stories. Effective social stories are written from a positive standpoint and avoid using negatives. For example, to change a behavior, the story might state, "I will do ____ when I get home." It would not say, "I won't do ____ when I get home."

Self-Management

Self-management strategies have been widely used to promote independence with tasks in which adult supervision is not needed, accepted, or expected. Youth often evaluate and record their performance while completing an activity. Self-management is also used to help these individuals monitor social behaviors and disruptive behaviors and can involve rewards to reinforce positive behavior.

Psychological Approach:

Cognitive Behavioral Intervention Package

Cognitive behavioral therapy has long been an evidence-based intervention for individuals diagnosed with anxiety disorders and depressive disorders (i.e., without ASD). Some of these programs have been modified for youth and adolescents with ASD, such as The Coping Cat Program and Exploring Feelings. Modifications include adjusting materials (e.g., adding visual cues, role-play) or adjusting the structure of sessions. There are also cognitive behavioral programs developed and individualized for specific purposes (e.g., to address anger management).

Developmental Approaches:

Language Training

Language training (production) targets the ability of the individual with ASD to communicate verbally (i.e., functional use of spoken words). It makes use of various strategies to elicit verbal communication such as modeling verbalizations and using music and positive reinforcement. Language training is just one of many interventions that can be used in combination to help children with ASD develop effective communication strategies. Other frequently used interventions are listed in the "What Seems to Work" section of Table 4.

Scripting

Scripting occurs when a youth with ASD is provided guidance on how to use language to initiate or respond in certain situations. These interventions involve developing an oral and/or written script about a specific skill or situation that serves as a model for the child. Scripts are usually practiced repeatedly before the skill is used in the actual situation.

Educational Approaches:

Naturalistic Teaching Strategies (NTS)

NTS are a compilation of strategies that are used to teach children skills in their homes, schools, and communities. The basic concepts include using materials in the environment and naturally occurring activities as opportunities to increase adaptive skills. These strategies are primarily child-directed.

Peer Training Package

Difficulty interacting appropriately with peers is a commonly reported characteristic of ASD, and children with ASD often rely on adults for prompting and guidance. Peer training packages train peers on how to initiate and respond during social interactions with a child with ASD. Peer tutors can not only provide support to learners with disabilities, but also strengthen their own skills and knowledge in the process. These programs have been used in school and community settings.

Learning Experience: An Alternative Program (LEAP)

LEAP is an example of a peer-based educational program that embraces the educational and therapeutic value of peer-mediated interventions. It provides classroom instruction, parent education (as needed), and the provision of speech and occupational therapy and other services within the classroom. The range of activities varies from quiet to active and from small group to larger group. Activities are child directed, where youths are actively involved in the curriculum as intervention agents.

Schedules

Schedules can be used for children with ASD to increase their independence and allow them to plan for upcoming activities. A schedule simply identifies the activities that must be completed during a given time period and the order in which these activities should be completed. Schedules can be written, pictorial, or a combination. Children with ASD may better handle transitions when they can predict what will happen next.

Social-Relational Approaches:

Social Skills Package

Social skills refer to a wide range of abilities, such as making eye contact appropriately, using gestures, reciprocating information, and initiating or ending an interaction. The challenges individuals with ASD face regarding social skills vary greatly. The general goal of any social skills package intervention is to provide individuals with the skills necessary to participate meaningfully in social environments.

Parent Training Package

Parent training focuses on the interventions in which parents act as therapists or receive training to implement various strategies. This intervention acknowledges the critical role that parents and caregivers play in providing a therapeutic environment for their family members with ASD.

Pharmacological Treatment:

While no drug therapies currently target the underlying causes or core manifestations of autism, pharmaceutical treatments can ameliorate some of the behavioral symptoms. The FDA has approved two medications for alleviation of symptoms for youth and adolescent with ASD. The first, risperidone, targets aggressive behavior, deliberate self-injury, and temper tantrums. The second, aripiprazole, treats irritability. There are risks of side effects. Medications should be prescribed and monitored by a physician. Medication is most effective in combination with other therapies.

Table 4
Summary of Interventions for ASD[4]

What Works	
Applied behavior analysis (ABA)	Uses principles of learning theory to bring about meaningful and positive change in behavior, build a variety of skills (e.g., communication, social skills, self-control, and self-monitoring), and help generalize these skills to other situations; also known as early intensive behavioral intervention and comprehensive behavioral treatment for young children (CBTYC).
Discrete trial teaching or training (DTT)	A behavioral intervention that uses operant learning techniques to change behavior. Also known as the ABC model (antecedent, behavior, consequence).
Pivotal response training (PRT)	Involves targeting pivotal behaviors related to motivation to engage in social communication, self-initiation, self-management, and responsiveness to multiple cues.
Positive behavioral interventions	Behavioral interventions analyze the cause of a negative behavior and how it is being reinforced, and then offer techniques targeted to promoting positive behaviors.
Modeling	Involves demonstrating a target behavior to encourage imitation.
Story-based intervention	Uses stories to increase perspective-taking skills.
Self-management	Strategies that involve teaching youth to track performance while completing an activity.
Cognitive behavioral intervention package	CBT modified for ASD youth.
Language training	Targets the ability to communicate verbally.
Scripting	Provides scripted language to be used as a model in specific situations.
Naturalistic teaching strategies (NTS)	Child-directed strategies that use naturally occurring activities to increase adaptive skills.
Peer training package	Involves training peers on how to behave during social interactions with a youth with ASD.
Schedules	Used to increase independence in youth with ASD.
Learning experience: An alternative program (LEAP)	A type of peer training program for peers, teachers, parents, and others.
Social skills package	Aims to provide youth with the skills (such as making eye contact appropriately) necessary to participate in social environments.

[4] Interventions are taken from the National Autism Center's National Standards Project. More information can be found at: http://www.autismdiagnostics.com/assets/Resources/NSP2.pdf.

Parent training package	Involves training parents to act as therapists.
What Seems to Work	
Augmentative and alternative communication devices	Communication systems designed to complement speech (pictures, symbols, communication boards, or other assistive technology, like tablets, text-to-speech programs, 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 and help with social, communication, and motor skills. The value of exercise is not that stereotypic behaviors stop, but that stress, dysregulation, or feelings of being overwhelmed decrease as a result of physical activity.
Exposure package	Involves gradually exposing youth to the non-dangerous situations that they fear, with a focus on having them learn that their anxiety will decrease over time; at the same time, the use of maladaptive strategies used in the past is prevented.
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; promotes a “back-and forth” dynamic and the use of spontaneous language/vocalizations.
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	Uses deep tissue stimulation to induce physiological reactions in the body that have preventive, therapeutic, and relaxing effects.
Medication	Risperidone and aripiprazole are FDA-approved to target behavioral symptoms of ASD like aggression, self-injury, and irritability.
Multi-component package	Involves a combination of multiple treatment procedures that are derived from different fields of interest or different theoretical orientations.
Music therapy	Uses music to practice communication and social skills or behavioral goals.
Picture exchange communication system	Involves an alternative communication system designed to teach functional communication to youth with limited skills.
Reductive package	Relies on strategies designed to reduce problem behaviors without increasing alternative appropriate behaviors.

What Seems to Work (continued)	
Sign language instruction	Teaches sign language as a means of communicating.
Social communication intervention	Targets some combination of social communication impairments.
Structured teaching	Relies heavily on the visual organization, predictable schedules, and individualized use of teaching methods; can be used in educational, community, and home settings.
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/Floortime • Gluten-free and/or casein-free diet	• Movement-based intervention • SENSE theatre intervention • Sensory intervention package • Social-behavioral learning strategy • Social cognition intervention • Social thinking intervention
What Does Not Work	
Facilitated communication	A person with a disability is assisted by a facilitator in typing letters, words, phrases, or sentences on a keyboard.

RESOURCES AND ORGANIZATIONS

American Academy of Pediatrics
http://www.aap.org

American Speech-Language-Hearing Association
Autism Spectrum Disorder
https://www.asha.org/Practice-Portal/Clinical-Topics/Autism/

Autism Focused Intervention Resources and Modules (AFIRM)
http://afirm.fpg.unc.edu/selecting-ebp

Asperger/Autism Syndrome Education Network (ASPEN)
http://www.aspennj.org

Association of University Centers on Disabilities (AUCD)
http://www.aucd.org

Autism Research Institute (ARI)
https://www.autism.org/

Autism Society of America
http://www.autism-society.org/

Autism Speaks
http://www.autismspeaks.org

Autism Spectrum Connection
http://www.aspergersyndrome.org/

Centers for Disease Control and Prevention
Autism Spectrum Disorder (ASD)
http://www.cdc.gov/ncbddd/autism/index.html
Signs and symptoms
https://www.cdc.gov/autism/signs-symptoms/index.html
Developmental milestone information
https://www.cdc.gov/act-early/milestones/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Center for Parent Information and Resources
http://www.parentcenterhub.org/

Individuals with Disabilities Education Act (IDEA)
https://sites.ed.gov/idea/

National Autism Center
https://nationalautismcenter.org

National Standards Project
http://www.autismdiagnostics.com/assets/Resources/NSP2.pdf

National Association of the Dually Diagnosed (NADD)
http://thenadd.org/

National Institute of Child Health and Human Development
https://www.nichd.nih.gov/Pages/index.aspx

National Institute of Mental Health (NIMH)
Autism Spectrum Disorder
https://www.cdc.gov/act-early/milestones/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/actearly/milestones/index.html

National Institute on Deafness and Other Communication Disorders
http://www.nidcd.nih.gov

National Library of Medicine
https://www.nlm.nih.gov

National Professional Development Center on Autism Spectrum Disorder
http://autismpdc.fpg.unc.edu/
Evidence-based practices
https://autismpdc.fpg.unc.edu/ebps/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

U.S. Autism Association
http://www.usautism.org

U.S. Department of Education
U.S. Office of Special Education and Rehabilitative Services (OSERS)
https://www2.ed.gov/about/offices/list/osers/index.html

U.S. Department of Health and Human Services
Interagency Autism Coordinating Committee (IACC)
https://iacc.hhs.gov/

Wrightslaw
http://www.wrightslaw.com/

VIRGINIA RESOURCES AND ORGANIZATIONS

Autism Outreach, Inc.
http://autismoutreach.org/

Autism Society of America
Central Virginia Chapter
http://ascv.org

Commonwealth Autism
http://www.autismva.org/

Infant & Toddler Connection of Virginia
https://www.itcva.online/

Parent Educational Advocacy Training Center (PEATC)
http://www.peatc.org/

Partnership for People with Disabilities at Virginia Commonwealth University
https://partnership.vcu.edu/

Virginia Autism Council at Virginia Commonwealth University
https://autismtrainingva.vcu.edu/

Virginia Autism Project
http://www.virginiaautismproject.com/

Virginia Autism Center for Education
https://vcuautismcenter.org

Virginia Board for People with Disabilities
https://www.vbpd.virginia.gov/

Virginia Commonwealth University Autism Center for Excellence (VCU-ACE)
http://www.vcuautismcenter.org/projects/diagnosis.cfm

Virginia Department for Aging and Rehabilitative Services (DARS)
https://www.dars.virginia.gov/drs/autismservices.htm#gsc.tab=0

Virginia Department of Behavioral Health and Developmental Services (DBHDS)
http://www.dbhds.virginia.gov/

Virginia Department of Education
Office of Special Education
https://www.doe.virginia.gov/programs-services/special-education

Publications:
Autism Spectrum Disorders
https://www.doe.virginia.gov/programs-services/special-education/specific-disabilities/autism
Autism Spectrum Disorders and the Transition to Adulthood
https://www.doe.virginia.gov/home/showpublisheddocument/7946/638010947358970000
Guidelines for Educating Students with Autism Spectrum Disorders
https://www.doe.virginia.gov/home/showpublisheddocument/7942/638010930376470000
Models of Best Practice in the Education of Students with Autism Spectrum Disorders
https://www.doe.virginia.gov/home/showpublisheddocument/7944/638010947355330000

Virginia Department of Medical Assistance Services (DMAS)
https://www.dmas.virginia.gov/
Cardinal Care Virginia Medicaid Program
https://www.dmas.virginia.gov/for-providers/cardinal-care-transition/

Virginia Institute of Autism
http://www.viaschool.org

Virginia Tech Autism Clinic & Center for Autism Research
https://www.vtcar.science.vt.edu/

Virginia's Training/Technical Assistance Centers (TTAC)
http://ttaconline.org/

ATTENTION–DEFICIT/ HYPERACTIVITY DISORDER

KEY POINTS

- **Characterized by problems with attention, impulsivity, and/or hyperactivity.**
- **Symptoms can lead to peer rejection and academic struggles, which can cause long-term issues.**
- **Proper diagnosis is critical because some medical and mental health disorders, including post-traumatic stress disorder, have similar symptoms.**
- **A combination of behavioral and pharmacological treatments has the most evidence-based support.**

OVERVIEW

All children sometimes show inattention, distractibility, impulsivity, or hyperactivity, but children with ADHD show severe and frequent symptoms that interfere with healthy functioning. If symptoms are not managed, children with ADHD frequently experience peer rejection, academic struggles, and social and behavioral difficulties, all of which can have long-term effects.

ADHD is classified as a chronic, neurodevelopmental disorder that emerges during childhood. The majority of children with ADHD do not outgrow the disorder, although they may experience some reduction in symptoms, particularly of hyperactivity and impulsivity, by adolescence or adulthood.

ADHD is classified as falling into one of the three subcategories listed below. Each of these subcategories can be classified as mild, moderate, or severe based on the number of symptoms present.

1. Predominantly hyperactive-impulsive presentation
2. Predominantly inattentive presentation
3. Combined presentation

Table 1 outlines common symptoms of ADHD. Several of the symptoms must have been present before the age of 12, must be present in two or more settings, and must interfere with quality of life.

Before diagnosing a child with ADHD, the clinician should rule out other potential reasons for the child's behavior. For instance, behaviors that mimic ADHD may be the result of trauma or post-traumatic stress disorder, a sudden change in the child's life, undetected seizures, a middle ear infection causing hearing problems, medical disorders affecting brain functioning, a specific learning disorder, communication disorders, anxiety, or depression. In addition, children with high energy levels, who are immature when compared to their peers, or who have been deemed "difficult" by parents or teachers can also be misdiagnosed with ADHD.

Getting a proper diagnosis is critical because many disorders and behaviors can be mistaken for ADHD. Qualified mental health professionals are the only individuals with the ability to properly diagnose and treat this disorder (and all mental health conditions). Qualified mental health professionals include child psychiatrists, psychologists, developmental/behavioral pediatricians, behavioral neurologists and, in some cases, clinical social workers, nurse practitioners, and licensed professional counselors.

Table 1
Common Signs and Symptoms of ADHD

Symptoms of Inattention	Symptoms of Hyperactivity and Impulsivity
• Trouble paying attention • Inattention to details and making careless mistakes • Easily distracted • Losing school supplies; forgetting to turn in homework • Trouble finishing class work and homework • Trouble listening • Trouble following more than one instruction at a time	• Blurts out answers • Is impatient or easily frustrated • Fidgets or squirms • Frequently leaves seat, runs about, or climbs excessively • Seems "on the go" or "driven by a motor" • Talks too much and has difficulty playing quietly • Interrupts or intrudes on others

In addition, co-occurring conditions and disorders can accompany ADHD and should be assessed during an evaluation for ADHD. The presence of a co-occurring disorder will influence treatment planning, especially pharmacological interventions.

CAUSES AND RISK FACTORS

Mounting evidence has demonstrated a neurological and a genetic basis for ADHD. A child diagnosed with ADHD is more likely than one without ADHD to have family members with the disorder. The heritability of ADHD averages approximately 80 percent, rivaling the heritability factor for the trait of height.[1] In fact, according to the National Institutes of Health (NIH) one-third of fathers who have or had ADHD will have children who will be diagnosed with ADHD.

ADHD has also been linked to certain environmental factors. A study of children with ADHD showed that most of ADHD development is genetically driven, but in certain cases, ADHD may also result from, or be exacerbated by, very early adverse childhood experiences. Children who have experienced negative experiences early in life are diagnosed sooner than those with only genetic connections. In these cases, the associated impulsivity and inattention is more severe, while the hyperactivity is less severe than in those children without negative experiences.[2]

[1] Barkley, R. (2007). Defiant children: A clinician's manual for assessment and parent training (2nd ed.). New York, NY: Guilford.
[2] Webb, E. (2013). Poverty, maltreatment, and attention deficit hyperactivity disorder. *Archives of Diseases in Childhood, 98*(6), 397-400.

EVIDENCE-BASED TREATMENTS

ADHD is a chronic disorder; therefore, management of symptoms and reduction of impairment is the goal of treatment. Treatment must be provided over long periods to assist those with ADHD in the ongoing management of their disorder. Current research suggests that a combination of behavioral and pharmacological treatments is the most effective. Treatments are summarized in Table 2.

Effective intervention also includes developing and utilizing appropriate educational supports. For this reason, it is important that parents advocate for their children in academic settings. Children with ADHD may be eligible for special educational services in the public schools through the Other Health Impairment classification under the Individuals with Disabilities in Education Act (IDEA), which governs special education requirements, and Section 504 of the Rehabilitation Act of 1973, which provides for reasonable accommodations for children with disabilities. Examples of Section 504 accommodations include:

- Reducing the number of homework problems without reducing level or content of material
- Providing students with a quiet place to take exams or study
- Providing students with additional time on exams
- Providing the student with access to counseling services

Psychological Treatments

Behavior therapy is the psychological treatment of choice for ADHD. Behavior therapy uses contingency management strategies that employ reward systems. These systems are designed to provide reinforcements to increase desired behaviors, including following directions, attentiveness, or turn-taking. Reward systems can take many forms, including, but not limited to, points, stickers, poker chips, or other tokens that can be traded for small prizes or special privileges. These strategies can also remove a reinforcer when undesirable behavior occurs in order to reduce that behavior.

Behavioral intervention systems can be put in place both in the classroom and at home. Through behavior management, parents, guardians, and other adults should focus on positive behaviors and seek to find the youth behaving properly as much as possible (e.g., aiming for feedback on three positive behaviors to every one misbehavior). A focus on positive behaviors is a more effective way to support short and long-term growth than a focus on problem behaviors.

Pharmacological Treatments

Stimulant medications are most frequently prescribed for the treatment of ADHD. Studies have found a significant majority of children with ADHD derive benefits from these medications and that they are effective at reducing ADHD symptoms in the short-term.

Two frequently prescribed stimulant medications for ADHD are methylphenidate (e.g., Ritalin or Concerta) and amphetamines (e.g., Adderall). The tolerability and safety of stimulant medications are comparable, with all medications demonstrating similar side effects, including effects on cardiovascular functioning, sleep disturbance, appetite suppression, and anxiety. The American Academy of Child & Adolescent Psychiatry has a

detailed guide for ADHD medication and monitoring side effects. There is also a potential for abuse of stimulant medications due to their effects on the brain. As a result, methylphenidate and dexamphetamine are listed as Schedule II drugs with the U.S. Food and Drug Administration (FDA), and public schools may not require any student to take these medications.

The FDA has also approved atomoxetine, a medication for treating ADHD that is not a stimulant and does not carry the same risk of addiction. The side effects of atomoxetine are similar to those of stimulant medications, but are milder.

Table 2
Summary of Treatments and Interventions for 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: Focalin, Methylin, Ritalin; Intermediate-acting: Metadate ER, Methylin ER, Ritalin SR, Metadate CD, Ritalin LA; Long-acting: Concerta, Daytrana patch, Focalin XR
Non-stimulant: Serotonin and norepinephrine reuptake inhibitor (SNRI)- atomoxetine	SNRIs do not carry the same risk for addiction as some other medications.
Non-stimulant: Alpha-agonists: guanfacine and clonidine	Can be an alternative for children who do not tolerate stimulants well; both are available in short and long-acting forms.
What Seems to Work	
Non-stimulant: Serotonin and norepinephrine reuptake inhibitor (SNRI)- viloxazine	FDA-approved in April 2021 for ADHD in youth ages 6 to 17.
Not Adequately Tested	
Dietary interventions	Interventions include elimination of food additives, elimination of allergens/sensitivities, and use of nutritional supplements. Best viewed as a potential complementary intervention.

Interactive metronome training	Involves synchronizing of hand and foot exercises to audible tones.
Neurofeedback	Involves monitoring brain waves and rewarding focused attention through computerized games and exercises.
Antidepressants	These include bupropion (Wellbutrin), imipramine (Tofranil), nortriptyline (Pamelor, Aventil).
What Does Not Work	
Some cognitive, psychodynamic, and client-centered therapies	Some talk therapies and some forms of 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 environment.
Office-based social skills training	Once-weekly, office-based training, either one-on-one or in a group setting, has not led to significant improvement in social skills. However, intensive group social skills training that uses behavioral interventions is considered well-established.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)
ADHD Resource Center
http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/ADHD_Resource_Center/Home.aspx
ADHD Parents' Medication Guide
https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/ADHD_Medication_Guide-web.pdf

American Psychiatric Association (APA)
https://www.psychiatry.org/patients-families/adhd/what-is-adhd

Attention Deficit Disorders Association – Southern Region
http://www.adda-sr.org/

Centers for Disease Control and Prevention (CDC)
Attention-Deficit/Hyperactivity Disorder
https://www.cdc.gov/ncbddd/adhd/

Children and Adults with Attention Deficit Disorders (CHADD)
http://www.chadd.org/

National Institute of Mental Health (NIMH)
Attention-Deficit/Hyperactivity Disorder
https://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd
Attention-Deficit/Hyperactivity Disorder in Children and Teens
https://www.nimh.nih.gov/health/publications/attention-deficit-hyperactivity-disorder-in-children-and-teens-what-you-need-to-know

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

U.S. Department of Education
Identifying and Treating Attention Deficit Hyperactivity Disorder: A Resource for School and Home
https://files.eric.ed.gov/fulltext/ED502959.pdf

US Department of Health and Human Services
Centers for Medicare and Medicaid Services
https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Pharmacy-Education-Materials/Downloads/stim-pediatric-factsheet11-14.pdf

VIRGINIA RESOURCES AND ORGANIZATIONS

Children and Adults with Attention Deficit Disorders (CHADD)

http://www.chadd.org/

Northern Virginia CHADD

24-Hour Information Line - 703-641-5451

chaddofnorthernviginia@gmail.com

CHADD of Tidewater

866-633-4871 (Toll free)

CHADD Shenandoah Valley Satellite

540-241-4754

Hampton Roads Satellite of CHADD

https://www.chadd.net/chapter/435

hamptons-CHADD@chadd.org

Parent Educational Advocacy Training Center

www.peatc.org

Virginia Department of Education

Attention-Deficit/Hyperactivity Disorder

https://www.doe.virginia.gov/programs-services/special-education/specific-disabilities/other-health-impairment/some-specific-conditions

Virginia Department of Health

Publication:

Guidelines for Healthcare Procedures in Schools (Page 405, ADHD)

https://www.vdh.virginia.gov/content/uploads/sites/58/2016/12/VDH-Guidelines-for-Healthcare-Procedures-in-Schools_2017.pdf

Virginia Tech

Child Study Center

http://childstudycenter.wixsite.com/childstudycenter

Psychological Services Center

https://support.psyc.vt.edu/centers/psc

MOTOR DISORDERS

Developmental Coordination Disorder
Stereotypic Movement Disorder
Tic Disorders

OVERVIEW

Motor disorders begin early in the developmental years and involve problems with movement. Children with motor disorders may be substantially delayed in reaching motor milestones (such as navigating stairs or tying shoes); they may make repetitive and driven movements (such as rocking); or they may have physical or verbal tics. As with other disorders, these behaviors cause impairment and result in negative physical and/or social consequences.

The three main categories of motor disorders are developmental coordination disorder, stereotypic movement disorder, and tic disorders (see Table 1). Because each category has different treatments, each will be discussed in its own section of this chapter.

Table 1
Motor Disorders Affecting Children & Adolescents

Disorder	Description
Developmental coordination disorder	Coordinated motor skills, both developing and executing, are substantially below expectations based on age and education. Symptoms include clumsiness and slow and inaccurate motor skills. Onset is early in development.
Stereotypic movement disorder	Includes repetitive, driven, and purposeless motor behavior like shaking, rocking and hitting oneself. Onset is early in development.
Tic disorders	Tics are involuntary movements, sounds, or words that are sudden, rapid, recurrent, and nonrhythmic. The 3 main kinds of tic disorders are outlined in Table 2.

Table 2
Types of Tic Disorders

Tic Disorder	Description
Tourette syndrome	Both vocal and motor tics are present for a period of more than one year, but not necessarily concurrently. The tics may wax and wane in frequency. Onset is prior to age 18.
Persistent (chronic) vocal or motor tic disorder	Single or multiple motor or verbal tics occurring multiple times daily or almost daily for more than one year. Onset before age 18. Both motor and verbal tics cannot be present for this diagnosis.
Provisional tic disorder	Single or multiple vocal and/or motor tics present for less than one year. Onset before age 18.

CAUSES AND RISK FACTORS

Underlying causes for the development of motor disorders are not well understood. However, as with many psychological disorders, the evidence suggests that numerous factors, such as genetic vulnerability, learning, and environment, may contribute to the development of these disorders.

Studies of families suggest the presence of genetic underpinnings in the development of tic disorders. For example, relatives of individuals with Tourette syndrome are 10 to 15 percent more likely to develop the syndrome and 15 to 20 percent more likely to have another tic disorder.[1] These risk levels are significantly higher than in the general population. Studies have also shown that 25 percent of youth with stereotypic motor disorder have an affected relative.[2] There is also likely to be a family history of obsessive tendencies often in the form of counting rituals.

There is reason to believe that learning factors are significant in the development and maintenance of motor disorders. In stressful situations, for example, youth can develop the urge to trigger their tics or to self-injure. After the tic or self-injury becomes habitual, all similar situations may elicit the same response. These situations may, in turn, elicit an urge to perform the habit. Youth with motor disorders report an uncomfortable urge that is satisfied by the tic or self-injury. The satisfaction or reduction of the urge may reinforce the habit and thus increase the likelihood that the youth will repeat the behavior.

Environmental factors have also been implicated in the development of motor disorders. Developmental coordination disorder may be caused by prenatal exposure to alcohol, and it is often associated with preterm births and children with a low birth weight. Stereotypic movement disorder is frequently seen in socially isolated children who tend to self-stimulate, which may progress to stereotypic movements and even repetitive self-injury. There have also been cases in which individuals who suffered from a traumatic head injury (e.g.

[1] Woods, D., Flessner, C., & Conelea, C. (2008). Habit disorders. In M. Hersen (Series Ed.), & D. Reitman (Vol. Ed.) *Handbook of psychological assessment, case conceptualization, and treatment: Vol 7. Children and adolescents* (pp. 542-570). New York: Wiley.
[2] Mills, S., & Hedderly, T. (2014). A guide to childhood motor stereotypies, tic disorders and the Tourette spectrum for the primary care practitioner. *The Ulster Medical Journal, 83*(1), 22-30.

concussion) had symptoms that mimic those seen in of stereotypic motor disorder. Movement disorders may also be a side effect of certain medication.

DEVELOPMENTAL COORDINATION DISORDER

Developmental coordination disorder presents early in development. A child with developmental coordination disorder develops and executes coordinated motor skills substantially below expectations based on the child's age and education. A child may be clumsy, or his or her motor skills may be slow, inaccurate, or both. Although onset is early in a child's life, most diagnoses normally do not occur prior to age five, when a child enters school. Problems remain in about 50 to 70 percent of children diagnosed, even after coordination improves.

KEY POINTS

- **Characterized by delays in reaching motor milestones.**
- **About half of children with this disorder also have ADHD.**
- **There are no evidence-based treatments at this time.**
- **Activity-oriented and body function-oriented treatments have the best results.**

For developmental coordination disorder, it is important to recognize that symptoms may be confused with those of other conditions. There are four criteria that must be met:

1. The child shows delays in reaching motor milestones.
2. The condition significantly interferes with activities of daily living and/or academic performance.
3. The symptoms begin early in the child's life.
4. Difficulties with motor skills are not better explained by intellectual disability, visual impairment, or brain disorders.

Young children with developmental coordination disorder may be delayed in reaching motor milestones such as climbing stairs and buttoning shirts. They may reach these milestones, but do so with awkward, slow, or imprecise movements when compared with their peers. Alternatively, older children may display slow or inaccurate movements with skills like handwriting, puzzles, model building, ball games, or self-care. Only when these slow, awkward movements interfere with performing or participating in daily activities can a developmental coordination disorder diagnosis be given. Also, the child must be assessed for any visual impairments and neurological disorders before they are diagnosed with developmental coordination disorder.

Attention-deficit/hyperactivity disorder (ADHD) is the most frequent coexisting condition in youth with developmental coordination disorder, with about 50 percent co-occurrence. Other common co-occurring disorders include autism spectrum disorder (ASD), disruptive and emotional behavior problems, speech and language disorder, and specific learning disorder, especially with reading and writing.

TREATMENTS FOR DEVELOPMENTAL COORDINATION DISORDER

There are no evidence-based practices identified for motor disorders at this time. This is, in part, because this disorder can manifest in a variety of ways, and because issues such as co-occurring conditions and associated

emotional difficulties vary from child to child. However, results have overwhelmingly shown that activity-oriented and body function-oriented interventions (such as physical and occupational therapy) have the best results. Table 3 describes treatments for developmental coordination disorder.

In general, therapies that aim to improve motor function can use a task-oriented or process-oriented approach.

- In a task-oriented approach, an observed motor challenge is identified (for instance, catching a ball), and the task is broken down into step-by-step interventions that focus on teaching and practicing the skill.
- In a process-oriented approach, the therapist focuses not on tasks (at least initially), but on how children manage their bodies and process sensory information. The assumption is that once the underlying mechanism causing the motor challenge is improved, related motor skills will also improve.

Table 3
Summary of Treatments for Developmental Coordination Disorder

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive motor intervention	Therapists design a set of exercises into steps for children to practice at home. Emotional, motivational, and cognitive aspects are emphasized, as children are taught how to plan a movement, how to execute it, and how to evaluate their success. Building self-confidence through positive reinforcement is a critical goal, as success depends upon the patient's motivation to practice outside of therapy.
Physical and occupational therapy	Tailored to a child's specific needs.

STEREOTYPIC MOVEMENT DISORDER

Stereotypic movement disorder presents early in a child's development. Symptoms include repetitive and driven motor behaviors (stereotypies), like shaking, rocking, and hitting oneself. Stereotypies frequently involve arms, hands, or the entire body. Simple stereotypic movements are often present in typically developing children under the age of three. As these children get older, they can stop repetitive motions when asked or when they choose. However, children with stereotypic movement disorder cannot stop the motions by force of will; instead, they will restrict their movements through other means such

KEY POINTS

- **Characterized by repetitive and driven motor behaviors, like rocking or hitting oneself, that the child cannot stop through force of will.**
- **Can be a symptom of another disorder.**
- **Often co-occurs with ID or ASD.**
- **Habit reversal therapy is the most effective treatment.**

as sitting on their hands or wrapping their arms in their clothing. Table 4 describes the difference between stereotypies and tics.

Table 4
Stereotypies vs. Tics

	Stereotypies	Tics
How do they manifest?	Rhythmic, prolonged, repetitive movements, such as rocking; movements are fixed, identical, and predictable.	Brief, rapid, sudden movements and/or vocalizations, such as grimacing or shouting a word; a tic is random and unpredictable.
What part of the body is involved?	Frequently involve arms, hands, or the entire body.	Frequently involve eyes, face, head, and shoulders.
In what circumstances do they occur?	Commonly occur: • When the child is engrossed in an activity. • During periods of anxiety, excitement, or fatigue.	Commonly occur during periods of anxiety, excitement, or fatigue.
Are they preceded by an urge or physical sensation?	No	Yes
How does the child feel?	Movements often appear enjoyable.	Tics are often associated with distress or discomfort.
Can they be reduced by distracting the child?	Yes (more immediately than tics)	Yes
Can they be suppressed?	Rarely; typically the child must stop the movement by other means (e.g., by sitting on hands).	Yes, temporarily; suppression usually causes distress.

There are two types of classifications for stereotypic movement disorder: “with self-injurious behavior” and “without self-injurious behavior.” Children with the classification “with self-injurious behavior” engage in movements that could be harmful to their bodies (e.g. lip biting, head banging, or eye poking). Conversely, children with the classification “without self-injurious behavior” engage in movements that are not physically harmful to themselves (e.g. body rocking, arm flapping, or head nodding).

Stereotypies are frequently a presenting symptom of intellectual disability and ASD, or may be a secondary diagnosis. Disorders such as ADHD, obsessive-compulsive disorder, tic disorders, and anxiety disorders can also co-occur with stereotypic disorder. In addition, stereotypies can be a manifestation of another disorder, such as Lesch-Nyhan syndrome, Rett syndrome, Fragile X syndrome, Cornelia de Lange syndrome, and Smith-Magenis syndrome. For these reasons, a comprehensive assessment is critical.

EVIDENCE BASED TREATMENTS FOR STEREOTYPIC MOVEMENT DISORDER

Table 5 describes treatments for stereotypic movement disorders.

Table 5
Summary of Treatments for Stereotypic Movement Disorder

What Works	
Habit reversal therapy (HRT)	Increases awareness to the feelings and context associated with the stereotypies and implements competing and inconspicuous habits in their place. HRT can be modified to include rewards, relaxation, education, self-awareness, and situational changes. It is sometimes combined with other therapies.
What Seems to Work	
Medication	Medications may be considered for moderate to severe stereotypies causing severe impairment in quality of life or when co-occurring conditions that would also benefit from the medication are present.

Habit Reversal Therapy (HRT)

HRT is the most well-studied and effective treatment for youth with motor disorders. HRT involves first teaching youth to become aware of instances of the habit, then teaching awareness of the associated environment and internal sensations (e.g., recognizing stressful situations that trigger stereotypies). Once the youth can identify feelings and situations likely to elicit the habit, he or she is taught a competing response. A competing response is a behavior that is physically incompatible with the habit and is socially inconspicuous. Supportive individuals are recruited to provide gentle reminders when the youth is engaging in the habit and praise when the competing response is implemented correctly. HRT can be modified to include other components, including rewards and relaxation training.

TIC DISORDERS

Tics are involuntary movements, sounds, or words that are sudden, rapid, recurrent, and nonrhythmic. Tics are often worse when a child is stressed, anxious, or tired. There are several kinds of tics:

- **Vocal tics** – examples include repeated throat clearing or spoken words
- **Motor tics** – examples include repeated blinking or arm movements
- **Simple tics** – a short, brief noise or movement

KEY POINTS

- **Characterized by rapid and nonrhythmic movements or vocal sounds.**
- **Can be a symptom of another disorder.**
- **Often co-occurs with obsessive-compulsive disorder or ADHD.**
- **Habit reversal therapies that target tics are the most effective treatments.**

- **Complex tics** – a vocalization, noise, or movement that appears to take effort, like a spoken word, a complex sound, or raising one's arm up over one's head

Tics vary from other childhood movement disorders in a few ways: They have varied severity, their movement characteristics change over time, the movements are temporarily suppressible, and they are associated with sensory phenomena. Table 4 describes the difference between tics and stereotypies.

The three primary tic disorders are outlined below:

- **Tourette syndrome** is the most well-known tic disorder, largely because of its depictions in movies and television shows, but it is relatively uncommon. Symptoms of Tourette syndrome must be present before age 18, and both vocal and motor tics must be present. The tics may vary over time and must persist for over one year since the onset of the original symptoms. Age of onset can be anywhere between the ages of two and 18, with the most severe tics occurring between the ages of 10 and 12. Less than one half of people who have Tourette's syndrome as children have moderate to severe tics as adults.

- **Persistent (chronic) motor or vocal tic disorder** involves one or more motor or vocal tics but cannot include both. If both motor and vocal tics occur, the child should be screened for Tourette disorder. The tics may vary in frequency and must persist for more than one year after onset. Tics must begin before age 18 and cannot be attributable to another disorder or substance.

- **Provisional tic disorder** is diagnosed when tics are present for less than one year. There can be one or more tics, which can include motor and/or vocal tics. Tics cannot be attributable to another disorder or substance. Additionally, the child cannot have been diagnosed with Tourette disorder or persistent (chronic) motor or vocal tic disorder in the past.

Assessment of tic disorders should include a medical examination to rule out conditions that can mimic tic disorders, such as behaviors related to allergies, eye problems that mimic tics, and stereotypic movement disorder. Other medical conditions that may cause tics, such as Huntington's disease or post-viral encephalitis, must also be considered prior to diagnosing a motor disorder.

Youth with tic disorders frequently experience co-occurring obsessive-compulsive disorder and ADHD. Individuals with tic disorders can also have other movement disorders, as well as depressive, bipolar, or substance-use disorders. Pre-pubertal children with tic disorders are more likely to experience ADHD, obsessive-compulsive disorder, and separation anxiety disorder than are teenagers and adults, who are more likely to experience the new onset of major depressive disorder, substance use disorder, or bipolar disorder.

Given the frequent comorbidity of tic disorders with other psychiatric conditions, any assessment of a child or adolescent that reveals the presence of tics should prompt assessment for co-occurring mental health disorders.

EVIDENCE-BASED TREATMENTS FOR TIC DISORDERS

Table 6 describes treatments for tic disorders.

Habit Reversal Therapy (HRT)

Habit reversal therapy (HRT) is the most well-studied and effective treatment for youth with motor disorders. HRT involves first teaching youth to become aware of instances of the habit, then teaching awareness of the associated environment and internal sensations, such as muscle tension and urges. Once the youth can identify feelings and situations likely to elicit the habit, he or she is taught a competing response. A competing response is a behavior that is physically incompatible with the habit and is socially inconspicuous. Supportive individuals are recruited to provide gentle reminders when the youth is engaging in the habit and praise when the competing response is implemented correctly.

Comprehensive Behavioral Intervention for Tics (C-BIT)

Comprehensive behavioral intervention for tics (C-BIT) combines habit reversal and awareness of tics through techniques like self-monitoring, along with education about tics and relaxation techniques. A therapist works with the child and his or her family to understand the types of tics and situations in which the tics occur. Where HRT combines tic awareness and competing-response training, C-BIT includes relaxation training and functional intervention. C-BIT helps the patient identify situations in which tics occur and develop strategies to overcome the tic.

Table 6
Summary of Treatments for Tic Disorders

What Works	
Habit reversal therapy (HRT) for tic disorder	A type of cognitive behavioral therapy, HRT increases awareness to the feelings and context associated with the urge to tic, then replaces it with competing, inconspicuous habits.
Comprehensive behavioral intervention for tics (C-BIT)	Combines HRT 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.
Medication	Medications may be considered for moderate to severe tics causing severe impairment in quality of life or when co-occurring conditions that would also benefit from the medication are present.

What Seems to Work (Continued)	
Massed negative practice (MNP)	Treatment involves developing reactive inhibition through the child's over-rehearsal of target tic in high-risk situations.
Not Adequately Tested	
Web-based exposure with response prevention (ERP)	ERP virtual treatment is considered generally effective, but there are limited studies on how it compares with in-person treatment.
What Does Not Work	
Deep brain stimulation (DBS)	A neurostimulator is surgically implanted into the brain; not proven to be effective and not recommended.
Repetitive transcranial magnetic stimulation (rTMS)	Uses magnetic fields and electrical pulses to affect neurons in the brain; 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 medications; not recommended until safety in children is established.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)
http://www.aacap.org/

American Academy of Family Physicians
Understanding Tics and Tourette's Syndrome
https://www.aafp.org/pubs/afp/issues/1999/0415/p2274.html

American Psychiatric Association (APA)
https://www.psychiatry.org/

Gillette Children's Specialty Healthcare
Complex Movement Disorders
https://www.gillettechildrens.org/conditions-care/complex-movement-disorders

Neuropediatric Journal
https://pubmed.ncbi.nlm.nih.gov/36423651/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

SCHIZOPHRENIA

OVERVIEW

Schizophrenia is a brain-based disorder that causes strange thinking and unusual behavior. It is primarily characterized by psychosis, a condition in which thoughts and emotions are so impaired that contact is lost with external reality. In schizophrenia, psychosis often presents as hallucinations, delusions, and/or disorganized speech and thinking. Although schizophrenia can be treated, it is considered to be a life-long disorder.

KEY POINTS

- **Characterized by psychosis, which can present as hallucinations, delusions, or disorganized thinking.**
- **Onset before age 18 is rare.**
- **Often episodic in nature, with periods of wellness between episodes.**
- **Associated with an increased risk of suicide.**
- **No evidence-based treatments at this time; a combination of pharmacological and psychosocial therapies has the best results.**

Onset of schizophrenia typically occurs between age 16 and 30; the rate of onset increases during adolescence, peaking at age 30. Onset before age 18 is categorized as early-onset schizophrenia (EOS). EOS is rare and occurs in only one percent of people with schizophrenia (or less than .01 percent of the population). Onset before age 13 is categorized as childhood-onset schizophrenia (COS). This very early onset is exceedingly rare and much more severe than EOS. For the purposes of this section of the *Collection,* the terms schizophrenia and EOS will be used interchangeably.

Schizophrenia in youth is hard to diagnose. Its symptoms can mimic a host of other disorders, which makes misdiagnosis common. Many medical conditions, such as delirium, seizure disorders, central nervous system lesions, neurodegenerative disorders, and developmental disorders can cause psychosis. Psychosis is a brain-based condition that is made better or worse by environmental factors like stress. Youth who experience psychosis often say "something is not quite right" or can't tell if something is real or not real.

Psychotic symptoms brought on by substance abuse should also be ruled out. Other conditions that should be ruled out prior to a diagnosis of schizophrenia include psychotic mood disorders, behavioral/emotional disorders, schizoaffective disorder, autism spectrum disorder, obsessive-compulsive disorder, and delusional disorders. Clinicians should also take care to differentiate true psychotic symptoms from overactive imaginations, idiosyncratic thinking, and perceptions caused by developmental delays and/or exposure to traumatic events.

The most common symptoms EOS are vivid hallucinations, disordered thinking, and flattened affect. Systematic delusions and catatonic symptoms are less common. Cognitive delays often co-occur with EOS, including memory, executive functioning, and attention deficits, as well as global impairments.

At onset of schizophrenia, children often show cognitive decline, social withdrawal, disruptive behavior disorders, difficulty in school, and speech and language problems. Signs of schizophrenia often present slowly over time, so parents often have difficulty recognizing psychotic symptoms in children with language delays and social withdrawal. Parents should look for unusual, suspicious, or paranoid thoughts, along with language and social decline.

Schizophrenia should be diagnosed by a child or adolescent psychiatrist with special training in evaluating and diagnosing children with schizophrenia. In order to receive a diagnosis of schizophrenia, there must be ongoing signs for six months. In addition, hallucinations, delusions, or disordered speech must be present for at least one month. Common symptoms of schizophrenia are described in Table 1.

Although schizophrenia is a life-long disorder, it is episodic (periods of relative wellness followed by periods of illness). During their lifetimes, people with schizophrenia may become actively ill only once or twice or may have many more episodes. Unfortunately, residual symptoms may increase and ability to function may decrease after each active phase. It is important to try to avoid relapses by following the prescribed treatment. Currently, it is difficult to predict at the onset how fully a person will recover.

Episodes of schizophrenia usually progress in phases. These phases are described in Table 2.

Youth suffering from EOS also have high rates of co-occurring disorders, including:

- Attention-deficit/hyperactivity disorder
- Depression
- Anxiety disorders
- Conduct disorder
- Oppositional defiant disorder

Because the presence of one or more co-occurring disorder can affect treatment, clinicians should perform a thorough assessment for other mental health disorders.

Between five and six percent of individuals with schizophrenia die of suicide, and approximately 20 percent attempt it. Even more of these individuals experience suicidal ideation (thoughts of suicide). According to the DSM-5, suicide risk is high throughout the life of both males and females. However, it may be highest in young males who also use or abuse drugs and similar substances. The likelihood of suicide is highest when a youth is in a depressive state or is experiencing depression-like symptoms, after a psychotic episode, or after being discharged from the hospital. Monitoring youth with EOS for suicide risk is extremely important. A review of suicide assessment tools is provided in the *Collection*'s "Youth Suicide" section. If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide & Crisis Lifeline.

Table 1
Common Symptoms of Schizophrenia

Symptom	Description
Hallucinations *Children are **more** likely than adults to experience hallucinations.*	Hallucinations are seeing or hearing things that are not real. People who have hallucinations cannot usually distinguish them from real sights and sounds because they seem to be experienced through the senses. These experiences can cause extreme distress. It is important to note that hallucinations can indicate another mental health or sensory processing disorder.
Delusions *Children are **less** likely than adults to experience delusions.*	Delusions are false beliefs that a person holds in spite of overwhelming evidence that the belief is false. Some common delusions are listed below. • Belief that a person or group will harm, harass, or otherwise bother the individual (most common type of delusion) • Belief that certain gestures, comments, and environmental cues are directed at the individual • Individual believes they have exceptional abilities, wealth, or fame • Individual falsely believes someone is in love with them • Belief that a major catastrophe will occur • Focus on preoccupations with health and organ function • Belief that one is a religious figure
Disorganized speech	Speech is incoherent or non-linear. Disorganized speech indicates disordered thinking.
Disorganized or abnormal motor behavior	• Catatonia: Lack of response to environment; motor immobility; mutism • Excessive or unconventional motor behavior; unconventional verbal behaviors • Imitation of movements of others
Negative symptoms *Symptoms that diminish a person's abilities.*	• Flattened affect: Reductions in facial expression, eye contact, hand movements, and speech intonation; diminished speech • Lack of motivation • Inability to experience pleasure; lack of interest in social interactions
Associated symptoms *These symptoms can also be present in a variety of psychological or biological disorders.*	• Bizarre thoughts and ideas; odd behavior and speech • Unable to discern television and dreams from reality • Paranoia • Cognitive defects, such as problems with learning or understanding information, with memory, with focus or attention, or with completing tasks or making decisions • Unable to infer the intentions of others, which can lead to explanatory delusions • Lack of insight into illness (typically a symptom rather than a coping strategy) • Withdrawn and increased isolation • Decline in personal hygiene • Insomnia; daytime sleeping and nighttime activity • Lack of interest in or refusal of food • Problems with self-control • Hostility or aggression • Inappropriate affect: for instance, laughing at inappropriate times • Symptoms of depressive or anxiety disorders; extreme moodiness

Table 2
Phases of Schizophrenia

Phase	Description
Prodromal Phase *The period of time when an adolescent experiences the early warning signs of psychosis*	Before a child displays very obvious symptoms, they may decline in any of the following ways: • Decreasing social function • Odd preoccupations • Unusual behaviors • Trouble in school • A lack of self-care
Active Phase	• Hallucinations • Delusions • Marked distortions in thinking • Disturbances in behavior and feelings
Residual Phase	• Listless • Trouble concentrating • Withdrawn • Other symptoms similar to Prodromal Phase

CAUSES AND RISK FACTORS

It is likely that genetic, behavioral, and environmental factors influence the development of EOS. Environmental factors associated with schizophrenia include maternal malnutrition, infections during critical periods of fetal development, fetal hypoxia (a lack of oxygen to the brain), and other birth and obstetric complications. The literature shows no evidence that psychosocial factors cause schizophrenia.

Studies have shown that schizophrenia is highly influenced by genetics. Compared to the general population, the risk of being diagnosed with schizophrenia is five times higher for second-degree relatives of persons who have schizophrenia, ten- to fifteen-fold higher for first-degree family members, and forty to fifty times higher for identical twins or when both parents have schizophrenia.

TREATMENTS

Schizophrenia is treated with a combination of pharmacological and psychosocial therapies. Antipsychotic medications are usually prescribed immediately following a diagnosis of schizophrenia. Typically, treatment is continuous throughout a child's or adolescent's life, as relapses are linked with the discontinuation of treatment. After each subsequent relapse, it becomes more difficult to return to normal health and functioning, and the likelihood of more relapses increases. This decline can have irreversible effects; therefore, vigilance is essential.

Currently, there are no pharmacological or psychosocial therapies with enough evidence in youth samples to meet the highest standard for evidence-based treatments. Thus, research on treatment of EOS is recent and sparse. Table 3 summarizes treatments for EOS.

Table 3
Summary of Treatments for Early-Onset Schizophrenia

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Medication treatment with second-generation (atypical) antipsychotics	Risperidone Aripiprazole Quetiapine Paliperidone Olanzapine
Medication treatment with traditional neuroleptics/first generation antipsychotics	Molindone Haloperidol
Family psychoeducation and support	Helps to improve family functioning, problem solving, and communication skills, and decreases 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.

Pharmacological Treatments

Due to the limited number of controlled studies related to the efficacy and safety of psychopharmacological medications for youth with EOS that currently exist, pharmacological treatment of youth diagnosed with schizophrenia is modeled after treatment studies with adults. The most widely prescribed class of drugs for youth under 18 years of age are second-generation antipsychotics. The FDA has approved risperidone, aripiprazole, quetiapine, paliperidone, and olanzapine for the purposes of treating children over the age of 13, but these medications still do not meet the criteria for evidenced-based treatments.

Long-term monitoring of therapy compliance and side effects is essential for any treatment regimen requiring antipsychotic agents. Serious side effects of antipsychotics include seizures and neutropenia, a blood condition in which cells that defend the body against bacterial infections (neutrophils) are significantly reduced. Cognitive side effects, such as problems with word retrieval, working memory, and cognitive dulling, can also occur. Other side effects include weight gain, abnormal involuntary movements, and neuroleptic malignant syndrome.

Psychological Treatments

There are many different psychological treatment options for youth with schizophrenia. A proper psychological treatment paired with medication can be extremely effective in improving a patient's functioning (emotionally, socially, and cognitively).

The goal of therapy is both to help the youth return to a normal level of functioning and to promote the mastery of age-appropriate developmental tasks. Family involvement in treatment for EOS is especially important. Evidence suggests that family involvement can make treatment more effective and decrease the amount of time a youth spends in institutional care.

RESOURCES AND ORGANIZATIONS

American Academy of Child and Adolescent Psychiatry (AACAP)
Facts for Families: Schizophrenia in Children
http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Schizophrenia-In-Children-049.aspx

American Psychiatric Association
Schizophrenia
https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia

Association for Behavior and Cognitive Therapies (ABCT)
Schizophrenia
https://www.abct.org/fact-sheets/schizophrenia/

Brain & Behavior Research Foundation
https://www.bbrfoundation.org/

Mental Health America (MHA)
https://mhanational.org/

National Alliance on Mental Illness (NAMI)
https://www.nami.org/Learn-More/Mental-Health-Conditions/Schizophrenia

National Institute of Mental Health (NIMH)
https://www.nimh.nih.gov/health/topics/schizophrenia

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/

BIPOLAR AND RELATED DISORDERS

OVERVIEW

Families of children with bipolar disorder often notice the child has intense and extreme changes in mood and behavior. This may include the child varying between being excited, highly agitated, and very sad. The two "poles," or extreme moods, of bipolar disorder are mania and depression. When children with bipolar disorder feel very happy or "up" and are much more active than usual, they are experiencing mania. A manic episode is a period of abnormally and persistently elevated mood. The child exhibits an increase in goal-directed activity or energy that lasts at least one week. Mania is often described as a period of euphoria or excessive cheerfulness, and often it is easily recognized. When the same child feels very sad or "down" and is much less active than usual, he or she is experiencing depression.

KEY POINTS

- **Characterized by episodic mood swings that can include:**
  - **Abnormally elevated mood (mania)**
  - **Pronounced sadness (depression)**
  - **Mixed episodes (both up and down symptoms)**
- **Many medical and mental health conditions have similar symptoms.**
- **Associated with an increased risk of suicide.**
- **No evidence-based treatments at this time; tailored treatment that includes mood stabilizing medication and/or psychotherapy has the best results.**

Some episodes may be mixed episodes, including both up and down symptoms. Children with bipolar disorder may have more mixed episodes than adults with bipolar disorder.

Table 1 describes some of the symptoms of both mania and depression. The list is not exhaustive.

There are three main types of bipolar disorder:

1. **Bipolar I disorder:** Requires a manic (or mixed) episode lasting at least one week, or manic symptoms so severe that immediate hospital care is needed. Depressive episodes are also common, and if present, often last for at least 2 weeks.

2. **Bipolar II disorder:** Requires major depressive episodes with at least one hypomanic episode (a lesser form of mania) lasting at least four days. There are no full manic or mixed manic episodes.

3. **Cyclothymic disorder:** Requires at least two years (one year in children and adolescents) of numerous periods of hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous

periods of depressive symptoms that do not meet criteria for a major depressive episode. Cyclothymic disorder is primarily a chronic, fluctuating mood disturbance.

Table 1
Manic and Depressive Symptoms

Manic Symptoms	Depressive Symptoms
• Severe changes in mood to either unusually happy or silly, or very irritable, angry, or agitated • Unrealistic highs in self-esteem • Greatly increased energy and the ability to operate on little or no sleep for days • Increased talking • Increasingly distracted, moving from one thing to the next • Repeating high risk behavior	• Irritability, persistent sadness, frequent crying • Thoughts of death or suicide • No longer enjoys favorite activities • Frequent complaints of physical illness, like headaches • Decreased energy level • Major change in eating and sleeping patterns

It is important to note that bipolar disorder in children and, to a lesser extent, in adolescents, can manifest in ways that do not always meet the full criteria described above. For instance, in adolescents, mania is commonly associated with psychotic symptoms (thought and emotions are so impaired that contact is lost with external reality), rapidly changing moods, and mixed manic and depressive features. Mania in younger children is usually defined by erratic changes in mood, energy levels, and behavior. Irritability and mixed manic/depressive episodes are usually more common than euphoria. Also, well-defined and discrete episodes of abnormal mood are often missing in children and adolescents. Accurate diagnosis involves careful observation over time. There is also sparse evidence of the validity of a bipolar diagnosis in pre-school aged children, and that diagnosis should be made with extreme caution.

To further complicate diagnosis, there are many conditions and disorders that frequently co-occur with bipolar disorder, including:

- Attention-deficit/hyperactivity disorder (ADHD) (up to 90 percent co-occurrence)
- Anxiety disorders, like separation anxiety (up to 78 percent co-occurrence)
- Substance abuse
- Conduct disorders
- Other mental illnesses, including depression

In addition, many mental illnesses (including those listed above) and medical conditions (such as hyperthyroidism, epilepsy, or head trauma) can have symptoms similar to bipolar disorder, which can lead to misdiagnosis and unnecessary or too aggressive pharmacological treatment. For this reason, it is imperative that children exhibiting bipolar symptoms be thoroughly assessed by a mental health professional specializing in bipolar disorders in youth. *Parents Med Guide* offers tips for distinguishing between bipolar disorder and other disorders as outlined in Table 2.

Families should be mindful of the signs and risk factors of bipolar disorder described in Table 3, and should seek assessment for the disorder if they notice any red flags.

Ongoing assessment of suicide risk is important due to the high risk of suicide attempts among youth with bipolar disorder. The lifetime risk of suicide in all individuals with bipolar disorder may be 15 times that of the general population. Information about suicide is provided in the "Youth Suicide" section of the *Collection*. If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide and Crisis Lifeline.

Table 2
Tips for Distinguishing Between Bipolar Disorder and Other Disorders

Similar Disorders	Symptoms
Suspect bipolar disorder instead of ADHD if…	• Disruptive behaviors appear later in life (after 10 years of age) • Disruptive behaviors come and go and tend to occur with mood changes • The child has periods of exaggerated elation, depression, no need for sleep, and inappropriate sexual behaviors • The child has severe mood swings, temper outbursts, or rages • The child has hallucinations or delusions • There is a strong family history of bipolar disorder
Suspect bipolar disorder instead of childhood depression if…	• The child experiences mania as well as depression • The depressive episodes are severe rather than mild or moderate
Suspect bipolar disorder instead of oppositional defiant disorder (ODD) or conduct disorder (CD) if…	• Disruptive behaviors only occur when the child is having a manic or depressive episode • Disruptive behaviors disappear when the mood symptoms improve • Disruptive behaviors only occur periodically • The child sleeps only a few hours at night and is not tired the next day • The child has hallucinations or delusions • There is a strong family history of bipolar disorder

CAUSES AND RISK FACTORS

The causes of bipolar disorder aren't always clear, and scientists are continually researching possible causes and risk factors. Experts believe that bipolar and related disorders can be caused by several things, including:

- Genetics: A child with a parent or sibling with bipolar disorder is four times more likely to be diagnosed with the disorder. Having a parent or sibling who has schizophrenia is also a risk factor.
- Brain structure and function
- Anxiety disorders
- Gestational influenza: A child whose mother had influenza during pregnancy is four times more likely to be diagnosed with bipolar disorder

Table 3
Red Flags that Can Trigger Assessment for Bipolar Disorder[1]

Red Flag	Description	Reason
Family history of bipolar disorder	Bipolar disorder has a genetic contribution; family environment can amplify risk and affect treatment adherence and relapse	5 to 10 times increase for 1st degree relative; 2.5 to 5 times for 2nd degree relative; 2 times for "fuzzy" bipolar disorder in relative
Early onset depression	Onset less than 24 years of age; also, treatment resistant, recurrent, or atypical depression may be more likely to be bipolar	First clinical episode is often depression; 20% to 30% of depression ultimately shows a bipolar course
Antidepressant-coincident mania	Manic symptoms while being treated with antidepressants	The FDA recommends assessing for hypomania and family history of bipolar disorder before prescribing antidepressants
Episodic mood lability (marked fluctuation of mood)	Rapid switching between depressive and manic symptoms, depressive and manic symptoms at the same time	Common presentation; multiple episodes more suggestive of mood diagnosis
Episodic aggressive behavior	Episodic, high-energy, not instrumental or planned, reactive	Not specific to bipolar disorder but common
Psychotic features	True delusions/hallucinations in the context of mood	Delusions/hallucinations common during mood episode; bipolar more common as source of psychosis than schizophrenia in children
Sleep disturbance	Decreased need for sleep; less sleep but maintains high energy	More specific to bipolar disorder; indicates sleep hygiene treatment

[1] Youngstrom, E., Jenkins, M. M., Jensen-Doss, A., & Youngstrom, J. K. (2012). Evidence-based assessment strategies for pediatric bipolar disorder. *Israel Journal of Psychiatry and Related Sciences, 49*(1), 15-27.

TREATMENT

Currently, there are no pharmacological or psychosocial therapies with enough evidence in youth samples to meet the standards for evidence-based treatments, although the treatments discussed in this section have been shown to be probably efficacious. Treatment should be tailored to the individual and based on several different factors, including treatment setting, the chronic nature of the disorder, the age of the child, and the family environment. Treatment involves three distinct features: (1) strategies to prevent new episodes, (2) treatment of bipolar depression, and (3) treatment of mania or hypomania.

Table 4 summarizes the treatments for bipolar and related disorders.

Table 4
Summary of Treatments for Bipolar and Related Disorders

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Medication	Mood stabilizers (lithium)/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.

Pharmacological Treatments

The goal of pharmacological treatment for bipolar and related disorders is to immediately reduce the severity of symptoms. Pharmacotherapy, combined with psychotherapy, offers the best chance for symptom recovery. However, because few large-scale prospective studies have examined pharmacologic treatment for youth with bipolar and related disorders, many of these medications are used without specific FDA approval for youth.

Lithium is currently the most extensively studied medication for use with bipolar disorder. Lithium has been found to be effective in approximately 60-70 percent of adolescents and children with bipolar disorder and remains the first-line therapy in many settings. However, youth experience the same safety problems with lithium that adults may experience, such as toxicity and impairment of renal and thyroid functioning. Lithium is not recommended for families unable to keep regular appointments, which are necessary to ensure monitoring of serum lithium levels in the blood and to manage conflicting side effects. Relapse is also high for those youth who discontinue the medication.

Youth diagnosed with bipolar disorder and comorbid ADHD respond less favorably to lithium treatment than youth who do not have ADHD. However, mood stabilizers show better results than stimulants in youth with bipolar disorder and comorbid ADHD.

Unfortunately, mood stabilizers and atypical antipsychotics have a number of adverse side effects, including, but not limited to: weight gain, drowsiness, decreased motor activity, constipation, increased salivation, rigidity, and dystonia. It is very important that children on these medications be monitored for the development of serious side effects. These side effects need to be weighed against the dangers of the manic-depressive illness itself.

Psychosocial Treatments

Although no psychosocial treatments for bipolar disorder are considered evidence-based, recent evidence has shown that family-focused psychoeducational therapy (FFT), child- and family-focused cognitive behavioral therapy (CFF-CBT), and multifamily psychoeducation groups (MFPG) have promise when used in conjunction with pharmacological treatment. These three treatments have demonstrated symptom improvement and increased functioning in youth with bipolar disorder. The rationale behind these family-focused treatments are to give youth with bipolar disorder and their families knowledge and skills that could help limit the debilitating cycles of relapse and impairment that are characteristic of this disorder.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)

http://www.aacap.org

Bipolar Disorder: Parents' Medication Guide for Bipolar Disorder in Children, & Adolescents

https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/parentsmedguide_bipolar.pdf

American Psychiatric Association (APA)

https://www.psychiatry.org

American Psychological Association (APA)

http://www.apa.org/

Association for Behavioral and Cognitive Therapies (ABCT)

http://www.abct.org/Home/

American Foundation for Suicide Prevention (AFSP)

https://afsp.org/

Anxiety and Depression Association of America (ADAA)

https://adaa.org/

Association for Behavior and Cognitive Therapies (ABCT)

http://www.abct.org/Home/

The Bipolar Child

https://bipolarchild.com/

Depression and Bipolar Support Alliance (DBSA)

http://www.dbsalliance.org

Effective Child Therapy

http://effectivechildtherapy.org/

International Bipolar Foundation

https://ibpf.org/

Juvenile Bipolar Research Foundation

https://www.jbrf.org/about-jbrf

Child Bipolar Questionnaire

https://www.jbrf.org/the-child-bipolar-questionnaire/

Mental Health America (MHA)

Bipolar Disorder in Children

http://www.mentalhealthamerica.net/conditions/bipolar-disorder-children

National Alliance on Mental Illness (NAMI)

Bipolar Disorder

https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder/Support

National Institute of Mental Health (NIMH)

Bipolar Disorder in Children and Teens

https://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens/index.shtml

Ryan Licht Sang Bipolar Foundation

http://www.ryanlichtsangbipolarfoundation.org

Society of Clinical Child and Adolescent Psychology

https://sccap53.org/

VIRGINIA RESOURCES AND ORGANIZATIONS

National Alliance on Mental Illness Virginia (NAMI Virginia)

https://namivirginia.org/

DEPRESSIVE DISORDERS

KEY POINTS

- **Characterized by persistent sadness and/or irritability, hopelessness, guilt, and apathy.**
- **Associated with an increased risk of suicide; for this reason, early intervention is critical.**
- **A combination of cognitive behavioral therapy and medication therapy, (fluoxetine) usually offers maximum therapeutic benefits.**

OVERVIEW

Like adults, children and adolescents experience depression with the accompanying feelings of hopelessness, guilt, or sadness. However, depression in children and adolescents can manifest in different ways than it does in adults. For instance, in children and adolescents, an irritable mood, rather than a sad or dejected mood, often predominates.

Approximately 60 percent of children and adolescents with depression have recurrences throughout adulthood. The emotional and behavioral dysfunction associated with these mood disorders can cause impairments across areas of functioning, including academic and social arenas.

There are three major categories of depressive disorders: disruptive mood dysregulation disorder, major depressive disorder, and persistent depressive disorder (dysthymia). Common symptoms are listed in Table 1. Children tend to have more physical complaints than adults, such as frequent headaches or stomach aches.

Because depressive disorders can result in suicide, depression among children and adolescents is of grave concern. Information about suicide is provided in the "Youth Suicide" section of the *Collection*. If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide and Crisis Lifeline.

Disruptive Mood Dysregulation Disorder

This diagnosis is new to the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-5). It was created to reduce the risk of overdiagnosis and treatment of bipolar disorder in children.

The core feature of disruptive mood dysregulation disorder is chronic, severe, persistent irritability, which can include frequent temper outbursts. This irritable or angry mood must be characteristic of the child, be present most of the day, nearly every day, and noticeable by others in the child's environment. Symptoms begin between age six and ten, are present for at least one year, and occur in more than one place (at home, school, and/or with peers). Disruptive mood dysregulation disorder often co-occurs with oppositional defiance disorder (ODD), and frequently occurs with other disorders as well, including behavior, mood, anxiety, and autism spectrum disorder diagnoses.

Table 1
Types and General Symptoms of Depressive Disorders

Major Depressive Disorder
Experiences symptoms most of the time for at least two weeks. • Sadness • Hopelessness • Feelings of worthlessness • Loss of feelings of pleasure • Guilt (preschool feature) • Loss of interest in enjoyable activities (preschool feature) • Irritability (adolescent feature) • Change in weight/failure to gain as expected (preschool feature) • Sleep disturbance (preschool feature) • Unintentional or purposeless motions • Fatigue and/or excess sleeping (adolescent feature) • Difficulty thinking or concentrating (preschool feature) • Recurrent thoughts of death or suicide (adolescent feature) • Deterioration in school or home functioning • Persistent physical complaints (age 6-9 feature) • Abusing substances (adolescent feature) • More accident prone than usual (preschool feature) • Develops phobias (preschool feature) • Increased aggression (age 6-9 feature) • Clings to parents or avoids new events and people (age 6-9 feature)
Persistent Depressive Disorder (Dysthymia)
Experiences symptoms for most of the day, for more days than not, for at least one year. Symptoms are not as severe as those seen in major depression. • Altered appetite (eating too much or too little) • Sleep disturbance • Fatigue • Low self-esteem • Hopelessness
Disruptive Mood Dysregulation Disorder
Symptoms begin between age six and ten, are present for at least one year, and occur in more than one place (at home, school, and/or with peers). • Severe temper outbursts at least three times per week • Sad, irritable, or angry mood almost daily • Reactions to adverse events is bigger than expected

Major Depressive Disorder

Major depressive disorder is characterized by a period of at least two weeks during which the youth experiences sadness, hopelessness, guilt, loss of interest in activities that are usually enjoyable, and/or irritability most of the time. Insomnia or fatigue is often the first noticeable and complained of symptom.

It is important to note that the youth's mood must differ from his or her usual mood and cannot be attributable to bereavement, a general medical condition, and/or substance abuse, although those conditions may co-occur and even contribute to depression.

About 40 to 90 percent of youth with major depressive disorder have at least one other psychiatric disorder. The most commonly co-occurring disorders are persistent depressive disorder (dysthymia), anxiety disorders, disruptive disorders, and substance abuse disorders. Depression is more likely to begin after the onset of the comorbid disorder, with the exception of substance abuse, which tends to occur after the onset of depression.

Persistent Depressive Disorder (Dysthymia)

Persistent depressive disorder (dysthymia) is a depressive disorder in which the symptoms are chronic and persistent but less severe than major depressive disorder. The disorder occurs when youth experience a sustained depressed mood for most of the day, for more days than not, and for at least one year.

Because persistent depressive disorder is a chronic disorder, youth often consider their symptoms a part of who they are and do not report them unless asked directly.

CAUSES AND RISK FACTORS

The exact causes of depressive disorders are not known. There is evidence, however, that genetics contributes to a child's vulnerability to a depressive disorder. Other contributing factors are environment and biology (neurotransmitters, hormones, and brain structure).

EVIDENCE-BASED TREATMENTS

This section will focus on treatments that can apply to the most commonly diagnosed forms of depression among children and adolescents: major depressive disorder and persistent depressive disorder (dysthymia). Research has shown that a combination of the psychosocial and pharmaceutical treatments offers maximum therapeutic benefits.

Because youth who experience the onset of depressive disorders at a younger age typically have a worse prognosis, early intervention is critical to prevent additional functional breakdown, relapse, and suicidal behavior. Tables 2 and 3 summarize the treatments for depressive disorders in children and adolescents.

Table 2
Summary of Treatments for Children with Depression

What Works	
Stark's cognitive behavioral therapy (CBT)	Stark's CBT (child only or child plus parent) includes mood monitoring, mood education, increasing positive activities and positive self-statements, and problem solving. CBT is based on the premise that patients with depression have thinking that is characterized by dysfunctional negative views of oneself, experiences, and the future. CBT helps individuals identify and modify maladaptive thinking and behavior patterns.
Fluoxetine in combination with CBT	Fluoxetine, a selective serotonin reuptake inhibitor (SSRI), is the only antidepressant approved by the FDA for use in children (eight years old or older) for depression. For moderate to severe depression, fluoxetine in combination with psychosocial therapy may be warranted. However, because SSRIs can increase suicidal behavior in youth, children taking fluoxetine must be closely monitored by a mental health professional.
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	Behavioral therapy includes pleasant activity monitoring, social skills training, and relaxation.

Psychosocial Treatments

The evidence-based psychological treatments for depressive disorders are cognitive behavioral therapy (CBT) and interpersonal therapy (IPT). Research indicates that treatment can be effective regardless of where it is provided (school, community clinics, primary care clinics, hospitals, or research settings).

Pharmacological Treatments

Currently, only one pharmacological treatment has been approved for use in youth with depressive disorders by the Food and Drug Administration (FDA). This medication, fluoxetine (a selective serotonin reuptake inhibitor [SSRI]), has been approved by the FDA for treating children eight years of age or older. More research has been completed on fluoxetine than any other SSRI.

There has been considerable debate about the use of antidepressants to treat youth with depression, specifically whether their use increases the risk of suicidal behaviors. U.S. manufacturers are now required by the FDA to place a "black box" warning label on antidepressant medications prescribed for youth. Antidepressants are not usually prescribed in children and are not the first line of treatment in adolescents. A more detailed discussion of the use of antidepressants to treat children and adolescents is provided in the "Antidepressants and the Risk of Suicidal Behavior" section of the *Collection*.

Table 3
Summary of Treatments for Adolescents with Depression

What Works	
Cognitive behavioral therapy (CBT) provided in a group setting	CBT for depression focuses on identifying thought and behavior patterns that lead to or maintain the problematic symptoms.
Interpersonal therapy (IPT)	In IPT, the therapist and patient address the patient's interpersonal communication skills, interpersonal conflicts, and family relationship problems.
Fluoxetine in combination with CBT	Fluoxetine, a selective serotonin reuptake inhibitor (SSRI), is the only antidepressant approved by the FDA for use in children (eight years old or older) for depression. For moderate to severe depression, fluoxetine in combination with psychosocial therapy may be warranted. However, because SSRIs can increase suicidal behavior in youth, children taking fluoxetine must be closely monitored by a mental health professional.
What Seems to Work	
CBT in a group or individual setting with a parent/family component	CBT for depression focuses on identifying thought and behavior patterns that lead to or maintain the problematic symptoms.
Adolescent 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 three times a week for a period of between 6 to 11 or 12 weeks may bring about an improvement in depression.
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.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry
Depression Resource Center
https://www.aacap.org/AACAP/Families_Youth/Resource_Centers/AACAP/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Depression_Resource_Center.aspx
American Psychiatric Association
https://www.psychiatry.org/
American Psychological Association
http://www.apa.org/
Anxiety and Depression Association of America (ADAA)
https://adaa.org/
Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org
Centers for Disease Control and Prevention (CDC)
Anxiety and Depression in Children
https://www.cdc.gov/children-mental-health/about/about-anxiety-and-depression-in-children.html
Child Mind Institute
Depression & Mood Disorders
https://childmind.org/topics/depression-mood-disorders/
Mental Health America
Depression in Teens
https://www.mhanational.org/depression-teens-0
Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

VIRGINIA RESOURCES AND ORGANIZATIONS

Children's Hospital of Richmond at VCU
Mental Health
https://www.chrichmond.org/services/mental-health/
Virginia Tech
Child Study Center
http://childstudycenter.wixsite.com/childstudycenter
Psychological Services Center
https://support.psyc.vt.edu/centers/psc

ANXIETY DISORDERS

OVERVIEW

KEY POINTS

- **Characterized by anxiety that impairs normal functioning and impacts quality of life.**
- **Often co-occurs with other mental health disorders and can precede depression.**
- **Cognitive behavioral therapy is well established as an effective treatment. Medication therapy (SSRIs) is also evidence-based.**

It is normal for all children to experience anxiety. Most young children have fears about the dark, storms, animals, separation, or strangers. The difference between regular anxiety and an anxiety disorder is that an anxiety disorder is debilitating. It leaves the child in a state of persistent distress or unable to function in a normal, productive manner. Anxiety responses that are intense or severe but proportional to events are not considered signs of an anxiety disorder. When both anxiety and the impairment of normal activities are evident, an anxiety disorder may be present.

If the child's fears or anxieties are frequent, severe, and interfere with the child's life activities, the family should seek an evaluation by a qualified mental health professional, including a child and adolescent psychiatrist. Youth with anxiety problems experience significant and often lasting impairment, such as poor performance at school and work, social problems, and family conflict. Early intervention can prevent these complications.

There are several different types of anxiety disorders. Characteristics of each are outlined in Table 1. The *Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition* (DSM-5) no longer considers obsessive-compulsive disorder (OCD) or post-traumatic stress disorder (PTSD) as anxiety disorders, which was the case in prior editions. These disorders will be discussed in separate sections of the *Collection*.

Youth diagnosed with an anxiety disorder may also have one or more other mental health disorders, such as attention-deficit/hyperactivity disorder, conduct disorder, depression, or another anxiety disorder. In addition, anxiety sometimes precedes the onset of major depressive disorder. When depression and anxiety occur together, there is a significantly higher risk for impairment.

Substance use disorder may also co-occur with anxiety disorders. Youth may use alcohol, marijuana, and other substances to reduce the symptoms of anxiety. This practice is known as self-medication. Self-medication can be extremely detrimental because the use or abuse of substances can ultimately worsen symptoms, and certain substances may even generate symptoms of anxiety.

Anxiety is termed the "great masquerader," since it manifests in a variety of ways. While symptoms of anxiety disorders vary, some of the most common are hypervigilance, reactivity, physical complaints, avoidance, and behavioral issues (ranging from difficulty focusing to full-blown tantrums).

Table 1
Types and Characteristics of Anxiety Disorders

Separation Anxiety Disorder
• Persistent and excessive fears of being apart from major attachment figure • Constant thoughts and fears regarding well-being of parents and caretakers • Refusal to go to school • Frequent stomach aches and other physical complaints when separation from major attachment figure occurs or is anticipated • Extreme worries about sleeping away from home • Panic or tantrums at times of separation from parent(s) or attachment figures • Recurring separation-themed nightmares
Social Anxiety Disorder/Social Phobia
• Extreme fear, anxiety, or discomfort associated with social situations (e.g., meeting or talking to people) • As a possible consequence, avoids social situations or has few friends • The anxiety must occur in peer settings and not just in interactions with adults
Specific Phobia
• Extreme and excessive fear of a specific thing or situation (e.g., animals, needles, flying) • Fear must cause significant distress or interfere with usual activities
Generalized Anxiety Disorder
• Excessive and persistent worrying about everyday things (e.g., money, academics) before they happen • Restlessness or feeling on edge • Sleep disturbance
Panic Disorder
Characterized by recurrent, unexpected panic attacks. Panic attacks are an abrupt surge of intense fear or discomfort reaching its peak within minutes, with symptoms including: • Intense fearfulness, including fear of dying or losing control (going crazy) • Feeling short of breath or smothered • Dizziness • Trembling or shaking • Chest pain or tightness • Paresthesia (numbness or tingling sensations)
Agoraphobia
Consistent, significant fear about situations such as the following: • Using public transportation • Being in open spaces • Being in enclosed spaces • Standing in line or being in a crowd • Being outside of the home alone • Fear is out of proportion to the actual danger • Fear causes clinically significant distress or impairment in functioning

Selective Mutism
• Unable to speak in certain social situations (e.g., at school) despite being able to speak in other settings

CAUSES AND RISK FACTORS

Risk factors for anxiety disorders include:

- Having some biological predisposition to anxiety
- Having a psychological vulnerability related to "feeling" an uncontrollable or unpredictable threat or danger
- Having a direct experience with anxiety-provoking situations

When these three factors combine, a child is especially at risk for developing anxiety.

EVIDENCE-BASED TREATMENTS

The treatment of anxiety disorders in youth is usually multimodal in nature. Wide-ranging treatments have been described in the literature, but only two primary types of treatment have been designated as evidence-based: behavioral (e.g., exposure) & cognitive behavioral therapies (CBT), and treatment with selective serotonin reuptake inhibitors (SSRIs). It is worth noting that CBT has been tested and found to be effective for anxiety disorders in youth in over 35 separate randomized trials. Treatments are outlined in Table 2.

Psychological Treatments

Behavioral therapy and cognitive behavioral therapy (CBT) are the most studied and best-supported psychological treatments for helping youth diagnosed with an anxiety disorder. A core concept in CBT is that thoughts, feelings, and actions influence each other. CBT interventions target thoughts and actions. For anxiety, they often include exposure therapy. Exposure therapy involves exposing youth in a graduated fashion to the non-dangerous situations they fear, with a focus on having them learn that their anxiety will decrease over time. However, exposure therapy alone has been shown to be effective. As an example, a youth with a specific phobia might be gradually exposed to either actual or imagined examples of the fear-inducing stimulus. Often, exposure therapy involves using a hierarchy, or fear ladder, such that youth may be exposed to moderately stressful situations and work towards more difficult ones. This approach allows these youth to experience mastery and increases their self-confidence.

Other elements common to behavioral therapy and CBT include psychoeducation, relaxation, and cognitive skills. Psychoeducation entails teaching older youth and parents about what causes anxiety, the effects of anxiety, how to distinguish between problematic and non-problematic anxiety, and how to overcome problematic anxiety. Psychoeducation also teaches youth and parents to monitor levels of anxiety across a variety of situations. Both forms of therapies often use praise and/or rewards to encourage the youth's progress. Both also include relationship building between the therapist and the parents and children. Relaxation entails teaching youth how to relax through breathing exercises or by alternating muscle tension and release. Cognitive skills involve teaching youth how to observe and change their thinking patterns so they can change

how they feel and reduce their feelings of anxiety. Most versions of behavioral therapy and CBT include parental involvement, with some versions involving the parents attending all sessions with their children.

Both behavioral therapy and CBT have been found to be helpful to youth of all ages and can be administered in individual and group settings. They have also been delivered with good effects in schools, clinics, hospitals, daycare centers, and homes.

Pharmacological Treatments

Selective serotonin reuptake inhibitors (SSRIs) are generally the first pharmacological treatment for children with anxiety disorders. However, the FDA issued a public health advisory regarding the safety of SSRIs in children with major depressive disorder due to the risk of increased suicide attempts and suicidal ideation. In addition, although some antidepressants are approved by the FDA for use in children, not all are. For more information, see the "Antidepressants and the Risk of Suicidal Behavior" section of the *Collection*.

Table 2
Summary of Treatments for Youth with Anxiety Disorders

What Works	
Behavioral (e.g., exposure) & cognitive behavioral (CBT) therapies	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 (SSRIs)	Treatment with certain SSRIs have been proven to help with anxiety; however, SSRIs may increase suicidal ideation in some youth.
What Seems to Work	
Educational support	Psychoeducational information on anxiety provided to parents, usually in a group setting.
Benzodiazepines	While proven effective, not a first choice treatment because of an increase in the risk of behavioral disinhibition.
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 and healing.
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.
Neurofeedback	A type of non-invasive brain training that enables an individual to learn how to change mental and/or physiological activity.

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.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)
Anxiety Disorders Resource Center
https://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx

Anxiety and Depression Association of America (ADAA)
https://adaa.org/

Association for Applied Psychophysiology and Biofeedback (AAPB)
https://www.aapb.org

Association for Behavioral and Cognitive Therapies
http://www.abct.org/Home/

Centers for Disease Control and Prevention (CDC)
Anxiety and Depression in Children
https://www.cdc.gov/children-mental-health/about/about-anxiety-and-depression-in-children.html

Child Mind Institute
Anxiety
https://childmind.org/topics/anxiety/

Mental Health America
Anxiety
https://mhanational.org/conditions/anxiety/

National Institute of Mental Health (NIMH)
https://www.nimh.nih.gov

Social Anxiety Association
http://socialphobia.org/

Society of Clinical Child & Adolescent Psychology
https://sccap53.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/

VIRGINIA RESOURCES AND ORGANIZATIONS

University of Virginia Health System
Anxiety Disorders in Children
https://childrens.uvahealth.com/services/pediatric-psychiatry/anxiety-disorders

VCU Health – Children's Hospital of Richmond
Cameron K. Gallagher Mental Health Resource Center
https://www.chrichmond.org/services/mental-health/cameron-k-gallagher-mental-health-resource-center

Virginia Tech
Child Study Center
http://childstudycenter.wixsite.com/childstudycenter
Psychological Services Center
https://support.psyc.vt.edu/centers/psc

OBSESSIVE–COMPULSIVE AND RELATED DISORDERS

Obsessive-Compulsive Disorder • Body Dysmorphic Disorder
Hoarding Disorder • Trichotillomania • Excoriation Disorder

OVERVIEW

Obsessive-compulsive and related disorders (OCRDs) is the umbrella term that describes disorders that have several features in common, including obsessions and compulsions.

Obsessions are persistent and intrusive thoughts, ideas, impulses, or images that result in anxiety. Often, the obsessive thoughts or worries are irrational and/or unrealistic. Compulsions are a temporary escape from the stress and anxiety associated with obsessions, and usually take the form of overt behavioral acts or rituals. Figure 1 provides additional information about obsessions and compulsions.

Figure 1
Obsessions and Compulsions

Obsessions	Recurrent and persistent thoughts, urges, or images the youth deems intrusive and unwanted at some point in the experience. Such thoughts, urges, or images are distressing and cause anxiety. The youth attempts to ignore or suppress the thoughts, urges, or images, or alternatively, neutralizes them with another thought or action (e.g., a compulsion).
Compulsions	Repetitive behaviors or mental acts the youth feels compelled to perform in response to an obsession. • Repetitive behaviors may include handwashing, ordering, checking, hoarding, hair pulling, skin picking, or other body-centric behaviors. • Mental acts may include such activities as counting or repeating words silently. These behaviors/actions are performed in an attempt to prevent or reduce anxiety, distress, or a feared event. Actions are excessive and may not realistically be connected to that which they aim to prevent.

Most youth experience the types of intrusive thoughts that cause distress in youth with OCRDs. These thoughts may originate from a traumatic experience, illness, or information from others (e.g., family, friends, news reports). However, youth with OCRDs may experience shame, guilt, or fear in response to these thoughts and have difficulty dismissing them. As a result of these unpleasant and/or fearful feelings, the youth attempts to escape or avoid the fear through various behaviors. If these behaviors become associated with the reduction in fear, they are reinforced—even if they do not directly cause fear to be reduced.

Younger children with OCRDs can present differently than adults. Adults with OCRDs often recognize that their behaviors are abnormal and problematic. However, due to undeveloped cognitive abilities, children with OCRDs may not understand that their behaviors are abnormal. In addition, they often cannot explain why it is important to complete a compulsion and may only report a vague sense that "something bad might happen." Finally, their distress at not being able to complete a compulsion can manifest as tantrums or angry outbursts.

The impairment caused by OCRDs is significant. Because compulsions serve as the primary coping mechanism, youth with OCRDs who experience increased levels of distress will respond by increasing the intensity and/or magnitude of their compulsion. Thus, these youth may spend more and more time engaging in their rituals, which can interfere with school, work, and social functioning. Accordingly, youth with OCRDs may be reluctant to attend school for fear of embarrassment, and they often withdraw from social activities. Youth with OCRDs also possess a higher risk for comorbid anxiety disorders (e.g., social anxiety and panic disorder) and depression. While symptoms may fluctuate, the overall trend in symptom severity increases over the lifetime.

The main types of OCRDs are obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), and excoriation (skin-picking disorder). Because each category has different treatments, each will be discussed in its own section of this chapter. There are other uncommon OCRDs (Olfactory Reference Syndrome, Mysophobia, Emetophobia, and more), but they are not listed here.

Studies show that the suicide risk may be higher for youth who have OCRDs. While this risk does not solely affect children and adolescents, families should be aware of this risk and monitor their children for signs of suicidal ideation (thinking about suicide). For additional information on this topic, families should consult the "Youth Suicide" section of the *Collection*. If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide and Crisis Lifeline.

CAUSES AND RISK FACTORS

OCRDs tend to run in families, but they may develop even without any previous family history. The biological risk factors of OCRDs are genetic and have a neurological basis. OCRDs are not caused by parenting or other family issues. However, the way a family reacts to a youth with an OCRD can affect the disorder by either increasing or decreasing anxiety. For instance, one study found that parents of children with OCRDs (compared to parents of non-OCRD children) did not use problem-solving with their children as frequently, did not encourage their children's independence, and did not have as much confidence in their children's abilities.[1] In addition, physical and sexual abuse or severe trauma may contribute to the likelihood of developing the disorder.

PANDAS

There is evidence that a subset of children with obsessive-compulsive disorder developed symptoms after an infection of Group A beta hemolytic streptococcus (i.e., strep throat) or Sydenham's chorea, a variant of

[1] Barrett, P., Shortt, A., & Healy, L. (2002). Do parent and child behaviours differentiate families whose children have obsessive-compulsive disorder from other clinic and non-clinic families? *Journal of Child Psychology and Psychiatry, 43*, 597-607.

rheumatic fever. This is called pediatric autoimmune neuropsychiatric disorder associated with strep (PANDAS). PANDAS is typically treated with antibiotics. While PANDAS is well accepted by some, there are still dissenters.

OBSESSIVE-COMPULSIVE DISORDER

Obsessive-compulsive disorder is characterized by elevated anxiety or distress caused by uncontrollable and intrusive thoughts (called obsessions) and repetitive, ritualistic behaviors (called compulsions). Obsessions and/or compulsions that take up a significant portion of the youth's day and that cannot be attributed to any other disorders are the hallmark of obsessive-compulsive disorder. Figure 1 in the Overview section details additional information about obsessions and compulsions.

KEY POINTS

- **Characterized by:**
  - **Uncontrollable thoughts that cause distress (obsessions), and**
  - **Repetitive, ritualistic behavior meant to alleviate distress (compulsions).**
- **Evidence-based treatments include:**
  - **Cognitive behavioral therapy, which can involve the family and/or include exposure and response prevention therapy (ERP).**
  - **Medication therapy with approved SRIs or SSRIs.**

The first challenge in diagnosing a child with obsessive-compulsive disorder is distinguishing developmentally appropriate beliefs and behaviors from those symptomatic of obsessive-compulsive disorder. For example, youth with obsessive-compulsive disorder may fear that, by merely thinking a thought (e.g., hurting a loved one), they will cause it to happen. In children, it is important to differentiate developmentally normal, magical thinking from pathological beliefs that drive compulsions and cause disproportionate distress. For instance, young children may insist on sameness and order or adhere to rigid routines, such as elaborate bedtime rituals, as part of normal development in early childhood, reflecting the need for mastery and control. Typical symptoms in youth also include eating rituals, unusual secretiveness, inability to make decisions, severe separation anxiety, and temper tantrums.

Assessment of obsessive-compulsive disorder should include obtaining complete developmental, medical, and family histories; evaluation of psychosocial functioning across multiple domains (e.g., family, friends, school, and home); and history of current and past symptoms. Both the parents and the child should complete diagnostic interviews to determine mental rituals and/or obsessions that the parent might not be aware of and behavior problems that the youth may be reluctant to report.

EVIDENCE-BASED TREATMENTS FOR OBSESSIVE-COMPULSIVE DISORDER

Effectively treating obsessive-compulsive disorder in youth is crucial to aiding in their lifelong functioning. Individual features of obsessive-compulsive disorder may have important implications for treatment. Mild obsessions or compulsions that are not the source of substantial distress or impairment may warrant monitoring over time. If such obsessions or compulsions are related to external or developmental stressors, psychotherapy or other psychosocial interventions targeted to these stressors may be useful. Treatments for obsessive-compulsive disorder are discussed in Table 1.

Table 1
Summary of Treatments for Obsessive-Compulsive Disorder

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.
Serotonin reuptake inhibitors (SRIs)	Clomipramine: Approved for children aged ten and older; recommend periodic electrocardiographic (ECG) monitoring.
Selective serotonin reuptake inhibitors (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. However, each study addresses complex comorbidity and issues impacting community-based treatment.
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.
Deep Brain Stimulation (DBS)	Involves implanting electrodes in the brain to monitor abnormal impulses. There is strong evidence for success in young adults, but not enough adolescent studies.
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 (PANDAS).
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 medications.

Psychosocial Treatments

Cognitive behavioral therapy (CBT) that includes exposure and response prevention (ERP) therapy is the clinically standard first treatment path for obsessive-compulsive disorder in youth. Research suggests that ERP-based CBT may be more effective than pharmacological treatments. Both individual and individual family-based CBT treatments have been shown to be effective.

Clinicians should treat mild to moderate cases of obsessive-compulsive disorder youth with CBT, and for moderate to severe cases, CBT should accompany pharmacotherapy. For caregivers wondering what questions to ask a therapist during diagnosis, the Anxiety and Depression Association of America has an extensive list.

Pharmacological Treatment

Although traditionally used to treat depression, three selective serotonin reuptake inhibitors (the SSRIs fluoxetine (Prozac), sertraline (Zoloft), and fluvoxamine (Luvox)) and one serotonin reuptake inhibitor (the SRI clomipramine) are approved by the FDA for treatment of obsessive-compulsive disorder in youth.

While these medications may be helpful in conjunction with CBT treatments, they are not without risks and side-effects. For instance, in high doses, clomipramine has been associated with seizures and electrocardiographic (ECG) changes. Youth taking clomipramine should receive periodic ECG monitoring. Other side effects of clomipramine include dry mouth, constipation, dizziness, postural hypotension, sweating, and sedation.

There has also been greater awareness of an increased risk of suicidal ideation in youth taking antidepressants, including SSRIs. These risks must be weighed against the potential benefit from the medication when making treatment decisions. Youth taking these medications should be monitored for potential medical or psychological side-effects throughout treatment, particularly if other medications are also prescribed. The interaction of medications is poorly researched, particularly in children and adolescents; therefore, combinations of medications should be carefully considered. For additional information on this topic, please refer to the *Collection's* section "Antidepressants and the Risk of Suicidal Behavior."

BODY DYSMORPHIC DISORDER

Body dysmorphic disorder causes affected youth to perceive deficits in their physical appearance. Concerns about weight or body fat are related to eating disorders, not body dysmorphic disorder. However, the body imperfections characterizing body dysmorphic disorder are either not observable or only slightly observable to others. A child or adolescent with body dysmorphic disorder may seek out (possibly repetitive or compulsive) ways to fix these perceived flaws by: checking the mirror, seeking surgery or cosmetic procedures, exercise or groom excessively, skin

KEY POINTS

- **Characterized by obsessions and compulsions related to perceived physical deficits (not including body weight).**
- **Physical deficits are not readily perceivable to others.**
- **Occurs when no other mental disorder, for example, an eating disorder, is causing these consuming feelings.**
- **No evidence-based treatments at this time, but cognitive behavioral therapy and medication therapy (SSRIs) show promise.**

picking, changing clothes frequently, and/or seeking reassurance repetitively. Moreover, the child may compare his or her appearance to others. Muscle dysmorphia is a form of body dysmorphic disorder evidenced by a concern that one is too small or not muscular enough.

Males and females are equally likely to present with body dysmorphic disorder symptoms. The median onset age is 15 years; however, the most common onset age is 12 to 13 years. Almost two thirds of those with body dysmorphic disorder experience onset prior to age 18. These individuals are more likely to have a gradual onset and are more likely to attempt suicide. As compared to youth without BDD, youth who have BDD are four times more likely to have suicidal thoughts and 2.6 times more likely to attempt suicide.[2] Clinicians should be aware of the potential for slow onset suicide ideation.

It is important that the clinician distinguishes normal adolescent concerns from body dysmorphic disorder concerns. In addition, developmental changes in the adolescent brain may contribute to the onset of body dysmorphic disorder.[3] These changes increase adolescents' self-consciousness and awareness of social status. Therefore, body dysmorphic disorder may be a disordered response to the psychological, social, and physical changes of adolescence itself.

TREATMENT FOR BODY DYSMORPHIC DISORDER

Unfortunately, there are no evidence-based treatments yet available for youth with body dysmorphic disorder. CBT shows promise because of its effectiveness with similar disorders, as does pharmacotherapy. Treatments are presented in Table 2.

Table 2
Summary of Treatments for Body Dysmorphic Disorder

What Works	
There are no evidence-based practices at this time.	
Not Adequately Tested	
Selective serotonin reuptake inhibitors (SSRIs)	Possibly effective because of effectiveness with similar disorders.
Cognitive behavioral therapy (CBT)	Shows promise because of effectiveness with similar disorders.

[2] Angelakis I, Gooding PA, Panagioti, M. (2019). Suicidality in body dysmorphic disorder (BDD): a systematic review with meta-analysis. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC6343413/#ref19.
[3] Smith, A. R. (2011). When body image becomes a disorder. Retrieved from https://www.counseling.org/docs/default-source/vistas/vistas_2011_article_09.pdf?sfvrsn=11http://counselingoutfitters.com/vistas/vistas11/Article_09.pdf.

HOARDING DISORDER

Hoarding disorder is characterized by ongoing difficulty discarding or parting with possessions (regardless of value), perceived need to save the items, and distress associated with discarding them. Individuals with hoarding disorder accumulate and retain so many items that they congest their living area and substantially compromise the use of the retained items.

KEY POINTS

- **Characterized by overaccumulation of items and difficulty parting with items, which often causes embarrassment and distress.**
- **No evidence-based treatments at this time, but cognitive behavioral therapy tailored to hoarding seems to work.**

Hoarding disorder begins to present symptoms around 11 to 15 years of age, begins to interfere with life around the mid-20s, and causes clinically significant impairment by the mid-30s.

Hoarding can be distinguished from collecting by analyzing how the youth views his or her possessions. Generally, collectors are proud of their possessions and experience joy in displaying and discussing them. Alternatively, those who hoard are embarrassed about their possessions and feel uncomfortable when others see them. Clutter often replaces livable space, and the owner is sad or ashamed after acquiring additional items. Debt frequently accompanies hoarding disorder.

TREATMENTS FOR HOARDING DISORDER

Unfortunately, no treatments that meet the level of evidence-based standards are available for youth with hoarding disorder. Historically, hoarding as a symptom of an OCRD did not react well to medication or standard CBT, although CBT treatment designed specifically for hoarding has shown success in limited trials. Treatments are presented in Table 3.

Table 3
Summary of Treatments for Hoarding Disorder

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT) for hoarding	A multi-component, cognitive behavioral treatment designed specifically for hoarding has shown promising results in adults.
Not Adequately Tested	
Selective serotonin reuptake inhibitors (SSRIs)	Possibly effective because of their effectiveness with similar disorders.

TRICHOTILLOMANIA AND EXCORIATION DISORDER

TRICHOTILLOMANIA (HAIR-PULLING DISORDER)

KEY POINTS

- **Trichotillomania is characterized by compulsive pulling and removing body hairs, which results in significant hair loss.**
- **Excoriation disorder is characterized by compulsive picking of one's skin, leading to physical damage.**
- **No evidence-based treatments at this time, but habit reversal therapy and cognitive behavioral therapy seem to work.**

Trichotillomania involves hair pulling from some or many body parts, including the scalp. Some studies suggest that there are two subtypes of pulling: automatic pulling, which occurs largely outside of the individual's awareness, and focused pulling, which is a deliberate response to an urge, unpleasant emotion, or sensation. In addition to subtypes, hair pulling is often accompanied by ritual, such as choosing the right type of hair, pulling it with the root intact, or examining or manipulating the hair after pulling, including rolling it between fingers, biting, or swallowing it. Usually hair pulling only occurs when the individual is alone or around immediate family. Some individuals will pull hair from others in secret, or from rugs or dolls to satisfy their urges. Youth may report triggers such as tension, anxiety, or specific cognitions like the appearance of the hair, an itch, boredom, or specific settings. Trichotillomania onset typically begins during childhood or early adolescence.

Hair loss must occur to diagnose trichotillomania, but some youth will pull individual hairs throughout an area such that hair loss is less obvious. Additionally, individuals may wear hats or wigs to camouflage hair loss.

EXCORIATION DISORDER (SKIN PICKING DISORDER)

Excoriation (skin-picking) disorder is characterized by picking at one's own skin, including healthy skin, calluses, and pimples. Individuals with excoriation disorder pick at actual and perceived skin defects, leading to physical damage. Most individuals use fingernails, but they may also use tweezers or pins, and they may also rub or squeeze the skin. The individual will frequently seek out a scab or other area to pick, and then examine, play with, or mouth the removed piece of skin or scab. Some picking is focused, with preceding anxiety or tension and subsequent relief, while in others picking is automatic without full awareness. Most individuals engage in both focused and automatic picking. For a diagnosis of excoriation, skin picking must lead to physical damage.

Skin picking may occur as a result of boredom or anxiety, and it may lead to a sense of gratification when successfully completed. At least some symptoms of skin picking can be common. Only when the symptoms reach the criteria for skin picking disorder (lesions, an attempt to stop, and accompanying distress) should the symptoms require intervention. Some research suggests that excoriation most frequently occurs in females from teens to late 30s.

TREATMENTS FOR TRICHOTILLOMANIA AND EXCORIATION DISORDER

Research exploring treatments for childhood trichotillomania and excoriation is promising, but the treatments have not been researched sufficiently enough to warrant the designation of evidence-based treatment. These and other treatments are summarized in Table 4.

CBT is emerging as a promising treatment for trichotillomania and excoriation disorder. CBT for these disorders involves many components common to habit reversal therapy (HRT), such as awareness training and developing a competing response. However, CBT treatments also incorporate several additional elements like psychoeducation and cognitive skills that are thought to provide additional benefits. Psychoeducation entails teaching youth and parents about the disorder and how to monitor behavior. Cognitive restructuring helps youth identify and change maladaptive beliefs associated with stressful situations and to distinguish between minor setbacks and full-blown relapses.

Components have also been added to HRT to target additional problems. In the treatment of trichotillomania or excoriation disorder, therapists may employ either emotion-regulation techniques (which help youth learn more adaptive ways of coping with emotion) or cognitive restructuring (which helps youth recognize and change the thoughts or emotions that occur before or after pulling or picking).

Table 4
Summary of Treatments for Trichotillomania and Excoriation

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)	Treatment involves exposing children to the stimuli associated with the urge, while challenging thoughts associated with high-risk situations.
Not Adequately Tested	
Selective serotonin reuptake inhibitors (SSRIs) N-acetylcysteine Naltrexone	Some demonstrated improvement on certain measures of picking behavior has been shown in some pharmacological studies of adults.

RESOURCES AND ORGANIZATIONS

Anxiety and Depression Association of America (ADAA)
https://adaa.org

Association for Behavioral and Cognitive Therapies (ABCT)
https://www.abct.org/

International OCD Foundation
https://iocdf.org

Mayo Clinic
Obsessive-Compulsive Disorder
https://www.mayoclinic.org/diseases-conditions/obsessive-compulsive-disorder/symptoms-causes/syc-20354432

Mental Health America (MHA)
Obsessive-Compulsive Disorder
https://mhanational.org/conditions/obsessive-compulsive-disorder-ocd/
Trichotillomania
https://mhanational.org/conditions/trichotillomania-hair-pulling/

National Alliance on Mental Illness (NAMI)
https://www.nami.org/

National Institute of Mental Health (NIMH)
Obsessive-Compulsive Disorder
https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml

TLC Foundation for Body-Focused Repetitive Behaviors
http://www.bfrb.org/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/

VIRGINIA RESOURCES AND ORGANIZATIONS

National Alliance on Mental Health (NAMI) Virginia
https://namivirginia.org/

VCU Health - Children's Hospital of Richmond
Cameron K. Gallagher Mental Health Resource Center
https://www.chrichmond.org/services/mental-health/cameron-k-gallagher-mental-health-resource-center
Virginia Treatment Center for Children (VTCC)
https://www.chrichmond.org/services/mental-health/

Virginia Department of Behavioral Health and Developmental Services (DBHDS)
http://www.dbhds.virginia.gov/

Virginia Tech
Child Study Center
http://childstudycenter.wixsite.com/childstudycenter
Psychological Services Center
https://support.psyc.vt.edu/centers/psc

University of Virginia Children's Hospital
Obsessive-Compulsive Disorder
https://childrens.uvahealth.com/services/pediatric-psychiatry/obsessive-compulsive-disorder-ocd

TRAUMA- AND STRESSOR-RELATED DISORDERS

Acute Stress Disorder • Post-Traumatic Stress Disorder
Adjustment Disorders • Attachment Disorders of Early Childhood

OVERVIEW

Trauma is a lasting adverse effect on an individual caused by an event that involves a threat or danger. Events are not traumatic simply because they involve violence; instead, an individual's perception of threat or danger is what can cause trauma. Trauma can result when an individual directly experiences an adverse event, witnesses that event, or learns about it from others.

Exposure to trauma is very common. For instance, one study found that about 60 percent of children experience at least one trauma each year, with about 22 percent of these youth experiencing four or more different types of traumas.[1] Certain events can be more likely to trigger trauma- and stressor-related disorders, including being the victim of or witness to physical or sexual abuse, violence, accidents, and natural disasters, or being diagnosed with a life-threatening illness. However, the likelihood of an adverse outcome is determined by both the nature of the stressor(s) and the characteristics of the child, family, and post-stressor environment, as well as what interventions are offered after the traumatic event.

The primary trauma- and stressor-related disorders that affect children and adolescents are presented in Table 1. Each disorder has different treatments and will be discussed in its own section of this chapter. Recognizing that your child is struggling is the first and most difficult step. It may be difficult to acknowledge that trauma has taken place, because it may evoke guilt in a caregiver. Caregivers must keep in mind the occurrence of trauma does not necessarily mean they have failed in their caregiving responsibilities.

Experiencing trauma can lead to a broad range of potential psychological outcomes, many of which are presented in Table 2. However, it is important to note that, while these factors may be consequences of trauma, they do not always occur following trauma.

Families should take care, as thoughts or attempts of suicide may occur with trauma- and stressor-related disorders. Information about suicide is provided in the "Youth Suicide" section of the *Collection*. If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide and Crisis Lifeline.

Risk Assessment

The ACE trauma score is a screening assessment used to evaluate the number of adverse childhood experiences (ACEs) that a person has had. Adverse Childhood Experiences are traumatic events that occur prior to the age of

[1] Finkelhor, D., Turner, H., Ormrod, R., & Hamsby, S. (2009) Violence, abuse and crime exposure in a national sample of children and youth. *Pediatrics*, 1124, 1-13.

18 and include physical or emotional neglect; physical, emotional or sexual abuse; substance or mental illness in the household; parental separation or divorce; incarcerated household member; and witnessing domestic or other violence. Ten questions ask whether or not a person has had specific types of traumatic experiences and every YES answer contributes to the ACEs score; a higher score means the person had more trauma and stress in their life as a child. A higher ACE score has shown in research that the individual is at greater risk for chronic diseases, mental health disorders, behavioral problems, and suicide attempts.[2]

Trauma-Informed Care

A new form of care is emerging that takes into consideration trauma that individuals experienced in the past. Trauma-informed care programs are based on recognition that trauma survivors are vulnerable and potentially have triggers that may be aggravated by traditional service approaches. Trauma informed care programs seek to avoid those triggers and prevent the trauma from reoccurring.

The treatments for trauma-informed care are similar to treatments for PTSD. Because such a large proportion of children have had an experience that can be classified as a traumatic experience, trauma-informed care is appropriate. Such care avoids situations wherein undue stress is inadvertently placed upon a child. These triggers are thought to have negative short-term effects on emotional health, as well as long-term effects on physical and cognitive health.

Table 1
Disorders Affecting Children and Adolescents Exposed to Trauma

Disorder		Description
Acute Stress Disorder		Dissociative, re-experiencing, avoidance, and hyper-arousal symptoms following a traumatic event that are diagnosed after lasting three days to 1 month after trauma.
Post-traumatic Stress Disorder (PTSD)	PTSD	Re-experiencing, avoidance, and hyper-arousal symptoms following a traumatic event that are diagnosed at least 1 month after trauma exposure.
	Preschool Subtype	Recreating trauma in play; ongoing dreams or nightmares related or unrelated to the traumatic event; avoiding activities or places that trigger memories of the trauma; fear, guilt, and sadness; or withdrawing from friends and activities. Symptoms present for at least one month.
	Dissociative Subtype	Symptoms of PTSD combined with depersonalization, ongoing feeling of detachment from the body or mind, and derealization (regularly feeling that one's surroundings are unreal, dreamlike, or distorted).

[2] Centers for Disease Control. (2021, April 6). About the CDC-Kaiser ACE Study. Retrieved from https://www.cdc.gov/violenceprevention/aces/about/html#.

Adjustment Disorders		Emotional and/or behavioral symptoms in response to an identifiable stressor, such as termination of a relationship or a persistent painful illness (discussed in a separate chapter in the *Collection*). Symptoms occur within 3 months of the onset of the stressor and do not persist for more than 6 months after the stressor or its consequences have terminated.
Attachment Disorders of Early Childhood	Disinhibited Social Engagement Disorder (DSED)	This disorder is diagnosed only in children. Children with DSED exhibit overly familiar and comfortable behavior with relative strangers, including a willingness to go off with strangers with minimal or no hesitation. The child rarely checks back with caregivers, even in unfamiliar situations.
	Reactive Attachment Disorder (RAD)	This disorder is diagnosed only in children. RAD affects infants and very young children. A child with RAD has a pattern of showing disturbed and developmentally inappropriate attachment behaviors. The child rarely or minimally turns to an attachment figure for comfort, support, protection, and nurturance.

Table 2
Symptoms and Consequences Related to Trauma in Children and Adolescents

Domain	Potential Symptoms or Consequences
Physical/Physiological	• Hypersensitivity to physical contact • Numbness • Problems with coordination and balance • Unexplained physical pain (e.g., headaches, stomachaches)
Medical/Mental Health	• Asthma • Autoimmune disorders • Pseudoseizures • Sleep disturbances and/or nightmares • Disordered eating • Dissociation (feeling that the self or world is not real) • Depression • Anxiety disorders • Substance abuse • Attention-deficit/hyperactivity disorder (ADHD) or ADHD-like symptoms • Suicide
Cognitive	• Poor attention • Problems with planning and goal-oriented behavior • Problems with learning • Lack of sustained curiosity • Problems processing new information • Difficulties with language • Impairments in auditory, visual, or spatial perception and comprehension

Attachment/ Relationships	• Distrust of and/or uncertainty about those around them • Problems attaching to caregivers and/or fearing separation from caregivers • Difficulties with boundaries • Interpersonal difficulties
Behavioral	• Poor impulse control • Self-destructive behavior • Aggression • Difficulty complying with rules • Oppositional behavior • Excessive compliance • Inappropriate sexual behaviors
Emotional	• Problems regulating emotions • Amnesia • Low self-esteem • Shame or guilt • Disturbances of body image

ACUTE STRESS DISORDER

Acute stress disorder is diagnosed when trauma-induced symptoms last for at least three days after the trauma. Any other symptoms that are resolved within three days do not meet the criteria for acute stress disorder. The manifestation of the disorder differs in every individual, but symptoms can mirror many of the symptoms of PTSD (which is discussed in the next section). Typically, symptoms consist of anxiety that includes some form of re-experiencing the trauma, or reactivity related to the trauma.

KEY POINTS

- **Characterized by problematic symptoms of trauma that last between three days and four weeks after the traumatic event.**
- **Half of youth with acute stress disorder later develop PTSD.**
- **Treatment involves therapies that restore a sense of safety and assist youth with processing the event.**

If symptoms persist past 1 month, the youth may then be diagnosed with PTSD. However, it is important to note that a youth may be diagnosed with PTSD without having been previously diagnosed with acute stress disorder. Approximately 50 percent of individuals with acute stress disorder may later develop PTSD. Recognizing acute stress symptoms in children and adolescents is a critical first step in the path towards preventing PTSD.

TREATMENT FOR ACUTE STRESS DISORDER

There are no standard treatments for acute stress disorder. The goal of intervention is to restore a sense of safety and assist in the processing of the traumatic event. In the days and weeks after a traumatic event, crisis intervention can involve elements of cognitive-behavioral therapy, supporting therapy, psychoeducational therapy, group and family therapy, and other age-appropriate therapies.

POST-TRAUMATIC STRESS DISORDER (PTSD)

PTSD is diagnosed when problematic symptoms related to trauma last longer than 1 month following a traumatic event. Children with PTSD show symptoms including, but not limited to, angry outbursts, insomnia, worrying about dying, and acting younger than their ages. The manifestation of PTSD can be different in every child or adolescent. Some youth experience PTSD through fear-based re-experiencing, while others have dysphoric mood states. PTSD can also manifest as arousal and reactive-externalizing symptoms. Symptoms of PTSD have the following components:

KEY POINTS

- **Characterized by symptoms such as re-experiencing the event, hypervigilance, avoidance, and negative thoughts.**
- **Symptoms in young children can include recreating the trauma in play, reoccurring nightmares, and fear, guilt, or sadness.**
- **Trauma-focused cognitive behavioral therapy (TF-CBT) has the most support as an evidence-based treatment.**

1. Recurrent experiences of the event, as in memories, dreams, or flashbacks
2. Amplified arousal, including sleep disturbances and reckless behavior
3. Avoiding thoughts, places, and memories about the event
4. Negative thoughts, moods, or feelings

Families should look for the following symptoms:

- Recurring memories of the event, which elicit strong and traumatic feelings
- Bad dreams
- Reenacting trauma during play
- Fear of dying early
- Loss of interest in activities
- Physical symptoms like headaches and stomachaches
- Sudden and extreme emotional reactions
- Dissociation from emotions
- Problems sleeping, both in falling and staying asleep
- Irritability or angry outbursts
- Trouble concentrating
- Acting younger than their age, including thumb sucking, whining, and clinging to an adult
- Increased awareness or alertness to their surroundings
- Repeating behavior that reminds them of the trauma
- Avoiding situations or places that remind them of the trauma

A. PTSD Preschool Subtype (6 Years and Younger)

- Recreating trauma in play/recurrent dreams of the trauma
- Ongoing nightmares with or without recognizable content about the traumatic event
- Avoiding activities or places that remind the child of the trauma
- Exhibiting fear, guilt, and sadness, or withdrawing from friends and activities

These symptoms cause major distress to the child; impair relationships with parents, family members, and/or friends; and affect the child's behavior in preschool or childcare.

B. PTSD Dissociative Subtype

A child or adolescent with PTSD Dissociative Subtype also has symptoms of either depersonalization or derealization. Depersonalization is an ongoing feeling that the youth is detached from his or her body or mind. Derealization is the recurring experience that the youth's surroundings are unreal, dreamlike, or distorted. Some experts believe that dissociation may be a coping response, and it is sometimes seen after sexual abuse.

EVIDENCE-BASED TREATMENT FOR PTSD

Children suffering from PTSD symptoms following a trauma should be treated quickly. The earlier the intervention, the more effective the treatments. The greatest emphasis should be placed on establishing an environment in which the child feels safe. An evaluation by a qualified mental health professional should be sought for any child showing recurring problems handling a traumatic event. Treatments are presented in Table 3.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT has been shown to be effective at improving PTSD, as well as symptoms of depression, shame, and behavioral problems. Parents who participated in treatment with their children have also been shown to have improved parenting skills, in addition to decreased levels of trauma, distress, and depression.

TF-CBT treatment includes core elements that make up the acronym PRACTICE. Each PRACTICE component builds on skills gained in previous sessions:

Psychoeducation is provided to children and parents about trauma and PTSD symptoms, while parents are provided with parenting skills to aid in the management of the child's symptoms.

Relaxation skills are provided.

Affective expression and modulation skills are treatment components.

Cognitive coping skills are provided.

Trauma narrative is developed and processed.

In-vivo mastery of trauma reminders is introduced to differentiate between reminders and dangerous cues in the environment.

Conjoint sessions, where the child and parent focus on having the child share his or her narrative and work on family communication, are also included.

Enhancing safety focuses on safety planning in the future.

These components typically take 12 to 16 sessions to complete. It is important to note that if the youth has complex trauma involving several traumatic incidences, treatment may take longer. Like other cognitive-behavioral treatments, parent involvement and knowledge of skills are important components of treatment. Then, parents or caregivers can help children with the skills outside of the therapy sessions.

TF-CBT is most effective with some degree of caregiver involvement; however, the treatment can still be effective with limited caregiver participation. TF-CBT may not be appropriate when the youth's predominant problems are disruptive behaviors such as defiance, disobedience, aggression, or rule breaking. Similarly, children who are severely depressed or suicidal, or who have active substance abuse, should first receive treatments specific to those conditions.

Table 3
Summary of Treatments for Youth with PTSD

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	
Family centered treatment (FCT) trauma treatment	FCT trauma treatment provides intensive in-home services and seeks to address the causes of trauma, including parental system breakdown, while integrating behavioral change.
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.
Medication	Includes treatment with selective serotonin reuptake inhibitors (SSRIs).
Resilient peer treatment	Classroom treatment that pairs withdrawn children with resilient peers with a parent present for assistance.
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.
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. Recent research suggests this approach is ineffective and potentially harmful.

ADJUSTMENT DISORDERS

For a full discussion of adjustment disorders, see the "Adjustment Disorder" section of the *Collection*.

Adjustment disorders are emotional and behavioral symptoms in response to an identifiable stressor. Examples of stressors include, but are not limited to, experiencing the end of a romantic relationship, experiencing persistent pain with increasing disability, living in a high-crime neighborhood, or experiencing a natural disaster. The diagnosis should be reevaluated if the symptoms persist for more than six months following the termination of the stressor. Adjustment disorders represent a simple response to some type of life stress, which may or may not be traumatic, and they are quite common in children and adolescents.

ATTACHMENT DISORDERS OF EARLY CHILDHOOD

In humans, healthy brain development depends upon forming strong attachments in infancy and early childhood to one or more caregivers. In rare cases, attachment is never established or is severely disrupted. When this happens, a child's ability to form attachments can be severely compromised.

Disinhibited social engagement disorder (DSED) and reactive attachment disorder (RAD) are attachment disorders that manifest in early childhood in situations of profound neglect. These disorders are rare and are only diagnosed in young children.

RAD and DSED are sometimes seen in young children who have come into foster care after having been severely neglected, who have been hospitalized or institutionalized, or who experienced severe neglect in infancy or early childhood in an orphanage or other group care setting.

KEY POINTS

- **Rare disorders caused by a severe disruption in attachment to a primary caregiver in infancy or early childhood.**
- **Characterized by an inability to relate appropriately to caregivers and others (too familiar, too aloof, unable to accept comfort, etc.).**
- **Can indicate severe neglect or severe trauma in infancy or early childhood; sometimes seen in children who have grown up in orphanages or war-torn areas.**
- **No standard treatments have been identified. Treatments should focus on establishing a strong bond with a caregiver.**

A. Disinhibited Social Engagement Disorder (DSED)

DSED is characterized by a pattern of behavior in which a child exhibits inappropriately familiar behavior with strangers. The disorder is characterized by:

- Violations of normal social boundaries
- Unusually familiar behavior (verbal or physical)

- Diminished checking with caregiver when venturing away in unfamiliar settings
- A lack of fear in approaching and interacting with unfamiliar adults
- A willingness to go off with unfamiliar adults

DSED stems from extremely insufficient care of the child. DSED is rare, even in children who have been severely neglected.

Onset for DSED is typically before age five, and it may continue for life unless the child is treated and able to form new attachments. In high-risk populations, including severely neglected children placed in foster care or institutions, approximately 20 percent exhibit signs of DSED.

B. Reactive Attachment Disorder (RAD)

RAD is characterized by a consistent pattern of emotionally withdrawn behavior by the child towards his or her caregiver. A child with RAD rarely seeks comfort when distressed and rarely responds to comfort if given. Children with RAD exhibit limited emotional responses, are often bewildered or confused, and have unexplained episodes of sadness and irritability. They may also be unhygienic and have underdeveloped motor coordination.

Symptoms typically occur around age five but may occur at any age. Caregivers usually notice some or all of the following symptoms:

- Severe colic or difficulties feeding
- Failure to gain weight appropriately
- Difficulty accepting comfort or being calmed or soothed by caregiver
- A preoccupied or defiant attitude
- Being inhibited or hesitant in social interactions
- Being disinhibited or inappropriately familiar with strangers

Frequently, these symptoms occur in children who have been physically or emotionally abused and neglected. Often, RAD occurs in children raised in hospitals or institutional settings, those who have experienced traumatic loss, or those whose primary caregiver changes frequently. In high-risk populations, including severely neglected children placed in foster care or institutions, almost 10 percent exhibit signs of RAD.

RAD symptoms are very similar to those exhibited by children with Autism Spectrum Disorder, and children exhibiting these symptoms should be evaluated for both disorders.

TREATMENTS FOR ATTACHMENT DISORDERS OF EARLY CHILDHOOD

There are no standard treatments for attachment disorders that manifest in early childhood. Treatments have been shown to be beneficial when they emphasize the following in the child/caregiver relationship: psychological safety, stability in the time spent with the child, empathy when listening, permanence of an attachment figure, and emotional availability or attentiveness to the child's needs. Treatment can also include individual and family therapy, education, and parenting skills classes. A child with RAD or DSED may take a year or longer to trust a caregiver again.

RESOURCES AND ORGANIZATIONS

Anxiety & Depression Association of America (ADAA)
https://adaa.org/

Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org/Home/

Child Welfare League of America (CWLA)
http://www.cwla.org

Georgetown University Center for Child and Human Development
Trauma Informed Care
https://gucchd.georgetown.edu/TraumaInformedCare/

International Society for Traumatic Stress Studies (ISTSS)
https://istss.org/home

Medical University of South Carolina (MUSC)
Trauma Focused-Cognitive Behavioral Therapy
http://tfcbt.musc.edu

National Child Traumatic Stress Network
https://www.nctsn.org

Prevent Child Abuse America
800-CHILDREN (244-5373) or (312) 663-3520
http://preventchildabuse.org/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)
National Child Traumatic Stress Initiative (NCTSI)
https://www.samhsa.gov/child-trauma

VIRGINIA RESOURCES AND ORGANIZATIONS

Ainsworth Attachment Clinic & Circle of Security
(434) 984-2722
http://theattachmentclinic.org

Child Savers Guidance Clinic & Trauma Response
(804) 644-9590
https://childsavers.org/

Families Forward
https://www.familiesforwardva.org/

University of Virginia Children's Hospital
https://childrens.uvahealth.com/

VCU Health – Children's Hospital of Richmond
Cameron K. Gallagher Mental Health Resource Center
https://www.chrichmond.org/services/mental-health/cameron-k-gallagher-mental-health-resource-center
Virginia Treatment Center for Children (VTCC)
https://www.chrichmond.org/services/mental-health/virginia-treatment-center-for-children

Virginia Child & Family Attachment Center
(434) 242-2960
https://securechild.center/for-caregivers/

Virginia Commonwealth University (VCU)
Center for Psychological Services and Development
https://cpsd.vcu.edu/

Virginia Department of Behavioral Health and Developmental Services
http://www.dbhds.virginia.gov/
List of TF-CBT Certified Providers
https://dbhds.virginia.gov/developmental-services/children-and-families/trauma-informed-care/

Virginia Tech
Child Study Center
http://childstudycenter.wixsite.com/childstudycenter
Psychological Services Center
https://support.psyc.vt.edu/centers/psc

ADJUSTMENT DISORDER

KEY POINTS

- **Characterized by difficulty coping with a stressful event or situation.**
- **Symptoms of depression, defiant or impulsive behavior, or nervous demeanor are more severe than expected.**
- **Associated with an increased risk of suicide.**
- **No evidence-based treatments have been identified. A variety of psychotherapeutic treatments seem to work.**

OVERVIEW

Adjustment disorders occur when a youth finds it unusually difficult to cope with a stressful event or situation. Symptoms can include emotional and/or behavioral manifestations. Mental and physical symptoms of adjustment disorders include:

- Feeling sad or hopeless, crying or withdrawing from others, loss of self-esteem
- Defiant or impulsive behavior, including vandalism and ignoring school work
- Nervous or tense demeanor
- Anxiety and/or depression
- Arrhythmia (skipped heartbeats), twitching, trembling, insomnia or other physical symptoms

The above list is not exhaustive, but it may help determine whether a physical or emotional symptom is in reaction to a stressor. The symptoms must appear soon after a stressor, be more severe than expected, not be part of another disorder, and not have any other reasonable explanation.

Families should take care, as thoughts or attempts of suicide may occur with adjustment disorders. Information about suicide is provided in the "Youth Suicide" section of the *Collection*. If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide and Crisis Lifeline.

In order to be diagnosed as an adjustment disorder, the child's reaction must occur within three months of the identified event. Typically, the symptoms do not last more than six months from when the stressor or its associated consequences end, and the majority of children quickly return to normal functioning. Adjustment disorders differ from post-traumatic stress disorder (PTSD) in that PTSD usually occurs in reaction to a life-threatening event and may last longer. Adjustment disorders may be difficult to distinguish from major depressive disorder.

Adjustment disorders can occur with many different mental disorders and any medical disorders. As many as 70 percent of all individuals diagnosed with an adjustment disorder are also diagnosed with a co-occurring disorder or illness. In children, adjustment disorders are also most likely to occur with conduct or behavioral problems. Patients with adjustment disorders may engage in deliberate self-harm.

CAUSES AND RISK FACTORS

There is no evidence to indicate that biological factors influence the cause of adjustment disorders; the most widely accepted thought is that stress itself is the precipitating factor. Because children possess varying dispositions, as well as different vulnerabilities and coping skills, it is impossible to attribute a single explanation as to why some stressors trigger adjustment disorders in some children and others do not. However, experts have found that the developmental stage of the child and the strength of the child's support system influence their reaction to the stressor. One common trigger for adjustment disorder is grief and bereavement, especially following the death of a family member or sibling.

Stressors that may cause adjustment disorders can include the following:

- Death of a loved one
- Illness in the youth or a family member
- Moving to a different home or a different environment
- Unexpected catastrophes, including natural disasters
- Family problems
- School problems
- Peer problems
- Sexuality or identity issues
- Any other circumstances experienced by a youth as highly stressful

Many individuals will not develop an adjustment disorder after one or even several of these life events. Better social skills and coping techniques may help prevent adjustment disorders. The *Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition* (DSM-5) notes that individuals in "disadvantaged life circumstances" experience a high stressor rate and, as a result, may be at greater risk for developing adjustment disorders.

TREATMENT

Currently, there are no evidence-based treatments identified for adjustment disorders. That does not mean that treatment intervention is unhelpful or that children with adjustment disorders should not be seen by treatment providers. Children and adolescents can work with clinicians to address and ideally resolve the symptoms of adjustment disorders. Intervention may involve addressing the stressor itself or may focus on ways the youth can manage it. One type of therapy is cognitive behavioral therapy (CBT), wherein the therapist will help the youth identify maladaptive feelings and thoughts and then help the youth identify how to change those thoughts into healthy, positive thoughts and actions.

Families can also utilize the following techniques to help reduce stress:

- Reduce or eliminate the stressors when appropriate
- Allow your child to talk about the stress in a supportive environment
- Encourage your child to eat a healthy diet
- Support a regular sleep routine for your child
- Ensure that your child gets regular physical activity
- Encourage your child to engage in a hobby, either alone or with family
- Offer support and understanding

- Reassure your child that his or her reactions are common
- Work with teachers to track progress at school
- Give your child a sense of control over actions by allowing them to make decisions when possible (from simple routines like including dinner and movie choices to more substantive ones, when appropriate)

Because an adjustment disorder is a psychological reaction to a stressor, the most widely accepted treatment process involves identifying the stressor and having a child communicate that stressor effectively. If the stressor is eliminated, reduced, or accommodated, the child's maladaptive response can also be reduced or eliminated. Accordingly, treatment of adjustment disorders usually involves psychotherapy that seeks to reduce or remove the stressor or improve coping ability.

Treatments for adjustment disorders must be tailored to the needs of the child, based on the child's age, health, and medical history. There is no consensus on a clear treatment plan. Treatment selection is a clinical decision to be made with the treating clinician and the patient. However, because of the brevity of adjustment disorders, short-term psychotherapy is generally preferred to long-term. Treatments are outlined in Table 1.

Table 1
Summary of Treatments for Adjustment Disorder

What Works	
There are currently no evidence-based practices.	
What Seems to Work	
Interpersonal psychotherapy (IPT)	IPT helps children and adolescents 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 like-minded/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	
Medication alone	Medication is seldom used as a singular treatment because it does not aid the child in learning how to cope with the stressor. Targeted symptomatic treatment of the anxiety, depression, and insomnia may effectively augment therapy.

Psychotherapy

Psychotherapy is the treatment of choice for adjustment disorders because the symptoms are a direct reaction to a specific stressor. However, the type of therapy depends on the needs of the child, with the focus being on addressing the stressors and working to resolve the problem. Interpersonal psychotherapy (IPT) has the most support for treating children with adjustment disorders. For depressed adolescents, IPT is a well-established treatment. IPT helps children and adolescents address problems in their relationships with family members and friends. Typically, the clinician works one-on-one with the child and his or her family.

Within preliminary clinical trials, brief treatment using cognitive-behavioral strategies also shows promise. Cognitive-behavioral approaches are used to improve age-appropriate problem-solving skills, communication skills, impulse control, anger management skills, and stress management skills. Additionally, therapy assists with shaping an emotional state and support systems to enhance adaptation and coping.

There are specific goals that should be met during psychotherapy for it to be successful for the patient. During psychotherapy the following should occur:

- Analyze stressors affecting patient
- Clarify and interpret the meaning of the stressor
- Attempt to reframe stressor
- Illuminate concerns of the patient
- Configure a plan to reduce stressor
- Increase coping skills of patient

Stress management and group therapy are particularly beneficial in cases of work-related and/or family stress. Family therapy is frequently utilized, with the focus on making needed changes within the family system. These changes may include improving communication skills and family interactions and increasing support among family members.

Preventive measures to reduce the incidence of adjustment disorders in children are not known at this time. However, early detection and intervention can reduce the severity of symptoms, enhance the child's normal growth and development, and improve quality of life.

Pharmacological Treatment

Medication is seldom used as a single treatment for adjustment disorders because the child requires assistance in coping with the stressor, as well as his or her reaction to it. However, treatment that targets symptoms like anxiety, depression, and insomnia that can occur with adjustment disorders may effectively augment therapy. But, it is not recommended as the primary treatment.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)
http://www.aacap.org/

Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org/Home/

Child Mind Institute
Adjustment Disorders
https://childmind.org/guide/adjustment-disorders-in-children-quick-guide/

Child Welfare Information Gateway
https://www.childwelfare.gov/

John's Hopkins Medicine
https://www.hopkinsmedicine.org/health/conditions-and-diseases/adjustment-disorders

Mental Health Matters
https://mhmyouth.org

New York University School of Medicine
Department of Child & Adolescent Psychiatry
https://med.nyu.edu/child-adolescent-psychiatry/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

U.S. Department of Health and Human Services
https://www.hhs.gov/

Virginia Tech
Child Study Center
http://childstudycenter.wixsite.com/childstudycenter
Psychological Services Center
https://support.psyc.vt.edu/centers/psc

FEEDING AND EATING DISORDERS

Anorexia Nervosa • Bulimia Nervosa • Binge Eating Disorder

OVERVIEW

The three main categories of feeding and eating disorders are anorexia nervosa, bulimia nervosa, and binge eating disorder (see Table 1). Because each category has different treatments, each will be discussed in its own section of this chapter.

Table 1
Feeding Disorders Affecting Children & Adolescents

Disorder	Description
Anorexia nervosa (AN)	Distorted body image and pathological fear of becoming fat that leads to excessive dieting and extreme weight loss; can include purging or excessive exercise.
Bulimia nervosa (BN)	Frequent episodes of binge eating followed by purging behaviors such as vomiting or laxative use to avoid weight gain; weight unduly influences self-concept.
Binge eating disorder (BED)	Excessive, out-of-control eating without purging that causes marked distress; weight does not need to unduly influence self-concept.

Eating disorders are a significant problem in the United States among children and adolescents of all ethnic groups. Individuals at any weight may be malnourished and/or engage in unhealthy practices. People with eating disorders may appear healthy, yet be extremely ill. The American Psychiatric Association (APA) has reported that eating disorders are now the third most common form of chronic illness in the adolescent female population, with numbers steadily increasing for the male population. Prevalence rates are as high as 8.6 percent for females and 4.07 percent for males. Over 30 million Americans will have an eating disorder in their lifetime, and this contributes to the second highest mortality rate for individuals with psychiatric disorders, after number one opiate addiction.

While feeding and eating disorders are considered to be psychiatric in nature, accompanying nutrition and medical problems may make them life-threatening.

Psychological disorders often co-occur with AN, BN, or BED. For instance, as many as 50 percent of individuals with a feeding and eating disorder also have depression. These disorders can precede or accompany the onset of feeding or eating disorder, and they sometimes remit after treatment. Co-occurring disorders include:

- Depressive disorders

- Anxiety disorders
- Bipolar disorder
- Substance abuse disorders
- Obsessive-compulsive disorder

The risk of suicide in individuals diagnosed with an eating disorder is substantial. Individuals with BN report a greater number of suicidal attempts (25 to 35 percent), compared to those with AN (10 to 20 percent). Researchers speculate that the link between purging and suicidal attempts may point to a general lack of impulse control, whereas the higher prevalence of suicidal thoughts among individuals with AN suggests chronic self-harming behavior. Studies have found that approximately 31% of individuals with anorexia nervosa, 23% of individuals with bulimia nervosa, and 23% of individuals diagnosed with binge eating disorder have attempted suicide.[1] For more information, see the "Youth Suicide" section of the *Collection*. If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide and Crisis Lifeline.

Denial of the seriousness of the disorder is a common symptom for all eating disorders. Competence in other realms of life may mask the severity of the problem. The National Association of Anorexia Nervosa and Associated Disorders outlines several strategies that parents/caregivers can use to bring up their concerns in a non-threatening manner.

CAUSES AND RISK FACTORS

Attempts to identify a single cause of eating disorders have been abandoned and replaced by a more multifaceted theory. Studies suggest disordered eating typically develops from a complex interaction of psychological risk factors, sociocultural influences, and biological or genetic predispositions. Common risk factors are provided in Table 2.

Table 2
Risk Factors for Feeding and Eating Disorders

Category	Common Risk Factors
Psychological factors and personality traits	• Negative affect or outlook • Low self-esteem • Intense dissatisfaction with appearance • Perfectionism • Impulsivity • Rigid cognitive styles and/or need for control • Obsessive-compulsiveness • Avoidance traits • Lack of self-direction
Dysfunctional families and relationships	• Conflict avoidance • Significant parental enmeshment • Rigid/overprotective parenting

[1] Ibid.

History of abuse or trauma	• Physical abuse • Sexual abuse • Traumatic events
Involved in activity that has an emphasis on body shape or weight	• Sports that emphasize aesthetics or thinness (e.g., gymnastics, dance, running) • Sports that include weight classes (e.g., wrestling) • Dance or other performance arts • Appearance-centric activities (e.g., modeling, beauty pageants) • For more information, see Stanford Medicine Children's Health (Resources)
Genetic factors	Unclear; however, first-degree female relatives and identical twin siblings have higher rates of eating disorder diagnoses.

TREATMENT CONSIDERATIONS

The earlier an eating disorder is identified and treated, the better the chances for recovery. However, families should be aware that it might take as long as 10 years from the commencement of treatment to behavioral cure, including normal eating and normal weight. A comprehensive treatment plan should include medical care and monitoring, psychosocial interventions, nutritional counseling, and, when appropriate, medication management.

Treatment locations range from intensive outpatient settings, in which general medical consultation is readily available, to partial hospital and residential programs with varying levels of outpatient care. The individual's weight, cardiac status, and metabolic status are the most important physical parameters for determining treatment setting. Individuals who weigh under 85 percent of their estimated healthy weights are likely to require a highly structured program and possibly 24-hour hospitalization. Hospitalization should occur before the onset of medical instability, as manifested by severely abnormal vital signs.

ANOREXIA NERVOSA (AN)

The primary characteristic/criterion of AN is intense fear of gaining weight or becoming fat, even when the individual is underweight. Individuals with AN resist maintaining their body weight at or above a minimally normal weight for their age and height. Youth with AN will often exhibit significantly low weight. Some may also exhibit purging or binge/purging behaviors.

Individuals with AN sometimes have specific personality traits, including perfectionist traits and low self-esteem (see Table 2), and they can be high achievers. Many have an intense need for a feeling of mastery over their lives. Primary features and signs

KEY POINTS

- **Characterized by distorted body image, fear of becoming fat, and excessive dieting; can include purging.**
- **If untreated, can cause extremely low body weight, malnutrition, dehydration, and death.**
- **Associated with an increased risk of suicide.**
- **Family-based psychotherapy is the most well-established treatment.**

and symptoms of AN appear in Table 3. Warning signs for caregivers are listed in Table 4.

Table 3
Primary Features and Common Symptoms of Anorexia Nervosa

Primary Features	Common Signs and Symptoms
• Excessive food restriction • Distorted body image • Undue influence of body weight and shape in self-evaluation/fear of gaining weight • Denial of the seriousness of the current low body weight May lead to: • Significant weight loss • Dangerous side-effects including malnutrition and dehydration, which can lead to death	• Starving oneself by fasting or calorie restriction • Purging or binge/purge behaviors • Excessive exercise • Changes in the mouth, including enlarged salivary glands, changed tooth color, tissue loss or lesions, heightened sensitivity to temperature, and tooth decay • Dry and/or yellowing skin • Dehydration • Abdominal pain and/or constipation • Lethargy, dizziness, and/or fatigue • Development of fine, downy body hair • Infrequent or absent menstrual periods • Intolerance to cold • Emaciation

Table 4
Warning Signs an Individual is Struggling with Anorexia Nervosa

Take note if an individual shows the following signs:
• Wears clothing that hides weight loss (i.e. layered, baggy) • Preoccupied with weight, food, calories, fat grams, and dieting • Restrictions against whole categories of foods • Makes frequent complaints about feeling “fat” or overweight despite weight loss • Denies feeling hungry • Consistently makes excuses to avoid mealtimes or situations involving food • Expresses a need to “burn off” intake calories • Maintains an excessive, rigid exercise routine - despite weather, fatigue, illness, or injury • Withdraws from friends and activities and becomes more isolated and secretive • Limited social spontaneity • Post puberty female loses period/menstrual irregularities (having irregular periods or only have a period while on hormonal contraceptives)

TREATMENTS FOR ANOREXIA NERVOSA

A summary of treatments for AN is presented in Table 5. The treatment of AN generally occurs in three phases:

1. Restoring the weight lost by severe dieting and purging
2. Treating psychological disturbances, such as distorted self-perception, low self-esteem, and interpersonal issues
3. Achieving long-term, full recovery

Family-Based Psychotherapy

Family-based psychotherapy is demonstrably superior to other treatments for AN in adolescents. The goal of family therapy is to involve family members in symptom reduction and to deal with family relational problems that may contribute to AN. Family-based therapy occurs over the following three stages:

1. Parents, along with the therapist, take responsibility to ensure the adolescent is eating sufficiently and controlling other pathologic weight control methods. Substantial weight recovery occurs before moving to the second phase.
2. Parents and the therapist help the adolescent gradually take over responsibility for his or her eating. Weight is restored in the second phase, and then the family moves on to the third phase.
3. The family addresses more general issues of the adolescent's development and how they were disrupted by the eating disorder.

Family psychotherapy may not be appropriate for families in which one or both parents exhibit psychopathy or hostility to the affected child, and it may not be appropriate for the most medically compromised adolescents.

In-Patient Behavioral Programs

These programs commonly provide a combination of nonpunitive reinforcers, such as privileges linked to weight goals and desired behaviors. They have been shown to produce good short-term therapeutic effects. Adolescents with AN may have the best outcomes after structured in-patient or partial hospitalization treatment.

Nutritional Rehabilitation

Evidence suggests that nutritional monitoring is effective in helping individuals return to a healthy weight, so long as it is conducted in a setting that meets the individual's needs. Increasing calories consumed may be difficult, but smaller, frequent meals, calorie dense foods, and substituting fruit juice for water may help negate psychological barriers, such as aversion to a feeling of fullness. For severely underweight individuals, individual treatment has been found to be most effective. Clinicians have reported that as weight is restored, other eating disorder and psychiatric comorbid symptoms diminish; however, they often do not disappear completely. Psychoeducational nutrition groups have also been associated with positive outcomes. Although helpful, it is important that nutrition counseling serve as only one component of a multidisciplinary treatment approach.

Table 5
Summary of Treatments for Anorexia Nervosa

What Works	
Family-based 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.
Nutritional rehabilitation	Entails developing meal plans and monitoring intake of adequate nutrition to promote healthy weight gain.
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.
Medication	Used primarily after weight restoration to minimize symptoms associated with psychiatric comorbidities.
Not Adequately Tested	
Individual psychotherapy	Controlled trials have not supported this treatment; however, it may be beneficial during the renourishing process and to minimize comorbid symptoms.
Imaginal Exposure therapy	Involves imagining fear-inducing situations and then working through resulting emotions and behaviors. Future randomized control trials still needed.
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.

BULIMIA NERVOSA (BN)

BN consists of recurrent episodes of binge eating, characterized by consumption of excessive amounts of food within a discrete period of time and lack of control in overeating during the episode. In order to prevent weight gain, the binges are followed by recurrent inappropriate responses, such as self-induced vomiting or misuse of laxatives and other medications (often referred to as purging), fasting, or excessive exercise. Purging is dangerous behavior and may seriously damage health, causing dehydration and hormonal imbalance, depleting minerals, and damaging organs.

KEY POINTS

- **Characterized by out-of-control binge eating followed by purging techniques such as vomiting or using laxatives.**
- **Can be hard to spot; many people with BN are within normal weight ranges.**
- **Excessive purging can seriously damage health.**
- **Dentists often notice signs first because excessive vomiting can cause changes in the mouth.**
- **Associated with an increased risk of suicide.**
- **Cognitive behavioral therapy is the superior treatment.**

Binge eating and compensatory behaviors both occur, on average, at least once a week for three months or more. Finally, like other eating disorders, the individual's self-evaluation is unduly influenced by body shape and weight. Recognizing BN can be challenging because many individuals with BN are within normal weight range.

Youth affected with BN are often embarrassed by their compulsion to eat and may also attempt to hide their symptoms. Primary features and signs and symptoms of BN appear in Table 6. Warning signs for caregivers are listed in Table 7.

Table 6
Primary Features and Common Signs and Symptoms of Bulimia Nervosa

Primary Features	Common Signs and Symptoms
• Undue influence of body weight and shape in self-evaluation/fear of gaining weight • Excessive and uncontrolled eating followed by purging methods such as vomiting, laxatives, enemas, diuretics, exercising May lead to: • Dehydration • Hormonal imbalance • Depleting important minerals • Damaging vital organs	• Alternating binges and severe diets • Severe weight fluctuations • Purging calories by self-induced vomiting and/or using laxatives • May run water to hide vomiting • Scars on the back of the hand caused by induced vomiting • Changes in the mouth, including enlarged salivary glands, changed tooth color, tissue loss or lesions, heightened sensitivity to temperature, and tooth decay • Excessive exercise • Dry hair and skin, hair loss, skin pigmentation changes

Table 7
Warning Signs an Individual is Struggling with Bulimia Nervosa

Take note if an individual shows the following signs:
• Appears uncomfortable eating around others • Evidence indicating consumption of large amounts of food (lots of empty wrappers and containers) • Develops food rituals (e.g., eats only a particular food or food group [e.g., condiments], excessive chewing, doesn't allow foods to touch) • Skips meals or takes small portions of food at regular meals • Disappears after eating, often to the bathroom • Any new practice with food or fad diets, including cutting out entire food groups (no sugar, no carbs, no dairy, vegetarianism/veganism) • Fear of eating in public or with others • Uses excessive amounts of mouthwash, mints, and gum • Hides body with baggy clothes • Maintains excessive, rigid exercise regimen – despite weather, fatigue, illness, or injury—due to the need to "burn off " calories • Has calluses on the back of the hands and knuckles from self- induced vomiting • Withdraws from usual friends and activities • Frequent checking in the mirror for perceived flaws in appearance • Extreme mood swings

TREATMENTS FOR BULIMIA NERVOSA

The primary goal of treatment for individuals with BN is to reduce or eliminate binge eating and purging behavior. Nutritional rehabilitation, psychosocial intervention, and medication management strategies are often used. Specifically, treatment includes establishing regular, non-binge meals, improving attitudes related to the disorder, encouraging healthy but not excessive exercise, and resolving any co-occurring mental health disorders such as anxiety or mood disorders. A summary of treatments for BN is presented in Table 8.

Cognitive Behavioral Therapy (CBT)

This form of psychotherapy, when specifically directed at BN symptoms and underlying conditions, is the intervention for which there is the most evidence of efficacy. It has been found to lead to significant reductions in binge eating, vomiting, and laxative abuse. CBT involves a combination of psychoeducation, self-monitoring, adjusting reactions to cues, confronting and restructuring automatic thoughts, problem solving, exposure while preventing response, and preventing relapse.

Combined Treatments

There is generally a better response to CBT than to pharmacotherapy; however, the combination of these two methods has been found to be superior to either treatment independently.

Table 8
Summary of Treatments for 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 medication seems to maximize outcomes.
What Seems to Work	
Medication	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 because they do not address nutritional or behavioral concerns.

BINGE EATING DISORDER (BED)

In 2013, the *Diagnostic and Statistical Manual for Mental Health Disorders* (DSM-5) included the diagnosis of BED as an official disorder. This addition is highly significant because BED is likely to be the most prevalent eating disorder. BED shares the binge-eating criterion of bulimia nervosa (BN) of consuming an objectively large quantity of food in a relatively short time while experiencing a loss of control. The disorder differs from BN, however, in that individuals with BED do not engage in compensatory behaviors, such as vomiting or laxative use, after binge eating. In addition, for an individual to be diagnosed with BN, body weight and shape must unduly influence his or her self-concept. This is not necessary for a diagnosis of BED.

KEY POINTS

- **Characterized by out-of-control binge eating with marked distress, but without purging.**
- **Can cause weight gain and obesity-related health risks.**
- **Body weight and shape do NOT need to unduly influence self-concept.**
- **Newly-recognized disorder; no evidence-based treatments for youth yet established.**

The second criterion for BED describes behaviors, emotions, and thoughts associated with binge eating. BED includes recurrent episodes of binge eating followed by marked distress. Binge eating is accompanied by an uncontrollable feeling that one cannot stop eating.

Primary features and signs and symptoms of BED appear in Table 9.

Table 9
Primary Features and Common Signs and Symptoms of Binge Eating Disorder

Primary Features	Common Signs and Symptoms
• Frequent episodes of excessive and uncontrolled eating that cause marked distress • Feeling that one cannot control or stop a binge • No purging like in bulimia nervosa • Self-concept need NOT be unduly influenced by body weight and shape • May lead to weight gain, health issues associated with obesity, and/or future purging behaviors	• Eating more rapidly than normal • Eating until uncomfortably full • Eating large amounts of food when not hungry • Eating alone because of embarrassment from the amount of food being consumed • Feeling disgusted with oneself, depressed, or very guilty after a binge • Weight gain

TREATMENTS FOR BINGE EATING DISORDER

The treatment goals and strategies for BED are similar to those for BN. The primary difference in the two disorders is that individuals with BED may present with difficulties associated with being overweight rather than being malnourished. Consequently, the treatment strategies tend to diverge only in the nature of medical interventions. However, BED has been relatively unexamined in younger patients, and no treatments yet meet evidence-based criteria.

A summary of treatments for BED is presented in Table 10.

Table 10
Summary of Treatments for 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.
Medication	Antidepressants, namely SSRIs, have effectively reduced binge/purging behaviors, as well as comorbid psychiatric symptoms.
Not Adequately Tested	
Dialectical behavior therapy (DBT)	Combines parts of CBT with principles of mindfulness.
Mindfulness and yoga-based interventions	Use of yoga as a therapeutic model to incorporate concentration, meditation, and physical and emotional awareness practices.
What Does Not Work	
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 because they do not address nutritional or behavioral concerns.

RESOURCES AND ORGANIZATIONS

Academy for Eating Disorders (AED)
https://www.aedweb.org/home

Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org/Home/

Eating Disorders Coalition for Research, Policy & Action (EDC)
http://www.eatingdisorderscoalition.org/

EDReferral.com (Eating Disorder Referral and Information Center)
https://www.edreferral.com/

Johns Hopkins Eating Disorders Program
https://www.hopkinsmedicine.org/psychiatry/specialty_areas/eating_disorders/index.html

National Association of Anorexia Nervosa and Associated Eating Disorders (ANAD)
http://www.anad.org/

National Eating Disorders Association (NEDA)
Information & Referral Helpline: 800-931-2237
https://www.nationaleatingdisorders.org/

National Eating Disorder Collaboration
https://nedc.com.au

National Institute of Mental Health (NIMH)
https://www.nimh.nih.gov

Society for Adolescent Health and Medicine (SAHM)
https://www.adolescenthealth.org/Home.aspx

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

Stanford Medicine Children's Health
Eating Disorders and Young Athletes
https://www.stanfordchildrens.org/en/topic/default?id=eating-disorders-and-young-athletes-160-28

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/

VIRGINIA RESOURCES AND ORGANIZATIONS

James Madison University
Help Overcome Problems with Eating and Exercise (HOPE)
https://www.jmu.edu/healthcenter/PreventionandEducation/hope-multiregion.shtml

Virginia Commonwealth University Health System
Department of Psychiatry
https://psych.vcu.edu/
Virginia Treatment Center for Children (VTCC)
https://www.chrichmond.org/services/mental-health/virginia-treatment-center-for-children

Virginia Tech
Cook Counseling Center
http://ucc.vt.edu/self_help_support_stategies/help_eating_disorders.html

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

OVERVIEW

A child being disagreeable is normal. Oppositional behavior is a serious concern only if it is extreme when compared to children of similar age and developmental level, and if it affects the child's social, family, and academic life. Impulse-control occurs when an inability to regulate internal experiences (like emotions or sensations) triggers disruptive behaviors. Defiant and oppositional behavior can manifest itself as oppositional defiant disorder (ODD), the more severe conduct disorder (CD), or intermittent explosive disorder (IED). Other disorders included in this category are pyromania and kleptomania.

KEY POINTS

- **Characterized by extreme oppositional behavior that affects a child's social, family, and academic life.**
- **Risk factors include living in dysfunctional or violent environments, child abuse and neglect, deviant peer associations, and genetic influences.**
- **Parent behavior management training is the primary intervention.**
- **Multisystemic therapy and cognitive behavioral therapy are also evidence-based treatments.**

While some characteristics of ODD and CD overlap, there are important distinctions. Youth with ODD may not display significant physical aggression and may be less likely to have problems with the law. Moreover, because ODD is seen as a disorder of noncompliance and CD involves the violation of another's rights, it is helpful to view these mental health disorders as two points on a continuum, rather than as two separate mental health disorders.

Increases in oppositional and antagonistic behaviors are somewhat typical at the onset of adolescence. Youth with autism spectrum disorder, ADHD, anxiety, or depression may also be more likely to exhibit these symptoms. Clinicians, therefore, should give careful consideration to determining whether oppositional behaviors are manifestations of typical development or of a primary mental health disorder.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) criteria for disruptive, impulse-control, and conduct disorders are outlined in the paragraphs that follow.

Oppositional Defiant Disorder (ODD)

ODD manifests as a pattern of hostile and oppositional behavior, including but not limited to:

- Frequent temper tantrums
- Excessive arguing with adults

- Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehavior
- Often being touchy or easily annoyed by others
- Frequent anger and resentment
- Aggressive behavior
- Mean and hateful talking when upset
- Vindictiveness —spiteful attitude and revenge seeking

Oppositional behaviors often manifest in the home setting and with familiar adults. Behaviors may or may not be present in the school and/or community settings, and thus may not be present in the mental health professional's office. To be diagnosed with ODD, the behaviors must occur with at least one individual who is not the person's sibling. The severity of the disorder is indicated by the number of settings in which the symptoms are present. Significant distress or impairment in functioning must also be present in order to make a diagnosis of ODD.

Conduct Disorder (CD)

Children and adolescents with CD exhibit persistent and critical patterns of misbehavior. Like children with ODD, youth with CD may have an issue with controlling their tempers; however, these youth also violate the rights of others and/or major societal norms. Following an episode, they may lack remorse or empathy.

The symptoms of CD include, but are not limited to, the following:

- Bullies, threatens, or intimidates others
- Deceitfulness and lying to obtain goods or favors or to avoid obligations
- Stealing from others, sometimes while confronting the victim
- Serious violations of rules (truant, runs away, etc.)
- Often initiates physical fights
- Deliberate destruction of property
- Aggression and/or physical cruelty to people and animals
- Use of a dangerous weapon on others with the intent to harm
- Forces someone into sexual activity

These disturbances must cause clinically significant impairment in social, academic, or occupational functioning. Children and adolescents diagnosed with CD have more difficulty in areas of academic achievement, interpersonal relationships, drugs, and alcohol use. They also are often exposed to the juvenile justice system because of their delinquent or disorderly behaviors. Some will develop adult antisocial personality disorder later in life.

Intermittent Explosive Disorder (IED)

IED involves impulsive or anger-based aggressive outbursts that begin rapidly. The outbursts often last fewer than 30 minutes and are provoked by minor actions of someone close, often a family member or friend. The aggressive episodes are generally impulsive and/or based in anger rather than premeditated.

Aggressiveness must be "grossly out of proportion" to the provocation and accompanying psychosocial stressors. The recurrent outbursts are neither premeditated, nor are they to achieve an outcome. Thus, outbursts are impulsive or based in anger, and are not meant to intimidate or to seek money or power. Finally, the outbursts must cause the individual considerable distress, impair his or her occupational or interpersonal functioning, or be associated with financial or legal consequences.

Children diagnosed with IED display:

- Verbal or physical aggression that occurs, on average, twice per week for three months but does not result in damage or injury to people or animals, **or**
- Behavioral outbursts that occur three or more times a year that do result in damage or injury to people or animals

Pyromania

The essential feature of pyromania is the deliberate and purposeful setting of fires. It involves multiple episodes. The symptoms of this disorder include:

- Deliberately and purposefully setting a fire more than one time.
- Tension or emotional arousal being present before the act of setting the fire.
- Having a fascination with, interest in, curiosity about, or attraction to fire and its uses and consequences.
- Feeling pleasure, relief, or gratification when setting fires or when seeing the aftermath of a fire or the damage it caused.
- The fires are not set for monetary gain, to cover up criminal activity, to express anger or vengeance, in response to any hallucinations or delusions, or as a result of impaired judgment (from another disorder or substance).
- The firesetting is not better explained by CD, a manic disorder, or antisocial personality disorder.

Pyromania as a primary diagnosis appears to be very rare. In people incarcerated for repeated firesetting, only about three percent meet all the symptoms for pyromania. For more information on this disorder, please refer to the "Juvenile Firesetting" section of the *Collection*.

Kleptomania

Kleptomania is distinct from theft in that it involves the impulsive and unnecessary stealing of often useless things. Individuals may hoard the things they steal, give them away, or even return them to the store. The disorder is not about the objects stolen; it is about the compulsion to steal and the lack of self-control over this compulsion. Females with kleptomania outnumber males at a ratio of three to one.

Kleptomania typically follows one of three patterns of stealing: 1) brief episodes of stealing with intermittent and long periods of remission, 2) longer periods of stealing with brief periods of remission, or 3) chronic and continuous episodes of stealing with only minor fluctuation in frequency. Kleptomania is very rare, with a prevalence rate of 0.3 to 0.6 percent in the general population. Accordingly, it will not be discussed in this section of the *Collection.*

CAUSES AND RISK FACTORS

As with most psychiatric disorders, there is no single cause of these disorders. Rather, they arise out of a complex combination of risk and protective factors related to biological and environmental/social influences.

Researchers agree that there is a strong genetic and biological influence on the development of disruptive, impulse-control, and conduct disorders. These and related behavioral disorders (e.g., ADHD, substance use disorders, and mood disorders) tend to cluster in families. Parents of children with ODD often have mood disorders, while parents of children with CD are more likely to have depression, substance use disorders, schizophrenia, ADHD, and/or antisocial personality traits or behaviors.

Several social factors may also present a risk, including poverty, lack of structure, community violence, and dysfunctional family environment. Youth who are neglected through lack of parental supervision and positive parenting behaviors and/or who experience harsh treatment, including child abuse, are at higher risk. Those with deviant peer associations are also more likely to meet the criteria for these disorders. This may be because youth can learn deviant behaviors from others and can have their negative behavior patterns reinforced in deviant relationships.

Characteristics of the coronavirus pandemic may exacerbate impulse-control disorders. For more information, see the "COVID-19 Pandemic and Lockdown" section of the *Collection*.

EVIDENCE-BASED TREATMENTS

Although ODD, CD, and IED are considered separate diagnoses, the treatment principles for these disorders are very similar. Individualized treatment plans should be developed to address the particular problems and severity of each child and family situation.

A summary of treatments is outlined in Table 1.

Parent behavior management training is the primary intervention for disruptive, impulse-control, and conduct disorders. The key strategies of these approaches include the following:

- Identification and reduction of positive reinforcement of structured behavior
- Increased reinforcement of prosocial and compliant behavior
- Utilization of nonviolent and consistent discipline for disruptive behaviors
- Emphasis on predictability and immediacy of parental contingencies

Multisystemic therapy (MST) is an individualized case management program that incorporates many aspects of parent management and child social skills training for youth with serious behavior disorders who are at risk for out-of-home placement. MST attempts to intervene with the multiple factors that can contribute to antisocial behavior at the individual, family, and broader social levels, including peer, school, and neighborhood factors. Trained clinicians identify strengths in each youth's social network and capitalize on these to promote positive change. By helping both parents and youth to manage their lives more effectively, the need for out-of-home placement may be eliminated.

No medications have been formally approved for impulse-control disorders, so medications are directed at specific symptoms to improve quality of life. Medication is not sufficient treatment by itself.

Table 1
Treatments for Disruptive, Impulse-Control, and Conduct Disorders

What Works	
Parent management training (PMT)	PMT programs focus on teaching and practicing parenting skills with parents or caregivers. Program models include: • Helping the Noncompliant Child • Incredible Years • Parent-child interaction therapy • Parent MT to Oregon model
Multisystemic therapy (MST)	MST is an intensive family- and community- based treatment that addresses the multiple determinants of serious antisocial behavior. MST clinicians use empirically validated approaches, such as cognitive-behavioral therapy and pragmatic family therapies, and typically provide individual and family counseling and 24-hour crisis management.
Cognitive behavioral therapy (CBT)	CBT emphasizes problem-solving skills and anger control/coping strategies.
CBT & PMT	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 home.
Not Adequately Tested	
Brief Strategic Family Therapy	Counselors establish relationships with the family, then coach to reshape patterns of interpersonal interactions.
Atypical antipsychotics medications	Risperidone (Risperdal), quetiapine (Seroquel), olanzapine (Zyprexa), and aripiprazole (Abilify); limited evidence for effectiveness in youth with ID or ASD; primarily short-term use recommended.
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; may also address aggression.

What Does Not Work	
Boot camps, "military schools," shock incarcerations	Ineffective at best; can lead to worsening of symptoms.
Dramatic, short-term, or talk therapy	Little to no effect as currently studied.

Severe and persistent cases of ODD that develop into CD may require an alternative placement when the safety of the youth and/or those around him or her are in jeopardy. Youth may require out-of-home placement when they require crisis management services or when their family is unable or unwilling to collaborate with treatment. When considering day treatment, residential treatment, or hospitalization, the least restrictive setting should be selected for the shortest possible time to ensure safety and progress. Other placements that may be considered are therapeutic foster care or respite care.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)
Conduct Disorder Resource Center
http://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Conduct_Disorder_Resource_Center/Home.aspx
Oppositional Defiant Disorder Resource Center
http://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Oppositional_Defiant_Disorder_Resource_Center/Home.aspx

American Psychiatric Association (APA)
https://www.psychiatry.org/

American Psychological Association (APA)
http://www.apa.org/

Association for Behavioral and Cognitive Therapies
http://www.abct.org/Home/

Johns Hopkins Medicine
Conduct Disorder
https://www.hopkinsmedicine.org/health/conditions-and-diseases/conduct-disorder

Mental Health America (MHA)
Fact Sheet on Conduct Disorder
https://www.mhanational.org/conditions/conduct-disorder

Society of Clinical Child and Adolescent Psychology
https://sccap53.org

Title IV-E Prevention Sources Clearinghouse
https://preventionservices.acf.hhs.gov/

VIRGINIA RESOURCES AND ORGANIZATIONS

Virginia Commonwealth University Health System
Department of Psychiatry
https://psych.vcu.edu/
Virginia Treatment Center for Children (VTCC)
https://www.chrichmond.org/services/mental-health/virginia-treatment-center-for-children

Virginia Tech
Child Study Center
http://childstudycenter.wixsite.com/childstudycenter
Psychological Services Center
https://support.psyc.vt.edu/centers/psc

SUBSTANCE USE DISORDERS

OVERVIEW

It is not uncommon for adolescents to experiment with a variety of substances, both legal and illegal. However, drug and alcohol use is a leading cause of morbidity and mortality among adolescents, and experimentation can lead to substance use disorder.

The earlier individuals try alcohol or drugs, the more likely they are to develop a substance use disorder. Studies have shown that children who experiment with substances at a young age are more likely to use other drugs later in life. These findings highlight the need to prevent or delay drug initiation among children and adolescents.

KEY POINTS

- **Characterized by problematic pattern of substance use leading to clinically significant impairment or distress.**
- **Can include physical addiction, which is characterized by intense cravings, increased tolerance, and physical and mental withdrawal symptoms.**
- **Depending upon the substance, medically supervised detoxification may be required.**
- **Evidence-based treatments include cognitive behavioral therapy, family therapies, and multisystemic therapy.**

Families should be aware of potential warning signs of drug use in children and adolescents. The first changes families often notice are in behavior and mannerisms. However, there are many warning signs, some of which include:

- Fatigue
- Red and glazed eyes
- Lasting cough
- Sudden mood changes
- Irresponsible behavior or poor judgment
- Depression
- Breaking rules and withdrawing from the family
- Loss of motivation or lack of interest in previous activities
- Negative attitude
- Drop in grades
- New friends that are less interested in standard home and school activities
- General discipline problems

The specific criteria used to diagnose substance use disorder are common across the classes of substances. Substance use disorder is diagnosed when there is a problematic pattern of substance use leading to significant impairment or distress, evidenced by at least two of the following patterns occurring within one year:

- The substance is taken in larger amounts or over a longer period than originally intended.
- There are multiple unsuccessful attempts to stop usage, despite a strong desire to do so.
- A great deal of time is spent obtaining, using, or recovering from the effects of the substance.
- The individual experiences cravings or a strong desire to use the substance.
- Recurrent use results in failure to fulfill major obligations at work, school, or home.
- Use continues despite persistent social or interpersonal problems caused by use.
- Important social, occupational, or recreational activities are given up or reduced because of use.
- Use continues in situations in which use is physically hazardous.
- Use continues despite knowing one has a physical or psychological problem that is likely to be caused or exacerbated by the substance.
- Tolerance, defined as requiring a markedly increased dose to achieve the desired effect, develops.
- Withdrawal symptoms occur, which lead the individual to use the substance in order to relieve the symptoms.

The severity of substance use disorder is estimated by the number of criteria present. An estimated two or three symptoms is mild, four or five is moderate, and six or more is severe.

Biological Process of Addiction

Addiction is a chronic brain disease that develops over time. Long-term substance use can cause profound changes in brain structure and function, which can result in uncontrollable, compulsive drug/alcohol craving and use. These brain changes can be persistent, which is why people in recovery from drug use disorders are at increased risk for returning to the drug even after years of not taking the drug.

Addiction occurs when substances hijack the reward center of the brain. The brain is designed to encourage life-sustaining and healthy activities through the release of the chemical dopamine. Dopamine not only causes feelings of pleasure, it also makes memory of that pleasure extremely salient, to ensure that pleasure-creating activities are repeated. Substances of abuse flood the brain's dopamine circuits with much more dopamine than natural rewards generate, causing feelings of euphoria. In addition, the presence of excess dopamine causes the brain to adapt by producing and absorbing less dopamine in a process called "tolerance." As an individual develops tolerance to a drug, the pleasure associated with it subsides, and he or she must take more of it to obtain the same dopamine reward and to ward off painful withdrawal symptoms. The result of this process is intense physical and mental craving. Eventually, the addicted individual becomes physiologically and psychologically compelled to take the drug.

Drugs of Addiction

There are a variety of illegal drugs and legal substances that youth utilize. Legally available drugs include alcohol, prescribed medications, inhalants (fumes from glues, aerosols, and solvents), and over-the-counter cough, cold, sleep, and diet medications. The most commonly used illegal drugs are marijuana (pot), stimulants (such as cocaine, crack, meth, and speed), LSD, PCP, opiates, heroin, and designer drugs (such as MDMA, also called ecstasy or molly).

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) divides substances into the following ten classes:

1. Alcohol
2. Caffeine
3. Cannabis
4. Hallucinogens
    - Phencyclidine (PCP)
    - Other hallucinogens
5. Inhalants
6. Opioids
7. Sedatives, hypnotics, and anxiolytics
8. Stimulants
9. Tobacco
10. Unknown or other substances

Substance use disorder is a possible diagnosis in every class except caffeine. These classes are described in the paragraphs that follow.

Alcohol

Alcohol use disorder is characterized by a cluster of behavioral and physical symptoms, which can include withdrawal, tolerance, and craving. Withdrawal develops approximately four to 12 hours after the reduction of intake, following prolonged, heavy alcohol ingestion. Once a pattern of repetitive and intense use develops, individuals with alcohol use disorder may devote substantial periods of time to obtaining and consuming alcoholic beverages. Withdrawal is unpleasant and triggers some individuals to continue consuming alcohol to avoid or reduce withdrawal symptoms. In serious cases, withdrawal can trigger life-threatening seizures. Alcohol cravings, indicated by a strong desire to drink, can incite certain individuals to use alcohol in physically hazardous ways, such as while driving or swimming. Resulting damage from alcohol use disorder can include poor school performance, social and interpersonal problems, blackouts, depression, and serious medical problems such as liver disease.

Studies show that one form of substance abuse, binge drinking, damages the adolescent brain more significantly than the adult brain. Research suggests that adolescents are more vulnerable than adults to the impact of alcohol on learning and memory. Heavy drinking in early or middle adolescence, with resulting cortical damage, can also lead to diminished control over cravings for alcohol and long-term poor decision-making.

Caffeine

Caffeine can be found in coffee, tea, caffeinated soft drinks, energy drinks and similar aids, over-the-counter analgesics and cold remedies, weight-loss aids, chocolate, and, increasingly, vitamins and food products. Symptoms of caffeine intoxication include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, and gastrointestinal complaints. Symptoms at higher doses include muscle twitching, rambling thoughts and speech, tachycardia or cardiac arrhythmia, periods of seemingly unlimited energy, and psychomotor agitation. These signs may not occur in those who have developed a tolerance. Caffeine withdrawal symptoms

include headache with marked fatigue or drowsiness, dysphoric or depressed mood, irritability, difficulty concentrating, nausea, vomiting, or muscle pain and stiffness.

Cannabis

Cannabis, also known as marijuana, is used in several forms, including plant form and a concentrated extraction called hashish. It is typically smoked (via pipes or water pipes, or in cigarette or cigar form) or ingested. A new intake method, called vaporizing, involves heating plant material to release psychoactive cannabinoids for inhalation. Synthetic formulations are available in pill or capsule form for medical indications such as relieving nausea and vomiting from chemotherapy, or stimulating appetite in individuals with AIDS. Cannabis has also been used to control seizures in persons with epilepsy who do not respond to other interventions.

Cannabis intoxication typically begins with a “high” feeling, followed by euphoria, inappropriate laughter and grandiosity, sedation, and lethargy. Additional symptoms include short-term memory impairment, difficulty completing complex mental processes, impaired judgment, distorted sensory perceptions, impaired motor performance, and the sensation that time is passing slowly. At times, cannabis use is accompanied by anxiety, dysphoria, or social withdrawal. Physical signs develop within two hours of cannabis use, including conjunctival injection (red, bloodshot eyes), increased appetite, dry mouth, and tachycardia.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), potential cannabis withdrawal syndrome may include irritability, anger or aggression, anxiety, depressed mood, restlessness, difficulty sleeping, and decreased appetite or weight loss.

Although cannabis use disorder can co-occur with other substance use disorders, this is uncommon.

Hallucinogens

Phencyclidine (PCP)

Phencyclidine (PCP or angel dust) and similar substances are referred to as dissociative hallucinogens. They produce feelings of separation from the mind and body in small doses, and stupor and coma can result from high doses. These substances include phencyclidine, ketamine, cyclohexanone, and dizocilpine. They are often smoked or taken orally, but they can also be snorted or injected. While these drugs are often used in an illicit manner, ketamine is also used to help treat major depressive disorder.

The primary effects of PCP last for a few hours, but the drug stays in the body eight days or more. The DSM-5 separates PCP intoxication from intoxication by other hallucinogens. Common symptoms of PCP intoxication include disorientation, confusion without hallucination, hallucinations or delusions, catatonic-like state, and coma of varying severity.

Other hallucinogens

Many hallucinogens are chemically different from one another, but as a group, they produce similar perception, mood, and cognition alterations in users. These substances are typically taken orally, but they are sometimes smoked. Duration of hallucinogenic effects varies depending upon the substance taken. Tolerance may develop

to hallucinogens, but hallucinogen tolerance does not create a cross-tolerance with other drug categories, such as amphetamines or cannabis.

Hallucinogen use may lead to hallucinogen persisting perception disorder, characterized by a sober individual re-experiencing perceptual disturbances. These persistent disturbances can happen either episodically or almost continually, and may last for weeks, months, or years. The disturbances are typically visual, including geometric hallucinations, false perceptions of movement in peripheral vision, intensified or flashing color, and trails of visual images. Additional disturbances include hallucinating entire objects, experiencing positive after-images and halos, and misperceiving the size of images.

The DSM-5 does not include hallucinogenic withdrawal syndrome as a criterion for abuse or as a diagnosis, because clinically significant withdrawal syndrome has not been consistently documented in humans. However, there is some evidence of hallucinogenic and stimulant withdrawal symptoms associated with MDMA (also called ecstasy or molly).

Inhalants

Inhalants are volatile hydrocarbons: toxic gases from glues, fuels, paints, and other volatile compounds. Inhalant intoxication develops during or immediately following volatile hydrocarbon substance inhalation, and the intoxication ends several minutes to several hours after inhalation. At times, inhalation is completed by inhaling substances within a closed container, like a plastic bag over the head. Inhalation may cause unconsciousness, anoxia, and death. Sudden death may also occur, often from cardiac arrhythmia or arrest or from the toxicity of the substance inhaled.

Inhalant use disorder exists when use persists even when the user knows the substance is causing serious problems. Lingering odors and peri-oral or peri-nasal rash may suggest the presence of the disorder. Medical complications like brain white matter pathology and rhabdomyolysis, in which muscle fibers break down and release into the bloodstream, is also a possible indication of inhalant use disorder.

Opioids

Opioids relieve pain and induce euphoria. Some opioids are illegal, such as heroin, while others are used by medical professionals to treat pain and are available by prescription. The brain also manufactures natural opioids, which human beings naturally crave. This natural craving, combined with the intense pleasure opioids can induce, can be a dangerous combination that can lead to abuse.

Opioid use disorder is the compulsive, prolonged self-administration of opioids for no legitimate medical purpose, or the use of opioids in great excess of what is needed to treat a medical condition. Prescription forms of opioids are sometimes acquired by falsifying or exaggerating medical conditions or by visiting several physicians for the same disorder (called “doctor shopping”). In addition, prescription opioids are sometimes easily accessible in the family home, which poses a significant risk to youth and adolescents. More than two thirds of teens who misused opioids reported obtaining them from family and friends, including home medicine cabinets. Safe storage and disposal of medications is an easy way to limit access.

Symptoms of opioid intoxication include initial euphoria, followed by apathy, dysphoria, and psychomotor agitation or impairment. Impaired judgment also occurs. Most individuals with opioid use disorder have developed significant tolerance to the drugs, and discontinuation causes withdrawal symptoms. Withdrawal can also occur independently of opioid use disorder and regardless of whether use is medical or recreational. In addition, other disorders can be induced by opioid use, such as opioid-induced depressive disorder, opioid-induced anxiety disorder, opioid-induced sleep disorder, and opioid-induced sexual dysfunction.

Overdose of opioids can result in respiratory depression, which can result in death.

Sedatives, Hypnotics, and Anxiolytics

Several drug types are included in this category. These include benzodiazepines, benzodiazepine-like drugs, carbamates, barbiturates, barbiturate-like hypnotics, all prescription sleeping medications, and almost all prescription anti-anxiety medications. One type of substance omitted from this category is nonbenzodiazepine antianxiety medications because they are not significantly misused.

These drugs are brain depressants and act similarly to alcohol. Individuals who misuse sedatives, hypnotics, or anxiolytics typically crave the substance and may mix it with other medicines and substances. Symptoms of intoxication associated with a substance use disorder include inappropriate sexual or aggressive behavior, marked fluctuation of mood, and impaired judgment. Additionally, intoxication may include slurred speech, lack of coordination to the level of causing falls or difficulty driving, unsteady gait, cognitive impairment, and stupor or coma. Clinicians can also look for nystagmus, or fast, uncontrollable eye movements. As with all substance use disorders, impaired social or occupational functioning also results.

Tolerance and withdrawal can occur with sedative, hypnotic, or anxiolytic use and can be very significant. However, tolerance and withdrawal that occur as a result of appropriate medical use does not meet the criteria for a substance use disorder. Sedatives, hypnotics, and anxiolytics are often prescribed to offset or alleviate effects of other substance use disorders. Nevertheless, with regular use, tolerance develops, and the affected individual must take more of the substance to reach desired effects.

Withdrawal from sedatives, hypnotics, and anxiolytics typically occurs after several weeks of use and is similar to alcohol withdrawal. Symptoms include increased heart and respiratory rate, elevated blood pressure or body temperature, sweating, hand tremors, nausea occasionally with vomiting, insomnia, and anxiety. Another possible symptom of withdrawal is psychomotor agitation, which is unintentional motor activity manifested as fidgeting, pacing, and hand-wringing. As many as 20 to 30 percent of individuals treated for sedative, hypnotic, or anxiolytic withdrawal may experience grand mal seizures. The time between last dose and onset of withdrawal symptoms depends upon the substance. For example, withdrawal symptoms from triazolam can begin within a few hours, while withdrawal symptoms from diazepam (which lasts much longer in the body) may take one to two days to develop.

Stimulants

Stimulants include amphetamines and amphetamine-type substances (such as cocaine, crack cocaine, and methamphetamine). Stimulants are typically taken orally, intravenously, or by being inhaled. Stimulant

medications are often prescribed for obesity, attention-deficit/hyperactivity disorder (ADHD), and narcolepsy. Stimulant use disorder can develop within one week of onset of use, and tolerance occurs regardless of whether a substance use disorder develops. Stimulants stimulate the central nervous system and produce psychoactive and sympathomimetic effects. Dopamine levels increase in the brain, causing intense pleasure and increased energy, or in some cases, anxiety and paranoia. With repeated use, stimulants can disrupt the dopamine system, reducing an individual's ability to feel pleasure. Long term effects include panic attacks, paranoid psychosis, and increased risk for heart attacks.

Withdrawal symptoms include hypersomnia (excessive daytime sleepiness or prolonged nighttime sleep), increased appetite, and dysphoria. Occasionally, vivid and unpleasant dreams will also occur, and appetite will increase. Additionally, intense depressive symptoms that resolve within one week often signal stimulant withdrawal.

Tobacco

Tobacco use disorder typically occurs in those who smoke or use tobacco products daily, but not in those who do not use tobacco daily or who use nicotine medications such as smoking cessation aids. Individuals who are not used to using tobacco often feel nausea and dizziness upon use, symptoms that are more pronounced with the first use of tobacco each day. Those with tobacco use disorder typically do not experience these symptoms. Most tobacco users report strong cravings when they do not use tobacco for several hours, and many tobacco users chain smoke (smoke cigarettes all day with no break in between cigarettes). Tobacco users may forego social events for a lack of tobacco-friendly areas.

When tobacco use is stopped, very distinct withdrawal symptoms occur. These symptoms are much stronger in users who smoke or use smokeless tobacco than in those who use nicotine medications. The symptomatic discrepancy is potentially because of the higher levels of nicotine in cigarettes and smokeless tobacco in comparison to levels in nicotine medications. People who have ceased tobacco use often experience a heart rate decline of five to 12 beats per minute and a weight increase of four to seven pounds.

Unknown or Other Substance

The DSM-5 provides for diagnostic criteria for a substance use disorder with unknown origin. The following substances meet this criterion:

- Anabolic steroids
- Nonsteroidal anti-inflammatory drugs
- Cortisol
- Antiparkinsonian medications
- Antihistamines
- Nitrous oxide
- Amyl-butyl- or isobutyl-nitrites
- Betel nut, chewed in many cultures for mild euphoria and a floating sensation
- Kava, often taken for sedation, incoordination, weight loss, mild hepatitis, and lung abnormalities
- Cathinones, or "bath salts", which produce a stimulant effect

Unknown substance use disorder is associated with an intoxicant the individual cannot identify or with new illegal drugs that are not yet identified.

Intoxication by unknown substances is challenging to diagnose. Clinicians may ask for patient history to determine whether the youth has experienced similar symptoms in the past and if the youth knows a street name for the substance.

CAUSES AND RISK FACTORS

While nobody knows which youth will develop serious substance use problems, certain adolescents are at higher risk for developing substance use disorder. These youth include those:

- With a family history of substance use disorders
- Who are depressed or anxious
- Who have low self-esteem
- Who feel like they don't fit in or are out of the mainstream

Table 1 outlines additional risk factors, including those associated with the individual and the family. While none of these factors guarantee an adolescent will develop substance use disorder, families should be cognizant of the potential risks.

For many youth, addiction begins as self-medication: using substances to cope with temporary stress or mental health problems they may not even know they have. Substance use, especially alcohol, can be a more socially acceptable way to deal with negative emotions.

As with many other mental health disorders, the coronavirus pandemic may have exacerbated the risks for substance abuse disorders. Stress, limited availability of treatment, and poor home environments all may put individuals more at risk. See the "Covid-19 Pandemic and Lockdown" section of the *Collection* for more information.

EVIDENCE-BASED TREATMENTS

Treatment for substance use disorders is delivered at varying levels of care in many different settings. Because no single treatment is appropriate for every child or adolescent, treatments must be tailored for the individual. The ultimate goal is to eliminate drug use, but if this is not possible, the goal becomes harm reduction, or reducing the risks of ongoing use. The success rate of treatment varies, and can be affected by the person's age, motivation, social and family support, and the presence of friends who are still using. Settings include:

Outpatient/Intensive Outpatient: Child and adolescent substance abuse treatment is most commonly offered in outpatient settings. When delivered by well-trained clinicians, this can be highly effective. Outpatient treatment is traditionally recommended for adolescents with less severe addictions, few additional mental health problems, and a supportive living environment, although evidence suggests that more severe cases can be treated in outpatient settings as well. Outpatient treatment varies in the type and intensity of services offered and may be delivered on an individual basis or in a group format. Low or moderate intensity outpatient care is generally delivered once or twice a week. Intensive outpatient services are delivered more frequently, typically

more than twice a week for at least three hours per day. Outpatient programs may offer substance use prevention programming focused on deterring further drug use or other behavioral and family interventions.

Table 1
Risk Factors for Substance Use Disorder in Adolescents and Teens

Type of Risk Factor	Description
Family Risk Factors	• Inadequate supervision from the family • Inconsistent or severe discipline from the family • Poor communication • Family tension and conflicts • Broken homes
Individual Risk Factors	• History of early childhood negative and aggressive behavior or physical or sexual abuse • Being an older adolescent Caucasian male • Emotional, social, or academic problems • Poor impulse control or thrill-seeking behaviors • Emotional instability • Very low perception of the dangers inherent in drug use
Other Risk Factors	• Low socioeconomic status • Lower levels of education • Living in a high crime and drug-use neighborhood • Ease of drug availability • Peer-group pressure • History of mental illness

Partial Hospitalization: Youth with more severe substance use disorders who can still be safely managed in their home living environment may be referred to a higher level of care called partial hospitalization or "day treatment." This setting offers adolescents the opportunity to participate in treatment four to six hours a day at least five days a week while living at home.

Residential/Inpatient Treatment: Residential treatment is a resource-intense, high level of care, generally for youth and adolescents with severe levels of addiction whose mental health, medical needs, and addictive behaviors require a 24-hour structured environment to make recovery possible. These adolescents may have complex psychiatric or medical problems or family issues that interfere with their ability to avoid substance use. One well-known, long-term residential treatment model is the therapeutic community (TC). TCs use a combination of techniques to "re-socialize" the adolescent and enlist all the members of the community, including residents and staff, as active participants in treatment. Treatment focuses on building personal and social responsibility and developing new coping skills. Such programs offer a range of family services and may require family participation if the TC is sufficiently close to where the family lives. Short-term residential programs also exist.

Once the treatment setting has been determined, numerous methods are used to treat children and adolescents with substance use disorders. These treatments are discussed in the following paragraphs and are outlined in Table 2.

Table 2
Summary of Treatments for Substance Use Disorder

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 co-occurring conduct and delinquent behaviors. It combines a focus on family relationships with CBT interventions to change 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.
Medication	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.
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.

Table 2 (continued)
Summary of Treatments for Substance Use Disorder

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; 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.
Neurofeedback	A type of non-invasive brain training that enables an individual to learn how to change mental and/or physiological activity.

Psychological Treatments

The numerous psychological treatments used to treat youth with substance use disorders are discussed below.

Cognitive Behavioral Therapy (CBT)

The goal of CBT is the identification and modification of maladaptive thinking patterns to reduce negative thoughts, feelings, and behavior. For substance abusers, the focus of this intervention is generally relapse prevention. CBT can help the adolescent develop greater self-control, identify environmental and internal triggers leading to relapse, and develop strategies for dealing with stressors, triggers, and lapses into substance use. The role of clinicians is to aid the youth in anticipating the problems that they are likely to meet and to help them develop effective coping strategies. The two main elements of CBT are functional analysis, identifying the thoughts and feelings before and after substance use, and skills building, such as ways to overcome peer pressure and increase pleasant activities. CBT also addresses social skills, anger control, and problem-solving.

Family Therapy

Although family therapy is considered an important modality in the treatment of adolescents with substance use disorders, clinicians and consumers should be aware that family therapy is a very broad term that encompasses a large number of treatment programs. Not all of these family therapies have been tested on children and adolescents with substance use disorder. Thus, it is important and relevant to ask, “What kind of family therapy?” when family therapy is recommended. Common elements across most family therapies include:

- Engaging the family (versus working with the child alone);
- Focusing on education about substance use and abuse;
- Emphasizing communication skills to improve family functioning; and
- Reestablishing parental influence through parent management training.

Though family therapy is important, it may be contraindicated if family members actively abuse substances, are violent, deny that the youth's substance use is problematic, or remain unreasonably angry.

One program with empirical support is Multidimensional Family Therapy (MDFT), an outpatient, family-based treatment for adolescents with serious substance abuse issues. This approach views drug use in terms of a network of influences (individual, family, peer, community) and encourages treatment across settings in multiple ways. Sessions may be held in a clinic, home, court, school, or other community location. For the child or adolescent, the emphasis of treatment is on skill-building, and the treatment plan often incorporates practicing developmental tasks such as decision-making, negotiation, problem-solving, performing vocational skills, communication, and dealing with stress. Parallel sessions are held with family members, in which parents examine their parenting style, learn to distinguish influence from control, and learn to have a positive and developmentally appropriate influence on their child. Research supports the use of this type of therapy for adolescents with substance use disorders.

Another well-established therapy method is Functional Family Therapy (FFT). FFT is best used in youth with conduct and delinquent behaviors along with substance abuse. This short-term process combines relationship with CBT interventions to change relationship patterns and improve the family's functioning. FFT is specifically designed for youth ages 12 to 18, and is successful across locations and ethnic groups. The effects of FFT endure years after treatment, at times into adulthood, and can positively impact siblings of affected youth as well.

A method of strategic family therapy has also been tested and found effective with substance using adolescents: Brief Strategic Family Therapy (BSFT). BSFT attempts to reduce negative behaviors, promote positive behaviors (such as school attendance and performance), and improve family functioning. Clinicians typically administer 12 to 16 family sessions in convenient locations, at times even in the family home.

Multisystemic Therapy (MST)

MST aims to address the multifaceted nature of antisocial behavior at the individual, family, and community levels. This form of therapy is intended to address serious antisocial behavior in children and adolescents who abuse substances. Therapeutic efforts target the child's behavior within the context of the family environment, the school environment, and the neighborhood and community. MST helps develop a support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes. Treatment occurs in each of the child's natural settings. MST is associated with significant, long-term reduction of aggressive behaviors in chronic and violent juvenile offenders.

RESOURCES AND ORGANIZATIONS

American Academy of Pediatrics Committee on Substance Abuse
Substance Use Screening, Brief Intervention, and Referral to Treatment
https://publications.aap.org/pediatrics/article/138/1/e20161210/52573/

ASAM Criteria
https://www.asam.org/asam-criteria/about-the-asam-criteria

Association for Behavioral and Cognitive Therapies (ABCT)
https://www.abct.org/

Association for Applied Psychophysiology and Biofeedback (AAPB)
https://www.aapb.org

Food and Drug Administration (FDA)
Risk Evaluation and Mitigation Strategy (REMS) (Extended-Release and Long-Acting Opioid Analgesics)
https://opioidanalgesicrems.com/home.html

Mental Health America (MHA)
https://mhanational.org/

National Alliance on Mental Illness (NAMI)
https://www.nami.org/

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
https://www.niaaa.nih.gov/

National Institute on Drug Abuse (NIDA)
https://www.drugabuse.gov/

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
https://www.ojjdp.gov/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

Stop Underage Drinking
Portal of Federal Research and Resources
https://www.stopalcoholabuse.gov/

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/

Office of the Surgeon General (OSG)
https://addiction.surgeongeneral.gov/executive-summary/report/prevention-programs-and-policies

The GAINS Center for Behavioral Health and Justice Transformation
https://www.samhsa.gov/gains-center

VIRGINIA RESOURCES AND ORGANIZATIONS

Drug Rehab Services
Drug Rehab Centers in Virginia
https://www.addicted.org/virginia-long-term-drug-rehab.html

Virginia Department of Behavioral Health and Developmental Services (DBHDS)
http://www.dbhds.virginia.gov/

Virginia Cannabis Control Authority
https://cca.virginia.gov/

Virginia Department of Health
Resources for Child Safety
https://www.vdh.virginia.gov/medical-examiner/fatality-review-surveillance-programs-reports/child-fatality-review-in-virginia/additional-resources/

YOUTH SUICIDE

KEY POINTS

- **46 percent of adolescents who die by suicide suffer from at least one psychiatric disorder at the time of death.**
- **No evidence-based interventions have been identified. Cognitive behavioral therapy, dialectical behavior therapy, and possible appropriate medication therapy are promising interventions.**
- **Early intervention is critical. Families should be alert to warning signs.**

OVERVIEW

Most teenagers experience stress while growing up. Stressors can include societal pressures to adhere to social and cultural norms, pressure to succeed, divorce within a family, and financial difficulty. Social media use has compounded the impact of these stressors. Youth may view suicide as the answer to these stressors if proper treatment is not rendered in time.

Suicide is one of the leading causes of death for 10-24 year-olds. However, deaths from suicide are only part of the problem. Each year, approximately 157,000 youth between the ages of 10 and 24 receive medical care for self-inflicted injuries at emergency departments across the U.S.

Nationwide, firearms are the most common method of suicide for youth, followed by suffocation and poisoning.

It is important to note that although non-suicidal self-injury (NSSI) is very serious, the individual's intention and ambivalence about the outcome distinguish it from suicidal behavior. A more detailed discussion of NSSI is included in the "Non-Suicidal Self-Injury" section of the *Collection*.

If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide and Crisis Lifeline.

RISK FACTORS

While there are important risk factors to note, the presence of risk factors does not necessarily mean a youth will die by suicide. It is important to have a communication system in place that allows the youth to express their feelings. Talking about suicide is difficult, but with more open communication and less stigmatization, it could be an easier subject to broach. Talking about those feelings can be the first step in encouraging an individual to live. Families and friends should be aware of the warning signs of suicide and should seek help immediately if they believe a family member or friend is contemplating suicide. Table 1 outlines risk factors that may indicate the possibility of a suicide attempt; however, risk factors cannot be used to predict whether a suicide will occur. Table 2 lists warning signs an individual may be suicidal. Four out of every five individuals considering suicide give some sign of their intentions, either verbally or behaviorally.

Table 1
Factors that Put Youth at Risk of Suicide

Risk Factors	Description
General risk factors	• Past suicide attempts • Being diagnosed with a mood or conduct disorder • Substance use, especially among males • Aggression or fighting • Living alone or in a violent community • Currently depressed, manic, hypomanic, and/or severely anxious • Irritable, agitated, delusional, or hallucinating • Experiencing physical, emotional, and/or sexual abuse • Family history of suicide and suicide attempts • Serious illness • Chronic pain • Legal problems • Current or prior history of adverse childhood experiences • Sense of hopelessness
Mental health disorders	Studies have shown that as many as 90 percent of adolescents who died by suicide suffered from at least one psychiatric disorder at the time of death, and that more than half suffered from a psychiatric disorder for at least two years preceding the event. The most common disorders include major depressive disorder, anxiety disorder, bipolar disorder, substance abuse, and conduct disorder. If suicidal ideation is not present, this does not mean that there will not be a suicide attempt.
Environmental stressors	Stress has been identified as a precipitator for suicide. One national study reported that 35 percent of youth suicides occurred the same day those youth experienced a crisis, such as a relationship breakup or an argument with a parent. Another study found that non-intimate-partner relationship problems, such as issues with parents or friends, preceded over 51 percent of suicides in the study, and a crisis that occurred in the past two weeks preceded 42.4 percent of suicides.
Bullying	Being the victim of school bullying or cyberbullying is associated with substantial distress, and researchers have found a clear relationship between bullying (victimization and perpetration) and suicidal ideation (thoughts/plans about suicide).
Gender identity and sexual orientation	Among lesbian, gay, bisexual, and transgender (LGBT) adolescents, a history of attempted suicide, impulsivity, prospective LGBT victimization, and limited social supports were linked to increased risk for suicidal ideation.
Exposure to suicide	Sometimes the suicide rate among adolescents rises following a highly publicized suicide. This likelihood of co-occurring suicide is also referred to as “contagion.” Co-occurring suicide may occur when a classmate or someone with whom the youth has a personal relationship dies by suicide. The associations between both ideation and attempts remained for at least two years after the initial exposure, suggesting that intervention and therapy should extend past the first few months following a suicide.
Sleep disturbance	Sleep disturbance has been associated with an elevated risk of suicide in youth. Assessing sleep patterns may assist in assessing the presence of suicidal ideation and depression.

Access to lethal substances (firearms, pills)	Having firearms in the home is associated with both suicide attempts and suicide completion. 9 out of 10 child and adolescent suicides by gun involve firearms from the victim's own home or that of a relative. Gun safety practices such as keeping firearms unloaded, locking firearms, and storing ammunition separately helps decrease this risk.

Table 2
Warning Signs Someone May Be Suicidal

A child or youth may be suicidal if you notice one or more the following…
• Talking about suicide/wanting to die • Talking about being hopeless or having no reason to live • Sudden increase/decrease in appetite • Sudden changes in appearance (different style of dress than normal, lack of personal hygiene) • Dwindling academic performance • Preoccupation with death and suicide • Final arrangements (giving away prized/favorite possessions, saying goodbye, talking about funeral) • Increasing use of alcohol or drugs • Extreme mood swings

INTERVENTIONS

Currently there are no interventions that have been deemed conclusively evidence-based; however, SAMHSA's "Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth" highlights promising treatments. Despite limitations in the literature, there is research to support the use of some techniques over others. A summary of interventions is included in Table 3. There is no one-size-fits all approach to treatment, but each path should include ongoing safety planning, coping skills training, continuity of care, and family involvement. Continual intervention trainings are necessary to remain competent.

Table 3
Interventions for Youth Suicide

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT) Dialectical behavior therapy (DBT)	Both of these psychotherapies have 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. Suicide focused treatment can be effective without medication therapy in some cases.
Selective serotonin reuptake inhibitors (SSRIs)	These antidepressants may help reduce suicidal ideation in teens with diagnosed depression; however, in some individuals they

	may cause suicidal ideation. Youth taking SSRIs must be closely monitored. Limitations: SSRIs must be taken consistently, require a therapeutic dose per individual, and can take up to 3 months to show effectiveness.
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. Includes a screening component.
Safety Planning	Clinicians help patients identify effective coping techniques to use during crisis events (American Academy of Pediatrics).
Sources of Strength	Peer leaders model and encourage friends to name and engage trusted adults; reinforce and create an expectancy that friends ask adults for help for suicidal friends; and identify and use interpersonal and formal coping resources.
Attachment-Based Family Therapy	Most effective for youth aged 12-24; based on the idea that the quality of familial relationships has the potential to exacerbate or mitigate depression, suicide, and suicidal ideation; the only treatment adapted specifically for LGBTQ+ youth.
Not Adequately Tested	
Collaborative Assessment and Management of Suicidality (CAMS)	Centered on building a relationship between the physician and individual that allows the individual to identify and manage suicidal thoughts, feelings, and behaviors.
Gatekeeper training	Involves educating youth, parents, and caregivers about warning signs of suicide to encourage early intervention.
What Does Not Work	
Group counseling	Multiple randomized control trials fail to demonstrate efficacy.
Tricyclic antidepressants	Not recommended; effectiveness has not been demonstrated. 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.

SSRIs may be successful in reducing suicidal ideation and suicide attempts in non-depressed adults with certain personality disorders. However, it is necessary to closely monitor youth taking SSRIs, as there is some evidence that suggests that SSRIs can increase suicidality in youth and young adults under age 24. A more detailed discussion of the use of antidepressants in treating children and adolescents is included in the "Antidepressants and the Risk of Suicidal Behavior" section of the *Collection*.

Psychotherapy, although not included as an evidence-based practice in this document due to limitations surrounding randomized controlled trials, is an important component to the treatment of suicidality in youth.

CBT has seen promising results in recent years. When paired with the appropriate pharmacological treatments, CBT can be effective in reducing suicidal ideation. In addition, DBT has promise for youth with borderline personality disorder and recurrent suicidal ideation and behaviors.

The SOS Signs of Suicide Prevention Program (ages 11-13 and 13-17) is a universal, school-based education and screening program that teaches students to recognize warning signs of depression and suicidality in themselves or their peers and to seek help from a trusted adult. The screenings within the SOS Program are informational, not diagnostic. The goal of the screening is to identify students with symptoms consistent with depression and/or suicidality, and to recommend a complete professional evaluation.

RESOURCES AND ORGANIZATIONS

988 Suicide & Crisis Lifeline
https://988lifeline.org/
American Association of Suicidology
http://www.suicidology.org/
American Foundation for Suicide Prevention (AFSP)
https://www.afsp.org/
Anxiety and Depression Association of America (ADAA)
https://adaa.org/
Association for Behavioral and Cognitive Therapies (ABCT)
https://www.abct.org/
Center for Disease Control and Prevention
Suicide Prevention
https://www.cdc.gov/suicide/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fsuicide%2Findex.html
Children's Safety Network (CSN)
http://www.childrenssafetynetwork.org
Jason Foundation
http://jasonfoundation.com/
National Action Alliance for Suicide Prevention
http://actionallianceforsuicideprevention.org
National Alliance on Mental Illness (NAMI)
http://www.nami.org
National Center for Injury Prevention and Control
Suicide Prevention
1-800-CDC-INFO (232-4636)
http://www.cdc.gov/violenceprevention/suicide/index.html
National Child Traumatic Stress Network
https://www.nctsn.org/
National Institute of Mental Health (NIMH)
https://www.nimh.nih.gov
Society of Clinical Child and Adolescent Psychology
https://sccap53.org/
Society for the Prevention of Teen Suicide
http://www.sptsusa.org
Suicide Awareness/Voices of Education (SA/VE)
http://www.save.org
Suicide Prevention Resource Center (SPRC)
https://www.sprc.org/
Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov
The Trevor Project
http://thetrevorproject.org

VIRGINIA RESOURCES AND ORGANIZATIONS

Virginia Department of Health
vdh.virginia.gov/suicide-prevention/
Virginia Suicide Prevention Resource Directory
https://www.vdh.virginia.gov/suicide-prevention/resources/

National Crisis Hotlines

988 Suicide & Crisis Lifeline
3-digit dial: 988
1-800-273-TALK (8255)
TTY: Dial 711 then 1-800-273-8255
Veterans: Press 1
Spanish: Press 2

National Youth Crisis Hotline
1-800-442-HOPE (4673)

Crisis Text Line
Text HOME to 741741,
http://crisistextline.org

Military One Source
24-hour resource for military members, spouses and families
1-800-342-9647

LGBTQ Youth Suicide Hotline
Trevor Project
Call: 1-866-488-7386
Text: 678-678

Trans Lifeline
1-(877)-565-8860

Girls and Boys Town Home National Hotline
Crisis and resource referral services for adolescents age 11-17
1-800-448-3000

Coping with Grief and Finding Treatment

The Dougy Center for Grieving Children and Families
503-775-5683
dougy.org

The Compassionate Friends
630-990-0010
compassionatefriends.org

Mental Health America
703-684-7722
mentalhealthamerica.net

MentalHelp
888-993-3112
mentalhelp.net

Theravive
360-350-8627
theravive.com

Mental Health, Suicide Prevention, and Community Resources

Teen Line – Youth Crisis
310-855-4673
Text TEEN to 839863
teenlineonline.org

Depression and Bipolar Support Alliance
800-826-3632
dbsalliance.org

Virginia Crisis Centers and Hotlines

Concern Hotline

Clarke Hotline: 540-667-0145

Frederick Hotline: 540-667-0145

Page Hotline: 540-743-3733

Shenandoah Hotline: 540-459-4742

Warren Hotline: 540-635-4357

Winchester Hotline: 540-667-0145

https://www.concernhotline.org/

CrisisLink

Serving Arlington and the Washington Metropolitan area

Hotline: 703-527-4077

Text CONNECT to 85511

https://prsinc.org/crisislink/

HELP Line

Serving Albemarle County, City of Charlottesville, and UVA Students

Hotline: 434-924-TALK

https://www.helplineuva.com/

New River Valley Community Services

Serving counties of Floyd, Giles, Montgomery, Pulaski and the City of Radford

Hotline: 540-961-8300

http://www.nrvcs.org/

Regional Education Assessment Crisis Services Habilitation (REACH)

Region 1 (Charlottesville and Surrounding Areas): 888-908-0486

Region 2 (Northern VA): 855-897-8278

Region 3 (Southwest VA): 855-887-8278

Region 4 (Richmond and Surrounding Areas): 833-968-1800

Region 5 (Southeast VA/Tidewater): 888-255-2989

Richmond Behavioral Health Authority (RBHA)

Hotline: 804-819-4100

ANTIDEPRESSANTS AND THE RISK OF SUICIDAL BEHAVIOR

OVERVIEW

Research indicates that as many as 18-20 percent of high school students have experienced depression or anxiety between 2021-2023.[1] Because depression substantially increases the risk of suicide, much focus has been placed on measuring the effectiveness of treatments. This is particularly true for adolescents because depression in that age group is a strong indicator of suicidal behavior.

KEY POINTS

- **Research has revealed a link between suicidal thoughts and use of SSRI medications in children.**
- **Fluoxetine (SSRI) is currently the only medication approved for children suffering from depression.**
- **Children taking SSRIs must be carefully monitored by caregivers and professionals for suicidal thinking and behavior.**

Currently, only one pharmacological treatment has been approved for use in youth with depressive disorders by the Food and Drug Administration (FDA). This medication, fluoxetine (a selective serotonin reuptake inhibitor [SSRI]), has been approved by the FDA for treating children eight years of age or older. More research has been completed on fluoxetine than any other SSRI. For older youth (ages 12 and up), The FDA has approved the use of another SSRI, escitalopram, for depression.

However, research has also revealed a possible relationship between suicidal thoughts or actions and the use of SSRIs in children and adolescents with depression. This section outlines the benefits and risks associated with fluoxetine use in children and adolescents with depression.

FOOD AND DRUG ADMINISTRATION ADVISORY STATEMENT

In response to findings that antidepressant use in pediatric patients had the potential to increase suicidal thinking and behavior, the FDA directed manufacturers to add a black-box warning to the health professional label on antidepressants. A summary of key points in this labelling is outlined in Figure 1.

The FDA also recommended that clinicians should screen for bipolar disorder, because symptoms of depression may be part of bipolar disorder. Antidepressants used alone may trigger a mixed/manic episode in these at-risk patients, which may contribute to suicidal thinking or behavior.

[1] Centers for Disease Control and Prevention. (2025, June 5). Data and statistics on children's mental health. Retrieved from https://www.cdc.gov/children-mental-health/data-research/index.html.

In addition, dosage appears to be a contributing factor. One study found that younger patients who began treatment with higher-than-recommended doses of antidepressants were more than twice as likely to try to harm themselves as those who were initially treated with the same drugs at lower, recommended doses. The risk of suicide attempts seemed to be highest in the first 90 days on the medications.

In response to the black-box warning, practitioners such as pediatricians and family practitioners have ceased prescribing antidepressants to children and have begun to refer patients to child and adolescent psychiatrists.

Figure 1
Key Points of FDA Black-Box Warning Label For Suicidality and Anti-Depressant Drugs

- Antidepressants increase the risk of suicidal thinking and behavior in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders.
- Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance the risk of increased suicidality with the clinical need.
- Taper dosage to prevent risks of discontinuation syndrome if stopping SSRI treatment.
- Patients who are started on antidepressant therapy should be observed closely for agitation, irritability, clinical worsening, suicidality, or unusual changes in behavior.
- Families and caregivers should be advised to closely observe the patient and communicate with the prescriber.
- A statement regarding whether the particular drug is approved for any pediatric indication(s), and if so, which one(s), should be present.

EFFECTIVENESS OF SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs) VERSUS THE RISK OF SUICIDALITY

When making decisions about the risks associated with antidepressants, particularly SSRIs, it is important to understand the limitations of the research. Suicidality can be very difficult to measure, as these events are rare, and the statistical method used to evaluate the risk associated with treating children and adolescents with antidepressants can only be used in studies where a minimum of one adverse event has taken place. Conversely, a study that fails to detect a significant increase in suicidal risk associated with antidepressant medication does not necessarily indicate that there is not a risk.

A full review of the current literature on the benefits and risks associated with antidepressant use in children and adolescents with depression is provided in the *Collection, 6th Edition.*

In summary, an evaluation of the risk-benefit ratio of using fluoxetine with children and adolescents diagnosed with depression has revealed that the benefits associated with treating moderately to severely depressed youth with this SSRI can outweigh the risks. Outcomes can be improved and risks of suicidal thinking and behavior can be reduced by combining cognitive-based therapy with fluoxetine. It is imperative, however, that when antidepressants are prescribed, youth should be closely monitored by both parents and clinicians. Additional

information about effective treatments for youth with depression is located in the "Depressive Disorders" section of the *Collection*.

About 40 percent of adolescents with depression do not adequately respond to a first treatment course. Persistence in finding the right medication, or combination of medications, may be necessary for successful treatment.

RESOURCES AND ORGANIZATIONS

Anxiety & Depression Association of America (ADAA)
https://adaa.org/

Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org/Home/

Child Welfare League of America (CWLA)
http://www.cwla.org

Georgetown University Center for Child and Human Development
Trauma Informed Care
https://gucchd.georgetown.edu/TraumaInformedCare/

International Society for Traumatic Stress Studies (ISTSS)
https://istss.org/home

National Child Traumatic Stress Network
https://www.nctsn.org

Prevent Child Abuse America
800-CHILDREN (244-5373) or (312) 663-3520
http://preventchildabuse.org/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/

VIRGINIA RESOURCES AND ORGANIZATIONS

Child Savers Guidance Clinic & Trauma Response
(804) 644-9590
https://childsavers.org/

Families Forward
https://www.familiesforwardva.org/

University of Virginia Children's Hospital
https://childrens.uvahealth.com/

University of Virginia, Department of Psychology
https://psychology.as.virginia.edu/ainsworth

VCU Health – Children's Hospital of Richmond
Cameron K. Gallagher Mental Health Resource Center
https://www.chrichmond.org/services/mental-health/cameron-k-gallagher-mental-health-resource-center

Virginia Treatment Center for Children (VTCC)
https://www.chrichmond.org/services/mental-health/virginia-treatment-center-for-children

Virginia Child & Family Attachment Center
Phone number: (434)-242-2521
Email: info@secureshild.center
https://securechild.center/for-caregivers/

Virginia Department of Behavioral Health and Developmental Services
http://www.dbhds.virginia.gov/

List of TF-CBT Certified Providers
https://dbhds.virginia.gov/developmental-services/children-and-families/trauma-informed-care/

NONSUICIDAL SELF-INJURY

OVERVIEW

Many terms are used to describe nonsuicidal self-injury (NSSI): self-injury, parasuicide, deliberate self-harm, self-abuse, self-mutilation, self-inflicted violence, and cutting. All can be defined as the deliberate harming of one's body, resulting in tissue damage, without the intent of suicide. It does not include culturally-sanctioned activities, including tattoos or actions within a religious or cultural ritual. For additional information on self-inflicted injury with suicidal intent, see the "Youth Suicide" section of the *Collection*.

KEY POINTS

- **Characterized by deliberate harming of one's body, resulting in tissue damage, without the intent of suicide.**
- **Sometimes used to regulate emotion through the release of endorphins, which can temporarily reduce negative emotions such as tension, anxiety, and self-reproach.**
- **No evidence-based treatments have been identified at this time.**
- **Treatments such as cognitive behavioral therapy aim to replace NSSI with healthier coping skills.**

NSSI occurs among all ages, genders, ethnicities, and socioeconomic statuses; however, much research is centered on adolescents, as this behavior tends to begin during teen years. Family members can look for signs of self-injury, including:

- Scratching (excoriation)
- Cutting
- Burning
- Hitting or biting oneself
- Ingesting or embedding toxic substances or foreign objects
- Hair pulling or skin picking
- Interfering with wound healing

This list is not exclusive, and families may also see other types of personal harm. Children who self-harm may exhibit more than one form of self-injurious behavior. Figure 1 lists warning signs a child may be engaging in self-harming behaviors.

Figure 1
Warning Signs Someone May Be Self-Injuring

- Inappropriate dress for season (consistently wearing long sleeves or pants in summer)
- Constant use of wristbands/coverings
- Unwillingness to participate in events/activities which require less body coverage (ex. swimming, gym class)
- Odd or unexplainable paraphernalia (such as razor blades, bandages)
- Heightened signs of depression or anxiety

It is not always clear whether an act of self-harm should be categorized as NSSI or as a suicide attempt because the intended outcome is not certain. Suicide attempts are not always lethal, and NSSI may be lethal. Furthermore, this distinction may not be important, since NSSI is one of the strongest predictors of suicide ideation and future suicide attempts.

Repeated shallow but painful injuries that the youth inflicts on his or her body are the critical feature of NSSI. Youth most frequently injure the top of the forearm, wrists, stomach, or thigh with knives, needles, razors, or other sharp objects, and they often create several cuts or scratches in a single session. Commonly, these cuts bleed and leave scars. Injury may also be caused by stabbing, burning, or causing burns by rubbing the skin with another object. Other forms of self-injury discussed in this *Collection* are trichotillomania and excoriation (skin-picking) disorder, discussed in the "Obsessive-Compulsive and Related Disorders" section. Stereotypic self-injury, such as head banging, self-biting, or self-hitting, may be connected to developmental delay.

Suicide attempts and NSSI are thought to serve different functions, with suicide being used as a way to escape from pain and NSSI used to regulate emotion. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) notes that the most common purpose of NSSI is to reduce negative emotions such as tension, anxiety, and self-reproach. In certain cases, the injury is conceived as a deserved self-punishment to make up for acts that harmed or distressed others. The youth may then report an immediate sensation of relief that occurs during the process.

Some reasons that youth may engage in NSSI include:

- Distracting from emotional pain (this is most common)
- Punishing oneself
- Relieving tension
- Sense of being real by feeling pain or seeing evidence of injury
- Numbing feelings, to not feel anything
- Experiencing a sense of euphoria
- Communicating pain, anger, or other emotions to oneself or others
- Nurturing oneself through the caring for wounds

Studies show that females self-injure more frequently than males. While self-injury typically begins in adolescence, it may begin earlier or later and can continue into adulthood.

CAUSES AND RISK FACTORS

Researchers have identified many risk factors associated with NSSI, which are outlined in Figure 2.

Studies have shown that adolescents with any comorbid condition are at increased risk of NSSI and those with greater than two comorbid conditions have nearly three times the risk of developing the disorder. Specific comorbid conditions revealed in research include obesity, alcoholism, borderline personality disorder (BPD), and suicidal behavior disorder (discussed in the Youth Suicide section of the *Collection*).

Research has indicated that there is a clear familial component to NSSI, but points out that it is still uncertain whether this is due to genetics, environment, or both. Relatives of individuals who have engaged in NSSI are three times more likely to engage in such behavior themselves. Patients diagnosed with BPD often grow up in environments where emotional expression goes unrecognized or is punished, the outcome being that emotional regulation skills are underdeveloped. There is also consistent evidence to support a genetic component for impulsivity, affective instability, and aggression—all risk factors for NSSI.

Figure 2
Risk Factors Associated With NSSI

- Risk taking and reckless behavior
- Childhood sexual abuse
- Childhood physical abuse
- Neglect
- Family violence during childhood
- Family alcohol abuse
- Childhood separation and loss
- Single parent family
- Parental illness or disability
- Poor emotional regulation skills, which can be due to family environments in which emotional expression is unrecognized or punished
- Poor security with childhood attachment figures
- Emotional reactivity
- Emotional intensity
- Hopelessness
- Loneliness
- Anger
- Alcohol use or alcoholism
- Obesity
- Comorbid mental health condition, especially borderline personality disorder and suicidal behavior disorder

TREATMENT

No evidence-based treatments for NSSI have been identified at this time. Table 1 lists available treatments for NSSI.

NSSI represents a pattern of behavior, rather than a single isolated event, and is perpetuated through both positive and negative reinforcement. For example, NSSI is positively reinforced when the adolescent experiences a sense of control or relaxation following self-harm. NSSI is negatively reinforced when the adolescent experiences distressing or unpleasant emotions and or thoughts—for example, sadness, loneliness, emptiness, emotional pain, and self-hatred—following self-harm. Therefore, many experts believe that interventions aimed at reducing NSSI should focus on strengthening emotional regulation skills. This approach varies from interventions aimed at reducing suicidal behavior, which instead help the adolescent identify reasons for living.

An important treatment element for youth who have engaged in NSSI is the establishment of a strong therapeutic alliance between the youth and the service provider. Once the alliance is formed, an important treatment goal is to reduce and ultimately eliminate NSSI by replacing it with healthier coping skills. Another recommended component is the establishment and maintenance of meaningful connections between adolescents and their families.

Cognitive behavioral therapy (CBT) is one treatment for NSSI that has been tested. The premise of CBT for NSSI is to reduce NSSI behaviors by helping clients develop new coping skill sets, address motivational obstacles during treatment, and promote skill generalization outside the therapy setting. Dialectical behavioral therapy (DBT) is effective for the treatment of NSSI among adults and thus has received a lot of attention; however, its effectiveness for children and adolescents is still being tested.

Table 1
Summary of Treatments for Nonsuicidal Self-Injurious Behavior

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.
Medication	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.
What Does Not Work	
Benzodiazepines or trazodone	May potentially increase incidence of NSSIs in depressed or anxious individuals.

RESOURCES AND ORGANIZATIONS

988 Suicide & Crisis Lifeline
Dial or Text: 988
https://988lifeline.org/
Anxiety and Depression Association of America (ADAA)
https://adaa.org/
Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org/Home/
Cornell University Self-injury & Recovery Resources (SIRR)
http://www.selfinjury.bctr.cornell.edu/
Mayo Clinic
https://www.mayoclinic.org/diseases-conditions/self-injury/symptoms-causes/syc-20350950
Mental Health America (MHA)
https://mhanational.org
National Alliance on Mental Illness (NAMI)
Self-Harm
https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Self-harm
National Institute of Mental Health (NIMH)
https://www.nimh.nih.gov
S.A.F.E. Alternatives (Self-Abuse Finally Ends)
800-DON'T CUT (366-8288)
https://selfinjury.com/
Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

VIRGINIA RESOURCES

National Center for Health Promotion and Disease Prevention-Virginia
https://www.prevention.va.us
Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/mental-health/what-is-mental-health/conditions/self-harm
Suicide Prevention Resource Center-Virginia
https://sprc.org/states/virginia
Virginia Department of Behavioral Health and Developmental Services
https://dbhds.virginia.gov
Virginia Department of Health
https://https://www.vdh.virginia.gov/suicide-prevention/
Virginia Mental Health Access Program
https://vmap.org/2024/03/18/how-to-help-your-teen-stop-self-harming

JUVENILE OFFENDING

OVERVIEW

The juvenile brain is not fully mature. Adolescents are still developing socially, emotionally, and cognitively. For this reason, young people are less able to use good judgment and are more prone to influences from family, school, peers, and the community. In addition, stress, peer pressure, and immediate reward are more likely to influence juveniles' behavior than adults'. This can result in offending behaviors that bring youth in contact with the juvenile justice system.

KEY POINTS

- **50 to 75 percent of juvenile offenders have one or more mental health disorders, which frequently go undetected.**
- **Offenders who receive appropriate mental health & (if appropriate) substance abuse treatment are less likely to re-offend.**
- **Evidence-based treatments include multisystemic therapy, functional family therapy, and Treatment Foster Care Oregon.**

Although most youth who have a mental health disorder do not become involved in the juvenile justice system, youth who do become involved often have a mental health disorder. Studies indicate that 50 to 75 percent of the two million U.S. youth who encounter the juvenile justice system meet criteria for a mental health disorder.[1] In Virginia, more than 92 percent of juveniles committed to the Department of Juvenile Justice have significant symptoms of attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), oppositional defiant disorder (ODD), or a substance use disorder, and 77 percent of admitted juveniles had significant symptoms of other mental health disorders.[2] Such numbers are particularly troubling when compared to the general youth population, of which only about 20 percent of youth suffer from a diagnosable mental health disorder.

Some behaviors that lead to justice system involvement are directly influenced by symptoms of mental health disorders, including impulsivity, anger, and cognitive misperceptions. In other cases, mental health problems lead to problems like substance use or social isolation, which may increase the likelihood of rule-violating behaviors. Limited mental health screening and referrals mean that such problems frequently go undetected in juvenile offenders, increasing the likelihood that these juveniles will have persistent difficulties. Screening and assessment of juvenile offenders helps determine how the juvenile justice system can address their treatment needs, and treating these disorders may help youth overcome other causes of juvenile delinquency. Common mental health disorders seen among juvenile offenders include:

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[1] Underwood, L. A., & Washington, A. (2016). Mental illness and juvenile offenders. *International Journal of Environmental Research and Public Health, 13*(2), 228.

[2] Virginia Department of Juvenile Justice (VDJJ). (2022). *Data resource guide for fiscal year 2022.* Retrieved from https://www.djj.virginia.gov/documents/about-djj/drg/FY2022_DRG.pdf.

- Conduct disorder (CD)
- Oppositional defiant disorder (ODD)
- Major depressive disorder and persistent depressive (dysthymic) disorder
- Anxiety disorders
- Bipolar disorder
- Attention-deficit/hyperactivity disorder (ADHD)
- Posttraumatic stress disorder (PTSD)
- Substance use disorders

RISK AND PROTECTIVE FACTORS

Figure 1 outlines factors that may make it more or less likely that youth will enter the juvenile justice system. No single risk or protective factor can predict whether a youth will become a juvenile offender, but the more risk factors and fewer protective factors present, the greater the likelihood of delinquent behavior. For this reason, reducing risk factors and promoting protective factors may help keep youth out of the juvenile justice system.

Figure 1
Risk and Protective Factors Affecting Entrance into the Juvenile Justice System

Protective Factors	• High self esteem • High expectations • Structure and rules at home • Positive attitudes about school • Access to adults with whom the child can discuss problems • Involvement in learning • Secure attachment to caregivers • Sense of belonging • Social support • Healthy adult attachments • The presence of a stable adult mentoring figure	
Early Disruptions in Parenting/Caregiving	• Impulsiveness • Substance use • Antisocial or aggressive beliefs and attitudes • Aggressive responses to shame • Poor behavior controls • High emotional distress • Weak connection to school • Chronic school truancy • Learning difficulties or low school achievement • Involvement with delinquent peers or gangs • Lack of involved adults in community	• Experiencing child abuse and neglect; trauma • Disengaged family, or family members engaged in delinquent or criminal behavior • Parental substance abuse • Parental or caregiver use of harsh or inconsistent discipline • Exposure to violence in the home or community • Lack of appropriate supervision • Having one or more mental health disorders

EVIDENCE-BASED TREATMENTS

Heightened awareness of mental health disorders has led to increased research and new treatment practices in the juvenile justice system. Among delinquent juveniles who receive structured, meaningful, and sensitive treatment, recidivism rates are 25 percent lower than those in untreated control groups, and highly successful programs reduce rates of recidivism by as much as 80 percent.[3] Treatment should be gender responsive and should integrate recent advances in trauma-based care. Mental health treatment should also involve families as fully as possible in the treatment of their children. Mental health treatment and reduction of delinquency overlap within the juvenile justice system; however, mental health treatments should be sought as early interventions in of themselves, where applicable. Treatments are outlined in Table 1.

It is important to note that delinquent behaviors have many causes, and just as there is no one way to understand these behaviors, there is not one ideal treatment approach. Reducing delinquent behaviors is most likely when the context of the behavior is understood and when the youth's specific risk and protective factors are addressed.

Although several of the following treatment approaches may be applied and utilized in an institutional setting, this discussion refers to the application of these approaches in a community setting.

Both Multisystemic Therapy (MST) and Functional Family Therapy (FFT) are family-based approaches that integrate behavioral approaches to care. They differ in the number of systems they address. MST addresses family, peers, school, and neighborhood support, while FFT is focused primarily on the family. MST is more often assigned for serious offenders, but both approaches are equally effective.[4]

Multisystemic Therapy

Multisystemic therapy (MST) is an integrative, family-based treatment that focuses on improving psychosocial functioning in youth and families with the goal of reducing or eliminating the need for out-of-home placements. MST addresses the numerous factors that shape serious antisocial behaviors in juvenile offenders while focusing on the youth and his or her family, peers, school, and neighborhood/community support. The underlying premise of MST is that the behavioral problems in children and adolescents can be improved through the interaction with or between two or more of these systems.

MST has an extensive body of research to support its effectiveness in juveniles who have emotional and behavioral problems. It is considered to be an effective, intensive, community-based treatment for justice-involved youth. Evaluations have shown reductions of up to 70 percent in long-term rates of re-arrest, reductions of up to 64 percent in out-of-home placements, improvements in family functioning, and decreased mental health problems.[5]

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[3] Coalition for Juvenile Justice. (2000). Handle with care: Serving the mental health needs of young offenders coalition for juvenile justice. 2000 Annual Report.

[4] Eeren, Goossens, Scholte, et al. (2008). MST and FFT Compared on their Effectiveness Using the Propensity Score Method. *Journal of Abnormal Child Psychology*. 46(5): 10037-1050.

[5] National Mental Health Association (NMHA). (2004). Mental health treatment for youth in the juvenile justice system: A compendium of promising practices. Chicago, IL: MacArthur Foundation.

Functional Family Therapy

Functional family therapy (FFT) is a family-based prevention and intervention program that integrates established clinical therapy, empirically supported principles, and extensive clinical experience. FFT is often used for youth ages 11 to 18 who are at risk for and/or presenting with delinquency, violence, substance use, conduct disorder (CD), oppositional defiant disorder (ODD), or disruptive behavior disorders. This model allows for intervention in complex problems through clinical practice that is flexibly structured, culturally sensitive, and accountable to families. FFT focuses on treating youth who exhibit delinquency and maladaptive "acting out" behaviors by seeking to reduce them through identifying obtainable changes.

Table 1
Summary of Treatments for Juvenile Offenders

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 (BSFT)	A short-term, family-focused therapy that focuses on changing family interactions and contextual factors that lead to behavior problems.
Aggression replacement training (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 (DBT)	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.

Treatment Foster Care Oregon

Treatment Foster Care Oregon (TFCO) (formerly Multidimensional Treatment Foster Care) recruits, trains, and supervises foster families to provide youth with close supervision, fair and consistent limits and consequences, and a supportive relationship with an adult. As an alternative to corrections, this treatment model places juvenile offenders who require residential treatment with these carefully trained foster families. TFCO also provides individual and family therapy, educational programming, and psychiatric care. It is effective in reducing delinquent behaviors, justice system contacts, substance use, depression, and teen pregnancy. TFCO prioritizes both rehabilitation and public safety. During the placement timeframe, the youth's biological or adoptive family also receives family therapy to further the goal of returning the youth to that family.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)
https://www.aacap.org/

Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org/Home/

National Center for Juvenile Justice (NCJJ)
http://www.ncjj.org/

National Child Traumatic Stress Network (NCTSN)
https://www.nctsn.org/

National Council of Juvenile and Family Court Judges (NCJFCJ)
https://www.ncjfcj.org/

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
https://www.ojjdp.gov

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

VIRGINIA RESOURCES AND ORGANIZATIONS

Virginia Department of Behavioral Health and Developmental Services (DBHDS)
http://www.dbhds.virginia.gov/

Virginia Department of Criminal Justice Services (DCJS)
http://www.dcjs.virginia.gov/

Virginia Department of Juvenile Justice (DJJ)
http://www.djj.virginia.gov/

Virginia Tech

Child Study Center
http://childstudycenter.wixsite.com/childstudycenter

Psychological Services Center
https://support.psyc.vt.edu/centers/psc

ARTICLE

Lipsey, M. (2009). The primary factors that characterize effective interventions with juvenile offenders: a meta-analytic overview. *Victims and Offenders,* 4(4):124–147. https://www.researchgate.net/publication/228662112_The_Primary_Factors_that_Characterize_Effective_Interventions_with_Juvenile_Offenders_A_Meta-Analytic_Overview

JUVENILE FIRESETTING

KEY POINTS

- **Children set fires for a wide variety of reasons.**
- **Pyromania is an extremely rare disorder and is not usually the cause of juvenile firesetting.**
- **Children who deliberately set fires should be evaluated by a therapist or other professional.**
- **Fire safety education and cognitive behavioral therapy are common treatments.**

OVERVIEW

When juvenile delinquency is mentioned, arson is not usually the first type of offense that comes to mind. However, between 2014-2018, the National Fire Protection Association (NFPA) reported that 52,260 intentional structure fires were reported to U.S. fire departments with about 267,000 intentional fires annually.[1] Fifty percent of individuals arrested for these intentional fires were less than 18 years of age. The most common reasons for setting the fires were excitement, vandalism, crime concealment, revenge, other and unknown motivations.[2] According to the Bomb Arson Tracking System (BATS), there were 181 incendiary fires set by juveniles with residential and educational buildings making up 63 percent of the property types targeted by juveniles.[3] From multiple official sources, it is clear that juveniles setting fires continues to be a challenge.

Families can prevent firesetting by setting a few rules, such as the following the U.S. Fire Administration guidelines on fire prevention:

1. Teach children that matches and lighters are not toys.
2. Never allow children to play with lighters or matches. About half of fires started by children are caused by children playing with matches and lighters.
3. Keep all matches and lighters out of the reach of children. Store in a high cabinet, preferably locked.
4. Do not leave young children unattended.
5. Teach young children to tell a grown-up when they see matches or lighters. Praise children when they tell you about found matches and lighters.

[1] Campbell, R. (2021, September 1). Intentional structure fires. Retrieved from https://www.nfpa.org/education-and-research/research/nfpa-research/fire-statistical-reports/intentional-fires.
[2] United States Bomb Data Center. (2023). 2023 Arson incident report (AIR). p. 13. Retrieved from https://www.atf.gov/resource-center/docs/report/2023arsonincidentreportpdf/download.
[3] Ibid.

6. If a child is overly interested in fire, has played with matches and lighters, or has started a fire, the family must address this natural curiosity immediately and teach the child about the dangers of fire. In this event, call your local fire department and ask if they have a juvenile firesetters intervention program.

Consult a mental health professional if your child exhibits behaviors such as adding more fuel to fires against your directions, lighting candles or other things despite being told not to, pocketing matches, or hiding fire-starting materials. If a school-age child intentionally sets fires, even after being appropriately disciplined, families must consider getting professional help. If you discover your child setting a fire, do not ignore it or assume that your child will not do it again after being disciplined. Many children who set fires do so repeatedly. Intervention is even more important if the child is setting fires to larger items or in instances where the flames can easily spread, causing injury and damage.

CAUSES AND RISK FACTORS

Children set fires for a variety of reasons, including curiosity about fire, crying for help, or engaging in delinquent behavior. Some of the reasons youth set fires are outlined in Table 1.

Table 1
Reasons for Juvenile Firesetting

Reasons	Description
Curiosity	A child sets a fire to learn more about fires and how they can be set.
Crisis motivated	A child sets a fire because they feel they have lost power. The fire gives them a false sense of mastery.
Delinquent firesetting	A child sets a fire to rebel against authority.
Pathological firesetting	A severely disturbed youth may set fires because of a severe mental disorder.
Cognitive impairment	A cognitively-impaired child may set a fire because they lack good judgment.
Sociocultural firesetting	A child sets a fire because of peer pressure, external pressures, or religious motives.

There is little consensus regarding specific risk factors or characteristics common to all juvenile firesetters because the factors are widely variable. The evidence suggests that the cause for firesetting in juveniles is likely a complex interplay between environmental, psychological, and biological factors.

The concept of fire interest has consistently been associated with firesetting behavior in multiple studies and has been identified as a risk factor for recidivism. In addition, early experiences with fire, early exposure to firesetting, and previous intentional firesetting behaviors are associated with juvenile firesetting behavior.

Being male is frequently reported as a risk factor for firesetting. Substance use, specifically alcohol and cannabis, is another common risk factor. In addition, children who have experienced emotional and physical abuse are more likely to have a history of firesetting than children who did not experience abuse.

Children with firesetting behaviors were more likely than other juvenile offenders to have received mental health treatment and to have had suicidal thoughts in the past. Conduct disorder and attention-deficit/hyperactivity disorder (ADHD) have been associated with juvenile firesetting in some studies. Research also suggests that firesetting may be an attempt by the youth to regulate difficult cognitive, social, and/or emotional experiences. These actions may serve to change the youth's current state of feelings by deliberately setting a fire, which in turn changes their current negative sensation. Firesetting can become a sensation-seeking practice for youth.

Some firesetting may be precipitated by a crisis and the subsequent need to assert control over the self or the environment. For these children, fire, as a powerful element, may offer a sense of mastery and competence. Depression, ADHD, or family stress may accompany this type of firesetting.

Delinquent-motivated firesetting conceptualizes the use of fire as one way of acting out against authority. These children rarely show empathy but tend to avoid harming others. Given that firesetting is one of 15 symptoms for conduct disorder, it makes sense to explore the relationship between delinquency and firesetting.

Pathological-motivated firesetting is the rarest of the motivations seen by practitioners in this field and describes a severely disturbed juvenile. It includes those who are actively psychotic, acutely paranoid or delusional, or who have lived in chronically disturbed and bizarre environments. A small, rare subtype of this group may meet criteria for pyromania. Pyromania is discussed in the "Disruptive, Impulse Control, and Conduct Disorders" section of the *Collection.*

Other variables linked to juvenile firesetting include peer pressure, curiosity, mental health and substance abuse problems, and lack of adult supervision. Research has also found a relationship between involvement in firesetting and parents/caregivers who smoke, due to the availability of matches and cigarette lighters, and because the purposive use of fire is familiar to the juvenile.

TREATMENTS

Currently, there are no evidence-based treatment approaches for the juvenile firesetting population. There is little to no research that supports pharmacological treatment. However, many other treatments have proven beneficial in the management of this behavior. These treatments are appropriately applied to firesetters with consideration for their age and are outlined in Table 2.

Cognitive behavioral therapy (CBT) and fire safety education (FSE) are found to significantly curtail firesetting and match-play behaviors up to a year after intervention. Firefighter home visits (FHV) have also been shown to significantly decrease the likelihood of juvenile firesetting. However, structured treatments designed to intervene with children who set fires were still found to have greater effect in the long-term than brief visits with a firefighter. Both CBT and FSE were also shown to be effective at reducing other activities associated with firesetting, such as playing with matches and being seen with matches or lighters.

Regardless of the seriousness of an incident or the child's motive for starting a fire, education regarding fire should be part of the intervention strategy. Education should include information about the nature of fire, how rapidly it spreads, and its potential for destructiveness. Information about how to maintain a fire-safe

environment, utilize escape plans and practice, and use fire appropriately has been shown to be an effective component of comprehensive arson intervention programs, at least for younger youth.

Social skills training may also help juveniles who have trouble expressing and adaptively managing their emotions. These skills include asking for help, making friends, solving problems, responding to failure, answering complaints, expressing affection, and negotiating.

Table 2
Summary of Treatments for Juvenile Firesetting

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT)	Structured treatments designed to intervene with children who set fires. Because firesetting is a maladaptive behavior, CBT is a reasonable intervention to consider for behavior modification.
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.
What Does Not Work	
Ignoring the problem	Leaving youth untreated is not beneficial because they typically do not outgrow this behavior. Behavior may increase.
Satiation	Satiation, repetitively lighting and extinguishing fires, 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 and abusive. It will not decrease the likelihood of the juvenile setting fires or 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 may even increase the likelihood that firesetting traits continue.

RESOURCES AND ORGANIZATIONS

Association for Behavioral and Cognitive Therapies
http://www.abct.org

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
https://ojjdp.ojp.gov/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

U.S. Fire Administration
https://www.usfa.fema.gov/index.html

Youth Firesetting Information Repository & Evaluation System (YFIRES)
https://yfires.com/

VIRGINIA RESOURCES AND ORGANIZATIONS

Virginia Department of Fire Programs (VDFP)
https://www.vafire.com/

Virginia Tech

Child Study Center
http://childstudycenter.wixsite.com/childstudycenter

Psychological Services Center
https://support.psyc.vt.edu/centers/psc

SEXUAL OFFENDING

KEY POINTS

- **Sexually abusive behaviors include contact offenses (unwanted or forced sexual contact) and non-contact offenses (e.g., Internet crimes).**
- **90 percent of juvenile sexual offenders are male, and 80 percent have one or more mental health disorders.**
- **Previous sexual victimization is correlated with later sexually abusive behavior.**
- **Multisystemic therapy and cognitive behavioral therapy that specifically targets sexual offending are the preferred treatments.**

OVERVIEW

Juvenile sexual offenders can be defined as youth who commit any sexual interaction with persons of any age against the will of the victim, without consent, or in an aggressive, exploitative, or threatening manner. While the majority of juvenile sexual offenders are between puberty and the age of legal majority, a small number of juvenile offenders are younger than 12 years of age. Sexually abusive behaviors can vary from non-contact offenses to contact offenses. A contact offense requires unwanted physical contact with a victim. With a non-contact offense, the perpetrator has no physical contact with the victim (e.g., Internet crimes such as online stalking, sexual harassment, and unsolicited sexual images and texts). The role of the Internet in juvenile sexual offending is not well understood, but it is an environment where youth have easy access to highly sexualized materials.

Juvenile sexual offenders' behaviors have the potential to cause significant harm to others and have significant legal ramifications. It is important to note that it is not until the youth has been found guilty or adjudicated in a court of law that the term "juvenile sexual offender" is technically accurate. However, the term "juvenile sexual offender" will be utilized in this section, since much of the research utilizes this term.

Juvenile sexual offenders are fundamentally different from adults in their cognitive capabilities and their ability to regulate emotions and control behavior. Juvenile sexual offending is not a predictor of adult offending outcomes. Juveniles also have less capacity than adults in weighing the consequences of their actions. Research demonstrates that the regions of the brain associated with foresight and planning continue to develop well beyond adolescence. These factors must be acknowledged in the assessment and treatment of juvenile sexual offenders.

Research has shown that there are two types of juvenile sexual offenders: those who target children, and those who offend against their peers or against adults. Moreover, there are also differences in motivation. Some offenders have histories of violating the rights of others, some are sexually curious, and some have serious mental health issues or poor impulse control.

A significant proportion of juvenile sexual offenders may present with a diverse range of disordered behaviors, such as aggressive behavior, bullying, vandalism, firesetting, cruelty to animals, shoplifting, and drug/alcohol abuse. However**,** juvenile sexual offenders differ from their adult counterparts in that juveniles typically do not present with the same types of sexual deviancy and psychopathic tendencies that may be observed among adult offenders.

In general, 90 percent of all juvenile sexual offenders are male. Of that number, a significant portion of those ages 12 to 14 years target four- to seven-year-old boys. By contrast, older offenders tend to abuse older female victims, peaking with 15- to 17-year-old boys targeting 13- to 15-year-old girls. This suggests that teen offenders targeting boys seek younger, sexually immature boys rather than peers, and older teen offenders target sexually mature females.

Figure 1 outlines the characteristics of sexually abusive juveniles.

Figure 1
Characteristics of Sexually Abusive Juveniles

- Perpetrators are typically adolescents between the ages of 12 and 17.
- Perpetrators are predominantly male.
- Perpetrators have difficulties with impulse control and judgment.
- Up to 80 percent of perpetrators have a diagnosable psychiatric disorder.
- Between 30 to 60 percent of perpetrators exhibit learning disabilities and academic dysfunction.

Preliminary research indicates that juvenile sexual offenders share some characteristics other than sexual offending, including:

- High rates of learning disabilities and academic dysfunction
- Attention-deficit/hyperactivity disorder
- The presence of other behavioral problems and conduct disorder
- Difficulties with impulse control and judgment
- Exposure to sexual behaviors or materials (such as pornography)

Ignoring comorbid mental health disorders may compromise the efficacy of structured sex offender treatment. Treatment for comorbid mental health disorders may sometimes be provided simultaneously with other forms of sexual offender treatment. However, if the juvenile offender is psychotic, manic, or severely depressed, treatment in an inpatient setting may be necessary.

DATING VIOLENCE

Dating violence can occur within adolescent romantic relationships. It can take many forms, including physical violence, sexual violence, stalking, and psychological aggression. At least 1 in 12 high school students report experiencing sexual dating violence, and rates are higher among female and LGBTQ+ students.

CAUSES AND RISK FACTORS

The causes of juvenile sexual offending are not well understood. However, sexual abuse, physical abuse, child neglect, and exposure to family/domestic violence are all factors associated with juvenile sexual offending. There is strong evidence that indicates that sexual victimization in childhood plays a role in the development of sexually abusive behavior in adolescents. For this reason, clinicians should consider incorporating principles of trauma-informed care into evidence-based sex offender treatment models. Early trauma paves the way for maladaptive coping and interpersonal deficits, which can lead to abusive behavior.

Female sexual offending has been under-reported and under-represented in sexual offender literature, but preliminary research has revealed that many of these females had very disruptive and tumultuous childhoods, with high levels of trauma and exposure to dysfunction with post-traumatic stress disorder (PTSD) being especially prevalent. Compared to those of juvenile males, the histories of females in certain studies reflect even more extensive and pervasive childhood maltreatment by both females and males. They were also victimized at younger ages and were more likely to have had multiple perpetrators. In prepubescent female sexual offenders, rates of sexual victimization are extraordinarily high, with rates greater than 90 percent.

TREATMENTS

Once a juvenile sexual offender has been identified, careful assessment is critical so that his or her needs can be matched to the correct type and level of treatment. Ideally, the assessment will indicate the level of danger that the juvenile presents to the community, the severity of psychiatric and psychosexual problems, and the juvenile's amenability to treatment. All available participants should be included in the assessment process, including the youth, his or her parents or guardians, and all other professionals involved, such as teachers, case workers, social workers, and mental health treatment providers. It should be expected that the youth and his or her family may be at various psychological stages, ranging from complete denial to full acknowledgment of the sexual offense(s). For this reason, it is important that full acknowledgment of offending behaviors and their impact on others is a primary goal of treatment. Decisions about whether an adolescent sexual offender should remain in the same home as the victim of his or her offense should be made carefully on a case-by-case basis. The decision may involve input from a variety of professionals (e.g., child protection workers, therapists, etc.). It is essential that the community and other children be protected from potential harm, both physical and psychological.

Research has demonstrated that the overall prognosis for children with sexual behavior problems is good and that sexually abusive juveniles benefit from treatment. Although there are currently no evidence-based treatments, promising sexual offender treatment programs often combine an intensive, multi-modal approach with early intervention. Comprehensive treatment may focus on taking responsibility for one's sexual behavior, developing victim empathy, and developing skills to prevent future offending. A summary of promising treatments is provided in Table 1.

Several controversial forms of assessments for juvenile sexual offenders include the polygraph, "visual reaction time," and plethysmograph testing. These are not effective in improving treatment or reducing recidivism.

When seeking professional services for sexual offenders, it is prudent to ensure that the qualifications of the service provider indicate expertise in the treatment of sexual offenders. One way to ensure such expertise is to select a professional with this certification (CSOTP). Qualifications include a minimum of a master's or doctoral degree in a selected field, a Doctor of Medicine (M.D.), or Doctor of Osteopathic Medicine (D.O.) degree from an institution that is approved by an accrediting agency recognized by the Virginia Board of Medicine. Qualifications also include 50 hours of sex offender treatment-specific training, 2,000 hours of post-degree clinical experience (200 of which must be face-to-face treatment/assessment of sexual offenders), and 100 hours of face-to-face supervision within the 2,000 hours experience (minimum of six hours per month). A minimum of 50 hours shall be in individual, face-to-face supervision.

Table 1
Summary of Treatments for Sexually Offending Youth

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	
Medication	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.

Multisystemic Therapy for Problem Sexual Behaviors (MST-PSB)

MST-PSB is an intensive family- and community-based treatment that addresses the multiple factors of serious antisocial behavior in juvenile sexual abusers. Treatment can involve any combination of individual, family, and extra-familial factors (e.g., peer, school, or neighborhood). MST-PSB promotes behavior change in the juvenile's natural environment, using the strengths of the juvenile's family, peers, school, and neighborhood to facilitate change.

Like standard multisystemic therapy, MST-PSB specifies a model of service delivery rather than a manualized treatment with sequential session content. It utilizes several standard interventions, including individual (e.g., social skills training, cognitive restructuring of thoughts about offending), family (e.g., caregiver skills training, communication skills training, marital therapy), peer (e.g., developing prosocial friendships, discouraging affiliation with delinquent and drug-using peers), and school levels (e.g., establishing improved communication

between caregivers and school personnel, promoting academic achievement). The overarching goal of MST-PSB is to empower caregivers and other important adult figures with the skills and resources needed to address the youth's problematic sexual behaviors and any other behavioral problems. Services are delivered to the youth and their caregivers in home, school, and neighborhood settings at times convenient to the family (including evenings and weekends), with intensity of treatment matched to clinical need. Client contact hours are typically higher in the initial weeks of treatment (three to four times per week if indicated) and taper off during a relatively brief course of treatment (five to seven months on average).

Cognitive Behavioral Therapy (CBT)

CBT is the most common treatment for juvenile sexual offenders. One form of CBT that has positive results is Children with Problematic Sexual Behavior–Cognitive Behavioral Therapy (PSB-CBT). The primary goal of PSB-CBT is to reduce and eliminate sexual behavior problems among school-age children. The program provides cognitive-behavioral, psychoeducational, and supportive services to children and their families referred to the program for the child's sexual behavior problems. Intermediate goals are to increase awareness of sexual behavior rules and expectations, strengthen parent-management skills, improve parent-child communications and interactions, improve the child's self-management skills related to coping and self-control, improve the child's social skills, and decrease the child's internalizing and externalizing behaviors. Interventions are offered in community-based and/or residential settings and are primarily delivered in individual and/or group therapy sessions, although family sessions are frequently incorporated as well.

Female Juvenile Sexual Offenders Treatment

Because assessment and treatment tools have only been validated on male offenders and are primarily tested on adult subjects, it is unclear how effective they are with juvenile female offenders. Preliminary research suggests that traditional psychological evaluation (e.g., intellectual and personality assessment) may be of more value with female juvenile offenders, and treatment approaches should address the early and repetitive developmental traumas experienced by these offenders. Furthermore, female juvenile sexual offenders may benefit from focus on the unique considerations of gender issues, including sexual and physical development, intimacy and social skills, self-image, self-esteem, impulsivity, comorbid symptoms of PTSD, and the common societal expectation of females as caregivers/nurturers.

VIRGINIA'S SEXUAL OFFENDER TREATMENT PROGRAM

Currently, the Virginia Department of Juvenile Justice (VDJJ) provides cognitive-behavioral sexual offender evaluation and treatment services. These are provided in specialized treatment units and in the general population.

Inpatient and moderate treatment is delivered in a group format in self-contained units for high-risk juveniles, with inpatient treatment more intensive than moderate treatment. Prescriptive treatment is delivered individually as needed. Juveniles in sex offender treatment units receive intensive treatment by a multidisciplinary treatment team that includes a community coordinator, counselor, and specially trained therapists. Specialized sex offender treatment units offer an array of services, including individual, group, and

family therapy. Each juvenile receives an individualized treatment plan that addresses programmatic goals, competencies, and core treatment activities. Successful completion of sex offender treatment may require six to 36 months, depending on treatment needs, behavioral stability, and motivation of the juvenile. The median treatment time is approximately 18 months.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)
https://www.aacap.org/

Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org

Association for the Treatment of Sexual Abusers (ATSA)
http://www.atsa.com/

National Center on the Sexual Behavior of Youth
http://www.ncsby.org/

National Council of Juvenile and Family Court Judges (NCJFCJ)
Juvenile Sex Offenders
https://www.ncjfcj.org/our-work/juvenile-sex-offenders

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
Juvenile Sex Offenders
https://ojjdp.ojp.gov/taxonomy/term/76216

Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART)
https://ojp.gov/smart/

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

Virginia Department of Juvenile Justice (DJJ)
http://www.djj.virginia.gov/

THE EFFECTS OF SOCIAL MEDIA ON YOUTH

OVERVIEW

Social media is an integral part of daily life for most young people. Recent data demonstrates that youth widely and frequently use social media apps. According to the Centers for Disease Control and Prevention, 30% of teens reported using social media more than once per hour, and 77% reported frequent social media use (typically more than 3-4 hours per day).[1] Despite age restrictions on many social media apps, nearly 40% of children between ages 8-12 use social media daily.[2] The increase in social media use correlates to increases in bullying, feelings of sadness and hopelessness, and suicide risk among young children and teens.[3] Studies show that less frequent social media use is associated with higher life satisfaction, as well as improved social-emotional health and academic performance.[4] While more research is needed to determine the full impact of social media use on youth mental health, the current alarming associations are cause for concern.

KEY POINTS

- **The growth of social media correlates with a sharp rise in depression and anxiety among young people.**
- **Social media use releases dopamine (the feel-good hormones) in the brain, making it potentially addictive.**
- **Between 5% and 20% of teenagers are addicted to social media.**
- **Social media can facilitate social relationships that build support networks, maintain friendships, and share hobby interests.**
- **Establishing limitations on youth social media use is the best option as research into its impact on developing brains continues.**

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[1] Young, E., McCain, J.L., Mercado, M.C. et al. (2024). Frequent social media use and experiences with bullying, victimization, persistent feelings of sadness or hopelessness, and suicide risk among high school students—youth risk behavior survey, United States, 2023. *Supplements*, Mobidity and Mortality Weekly Report, October 10, 2024, 73(4); 23-30. Retrieved from **https://www.cdc.gov/mmwr/volumes/73/su/su7304a3.htm**.

[2] Vidal, C., Katzenstein, J. (2025). Social Media and Mental Health in Children. Johns Hopkins Medicine. Retrieved from **https://www.hhr.virginia.gov/initiatives/safe-kids-strong-families**.

[3] Young, E., McCain, J.L., Mercado, M.C. et al. (2024). Frequent social media use and experiences with bullying, victimization, persistent feelings of sadness or hopelessness, and suicide risk among high school students—youth risk behavior survey, United States, 2023. Supplements, Mobidity and Mortality Weekly Report, October 10, 2024, 73(4); 23-30. Retrieved from **https://www.cdc.gov/mmwr/volumes/73/su/su7304a3.htm**.

5 Office of the Surgeon General, U.S. Department of Health and Human Services. (2023). Social media has both positive and negative impacts on children and adolescents. Bookshelf ID: NBK594763. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK594763/.

SOCIAL MEDIA AND THE DEVELOPING BRAIN

Social media impacts developing brains more acutely. The prefrontal cortex brain regions are not fully developed in preteens and teenagers. The prefrontal lobe contributes to cognitive processing and emotional regulation, and the underdeveloped prefrontal cortex can prevent youth from fully processing the long-term impacts of their actions.[5] Additionally, research shows cerebellum volume decreases slightly with increased social media use.[6] The cerebellum makes up only 10 percent of the physical brain, yet includes over half of the entire brain's neurons with possible cognitive functions, so social media may prevent or delay development. Social media also influences the brain's reward system through unpredictable and rapid gratification. Social media notifications, likes, and comments cause the brain to release dopamine and repeatedly crave engagement.[7] This pattern can ultimately lead to a cycle of obsessive behavior and addiction, which has been noted to look "remarkably similar to your brain on cocaine."[8] This is especially worrisome for young, developing brains exposed to the dopamine-addictive nature of social media.

POTENTIAL BENEFITS OF SOCIAL MEDIA

When used responsibly, social media can provide young people with opportunities for interpersonal connection, self-expression, and learning. Youth can utilize social media to build support networks and share hobby interests. These benefits especially extend to young people who may feel geographically or culturally isolated.[9] Social media platforms can spark creativity for young people who can express their emotions through photography, music, and other media. Creative outlets expressed through social media present opportunities for youth to develop a sense of identity during their formative years. The U.S. Surgeon General's Advisory from 2023 also notes that social media can provide a gateway for youth to learn about mental health and pursue proper care.

RISKS OF SOCIAL MEDIA USE

Recent research into youth social media use identifies potential harms and links excessive social media use with poor mental health. Youth aged 12-15 participating in a longitudinal study who spent over 3 hours per day on social media showed a twofold increase in negative mental health outcomes, including symptoms of depression and anxiety. Similarly, several studies on college-aged youth have found a relationship between social media use and increased depression and anxiety. One study has attributed over 300,000 new cases of depression across

[5] ProCare Therapy. (2020, February 27). The dangers of social media on teens. Retrieved from https://www.procaretherapy.com.
[6] Hartman, A. (2025, June 25). The neuroscience of social media: how algorithms hijack your brain. Richmond Integrative and Functional Medicine
[7] Masri-Zada T, Martirosyan S, Abdou A, et al. The Impact of Social Media & Technology on Child and Adolescent Mental Health. *J Psychiatry Psychiatr Disord*. 2025;9(2):111-130.
[8] Hartman, A. (2025, June 25). The neuroscience of social media: how algorithms hijack your brain. Richmond Integrative and Functional Medicine
[9] U.S. Department of Health and Human Services, Office of the Surgeon General. *Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory.* 2023.

college-aged youth to the introduction of a new social media platform. These adverse outcomes are even more concerning for adolescents whose brains are in an earlier stage of development. [10]

The negative mental health trend since the advent of social media is more pronounced among girls than their male peers. Social media use among girls is linked with higher risks of poor body image, low self-esteem, and depressive symptoms. Studies into the disparate impact of social media on girls identify comparison with unrealistic bodily expectations as the primary contributing factor. Furthermore, girls and LGBTQ youth are disproportionally targeted by harassment and abuse on social media sites, likely contributing to the higher rates of anxiety and depression. [11]

Social media can also reduce a young person's capacity to be attentive and mindful. Recent research suggests that young people that use social media excessively are more likely to develop symptoms of Attention-Deficit/Hyperactivity Disorder (ADHD).[12] While further research is needed into the links between social media use and ADHD, researchers point to the increase in short-form content across social media platforms as a potential explanation for current findings. Short-form content is fast-paced and provides instant gratification that can interfere with the brain's natural reward system over time.[13]

Over time, compulsive social media use can grow into an addiction, which has several psychological and social consequences for youth. Researchers estimate that between 5% and 20% of teenagers are addicted to social media. Researchers point to infinite scrolling features and personalized algorithm-driven content as potential drivers of social media addiction. Young people may turn to social media for entertainment, but it can quickly become a coping mechanism that draws them away from personal relationships and interferes with daily responsibilities.[14]

EVIDENCE-BASED TREATMENTS

The impact of social media on our children and youth is not yet fully known. More research is needed to determine the best way to counteract the adverse mental health outcomes associated with social media use. Since social media is designed to keep users engaged with a variety of content as long as possible, the American Academy of Pediatrics recommends that parents monitor social media use for positive content and limit their children's time spent on social media. Parents must be proactive in setting boundaries and having open discussions about safety online. Table 1 displays strategies that have been used to help reduce the risks of social media use.

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[10] U.S. Department of Health and Human Services, Office of the Surgeon General. *Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory.* 2023.
[11] U.S. Department of Health and Human Services, Office of the Surgeon General. *Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory.* 2023.
[12] Hassan, M.M., Orebi, H.A., Salama, B. *et al.* The association of social media use and other social factors with symptoms of attention-deficit/hyperactivity disorder in Egyptian university students. *BMC Psychiatry* 25, 19 (2025). https://doi.org/10.1186/s12888-024-05988-6.
[13] Chiencharoenthanakij R, Yothamart K, Chantathamma N, et al. Short-Form Video Media Use Is Associated With Greater Inattentive. Symptoms in Thai School-Age Children: Insights From a Cross-Sectional Survey. *Brain Behav*. 2025;15(7):e70656. doi:10.1002/brb3.70656.
[14] Amirthalingam J, Khera A. Understanding Social Media Addiction: A Deep Dive. Cureus. 2024;16(10):e72499. Published 2024 Oct 27. doi:10.7759/cureus.72499.

Table 1
Strategies to Reduce the Risks of Youth Social Media Use

Strategies:
• Studies have shown that depression and anxiety are alleviated when social media time is reduced or eliminated. Apps such as FamilyPause, ScreenTime (Apple), Digital Wellbeing (Android), and Google Family Link allow parents to lock the child's phone, set screen time limits and manage the child's phone remotely, or manage the child's Google account. Phones may also be suspended with the carrier. • Using Cognitive Behavioral Therapy, instead of turning to social media, is helpful in processing any impact from negative social media use. Young people may discuss concerns and issues with a therapist who is nonjudgmental and incorporates age-appropriate strategies, such as problem-solving and education. • Stop using screens at least one hour before bedtime. Blue light from the screen interferes with quality sleep and contributes to sleep deprivation, which contributes to depression and thoughts of suicide. Keep the phone and screens out of the bedroom, if at all possible, but especially one hour before bedtime. • Setting boundaries to limit social media use and enforcing them reduces the risk of cyberbullying, poor grades, mental health concerns, and suicide. • Creating a Family Media Plan to establish clear guidelines about the amount of screen time, digital etiquette, and appropriate online behavior. • Enforcing tech-free areas at home or on vacation (dinner, breakfast, company). • Having parents get to know their child's in-person friend group, and staying in touch with their child's activities on and off social media. • Having a conversation with the child about harmful content, and about not really knowing who these online strangers are. Strangers may lie about their name, gender, age, situation, etc. • Encourage the use of critical thinking while using social media. (e.g., If it seems too good to be true, it probably is; don't believe everything on social media; some people are endorsing products or doing crazy challenges for their own gain; etc.) • Role-modeling positive online behavior by commenting respectfully on social media and balancing social media with non-screen activities and personal connections. • Encouraging youth to participate in extracurricular activities, such as sports, theater, music performance, chorus, writing, cheering, or other school clubs. • Using incentives to provide rewards for time spent away from screens and interacting personally with others. • Parents following and checking their child's social media accounts (and possibly their friends' accounts) for appropriateness.

RESOURCES AND ORGANIZATIONS

American Academy of Pediatrics' Center of Excellence on Social Media and Youth Mental Health
https://www.aap.org/en/patient-care/media-and-children/center-of-excellence-on-social-media-and-youth-mental-health/

American Psychological Association
https://www.apa.org/monitor/2024/04/teen-social-use-mental-health

Annie E. Casey Foundation
https://www.aecf.org/blog/social-medias-concerning-effect-on-teen-mental-health?gad_source=1&gad_campaignid=11154517408&gbraid=0AAAAAD3xzvFYfxWZmh8UB_P0wXjZGJyHP&gclid=Cj0KCQjwmK_CBhCEARIsAMKwcD6NOcISQce7lFTTn29tEjrZElyXzDgjg0v-wBBVVOTp7ELtJNzBMEcaAi3YEALw_wcB

Behavioral Health News
https://behavioralhealthnews.org/the-impact-of-social-media-on-youth-mental-health-risks-benefits-and-family-approaches/

Centers for Disease Control and Prevention
https://www.cdc.gov/mmwr/volumes/73/su/su7304a3.htm

Child Mind Institute
https://www.childmind.org

Common Sense Education
https://www.commonsense.org

Connect Safely
https://connectsafely.org

Internet Matters
https://www.internetmatters.org

John Hopkins Medicine
https://www.hopkinsmedicine.org/health/wellness-and-prevention/social-media-and-mental-health-in-children-and-teens

Mayo Clinic
https://www.mayoclinic.org/healthy-lifestyle/tween-and-teen-health/in-depth/teens-and-social-media-use/art-20474437

Mental Health Coalition
https://www.thementalhealthcoalition.org

National Institutes of Health
https://pmc.ncbi.nlm.nih.gov/articles/PMC10476631/

Organization for Social Media Safety
https://www.socialmediasafety.org/about/

Pew Research Center
https://www.pewresearch.org/internet/2025/04/22/teens-social-media-and-mental-health/

Safe Surfin' Foundation
https://safesurfin.org/resources/

Social Media TestDrive
https://socialmediatestdrive.org

Stanford Law School
https://law.stanford.edu/2024/05/20/social-media-addiction-and-mental-health-the-growing-concern-for-youth-well-being/

U.S. Department of Health and Human Services
https://www.hhs.gov/surgeongeneral/reports-and-publications/youth-mental-health/social-media/index.html

World Health Organization
https://www.who.int/europe/news/item/25-09-2024-teens--screens-and-mental-health

Young Minds
https://www.youngminds.org.uk

Yale Medicine
https://www.yalemedicine.org/news/social-media-teen-mental-health-a-parents-guide

VIRGINIA RESOURCES AND ORGANIZATIONS

Governor Younkin's Executive Order 43
https://www.governor.virginia.gov/newsroom/news-releases/2024/november/name-1036768-en.html#:~:text=RICHMOND%2C%20VA%20%E2%80%93%20Governor%20Glenn%20Youngkin,the%20unrestricted%20use%20of%20cell

National Alliance on Mental Illness (NAMI) Virginia
https://namivirginia.org/?s=Social+media+use

Reclaiming Childhood—A Virginia Initiative by Governor Youngkin
https://www.hhr.virginia.gov/initiatives/reclaiming-childhood/

BOOK

Haidt, J. (2024). *The anxious generation*; *how the great rewiring of childhood is causing an epidemic of mental illness.* Penguin Press.

IMPACT OF COVID-19 PANDEMIC AND LOCKDOWN

KEY POINTS

- **Youth experienced unprecedented levels of isolation and stress.**
- **Mental health diagnoses and need for treatment services dramatically increased.**
- **Vulnerable communities, including children with disabilities, were disproportionately impacted.**

OVERVIEW

In the spring of 2020, the coronavirus spread rapidly across the globe. In the absence of a vaccine, states and localities attempted to combat the contagion by restricting in-person activities. For most families, this meant that some combination of both work and school would take place in the home. Across the country, children and families faced unprecedented isolation and stress. The pandemic's negative effects disproportionately affected already vulnerable populations, especially children with disabilities. While the exact impacts of the pandemic on youth mental health are still being researched, experts agree that the impacts are widespread and severe.

Youth and adolescent mental health problems skyrocketed during the pandemic, and in its wake. In 2021, 42 percent of students felt persistently sad or hopeless, and nearly one-third experienced poor mental health. In 2021, 22 percent of students seriously considered suicide and 10 percent did attempt suicide. A confluence of many factors, both direct and indirect, contributed to this mental health crisis.

Direct threats to children's mental health from the pandemic included threats to family stability, loss of income, and change in employment status of family. For some children, staying at home also increased the potential for physical or emotional abuse by a caregiver. More than a quarter of adolescents reported that a parent or other adult in their home lost a job. Some youth lost their loved ones or caregivers themselves. From April 2020 to June 2021, more than 140,000 U.S. children lost primary or secondary caregivers because of the pandemic.

Indirect threats from the pandemic resulted from physical distancing restrictions and virtual education. At-home learning and in-person gathering restrictions isolated children from their peers, mentors, extended family, and social networks. Additional challenges included adapting to virtual learning and changes to sleep habits and other routines. Children experienced increased levels of persistent stress, fear, and grief. Limited interactions with professionals (teachers, pediatricians, school counselors, etc.) also made it harder to recognize and report signs of child abuse, mental health concerns, and other challenges.

Further, youth and adolescent social media increased during the pandemic and lockdown. Initial studies have shown that time spent on social media was associated with increased anxiety and depressive symptoms.

Moreover, the interplay of broader societal issues, like the national focus on racial justice, combative political environment, and economic instability, may have further exacerbated stress on youth.

MENTAL HEALTH IN CRISIS

The need for mental health services for children and adolescents increased by almost 25 percent during the pandemic. According to the Center for Disease Control and Prevention, in March 2021, more than a third of high school students reported experiencing poor mental health. With any traumatic event, anxiety, depression, and post-traumatic stress disorder (PTSD) increases among some or all populations. Adolescents in particular are affected. About 20 percent of adolescents had moderate or worse psychological trauma symptoms during 2020-2021, which is double the pre-pandemic rates. Forty-four percent reported feeling persistently sad or hopeless during the past year. In particular, LGBTQ+ youth and females reported greater levels of poor mental health, emotional abuse by a parent or caregiver, and suicide attempts. Emergency rooms reported suicide-related visits increased by nearly a third.

Older youth who had emotional regulation issues before the pandemic were at risk for experiencing more severe mental health symptoms, as were adolescents with attention-deficit/hyperactivity disorder (ADHD). Negative emotions or behaviors such as impulsivity and irritability, associated with conditions such as ADHD, appear to have moderately increased.

Substance abuse also increased, particularly among youth with ADHD. Surveys show alcohol use rose during the COVID-19 pandemic, including increased use by stressed parents.

Providers in Virginia also reported on the negative mental health impacts felt by children during the pandemic. According to a survey of the Virginia Chapter of the American Academy of Pediatrics, 98 percent reported an increase in child and adolescent anxiety and 95 percent reported an increase in depression. In the same survey, 86 percent of providers reported seeing an increase in child and adolescent behavior problems since the start of the pandemic.

SCHOOL-RELATED CHALLENGES AND LASTING IMPACTS

Millions of children's educational environment transitioned abruptly to the virtual learning platform, if they were lucky enough to have access to a laptop or computer. For children without computers or online access, teachers provided worksheets and instruction in any way they could. Many children had to navigate new challenges of online learning: focusing on a computer screen for extended periods of time, independent responsibility for completing assignments, and teachers with limited online training. Children experienced isolation, disruption in routine, and higher levels of stress. Peer interaction helps develop imagination, problem-solving skills, and communication, as well as provide stress relief. The absence of this connection during such developmental years may have longer-term effects.

Students in rural areas faced particular challenges in acquiring the resources necessary for virtual learning. The majority of Virginia students in rural Appalachia (87%) did not receive the recommended amount of direct remote instruction during the Governor's stay-at-home order. This caused a major learning gap for many

children in lower-income areas. Such areas are also less likely to have access to mental health treatment or suicide prevention services.

Remote learning also posed particular challenges for children with Individualized Education Programs and 504 Plans.

CHILDREN WITH DISABILITIES

Families of children with disabilities had to constantly adapt to accommodate the changes in supports, services, and supplies. Many families juggled some or all of the following issues: loss of home nursing therapies, educational supports, school provided meals, informal caregiving from extended family members, safe access to medical providers and medical supplies. Limited therapy and treatment jeopardized visits that provided social connections in addition to fulfilling medical needs. Hospitals delayed planned quality-of-life surgeries and delivery of medical equipment, such as wheelchairs, bathing aids, or therapeutic equipment. Some insurance companies required face-to-face meetings to cover costs and refused to adapt their policies in the face of the pandemic.

According to the Virginia Chapter of the American Academy of Pediatrics, 59 percent of providers saw a decline in social and behavioral progress in children and adolescents with autism. One possible linkage noted was the decreased use of speech-language therapy, occupational therapy, physical therapy, and applied behavior analysis by families, because they were only available virtually.

CAREGIVERS AND PARENTS

Virtual learning was a challenging adjustment for caregivers and parents. In addition to managing the household and/or working, caregivers became newly involved in distance learning, and if their child had disabilities, they implemented therapy, exercises, or care routines.

Parents who are stretched too thin trying to balance work with family life can minimize the mental health stress of their children by taking care of themselves first. Getting help to tackle any financial and emotional distress may be life saving for the whole family. During the pandemic, child academic problems, child emotional and behavioral challenges, family conflict, and other day-to-day family issues were greatly impacted by the quality of a parent or caretaker's work-life balance.

During the pandemic and lockdown, and in the future as needed, finding virtual resources for academic assignments and supports can help parents assist with remote learning. Establishing regular household routines, utilizing telehealth services, spending short bursts of quality time with each child, listening to music together, talking with their child about the child's thoughts and feelings, and enjoying the outdoors with their child are all ways to help their children de-stress and regroup. Minimizing stress for both the children and caregivers helps facilitate optimal health and learning.

RESOURCES AND ORGANIZATIONS

American Psychological Association
https://www.apa.org/
Center for Disease Control and Prevention
https://www.cdc.gov/
Child Mind Institute
https://childmind.org/
National Alliance on Mental Illness (NAMI)
https://nami.org/Home
National Institute on Drug Abuse
https://nida.nih.gov/
National Institute of Mental Health
https://www.nimh.nih.gov/
Office of the Surgeon General (OSG)
https://www.hhs.gov/surgeongeneral/index.html

ARTICLES

Barendse, M. E. A., Flannery, J., Cavanagh, C., et al. (2022). Longitudinal change in adolescent depression and anxiety symptoms from before to during the COVID-19 pandemic: A collaborative of 12 samples from 3 countries. Journal of Research on Adolescence. Advanced Online Publication. https://doi.org/10.1111/jora.12781.

Becker, S. P., Breaux, R., Cusick, C. N., Dvorsky, M. R., Marsh, N. P., Scriberras, E., & Langberg, J. M. (2020). Remote learning during COVID-19: Examining school practices, service continuation, and difficulties for adolescents with and without ADHD. Journal of Adolescent Health, 67, 769-777. https://doi.org/10.1016/j.jadohealth.2020.09.002.

Breaux, R., Dvorsky, M. R., Marsh, N. P., et al. (2021). Prospective impact of COVID-19 on adolescent mental health functioning in adolescents with and without ADHD: Protective role of emotion regulation abilities. Journal of Child Psychology and Psychiatry, 62, 1132-1139. https://doi.org/10.1111/jcpp.13382.

Fleming, L. (2021). The difficulties of the COVID-19 pandemic for children with disabilities. Very Well Family, June 15, 2021. https://www.verywellfamilies.com/pendemics-impact-on-the-children-with-disabilties-5185783.

Houtrow, A., Harris, D., Molinero, A., et al. (2020). Children with disabilities in the United States and the COVID-19 Pandemic. Journal of Pediatric Rehabilitation Medicine, Vol. 13, #3, pp. 415-424.

Karbasi, Z., Eslami, P. (2022). Prevalence of post-traumatic stress disorder during the COVID-19 pandemic in children: a review and suggested solutions. Middle East Current Psychiatry 29, 74. https://doi.org/10.1186%2Fs43045-022-00240-x.

Leeb, R.T., Bitski, R.H., Radhakrishnan, L., et al. (2020). Mental health-related emergency department visits among children aged <18 years during the COVID-19 pandemic- United States, January 1-October 17, 2020. MMWR Morb Mortal Wkly Rep, 69, 1675-1680. https://doi.org/10.15585/mmwr.mm6945a3.

McFayden, T. C., Breaux, R., Bertollo, J. R., Cummings, K., & Ollendick, T. H. (2021). COVID-19 remote learning experiences of youth with neurodevelopmental disorders in rural Appalachia. Journal of Rural Mental Health, 45, 72–85. https://psycnet.apa.org/doi/10.1037/rmh0000171.

Theberath, M., Bauer, D., Chen, W., et al. (2022). Effects of COVID-19 pandemic on mental health of children and adolescents: A systematic review of survey studies. National Library of Medicine. https://doi.org/10.1177/20503121221086712.

Podcast by White, C., Westers, N. Children's Health Checkup. Supporting your child's mental health during COVID-19. Children's Health Checkup (childrens.com).

FAMILY FIRST: FOSTER CARE PREVENTION SERVICES

The Family First Prevention Services Act of 2018[1] allows states to use Title IV-E foster care funds to provide enhanced support to at-risk children and families and prevent foster care placements. Approved programs and services in the categories of in-home parent skill-based programs, mental health prevention treatment services, substance abuse prevention treatment services, and kinship navigator programs are eligible for funding.

The Title IV-E Prevention Services Clearinghouse[2] is charged with reviewing and approving for reimbursement evidence-based programs and services intended to allow "candidates for foster care" (children who, without the provision of services to reduce risk factors, would enter foster care) to stay with their parents or relatives. The Clearinghouse conducts its evaluation based on unique criteria that do not necessarily replicate criteria used by other evidence-based practice rating systems. The Prevention Services Clearinghouse rates programs and services in four categories. Categories are defined in Table 1.

Table 1
Evidence-based Rating Scale Used by the Prevention Services Clearinghouse[3]

Rating	Definition
Well-supported	Has at least two contrasts with non-overlapping samples in studies carried out in usual care or practice settings that achieve a rating of moderate or high on design and execution and demonstrate favorable effects in a target outcome domain. At least one of the contrasts must demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.
Supported	Has at least one contrast in a study carried out in a usual care or practice setting that achieves a rating of moderate or high on design and execution, and demonstrates a sustained favorable effect of at least six months beyond the end of treatment on at least one target outcome.
Promising	Has at least one contrast in a study that achieves a rating of moderate or high on study design and execution and demonstrates a favorable effect on a target outcome.
Does not currently meet criteria	Does not achieve a rating of *well-supported, supported,* or *promising.*

[1] For a summary of the Family First Prevention Services Act of 2018, visit http://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx. For full text of the Act, see Title VII of the Bipartisan Budget Act of 2018 at https://www.congress.gov/bill/115th-congress/house-bill/1892/text.
[2] For more information about the Prevention Services Clearinghouse, visit https://preventionservices.abtsites.com/.
[3] Definitions taken from: Title IV-E Prevention Services Clearinghouse, *Handbook of Standards and Procedures, Version 1.0.* Available on the Family First Prevention Services website or by using this link: https://preventionservices.abtsites.com/themes/ffc_theme/pdf/psc_handbook_v1_final_508_compliant.pdf.

Programs and services that are designated as *well-supported, supported,* or *promising* are eligible for federal reimbursement with Title IV-E funds. States must meet certain criteria detailed in the Family First Prevention Services Act to be eligible. For more information, visit the Family First Virginia website at: **http://familyfirstvirginia.com/**.

Approved Programs and Services

The Prevention Services Clearinghouse evaluates programs and services on a rolling basis. Table 2 describes prevention programs and services that have been approved as of September 2025. For the most current list of programs and services approved by the Clearinghouse, visit **https://preventionservices.acf.hhs.gov/**.

Table 2
Programs and Services Approved for Family First Prevention Services Reimbursement

IN-HOME PARENT SKILL-BASED PROGRAMS AND SERVICES

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
ACT Raising Safe Kids	Promising	For adults with children ages 0-8.	Behavioral and emotional functioning Positive parenting practice
Attachment and Biobehavioral Catch-up – Early Childhood	Supported	Caregivers of infants ages 24-48 months who have experienced early adversity.	Behavioral and emotional functioning Positive parenting practices
Attachment and Biobehavioral Catch-up - Infant	Well-supported	Caregivers of infants ages 6-24 months who have experienced early adversity.	Behavioral and emotional functioning Positive parenting practice Family functioning
Brief Strategic Family Therapy	Well-supported	Families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors, including: drug use and dependency, antisocial peer associations, bullying, or truancy.	Behavioral and emotional functioning Delinquent behavior Parent/caregiver substance use Family functioning
Child First	Supported	Families with young children (prenatal through age five at entry) with social-emotional, behavioral, developmental, or learning problems.	Child welfare administrative reports Behavioral and emotional functioning Cognitive functions and abilities Parent/caregiver mental or emotional health Family functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Creating Lasting Family Connections® Fatherhood Program: Family Reintegration	Promising	Fathers or mothers experiencing family separation, such as those who are experiencing recovery for substance use, current or recent incarceration, or military service deployment.	Parent/caregiver criminal behavior Family functioning
Familias Unidas	Well-supported	Hispanic adolescents (ages 12 to 16) and their families.	Behavioral and emotional functioning Substance abuse Positive parenting practices Family functioning
Families First (Utah Youth Village Model)	Well-supported	Designed to serve families with youth (ages birth to 17) who have been referred for intensive in-home services from child welfare services, juvenile justice, or court systems. It also serves families that self-refer.	Child welfare administrative reports Delinquent behavior
Family Centered Treatment	Supported	Families with youth who are at-risk for out-of-home placements, have trauma exposure, have histories of delinquent behavior, or are working toward reunification.	Out-of-home placement
Family Check Up®	Well-supported	Families with children (ages 2 to 17).	Positive parenting practices
Family Foundations	Well-supported	Couples expecting their first child. In FF, couples are defined as any two individuals who plan to care for the child together and can include the parent and another individual such as a grandparent or new romantic partner.	Behavioral and emotional functioning Cognitive functions and abilities Positive parenting practices Parent/caregiver mental or emotional health Parent/caregiver criminal behavior Family functioning
Family Spirit®	Promising	Young American Indian mothers (ages 14-24) who enroll during the second trimester of pregnancy.	Behavioral and emotional functioning Parent/caregiver mental or emotional health Parent/caregiver substance use

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
GenerationPMTO – Individual	Promising	Serves parents of children (ages 2 to 17) with behavioral problems such as aggression, antisocial behaviors, conduct problems, oppositional defiance, delinquency, and substance use.	Behavioral and emotional functioning Social functioning Parent/caregiver mental or emotional health Positive parenting practices
Guiding Good Choices®	Well-supported	Designed to serve families with children (ages 9 to 14).	Substance abuse Positive parenting practices Family functioning
Healthy Families America	Well-supported	Families of children who have increased risk of adverse childhood experiences or maltreatment, from pregnancy until the child is three months of age.	Self-reports of maltreatment Behavioral and emotional functioning Cognitive functions and abilities Delinquent behavior Educational achievement and attainment Positive parenting practices Parent/caregiver mental or emotional health Family functioning
Homebuilders – Intensive Family Preservation and Reunification Services	Well-supported	Families who have a child (0 to 18 years old) at imminent risk of out-of-home placement or who is in placement and cannot be reunified without intensive in-home services.	Out-of-home placement Planned permanent exits Economic and housing stability
Intercept®	Well-supported	Children from birth to age 18 who are at risk of entry or re-entry into out-of-home placements (e.g., foster care, residential facilities, or group homes) or who are currently in out-of-home placements. Designed to serve children who have emotional and behavioral problems or have experiences with abuse and/or neglect.	Out-of-home placement Planned permanent exits
Iowa Parent Partner Approach	Promising	Parents whose children (birth to 17 years old) have been removed from the home.	Out-of-home placement
KEEP Standard	Promising	Foster and Kinship parents of children ages 4-12.	Planned permanent exits Behavioral and emotional functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Maternal Early Childhood Sustained Home-visiting®	Supported	Families with children under age 2 who are at risk of poor maternal or child health and development outcome.	Cognitive functions and abilities Positive parenting practices Parent/caregiver mental or emotional health Parent/caregiver physical health
Multidimensional Family Therapy	Supported	Adolescents and young adults (9 to 26 years old) with substance abuse, delinquency, mental health, academic/vocational, and emotional problems.	Behavioral and emotional functioning Social functioning Substance use Delinquent behavior Educational achievement and attainment Positive parent practices Family functioning
Multisystemic Therapy – Building Stronger Families	Supported	Designed for families with youth ages 6–17 who come under the guidance of child protective services due to co-occurring parental substance use and physical abuse or neglect of a child. MST-BSF combines three program models: (1) MST, (2) MST for Child Abuse and Neglect, and (3) Reinforcement-Based Treatment for substance use disorders.	Child safety Child permanency
Nurse-Family Partnership	Well-Supported	Young, first-time, low-income mothers from early pregnancy until the child turns two.	Child welfare administrative reports Cognitive functions and abilities Physical development and health Economic and housing stability
On the Way Home	Promising	Designed to serve families with youth (ages 12 to 18) transitioning from residential out-of-home care to home, school, and community settings.	Out-of-home placement
Parent-Child Care	Promising	Designed to serve caregivers with children ages 1-10. The caregiver should have either custody of or regular visits with the child and be willing and able to participate in the “Daily CARE” activity.	Behavioral and emotional functioning Positive parenting practices

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Parenting With Love and Limits®	Supported	Families with teenagers (ages 10 to 18) who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, attention-deficit/hyperactivity disorder).	Delinquent behavior
Parents Anonymous®	Supported	Families with children/youth (birth to 18) experiencing difficulties related to mental health, substance use disorders, or challenging life situations.	Child welfare administrative reports
Parents as Teachers	Well-supported	New and expectant parents from pregnancy until the child enters kindergarten. Many PAT programs target families in high risk environments.	Child welfare administrative reports Social functioning Cognitive functions and abilities
Promoting First Relationships	Supported	Designed for caregivers of children ages 0–5 years. PFR aims to promote secure and healthy relationships between caregivers and children through strengths-based parenting strategies.	Child well-being: behavioral and emotional functioning Adult well-being: positive parenting practices
Safe Families for Children	Supported	Designed to serve parents and children ages 0-18 in families experiencing a crisis that affects children's safety.	Out-of-home placement Planned permanent exits
SafeCare	Supported	Parents/caregivers of children (ages 0 to 5) who are either at-risk for or have a history of child neglect and/or abuse.	Out-of-home placement
Smart Beginnings	Promising	Designed to serve parents and children ages 0-3.	Positive parenting practices
Sobriety Treatment and Recovery Teams	Supported	Designed to serve families involved in the child welfare system with at least one child (age five or younger) and one parent diagnosed with a substance use disorder (SUD).	Child welfare administrative reports Out-of-home placement
Together Facing the Challenge	Supported	Therapeutic foster parents who care for children with emotional or behavioral problems.	Behavioral and emotional functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Treatment Foster Care Oregon for Adolescents	Promising	Youth ages 12-17 with severe emotional and behavioral problems.	Substance use Delinquent behavior
Triple P – Positive Parenting Program – Online (Level 4)	Supported	Families with children (up to 12 years) with significant social, emotional or behavioral problems.	Behavioral and emotional functioning Positive parenting practices Parent/caregiver mental or emotional health
Triple P – Positive Parenting Program – Self-Directed (Level 4)	Promising	Families with children (up to 12 years) who live in rural or remote areas or who want help without direct contact with a practitioner.	Behavioral and emotional functioning Positive parenting practices Parent/caregiver mental or emotional health
Triple P – Positive Parenting Program – Standard (Level 4)	Promising	Families with children (up to 12 years) who exhibit behavior problems or emotional difficulties.	Behavioral and emotional functioning Positive parenting practices Parent/caregiver mental or emotional health
Video Interaction Project	Promising	Designed to serve parents and children ages 0-5.	Behavioral and emotional functioning Positive parenting practices

MENTAL HEALTH PREVENTION TREATMENT PROGRAMS AND SERVICES

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
ACT Raising Safe Kids	Promising	Adults who raise and care for children ages 0-8.	Behavioral and emotional functioning Positive parenting practices
Aggression Replacement Training®	Promising	Youth (ages 13 to 18) who exhibit violent or aggressive behavior.	Behavioral and emotional functioning
Bounce Back	Promising	Used with students from kindergarten through 5th grade who have witnessed or experienced traumatic life events and are experiencing traumatic stress symptoms.	Behavioral and emotional functioning Social functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Brief Strategic Family Therapy	Well-supported	Families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors, including: drug use and dependency, antisocial peer associations, bullying, or truancy.	Behavioral and emotional functioning Delinquent behavior Parent/caregiver substance use Family functioning
Child First	Supported	Families with young children (prenatal through age five at entry) with social-emotional, behavioral, developmental, or learning problems.	Child welfare administrative reports Behavioral and emotional functioning Cognitive functions and abilities Parent/caregiver mental or emotional health Family functioning
Child-Centered Group Play Therapy	Promising	Designed for children (ages 3 to 10) who are experiencing social, emotional, behavioral, and relational disorders, especially children who struggle with peer or sibling relationships.	Behavioral and emotional functioning Social functioning
Child-Centered Play Therapy	Promising	Designed for children (ages 3 to 10) who are experiencing social, emotional, behavioral, and relational disorders.	Behavioral and emotional functioning Social functioning Educational achievement and attainment
Child-Parent Psychotherapy	Promising	Children ages birth through 5 and their parents/caregivers.	Behavioral and emotional functioning Parent/caregiver mental or emotional health
Child-Parent Relationship Therapy	Promising	Designed for parents of children (ages 2 to 10) who are experiencing social, emotional, behavioral, and relational disorders.	Behavioral and emotional functioning Social functioning Positive parenting practices Parent/caregiver mental or emotional health Family functioning Parent/caregiver physical health
Cognitive Behavioral Intervention for Trauma in Schools	Promising	Used with students from 4th grade through 12th grade who have witnessed or experienced traumatic life events and have significant symptoms of PTSD or depression.	Behavioral and Emotional functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Cognitive Processing in Therapy	Promising	Designed to treat adults with PTSD. CPT is not appropriate for individuals without trauma symptoms, those who are an immediate danger to themselves or others, or those who are experiencing psychotic symptoms.	Parent/caregiver mental or emotional health
Common Sense Parenting- School Age	Promising	CSP – School Age is designed for parents of children ages 6–16. The program aims to teach positive parenting techniques to strengthen the parent-child bond, and behavior management strategies to help increase positive child behaviors, decrease child problem behaviors, and model appropriate options to address child behaviors.	Family functioning
Coping Cat - Group	Promising	Designed to treat children (ages 7 to 13) who are diagnosed with an anxiety disorder (e.g., generalized anxiety disorder, social phobia, and separation anxiety disorder) and their parents.	Behavioral and emotional functioning
Creating Lasting Family Connections® Fatherhood Program: Family Reintegration	Promising	Fathers or mothers experiencing family separation, such as those who are experiencing recovery for substance use, current or recent incarceration, or military service deployment.	Parent/caregiver criminal behavior Family functioning
Dialectical Behavior Therapy for Adolescents	Promising	Adolescents ages 13-18 with difficulty regulating their emotions, including adolescents with characteristics associated with borderline personality disorder, suicidality, depression, posttraumatic stress disorder, bipolar disorder, and substance use disorder.	Behavioral and emotional functioning
Dialectical Behavior Therapy for Binge Eating Disorder and Bulimia Nervosa	Promising	Adults with binge eating disorder or bulimia nervosa.	Parent/caregiver mental or emotional health

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Dialectical Behavior Therapy®	Supported	Adults and teens with difficulty regulating their emotions, including people with borderline personality disorder, suicidality, depression, posttraumatic stress disorder, bipolar disorder, and substance use disorder.	Parent/caregiver mental or emotional health Parent/caregiver physical health
Families and Schools Together ® - Elementary School Level	Promising	Designed to serve families with children (ages 4 to 10). Additional family members, including siblings and grandparents, are invited to attend multi-family group sessions.	Behavioral and emotional functioning Social functioning Cognitive functions and abilities Delinquent behavior Educational achievement and attainment Positive parenting practices Parents/caregiver mental or emotional health Family functioning
Families First (Utah Youth Village Model)	Well-supported	Designed to serve families with youth (birth to age 17) who have been referred for intensive in-home services from child welfare services, juvenile justice, or court systems. It also serves families that self-refer.	Child welfare administrative reports Delinquent behavior
Family Check-Up®	Well-supported	Families with children (ages 2 to 17).	Positive parenting practices
Fostering Healthy Futures® for Preteens	Supported	Designed for children (ages 9 to 11) with current or previous child welfare involvement due to maltreatment and one or more adverse childhood experiences (e.g., exposure to violence, experiencing homelessness, parental substance use, mental illness, or incarceration).	Placement stability Behavioral and emotional functioning Social functioning Delinquent behavior
Functional Family Therapy	Well-Supported	Youth (ages 11 to 18) who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.	Behavioral and emotional functioning Child substance use Delinquent behavior Family functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Generation PMTO - Group	Well-supported	Serves parents of children (ages 2 to 17) with behavioral problems such as aggression, antisocial behaviors, conduct problems, oppositional defiance, delinquency, and substance use.	Behavioral and emotional functioning Social functioning Delinquent behavior Positive parenting practices Parents/caregiver mental or emotional health Family functioning Parent/caregiver physical health Economic and housing stability
Generation PMTO - Individual	Promising	Serves parents of children (ages 2 to 17) with behavioral problems such as aggression, antisocial behaviors, conduct problems, oppositional defiance, delinquency, and substance use.	Behavioral and emotional functioning Social functioning Positive parenting practices Parent/caregiver mental or emotional health
Guiding Good Choices®	Well-supported	Designed to serve families with children (ages 9 to 14).	Substance abuse Positive parenting practices Family functioning
Incredible Years® - School Age Basic Program	Promising	Parents of children (ages 6 to 12) who have behavior problems.	Child welfare administrative reports Positive parenting practices
Incredible Years® - Toddler Basic Program	Promising	Parents with toddlers (ages 1 to 3) who need support forming secure attachments with their toddlers or addressing their toddlers' behavior problems.	Positive parenting practices
Intensive Care Coordination Using High Fidelity Wraparound	Promising	Typically targeted toward children and youth (birth to age 21) with complex emotional, behavioral, or mental health needs, and families of these effected youth.	Child welfare administrative reports Least restrictive placement Placement stability Behavioral and emotional functioning Social functioning Delinquent behavior
Interpersonal Psychotherapy (Weissman, et al. Manual)	Supported	Adult patients diagnosed with major depression.	Parent/caregiver mental or emotional health Family functioning
Interpersonal Psychotherapy for Depressed Adolescents	Promising	Adolescents (ages 12 to 18) with mild to moderate symptoms of a depressive disorder.	Behavioral and emotional functioning Social functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Keep Standard	Promising	Foster and kinship parents of children ages 4-12.	Planned permanent exits Behavioral and emotional functioning
Mindful Mood Balance	Promising	Designed to treat adults with histories of depression and residual depression symptoms.	Parent/caregiver mental or emotional health
Mindfulness-Based Cognitive Therapy	Well-supported	Designed to treat adults with depression symptoms. MBCT can also be used to treat adults with other mental disorders, such as anxiety.	Parent/caregiver mental or emotional health Parent/caregiver physical health
Mindfulness-Based Cognitive Therapy for Parents	Supported	Designed to help parents of children (ages 2 to 12) with parental depression symptoms.	Behavioral and emotional functioning Parent/caregiver mental or emotional health
Multidimensional Family Therapy	Supported	Adolescents and young adults (ages 9 to 26) with substance abuse, delinquency, mental health, academic/vocational, and emotional problems.	Behavioral and emotional functioning Social functioning Substance use Delinquent behavior Educational achievement and attainment Positive parent practices Family functioning
Multisystemic Therapy	Well-Supported	Youth (ages 12 to 17) who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.	Out-of-home placement Behavioral and emotional functioning Child substance use Delinquent behavior Positive parenting practices Parent/caregiver mental or emotional health Family functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Multisystemic Therapy – Building Stronger Families	Supported	Designed for families with youth ages 6–17 who come under the guidance of child protective services due to co-occurring parental substance use and physical abuse or neglect of a child. MST-BSF combines three program models: (1) MST, (2) MST for Child Abuse and Neglect, and (3) Reinforcement-Based Treatment for substance use disorders.	Child welfare administrative reports Out-of-home placement
Narrative Exposure Therapy	Promising	Child, adolescent, or adult survivors of traumatic experiences such as childhood abuse, war, torture, sexual assault, rape, and other forms of violence.	Parent/caregiver mental or emotional health Parent/caregiver physical health
On The Way Home	Promising	Designed to serve families with youth (ages 12 to 18) transitioning from residential out-of-home care to home, school, and community settings.	Out-of-home placement
Parent-Child Interaction Therapy	Well-Supported	Families with children (ages 2 to 7) who experience emotional and behavioral problems that are frequent and intense	Behavioral and emotional functioning Positive parenting practices Parent/caregiver mental or emotional health
Parent-Child Care	Promising	Designed to serve caregivers with children ages 1-10. The caregiver should have either custody of or regular visits with the child and be willing and able to participate in the "Daily CARE" activity.	Behavioral and emotional functioning Positive parenting practices
Parenting With Love and Limits®	Supported	Families with teenagers (ages 10 to 18) who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, attention-deficit/hyperactivity disorder).	Delinquent behavior
Parents Anonymous®	Supported	Families with children/youth (birth to 18) experiencing difficulties related to mental health, substance use disorders, or challenging life situations.	Child welfare administrative reports

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Prolonged Exposure Therapy for Adolescents with PTSD	Supported	Adolescents (ages 13 to 18) who are diagnosed with PTSD or who manifest trauma-related symptoms.	Behavioral and emotional functioning
Prolonged Exposure Therapy for PTSD	Promising	Adult patients who are diagnosed with PTSD or who manifest trauma-related symptoms.	Parent/caregiver mental or emotional health
Promoting First Relationships	Supported	Designed for caregivers of children ages 0–5 years. PFR aims to promote secure and healthy relationships between caregivers and children through strengths-based parenting strategies.	Behavioral and emotional functioning Positive parenting practices
Radically Open Dialectical Behavior Therapy	Supported	Clients with over control disorders such as refractory depression, anorexia nervosa, and obsessive-compulsive personality disorder.	Parent/caregiver mental or emotional health
Smart Beginnings	Promising	Designed to serve parents and children ages 0-3.	Positive parenting practices
Strengthening Families Program: Parents and Youth ages 10 to 14	Supported	Designed to serve families with youth (ages 10 to 14).	Behavioral and emotional functioning Substance use Positive parenting practices
Strong African American Families	Well-supported	Designed to serve families with youth (ages 10 to 14) who identify as being African American or Black.	Behavioral and emotional functioning Social functioning Physical development and health Substance use Positive parenting practices Family functioning
TBRI® 101	Promising	Parents and/or caregivers of children who have experienced adversity, early harm, toxic stress, and/or trauma.	Behavioral and emotional functioning
Together Facing the Challenge	Supported	Therapeutic foster parents who care for children with emotional or behavioral problems.	Behavioral and emotional functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Trauma-Focused Cognitive Behavioral Therapy	Promising	Children and adolescents who have experienced trauma and have PTSD symptoms, dysfunctional feelings or thoughts, or behavioral problems.	Behavioral and emotional functioning Social functioning Positive parenting practices Parent/caregiver mental or emotional health
Treatment Foster Care Oregon for Adolescents	Promising	Youth ages 12-17 with severe emotional and behavioral problems.	Substance use Delinquent behavior
Triple P – Positive Parenting Program Group (Level 4)	Promising	Parents with children (up to 12 years) who are interested in promoting their child's development or who are concerned about their child's behavioral problems.	Behavioral and emotional functioning Positive parenting practices Parent/caregiver mental or emotional health
Triple P – Positive Parenting Program – Online (Level 4)	Supported	Families with children (up to 12 years) with significant social, emotional or behavioral problems.	Behavioral and emotional functioning Positive parenting practices Parent/caregiver mental or emotional health
Triple P – Positive Parenting Program – Self-Directed (Level 4)	Promising	Families with children (up to 12 years) who live in rural or remote areas or who want help without direct contact with a practitioner.	Behavioral and emotional functioning Positive parenting practices Parent/caregiver mental or emotional health
Triple P – Positive Parenting Program – Standard (Level 4)	Promising	Families with children (up to 12 years) who exhibit behavior problems or emotional difficulties.	Behavioral and emotional functioning Positive parenting practices Parent/caregiver mental or emotional health
Trust-Based Relational Intervention® – Caregiver Training	Promising	Parents and/or caregivers of children (ages 0 to 17) who have experienced adversity, early harm, toxic stress, and/or trauma.	Behavioral and emotional functioning
Video Interaction Project	Promising	Designed to serve parents and children ages 0-5.	Behavioral and emotional functioning Positive parenting practices

SUBSTANCE ABUSE PREVENTION TREATMENT PROGRAMS AND SERVICES

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Adolescent Community Reinforcement Approach	Promising	Adolescents and young adults (ages 12 to 24) with substance use disorders.	Substance use
Brief Strategic Family Therapy	Well-supported	Families with children or adolescents (ages 6 to 17) who display or are at risk for developing problem behaviors, including: drug use and dependency, antisocial peer associations, bullying, or truancy.	Behavioral and emotional functioning Delinquent behavior Parent/caregiver substance use Family functioning
Community Reinforcement Approach + Vouchers	Promising	Designed to treat adults with cocaine use issues. The program may also be implemented with adults with other substance use issues.	Parent/caregiver substance use
Creating Lasting Family Connections® Fatherhood Program: Family Reintegration	Promising	Fathers or mothers experiencing family separation, such as those who are experiencing recovery for substance use, current or recent incarceration, or military service deployment.	Parent/caregiver criminal behavior Family functioning
Dialectical Behavior Therapy for Adolescents	Promising	Adolescents ages 13-18 with difficulty regulating their emotions, including adolescents with characteristics associated with borderline personality disorder, suicidality, depression, posttraumatic stress disorder, bipolar disorder, and substance use disorders.	Behavioral and emotional functioning
Dialectical Behavior Therapy®	Supported	Adults and teens with difficulty regulating their emotions, including people with borderline personality disorder, suicidality, depression, posttraumatic stress disorder, bipolar disorder, and substance use disorders.	Parenting/caregiver mental or emotional health Parent/caregiver physical health

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Familias Unidas	Well-supported	Hispanic adolescents (ages 12 to 16) and their families.	Behavioral and emotional functioning Substance use Positive parenting practices Family functioning
Families Facing the Future	Supported	Parents in methadone treatment who have children or young adolescents.	Parent/caregiver substance use
Methadone Maintenance Therapy	Promising	Parents who have opioid use disorder.	Parent/caregiver substance use
Motivational Interviewing	Well-supported	Promotes behavior change with a range of target populations and for a variety of problem areas.	Parent/caregiver substance use
Multidimensional Family Therapy	Supported	Adolescents and young adults (ages 9 to 26) with substance use, delinquency, mental health, academic/vocational, and emotional problems.	Behavioral and emotional functioning Social functioning Child substance use Delinquent behavior Educational achievement and attainment Positive parenting practices Family functioning
Multisystemic Therapy	Well-Supported	Youth (ages 12 to 17) who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.	Out-of-home placement Behavioral and emotional functioning Child substance use Delinquent behavior Positive parenting practices Parent/caregiver mental or emotional health Family functioning

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
Multisystemic Therapy – Building Stronger Families	Supported	designed for families with youth ages 6–17 who come under the guidance of child protective services due to co-occurring parental substance use and physical abuse or neglect of a child. MST-BSF combines three program models: (1) MST, (2) MST for Child Abuse and Neglect, and (3) Reinforcement-Based Treatment for substance use disorders.	Child safety: Child welfare administrative reports Child permanency: Out-of-home placement
Parents Anonymous®	Supported	Families with children/youth (birth to 18) experiencing difficulties related to mental health, substance use disorders, or challenging life situations.	Child welfare administrative reports
Prize Contingency Management	Supported	People struggling with substance use. Prize CM is not appropriate for participants in recovery from pathological gambling.	Parent/caregiver physical health
Screening, Brief Intervention, and Referral to Treatment	Promising	SBIRT is designed to serve any youth and adults at risk for harmful substance use, regardless of an identified disorder or whether the individual is actively seeking services.	Adult well-being: parent/caregiver substance use
Sobriety Treatment and Recovery Teams	Promising	Families with at least one child under six years of age who are involved in the child welfare system and have a parent with substance use disorders (SUD).	Out-of-home placement Child welfare administrative reports
Strengthening Families Program: For Parents and Youth 10-14	Supported	Designed to serve families with youth (ages 10 to 14).	Behavioral and emotional functioning Substance use Positive parenting practices Family functioning
Strong African American Families	Well-supported	Designed to serve families with youth (ages 10 to 14) who identify as being African American or Black.	Behavioral and emotional functioning Social functioning Physical development and health Substance use Positive parenting practices Family functioning

KINSHIP NAVIGATOR PROGRAMS

Program or Service	Rating	Target Population	Proven to Impact Favorably On:
30 Days to Family®	Well-supported	Designed to serve families with children ages 0-17 who are involved in the child welfare system and are being placed out-of-home.	Least restrictive placement
Arizona Kinship Support Services	Supported	Designed to serve kinship caregivers.	Least restrictive placement Planned permanent exits
Colorado Kinnected Kinship Navigator Program	Supported	Designed for children and families with open child welfare cases who are entering a new kinship placement.	Least restrictive placement Planned permanent exits
Foster Kinship Navigator Program	Promising	Designed to serve kinship caregivers, both relatives and non-relative kin who are raising children in nonparental care. Foster Kinship Navigator Program aims to strengthen kinship caregivers' capacity to provide safe, stable, nurturing homes for children who cannot live with their parents.	Child permanency: Placement stability
Kinship Interdisciplinary Navigation Technologically-Advanced Model (KIN-TECH)	Supported	Designed to serve relative caregivers (grandparents, aunts, uncles, cousins, brothers, sisters, or any adult with close kinship bond with the child) who are providing full time care of a child.	Child welfare administrative reports Placement stability Behavioral and emotional functioning Parent/caregiver mental or emotional health Family functioning
Ohio's Kinship Supports Intervention/ Protect OHIO	Promising	Kinship caregivers (relatives and fictive kin) of children involved in the child welfare system.	Placement stability
Washington State Kinship Navigator Program	Supported	Designed to support formal and informal kinship caregivers and the children they are raising.	Parent/caregiver mental or emotional health

Programs and Services Ranked as "Does Not Currently Meet Criteria"

The following programs and services have been evaluated by the Prevention Services Clearinghouse and have been ranked in the ***Does Not Currently Meet Criteria*** category:

- Active Parenting of Teens: Families in Action™
- Active Parenting of Teens: Teens in Action
- Active Parenting of Teens™
- Active Parenting: First Five Years™
- Active Parenting™
- Addressing Family Violence and Abuse®
- Alternatives for Families: A Cognitive-Behavioral Therapy
- Assertive Community Treatment
- Autism Parent Navigators
- A Second Chance, Inc. Kinship Navigator
- Attachment and Biobehavioral Catch-up – Toddler
- Being Brave
- BRAVE
- C.A.T. Project
- Camp Cope-A-Lot
- Celebrating Families!™
- Celebrating Families!™ 0 Thru 3 Years
- Chicago Parent Program
- Children's Home Society of New Jersey Kinship Navigator Model
- Circle of Security – Intensive™
- Circle of Security – Parenting™
- Common Sense Parenting of Toddlers and Preschoolers
- Creating Lasting Family Connections®
- Creating Lasting Family Connections®: Overcoming and Understanding Stress and Trauma
- Criando con Amor: Promoviendo Armonia y Superacion – Jovenes
- Dialectical Behavior Therapy for Special Populations
- Dialectical Behavior Therapy Skills Training for Emotional Problem Solving for Adolescents
- e-Family Foundations
- Early Pathways
- ezParent
- Familias Fuertes
- Familias Unidas – eHealth
- Families Actively Improving Relationships
- Families and School Together ® – Early Childhood Education Level
- Families and Schools Together ®– Middle School Level
- Families and Schools Together ® – High School Level
- Family Behavior Therapy – Adolescent

- Family Behavior Therapy – Adult
- Family Behavior Therapy – Adult with Child Welfare Supplement
- Fatherhood is Sacred®/Motherhood is Sacred®
- FF@Home
- Fostering Healthy Futures ® for Teens
- Functional Family Probation and Parole
- Functional Family Therapy – Child Welfare
- Functional Family Therapy – Therapeutic Case Management
- Gathering of Native Americans/Gathering of Alaska Natives
- Group Combined Parent-Child Cognitive Behavioral Therapy
- Helping Women Recover + Beyond Trauma
- Incredible Years® – Parents and Babies Program
- Incredible Years® – Preschool Basic Program
- Indiana Family Preservation Services
- Individual Combined Parent-Child Cognitive Behavioral Therapy
- Interpersonal Psychotherapy (Stuart & Robertson Manual)
- KEEP SAFE
- KEEP Toddler
- Kentucky Strengthening Ties and Empowering Parents
- Linking Generations By Strengthening Relationships®
- Make Parenting a Pleasure®
- Men's Trauma Recovery and Empowerment Model
- Mindfulness-Based Cognitive Therapy for Anxious Children
- Multimedia Circle of Life
- Multisystemic Therapy – Prevention
- Multisystemic Therapy – Substance Abuse
- Multisystemic Therapy for Child Abuse and Neglect
- Nurturing Families®
- Nurturing Parenting Program for Parents and Their Infants, Toddlers, and Preschoolers
- Nurturing Parenting Program for Parents and Their School Age Children 5 to 11 Years
- Nurturing Skills™ for Families
- Parent Connectors
- Parent-Child Assistance Program
- Parenting Now!™
- Parenting Wisely – Teen Edition
- Parenting Wisely – Young Child Edition
- Positive Indian Parenting
- Relief Nursery
- Sacred Journey
- Safe Environment for Every Kid (SEEK™)

- SafeCare Augmented
- Seeking Safety
- Solution-Based Casework
- Strengthening Families Program – 12-16
- Strengthening Families Program – 3-5
- Strengthening Families Program – 6-11
- Strengthening Families Program – birth to 3
- Strong African Families - Teen
- Strong Foundations
- Substance Abuse and Men's Trauma Recovery and Empowerment Model
- The Matrix Model
- The Seven Challenges – Adolescent
- The Seven Challenges – Adult
- Trauma Recovery and Empowerment for Adolescent Girls and Young Women Ages 12-18
- Trauma Recovery and Empowerment Model
- Trauma Systems Therapy
- Trauma Systems Therapy for Foster Care
- Treatment Foster Care Oregon for Middle Childhood
- Treatment Foster Care Oregon for Preschoolers
- Wellbriety & Celebrating Families!™
- WISE Teens

Programs and Services Planned for Review

Table 3 describes treatments that are under review as of September 2025 For the most current list of programs and services approved by the Clearinghouse, visit **https://preventionservices.acf.hhs.gov/**.

Table 3
Programs and Services Planned for Review as of September 2025

Mental Health Prevention Treatment Services	Substance Abuse Prevention Treatment Services	In-Home Parent Skill-Based Programs	Kinship Navigator Programs
• 1-2-3 Magic • Acceptance and Commitment Therapy • Attachment, Regulation and Competency • BRAVE (Re-Review) • Connect: An Attachment Based Program for Parents and Caregivers • Family Group Decision Making • Family-Based Recovery • Incredible Years® - Preschool Basic Program (Re-Review) • Indiana Family Preservation Services (Re-Review) • Mindfulness-Based Stress Reduction • Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Programs • Multidimensional Family Therapy (Re-Review) • Multimedia Circle of Life (Re-Review) • Multisystemic Therapy for Child Abuse and Neglect (Re-Review) • Promoting First Relationships (Re-Review) • Solution-Focused Brief Therapy • Strong African American Families – Teen (Re-Review) • Transition to Independence Process Model	• Acceptance and Commitment Therapy • Family Group Decision Making • Family-Based Recovery • Mindfulness-Based Stress Reduction • Motivational Enhancement Therapy and Cognitive-Behavioral Therapy • Multidimensional Family Therapy (Re-Review) • Multimedia Circle of Life (Re-Review) • Multisystemic Therapy for Child Abuse and Neglect (Re-Review) • Solution-Focused Brief Therapy • Strong African American Families – Teen (Re-Review)	• 1-2-3 Magic • 24/7 Dad • Connect: An Attachment Based Program for Parents and Caregivers • Early Head Start Home-Based Option • Family-Based Recovery • Incredible Years® - Preschool Basic Program (Re-Review) • Indiana Family Preservation Services (Re-Review) • Kentucky Family Preservation Program • Mindfulness-Based Stress Reduction • Multidimensional Family Therapy (Re-Review) • Multisystemic Therapy for Child Abuse and Neglect (Re-Review) • Parents for Parents Program • Period of PURPLE Crying • Promoting First Relationships (Re-Review) • Strong African American Families – Teen (Re-Review) • Systematic Training for Effective parenting	• Ohio Kinship and Adoption Navigator Program

States interested in utilizing the federal funding associated with Family First must first submit and receive approval of their state IV-E Prevention Services Plan. This plan details the state's strategy for implementation of prevention services to meet the requirements of Family First. Plans must include which evidence-based programs (EBP) from the Title IV-E Prevention Services Clearinghouse for which the state will implement and request reimbursement. Virginia's initial Prevention Plan was approved and implemented in 2021. Virginia included three well-supported EBPs with initial implementation: Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Parent-Child Interaction Therapy (PCIT).

The Virginia Department of Social Services (VDSS) partnered with the Center for Evidence-based Partnerships in Virginia (CEP-Va) at Virginia Commonwealth University (VCU) to build capacity for EBPs across the state. CEP-Va engages in an ongoing needs assessment and gaps analysis (NAGA), reporting out to VDSS to support capacity building and provide recommendations. Based on these recommendations, VDSS identified five additional EBPs to add to the Virginia Prevention Plan (submitted to the Children's Bureau for review and approval in early 2023). Funded by VDSS, CEP-Va offers training awards for providers to train clinicians and teams to include EBPs in their service array. The Family First Virginia website includes more information on these EBPs. In order to meet the requirements of Family First, Virginia aligned the previous practices of prevention cases and child protective services' ongoing cases with Family First to create in-home services, implemented in April 2021. In-home services are offered to families where the child(ren) can safely remain in their home or the home of kin caregivers during the provision of services to prevent foster care placement. The VDSS Child and Family Services Manual chapters on Prevention and In-Home Services to Families and Title IV-E Prevention guide local departments of social services on the policies and practices of these cases and the utilization of IV-E prevention services funds.

COMPLEX TRAUMA: A RESOURCE FOR FOSTER PARENTS

CASE STUDIES

Four-year-old Dani was recently diagnosed with ADHD by her pediatrician. When her mother was incarcerated, she was placed with a kinship caregiver, her grandmother. Dani seems to cry all the time, but her grandmother is unable to comfort or calm her. When she is told no, she sometimes cries for hours. She is unable to focus or concentrate on tasks, and she is behind her peers socially and developmentally. Her grandmother is overwhelmed by her behaviors and wonders if Dani would be better off in foster care.

Seven-year-old Chandra was placed in foster care when her mother could no longer care for her. Chandra rarely speaks or makes eye contact, and she gets upset when she is touched. She has the verbal ability of a much younger child, and she often ignores her foster family. When she becomes frustrated or doesn't get her way, she acts out violently. When she hit a younger child in the home, her foster family asked for her to be placed elsewhere.

Eleven-year-old Dylan has been in foster care since he was eight. He has no memory of abuse and neglect and only a vague memory of his biological mother, who died of a drug overdose. He has been diagnosed with ADHD and depression. Dylan is easily frustrated and gives up on tasks quickly. When he becomes irritable and is corrected by a caregiver or teacher, he hits and scratches himself. He often says he is worthless and has threatened to kill himself. His foster parents are afraid Dylan will attempt suicide.

Fifteen-year-old Christopher has an explosive temper and was diagnosed by his pediatrician with oppositional defiant disorder. He was placed with his uncle after getting in a violent fight with his father. During an argument with his uncle, Christopher assaulted him and was arrested. He told the judge, "I felt like it was him or me—like he was going to kill me."

Although their caregivers do not know this, the four children described in the fictional case studies above have all experienced profound and extended abuse and neglect in their early years. Caregivers of children displaying these types of behaviors often don't understand why the children behave the way they do, or why their tried-and-true parenting techniques don't work. Some worry that the behaviors are somehow their fault or that their efforts to parent are just making matters worse.

The children described above are all showing symptoms of "complex trauma"—a term that describes a constellation of symptoms and behaviors caused by traumatic experiences that have persisted for months or years. In the foster care system, complex trauma is usually caused by years of abuse and neglect. This can have a profound effect on a child's emotional, behavioral, and cognitive development—even when a child has no memory of traumatic events.

This guide is designed to help foster parents and kinship caregivers to 1) recognize the symptoms of complex trauma, 2) understand its impact on typical childhood development, and 3) seek out treatments and resources to help children in their care.

WHAT IS TRAUMA?[1]

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma results from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[2] Trauma often triggers the "fight, flight, or freeze" survival response and can cause feelings of helplessness and fear, as well as abrupt physiological reactions, such as a racing heart. Witnessing a traumatic event that threatens life or physical security of a loved one can also cause trauma.

Some people who experience a traumatic event recover quickly with no long-term effects. Others develop a trauma- or stressor-related disorder, such as post-traumatic stress disorder (PTSD). In general, people with PTSD continue to re-experience the "fight, flight, or freeze" response in benign situations—even if they know they are perfectly safe. This interferes with daily life and can cause the individual to avoid thoughts or situations that might "trigger" a fear response.

How the "Fight, Flight, or Freeze" Response Affects the Mind and Body

As adrenaline and cortisol (stress hormones) flood the body:

- Heart pounds, breathing speeds up.
- Senses sharpen; mouth gets dry; skin may sweat, break out in goosebumps, or feel hot or cold.
- "Normal" thinking process can be overwhelmed by feelings of terror, panic, dread, rage, or an impulse to act.
- Can experience the sensation of "watching" oneself act or being helpless to control impulses.
- Time may seem to slow down, speed up, or become disjointed; later, memories of traumatic event may be absent or confused.

WHAT IS COMPLEX TRAUMA?

Researchers are beginning to differentiate between short-duration traumatic experiences and "complex trauma"—a term that describes a response to traumatic experiences that have persisted for months or years. The impact of complex trauma on children can be profound, especially when that trauma is related to abuse and neglect. In addition to causing PTSD symptoms, complex trauma can disrupt many aspects of a child's development.

Complex trauma is especially damaging to very young children. When young children experience ongoing physical abuse, emotional abuse, sexual abuse, neglect, and/or chronic violence in the home, normal brain development can be disrupted. Young children who experience constant fear, stress, and unpredictability may not fully develop the ability to process negative emotions in a healthy, age-appropriate manner. In addition, because brain maturation has been affected, these children can have trouble learning, focusing, following directions, processing and remembering information, controlling their impulses, and forming healthy

[1] Adapted from information from the National Child Traumatic Stress Network (NCTSN). https://www.nctsn.org.
[2] From SAMHSA's webpage, "Trauma and Violence." https://www.samhsa.gov/trauma-violence.

relationships with others. They are also more susceptible to physical and mental health problems. This constellation of symptoms can continue long after the abuse has stopped and persist into adulthood.

Unfortunately, without therapeutic intervention, the damage complex trauma causes during the formative years may not heal itself over time. Adults who experienced significant childhood trauma are more likely to drop out of school, suffer from mental and physical health disorders, have difficulties maintaining employment, abuse substances, experience homelessness, become incarcerated, and perpetuate the cycle of abuse on their own children.

It is important to note that many children who have experienced abuse and neglect and who exhibit symptoms of complex trauma fully recover and lead happy, productive lives. Children have a remarkable capacity for resiliency, and with the right support, most will overcome their trauma and flourish.

COMPLEX TRAUMA AFFECTS THE DEVELOPING BRAIN

Case Study: Kai

An inexperienced young mother—who was abused by her own mother—is overwhelmed by caring for her first infant, Kai. Unable to cope, she sometimes ignores Kai for hours and frequently forgets to feed or change him. Sometimes, she gets so angry that she slaps the child over and over until he stops crying. Eventually, a relative calls CPS, and Kai is taken into foster care at 10 months old.

Kai's foster parents assume that such a young child cannot remember past abuse and neglect, and they are confident that consistent, supportive parenting will erase any damage that may have been done. However, despite their best efforts, Kai is extremely difficult to care for. He seems to cry constantly and cannot be consoled or soothed. As he gets older, he is hyperactive and unfocused, easily frustrated, and has frequent, violent tantrums. Although his caregivers are loving, experienced parents, none of their tried-and-true parenting techniques seem to help Kai or improve his behavior.

Kai shows symptoms of complex trauma caused by abuse and neglect in infancy.

Early childhood trauma can have a profound effect on healthy brain development, regardless of whether a child has any memory of the abuse. To understand why, it is important to consider these key concepts:

- **At birth, the human brain is not fully developed.** Instead, a baby's brain is a learning machine, forming millions of new neural connections every hour. The prefrontal cortex—the "thinking" part of the brain that can guide the expression of emotions and impulses—is especially underdeveloped. In fact, the prefrontal cortex doesn't fully mature until a person is in their mid-twenties. This is why infants are unable to sooth themselves without the help of a caregiver, why children can become overwhelmed by frustration and have temper tantrums, and why teens who "know better" find it so difficult to resist their impulses.

- **A child's brain develops through a bond with a primary caregiver.** The importance of a child's bond with a primary caregiver cannot be overstated. It is through this relationship that children learn to trust others, regulate their emotions, and interact with the world. This bond begins in infancy. Because babies have no ability to regulate their own emotions, it is imperative that a caregiver is in tune with an infant's emotional

state and sooths signs of distress. In this environment, the infant "learns" that the world is a predictable, safe place, and normal development proceeds rapidly.

- **Toxic stress affects brain development.** When the fear center—called the amygdala—of a child's brain is activated, the child may experience a "fight, flight, or freeze" response in which brain resources are focused on survival. Most children experience fear and stress in small doses. However, an abused child who lives in a constant state of toxic stress, unpredictability, and fear is constantly in survival mode—which affects how the brain develops. The ability to control impulses and emotional responses, as well as the ability to focus and concentrate, can develop more slowly when a child is constantly under stress. Insecure attachment to the caregiver can also impact the child's ability to trust and form healthy relationships with others, including foster parents.

- **Because brain development is affected by early childhood trauma, children are often "stuck" in an earlier stage of emotional development, especially in response to stress.** Older children who have not developed the ability to control their feelings and impulses may react like much younger children in response to stress—by shutting down, crying, or exploding with rage. Stress and frustration may also trigger the "fight, flight, or freeze" survival response—even though the child is no longer in any physical danger. The result is behavior that can appear to a caregiver to be out of character, difficult to understand, or irrational.

WHAT ARE THE SYMPTOMS OF COMPLEX TRAUMA?[3]

Symptoms of trauma and complex trauma exist on a spectrum and vary from person to person. In addition, many symptoms overlap with typical childhood behaviors or with symptoms of other disorders. The symptoms described below are intended to alert caregivers that a child may be suffering from complex trauma and that further evaluation and intervention may be needed. Signs and symptoms are summarized in Table 1.

Emotional Responses

Children who have experienced complex trauma often have difficulty identifying, talking about, and managing emotions. Instead, they internalize and/or externalize their negative emotions, which can lead to persisting depression, anxiety, and/or anger, in addition to other posttraumatic responses.

Their emotional responses may be unpredictable or explosive. Responses are often triggered by reminders of a traumatic event—even if they have no conscious recollection of that event. Reactions can be powerful, and they can have difficulty calming down afterwards. Since trauma is often of an interpersonal nature, even mildly stressful interactions with others may serve as trauma reminders and trigger intense emotional responses.

Having learned that the world is a dangerous place where even loved ones can't be trusted, children with histories of trauma are often vigilant and guarded in their interactions with others and are more likely to view even safe situations as stressful or dangerous. Alternately, many children also learn to "tune out" threats in their

[3] This section has been adapted from information provided by the National Traumatic Stress Network. https://www.nctsn.org.

environment, making them vulnerable to revictimization. Children may also experience disassociation (see next section).

Having never learned how to effectively calm themselves down once they are upset, many of these children become easily overwhelmed. For example, in school they may become so frustrated that they give up on even small tasks that present a challenge. This can affect their sense of competency and self-esteem, which can exacerbate feelings of low self-worth, shame, and depression.

What is Disassociation?

Dissociation is often seen in children with histories of complex trauma. When children encounter an overwhelming and terrifying experience, they may dissociate, or mentally separate themselves from the experience. They may perceive themselves as detached from their bodies, on the ceiling, or somewhere else in the room watching what is happening to their bodies. They may feel as if they are in a dream or some altered state that is not quite real, or as if the experience is happening to someone else. Or, they may lose all memories or sense of the experiences having happened to them, resulting in gaps in time or even gaps in their personal history. At its extreme, a child may close off or lose touch with various aspects of the self.

Although children may not be able to purposely dissociate, once they have learned to dissociate as a defense mechanism, they may automatically dissociate during other stressful situations or when faced with trauma reminders. Dissociation can affect a child's ability to be fully present in activities of daily life and can significantly fracture a child's sense of time and continuity. As a result, it can have adverse effects on learning, classroom behavior, and social interactions. It is not always evident to others that a child is dissociating, and at times, it may appear as if the child is simply "spacing out," daydreaming, or not paying attention.

Behavior

A child with a complex trauma history may be easily triggered or "set off" and is more likely to react very intensely. The child may struggle with self-regulation (i.e., knowing how to calm down) and may lack impulse control or the ability to think through consequences before acting. As a result, the child may frequently experience emotional dysregulation (see next section) and behave in ways that appear unpredictable, oppositional, volatile, and extreme. A child who feels powerless or who grew up fearing an abusive authority figure may react defensively and aggressively in response to perceived blame or attack. Alternately, they may at times be overcontrolled, rigid, and unusually compliant with adults. A child who dissociates may seem "spacey," detached, distant, or out-of-touch with reality.

Children with complex trauma are more likely to engage in high-risk behaviors, such as self-harm, unsafe sexual practices, and excessive risk-taking, such as operating a vehicle at high speeds. They may also engage in illegal activities, such as alcohol and substance use, assaulting others, stealing, running away, and/or prostitution, thereby making it more likely that they will enter the juvenile justice system. When these behaviors are present, it is important to recognize both the behavior itself and its context, in order to address it effectively.

What is Emotional Dysregulation?

Children who have experienced complex trauma often have great difficulty regulating their emotions. They often cannot cope with normal stressors in an age-appropriate way. When they experience frustration, anger, or fear, they may respond as a much younger child would respond—throwing tantrums, crying excessively, withdrawing, or displaying oppositional or aggressive behavior. Typical parenting techniques, such as instituting time outs or applying consequences, can be ineffective and sometimes cause the behavior to escalate. In addition, problematic behaviors can be triggered by situations that may seem benign but that the child associates with past abuse. Since many children who have experienced early childhood trauma cannot articulate (or in some cases even remember) the specifics about their trauma, avoiding these triggers can be extremely difficult for a caregiver.

Attachment and Relationships

When children have unstable or unpredictable relationships with their primary caregivers, they learn that they cannot rely on others to help them. When primary caregivers exploit and abuse a child, the child may believe that they are bad and the world is a terrible place. For this reason, many abused or neglected children have difficulty developing a strong, healthy attachment to foster or adoptive parents.

Children who do not experience healthy attachments may be distrustful and suspicious of others and may have trouble accepting comfort, even as young children. As they get older, they can have difficulty understanding the motivations, emotional states, and personal boundaries of others. Later in life, they may have trouble with romantic relationships, friendships, and authority figures, such as teachers or police officers.

Cognition: Thinking and Learning

When children grow up under conditions of constant threat, all of their internal resources go toward survival. Because their bodies and minds have learned to be in chronic stress response mode, they can have problems thinking clearly, reasoning, or problem solving—even when in a safe, calm environment. For instance, when compared to their peers, they may find it difficult to plan ahead, anticipate the future, and act accordingly. They may have trouble thinking a problem through calmly and considering multiple alternatives. They may find it hard to acquire new skills or take in new information. They may struggle with sustaining attention or curiosity or be distracted by reactions to trauma reminders. Or, they may show deficits in language development and abstract reasoning skills.

Many children who have experienced complex trauma have learning difficulties that may require support in the academic environment to reach their full potential.

Self-Concept and Future Orientation

Children learn their self-worth from the reactions of others, particularly those closest to them. Caregivers have the greatest influence on a child's sense of self-worth and value. Abuse and neglect may make a child feel worthless and despondent. Children who are abused will often blame themselves. It may feel safer to blame oneself than to recognize the parent as unreliable and dangerous. Shame, guilt, low self-esteem, and a poor self-image are common among children with complex trauma histories.

To plan for the future with a sense of hope and purpose, children need to value themselves. Children surrounded by violence in their homes and communities learn from an early age that they cannot trust, the world is not safe, and that they are powerless to change their circumstances. They may view themselves as powerless and "damaged" and may perceive the world as a meaningless place in which planning and positive action is futile. Having learned to operate in "survival mode," these children can live from moment-to-moment without pausing to think about, plan for, or even dream about a future.

To understand more about the thoughts, feelings, and behaviors of complex trauma victims, see Appendix 1.

Physical Health: Body and Brain

When a child grows up afraid or under constant or extreme stress, the immune system and body's stress response systems may not develop normally. Later on, when the child or adult is exposed to even ordinary levels of stress, these systems may automatically respond as if the individual is under extreme stress. For example, an individual may experience significant physiological reactivity, such as rapid breathing or heart pounding, or may "shut down" entirely when presented with stressful situations. These responses, while adaptive when faced with a significant threat, are out of proportion in the context of normal stress and are often perceived by others as "overreacting," or as unresponsive or detached.

Children with complex trauma histories who experience constant, toxic stress may develop chronic or recurrent physical complaints, such as headaches or stomachaches. Adults with histories of trauma in childhood have been shown to have more chronic physical conditions and problems. They may also engage in risky or otherwise unhealthy behaviors that compound these conditions (e.g., smoking, substance use, and diet and exercise habits that lead to obesity).

Children with complex trauma frequently suffer from body dysregulation, meaning they over-respond or under-respond to sensory stimuli. For example, they may be hypersensitive to sounds, smells, touch, or light, or they may suffer from anesthesia and analgesia, in which they are less aware of pain, touch, or internal physical sensations. As a result, they may injure themselves without feeling pain, or suffer from physical problems without being aware of them. Or, they may complain of chronic pain in various body areas for which no physical cause can be found.

Long-term Health Consequences of Complex Trauma

Traumatic experiences in childhood have been linked to increased medical conditions throughout the individuals' lives. The Adverse Childhood Experiences (ACE) Study is a longitudinal study that explores the long-lasting impact of childhood stressors. The ACE Study includes over 17,000 participants ranging in age from 19 to 90. Researchers gathered medical histories over time, while also collecting data on the subjects' childhood exposure to abuse, violence, and impaired caregivers. Results indicated that nearly 64% of participants experienced at least one exposure, and of those, 69% reported two or more incidents of childhood trauma. Results demonstrated the connection between childhood trauma exposure, high-risk behaviors (e.g., smoking, unprotected sex), mental health problems, chronic illness, such as heart disease and cancer, and early death.

Table 1
Some Possible Signs and Symptoms of Complex Trauma in Abused or Neglected Children

Emotional Responses	Behavior	Attachment and Relationships
• Problems managing or controlling emotions • Hypersensitivity to interpersonal conflicts • Hypervigilant—always looking for signs of danger or conflict • Easily overwhelmed or frustrated • Significant depression, anxiety, and/or anger • Reacts out of proportion to a stressful event • May dissociate or "tune out" when under stress • May feel numb, empty, or unreal	• Difficulty understanding or complying with rules • Poor impulse control • Volatile, aggressive, or oppositional behavior • Defensive or aggressive response to perceived blame or attack • Overcontrolled or rigid behavior • Overly compliant behavior • Self-destructive behaviors (e.g. self-harm, eating disorders, substance abuse, etc.) • Reenacts trauma • Inappropriate sexual behaviors • May engage in illegal activities	• Uncertainty about the reliability and predictability of the world • Problems attaching to caregivers • Inability to be comforted • Difficulties with personal boundaries • Difficulty attuning to other people's emotional states • Difficulty with perspective taking • Distrust and suspiciousness about those around them • Difficulty enlisting others as allies or making friends • Volatile relationships • Social Isolation
Cognition: Thinking and Learning	**Self-Concept/Future Orientation**	**Physical Health: Body and Brain**
• Poor attention • Problems with planning and goal-oriented behavior • Problems with learning • Problems thinking clearly, reasoning, or problem solving • Lack of sustained curiosity • Problems processing new information or acquiring new skills • Difficulties with language • Impairments in auditory, visual, or spatial perception and comprehension • Problems with memory, including amnesia about traumatic events	• Low self-esteem, feelings of worthlessness or despondency • Shame or guilt, blames self for trauma • Feelings of hopelessness and meaninglessness about the future • Feelings of powerlessness or helplessness • Disturbances of body image • Lack of awareness of emotional states of self and others	• Hypersensitivity or lack of sensitivity to pain, physical contact, noise, smells, etc. • Unexplained physical pain (e.g., headaches, stomachaches) • Problems with coordination and balance • Autoimmune disorders • Pseudo-seizures • Sleep disturbances • Disordered eating; substance issues • Depression and anxiety • Attention-deficit/hyperactivity disorder (ADHD) or ADHD-like symptoms • Self-harming behaviors, suicide

DIAGNOSIS

Children showing symptoms of complex trauma can be diagnosed with post-traumatic stress disorder (PTSD), complex trauma, complex PTSD (cPTSD), developmental trauma disorder, or early childhood trauma. Trauma may also be described in terms of Adverse Childhood Experiences (ACEs). In general, the official diagnosis and terms used are less important than the recognition that childhood trauma has occurred so that it can be addressed in a child's treatment plan.

It is important that a child is evaluated by a health care professional who is familiar with symptoms of childhood trauma disorders. Symptoms of complex trauma can differ from the typical symptoms of PTSD—especially if the trauma was perpetrated during the developmental years. Two common symptoms of PTSD are 1) re-experiencing the traumatic event (sometimes referred to as "flashbacks") and 2) avoiding situations that remind the individuals of the traumatic event. Children suffering from complex trauma often don't have either of these symptoms.

COMPLEX TRAUMA AND OTHER MENTAL HEALTH DISORDERS

Even though trauma disorders are common in children who suffer abuse and neglect, they can be very difficult to diagnose and are sometimes misdiagnosed or overlooked—especially if the extent of the abuse and neglect is not known. For instance, one of the core symptoms of complex trauma—emotional dysregulation—is also a common symptom of a host of other childhood mental health disorders. Therefore, emotional dysregulation may be due to past abuse and neglect, a mental health disorder, or both. It may also be a reaction to being removed from a primary caregiver—which is itself a traumatic experience.

This section describes some of the mental health disorders that share symptoms with trauma disorders or frequently co-occur with trauma disorders. Some key points to consider:

- Abuse and neglect can make some children more vulnerable to mental health disorders, and mental health disorders can make some children more vulnerable to abuse and neglect.
- It is common for complex trauma and other mental health disorders to occur at the same time.
- Complex trauma may be confused with another disorder because of common symptoms.
- Whether a child has experienced trauma can affect choice of treatment and how that treatment is delivered.

If abuse or neglect is suspected, it is crucial that a child is evaluated by a mental health care professional who is well-versed in trauma disorders and their treatments.

Anxiety and Depression

Children who have experienced trauma—including the trauma of being removed from their primary caregivers—can show symptoms of anxiety and depression, and in some cases, develop anxiety and depressive disorders. However, it's important to note that many of the symptoms of complex trauma overlap with those of anxiety and depression. Hypervigilance, restlessness, fear and nervousness, and avoidance of seemingly benign

situations are signs of complex trauma that can be easily mistaken for an anxiety disorder, especially if the extent of the abuse and neglect is not known. In addition, children often express depression as irritability and anger, which are both signs of complex trauma. For this reason, it is important that diagnosing clinicians assess for underlying trauma when treating for anxiety and depression to determine an appropriate treatment. Treatments should be trauma-informed to avoid re-traumatizing the child.

Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD is a neurodevelopmental disorder—in other words, it is a disorder present at birth that manifests in early childhood and persists throughout one's lifetime. The main characteristic of ADHD is difficulty focusing (especially on activities that are not particularly interesting to the child), with or without hyperactivity. This can lead to school problems, social problems, low self-esteem, and depression.

Children who have experienced childhood trauma can have very similar symptoms. Fear and anxiety, hypervigilance to danger, and emotional dysregulation can cause hyperactivity and prevent a child from being able to focus, stay on task, and learn—even after they have been removed from an abusive situation. These children can also have trouble trusting others or enlisting allies, which can cause social problems. Finally, abuse and neglect cause feelings of low self-worth and depression. For this reason, some clinicians mistake the symptoms of early childhood trauma for ADHD—especially if they are unaware that abuse has occurred.

This does not mean that a child who has experienced early childhood trauma does not also have ADHD. In fact, the challenges of parenting a child with ADHD may make that child more vulnerable to abuse and neglect.

If a child is suspected to have ADHD and has experienced early childhood trauma, they should be evaluated by a mental health care professional who is able to distinguish between organically-based ADHD and symptoms of trauma. A proper diagnosis is critical to ensuring that the child receives the correct treatment.

Autism Spectrum Disorder (ASD)

ASD is a neurodevelopmental disorder—in other words, it is a disorder present at birth that manifests in early childhood and persists throughout one's lifetime. The main characteristics of autism are 1) difficulty relating to and communicating with others, and 2) restricted, repetitive behaviors, interests, and activities.

Although ASD is well-studied and testing is usually reliable, ASD can be confused with complex trauma. Traumatized children can experience dissociation or cope with stress by withdrawing into themselves. If this behavior is chronic, they may never have learned to effectively communicate with others, or they may choose to stay silent because it is "safer." They also may have developed coping methods to sooth anxiety that can appear to be the restricted, repetitive behaviors seen in ASD.

ASD and trauma disorders also co-occur, and children with ASD can be more at risk for experiencing adverse childhood experience (ACEs)—which include child abuse and neglect—than typically developing children.

Borderline Personality Disorder (BPD)

Case Study: Maya

Fourteen-year-old Maya was removed from her home by CPS and placed with a foster family. At first, Maya is unusually affectionate and clingy with her foster family, wanting to call them "mom" and "dad" immediately. At her new school, she seems to attract drama, and she has a new circle of friends, including boyfriends, every week. Soon, she begins to exhibit extreme mood swings—she burst into tears over minor frustrations or breaks things when she doesn't get her way. When her foster mother refuses to let her go to a party, Maya flies into a rage and smashes a window and accuses her foster family of not wanting her, just like everyone else. Later she swallows a bottle of pills and must be rushed to the emergency room.

Maya shows symptoms of complex trauma and borderline personality traits.

Personality disorders involve severe disturbances in how individuals view themselves and other people. In general, these disorders involve clusters of maladaptive personality traits that interfere with social interaction. Because personality is somewhat fluid until adulthood, children are usually not diagnosed with personality disorders.

However, one of the personality disorders—borderline personality disorder (BPD)—has a strong correlation with childhood abuse and neglect. In fact, studies have shown that 30 to 90 percent of adults diagnosed with BPD have experienced early childhood trauma.[4] For this reason, abused children who have BPD traits are at increased risk of developing BPD as adults.

One of the main characteristics of BPD is an uncertain sense of self. People with BPD have a poorly developed or unstable self-image and often feel empty, disconnected, and extremely self-critical. They also have intense, unstable, short-lived relationships marked by neediness, mistrust, and an anxious preoccupation with abandonment. They lack self-direction and their goals and values are unstable. Finally, they have difficulty understanding the feelings and motivations of others.

In addition to these core traits, they can have frequent and abrupt mood swings and display chronic anxiousness, separation insecurity, depression, impulsivity, risk taking behavior, and hostility. They also are at very high risk of suicidal behavior—60 to 70 percent of people with BPD attempt suicide and 10 percent die by suicide.[5]

Because the suicide risk of youth with BPD traits is high, early intervention is critical. BPD is often treated with dialectical behavior therapy—therapy designed to help youth and their caregivers understand and manage strong emotions and impulses and successfully manage interpersonal relationships.

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[4] Nadia Cattane et. al., Borderline personality disorder and childhood trauma: Exploring the affected biological systems and mechanisms, *BMC Psychiatry*, 2017 (17:221). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5472954/#:~:text=Several%20studies%20have%20shown%20that,severity%20%5B9%E2%80%9311%5D.

[5] John M. Oldham, Borderline personality disorder and suicidality, *American Journal of Psychiatry*, January 2006. https://ajp.psychiatryonline.org/doi/pdfplus/10.1176/appi.ajp.163.1.20.

Oppositional Defiant Disorder (ODD) and Intermittent Explosive Disorder (IED)

ODD and IED are disorders related to disruptive behavior and a lack of impulse control and involve acting angrily or aggressively towards people or property. Some symptoms of ODD are a chronic angry or irritable mood, argumentative or defiant behavior, and a pattern of vindictiveness. Some symptoms of IED include frequent impulsive, aggressive, angry outbursts disproportional to the event that triggered them. Although childhood abuse and neglect is a risk factor for both disorders, many symptoms of ODD and IED overlap with those of trauma disorders. Children who have experienced complex trauma often display aggression, rage, and a lack of impulse control. They may have developed these behaviors to help them survive abuse.

Health care providers who do not have experience with childhood trauma, or who are not aware that abuse has occurred, may diagnose a child with ODD or IED based on their behavior. Unfortunately, a diagnosis of ODD or IED can carry stigma, because children with these disorders can progress to more serious antisocial behavior. For this reason, it is important that if abuse is suspected, children receive a thorough assessment from a clinician experienced in childhood trauma.

"Slow Learner" or "Lower Intelligence" Labels

Psychologists often administer intelligence quotient (IQ) tests to children who are not meeting developmental milestones or who are struggling academically. It is well established that IQ scores rarely change over time. Therefore, a child who scores low on an IQ test may be permanently labeled as being a "slow learner" in need of special education classes.

However, children who have experienced early childhood trauma can have learning difficulties, as well as difficulty taking IQ tests, even with an experienced proctor. They can have problems with memory, concentration, and following directions; they can become easily frustrated; they may be unwilling to put forth their best effort; they may have little experience with answering questions in a testing situation; and they may have one or more learning disorders. For these reasons, children with a history of abuse and neglect who test poorly on IQ tests should be tested again when their symptoms improve.

This does not mean that special education classes are not appropriate for a child who has difficulty in the learning environment due to complex trauma. However, the child should be reevaluated as trauma symptoms subside.

TREATMENTS

Usually, parents and caregivers do not choose a specific treatment for their child; instead they choose an individual therapist or service provider skilled in helping children and families deal with complex trauma. However, it is very useful for caregivers to understand what types of therapy are used with traumatized children so that they can participate more fully in their child's therapy and discuss alternate interventions when necessary.

While therapeutic treatments are an important part of healing from trauma, experts believe that children also must establish a secure attachment with a caregiver. For this reason, caregiver education and involvement is critical. Healing happens through consistent, loving, trauma-informed parenting in conjunction with therapy.

The following treatments are commonly used to treat PTSD or complex trauma in children. Those that have received a "not able to be rated" rating by the California Evidenced-Based Treatment Clearinghouse (CEBC) have been recommended by the National Child Traumatic Stress Network as effective treatments for complex trauma. Many of the program websites listed below have links to help caregivers find a provider, as well as parent resources, such as videos, books, and other educational materials. Treatments have been summarized in Table 2.

Children with behavioral issues often benefit from **Intensive In-Home Services.** These services are designed to help children and families "in the moment." They involve a therapist visiting the home for several hours, several times a week, so that they can deal with emotional and behavioral problems as they occur and involve the whole family. The type of treatment used by intensive in-home therapists usually depends upon the needs of the child and the training an individual therapist has received.

Table 2
Summary of Treatments for Trauma Disorders

Treatment	Age	Disorder	CEBC Rating[6]
Eye Movement Desensitization and Reprocessing (EMDR)	2-17	PTSD/Trauma	Well-supported
Prolonged Exposure Therapy for Adolescents (PE-A)	12-18	PTSD/Trauma	Well-supported
Trauma-Focused Cognitive Behavioral Therapy	3-18	PTSD/Trauma	Well-supported
Child-Parent Psychotherapy	0-5 (includes primary caregiver)	PTSD/Trauma	Supported
Dialectical Behavior Therapy (DBT)	7-18	Borderline personality disorder traits	Promising
Trust-Based Relational Intervention (TBRI)	Parent training	PTSD/Trauma	Promising

[6] Note that CEBC ratings only reflect the quality and amount of scientific evidence supporting a treatment. Programs with lower ratings are not necessarily less effective than those with higher ratings. Treatments proven to be ineffective or harmful have not been included.

Treatment	Age	Disorder	CEBC Rating[7]
Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A)	10-18 (includes caregivers)	Complex Trauma	Promising
Attachment, Regulation, and Competency (ARC)	0-21 (includes caregivers)	Complex Trauma	Not able to be rated
Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)	12-21 (may involve caregiver)	Complex Trauma	Not able to be rated
Real Life Heroes (RLH)	6-12 (includes caregivers)	Complex Trauma	Not able to be rated
Strengthening Family Coping Resources (SFCR)	0-17 (includes caregivers)	Complex Trauma	Not able to be rated
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	Adolescents	Complex Trauma	Not able to be rated

Rating: Well-Supported

Eye Movement Desensitization and Reprocessing (EMDR)

Summary Therapy that uses eye movements or sound in conjunction with other therapy to help the brain process trauma, with the goal of alleviating PTSD symptoms.

Target population Children ages 2 to 17 suffering from PTSD, anxiety, fears, and behavioral problems related to traumatic experiences.

Type and duration Typically one 50 to 90 minute session per week in an office-based setting. Often, major gains are apparent within a few weeks, ranging from 3 to 12 sessions.

Rating Rated "Well-Supported" (level 1) for trauma disorders in children and adolescents by the California Evidence-Based Clearinghouse.

Description

EMDR is based on the theory that the powerful and disturbing "re-experiencing" symptoms associated with trauma disorders are the result of the brain not properly processing traumatic experiences into long-term memory. Typically, the emotions connected with painful past experiences fade with time. However, a person with a trauma disorder often re-experiences an intense "fight, flight, or freeze" response when a traumatic memory is triggered. For instance, a caregiver who scolds an abused child may trigger extreme fear, violent or oppositional behavior, excessive passivity or "tuning out," or other extreme behaviors. These reactions are not in the child's control, and can happen even if the child does not have a clear memory of the abuse.

[7] Note that CEBC ratings only reflect the quality and amount of scientific evidence supporting a treatment. Programs with lower ratings are not necessarily less effective than those with higher ratings. Treatments proven to be ineffective or harmful have not been included.

According to the EMDR International Association, EMDR therapy helps the brain process traumatic memories. The therapist accomplishes this by leading the youth through sets of eye movements, sounds, or taps that alternately activate the left and right hemispheres of the brain. During this process, the therapist prompts the youth to remember elements of the traumatic event while carefully attending to the youth's emotional state. The goal of therapy is for distressing emotions and sensations to no longer be triggered by reminders of the event. The event is still remembered, but the fight, flight, or freeze response is resolved.

EMDR is a well-researched and effective treatment that tends to work faster than traditional talk therapy. Unlike trauma-focused cognitive behavioral therapy, it does not require the youth to talk in detail about the trauma or create a trauma narrative. Instead, it relies on the brain's natural capacity to process and heal from trauma. This can be beneficial to youth who are unable or unwilling to talk about traumatic experiences, or to youth who do not have a clear memory of specifics surrounding abuse.

Learn More:

EMDR website: **https://www.emdr.com/**

CEBC program information: **https://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/**

Prolonged Exposure Therapy for Adolescents (PE-A)

Summary	Therapy that repeatedly exposes children to trauma "triggers" to reduce their triggering effect.
Target population	Children ages 12 to 18 who have experienced a trauma and have experienced PTSD and related symptoms. Also used with children aged 6 to 12.
Type and duration	Once- or twice-weekly sessions that are 60 to 90 minutes in length, typically in an office-based setting. Treatment includes parental involvement and homework (practicing at home). Typically lasts 2 to 4 months.
Rating	Rated "Well-Supported" (level 1) for trauma disorders in children and adolescents by the California Evidence-Based Clearinghouse. However, it should be noted that experts caution against exposure therapy until a child is ready, to avoid retraumatizing the child.

Description

PE-A is a therapeutic treatment where clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment. The aim of therapy is to help clients emotionally process their traumatic memories and to learn that 1) they can safely remember the trauma and experience trauma reminders, 2) that the distress that initially results from confrontations with these reminders decreases over time, and 3) that they are capable of tolerating this distress.

Learn More:

PE-A website: **https://www.med.upenn.edu/ctsa/workshops_pet.html**

CEBC program information: **https://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adolescents/**

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Summary	Therapy that teaches children how to reduce symptoms and overcome trauma by changing the way they think.
Target population	Children ages 3 to 18 suffering from feelings of shame, distorted beliefs about self and others, acting out behavior problems, and PTSD and related symptoms of trauma.
Type and duration	Weekly 30 to 45 minute sessions in an office-based setting. Treatment typically continues for 12 to 16 weeks, but may take longer if the youth has experienced complex trauma.
Rating	Rated “Well-Supported” (level 1) for trauma disorders in children and adolescents by the California Evidence-Based Clearinghouse. Commonly adapted as a treatment for complex trauma.

Description

TF-CBT helps children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It incorporates trauma-sensitive interventions with the principles of cognitive behavioral therapy. Most therapists who treat children who have undergone complex trauma integrate some or all of the elements of TF-CBT into their treatment plans.

The basic premise of CBT is that emotions are difficult to change directly, so CBT targets maladaptive or distressing emotions by changing thoughts and behaviors that are contributing to the emotions. CBT builds a set of skills that enables an individual to be aware of thoughts and emotions; identify how situations, thoughts, and behaviors influence emotions; and improve feelings by changing dysfunctional thoughts and behaviors. The behavioral aspect of CBT addresses how behaviors influence mood. The therapist works with the child to increase behaviors to improve mood and reduce behaviors associated with negative mood. Treatment usually

includes the child developing a trauma narrative (in which the child learns to be able to discuss the events when they choose in ways that do not produce overwhelming emotions).

Learn More:

TF-CBT website: **https://tfcbt.org/**

CEBC program information: **https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/**

Rating: Supported

Child-Parent Psychotherapy (CPP)

Summary	Therapy that engages both parent and child to create secure, healthy attachment.
Target population	Children ages 0 to 5 who have been exposed to trauma and are displaying symptoms related to PTSD. Treatment typically includes parent or caregiver.
Type and duration	Weekly 1 to 1.5 hour sessions in a home-based setting. Treatment is recommended for one year.
Rating	Rated "Supported" (level 2) for trauma disorders in children and adolescents by the California Evidence-Based Clearinghouse.

CPP is a treatment for trauma-exposed children ages 0 to 5. Typically, the child is seen with the child's parent or primary caregiver, and the dyad is the unit of treatment. CPP examines how the trauma and the caregiver's relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture, socioeconomic, and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.

Learn More:

CPP website: **https://childparentpsychotherapy.com/**

CEBC program information: **https://www.cebc4cw.org/program/child-parent-psychotherapy/**

Rating: Promising

Dialectical Behavior Therapy (DBT)

Summary	Individual and group therapy for youth with borderline personality disorder traits that targets symptoms of BPD.
Target population	Youth ages 7 to 18 who suffer from emotional and behavioral dysregulation that leads to impulsive, self-destructive, or self-harming behaviors typically seen in borderline personality disorder, such as suicidal/self-harm ideation or behavior, substance abuse, disordered eating, or aggressive behavior. Developed as a treatment for symptoms of borderline personality disorder, DBT has also been used to treat symptoms of extreme emotional instability associated with other mental health disorders, including trauma disorders.
Type and duration	Individual and group sessions (typically one of each per week) delivered by a therapeutic team trained in DBT in an office-based or residential setting. Treatment typically lasts six months, although programs of more or less intensity are available.
Rating	Rated "Promising" (level 3) by the CEBC for chronically suicidal youth with behaviors found in borderline personality disorder.

Description

DBT is a type of cognitive-behavioral therapy that targets emotional and behavioral dysregulation. DBT helps individuals cope with extremely intense and seemingly uncontrollable negative emotions—especially when those emotions are related to interpersonal relationships, such as friends, romantic partners, and family members. DBT was originally developed to treat adults with borderline personality disorder (BPD), which has a strong association with childhood trauma. Although BPD is rarely diagnosed until adulthood, DBT can be an effective treatment for youth who have BPD-like symptoms, such as difficulty coping with intense emotion related to interpersonal conflict and impulsive, self-destructive, or self-harming behaviors, including nonsuicidal self-injury or suicidal behaviors.

DBT therapists help individuals avoid black and white, all-or-nothing styles of thinking and develop a balanced perspective. In addition, DBT provides individuals with new skills to manage painful emotions and decrease conflict in relationships.

DBT for adults is a well-established, evidence-based treatment for reducing symptoms related to borderline personality disorder. DBT has been adapted to treat adolescents ages 13 and older (DBT-A) and children ages 7-12 (DBT-C). In DBT-A and DBT-C, family members participate in group sessions. More research is required to establish DBT's effectiveness with youth, but uncontrolled studies have shown promising results. DBT can also be modified for use in residential settings, including juvenile detention settings, and has been shown to be effective in reducing aggressive behavior and recidivism rates.

Learn More:

DBT website: **https://behavioraltech.org/**

CEBC program information: **https://www.cebc4cw.org/program/dialectical-behavior-therapy-dbt/**

Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A)

Summary	Therapeutic program that helps youth and their caregivers understand and gain control of trauma-related reactions triggered by current daily life stresses.
Target population	Caregivers and children ages 10 to 18 with trauma symptoms, including PTSD and dissociative symptoms; problems with anxiety, depression, guilt, shame, and complicated grief; disruptive behavior disorders; problems with school/learning; and problems with peer and family relationships, addictions, and delinquency.
Type and duration	Weekly or twice-weekly 50 minute (individual) or 60 to 90 minute (family or group) sessions in a home-based, office-based, or residential setting. Treatment can continue for one month to six or more months.
Rating	Rated "Promising" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

TARGET is an educational and therapeutic approach for the prevention and treatment of post-traumatic stress disorders (PTSD). TARGET provides a seven-step sequence of skills - the FREEDOM Steps - that are designed to enable youth and adults to understand and gain control of trauma-related reactions triggered by current daily life stresses.

The goal in TARGET is to help youth and adults recognize their personal strengths using the FREEDOM Steps, and to use these skills consistently and purposefully when they experience stress reactions in their current lives. TARGET both empowers and challenges PTSD trauma survivors to become highly focused and mindful, to make good decisions, and to build healthy relationships.

TARGET explains post-traumatic stress disorder symptoms as the product of an ingrained, but reversible, biological change in the brain's alarm and information processing systems and the body's stress response systems.

Using graphics and simple language, TARGET describes the stress response system as an "alarm" in the brain that is triggered by trauma or extreme stress. When the brain becomes stuck in "alarm" mode, a person cannot access the brain's capacities for clear thinking, and therefore reacts to all types of current stressors as survival threats. This causes serious difficulties in relationships and daily life activities that can be addressed by using the FREEDOM skill set.

Learn More:

TARGET website: **https://www.atspro.org/targetcurricula**

CEBC program information: **https://www.cebc4cw.org/program/trauma-affect-regulation-guide-for-education-and-therapy-adolescents/**

Trust-Based Relational Intervention (TBRI)

Summary	Caregiver training program that teaches effective parenting strategies for children who have experienced trauma.
Target population	Caregivers of children ages 0 to 17 who have experienced maltreatment, abuse, neglect, multiple home placements, or violence, and are exhibiting behavior problems.
Type and duration	Typically delivered in four six-hour group sessions in an office-based or community setting. An online version is also available here: https://child.tcu.edu/tbri101/#sthash.7ELfcRTh.o7S8AUYq.dpbs
Rating	Rated "Promising" (level 3) for caregivers by the California Evidence-Based Clearinghouse.

Description

TBRI Caregiver Training is a trauma-informed caregiver training program that centers on creating trust and attachment between caregiver and child. TBRI consists of three sets of harmonious principles: Connecting, Empowering, and Correcting. TBRI is based upon how optimal development should have occurred. By helping caregivers understand what should have happened in early development (including prenatal development), TBRI principles can be used by parents and caregivers to help guide children and youth back to their natural developmental trajectory.

TBRI is designed to help caregivers who have children experiencing the following:

- Inability to give and/or receive nurturing care
- Hyper-vigilance and perceived lack of safety
- Inability to regulate their own emotions and/or behavior
- Problem behavior, including both internalizing and externalizing behaviors
- Sensory related deficits, including, for example, hypersensitivity and/or hypo-sensitivity to touch
- Poor social skills (e.g., doesn't know how to appropriately ask for their needs)

Learn More:

TBRI website: **https://child.tcu.edu/#sthash.mVpw0fUc.dpbs**

CEBC program information: **https://www.cebc4cw.org/program/trust-based-relational-intervention-tbri-caregiver-training/**

Rating: Not Able To Be Rated[8]

Attachment, Regulation, and Competency (ARC)

Summary	Home-based therapy that addresses symptoms of complex/developmental trauma and involves the family system.
Target population	Children and young adults ages 0 to 21 who have experienced chronic/complex trauma; caregivers.
Type and duration	The intensity and duration depends on client and type of settings. Treatment is typically delivered in a home-based or residential setting.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

ARC is organized around the core domains of attachment (e.g., building safe caregiving systems), regulation (e.g., supporting youth regulation across domains), and developmental competency (e.g., supporting factors associated with resilient outcomes). ARC treatment is designed to help children understand and gain control over their bodies and their feelings, and understand the links between those strong feelings and the experiences they may have had in the past. ARC also works to build and support important areas of developmental competency, such as being able to make good choices; finding activities and interests that are fulfilling and that support feelings of mastery and power; and being able to make and keep friendships and healthy relationships over time.

For children in a home setting, primary caregivers are a very important part of the treatment team. Caregivers may be supported in identifying strengths and challenges within their family system, learning more about their own emotional experience as relates to their child(ren) and to parenting, and improving the relationship between caregiver and child(ren).

Learn More:

ARC website: **https://arcframework.org/**

CEBC program information: **https://www.cebc4cw.org/program/attachment-regulation-and-competency-arc-client/**

[8] Interventions in this section have been designed specifically to treat complex trauma and have been recommended by the National Child Traumatic Stress Network. The rating "Not Able To Be Rated" indicates that not enough quality studies have been performed to enable the CEBC to rate the effectiveness of the treatment.

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)

Summary	Office-based therapy that addresses symptoms of complex/developmental trauma and is designed to adapt to the youth's changing needs.
Target population	Youth and young adults ages 12 to 21 who have experienced chronic/complex trauma.
Type and duration	Weekly 45 to 60 minute session, in an office-based or residential setting. Caregivers may have sessions as well. Treatment length varies.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

ITCT-A integrates treatment principles from complex trauma literature, attachment theory, the self-trauma model, affect regulation skills development, and components of cognitive behavioral therapy. It involves structured protocols and interventions that are customized to the specific issues of each client, since complex posttraumatic outcomes are notable for their variability across different individuals and different environments.

A key aspect of ITCT-A is its regular and continuous monitoring of treatment effects over time. The client's social and physical environment is also monitored for evidence of increased stressors or potential danger from revictimization or broader community violence.

Learn More:

ITCT-A website: **https://keck.usc.edu/adolescent-trauma-training-center/**

CEBC program information: **https://www.cebc4cw.org/program/integrative-treatment-of-complex-trauma-for-adolescents/**

Real Life Heroes (RLH): Resiliency-focused Treatment for Children and Families with Traumatic Stress

Summary	Home-based therapy that emphasizes empowerment and a child's "hero's journey." May be used in conjunction with other treatments.
Target population	Children ages 6 to 12 who show symptoms of complex trauma, including high risk behaviors and developmental delays. Includes caregiver and family system.
Type and duration	Weekly 30 to 90 minute sessions in a home-based setting, which may include separate caregiver sessions. Treatment typically continues for 25 to 40 weeks.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

RLH is a resiliency-focused treatment program for children and families with toxic stress and complex trauma. RLH provides practitioners with easy-to-use, tools including a life storybook, manual, multi-sensory creative arts activities, and psycho education resources to engage children and families in evidence-supported trauma treatment. Practitioners can use RLH to reframe referrals based on pathologies and blame into a shared 'journey,' a 'pathway' to healing and recovery focused on restoring (or building) emotionally supportive and enduring relationships and promoting development of affect regulation skills for children, parents and other caregivers. Creative arts, movement activities, and shared life story work provide a means for children and families to develop the safety, attunement and trust needed for re-integration of traumatic memories.

RLH focuses on "relational healing for relational traumas" and can be used to engage hard-to-reach children and families with principles of "the hero's journey" and tools that highlight child, parent/caregiver, and cultural strengths.

Learn More:

RLH website: **https://reallifeheroes.net/**

CEBC program information: **https://www.cebc4cw.org/program/real-life-heroes-rlh/**

Strengthening Family Coping Resources (SFCR)

Summary	Trauma-focused skill building intervention to increase coping resources for the family.
Target population	Caregivers and their children ages 0 to 17 living in traumatic contexts who are vulnerable to and show symptoms of trauma exposure.
Type and duration	Weekly two hour sessions in an office-based or community setting. Treatment typically continues for 10 to 15 weeks. Sessions may be individual family sessions or multifamily group sessions.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

SFCR is a trauma-focused, skill-building intervention designed for families living in traumatic contexts with the goal of reducing the symptoms of posttraumatic stress disorder (PTSD) and other trauma-related disorders in children and adult caregivers. SFCR provides accepted, empirically supported trauma treatment within a family format.

Since most families living in traumatic contexts contend with on-going stressors and threats, SFCR is also designed to increase coping resources in children, adult caregivers, and in the family system to prevent relapse and re-exposure. SFCR builds the coping resources necessary to help families boost their sense of safety, function with stability, regulate their emotions and behaviors, and improve communication about and

understanding of the traumas they have experienced. SFCR's therapeutic strategies promote contextual change within the family milieu through encouraging positive modifications in important aspects of daily life and home environment.

SFCR has the dual goals of reducing the symptoms of trauma-related disorders in any family member and increasing coping resources in children, caregivers, and in the family system. SFCR is designed to build the skills necessary to help families boost their sense of safety; function with stability; co-regulate their stress reactions, emotions, and behaviors; and make use of support resources.

Learn More:

SFCR website: **https://www.sfcresources.org/**

CEBC program information: **https://www.cebc4cw.org/program/strengthening-family-coping-resources/**

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

Summary	Group therapy that uses the principals of cognitive behavioral therapy to increase resiliency and enhance strengths.
Target population	Adolescents with a history of exposure to trauma who are still living with ongoing stress and are in unstable environments. Suitable for youth who may not meet the criteria for PTSD but who are experiencing behavior problems.
Type and duration	Weekly one hour group sessions in an office-based or residential setting. Treatment consists of 16 sessions.
Rating	Rated "Not Able to be Rated" by the California Evidence-Based Clearinghouse. Recommended by the NCTSN as a treatment for complex trauma.

Description

SPARCS is designed to address the needs of adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning. This can include difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life, as well as worldviews that make it difficult for them to see a future for themselves.

SPARCS is based primarily on cognitive-behavioral principles and teaches skills to foster resilience and enhance group members' current strengths. Experiential activities and discussion topics have been specifically developed for use with adolescents, and are designed to capitalize on developmental considerations that are particularly relevant for teenagers (e.g., issues related to autonomy and identity). It should be noted that SPARCS is a present-focused intervention, and is not an exposure-based model. Although there is no direct exposure component (e.g., no construction of a trauma narrative), traumas are discussed in the context of how they relate to the adolescents' current behaviors and to their understandings of their problems and difficulties in the here and now.

The curriculum, which draws from the core components of complex trauma treatment, incorporates techniques from Dialectical Behavioral Therapy (DBT), Trauma and Grief Components Therapy (TGCT), and early versions of Trauma Adaptive Recovery Group Education and Therapy (TARGET). These techniques are utilized with participants throughout many of the group sessions.

Learn More:

National Child Traumatic Stress Network: **https://www.nctsn.org/interventions/structured-psychotherapy-adolescents-responding-chronic-stress**

CEBC program information: **https://www.cebc4cw.org/program/structured-psychotherapy-for-adolescents-responding-to-chronic-stress/**

CAREGIVER EDUCATION, TRAINING, AND RESOURCES

For a child to recover from complex trauma, caregiver involvement is critical. Experts agree that healing depends upon a child developing a secure attachment to a caregiving figure. Best outcomes occur when that caregiver understands how complex trauma has affected the child in their care and when the caregiver is trained in techniques to create healthy attachment and manage behavior issues.

USEFUL WEBSITES

California Evidence-Based Clearinghouse (CEBC) for Child Welfare

https://www.cebc4cw.org/

The CEBC is a searchable database of evidence-based treatments, programs, and practices for children with mental health treatment needs. The CEBC is an excellent resource to learn more about evidenced-based mental health treatments.

Child Welfare Information Gateway

https://www.childwelfare.gov/

The Child Welfare Information Gateway promotes the safety, permanency, and well-being of children, youth, and families by connecting child welfare, adoption, and related professionals as well as the public to information, resources, and tools covering topics on child welfare, child abuse and neglect, out-of-home care, adoption, and more. Their resource, **"Factsheet" Parenting a Child Who Has Experienced Complex Trauma"** is available here: **https://www.childwelfare.gov/pubPDFs/child-trauma.pdf**.

Complex Trauma Resources

https://www.complextrauma.org/

This website contains "a curated collection of books, videos, articles and more to educate consumers, caregivers, and professionals about complex trauma." The resource is offered by the Boston nonprofit, the Foundation Trust.

Empowered to Connect

https://empoweredtoconnect.org/

Empowered to Connect (ETC) is an attachment rich community focused program that exists to support, resource, and educate caregivers. ETC's resources and trainings are especially helpful for caregivers of children who have experienced adverse childhood experiences (ACEs), toxic stress, and maltreatment. ETC relies heavily on the model of Trust Based Relational Intervention (TBRI). Information about local trainings and trainers is available on the ETC website, as are other resources, such as the ETC podcast, blog, and educational resources.

The Karyn Purvis Institute of Child Development

https://child.tcu.edu/#sthash.nmnyIr2O.dpbs

The home of Trust-Based Relational Intervention (TBRI), developed by Dr. Karyn Purvis, this website has information and resources related to complex trauma, as well as information about TBRI, an attachment-based intervention designed to help caregivers parent children affected by complex trauma.

National Child Traumatic Stress Network (NCTSN)

https://www.nctsn.org/

The NCTSN website is an excellent resource for all caregivers of children who have experienced trauma. Its website contains comprehensive resources for caregivers parenting children who have experienced complex trauma. Some features include:

- Detailed information about various types of trauma, including complex trauma
- A comprehensive list of treatments and interventions for trauma disorders
- Educational materials, including resource guides, webinars, and videos. Some notable resources include the following:
  - For caregivers: "Complex Trauma: Facts for Caregivers" **https://www.nctsn.org/sites/default/files/resources/complex_trauma_caregivers.pdf**
  - For teens: "What is Complex Trauma? A Resource Guide for Youth and Those Who Care About Them" **https://www.nctsn.org/sites/default/files/resources/what_is_complex_trauma_for_youth.pdf**
- Online training for caregivers and others in the form of webinars and e-learning courses **https://www.nctsn.org/resources/training**

Zero to Three

https://www.zerotothree.org/

Trauma resources: **https://www.zerotothree.org/resources?topic=trauma-and-stress&type=**

Zero to Three is an organization that supports major efforts to address children's mental health, maltreatment, and the impact of trauma on infants and toddlers. Its website contains more than 130 resources and services related to trauma and stress.

VIRGINIA-BASED ORGANIZATIONS AND WEBSITES

ChildSavers

https://www.childsavers.org

Child Savers is a nonprofit organization in Virginia that uses a prevention and intervention model to assist with children's mental health. This prepares the children for future learning and helps them move on after a traumatic event.

Formed Families Forward (FFF)

https://formedfamiliesforward.org

FFF is a non-profit organization dedicated to supporting foster, kinship, and adoptive families of children and youth with disabilities and other special needs in the Northern Virginia area.

Greater Richmond SCAN (Stop Child Abuse Now)

http://grscan.com/

Greater Richmond SCAN (Stop Child Abuse Now) is a local nonprofit organization dedicated solely to the prevention and treatment of child abuse and neglect in the Greater Richmond area. Greater Richmond SCAN is part of the Virginia trauma-informed community network. Its website has information about parent resources and local trainings.

HopeTree Family Services

http://hopetreefs.org/

HopeTree Family Services is a faith-based organization that offers services and support for at-risk children and youth and their families across Virginia. Services include as private foster care, residential services, and community-based resources.

NewFound Families

https://newfoundva.org/

NewFound Families is the Virginia adoptive, foster, and kinship family association. They provide educational, advocacy, and support services to families caring for children unable to live with their birth parents. Their website provides a wealth of information about resources and supports for foster, adoptive, and kinship families.

SCAN of Northern Virginia (Stop Child Abuse Now)

https://www.scanva.org/

SCAN of Northern Virginia works to develop effective child abuse and neglect prevention programming for children and families. Its website includes a list of family programs, a parent resource center, and other online resources.

UMFS (United Methodist Family Services)

https://www.umfs.org/

UMFS is a nonprofit agency that provides a comprehensive array of programs to meet the needs of parents and high-risk children to enable them to overcome challenging circumstances and succeed. UMFS offers a network of flexible community-based services, such as intensive care coordination, parent support partners, community respite, supervised visitation, and community-based clinical support. Their website offers resources and educational information for foster, adoptive, and kinship families.

Virginia's Kids Belong

https://www.vakidsbelong.org/
Facebook: **https://www.facebook.com/vakidsbelong/**

Virginia's Kids Belong mobilizes government, faith-based, business, and creative leaders around the goal of permanency and belonging for every child. Through community partners, it promotes wrap-around support services for foster parents and other caregivers in need and hosts trauma trainings through local partners. Its Facebook page offers information about local events and resources for foster parents and other caregivers. Contact the organization through its website for more information.

Virginia's Trauma-Informed Community Networks

Throughout Virginia, there are more than 19 trauma-informed community networks (TICNs). These networks share common characteristics: spreading awareness, conducting training, and implementing new trauma-informed practices in schools, courts, and community services. Caregivers may be able to access local resources or trainings by contacting a TICN near their locality.

- A list of TICNs and contact information is maintained by Voices for Virginia's Children and can be found here: **https://vakids.org/trauma-informed-va/trauma-informed-community-networks**
- Details about the activities of various TICNs across Virginia can be found here: **https://vakids.org/wp-content/uploads/2019/04/Virginias-Trauma-Informed-Community-Networks-PDF.pdf**

Voices for Virginia's Children

https://vakids.org/
Trauma resources: **https://vakids.org/trauma-informed-va/for-professionals-and-families**

Voices for Virginia's Children is Virginia's only independent, multi-issue child policy and advocacy organization. Their website contains information of use to caregivers, including links to Virginia's Trauma-Informed Community Networks.

VIRGINIA'S KINSHIP NAVIGATOR PROGRAMS AND SUPPORT PROGRAMS

Kinship navigator programs help kinship caregivers find services, resources, and support. In addition, we suggest that you check with your local department of social services for information on any supports that they provide to kinship families.

City of Virginia Beach Kinship Care Portal (Virginia Beach)

https://hs.virginiabeach.gov/social-services/kinship-care

This site provides information on the regional kinship navigator pilot program in Virginia Beach and surrounding areas.

Kinship Care – Family Engagement Program (Fairfax)

Kinship Resource Line: (703) 324-4534

Fairfax County Department of Family Services offers a dedicated resource line that caregivers can call to get help with issues and services related to kinship care. In addition, the Department offers a virtual "Parent Café" each week where parents and caregivers can discuss parenting issues. More information about Parent Café can be found here: **https://www.fairfaxcounty.gov/familyservices/community-corner/parent-cafe-provides-community-of-support**

Kinship Care Support – Fairfax County Public Schools (Fairfax and surrounding areas)

https://www.fcps.edu/resources/family-engagement/kinship-care-support

Fairfax County Public Schools has collected county and state resources on their website to help kinship caregivers. Resources include educational materials and links to support groups and community agencies.

Kinship Connection of Chesterfield Virginia (Chesterfield and surrounding areas)

https://www.chesterfield.gov/199/Kinship-Connection

Kinship Connection is a program of the Aging & Disability Services office that offers two monthly support groups and resources for grandparents and other kin who are raising a child. The program is free and open to any grandparent (or other relative raising a child) in the area.

Kinship Navigator of Central Virginia (Central Virginia)

https://kinshipnav.org/

This site provides a selection of links to services throughout Central Virginia.

CAREGIVER TRAINING

Due to the coronavirus pandemic, many state-sponsored, in-person foster parent trainings were disrupted. The following organizations offer online trainings in complex trauma designed to help caregivers and the children in their care. Many trainings are fee based, but most websites offer free videos and educational materials.

Please note that the Virginia Commission on Youth has not evaluated these trainings and cannot attest to their effectiveness.

The Attachment Trauma Center Institute
https://www.atcinstitute.com/parents/parent-class/

The Center for Adoption Support and Education
https://adoptionsupport.org/

Child Trauma Academy
https://www.childtrauma.org/

ChildSavers Trauma Training
https://childsavers.org/trauma-basics/

Empowered to Connect
https://empoweredtoconnect.org/training/

Foster Care & Adoptive Community
http://www.fosterparents.com/

Foster Care Institute
https://www.drjohndegarmofostercare.com/

Foster Parent Academy
https://fostercareacademy.thinkific.com/

Foster Parent College
https://www.fosterparentcollege.com/

Institute of Child Psychology
https://instituteofchildpsychology.com/product/childhoodtrauma_online/

National Child Traumatic Stress Network (NCTSN)
https://www.nctsn.org/resources/training

UDEMY.com
https://www.udemy.com/

Trust-Based Relational Intervention (TBRI) Online
https://child.tcu.edu/tbri101/#sthash.7ELfcRTh.o7S8AUYq.dpbs

Appendix 1: How Complex Trauma Can Affect Children's Thoughts, Beliefs, and Behaviors[9]

How I May Feel

Beliefs About Self	Feelings	Body Messages
I am … weak, worthless, broken, pathetic. I am … a liar, a sneak, a suck-up, a hypocrite, a coward, a bully. I am … nobody, a failure, a loser, a freak, a skank, trash. I am … no good, psycho, messed up, crazy. I can't do anything right. I am … stupid, school is not for me. I have to … be perfect, fool everyone, convince them to love me.	I feel … sad, moody. I feel … angry, furious. I feel … spaced out, distracted, numb. I feel … lonely, afraid. I feel … helpless, hurt. I feel … confused, insecure, unsure. I feel … scared of myself and what happens when I lose control. I feel … ashamed. I feel … like I don't care anymore what happens to me or anyone else.	I feel … tense, jumpy, amped, about to blow. I feel … nothing at all. I don't notice when I cut or hurt myself. I feel … like I'm floating outside my body. My head aches. I'm always … in pain, sick to my stomach, fidgety, restless, exhausted … I can't sleep. I can't stand bright lights, loud noises, or tags on my clothes. I can't make eye contact with most people. I can't deal with people standing too close to me or wanting to touch me.
Thoughts	**Relationships**	**Beliefs about the Future**
It's not fair! I don't understand why everyone treats me this way. Everything I touch gets ruined. I want to … hurt myself, run away, die … I can't take it anymore. I can't get my thoughts to stop spinning. I get lost in my head. I don't understand why I do some of the things I do. Sometimes I just lose it.	I can't trust anyone. I trust the wrong people. Nobody wants me. Nobody likes me. I shut everyone out. I just want to be left alone. I can't make or keep friends. Relationships aren't worth it: there's always too much drama. Everyone I care about dies, betrays me, or leaves. I hurt everyone I love.	My life is ruined. It doesn't matter. What's the point? I'm never going to become anything. I don't see a future. I'll be dead or in jail by the time I'm 25. I'll never be good enough. I don't deserve to be happy. Happiness is for other people, not me. I'll never have a job. I'll never be a success. I'll never be good at anything.

[9] From the National Child Traumatic Stress Network (NCTSN). https://www.nctsn.org.

What I May Do

Situation	What I may do to cope	How it can cause problems for me
Physical Violence or Abuse	Pay really close attention to what others feel or want and try hard to make sure they are happy.	I put the needs of others ahead of my own. Sometimes others use this to take advantage of me.
	Learn to fight really well and always be ready to fight.	I get into a lot of fights. I think others want to fight me even when they really don't.
	Learn not to feel pain so I can "take it" and just wait for it to be over.	Sometimes, I can't feel anything at all—painful or good feelings.
Sexual Abuse	Get "out of" my body.	I flirt a lot and try to get others to have sex with me. I use sex to get friends or approval. At times, people use this to take advantage of me.
	Learn to use sexual feelings or sex to make myself feel better.	I touch myself sexually a lot, even when I'm not in private. Or, I have sex with a lot of people. People use this to take advantage me. I have caught diseases because of it.
	Learn to use affection or physical contact to comfort myself and try to get people to love and care for me.	I hug people I've just met. When I make a new friend, I want to touch and hug and tell them I love them a lot. Sometimes people start to avoid me or complain, and I get in trouble for having "bad boundaries."
	Keep my distance from others to avoid getting intimate or sexual.	I avoid relationships with others that may lead to anything sexual so that I won't be taken advantage of again. I feel lonely a lot.
Neglect	Get whatever I can when it is available and hold on to it.	I get in trouble because I steal, sometimes even when I don't need or want to.
	Take care of myself and don't rely on others to meet my needs.	I have a very hard time asking for help or accepting help.
	Develop ways to keep myself from feeling lonely, like watching a lot of TV. Do things by myself a lot.	I have a hard time making friends or relating to people. People sometimes think I'm "weird" or "different."
	Develop "imaginary friends" to comfort me when I'm hurt or upset.	I sometimes have trouble separating my "imaginary" world from the "real" world.
	Eat as much as possible.	I eat too much or when I'm not hungry.
Lots of Different Kinds of Trauma	Use drugs or alcohol to not feel or to feel better.	I sometimes do things that I later regret, or I don't do things I'm supposed to do.
	Take on the responsibility to care for or protect a parent, a sibling, or a friend.	I try to keep people safe but cannot. I try to help and care for people but end up failing and letting them down. I get blamed when things go wrong. I am attacked and pushed away when I try to keep the people I care about from making bad choices.
	Engage in extreme risk-taking to feel alive, in control, tempt fate, or take charge of "what's inevitably going to happen anyway."	I injure myself. I experience a temporary high or rush, then I crash, experience a huge letdown, and get really depressed and hopeless. This leads me to seek out the next, bigger risk.
	Hurt myself.	I damage my body to punish myself, to show others my pain, to make myself feel better, or to distract myself from emotional pain.
	Hurt others.	I ruin relationships because I'm afraid to get close to someone and risk getting hurt. I hurt others to deliver justice, to make me feel less helpless, or to show them how it feels.

PROVIDER DESCRIPTIONS

MEDICAL AND PSYCHIATRIC SERVICES

Psychiatrist

Psychiatrists are medical doctors whose education includes a medical degree and at least four additional years of study and training. Psychiatrists are experts in the diagnosis and treatment of mental health disorders and in the use of psychotropic medication. Those who pass the national examination administered by the American Board of Psychiatry and Neurology become board certified in psychiatry. Psychiatrists provide medical/psychiatric evaluation and treatment for emotional and behavioral problems and psychiatric disorders. As physicians, psychiatrists can prescribe and monitor medications. **Child and adolescent psychiatrists** have two additional years of advanced training beyond general psychiatry in work with children, adolescents, and families. Psychiatrists are regulated by the Virginia Board of Medicine.

Education/training: MD or DO, as well as completion of a multi-year residency in psychiatry, usually in a hospital setting and under supervision of senior psychiatrists

Where found: Hospitals (regular and psychiatric), community services boards, private outpatient mental health clinics, and private practice

Discussed in this chapter:

Pediatrician

A pediatrician is a primary care physician who focuses on the care of children from birth to 21 years of age, who specializes in preventive health maintenance for healthy children, and who provides medical care for those who are seriously or chronically ill. Pediatricians are also increasingly involved with the prevention, early detection, and management of behavioral, developmental, and functional social problems that affect children and adolescents. Pediatricians are regulated by the Virginia Board of Medicine.

Education/training: MD or DO, as well as completion of a multi-year residency in pediatrics

Where found: Hospitals, public and private health clinics, and private practice

Nurse Practitioner (NP)

Nurse practitioners engage in the practice of medicine in collaboration with and under the medical direction and supervision of a licensed physician. “Medical direction” means the collaborative development of a written protocol between the nurse practitioners and the physician. Nurse practitioners with prescriptive authority may prescribe medication within the scope of a written practice agreement in Virginia that is regulated by the Board of Nursing and the Board of Medicine under a Committee of the Joint Boards. Nurse practitioners hold national certification in an area of specialty (family practice, psychiatry, pediatrics, etc.). In Virginia, most nurse practitioners work under the supervision of licensed physicians, but under certain conditions they may practice independently.

Education/training: RN, MA in nursing with nurse practitioner concentration, certification from a national board

Where found: Psychiatric hospitals, community services boards, private outpatient mental health clinics, and private practice

Psychiatric Clinical Nurse Specialist

Psychiatric clinical nurse specialists are professionals are registered nurses who have a master’s degree in psychiatric mental health nursing and are licensed by the state to provide care, counseling, and therapy to persons with psychological, emotional and behavioral needs. An accreditation as an Advanced Practicing Registered Nurse (APRN) by an appropriate credentialing body is necessary for this provider to receive third party reimbursement. Psychiatric clinical nurse specialists are regulated by the Virginia Board of Nursing.

Education/training: RN, MA in psychiatric/mental health nursing

Where found: Psychiatric hospitals, community services boards, private outpatient mental health clinics, and private practice

PSYCHOLOGICAL AND THERAPEUTIC SERVICES

Psychologist

A psychologist is a mental health professional with an advanced degree in psychology. **Clinical psychologists** can provide psychological evaluation and treatment for emotional and behavioral problems and disorders. They specialize in the practice of psychotherapy in individual, family, marital, and group settings. **Child psychologists** specialize in diagnosing and treating the psychological, cognitive, emotional, developmental, behavioral, and family problems of children and adolescents. Psychologists are unable to prescribe medications. Psychologists are regulated by the Virginia Board of Psychology.

Education/training: PhD or PsyD

Where found: Psychiatric hospitals, residential treatment centers, community services boards, private outpatient mental health and substance abuse clinics, and private practice

School Psychologist

School psychologists are specifically licensed to provide psychological evaluation and treatment for emotional and behavioral problems and disorders in a school setting. Unlike clinical psychologists, school psychologists typically do not have a PhD. School psychologists are regulated by the Virginia Board of Psychology.

Education/training: MA with an endorsement in psychology

Where found: Public and private schools, special education residential schools, special education day schools, and therapeutic day treatment centers

Licensed Professional Counselor (LPC)

Licensed professional counselors (LPCs) are licensed to provide individual, group, family, and couples counseling. LPCs must obtain supervised clinical experience and must pass a state licensing exam. LPCs are regulated by federal and state laws, as well as their own code of ethics as developed by various national organizations such as the American Counseling Association. Not all counselors are LPCs. LPCs are regulated by the Virginia Board of Counseling.

Education/training: MA or MS, 3,400 hours of supervised residency in counseling practice, including 2000 hours of face-to-face contact with clients

Where found: Residential treatment centers, community services boards, private outpatient mental health, and substance abuse clinics

Licensed Marriage and Family Therapist (LMFT)

Licensed marriage and family therapists (LMFTs) are licensed to provide therapy in the context of family and marital relationships. These professionals are trained in the assessment and treatment of cognitive, affective, or behavioral, mental, and emotional disorders within the context of marriage and family systems through the

application of therapeutic and family systems theories and techniques. LMFTs are regulated by the Virginia Board of Counseling.

Education/training: MA or MS, 3,400 hours of supervised residency in marriage and family therapy practice including 2000 hours of face-to-face contact with clients

Where found: Community services boards, private outpatient mental health and substance abuse clinics, and private practices

Licensed Clinical Social Worker (LCSW)

Licensed Clinical Social Workers (LCSWs) are professionally qualified at the autonomous practice level to provide direct diagnostic, preventive, and treatment services that may include psychotherapy and counseling for mental disorders, substance abuse, marriage and family dysfunction, and problems caused by social and psychological stress or health impairment. LCSWs are regulated by the Virginia Board of Social Work.

Education/training: MSW or DSW, supervised experience in a treatment setting

Where found: Local social service agencies, hospitals (both regular and psychiatric), residential treatment centers, group homes, community services boards, and private outpatient mental health and substance abuse clinics

Licensed Social Worker

Licensed Social Workers are trained to provide diagnostic, preventive, and treatment services, but on a supervised rather than independent basis. Licensed social workers are regulated by the Virginia Board of Social Work.

Education/training: BA or MSW; supervised experience in a treatment setting

Where found: Local social service agencies, hospitals (both regular and psychiatric), residential treatment centers, group homes, community services boards, private outpatient mental health, and substance abuse clinics

SPECIALIZED THERAPEUTIC SERVICES

Certified Sex Offender Treatment Provider (CSOTP)

Certified sex offender treatment provider (CSOTPs) are mental health professionals from the disciplines of counseling, social work, psychology, nursing, or medicine who have received specialized training in sex offender evaluation and treatment. CSOTPs are regulated by the Virginia Board of Psychology.

Education/training: MA, PhD, PsyD, MD, or DO; 50 hours of training in sex offender treatment, 2000 hours of post-degree clinical experience in assessment/treatment with at least 200 hours with sex offender clients

Where found: Residential treatment centers, therapeutic group homes, community services boards, and private outpatient mental health clinics

Certified Substance Abuse Treatment Practitioner

Certified substance abuse treatment practitioners are licensed to provide advanced substance abuse treatment and independent, direct, and unsupervised treatment to such individuals or groups of individuals, and to plan, evaluate, supervise, and direct substance abuse treatment provided by others. Certified substance abuse treatment practitioners are regulated by the Virginia Board of Counseling.

Education/training: MA or MS, additional coursework, and a supervised residency in substance abuse treatment

Where found: Inpatient substance abuse treatment centers, community services boards, private outpatient mental health, and substance abuse clinics

Certified Substance Abuse Counselor (CSAC)

Certified Substance Abuse Counselors (CSACs) are certified to perform substance abuse treatment functions, which generally include screening, intake, orientation, assessment, recovery, relapse prevention planning, substance abuse treatment, and case management. However, CSACs must practice under the supervision of a licensed substance abuse treatment practitioner or another licensed mental health professional unless they hold another license for independent practice or are working in an exempt setting. CSACs may also supervise certified substance abuse counseling assistants. CSACs are regulated by the Virginia Board of Counseling.

Education/training: BA, additional coursework, and supervised experience in substance abuse treatment

Where found: Inpatient substance abuse treatment centers, community services boards, private outpatient mental health, and substance abuse clinics

Certified Substance Abuse Counseling Assistant

Certified Substance Abuse Counseling Assistants are certified to perform the substance abuse treatment functions of orientation, implementation of substance abuse treatment plans, case management, substance abuse or dependence crisis intervention, record keeping, and consultation with other professionals. Certified substance abuse counseling assistants may participate in recovery group discussions, but they cannot engage in counseling with either individuals or groups or engage in independent or autonomous practice. They act under the supervision of a certified substance abuse counselor or other licensed mental health professional. Certified Substance Abuse Counseling Assistant are regulated by the Virginia Board of Counseling.

Education/training: High school diploma or equivalent, 300 hours of substance abuse treatment education and experience, including 180 hours of supervised substance abuse tasks with clients

Where found: Inpatient substance abuse treatment centers, community services boards, private outpatient mental health, and substance abuse clinics.

TERMS USED IN VIRGINIA'S MENTAL HEALTH DELIVERY SYSTEM

*A list of **Commonly Used Acronyms and Abbreviations** appears at the end of this chapter.*

504 Plan – An individualized plan developed for a student with a disability that specifies what accommodations and/or services they will get in school to "level the playing field" so that they may derive as much benefit from their public educational program as their nondisabled peers. The plan follows from the requirements of Section 504 of the Rehabilitation Act of 1973. Section 504 applies to all public entities receiving federal monies or federal financial assistance. Students with disabilities that qualify them for an **individualized education program** (IEP) under the **Individuals with Disabilities Act** (IDEA) cannot also have a 504 plan.

adjustment disorder – A disorder that occurs when a child experiences emotional and behavioral symptoms that are clearly in response to an identifiable stressor or stressors. *See "Adjustment Disorders" section.*

anecdotal evidence – An informal account of evidence, often in the form of hearsay. For instance, when a patient reports he or she feels better after taking a drug, this is anecdotal evidence that the drug is effective. Anecdotal evidence has less authority than scientific evidence and is not used to support **evidence-based** treatments or practices.

anticonvulsant – A drug designed to prevent the seizures or convulsions typical of epilepsy or other convulsant disorders. Anticonvulsant medicines are also used to treat **bipolar disorder** and other disorders.

anxiety disorders – Disorders characterized by worries or fears that cause significant impairment in the child's functioning. When fears do not fade and begin to interfere with daily life and activities, an anxiety disorder may be present. *See "Anxiety Disorders" section.*

anorexia nervosa – An eating disorder characterized by low body weight (less than 85% of normal weight) distorted body image, and an intense fear of gaining weight. *See "Feeding and Eating Disorders" section.*

antidepressants – Medications used in the treatment of **depression** and other psychiatric disorders. Includes **SSRIs**, **SNRIs**, and **tricyclic antidepressants**.

antipsychotics – Medications used to treat **psychotic** symptoms, such as **hallucinations**, bizarre behavior, and **delusions**. There are two classes of antipsychotics. *Neuroleptics* (e.g., Hadol) are older (typical) antipsychotic medications. *Atypical antipsychotics* (e.g., Seroquel) are a newer class of antipsychotics that have fewer side effects and are sometimes used in an **off-label** capacity to treat nonpsychotic symptoms such as aggression.

Asperger's syndrome – A type of **pervasive developmental disorder** (PDD) characterized by the presence of impairments in social interaction like those observed in autism, but without the significant delay in language or cognitive behavior. The diagnosis of Asperger's syndrome was eliminated in 2013 and the disorder was

combined with other autism-related disorders under the umbrella term **autism spectrum disorder**. Research studies and clinicians may still use the term Asperger's syndrome. *See "Autism Spectrum Disorder" section.*

assessment – A professional review of a child's and family's needs conducted when they first seek services from a health care professional. It typically includes a review of physical and mental health, intelligence, school performance, family situation, **social history**, and behavior in the community.

assessment tool – A standardized and scientifically validated tool (such as a questionnaire) used to assist a health professional in diagnosing disorders during the assessment process. Many assessment tools require specific training in order to be conducted and scored correctly. Assessment tools usually have formal titles, such as the Eating Disorder Examination Questionnaire (EDE-Q).

attention-deficit/hyperactivity disorder (ADHD) – A **neurodevelopmental disorder**, usually first diagnosed in childhood, that is characterized by inattention, impulsivity, and in some cases, hyperactivity. *See "Attention-Deficit/Hyperactivity Disorder" section.*

atypical antipsychotics – see **antipsychotics**

autism spectrum disorder (ASD) – A complex **neurodevelopmental disorder** that is typically diagnosed during childhood. ASD is marked by two main characteristics: 1) persistent deficits in social communication and social interaction, and 2) restricted, repetitive behaviors, interests, and activities. Symptoms and characteristics of ASD are varied, both in scope and severity. *See "Autism Spectrum Disorder" section.*

behavior modification therapy – A form of **psychotherapy** in which a therapist analyzes a person's problematic behavior in terms of what reinforces or punishes that behavior. The behavioral therapist will systematically alter the reinforcers or punishers to help the person to change his or her behaviors. Behavior therapy has been adapted over the years into a type of therapy called **cognitive behavioral therapy** (CBT), which looks at the role of both thinking (cognition) and behavior in the context of human problems.

behavioral classroom management (BCM) – Teacher-implemented behavior modification strategies, including reward programs, point systems, and time-outs.

behavior intervention plan (BIP) – In educational settings, a formalized plan designed to address a student's problem behaviors by teaching and rewarding positive behaviors (if possible). BIPs are usually appended to a student's **individualized educational program**. A public school must attempt such a plan before changing a student's placement to a more restrictive environment (unless there is an emergency situation). A BIP should also detail the environmental or proactive changes the staff will make to decrease the likelihood of the undesirable behavior or symptom. BIPs should be preceded by a functional behavioral **assessment**.

behavioral health authorities (BHAs) – Agencies functioning in the same capacity and operating under the same requirements as **community services boards**. There is one behavioral health authority in Virginia.

behavioral parent training (BPT) – A technique for teaching management and discipline skills to parents so that treatment can continue in the home.

beta-blocker – a type of medication that inhibits the action of beta-adrenergic receptors, slowing cardiac and respiratory functions and constricting blood vessels. Beta-blockers are of value in the treatment of hypertension,

cardiac arrhythmias, and migraine. In psychiatry, they are used in the treatment of aggression and violence, anxiety-related tremors, **lithium**-induced tremors, **social phobias**, **panic** states, and alcohol withdrawal.

binge eating disorder (BED) – A disorder resembling **bulimia nervosa** that is characterized by episodes of uncontrolled eating (or bingeing). It differs from bulimia, however, in that its sufferers do not purge their bodies of the excess food. *See "Feeding and Eating Disorders" section.*

bipolar disorder – A mood disorder causing a person's moods to swing between states of **depression** (low mood and energy) and **mania** (heightened mood and energy). *See "Bipolar and Related Disorders" section.*

borderline personality disorder (BPD) – A pattern of behavior characterized by impulsive acts, intense but chaotic relationships with others, identity problems, and emotional instability.

bulimia nervosa (BN) – A pattern of behavior in which the individual eats excessive quantities of food and then purges the body by using laxatives, enemas, diuretics, vomiting, and/or exercising. *See "Feeding and Eating Disorders" section*.

case management – A service that assists children and their families in identifying and accessing services that meet their individual needs. The primary purpose of case management is to ensure that the needed services are delivered in an effective and efficient manner. The activities of a case manager may include identifying and reaching out to individuals in need of assistance, assessing needs and planning services, linking the individual to supports and services, coordinating services with other providers, monitoring service delivery, and advocating for these children in response to their changing needs. Case management services are typically provided by **community services boards**, private clinics, and social services agencies. A **case manager** is a health care professional or social worker who works directly with clients, coordinates various activities, and acts as the clients' primary contact with other members of the treatment team.

catatonia – A cluster of motor features that includes rigid posture, fixed staring, and stupor. Catatonia manifests in a variety of mental health disorders.

cerebral cortex – The outer layer of the brain. The cerebral cortex plays a key role in thought, planning, memory, attention, perceptual awareness, language, and consciousness. Also referred to as the cortex.

children's advocacy center – A facility used in the investigation of child abuse cases and treatment of victims. A children's advocacy center is a child-friendly and safe environment designed to be supportive of children who are victims of child abuse.

Children's Services Act (CSA) – Formerly the Comprehensive Services Act, a Virginia law that created a collaborative system in which state and local agencies work together and draw on the same pool of funds to plan and provide services for at-risk youth. The purpose of the Act is to provide high quality, child-centered, family-focused, cost effective, community-based services to high-risk youth and their families. The two primary teams that operate under the CSA are **Family Assessment and Planning Teams** (FAPTs) and **Community Policy and Management Teams** (CPMTs).

clinical trials or studies – Research studies designed to test how well new medical approaches work and to answer scientific questions about better ways to prevent, screen for, diagnose, or treat a disease. They may also

compare a new treatment to a treatment that is already available. Every clinical trial has a protocol or action plan, that describes the trial's goal and how it will be conducted. An independent committee of physicians, statisticians, and members of the community must approve and monitor the protocol and ensure that risks are worth the potential benefits. Most clinical trials are **double-blind studies**.

cognitive behavioral therapy (CBT) – A form of **psychotherapy** that helps people learn to change inappropriate or negative thought patterns and behaviors. The goal is to recognize negative thoughts or mind-sets (mental processes such as perceiving, remembering, reasoning, decision making, and problem solving) and replace them with positive thoughts or thoughts that better reflect reality, which can lead to more appropriate and beneficial behavior. For instance, cognitive behavioral therapy tries to replace thoughts that lead to low self-esteem ("I can't do anything right") with reality-based positive expectations ("I do many things right and can do this right, too").

cognitive impairment – A term that describes poor mental function that affects the ability to think, concentrate, formulate ideas, reason, and remember.

community-based care – Care and support rendered outside the institutional setting. Treatment is provided where the child lives, goes to school, and plays.

community policy and management teams (CPMTs) – These are teams that operate under the **Children's Services Act** to coordinate agency efforts, manage available funds, and see that eligible youths and their families get the assistance they need. CPMTs coordinate long-range, community wide planning that ensures that resources and services needed by children and families are developed and maintained in communities. CPMTs establish policies governing referrals and reviews of children and families to the **family assessment and planning teams** (FAPTs). Each CPMT establishes and appoints one or more FAPTs based on the needs of the community. CPMTs also authorize and monitor the use of funds by each FAPT. The CPMT includes a representative from the following community agencies: **community services boards**, **Juvenile Court Services Unit**, Department of Health, Department of Social Services, and the local school division. The team also includes a parent representative and a private provider organization representative for children or family services, if such organizations are located within the locality.

community services boards (CSBs) – These agencies serve as the single point of entry into the publicly-funded mental health system. They provide comprehensive mental health, intellectual disability, and substance abuse services. There are 39 CSBs throughout Virginia. Because these agencies are affiliated with local governments, there is tremendous variation in the number and types of services offered by each. However, CSBs usually provide certain core services: **crisis intervention services**, local **inpatient services**, **outpatient services**, **case management**, day support, **residential services**, and **early intervention services**.

comorbidity – A condition in which an individual has a co-occurring disorder. In mental health, the term *dual diagnosis* is typically used if the co-occurring disorder is a substance-related disorder (e.g., opioid use disorder and **depression**) or a **neurodevelopmental disorder** (e.g., **ADHD** and **bipolar disorder**).

compulsions – In terms of children's mental health, a compulsion is a repetitive behavior (such as hand washing) or mental act (such as praying or counting) that a child is driven to complete. Compulsive acts are often used to reduce anxiety or distress, though there is no connection between the act and the distress. See **obsessions**.

conduct disorder (CD) – Children with CD exhibit persistent and critical patterns of misbehavior. These children may indulge in frequent temper-tantrums like children with **oppositional defiant disorder** (ODD); however, they also violate the rights of others. *See "Disruptive, Impulse Control & Conduct Disorders" section.*

contingency management strategies – Strategies that use reward systems designed to provide reinforcements to increase desired behaviors, such as following directions or taking turns.

continuum of care – The delivery of healthcare provided over a period of time. Continuum of care typically describes the process of guiding the patient through various stages of care and tracking and managing needs and progress.

contraindicated – To indicate the inadvisability of a medical treatment.

co-occurring disorder – See **comorbidity**.

cortex – See **cerebral cortex**.

correlation vs. causal relationship – These terms are used in scientific research to describe the relationship between variables. When two variables have a causal relationship, research has shown that one variable causes the other. When two variables have a correlation, research has shown that they tend to occur together, but that one does not necessarily cause the other. For instance, research has proven that cigarette smoking causes lung cancer (causal relationship). Studies have also found a correlation between lung cancer and poverty. This does not mean that poverty itself causes lung cancer, only that those living in poverty are more likely to develop lung cancer.

cortisol – A hormone produced in the presence of stress.

court service units (CSU) – Local agencies operated by the Department of Juvenile Justice that serve as gatekeepers for children and families served by the local Juvenile and Domestic Relations Court. These units are responsible for handling petitions, intakes, investigations and reports, custody investigations, and probation supervision.

crisis intervention (emergency) services – 24-hour services that may be provided in either residential or nonresidential settings. These are short term interventions designed for children and adolescents who experience periodic crisis or **acute** episodes that require special services. The underlying goal of these services is to assist the child and family in resolving the situation so that **inpatient hospitalization** is unnecessary. Nonresidential crisis services include telephone hotlines, walk-in crisis intervention services, mobile crisis outreach services, and intensive **home-based interventions**. Residential services include runaway shelters, crisis stabilization units, and temporary placements in programs such as **therapeutic foster care** and crisis **group homes**.

cultural competence – A term that refers to improving the effectiveness of services through being sensitive and responsive to the cultural norms of the client. Culturally competent service providers are aware of the impact of their own culture and possess skills that help them to provide services that are culturally appropriate in terms of the values, customs, and beliefs of their client's culture. (A person can identify with a culture based on race, ethnicity, nationality, religion, sexual orientation, class, and so forth.)

cycling – A repeated, sequential event that can increase or subside. This term is often used in reference to mood swings. A patient who is experiencing rapid cycling has had at least four **manic**, **hypomanic**, or major **depressive bipolar** mood episodes in the previous 12 months. Full or partial remissions must occur for at least two months between episodes unless there is a change in polarity (i.e. from a manic to a major depressive episode). *See "Bipolar and Related Disorders" section.*

cyclothymic disorder – A mild form of **bipolar disorder** that causes emotional ups and downs.

daily report card – One strategy of **behavioral classroom management** that provides feedback to parents and/or the therapist about a child's progress in achieving target behaviors.

day treatment services – See **therapeutic day treatment**.

delusion – A fixed false belief that is resistant to reason or confrontation with actual fact. Delusions can be either bizarre (a belief that cannot possibly be true) or non-bizarre (a belief that could be true in other circumstances).

Department of Behavioral Health and Developmental Services (DBHDS) – DBHDS is the governmental entity in Virginia that administers services for individuals with mental illnesses, developmental disabilities, or addiction issues. Formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the Department's name was changed by the 2008 Virginia General Assembly.

depression – Depression is characterized by extreme and lasting feelings of sadness, lack of self-worth, irritability, fatigue, and other emotional and physical symptoms. *See "Depressive Disorders" section.*

developmental disability – A disability that originated at birth or during childhood that is characterized by a disruption of normal development. When development of the brain or central nervous system is affected, these disabilities are referred to as **neurodevelopmental disorders**.

Diagnostic and Statistical Manual of Mental Disorders – Official manual listing psychiatric and psychological disorders, published by the American Psychiatric Association and recognized by both mental health professionals and the insurance industry as the primary authority for the diagnosis of mental disorders. The latest revision was the *DSM Fifth Edition (DSM-5) (2013),* which replaced the *DSM Fourth Edition, Text Revision (DSM-IV-TR) (2000).*

dialectical behavioral therapy (DBT) – A cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients.

disassociation – A mental process in which a person consciously or unconsciously detaches (or disassociates) his or her thought processes about an experience from the emotions those experiences provoke. Disassociation can be an unhealthy coping strategy for dealing with **traumatic experiences** and/or a symptom of a mental health disorder.

discharge plan – A document that summarizes information pertaining to a person's stay in a health care facility and identifies what needs to occur post-discharge.

disinhibition – A lack of restraint with impulsivity driven by current thoughts or feelings without regard to consequences. Unconscious disinhibition can be a symptom of a mental health disorder.

disruptive disorders – These disorders are the most common reasons children are referred for mental health evaluations and treatment. Disruptive disorders include mental health problems, with a focus on behaviors that both identify emotional problems and create interpersonal and social problems for children and adolescents in the course of their development. **Conduct disorder** and **oppositional defiant disorder** are two classes of disruptive disorders. *See "Disruptive, Impulse Control & Conduct Disorders" section.*

disruptive mood dysregulation disorder – A new diagnosis to the **DSM-5**, this disorder applies to children up to age 18 who exhibit persistent irritability and frequent episodes of extreme inability to control their behavior.

dopamine – A **neurotransmitter** associated with attention, learning, and pleasure.

double-blind study – A scientific study in which neither the researchers nor the participants know details about the treatment received, including which participants received placebos. The goal of a double-blind study is to prevent bias or other factors to affect results.

DSM-5 – See ***Diagnostic and Statistical Manual of Mental Disorders.***

dual diagnosis – See **comorbidity**.

dysthymia – See **persistent depressive disorder (dysthymia)**.

early intervention services – Services intended to improve functioning or change behavior in children identified as experiencing problems, symptoms, or behaviors. The goal is to improve the child's behaviors in order to prevent a future need for more extensive treatment. This approach also includes infant and toddler intervention, which provides family-centered, **community-based** early intervention services designed to meet the developmental needs of infants and toddlers and their families to enhance the child's development and to prevent or minimize the potential for developmental delays. These types of services are most often provided by social service agencies, **community services boards**, pediatricians and nurses in health clinics, and schools.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – Medicaid's comprehensive and preventive child health program for individuals under the age of 21. The EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. Services include health and developmental history screening, immunization, nutritional status assessment, vision and hearing testing, dental services for children three years and older, and visual treatment including eyeglasses.

electroconvulsive therapy (ECT) – A treatment usually reserved for very severe or **psychotic depressions** or **manic** states that are not responsive to medication treatment. A low-voltage electric current is sent to the brain of an anesthetized patient to induce a convulsion or seizure, which has a therapeutic effect.

evidence-based – Treatments that have undergone scientific evaluation and are proven to be effective.

excoriation (skin-picking) disorder – A new **DSM-5** disorder characterized by recurrent skin picking resulting in skin lesions. *See "Obsessive-compulsive and Related Disorders" section.*

executive functioning – An umbrella term for the cognitive skills involved in mental control and self-regulation.

exposure therapy – A form of **psychotherapy** in which a patient is deliberately exposed, under controlled conditions, to the problem or event that triggers psychological problems, with the aim of reducing the impact of the triggering event.

Family Access to Medical Insurance Security (FAMIS) – Virginia's Title XXI Plan that helps families provide health insurance to their children.

family assessment and planning teams (FAPTs) – Local teams that operate through the **Children's Services Act**. The purpose of the team is to assess the strengths and needs of troubled youths and families who are approved for referral to the team, and identify and determine the services that are necessary to meet these unique needs. They are responsible for developing an individual family services plan (IFSP) for appropriate and cost-effective services, and for monitoring the child's progress under this plan.

family preservation services – See **home-based services**.

family support services – Services that are designed to assist families in dealing with the pressures and demands of raising children with severe emotional disturbance. A variety of services are provided to assist families in achieving balanced lives, including **respite care**; family **self-help**, support, advocacy groups, and assistance with financial or family survival needs (food, housing, transportation, home maintenance). Family support services may also include providing caregivers with the necessary education, information, and referrals to ensure that they are informed decision-makers. These services are typically provided by social service agencies, **community services boards**, and private agencies and organizations.

family systems therapy – A form of **psychotherapy** that focuses on how a child interacts with his/her most important social environment, the family. The underlying premise of the therapy is that the child's problems are best understood by observing how they fit into the larger scheme of relationships among the members of the family group.

fetal alcohol syndrome – A condition affecting the children of mothers who consume large quantities of alcohol during pregnancy; it can involve **cognitive impairment** or delays, attention difficulties, and physical and emotional disability. Deficits range from mild to severe, including growth retardation, brain damage, **intellectual disability**, anomalies of the face, and heart failure.

Free Appropriate Public Education (FAPE) – A statutory requirement that children with disabilities receive a public education appropriate to their needs, at no cost to their families.

functional family therapy (FFT) – A family-based prevention and intervention program that combines and integrates established clinical therapy, empirically supported principles, and extensive clinical experience.

generalized anxiety disorder – A mental disorder characterized by chronic, excessive worry and fear that seems to have no real cause. Children or adolescents with generalized anxiety disorder often worry a lot about things

such as future events, past behaviors, social acceptance, family matters, their personal abilities, and/or school performance. *See "Anxiety Disorders" section.*

group homes – See **therapeutic group homes**.

habit reversal therapy – Includes awareness training, competing response training, and social support. *See "Motor Disorders" section.*

halfway houses – See **therapeutic group homes**.

hallucinations – A strong perception of an event or object when no such situation is present; may occur in any of the senses (i.e., visual, auditory, gustatory, olfactory, or tactile).

hoarding disorder – The ongoing inability to discard or part with possessions, regardless of the value attributable by others. Hoarding may cause emotional, financial, legal, and physical harm to the affected individual as a result of the disorder. *See "Obsessive-compulsive and Related Disorders" section.*

home-based services (family preservation services) – Services typically provided in the residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned back into the home from an out-of-home placement. The treatments are family-focused and involve working within the home environment to preserve the family structure. The services may include crisis treatment, intensive **case management**, individual and family counseling, skill building (life, communication, and parenting), 24-hour emergency response, and assisting in obtaining and coordinating needed services, resources, and supports. Services vary based on the goals of the program and the needs of the family. The services tend to be of short duration (1 to 3 months) but highly intensive (5 to 20 hours per week). They are usually provided only when other interventions have proven unsuccessful. They are typically offered through child welfare agencies, **community services boards**, mental health centers, hospitals, juvenile justice agencies, or **private providers**.

independent living services – Programs specifically designed to help adolescents make the transition to living independently as adults. They provide training in daily living skills (financial, medical, housing, transportation) as well as vocational and job training. They are offered by **therapeutic group homes**, **residential treatment centers**, **day treatment programs**, **community services boards**, and private clinics.

individualized educational program (IEP) – A plan developed by parents, teachers, school administrators, and the student to meet the unique educational needs of a student with a disability; covered under the Individuals with Disabilities Act (IDEA). The plan should describe the services that are to be provided by the school system within the context of the educational program and contain specific objectives and goals. Students with an IEP cannot also have a **504 Plan**.

Individuals with Disabilities Act (IDEA) – Federal law mandating that a free and appropriate public education be available to all school-age children with certain disabilities. Students covered under IDEA must develop an individualized educational program (IEP) to receive services. Also known as Public Law 105-17.

inpatient hospitalization – Services provided on a 24-hour basis in a hospital setting. Tends to be reserved for children with difficult and ongoing problems. Inpatient hospitalization programs use a variety of interventions, including individual, group, and family therapy, medication management, and **behavior modification**.

intellectual disability – Previously termed *mental retardation,* intellectual disability is characterized by both a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, and getting along in social situations and school activities. *See "Intellectual Disability" section.*

intensive outpatient therapy (IOP) – A form of **partial hospitalization** that is more intense than regular once-per-week outpatient therapy and less intense than full **inpatient hospitalization**. Patients often participate in therapy several days per week for several hours at a time. This type of treatment is typically shorter in duration than most partial hospitalization programs.

intermediate care facility – An institution that provides health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under Title XIX (**Medicaid**) of the Social Security Act.

intermediate care facilities for persons with mental retardation (ICF/MR) – Facilities providing a community-based residential setting for individuals with **intellectual disability** who also have severe medical needs. They offer rehabilitative services designed to maximize independence and enhance the resident's quality of life. They provide residential care, skilled nursing, and specialized training, and may include training programs in language, self-care, independent living, socialization, academic skills, and motor development. While ICF/MRs most often serve adults, adolescents can sometimes be placed in these programs.

interpersonal therapy – A form of **psychotherapy** that focuses on improving interpersonal skills by exploring the relationships that the patient has with others. Patients learn to evaluate their interactions with others and to become aware of self-isolation and social difficulties.

juvenile correctional center (JCC) – A secure residential facility operated by the Virginia Department of Juvenile Justice. Juvenile offenders are committed to the JCC by the Juvenile and Domestic Relations District Courts and Circuit Courts for rehabilitation and confinement. This facility provides programs to address the treatment, disciplinary, medical, and recreational needs of the juveniles.

juvenile sex offender – Juvenile perpetrating sex offense(s) by committing any sexual act against the victims' will, without consent, or in an aggressive, exploitive, or threatening manner. *See "Sexual Offending" section.*

lithium – A type of mood stabilizing medication.

major depressive disorder – A disorder characterized by one or more major episodes of **depression** without a history of **mania**. *See "Depressive Disorders" section.*

mandated – In terms of children's mental health, required by law. This designation can refer to children receiving funding under the **Children's Services Act**. State and local governments are required by law to appropriate sufficient funds for services for these youth. Children and adolescents who fall within this category are generally those who receive individualized services from the education and foster care systems.

mania – A distinct period of abnormally and persistently elevated, expansive, or irritable mood. *See "Bipolar and Related Disorders" section.*

massed negative practice – One of the most frequently used **behavioral therapy** techniques in the treatment of children with **tic disorder,** in which the individual is asked to deliberately perform the tic movement for specified periods of time interspersed with brief periods of rest.

Medicaid – The federal program (Title XIX of the Social Security Act) that pays for health services for certain categories of people who are poor, elderly, blind, disabled, pregnant, or caretaker relatives of children under the age of 18, and who meet financial eligibility criteria.

Medicaid Waiver Program – In Virginia, individuals with disabilities may be eligible to receive services via Medicaid Home and Community-Based (HCBS) waivers. Medicaid HCBS waivers provide opportunities for individuals eligible for an institutional level of care to receive services in their own home or community rather than an institutional setting. Eligible individuals are screened for the waiver by their local community services board. If the child is found eligible for the waiver, the parent would "waive" the child's right to receive services in an institution and choose instead to receive services in the community. More information about Virginia's Medicaid waivers can be found on the Virginia Department of Behavioral Health and Development Services (DBHDS) website.

Medicare – The federal health insurance program for people who are 65 or older.

mental retardation – See **intellectual disability**.

mood stabilizer – Medication used in the treatment of **bipolar disorder** to suppress swings between **mania** and **depression**. Lithium is a commonly-used mood stabilizer.

multidimensional family therapy (MDFT) – An outpatient, family-based treatment for teenagers with serious substance abuse issues. This approach views drug use in terms of network of influences (individual, family, peer, community) and encourages treatment across settings in multiple ways. Sessions may be held in a clinic, home, court, school, or other community locations. *See "Substance Use Disorders" section.*

multisystemic therapy (MST) – An integrative, family-based treatment with focus on improving psychosocial functioning for youth and families so that the need for out-of-home placements is reduced or eliminated.

neurodevelopmental disorders – A group of disorders in which the development of the brain or central nervous system has been disturbed in early development. This disruption causes impairment in physical, learning, language, or behavior areas, may impact day-to-day functioning, and can cause **developmental disabilities** that can last throughout a person's lifetime.

neurofeedback – A type of biofeedback. Neurofeedback involves learning to consciously control mental and physical functions that are usually thought to be involuntary, such as symptoms of a mental disorder. The procedure uses electronic equipment to monitor brain activity and convert the measurement into a signal that a person can easily perceive, usually via a computer monitor. The person can then attempt to use conscious control to alter the signal.

neuroleptics – See **antipsychotics.**

neuropsychiatry – A branch of medicine that deals with mental disorders attributed to diseases or disorders of the brain and nervous system, including **neurodevelopmental disorders**.

neurotransmitters – In the brain, these chemicals transfer messages from one nerve cell to another and affect mood.

non-mandated – In children's mental health services, this means not required by law. This designation is given to youths who are referred for services under the **Children's Services Act** for which the Commonwealth is not required to provide complete funding. Children and adolescents who fall into this category are generally referred for treatment by the juvenile justice or mental health systems.

norepinephrine – A **neurotransmitter** that regulates blood pressure by causing blood vessels to narrow and the heart to beat faster.

obsessions – Unwanted ongoing urges or thoughts that cause anxiety and stress. Some individuals try to ignore or suppress obsessions by completing other thoughts or actions, which can become **compulsions.**

obsessive-compulsive disorder (OCD) – A disorder in which a person has an unreasonable thought, fear, or worry that he/she tries to manage through a ritualized activity to reduce the anxiety. Frequently occurring disturbing thoughts or images are called **obsessions**, and the rituals performed to try to prevent or dispel them are called **compulsions**. *See "Obsessive-Compulsive and Related Disorders" section.*

off-label use – The legal practice of prescribing a medication in a way that was not originally intended by the manufacturer.

Office of Juvenile Justice and Delinquency Prevention (OJJDP) – A federal agency within the U.S. Department of Justice that coordinates and provides resources to states and communities pertaining to the juvenile justice system.

oppositional defiant disorder (ODD) – An enduring pattern in children of uncooperative, defiant, and hostile behavior to authority figures that does not involve major antisocial violations. *See "Disruptive, Impulse-Control, and Conduct Disorders" section.*

outpatient psychiatric services – Services provided to individuals, groups, or families on an hourly schedule. Outpatient services are the most frequently used treatment method for children, and may either be provided for a short term (6 to 12 sessions) or a longer duration (a year or longer). Services are generally provided on a weekly basis, if not more often, depending on the individual needs of the child and family. However, under managed care and most insurance plans, brief therapy is likely to be mandated. It is the least restrictive form of service for children and families, and it is provided in a number of settings, including **community services boards**, outpatient psychiatry departments of hospitals, and private offices. It is most often provided by psychiatrists, psychologists, social workers, and counselors. Treatment efforts may include diagnosis and evaluation, intake and screening, counseling, **psychotherapy**, **behavior management**, psychological testing and **assessment**, and medication management.

panic attack – A distinct period of unexpected terror. Symptoms like shortness of breath, pounding heart, and fear of losing control may accompany the attack, which may be expected or a surprise. Panic attacks are sometimes mistaken for heart attacks or other health problems by the person experiencing the attack. **Panic disorder** is characterized by recurrent, unexpected panic attacks. Panic disorder is separate from **agoraphobia** in the **DSM-5**.

partial hospitalization – A form of **therapeutic day treatment** that is based in a psychiatric hospital. It provides the use of a psychiatric hospital setting during the day, with children returning to their home each night. It is frequently used for those children who are being released from a psychiatric hospital and must transition back into the community and the school system. It is also used to assist youths at risk of **inpatient hospitalization**.

pathological – Related to or caused by a mental health disorder or disease.

persistent depressive disorder (dysthymia) – A form of chronic **depression** in which an individual has a persistent depressed mood for more days than not for at least one year and when symptom-free intervals last no longer than two consecutive months. Symptoms of persistent depressive disorder typically are not as severe as those relating to **major depressive disorder**. *See "Depressive Disorders" section.*

pervasive developmental disorders (PDD) – These disorders can usually be identified in the early years of a child's life. Children with PDD have difficulty in areas of development or use of functional skills such as language, communication, socialization, and motor behaviors. In May 2013, the **DSM-5** recategorized pervasive developmental disorders under the umbrella term **autism spectrum disorder**. Research studies and clinicians may still use the term pervasive developmental disorder. *See "Autism Spectrum Disorder" section.*

pharmacotherapy – In mental health, an intervention that involves prescribing **psychotropic medications**.

phobia –An uncontrollable, irrational, and persistent fear of a specific object, situation, or activity. Fear and anxiety related to a phobia are out of proportion with any actual danger related to the object or situation. Also called *specific phobia. See "Anxiety Disorders" section.*

placebo – A pharmacologically inert substance (such as saline solution or a "sugar pill") that replaces a pharmacologically active substance. People can experience a reduction of symptoms or a measurable improvement in health after taking a placebo. This phenomenon is referred to as the placebo effect. Placebos are usually used as part of a **clinical trial** or double-blind study to help measure if a particular drug outperforms the placebo.

plan of care – A treatment plan that identifies the child and family's strengths and needs, establishes goals, and details appropriate treatment and services.

positive behavior support – Re-directive therapy used in the home or school environment that has the goal of helping the youth strengthen communication, social, and self-management skills.

post-traumatic stress disorder (PTSD) – A debilitating condition that often follows a **traumatic** physical or emotional event, causing the person who survived the event to have persistent, frightening thoughts and memories, or flashbacks, of the ordeal. *See "Trauma- and Stressor-Related Disorders" section.*

premonitory urge – A term commonly used to describe early, minor symptoms that precede a major health problem.

premorbid – Preceding the occurrence of disease.

prognosis – The expected outcome or course of a disease, which includes the patient's chance of recovery.

protective factor – See **risk and protective factors**.

prevention services – Services that promote families, communities, and systems working together to reduce the incidence of mental illness and substance abuse disorders and improve the quality of life for those who experience **intellectual** or other **neurodevelopmental disabilities**. Emphasis is on the enhancement of **protective factors and reduction of risk factors**. Activities may include information dissemination, prevention education, and problem identification and referral. Services are most often provided by social service agencies, **community services boards**, pediatricians and nurses in health clinics, and schools.

private inpatient units – Privately-owned hospitals that offer inpatient psychiatric and/or substance abuse services to individuals with severe, **acute** disturbances. They are licensed as hospitals under state regulations.

private residential units – Privately-owned **residential facilities** that provide intensive treatment services to children and adolescents with emotional or mental disorders. They are somewhat less restrictive than **private inpatient units**, but still tend to be highly structured and secure. They should be reserved for children and adolescents in crisis. However, the level of security and restrictiveness tend to vary across facilities.

psychological evaluation – A clinical examination conducted by a mental health professional that is used to determine the nature of a child's psychological difficulties. It often includes an analysis of components of the child's life, such as his/her development, behavior, education, medical history, and family and social relationships. An evaluation usually requires several hours to complete and is often best performed over several sessions, including sessions for the child and parents separately and together. In addition, a full evaluation usually requires the collection of information from a variety of outside sources, such as the school, child's pediatrician, psychological testing, and social service agencies. Psychological evaluations are typically more involved then mental health **assessments**.

psychosis – A disruption of thinking that impairs an individual's perception of reality. Psychosis is frequently associated with the diagnosis of **schizophrenia**.

psychotic – A person experiencing psychosis, or a break with reality. Although a person who is psychotic may also be agitated or aggressive, the term does not imply that the affected person is violent.

psychosocial treatments – Services that focus on the relationship between psychological, environmental, and social factors. These include certain forms of **psychotherapy**, as well as social and vocational training, and they are intended to provide support, education, and guidance to people with mental illnesses and their families. A psychiatrist, psychologist, social worker, or counselor typically provides psychosocial treatments.

psychostimulant – See **stimulant**.

psychotherapy – An intervention that involves regularly scheduled sessions between a patient and a mental health professional, such as a psychiatrist, psychologist, psychiatric social worker, or psychiatric nurse. The goal of this treatment is to help patients understand why they are acting and thinking in ways that are troubling or dangerous to themselves or others so they have more control over their behaviors and can correct them. It is commonly used in the treatment of children and youth with emotional and behavioral problems, either in conjunction with or in place of prescribed medications. This kind of therapy has many forms, including psychodynamic, **behavioral**, **cognitive-behavioral**, **interpersonal**, **supportive**, and **family systemic**.

psychotropic medications – Prescribed drugs that affect an individual's mental state. Psychotropic drugs are prescribed to reduce the symptoms of biologically based psychological disorders.

purging – A destructive pattern of ridding the body of excess calories (to control weight) by vomiting, abusing laxatives or diuretics, taking enemas, and/or exercising obsessively. Occurs most frequently in individuals suffering from **bulimia nervosa**. *See "Feeding and Eating Disorders" section.*

pyromania – A rare disorder characterized by an irresistible impulse to start fires. *See "Disruptive, Impulse Control & Conduct Disorders" section.*

randomized trial – A type of **clinical trial** in which the participants are assigned randomly (by chance alone) to different treatments.

reactive attachment disorder – A disorder characterized by serious problems in emotional attachments to others that usually presents by age five and that can be caused by **trauma** and/or neglect. *See "Trauma- and Stressor-Related Disorders" section.*

residential services – Services that provide overnight care in conjunction with intensive treatment or training programs. They are typically provided in psychiatric hospitals, residential treatment centers (RTCs), and **therapeutic foster homes**.

residential treatment center (RTC) – 24-hour facilities providing short-term intermediate care, crisis stabilization, and intensive mental health treatment programs. They are not licensed as hospitals and serve as an alternative to **inpatient psychiatric hospitalization**. The settings vary, with some being highly structured like psychiatric hospitals, and others being similar to **group homes** or halfway houses. They also vary in the range of services they offer, as some offer a full range of treatment services, while others are more limited or specialized. While these facilities were originally designed to serve as long-stay institutions, under managed care they are serving youth for periods as brief as one month only as a source for intensive evaluation and stabilization.

respite care – A type of **family support service**. Parents are given relief from childcare by either placing the child with another family or bringing a caretaker into the home for a few days. This service is usually provided on a planned basis under circumstances in which either there has been a prolonged crisis during which time the child has exhausted the family resources, or there has been another family crisis, such as illness or death of another family member. This service may be provided by **community services boards**, social service agencies, or private clinics.

risk and protective factors – Factors that either increase or decrease an individual's likelihood of developing a disorder or disease. Risk and protective factors are determined through population studies. Exposure to risk or protective factors does not mean that any one individual will definitely contract or avoid contracting a particular disorder or disease.

satiation – The practice of repetitively lighting and extinguishing fire. *See "Juvenile Firesetting" section.*

schizoaffective disorder – A mental health disorder characterized by recurring, alternating episodes of elevated and depressed moods with distorted perceptions.

schizophrenia – A severe, chronic, and disabling disturbance of the brain that causes faulty perception, inappropriate actions and feelings, withdrawal from reality, personal relationships into fantasy and delusion, and a sense of mental fragmentation. *See "Schizophrenia" section.*

screening tool – A brief **assessment tool**, such as a questionnaire, used to identify symptoms of a disorder or other problem. Screening tools are often used to determine if formal assessment is indicated.

secure treatment service – Provision of services for people with mental disorders or serious mental health problems who, based on clinical **assessment**, require treatment in a closed setting to ensure the safety of the person, the staff, and the community. Three levels of treatment are provided: acute inpatient secure treatment, extended secure treatment, and high security treatment.

selective serotonin reuptake inhibitors (SSRIs) – A class of drugs commonly prescribed for treating **depression**. SSRIs work by stopping brain receptor cells from absorbing **serotonin**, an action that allows more of this **neurotransmitter** to be available to be taken up by other cells. SSRIs can improve mood.

self-harm or self-injury – Also known as deliberate self harm, self-inflicted violence, self-injurious behavior, or self-mutilation, self-harm is a deliberate, intentional injury to one's own body that causes tissue damage or leaves marks for more than a few minutes. Self-harm is often done to cope with an overwhelming or distressing situation. *See "Nonsuicidal Self Injury" section.*

separation anxiety disorder (SAD) – Excessive worry and fear about being apart from family members or individuals to whom a child is most attached. Children with separation anxiety disorder fear being lost from their family or fear something bad will happen to a family member if they separated from them. *See "Anxiety Disorders" section.*

serious emotional disturbance (SED) – SED in children ages birth through 17 is defined as a serious mental health disorder that can be diagnosed using **DSM-5** criteria. Many of these disorders are discussed in the *Collection*.

serotonin – A **neurotransmitter** that is thought to affect mood and social behavior, appetite and digestion, sleep, memory, and sexual desire and function.

serotonin and norepinephrine reuptake inhibitors (SNRIs) – A class of drugs commonly prescribed for treating **depression**. SNRIs work by stopping brain receptor cells from absorbing both **serotonin** and **norepinephrine**, an action that allows more of these **neurotransmitters** to be available to be taken up by other cells. Affects mood.

social anxiety disorder (social phobia) – Persistent fear or **phobia** of social situations that involve interacting with other people; fear of being negatively judged and evaluated by others in social situations. Formerly termed *social phobia* in the *DSM-IV*. *See "Anxiety Disorders" section.*

somatization – The process of experiencing mental and emotional stress in a way that manifests as physical symptoms (such as stomach aches or headaches).

special education – Specially designed instruction that adapts, as appropriate, to the needs of a disabled child. Such education must ensure access for the child to the general curriculum, so that he or she can meet the educational standards that apply to all children. This education is to be provided at no cost to the parents and is

implemented under the guidelines of the **Individuals with Disabilities Act** (IDEA), which requires school to identify children with disabilities in need of special education.

special education day schools – A form of **therapeutic day treatment**. These are schools that are specially designed to meet the needs of children with severe behavior disorders who are unable to function at an age-appropriate level in the regular school system. The programs allow for collaboration between teachers and mental health professionals, and provide low student-teacher ratios and additional family services with the ultimate goal of returning the child to the regular school setting.

spectrum – A condition that is not limited to a specific set of values, but that can vary within a continuum.

standards of learning (SOLs) – The outline of the basic knowledge and skills that Virginia children will be taught in grades K-12 in the academic subjects of English, math, science, and social studies.

state mental health facilities – State-run facilities provide a range of psychiatric, psychological, rehabilitative, nursing, support, and other necessary services for children and adolescents with significant and **acute** psychiatric concerns. One facility in the Commonwealth is designated for children and adolescents: the Commonwealth Center for the Treatment of Children and Adolescents.

substance abuse medical detoxification – A form of **inpatient services** in which doctors and other medical personnel use medication to eliminate or reduce effects of alcohol or other drugs in the patient's body. These services are available in local hospitals or other emergency care facilities.

suicidal ideation – Persistent thoughts of suicide or wanting to take one's life. *See "Youth Suicide" section.*

system of care – A method of delivering mental health services that helps children and adolescents with mental health problems and their families get the full range of services in or near their homes and communities. These services must be tailored to each individual child's physical, emotional, social, and educational needs. In systems of care, local organizations work in teams to provide these services.

tardive dyskinesia – An involuntary movement disorder caused by the long-term use of **antipsychotic** drugs.

Temporary Assistance for Needy Families (TANF) – A block grant program designed to make welfare recipients self-sufficient and turn welfare into a program of temporary assistance. TANF replaced the national welfare program, known as Aid to Families with Dependent Children (AFDC), and the related programs, known as the Job Opportunities and Basic Skills Training (JOBS) program and the Emergency Assistance (EA) program. TANF recipients are usually eligible for full Medicaid benefits and include children younger than 18 (or expected to graduate from high school by age 19). One of the child's parents must be dead, absent, disabled, or unemployed. Administered by the VA Department of Social Services and the local DSS.

therapeutic day treatment – An outpatient treatment program that serves children with diagnoses that range from severe emotional disturbance to developmental delay. These services provide an integrated set of psychoeducational activities, counseling, and family treatments that involve the young person for several hours each day. Services typically include **special education**, individual and group counseling, family counseling and training, **crisis intervention**, skill building, **behavior modification**, and recreational therapy. However, the nature of these programs may vary widely due to factors such as setting, the population being served, the intensity of

treatment, the theoretical approach, and the treatment components. The integration of this broad range of services is designed to strengthen both individual and family functioning and to prevent a more restrictive placement of the child. The child is able to receive the benefits of a structured setting while being able to return home at night and continue involvement with family and peers. These services may be offered in regular school settings, **special education day schools**, **community services boards**, and hospitals. Currently, Medicaid is the only third party source that routinely covers this service.

therapeutic foster care – The least restrictive form of **residential treatment**, placing children in private homes with specially trained foster parents. It is typically provided to children and adolescents with emotional or behavioral disturbances. The intent of these programs is to provide treatment within a family context. Children are placed with foster parents who have been carefully selected to work with children with special needs. These parents receive education and training to assist in working effectively with the child, including topics such as active listening, behavioral management and programming, and age-appropriate behavioral expectations. During these placements, efforts are made to provide the biological family with counseling, support, and other types of assistance so that the child can be returned to the home as quickly as possible. Programs tend to differ in approach, structure, intensity, and type of training. Most serve youth from birth to 18 years, with most youth entering during early adolescence.

therapeutic group homes – Facilities that provide emotionally and behaviorally disturbed adolescents with an environment to learn social and psychological skills. These homes are located in the community, and residents attend the local schools. In Virginia, a group home is defined as a community-based, home-like, single dwelling or its acceptable equivalent, other than the private home of the operator, and serves up to 12 residents. An array of services is provided, such as individual **psychotherapy**, group therapy, and/or **behavior modification**. Vocational training and work experiences are typically included as part of the treatment program for adolescents. The amount of structure incorporated into the program varies based on the level of need of the youths served.

tic – A tic is an involuntary, sudden, rapid, recurrent, nonrhythmic motor movement or vocalization. *See "Motor Disorders" section.*

tic disorder – A type of motor disorder that may be classified as a vocal tic, a motor tic, a simple tic, or a complex tic. *See "Motor Disorders" section.*

Title IV-E – The Federal Social Security Act authorizing financial assistance for foster children and for families receiving adoption assistance.

Title V – Title V of the Social Security Act, which became the Maternal and Child Health Services Block Grant in 1981.

Title XVIII – Social Security Act Pertaining to Medicare.

Title XIX – Medicaid. A federally aided, state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. Authorized by Title XIX of the Social Security Act.

Title XXI – The State Children's Health Insurance Program (SCHIP), part of the Social Security Act, that authorizes states to provide health insurance coverage to uninsured children up to 200% of the federal poverty level (FPL). States may provide this coverage by expanding Medicaid or by expanding or creating a state children's health insurance program. **FAMIS** is Virginia's SCHIP program.

Tourette disorder – A disorder characterized by multiple motor **tics** and at least one vocal tic. *See "Motor Disorders" section.*

transitional services – Services that help children leave the system that provides help for children and move into adulthood and the adult service system. Services includes mental health care, **independent living services**, supported housing, vocational services, and a range of other support services.

trauma – Any injury, physical or emotional. A traumatic event is an occurrence that threatens injury, death, or the physical body, or that otherwise causes emotional harm to an individual. Traumatic events often cause feelings of shock, terror, or helplessness. Complex trauma refers to multiple traumatic events experienced by a child that occur within the caregiving system, where safety and stability would be expected. Trauma can cause **post-traumatic stress disorder**. *See "Trauma- and Stressor-Related Disorders" section.*

trauma informed care – Theory of care in which providers understand that trauma impacts children in a variety of ways, recognize those signs in children and their families, and treat both the trauma and resulting symptoms in a way that prevents additional trauma.

trichotillomania (hair-pulling disorder) – A disorder wherein an individual pulls hairs from the body as a response to a stressor. *See "Obsessive-Compulsive and Related Disorders" section.*

tricyclic antidepressants (TCA) – An older class of drugs used in the treatment of clinical **depression** and other disorders. Tricyclic refers to the presence of three rings in the chemical structure of these drugs.

Virginia Independence Program (VIP) – Virginia's welfare reform program.

Virginia Initiative for Education and Work (VIEW) – Work component of the **Temporary Assistance for Needy Families** (TANF) program. Name was changed from "Virginia Initiative for Employment not Welfare" as of July 1, 2019.

waiver – See **Medicaid Waiver Program**.

wraparound services – Child and family-driven services and supports that are **community-based**. They address the child's needs in the home, school, and community, and are developed through collaboration between the child, family, and all of the service providers who provide support to the child. The underlying purpose is to provide services that follow the child as he/she interacts in different environments in the community. The organizations involved in collaboration can include mental health, education, juvenile justice, and child welfare. **Case management** is usually necessary to coordinate services.

COMMONLY USED ACRONYMS AND ABBREVIATIONS

AAA	Area Agency on Aging
AACAP	American Academy of Child & Adolescent Psychiatry
AAIDD	American Association on Intellectual and Developmental Disabilities
AAP	American Academy of Pediatrics
ABA	Applied Behavior Analysis
ACT	Assertive Community Treatment
ADA	American Dietetic Association or Americans with Disabilities Act
ADDM	Autism and Developmental Disabilities Monitoring
ADHD	**Attention-Deficit/Hyperactivity Disorder**
AFDC	Aid to Families with Dependent Children
ALF	Assisted Living Facility
ALOS	Average Length of Stay
AN	**Anorexia Nervosa**
ANRED	Anorexia Nervosa and Related Eating Disorders
APA	American Psychiatric Association or American Psychological Association
Arc (The)	formerly the Association for Retarded Citizens
ART	Aggression Replacement Therapy
AS	**Asperger's Disorder**
ASAS	Australian Scale for Asperger's Syndrome
ASD	**Autism Spectrum Disorder**
ASFA	Adoption and Safe Families Act of 1997
ASQ	Ages and Stages Questionnaire
AZT	Azidothymidine
BCM	**Behavioral Classroom Management**
BED	**Binge Eating Disorder**
BES	Binge Eating Scale
BH-MCO	Behavioral Health Managed Care Organization
BHA	Behavioral Health Authority
BHO	Behavioral Health Organization
BHRS	Behavioral Health Rehabilitative Services
BIP	**Behavior Intervention Plan**
BMI	Body Mass Index
BN	**Bulimia Nervosa**
BPD	**Borderline Personality Disorder** or **Bipolar Disorder**
BPD-NOS	**Bipolar Disorder** Not Otherwise Specified
BPI	Behavioral Peer Intervention
BPT	**Behavioral Parent Training**
BT	**Behavioral Therapy**
BULIT- R	Bulimia Test-Revised

CAPS-CA	Clinician-Administered PTSD Scale for Children and Adolescents
CASA	Court Appointed Special Advocate
CBC	**Community-based Care**
CBT	**Cognitive Behavioral Therapy**
CD	**Conduct Disorder**
CDC	Centers for Disease Control and Prevention
CDIs	Child Development Inventories
CFI	Children's Firesetting Inventory
CHADD	Children and Adults with Attention Deficit Disorders
CHAT	Checklist for Autism in Toddlers
CHINS	Child in Need of Services
CHINSup	Child in Need of Supervision
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
COLA	Cost of Living Adjustment
COS	Childhood-onset **Schizophrenia**
COY	Virginia Commission on Youth
CPMT	**Community Policy and Management Team** (Virginia)
CPS	Child Protective Services
CSA	**Children's Services Act** for At Risk Youth and Families (Virginia)
CSAC	Certified Substance Abuse Counselor
CSB	**Community Services Board** (Virginia)
CSU	**Court Service Units**
CSOTP	Certified Sex Offender Treatment Provider
CT	Computer Tomography
DARE	Drug Abuse Resistance Education
DARS	Virginia Department for Aging and Rehabilitative Services
DBD	Disruptive Behavioral Disorder
DBD-NOS	Disruptive Behavioral Disorder Not Otherwise Specified
DBHDS	**Virginia Department of Behavioral Health and Developmental Services** (formerly DMHMRSAS)
DBT	**Dialectical Behavioral Therapy**
DCE	Virginia Department of Correctional Education
DCJS	Virginia Department of Criminal Justice Services
DCSE	Virginia Child Support Enforcement
DD	**Developmental Disability** or **Dually Diagnosed**
DHP	Virginia Department of Health Professions
DJJ	Virginia Department of Juvenile Justice
DMAS	Virginia Department of Medical Assistance Services
DMG	Dimethylglycine
DOC	Virginia Department of Corrections
DOE	Virginia Department of Education

DRC	**Daily Report Card**
DSH	**Deliberate Self-harm**
DSM-IV-TR	***Diagnostic and Statistical Manual of Mental Disorders***, *Fourth Edition, Text Revision*
DSM-5	***Diagnostic and Statistical Manual of Mental Disorders***, *Fifth Edition*
DSS	Virginia Department of Social Services
DTT	Discrete Trial Teaching
DUI	Driving Under the Influence
EA	Emergency Assistance
EAP	Employee Assistance Program
EAT	Eating Attitudes Test
ECT	**Electroconvulsive Therapy**
ED	Emotional Disturbance or **Eating Disorder**
EDDS	Eating Disorder Diagnostic Scale
EDE	Eating Disorder Examination
EDE-Q	Eating Disorder Examination Questionnaire
EDI-3	Eating Disorder Inventory - Revised
EDNOS	Eating Disorders Not Otherwise Specified
EEG	Electroencephalogram
EI	Eating Inventory
EOS	Early-onset **Schizophrenia**
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERP	Exposure and Response Prevention
ESL	English as a Second Language
FAMIS	**Family Access and Medical Insurance Security** Plan, Virginia's Title XXI Plan
FAMIS CPU	Application-processing unit for FAMIS (Virginia)
FAPE	**Free Appropriate Public Education**
FAPT	**Family Assessment and Planning Team**
FAS	**Fetal Alcohol Syndrome**
FBI	Federal Bureau of Investigation
FC	Foster Care
FCT	Family Centered Treatment
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FFT	**Functional Family Therapy**
FIA-C	Fire Incident Analysis for Children
FIA-P	Fire Incident Analysis for Parents
FPL	Federal Poverty Level
FRI	Firesetting Risk Inventory
GAD	**Generalized Anxiety Disorder**
HRT	**Habit Reversal Therapy**
HCBS	Home and Community Based Services
HIPAA	Health Insurance Portability and Accountability Act

HMO	**Health Maintenance Organization**
I&R	Information and Referral
ICF	Intermediate Care Facility
ICM	Intensive **Case Manager**
ICPC	Interstate Compact for the Placement of Children
ID	**Intellectual Disability**
IDEA	**Individuals with Disabilities Education Act** or Interview for the Diagnosis of Eating Disorders
IEP	**Individualized Educational Program**
IFSP	Individualized Family Service Plan
IOP	**Intensive Outpatient Therapy**
IPT	**Interpersonal Psychotherapy**
IQ	Intelligence Quotient
ISP	Individualized Service Plan
IVIG	Intravenous Immunoglobulin
JCC	**Juvenile Correctional Center**
JCHC	Joint Commission on Health Care
JFNAP	Juvenile Firesetter Needs Assessment Protocol
JLARC	Joint Legislative Audit and Review Commission
LCSW	Licensed Clinical Social Worker
LEAP	Learning Experiences: an Alternative Program
LPC	Licensed Professional Counselor
M-CHAT	Modified Checklist for autism in Toddlers
MAEDS	Multiaxial Assessment of Eating Disorder Symptoms
MCO	Managed Care Organization
MDD	**Major Depressive Disorder**
MDFT	**Multidimensional Family Therapy**
MH	Mental Health
MHA	Mental Health America
MI	Medically Indigent
MMR	Measles-Mumps-Rubella
MRI	Magnetic Resonance Imaging
MSW	Master of Social Work
MST	**Multisystemic Therapy**
MTFC	Multidimensional Treatment Foster Care
NAMI	National Alliance on Mental Illness
NCLB	No Child Left Behind
NCMHJJ	National Center for Mental Health and Juvenile Justice
NCSBY	National Center on Sexual Behavior of Youth
NCTSN	National Child Traumatic Stress Network
NES	Night Eating Syndrome
NICHCY	National Dissemination Center for Children with Disabilities
NIDA	National Institute of Drug Abuse

NIMH	National Institute of Mental Health
NOS	Not Otherwise Specified
NSIB	Nonsuicidal Self-Injurious Behavior
OCD	**Obsessive-compulsive Disorder**
ODD	**Oppositional Defiant Disorder**
OJJDP	**Office of Juvenile Justice and Delinquency Prevention**
PACCT	Parents and Children Coping Together
PACT	Program of Assertive Community Treatment
PBD	Pediatric **Bipolar Disorder**
PAIMI	Protection and Advocacy for Individuals with Mental Illnesses Act
Part C	Part C of the **Individuals with Disabilities Education Act** (IDEA)
PCP	Primary Care Provider
PCPID	President's Committee for People with Intellectual Disabilities
PDD	**Pervasive Developmental Disorder**
PDDST-II	Pervasive Developmental Disorder Screening Test-II
PEATC	Parent Educational Advocacy Training Center (Virginia)
PECS	Picture Exchange Communication System
PEDS	Parents Evaluation of Developmental Status
PMT	Parent Management Training
POS	Point of Service
PPO	Preferred Provider Organization
PRT	Pivotal Response Training
PTSD	**Posttraumatic Stress Disorder**
PRWORA	Personal Responsibility and Work Intermediate Care Facility for persons with Opportunity Reconciliation Act of 1996
PITS	Psychiatric Institute Trichotillomania Scale
RAD	**Reactive Attachment Disorder**
RCF	Residential Care Facility
RDI	Relationship Development Intervention
RTC	**Residential Treatment Center**
SAD	**Separation Anxiety Disorder** or Seasonal Affective Disorder
SAM	Society for Adolescent Medicine
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	The State Children's Health Insurance Program, Title XXI of the Social Security Act
SED	**Serious Emotional Disturbance**
SEDS	Stirling Eating Disorder Scale
SI	**Self-injury** or Sensory Integration
SNAP	Supplemental Nutrition Assistance Program
SNRIs	**Serotonin and Norepinephrine Reuptake Inhibitors**
SOC	**Systems of Care**
SOLs	**Standards of Learning**
SP	**Skin Picking** or **Specific Phobias**

SPED	**Special Education**
SRED	Sleep-related Eating Disorders
SSRIs	**Selective Serotonin Reuptake Inhibitors**
TANF	**Temporary Assistance for Needy Families**
VCOY	Virginia Commission on Youth
VDARS	Virginia Department for Aging and Rehabilitative Services
VDBHDS	Virginia Department of Behavioral Health and Developmental Services (formerly DMHMRSAS)
VDCE	Virginia Department of Correctional Education
VDCJS	Virginia Department of Criminal Justice Services
VDCSE	Virginia Child Support Enforcement
VDHP	Virginia Department of Health Professions
VDJJ	Virginia Department of Juvenile Justice
VDMAS	Virginia Department of Medical Assistance Services
VDOC	Virginia Department of Corrections
VDOE	Virginia Department of Education
VDSS	Virginia Department of Social Services
VIEW	**Virginia Initiative for Education and Work**
VIP	**Virginia Independence Program**

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