

ATTACHMENT C

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Treatment Protocols

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My opinions contained in these Treatment Protocols are incorporated by reference into my July 11, 2025 Expert Summary of Opinions. My findings and conclusions are held to a reasonable degree of medical and scientific certainty and are based on my knowledge, skill, experience, and training in the field of child & adolescent psychiatry and my review of scientific literature that I have considered and that have informed my opinions.

I have reviewed and considered the materials referenced in these Treatment Protocols as well as those listed in my Materials Considered List (Attachment B) in forming my opinions. I reserve the right to rely on any of these materials.

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Treatment Protocol for Youth and Adolescents with ADHD (11-17 Years)

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

Protocol Overview

This protocol provides comprehensive, evidence-based treatment guidelines for Attention-Deficit/Hyperactivity Disorder (ADHD) in youth and adolescents ages 11-17 years. The guidelines synthesize recommendations from the American Academy of Pediatrics (AAP) 2019 Clinical Practice Guidelines¹, the UK's National Institute for Health and Care Excellence (NICE) Quality Standard QS39 (updated May 2025)², and the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters³.

1. Diagnostic Assessment and Evaluation for Youth and Adolescents (11-17 Years)

AAP Key Action Statement 1 The pediatrician or other primary care clinician (PCC) should initiate an evaluation for ADHD for any youth and adolescent age 11-17 years who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity¹.

NICE Quality Statement 1 (Updated May 2025): Young people with symptoms of ADHD must be referred to an ADHD specialist for assessment. As an option, QbTest may be used to help diagnose ADHD in people aged 6 to 17 years, consistent with ICD-10 diagnostic frameworks².

1.1 Diagnostic Criteria and Process for Youth and Adolescents (11-17 Years)

AAP Key Action Statement 2 To make a diagnosis of ADHD, the PCC should determine that DSM-5 criteria have been met, including documentation of symptoms and impairment in more than 1 major setting (social, academic, or occupational), with information obtained primarily from reports from parents or guardians, teachers, other school personnel, and mental health clinicians. The PCC should also rule out any alternative cause¹.

DSM-5 ADHD Presentations (ICD-10 Codes):

- **Inattentive Presentation (ADHD/I):** 314.00 (F90.0)
- **Hyperactive-Impulsive Presentation (ADHD/HI):** 314.01 (F90.1)
- **Combined Presentation (ADHD/C):** 314.01 (F90.2)
- **Other Specified and Unspecified ADHD:** 314.01 (F90.8)

Essential Assessment Components for Youth and Adolescents Ages 11-17:

- Complete clinical and psychosocial assessment following standardized protocols^{37, 38}
- Developmental and psychiatric history with symptom onset before age 12, consistent with DSM-5 and ICD-10 criteria^{39, 40}
- Multiple informant evaluation (parents, teachers, other caregivers) using validated rating scales^{41, 42}

- Multi-setting documentation (home, school, work, social environments) as required by diagnostic criteria⁴³
- Functional impairment assessment in academic, social, or occupational domains using standardized measures^{44, 45}
- Alternative cause exclusion through comprehensive evaluation including medical and psychiatric screening^{46, 47}

1.2 Youth and Adolescent-Specific Assessment Considerations (Ages 11-17)

Unique Challenges in Assessment for Ages 11-17:

- **Secondary School Complexity:** Multiple teachers across different subjects and academic demands requiring coordinated information gathering^{48, 49}
- **Self-Report Limitations:** Tendency to minimize problematic behaviors during this developmental stage, supported by developmental psychology research^{50, 51}
- **Developmental Changes:** Hyperactivity and inattention symptoms frequently change as adolescents mature, following predictable patterns^{52, 53}
- **Increased Independence:** Parents may have less opportunity to observe behaviors, requiring additional informant sources⁵⁴
- **Peer Influence:** Complex social dynamics and peer relationships affecting symptom presentation and functional impairment^{55, 56}

1.3 Youth and Adolescent-Specific Assessment Considerations

Essential Information Sources:

- **Multiple Teachers:** Minimum 2 teacher reports, preferably from core academic subjects, using standardized rating scales^{57, 58}
- **Alternative Observers:** Coaches, school guidance counselors, community activity leaders providing cross-setting validation⁵⁹
- **Academic Records:** Grades, standardized test scores, disciplinary records providing objective functional data^{60, 61}
- **Self-Report:** Youth and Adolescent perspective while recognizing developmental limitations, using age-appropriate assessment tools^{62, 63}
- **Parent/Guardian Reports:** Historical and current functioning observations using validated parent rating scales^{64, 65}

Documentation Requirements:

- **Historical Evidence:** Symptoms must have manifestations before age 12, consistent with DSM-5 and ICD-10 criteria^{39, 66}

- **Current Impairment:** Significant functional problems in multiple settings, documented through standardized measures^{67, 68}
- **Differential Diagnosis:** Rule out mood disorders, anxiety, substance use effects using systematic screening protocols^{69, 70}
- **Comorbidity Assessment:** Systematic screening for co-occurring conditions using validated assessment tools^{71, 72}

1.4 Comprehensive Comorbidity Screening for Youth and Adolescents (11-17 Years)

AAP Key Action Statement 3 In the evaluation of a youth or adolescent for ADHD, the PCC should include a process to at least screen for comorbid conditions, including emotional or behavioral conditions, developmental conditions, and physical conditions¹.

Essential Comorbidity Assessment for Ages 11-17:

Emotional/Behavioral Conditions:

- **Anxiety Disorders:** Social anxiety, generalized anxiety, panic disorder⁷³
- **Mood Disorders:** Major depression, bipolar disorder, persistent depressive disorder⁷⁴
- **Disruptive Behavior Disorders:** Oppositional defiant disorder, conduct disorder⁷⁵
- **Substance Use Disorders:** Alcohol, cannabis, stimulants, other substances¹⁵
- **Eating Disorders:** Increased risk in adolescent females with ADHD⁷⁶

Developmental Conditions:

- **Learning Disabilities:** Reading, writing, mathematics disorders⁷⁷
- **Language Disorders:** Expressive and receptive language difficulties
- **Autism Spectrum Disorders:** Social communication difficulties⁷⁸
- **Intellectual Disabilities:** Cognitive functioning assessment

Physical Conditions:

- **Sleep Disorders:** Sleep apnea, delayed sleep phase syndrome, insomnia⁷⁹
- **Tic Disorders:** Motor and vocal tics, Tourette syndrome⁸⁰
- **Seizure Disorders:** Epilepsy and related conditions
- **Chronic Medical Conditions:** That may affect medication choice

1.5 Trauma-Informed Assessment for Youth and Adolescents

Essential Trauma Screening:

- **Adverse Childhood Experiences (ACE):** Comprehensive trauma history

- **Child and Adolescent Trauma Screen for PTSD (CATS):** Validated assessment tool
- **Environmental Stability:** Housing, family structure, safety assessment
- **Recent Traumatic Events:** Accidents, violence, loss, abuse

Differential Diagnosis Considerations:

- **Trauma Symptoms vs. ADHD:** Concentration difficulties, impulsivity, emotional dysregulation overlap
- **Complex Presentations:** Co-occurring ADHD and trauma require integrated treatment
- **Environmental Interventions:** Stability interventions may resolve trauma-related symptoms
- **Foster Care Populations:** Higher rates of both ADHD and trauma exposure

1.5 Pre-Treatment Medical Evaluation for Youth and Adolescents (11-17 Years)

Essential Medical Assessment Components:

- **Comprehensive Physical Examination:** General health and development
- **Cardiovascular Screening:** Including detailed family and personal history⁸¹
- **Growth Parameters:** Height, weight, BMI with growth curve plotting
- **Vital Signs:** Blood pressure, heart rate, temperature
- **Neurological Examination:** Basic neurological assessment

Cardiovascular Risk Assessment for Ages 11-17:

- **Family History Screening:**
 - Sudden cardiac death before age 50
 - Serious arrhythmias or congenital heart disease
 - Hypertrophic cardiomyopathy
 - Long QT syndrome
 - Wolff-Parkinson-White syndrome
- **Personal History Assessment:**
 - Syncope, especially with exercise
 - Chest pain or shortness of breath with activity
 - Exercise intolerance
 - Previous cardiac evaluation or treatment

Additional Considerations:

- **ECG:** Consider for high-risk patients or family history
- **Substance Use Impact:** Effects on cardiovascular health
- **Medication Interactions:** With other prescribed medications
- **Driving Medical Clearance:** Relevant for older adolescents

2. Treatment Framework and Chronic Care Management for Youth and Adolescents (11-17 Years)

2.1 Chronic Care Model for Adolescents

AAP Key Action Statement 4 ADHD is a chronic condition; therefore, the PCC should manage adolescents with ADHD in the same manner as adolescents with special health care needs, following the principles of the chronic care model and the medical home¹.

Adolescent-Specific Medical Home Principles for Ages 11-17:

- **Family-centered care** with increasing adolescent autonomy⁸²
- **Accessible, continuous care** coordination across settings
- **Comprehensive services** including academic, social, and vocational support
- **Coordinated care** with schools, mental health providers, and community resources
- **Systematic long-term management** with transition planning to adult services

2.2 Long-Term Outcome Evidence for Adolescents (11-17 Years)

MTA Study Adolescent Follow-up (8-year and 16-year data):

- **Symptom Persistence:** 89% of adolescents continued to meet ADHD criteria at 8-year follow-up¹³
- **Functional Impairment:** Significant impairment in 78% of participants
- **Treatment Benefits:** Early, intensive treatment provides better long-term outcomes
- **Treatment Discontinuation:** Associated with return of symptoms and increased impairment

Additional Long-term Outcome Data for Untreated Adolescent ADHD:

- **Academic Achievement:** Lower high school graduation rates (58% vs 82%)⁶⁰
- **Substance Abuse:** 2-3 times higher risk of substance use disorders¹⁵
- **Criminal Justice:** Increased arrest and incarceration rates⁸³
- **Motor Vehicle Safety:** 4 times higher accident risk¹⁴

- **Mental Health:** Higher rates of depression, anxiety, and suicide attempts⁸⁴
- **Mortality:** 1.9 times higher death rate (hazard ratio 1.9)⁸⁵

2.3 Multimodal Treatment Approach for Youth and Adolescents (11-17 Years)

Evidence-Based Treatment Components:

1. **Pharmacological interventions** with adolescent assent
2. **Skills training interventions** (organizational, social, academic)⁸⁶
3. **Educational accommodations** and supports (IEP or 504 plan)
4. **Family interventions** and support
5. **Driving safety** interventions and monitoring¹⁴
6. **Substance abuse prevention** and monitoring¹⁵
7. **Transition planning** for adult services¹⁶

Treatment Principles for Ages 11-17:

- **Collaborative approach** with adolescent as active participant
- **Individualized treatment** based on severity, comorbidities, and functional needs
- **Developmental appropriateness** recognizing adolescent autonomy needs
- **Multi-setting coordination** across home, school, work, and community
- **Risk management** for driving, substance use, and mental health crises

3. Youth and Adolescent ADHD Treatment Protocol (Ages 11-17 Years)

Substance Use Screening (Mandatory)^{87, 88}:

- **Clinical Significance:** More than 25% of substance-abusing adolescents meet ADHD criteria⁸⁹
- **Risk Factors:** Earlier substance use onset in adolescents with ADHD^{90, 91}
- **Assessment Tools:** CRAFFT screening tool, AUDIT-C, clinical interview^{92, 93, 94}
- **Active Substance Use:** Requires specialist referral before ADHD treatment⁹⁵

Comorbidity Assessment (Minimum Required)^{96, 97}:

- **Anxiety Disorders:** Higher rates in adolescents, impacts treatment selection^{73, 98}
- **Depression and Mood Disorders:** Affects medication choice and monitoring^{74, 99}
- **Learning Disabilities:** Academic accommodation needs^{77, 100}
- **Conduct Disorder:** Treatment approach modifications required^{75, 101}

- **Sleep Disorders:** Impact on medication timing and effectiveness^{79, 102}

Driving Assessment^{103, 104:}

- **Current Status:** Permit, license, driving experience, violations
- **Risk Factors:** Accidents, near misses, family concerns^{14, 105}
- **Functional Needs:** School, work, social transportation requirements
- **Safety Planning:** Medication coverage during driving hours¹⁰⁶

Functional Impairment Evaluation^{107, 108:}

- **Academic Performance:** Grades, test scores, homework completion, class participation^{60, 109}
- **Social Functioning:** Peer relationships, family interactions, romantic relationships^{55, 110}
- **Occupational:** Part-time work, volunteer activities, responsibility management¹¹¹
- **Independence Skills:** Self-care, time management, organization, planning^{112, 113}

3.1 Medication Management for Adolescents

AAP Key Action Statement 5c For youth and adolescents with ADHD, the provider should discuss and is encouraged to prescribe FDA-approved medications for ADHD. The provider is encouraged to prescribe evidence-based training interventions and/or behavioral interventions as treatment of ADHD, if available¹.

3.1.1 Youth and Adolescent Assent Process

Collaborative Decision-Making Requirements:

- **Education:** ADHD explanation, treatment options, expected outcomes
- **Risk-Benefit Discussion:** Medication benefits, potential side effects, alternatives
- **Autonomy Respect:** Adolescent participation in treatment decisions
- **Family Involvement:** Balance adolescent autonomy with family support
- **Ongoing Consent:** Regular reassessment of treatment agreement

Components of Informed Assent:

- **ADHD Understanding:** Neurobiological basis, chronic nature, functional impact
- **Treatment Options:** Medication types, dosing schedules, monitoring requirements
- **Expected Benefits:** Symptom improvement, functional gains, academic/social benefits
- **Potential Risks:** Side effects, monitoring needs, drug interactions

- **Alternative Treatments:** Behavioral interventions, accommodations, lifestyle modifications

3.1.2 Medication Selection for Youth and Adolescents (11-17 Years)

First-Line Medications:

Stimulant Medications (Effect Size 0.8-1.2)¹¹⁴:

Extended-Release Formulations (Preferred):

- **Methylphenidate-based:**
 - Concerta (12-hour duration)
 - Focalin XR (8-12 hour duration)
 - Quillivant XR (12-hour liquid formulation)
 - Daytrana patch (9-hour transdermal)
- **Amphetamine-based:**
 - Adderall XR (10-12 hour duration)
 - Vyvanse (12-14 hour duration)
 - Mydayis (16-hour duration for adolescents)

Second-Line Medications:

Non-Stimulant Options (Effect Size 0.7):

- **Atomoxetine (Strattera):** No abuse potential, 24-hour coverage
- **Extended-Release Guanfacine (Intuniv):** Useful for comorbid tics, anxiety
- **Extended-Release Clonidine (Kapvay):** Alternative alpha-2 agonist
- **Viloxazine (Qelbree):** Newer non-stimulant option¹¹⁵

3.1.3 Monitoring Protocol for Youth and Adolescents (11-17 Years)

NICE Quality Statement 7: Annual specialist review is mandatory for all patients on drug treatment².

Initial Phase (First 6 months):

- **Initial Assessment:** 45-90 minutes with provider
- **Weekly Visits:** First 4-6 weeks during titration (30 minutes)
- **Monthly Visits:** Months 2-6 for stabilization (30 minutes)
- **Assessment Focus:** Efficacy, side effects, functional improvement

- **Growth Monitoring:** Height, weight, BMI at each visit
- **Cardiovascular Monitoring:** Blood pressure, heart rate, symptom inquiry

Maintenance Phase (6+ months):

- **Quarterly Visits:** Every 3 months (30-minute check-ins)
- **Annual Review:** 45-60 minute comprehensive assessment
- **School Progress Reviews:** At least twice yearly with academic team
- **Crisis Availability:** 24/7 access for urgent concerns

Adolescent-Specific Monitoring Considerations:

- **Driving Coverage:** Ensure medication effectiveness during all driving hours
- **Academic Schedule:** Coordinate medication timing with school schedule
- **Social Functioning:** Monitor peer relationships and social interactions
- **Mood Changes:** Increased vigilance for depression, anxiety, suicidal ideation¹¹⁶
- **Substance Use:** Regular screening using validated tools¹⁵

3.1.4 Safety Monitoring and Side Effect Management

Common Stimulant Side Effects in Adolescents^{117, 118}:

- **Appetite Suppression (78%):** Monitor weight, provide nutritional counseling¹¹⁹
- **Sleep Difficulties (64%):** Assess timing, sleep hygiene, consider sleep aids¹²⁰
- **Mood Changes (48%):** Monitor for irritability, depression, anxiety¹²¹
- **Growth Effects:** 1-2 cm height reduction, weight suppression^{122, 123}

Adolescent-Specific Side Effect Considerations:

- **Academic Performance:** Monitor for over-focusing or cognitive dulling¹²⁴
- **Social Interactions:** Assess impact on peer relationships¹²⁵
- **Mood Liability:** Increased sensitivity to mood changes during adolescence¹²⁶

Side Effect Management Strategies^{127, 128}:

- **Dose Adjustment:** Reduction or timing modifications
- **Formulation Changes:** Switch between immediate and extended-release
- **Medication Class Change:** Methylphenidate to amphetamine or vice versa
- **Adjunctive Treatments:** Sleep aids, appetite stimulants, mood stabilizers

- **Non-Pharmacological:** Lifestyle modifications, behavioral strategies

3.1.5 Substance Abuse Prevention and Management

Risk Assessment for Youth and Adolescents (11-17 Years)^{129, 130:}

- **ADHD Severity:** Higher symptom severity increases risk¹⁵
- **Comorbidities:** Conduct disorder, depression, family substance use^{131, 132}
- **Environmental Factors:** Peer substance use, family conflict, academic failure¹³³
- **Developmental Factors:** Impulsivity, sensation-seeking, poor decision-making¹³⁴

Prevention Strategies^{135, 136:}

- **Early Treatment Benefits:** Earlier stimulant therapy associated with lower substance abuse risk^{137, 138}
- **Extended-Release Formulations:** Reduced abuse potential and diversion¹³⁹
- **Prescription Drug Monitoring:** Utilize state PDMP systems¹⁴⁰
- **Family Education:** Secure storage, warning signs, protective factors¹⁴¹
- **Regular Screening:** Ongoing substance use assessment using validated tools^{92, 93}

Active Substance Use Management^{142, 143:}

- **Subspecialist Referral:** Required for active substance abuse or dependence
- **Non-Stimulant Preference:** Atomoxetine, guanfacine, clonidine when substance abuse risk high¹⁴⁴
- **Integrated Treatment:** Simultaneous ADHD and substance abuse treatment¹⁴⁵
- **Family Involvement:** Family therapy, support groups, crisis planning¹⁴⁶

3.2 Behavioral and Psychosocial Interventions for Youth and Adolescents (11-17 Years)

3.2.1 Skills Training Interventions

Organizational Skills Training (OST):

- **Duration:** 10-16 weekly sessions over 3-4 months (45-60 minutes)
- **Format:** Individual or small group (2-3 youth or adolescents)
- **Components:**
 - Time management and planning skills
 - Homework organization and completion strategies
 - Material organization (backpack, locker, room)

- Goal-setting and self-monitoring
- Problem-solving for academic challenges
- **Evidence Base:** Consistent benefits for academic functioning⁸⁶

Homework, Organization, and Planning Skills (HOPS):

- **Duration:** 16 brief weekly sessions (20-30 minutes each)
- **Setting:** School-based implementation preferred
- **Components:**
 - Organization of materials and workspace
 - Tracking assignments and due dates
 - Planning and time management
 - Study skills and test preparation
- **Evidence:** Randomized controlled trials show significant improvement¹⁴⁷

Social Skills Training¹⁴⁸:

- **Duration:** weekly 60-minute sessions 4-12 weeks
- **Components:**
 - Communication and conversation skills
 - Conflict resolution and problem-solving
 - Peer relationship development
 - Social problem-solving in various contexts
- **Format:** Group-based with peer interaction opportunities
- **Evidence:** Modest benefits, requires real-world generalization support
- **Implementation:** Community mental health centers, school groups

Cognitive Behavioral Therapy (CBT) for ADHD^{149, 150}:

- **Duration:** 12-16 weekly sessions (60 minutes each)
- **Individual CBT Components:**
 - Executive function skills training
 - Cognitive restructuring for ADHD-related thoughts
 - Behavioral activation and goal setting

- Emotion regulation strategies
- Relapse prevention planning
- **Parent Sessions:** 4-6 concurrent sessions (60 minutes each) focusing on:
 - Behavioral management strategies
 - Communication techniques
 - Home structure and organization
 - Advocacy skills for school settings
- **Qualified Providers:** Licensed psychologists, licensed clinical social workers, licensed professional counselors with specialized ADHD training
- **Evidence Base:** Strong evidence for reducing ADHD symptoms and improving functional outcomes in youth and adolescents^{151, 152}

3.3 Educational Interventions and Supports for Youth and Adolescents (11-17 Years)

3.3.1 Individualized Education Program (IEP)

Eligibility Determination:

- **"Other Health Impairment"** category when ADHD significantly impacts learning
- **Educational Need:** Requires specialized instruction, not just accommodations
- **Assessment:** Comprehensive educational evaluation required
- **Team Decision:** Multidisciplinary team determines eligibility and services

Transition Planning Components (Required by age 16):

- **Post-Secondary Education:** College preparation, disability services coordination
- **Employment:** Job skills, vocational training, supported employment
- **Independent Living:** Daily living skills, self-advocacy, community resources
- **Agency Coordination:** Vocational rehabilitation, mental health services

3.3.2 Section 504 Accommodation Plan

Common 504 Accommodations for Youth and Adolescents (11-17 Years):

Testing Accommodations:

- Extended time (typically 50-100% additional)
- Reduced distraction environment
- Alternative test formats

- Breaks during testing

Assignment Modifications:

- Extended deadlines for projects
- Reduced homework assignments
- Alternative assignment formats
- Use of assistive technology

Classroom Accommodations:

- Preferential seating near teacher
- Movement breaks during class
- Access to fidget tools
- Copy of teacher notes or PowerPoint slides

3.4 Special Considerations for Youth and Adolescent ADHD (Ages 11-17)

3.4.1 Driving Safety Management

Risk Assessment and Education:

- **Crash Risk:** Teen drivers with ADHD have 4 times higher accident risk¹⁴
- **Contributing Factors:** Inattention, impulsivity, poor judgment, risk-taking behaviors
- **Family Education:** Understanding risks, implementing safety strategies
- **Professional Assessment:** Driving rehabilitation specialist evaluation when indicated

Safety Interventions:

- **Medication Coverage:** Ensure effectiveness during all driving hours
- **Extended-Release Preferred:** Consistent coverage throughout day
- **Supplemental Dosing:** Short-acting medication for evening driving if needed
- **Family-Based Programs:** STEER (Supporting Teens' Effective Entry to the Roadway)¹⁵³

3.4.2 Mental Health and Suicide Risk Management

Increased Risks in Youth and Adolescents with ADHD (Ages 11-17):

- **Depression:** Higher rates, especially in adolescent females⁸⁴
- **Anxiety Disorders:** Social anxiety, generalized anxiety, panic disorder⁷³
- **Suicide Risk:** 7 times higher suicide attempt rate compared to peers⁸⁴

- **Self-Harm:** Increased risk of non-suicidal self-injury behaviors

Screening and Assessment:

- **Regular Monitoring:** Mood changes, suicidal ideation, self-harm behaviors
- **Standardized Tools:**
 - PHQ-9A (Patient Health Questionnaire for Adolescents)
 - GAD-7 (Generalized Anxiety Disorder Scale)
 - Columbia Suicide Severity Rating Scale¹⁵⁴

Crisis Management:

- **Safety Planning:** When suicide risk identified
- **Crisis Resources:** National Suicide Prevention Lifeline (988), local crisis services
- **Family Education:** Warning signs, crisis response, safety strategies
- **School Coordination:** Threat assessment, safety planning, return to school protocols

4. Evidence Base and Guidelines Compliance

4.1 Primary Evidence Sources

Authoritative Guidelines:

- **AAP 2019 Clinical Practice Guidelines:** All relevant Key Action Statements for youth adolescents¹
- **NICE Quality Standard QS39 (Updated May 2025):** Youth and Adolescent-specific quality statements²
- **AACAP Practice Parameters:** Comprehensive youth and adolescent assessment and treatment approaches³

Research Foundation:

- **MTA Study Long-term Follow-up:** 16-year outcomes demonstrating chronic nature and treatment benefits¹³
- **Driving Safety Research:** Demonstrating 4x higher crash risk and medication benefits¹⁴
- **Substance Abuse Prevention Studies:** Early treatment protective effects¹³⁷
- **Transition Research:** Evidence-based approaches to adult service transition¹⁶

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Treatment Protocol for Adolescents with Eating Disorders (11-17 Years)

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

Protocol Overview

This treatment protocol provides evidence-based guidelines for the assessment and treatment of eating disorders in adolescents aged 11-17 years. Based on the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters⁷, UK National Institute for Health and Care Excellence (NICE) guidelines (2017)⁸, and current clinical standards, this protocol emphasizes that eating disorders are serious medical conditions requiring comprehensive multidisciplinary care.

DSM-5 Diagnoses and ICD-10 Codes

Primary Eating Disorder Diagnoses:

- F50.01 - Anorexia Nervosa, Restricting Type
- F50.02 - Anorexia Nervosa, Binge-eating/Purging Type
- F50.2 - Bulimia Nervosa
- F50.81 - Binge Eating Disorder
- F50.82 - Avoidant/Restrictive Food Intake Disorder (ARFID)
- F50.89 - Other Specified Feeding or Eating Disorder
- F50.9 - Unspecified Feeding or Eating Disorder

Common Comorbid Diagnoses:

- F32.x - Major Depressive Disorder
- F41.1 - Generalized Anxiety Disorder
- F40.10 - Social Anxiety Disorder
- F42.x - Obsessive-Compulsive Disorder
- F43.10 - Post-Traumatic Stress Disorder

1. Initial Assessment and Screening

1.1 Screening Requirements [Clinical Standard]

Per NICE Guidelines⁹:

- Be aware eating disorders can develop at any age, with particular consideration for preadolescents (ages 11-12)
- Highest risk: young men and women aged 11-17

- Do NOT use screening tools (e.g., SCOFF) as sole method to determine diagnosis
- Consider assessment/referral for any of the following:
 - Unusually low/high BMI or body weight for age
 - Rapid weight loss
 - Dieting/restrictive eating when underweight
 - Family reports of eating behavior changes
 - Social withdrawal involving food situations
 - Other mental health problems
 - Disproportionate weight/shape concerns
 - Problems managing chronic illness affecting diet
 - Menstrual/endocrine disturbances (or delayed menarche in younger adolescents)
 - Unexplained GI symptoms
 - Physical signs of malnutrition or compensatory behaviors
 - Abdominal pain with vomiting/diet restrictions
 - Unexplained electrolyte imbalance/hypoglycemia
 - Atypical dental wear
 - High-risk activities (professional sport, fashion, dance, modeling)

Children/Young People Additional Signs¹⁰:

- Faltering growth (low weight/height for age)
- Delayed puberty or pubertal arrest
- Growth velocity deceleration

Per AACAP Guidelines¹¹:

- Universal screening for ALL adolescent patients aged 11-17
- Plot height and weight on growth curves with particular attention to growth velocity in younger adolescents

1.2 Validated Screening Instruments

For adolescents 13-17 years¹²:

- SCOFF Questionnaire: Appropriate for ages 13 and up; most widely used as a general screening measure (not to be used as the sole measure for diagnosis)¹³
- Eating Disorder Examination-Questionnaire (EDE-Q): Standard version for ages 14+¹⁴
- Eating Attitudes Test (EAT-26): Validated for adolescent use¹⁵
- Eating Disorder Inventory (EDI-3): For ages 12 and up¹⁶

For youth (11-13 years)¹⁷:

- Youth EDE-Q (YEDE-Q): Adapted from EDE-Q with literacy level consistent with third grade (aged 8-9 years) reading ability, validated for adolescents aged 12-17¹⁸
- Child EDE-Q (ChEDE-Q8): 8-item short form validated for ages 7-18 years¹⁹
- Children's Eating Attitudes Test (ChEAT): Validated for ages 10-15 years²⁰
- Kids' Eating Disorder Survey (KEDS): Originally validated for ages 10-13, with modified version (M-KEDS) showing validity in Hispanic adolescents²¹
- EDI-C (Child version): 91-item measure appropriate for children as young as 8 years old, though limited published reliability and validity data²²

1.3 Comprehensive Diagnostic Evaluation [Clinical Standard]

1.3.1 Initial Assessment Components (NICE)²⁴

In primary/secondary mental health/acute settings, assess:

- Physical health including malnutrition/compensatory behavior effects
- Mental health problems commonly associated with eating disorders:
 - Depression, anxiety, self-harm, OCD
- Alcohol or substance misuse possibility (particularly relevant for older adolescents)
- Need for emergency care if:
 - Physical health compromised
 - Suicide risk present

Immediate Referral: If eating disorder suspected, refer immediately to community-based, age-appropriate eating disorder service

1.3.2 Complete Psychiatric Evaluation (AACAP)²⁵:

- Weight/height with percentile BMI calculation and growth velocity assessment
- Weight change patterns and rapidity

- Percentage and rapidity of weight loss
- Menstrual history (for post-menarchal females) or pubertal development assessment
Body image concerns (age-appropriate assessment methods)
- Dieting/calorie counting behaviors
- Exercise amount, type, frequency
- Binge eating/purging (frequency, amount, duration)
- Label checking and self-weighing
- Comorbidity screening
- Parent/caregiver history (critical for corroboration)
- School performance and social functioning assessment

1.3.3 Physical Examination & Laboratory Tests:

Initial labs (AACAP)²⁶:

- CBC, chemistry profile, liver functions, TSH
- Additional: Ca, Mg, PO₄, protein, albumin, ESR, amylase, B12, lipids
- Females: LH, FSH, estradiol (if post-menarchal)
- Pregnancy test if indicated (for sexually active adolescents)
- ECG for bradycardia/arrhythmia risk

DEXA scan indications²⁷:

- Females with >6 months amenorrhea
- All males with significant weight loss
- Repeat yearly if amenorrhea persists

1.4 Dietary Counseling and Nutritional Support

Per NICE Guidelines²⁸: For Anorexia Nervosa:

- Only offer dietary counseling as part of multidisciplinary approach
- Encourage age-appropriate oral multivitamin/mineral supplement until diet meets dietary reference values
- Include family/carers in dietary education for individual therapy
- Offer supplementary dietary advice for growth/development needs (especially puberty)

General Dietary Advice²⁹:

- Do not use nutritional counseling as sole treatment (per RCT evidence)
- Dietitian serves as consultant to team
- May provide direct consultation depending on treatment approach

2. Medical Stabilization and Hospitalization Criteria

2.1 Medical Hospitalization Indicators [Clinical Standard]

Based on American Academy of Pediatrics and Society of Adolescent Health and Medicine guidelines³⁰:

Cardiovascular:

- Bradycardia <50 bpm (adjusted for age: <40 bpm for ages 11-13, <45 bpm for ages 14-17) Orthostatic heart rate changes
- Orthostatic hypotension
- Prolonged QT interval

Physical:

- Hypothermia
- Severe malnutrition
- Electrolyte abnormalities requiring correction
- Arrested growth or pubertal development

Behavioral:

- Acute food refusal
- Uncontrolled vomiting or other purging
- Suicidal ideation or behavior

2.2 Management of Medical Complications [Clinical Standard]

2.2.1 Refeeding Syndrome Prevention³¹:

- Monitor for syndrome during initial re-nourishment
- Follow standard operating procedures (MARSIPAN guidelines)
- Avoid both under-nutrition and rapid refeeding

2.2.2 Monitoring Requirements³²:

- Daily weights and vital signs
- Cardiac monitoring for at-risk patients
- Electrolyte monitoring and oral supplementation (unless severe)

2.2.3 Special Considerations³³:

- Nasogastric feeding may be more efficient for weight gain, but long-term benefits not established
- Most physical abnormalities reversible with adequate nutrition and weight restoration
- Irreversible complications in longstanding cases: growth impairment, decreased bone density, structural brain changes

3. Evidence-Based Psychological Treatments

3.1 Anorexia Nervosa (F50.0x) Treatment Hierarchy

3.1.1 First-Line Family Therapy Options [Clinical Standard]

Anorexia-Nervosa-Focused Family Therapy (FT-AN) Per NICE Guidelines (2017)³⁴:

- **Format:** Single-family therapy or combination of single- and multi-family therapy
- **Duration:** Typically 18-20 sessions over 1 year, 60 min per session
- **Structure:**
 - Review needs at 4 weeks, then every 3 months
 - Option for some sessions with young person separately or together with family
 - Emphasize family role in recovery without blame
 - Include psychoeducation about nutrition and malnutrition effects
 - Phase 1: Parents take a temporary central role in managing eating
 - Phase 2: Support an appropriate independence level
 - Final phase: Focus on relapse prevention and treatment ending
- **Evidence:** Multiple RCTs support efficacy³⁵

Family-Based Treatment (FBT/Maudsley) Per AACAP Guidelines³⁶:

- **Evidence:** Six RCTs (n=323) support efficacy, superior to individual therapies

- **Duration:** 10-20 family sessions over 6-12 months, 60 minutes per session
- **Benefits:** High efficiency, decreases hospitalization need

3.1.2 Alternative Individual Therapies (when FT-AN unacceptable/ineffective):

Per NICE Guidelines³⁷ - Consider ONE of:

1. **Individual Eating-Disorder-Focused CBT (CBT-ED):**
 - a. Up to 40 sessions over 40 weeks, 60 minutes per session
 - b. Twice-weekly sessions in the first 2-3 week, 60 minutes per session
 - c. 8-12 additional brief family sessions, 60 minutes per session
 - d. Create personalized treatment plan
 - e. Include self-monitoring and homework
 - f. Address developmental needs
2. **Adolescent-Focused Psychotherapy for AN (AFP-AN)³⁸:**
 - a. 32-40 individual sessions over 12-18 months, 60 minutes per session
 - b. 8-12 additional family sessions, 60-90 minutes per session
 - c. More frequent early sessions for relationship building
 - d. Focus on self-image, emotions, interpersonal processes
 - e. Explore identity issues and build independence

Per AACAP Guidelines³⁹:

- **Adolescent-Focused Therapy (AFT):** For autonomy and self-efficacy
- **Enhanced CBT (CBT-E):** Shows promise in uncontrolled studies

3.2 Bulimia Nervosa (F50.2) Treatment Hierarchy

3.2.1 NICE Guidelines Recommendations⁴⁰:

First-Line for Adolescents: Bulimia-Nervosa-Focused Family Therapy (FT-BN) [Clinical Standard]:

- Typically, 18-20 sessions over 6 months, 60-90 minutes per session
- Good therapeutic relationship essential
- Support family to help recovery without blame

- Include information about:
 - Body weight regulation
 - Dieting
 - Adverse effects of compensatory behaviors
- Collaborative approach for regular eating patterns
- Regular individual meetings throughout treatment
- Later phases: establish appropriate independence
- Final phase: relapse prevention

If FT-BN unacceptable/ineffective: Individual Eating-Disorder-Focused CBT (CBT-ED)⁴¹:

- Typically, 18 sessions over 6 months, 60 minutes per session
- More frequent early sessions
- Up to 4 additional parent/carer sessions, 60 minutes per session
- Focus on building motivation to change
- Psychoeducation about symptom maintenance
- Case formulation development
- Self-monitoring of thoughts, feelings, behaviors
- Problem-solving and relapse prevention

3.2.2 AACAP Guidelines Recommendations⁴²:

Two Evidence-Based First-Line Options:

1. **Family-Based Treatment for BN (FBT-BN):**
 - a. 18-20 sessions over 6 months, 60-90 minutes per session
 - b. Evidence: 2 RCTs support effectiveness
 - c. Faster reduction in binge/purge behaviors
2. **Cognitive-Behavioral Therapy for BN (CBT):**
 - a. Psychoeducation and behavioral exercises
 - b. Self-monitoring through diet records
 - c. Evidence: Lower binge rates at end of treatment

Alternative Approaches:

- Individual Supportive Psychotherapy (SPT) less effective than FBT
- IPT and DBT effective in adults, limited adolescent data

3.3 Binge Eating Disorder (F50.81) Treatment

3.3.1 NICE Guidelines Recommendations⁴³:

First-Line Treatment: Binge-Eating-Disorder-Focused Guided Self-Help Program:

- Use cognitive behavioral self-help materials
- 4-9 sessions lasting 20 minutes each over 16 weeks
- Weekly sessions initially
- Focus on adherence to self-help program
- Explain that psychological treatments have limited effect on body weight

If guided self-help unacceptable/ineffective after 4 weeks: Group Eating-Disorder-Focused CBT (CBT-ED):

- Typically, 16 weekly group sessions over 4 months, 90 minutes
- Include psychoeducation and self-monitoring
- Daily food intake planning
- Body exposure training
- Relapse prevention strategies

If group CBT-ED unavailable/declined: Individual CBT-ED:

- 16-20 sessions, 60 minutes per session
- Develop psychological formulation
- Regular meals/snacks to avoid hunger
- Address emotional triggers
- Weekly monitoring of behaviors and weight
- Advise against dieting during treatment

3.3.2 AACAP Guidelines⁴⁴:

- Interpersonal Psychotherapy (IPT): Preliminary studies support adolescent use

- Limited research base for this age group
- Adult studies show CBT, IPT, and DBT effective

3.4 Avoidant Restrictive Food Intake Disorder (F50.82)

AACAP Guidelines⁴⁵ - No empirical studies available:

- Individualized behavioral plans addressing specific eating problems
- Gradual desensitization procedures
- Behavior reinforcement plans
- Family interventions and CBT may be helpful
- Hospitalization if medically unstable

3.5 Other Specified Feeding or Eating Disorders (F50.89)

Per NICE Guidelines⁴⁶:

- Consider using treatments for the eating disorder it most closely resembles
- Match treatment approach to symptom profile

3.7 Physical Therapy Exclusion

Per NICE Guidelines⁴⁷:

- Do NOT offer physical therapy as part of eating disorder treatment
- This includes: transcranial magnetic stimulation, acupuncture, weight training, yoga, warming therapy

4. Pharmacological Interventions

4.1 General Principles (NICE & AACAP Consensus)⁴⁸

- **Do NOT offer medication as sole treatment** for any eating disorder [Clinical Standard]
- Reserve medications for:
 - Comorbid conditions
 - Refractory cases
- Consider impact of malnutrition on medication effectiveness

4.2 Anorexia Nervosa - Limited Evidence

Per NICE Guidelines⁴⁹:

- **Do not offer medication as sole treatment** [Clinical Standard]

Per AACAP Guidelines⁵⁰:

4.2.1 SSRIs:

- No systematic studies in adolescents
- Adult studies show no benefit for relapse prevention
- Limited effectiveness until partial weight restoration

4.2.2 Atypical Antipsychotics:

- Small RCTs with mixed results
- Risperidone: Well-tolerated but few benefits
- Olanzapine: No significant benefit over placebo
- Quetiapine: Some improvement (non-significant)
- Major barrier: Fear of weight gain

4.3 Bulimia Nervosa

Per NICE Guidelines⁵¹:

- **Do not offer medication as sole treatment** [Clinical Standard]

Per AACAP Guidelines⁵²:

4.3.1 Fluoxetine:

- FDA-approved for BN treatment (ages 8 and older)
- Dose: 60mg/day (higher than depression dose)
- Limited adolescent studies
- CBT superior to medication alone
- Monitor for suicidal ideation (black box warning)

4.3.2 Recommendations:

- Reserve for CBT refusal or inadequate response
- Most effective combined with CBT for comorbid depression

4.4 Binge Eating Disorder

Per NICE Guidelines⁵³:

- **Do not offer medication as sole treatment** [Clinical Standard]

Per AACAP Guidelines⁵⁴:

- No adolescent studies available
- Adult medications not studied in adolescents

4.5 Medication Risk Management (NICE Guidelines)⁵⁵

4.5.1 Prescribing Considerations:

- Account for impact of malnutrition and compensatory behaviors
- Assess how eating disorder affects medication adherence
- Consider risks of medications that compromise physical health

4.5.2 ECG Monitoring Required For:

- Medications causing electrolyte imbalance
- Bradycardia below 40 bpm
- Hypokalaemia
- Prolonged QT interval

4.5.3 Substance/Medication Misuse:

- Provide eating disorder treatment unless misuse interferes
- If interference occurs, use multidisciplinary approach with substance services

4.6 Important Considerations⁵⁶

- Obsessionality and mood often improve with weight gain alone
- Lower doses may be needed in malnourished states
- Follow disorder-specific guidelines for comorbidities

5. Multidisciplinary Team Approach and Coordination of Care

5.1 Core Team Composition [Clinical Standard]

Per AACAP Guidelines⁵⁷ - Essential for addressing psychological and physical health impacts:

5.1.1 Psychotherapist:

- Delivers evidence-based psychological treatment
- May be psychiatrist serving dual role

5.1.2 Pediatrician/Medical Provider:

- Monitors medical stability per AAP/SAHM guidelines
- Manages physical complications
- Determines outpatient safety

5.1.3 Registered Dietitian:

- Consultant to physician/therapist
- May provide direct consultation depending on treatment approach
- Note: Nutritional counseling alone not effective as sole treatment

5.1.4 Child Psychiatrist:

- Medication management when indicated
- May serve as psychotherapist and psychopharmacologist

5.2 Team Requirements and Training

Per NICE Guidelines⁵⁸: **Professional Competencies:**

- Competent to assess and treat age groups they care for
- Trained and skilled in multidisciplinary team work
- Base psychological treatments on relevant eating disorder manuals
- Receive appropriate clinical supervision
- Use standardized outcome measures (e.g., EDE-Q)
- Monitor competence through recordings, external audit
- Monitor treatment adherence

Team Coordination (NICE)⁵⁹:

- Take particular care when:
 - Young person moves from children's to adult services
 - Multiple services involved (inpatient/outpatient, separate comorbidity services)
 - Care needed in different places at different times (e.g., university students)
- Healthcare teams should collaborate for effective comorbidity treatment
- Use outcome measures for both eating disorder and comorbidities

5.3 Service Access and Coordination (NICE)⁶⁰

Improving Access:

- Be aware patients may find discussion difficult/distressing
- Vulnerable to stigma and shame
- Need age-appropriate information/interventions

Support Requirements:

- Assess impact of home, education, work, social environment (including internet/social media)
- Address emotional, educational, employment, social needs throughout treatment
- Encourage family/teacher/peer support when appropriate

6. Level of Care Decisions

6.1 Outpatient Treatment

Per NICE & AACAP Guidelines⁶¹:

- **First-line choice** for all eating disorders
- No evidence that hospitalization more effective than outpatient
- People with eating disorders should be assessed and receive treatment at earliest opportunity
- Early treatment particularly important for severe emaciation

6.2 Higher Levels of Care

6.2.1 NICE Guidelines for Admission Decisions⁶³:

Do NOT use:

- Absolute weight or BMI threshold for admission decisions
- Inpatient care solely for psychological treatment
- Do not discharge solely because healthy weight reached

Consider for admission:

- BMI/weight that cannot be safely managed in day patient service (age-adjusted criteria)
- Rate of weight loss (e.g., >1 kg/week) requiring inpatient care

- Medical risk parameters in concern/alert ranges (per MARSIPAN):
- Age-adjusted bradycardia or prolonged QT interval
- Blood tests, physical observations requiring active monitoring
- Current physical health significantly declining
- Parents/carers cannot support/keep from harm as day patient
- Growth arrest or pubertal delay

6.2.2 Inpatient Care Principles (NICE)⁶³:

When admitted for medical stabilization:

- Specialist eating disorder/liaison psychiatry should:
 - Maintain contact with inpatient team
 - Keep family involved
 - Consider starting/continuing psychological treatments
- Collaborate with community team for treatment/transition
- Use age-appropriate facilities near home
- Provide appropriate educational activities

Care Planning Requirements:

- Clear objectives and outcomes for admission
- Developed with patient, family, and community team
- Define discharge process and community care transition
- Review within 1 month whether to continue/step down
- Schedule reviews at least monthly
- Consider institutionalization risk with long admissions
- Seek second opinion if disagreement about continued care

6.2.3 AACAP Guidelines⁶⁴:

Consider only when:

- Outpatient interventions unsuccessful

- Appropriate outpatient treatment unavailable
- Medical instability requires intensive monitoring

Options:

1. Day Programs/Partial Hospitalization
2. Residential Programs
3. Psychiatric Hospitalization

Key Principles:

- Keep length of stay short
- Use lowest safe level of care
- Involve families in programming
- Employ highly expert staff
- Mitigate separation from family/community

7. Special Populations and Considerations

7.1 Gender Differences

7.1.1 Male Adolescents⁶⁵:

- Prevalence: 1:10 ratio (some estimates up to 1:3)
- More likely to present with overexercise and steroid use
- Higher risk in sports emphasizing weight/appearance
- Gay and bisexual males may be at higher risk
- Increasing incidence/detection rates
- Later age of recognition and treatment

7.1.2 Assessment Adaptations:

- Consider male-specific body image concerns
- Screen for muscle dysmorphia
- All males with significant weight loss require DEXA scan
- Assess steroid use and performance-enhancing substances

7.2 Developmental Considerations

7.2.1 Communication and Information (NICE Guidelines)⁶⁶:

- Be aware patients may find discussion difficult/distressing
- Vulnerable to stigma and shame
- Need age-appropriate information and interventions
- Healthcare professionals should be alert to signs of:
 - Bullying, teasing
 - Abuse (emotional, physical, sexual)
 - Neglect

7.2.2 Younger Adolescents (11-13 years)⁶⁷:

- Less likely to engage in binge/purge behaviors
- May be unable to verbalize abstract thoughts
- Behaviors as nonverbal emotional representations
- Parent reports critical due to minimization/denial
- Look for behavioral indicators of weight fear
- Consider cognitive developmental stage in treatment planning

7.2.3 Early vs. Late Adolescence⁶⁹:

- Early adolescence (11-14): Greater family involvement needed
- Middle adolescence (15-16): Balance independence with family support
- Late adolescence (17): Transition planning for adult services

7.3 Comorbidity Management

7.3.1 Physical Health Comorbidities (NICE)⁶⁹

Diabetes Management:

- Eating disorder and diabetes teams must collaborate on:
 - Explaining importance of physical health monitoring
 - Agreeing monitoring responsibility
 - Managing mental/physical comorbidities
 - Low threshold for glucose/ketone monitoring

- Address insulin misuse in psychological treatment
- For insulin misuse, offer:
 - Gradual carbohydrate increase if safe
 - Gradual insulin dose increases
 - Adjusted glycemic load to prevent rapid weight gain
 - Psychoeducation about misuse problems
- Monitor for glucose toxicity, insulin resistance, ketoacidosis, edema in BN
- When control challenging:
 - Avoid rapid hyperglycemia treatment
 - Monitor potassium regularly
 - Never stop insulin completely (DKA risk)

Growth and Development:

- Monitor linear growth velocity
- Assess pubertal development
- Consider growth hormone evaluation if significant growth delay
- Collaborate with pediatric endocrinology when indicated

Pregnancy and Conception:

- Provide preconception advice on:
 - Maintaining mental health
 - Adequate nutrition and healthy weight
 - Stopping compensatory behaviors
- Nominate dedicated professional for monitoring
- Consider intensive prenatal care for AN
- Offer eating disorder treatment during pregnancy/perinatal period

7.3.2 Mental Health Comorbidities (NICE)⁷⁰

Treatment Order Decisions - Consider:

- Severity and complexity of both conditions

- Patient's level of functioning
- Preferences of patient and family

Common Comorbidities:

- AN: 55.2% have ≥ 1 comorbid disorder
- BN: 88% have ≥ 1 comorbid disorder
- BN suicide risk: 53% ideation, 26% plans, 35% attempts

7.4 Environmental Considerations (NICE)⁷¹

Assessment Should Include:

- Impact of home environment
- Education setting
- Work environment
- Wider social environment (internet, social media)
- Address emotional, educational, employment, social needs throughout treatment

Family and Peer Support:

- Encourage family/carer/teacher/peer support during treatment
- Be aware family may feel guilty/responsible
- Address misconceptions about eating disorders

8. Monitoring and Outcome Measures

8.1 Treatment Monitoring Requirements

8.1.1 Physical Health Assessment (NICE Guidelines)⁷²

Fluid and Electrolyte Monitoring:

- Assess in patients with compensatory behaviors (vomiting, laxatives, diuretics, water loading)
- Provide oral supplements unless GI absorption problems or severe disturbance
- Investigate continued unexplained imbalance for other conditions

ECG Monitoring Indicated For:

- Rapid weight loss

- Excessive exercise
- Severe purging behaviors
- Bradycardia, hypotension
- Excessive caffeine intake
- Prescribed/non-prescribed medications
- Muscular weakness
- Electrolyte imbalance
- Previous abnormal heart rhythm

Dental Health (for vomiting):

- Regular dental and medical reviews
- Avoid brushing immediately after vomiting
- Rinse with non-acid mouthwash
- Avoid highly acidic foods/drinks

Education for Misuse:

- Laxatives/diuretics do not reduce calorie absorption or help weight loss
- Advise gradual reduction and cessation
- Advise cessation of excessive exercise

8.1.2 AN-Specific Monitoring (NICE)⁷³

Pediatrician/PCP Regular review (minimum) should Include:

- Weight or BMI (age-adjusted)
- Blood pressure
- Relevant blood tests
- Daily functioning problems
- Risk assessment (physical and mental)
- ECG for purging/significant weight changes
- Treatment options discussion

Growth and Development⁷⁴:

- Monitor in those who haven't completed puberty
- Seek specialist advice for delayed development/faltering growth
- Growth charts and bone age assessment when indicated

8.1.3 Bone Density Monitoring (NICE)⁷⁵

DEXA Scan Indications:

- After 1 year underweight in children/young people (earlier if bone pain/fractures)
- After 2 years underweight in adults (earlier if bone pain/fractures)
- Use BMAD measures for faltering growth
- Repeat no more than yearly unless bone pain/fractures
- Main prevention/treatment: healthy weight restoration

8.2 Outcome Measurement Standards

Per AACAP Guidelines [Clinical Standard]⁷⁶:

- Use validated instruments (e.g., EDE-Q)
- Monitor treatment adherence
- Assess competence through session recordings
- External audit and scrutiny
- Regular clinical supervision required

Per NICE Guidelines⁷⁷:

- Professionals should receive appropriate clinical supervision
- Use standardized outcome measures
- Monitor competence and treatment adherence

8.3 Recovery Indicators and Prognosis

8.3.1 Anorexia Nervosa⁷⁸:

- Adolescent prognosis better than adults
- Adult outcomes: 7-15% chronicity, 5-7% mortality
- Key recovery indicators:

- Weight restoration to healthy BMI percentile
- Resumption of menses
- Normalized eating behaviors
- Improved psychological functioning
- Age-appropriate social and academic functioning

8.3.2 Bulimia Nervosa⁷⁹:

- Short-term: Fluctuating symptoms
- Long-term: 50% symptom-free at 5-10 years
- Longer illness predictors: Low self-esteem, childhood obesity, personality disorders

8.3.3 Treatment Timeline⁸⁰:

- Early treatment = better outcomes
- Review at 4 weeks, then every 3 months
- Adjust session frequency based on progress

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Treatment Protocol for Adolescent Sleep Deprivation (Ages 11-17)

This evidence-based treatment protocol addresses sleep deprivation in adolescents aged 11-17 years, incorporating current research on circadian rhythm development, cognitive behavioral interventions, and developmental considerations specific to this population.^{1, 2}

I. Assessment Protocol

Initial Evaluation Components

Clinical Interview

- Sleep history and current patterns
- Medical history and medications
- Psychiatric screening (depression, anxiety, ADHD)⁷
- Substance use assessment
- Academic and social functioning
- Family sleep patterns and home environment
- Technology use patterns and evening screen exposure⁸

Standardized Assessment Tools

- Pediatric Sleep Questionnaire (PSQ)⁹
- Epworth Sleepiness Scale for Children and Adolescents¹⁰
- Sleep Hygiene Index - Adolescent Version¹¹
- Morningness-Eveningness Questionnaire for Children and Adolescents¹²
- Pediatric Insomnia Severity Index (when available)¹³

Objective Measures

- Two-week sleep diary with sleep/wake times, naps, caffeine intake, screen time¹⁴
- Consider polysomnography if a sleep disorder is suspected¹⁵

II. Diagnostic Criteria

Sleep Deprivation Classification (Clinical Severity)

Sleep Duration Requirements (AASM/AAP Guidelines)

- **Ages 11-12:** 9-12 hours optimal range¹

- **Ages 13-17:** 8-10 hours optimal range¹
- Optimal range varies by individual, but consistently <8 hours indicate deprivation
- Weekend "catch-up" sleep does not fully compensate for weekday deficits¹⁶

Severity Classification

- **Mild:** 7-8 hours sleep, minimal daytime impairment
- **Moderate:** 6-7 hours sleep, noticeable academic/social impact
- **Severe:** <6 hours sleep, significant functional impairment¹⁷

III. Treatment Protocol

Phase 1: Sleep Hygiene and Environmental Modifications (Weeks 1-4)

Treatment Parameters

- **Duration:** 4-6 sessions over 4 weeks^{18, 19, 20}
- **Session frequency:** 1-2 sessions per week^{21, 22, 23}
- **Session length:** 30-60 minutes per session^{21, 19, 24}
- **Format:** Individual, group, or family-based sessions depending on needs¹⁸

Qualified Providers Sleep hygiene education can be delivered by various healthcare professionals with appropriate training:^{18, 22, 25}

- **Primary care providers:** Pediatricians, family medicine physicians
- **Nursing professionals:** Registered nurses, nurse practitioners, advanced practice nurses
- **Mental health professionals:** Clinical psychologists, licensed clinical social workers, licensed professional counselors
- **Other qualified providers:** Occupational therapists, health educators, trained research staff¹⁸
- **School-based providers:** School nurses, health teachers, trained educators^{4, 20}

Sleep Environment Optimization

- Cool, dark, quiet bedroom (65-68°F optimal)²⁶
- Remove electronic devices 1 hour before bedtime, as adolescents exposed to more light (room lighting, or lighting from electronics) in the evening are less likely to get enough sleep⁴

- Blackout curtains or eye masks²⁷
- White noise machine if needed²⁸
- Comfortable mattress and pillows²⁹

Sleep Hygiene Education

- Set a regular bedtime and rise time, including on weekends, as adolescents with parent-set bedtimes usually get more sleep than those whose parents do not set bedtimes^{4, 30}
- No caffeine after 2 PM³¹
- Avoid large meals 3 hours before bedtime³²
- Regular exercise (not within 4 hours of bedtime)³³
- Limit daytime naps to <30 minutes before 3 PM³⁴

Light Exposure Management

- Bright light exposure upon waking³⁵
- Morning sunlight exposure for 15-30 minutes³⁶
- Dim lighting 2 hours before bedtime³⁷
- Blue light blocking glasses if screen use necessary³⁸

Phase 2: Cognitive Behavioral Therapy for Insomnia - Adolescent (CBT-I-A) (Weeks 5-12)

Based on latest AASM Clinical Practice Guidelines and adolescent-specific adaptations³⁹

Treatment Parameters

- **Duration:** 6-8 sessions over 6-12 weeks^{40, 41, 42}
- **Session frequency:** Weekly or bi-weekly sessions depending on individual needs⁴³
- **Session length:** 45-60 minutes per session^{44, 42}
- **Format:** Individual sessions preferred for adolescents, with separate parent sessions when clinically indicated

Qualified Providers CBT-I-A should be delivered by licensed healthcare professionals with specialized training in behavioral sleep medicine, including:^{40, 45}

- **Licensed psychologists with CBT-I training**

- **Licensed clinical social workers with sleep medicine specialization**
- **Licensed professional counselors with behavioral sleep medicine credentials**
- **Physicians with behavioral sleep medicine training**
- **Master's-level practitioners with appropriate CBT-I training and supervision⁴⁶**

CBT-I should be the preferred intervention for the treatment of insomnia in adolescents, characterized by low risk and high therapeutic benefits and serving as alternative or adjuvant approaches to medication.⁴⁷ CBT-I might be effective in the treatment of children and adolescents with insomnia, with significant pooled effect sizes observed for sleep onset latency and sleep efficiency.^{48, 49}

Sleep Restriction Therapy

- Calculate sleep efficiency from sleep diary⁵⁰
- Restrict time in bed to actual sleep time + 30 minutes
- Gradually increase as sleep efficiency improves (>85%)⁵¹
- Maintain consistent wake time

Stimulus Control Instructions

- Use bed only for sleep (no homework, phone use, etc.)⁵²
- Leave bedroom if unable to fall asleep within 20 minutes
- Return only when sleepy
- Establish relaxing pre-sleep routine⁵³

Cognitive Restructuring

- Identify, challenge, and alter thoughts and beliefs that contribute to insomnia⁵⁴
- Address catastrophic thinking about sleep loss⁵⁵
- Develop realistic expectations about sleep needs
- Problem-solving for academic/social pressures⁵⁶

Relaxation Training

- Progressive muscle relaxation^{57, 58}
- Deep breathing exercises⁵⁹
- Mindfulness meditation techniques⁶⁰
- Guided imagery for sleep⁶¹

Phase 3: Circadian Rhythm Interventions (Weeks 8-16)

Treatment Parameters

- **Duration:** Variable depending on intervention type and individual response
- **Session frequency:** Daily to weekly depending on specific intervention
- **Session length:** 15-60 minutes per session depending on treatment modality

Qualified Providers Phase 3 interventions require specialized training and medical oversight:^{65, 66, 67}

- **Primary providers:** Sleep medicine physicians, psychiatrists with chronotherapy training
- **Supervised providers:** Clinical psychologists, advanced practice nurses, physician assistants with appropriate training
- **Medical oversight required for:** Melatonin prescribing and monitoring^{67, 68, 69}
- **Specialized settings:** Sleep disorders centers, chronotherapy programs^{70, 71}

Chronotherapy (when appropriate)

- Gradual sleep time advancement (15-30 minutes earlier each night)⁷²
- Coordinate with light therapy⁷³
- Monitor with sleep diary and actigraphy⁷⁴

Light Therapy

- **Session length:** 30 minutes daily^{66, 75}
- **Provider supervision:** Initial setup and monitoring by trained healthcare professionals⁷⁶
- 10,000 lux light box for 30 minutes upon waking⁷⁷
- Timing adjusted based on chronotype assessment⁷⁸
- **Ongoing monitoring:** Regular follow-up to assess response and adjust timing

Melatonin Therapy

- **Provider requirements:** Must be prescribed and monitored by licensed healthcare provider^{67, 68, 69}
- **Supervision:** Regular medical supervision required for safety monitoring^{79, 80}
- **Session monitoring:** Periodic follow-up appointments (typically every 2-4 weeks initially, then monthly)⁸¹

- Consider melatonin supplementation (0.5-3mg, 1-2 hours before desired bedtime)^{82, 83}
- Coordinate with pediatrician for melatonin prescription⁸⁴

Phase 4: Family and School Interventions (Ongoing)

Aligned with AAP Policy Statement on School Start Times (2014)

Family Component

- Integration of parents, especially in school-aged children with insomnia, is highly recommended⁶²
- Family education about adolescent sleep needs⁶³
- Consistent household routines
- Address parent-teen conflicts about bedtime⁶⁴

School Collaboration

- Advocate for delayed school start times, as the American Academy of Pediatrics recommended in 2014 that middle schools and high schools start no earlier than 8:30 AM⁶
- Later school start times for adolescents result in more students getting enough sleep, with studies showing significantly longer weekday and weekend total sleep time and improved sleep hygiene^{85, 86}
- Develop accommodations for severe cases (delayed start, modified schedule)
- Academic support during treatment phase⁸⁷

Adjunctive Interventions

Technology Management

- Limit electronic device usage before bed, as mobile phone and social media usage at night have been associated with reduced sleep duration during school days^{8, 88}
- Establish device curfews 1-2 hours before bedtime⁸⁹
- Use apps that limit blue light exposure⁹⁰
- Create phone-free bedroom policies⁹¹
- Develop alternative evening activities⁹²

Physical Activity Protocol

- Promote physical activity, as increasing physical activity can help improve sleep quality and overall well-being in adolescents^{93, 94}
- Regular aerobic exercise 3-4 times per week⁹⁵
- Timing: Morning or afternoon preferred⁹⁶
- Avoid vigorous exercise within 4 hours of bedtime⁹⁷
- Consider yoga or gentle stretching in evening⁹⁸

Nutritional Considerations

- Avoid caffeine after 2 PM (including hidden sources)
- Light protein snack if hungry before bed
- Avoid alcohol and recreational substances
- Maintain regular meal timing

IV. Crisis Intervention Protocol

Severe Sleep Deprivation (Acute)

- Medical evaluation to rule out underlying conditions⁹⁹
- Temporary sleep aids under medical supervision, with thorough risk-benefit analysis employed when considering pharmacological interventions for pediatric insomnia¹⁰⁰
- Modified school schedule if necessary
- Intensive monitoring and support
- Consider psychiatric evaluation if mood symptoms present¹⁰¹

Safety Considerations

- Assess driving safety and restrict if necessary, as sleep-deprived teenagers are more likely to engage in risk-taking behaviors^{102, 103}
- Monitor for depression/suicidal ideation, as insufficient sleep in teenagers has been found to increase the risk of depression and is associated with increased risk of self-harm, suicidal thoughts and suicide attempts^{7, 104}
- Evaluate impact on judgment and decision-making¹⁰⁵
- Family safety planning¹⁰⁶

V. Monitoring and Follow-up

- Improved sleep diary metrics (sleep latency, total sleep time, efficiency)¹⁴

- Reduced daytime sleepiness scores¹⁰
- Better academic and social functioning¹⁰⁷
- Improved attention, behavior, learning, memory, emotional regulation, quality of life, and mental and physical health¹

Follow-up Schedule

- Weekly sessions during active treatment (Weeks 1-12)³⁹
- Bi-weekly sessions during maintenance (Weeks 13-16)
- Monthly follow-up for 3 months
- Quarterly maintenance sessions as needed¹⁰⁸

Outcome Measures

- Pre/post standardized assessment scores
- Sleep diary analysis¹⁴
- Academic performance indicators¹⁰⁹
- Functional improvement measures¹¹⁰
- Quality of life assessments¹¹¹

VI. Treatment Modifications

Comorbid Conditions

- **ADHD:** Coordinate with stimulant medication timing, consider sleep impact^{112, 113}
- **Depression/Anxiety:** CBT-I presents a promising treatment for depression comorbid with insomnia^{114, 115}
- **Substance Use:** Address substance-related sleep disruption¹¹⁶
- **Medical Conditions:** Coordinate with medical team for comprehensive care¹¹⁷

Digital/Technology-Based Interventions

- Digital CBT-I is effective for treating insomnia in children, adolescents, and adults, with improvement in insomnia symptoms from dCBT-I appearing to be similar to face-to-face approaches^{118, 119}
- Consider evidence-based digital platforms when in-person therapy is not available¹²⁰

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Treatment Protocol for Anxiety Disorders in Youth and Adolescents (11-17 Years)

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

Protocol Overview

This protocol synthesizes evidence-based treatment recommendations from the American Academy of Child and Adolescent Psychiatry (AACAP) 2020 Clinical Practice Guidelines¹, American Academy of Pediatrics (AAP) guidelines², National Institute for Health and Care Excellence (NICE) recommendations³⁻⁴, and the Child/Adolescent Anxiety Multimodal Study (CAMS) findings⁵ for managing anxiety disorders in youth and adolescents aged 11-17 years. Diagnostic criteria are based on DSM-5-TR⁶ with corresponding ICD-10 codes⁷.

I. ASSESSMENT AND SCREENING FRAMEWORK

A. DIAGNOSTIC CONSIDERATIONS

Primary Anxiety Disorders in Youth and Adolescents (DSM-5-TR⁶)

Generalized Anxiety Disorder (GAD)

- DSM-5-TR Code: 300.02
- ICD-10 Code: F41.1
- Prevalence: 6.5% in adolescents aged 13-17⁸

Social Anxiety Disorder (Social Phobia)

- DSM-5-TR Code: 300.23
- ICD-10 Codes:
 - F40.10 (Social phobia, unspecified)
 - F40.11 (Social phobia, generalized)
- Note: DSM-5-TR replaces "generalized" specifier with "performance only" specifier⁹

Specific Phobias

- DSM-5-TR Code: 300.29
- ICD-10 Codes:
 - F40.218 (Animal type)
 - F40.228 (Natural environment type)
 - F40.231 (Blood type)
 - F40.232 (Injection type)
 - F40.233 (Other medical type)

- F40.248 (Situational type)
- F40.298 (Other type)

Panic Disorder

- DSM-5-TR Code: 300.01
- ICD-10 Code: F41.0

Agoraphobia

- DSM-5-TR Code: 300.22
- ICD-10 Codes:
 - F40.00 (Agoraphobia without panic disorder)
 - F40.01 (Agoraphobia with panic disorder)

Separation Anxiety Disorder

- DSM-5-TR Code: 309.21
- ICD-10 Code: F93.0
- Note: Reclassified from childhood disorders to anxiety disorders in DSM-5⁹

B. DIAGNOSTIC CRITERIA APPLICATION

Standard of care requires adherence to DSM-5-TR criteria⁶:

Generalized Anxiety Disorder (GAD):

- Excessive anxiety/worry occurring more days than not for at least 6 months
- Difficulty controlling worry
- At least 3 of 6 associated symptoms (restlessness, fatigue, concentration problems, irritability, muscle tension, sleep disturbance)
- Significant distress or functional impairment
- Not attributable to substance use or medical condition

Social Anxiety Disorder:

- Marked fear/anxiety about social situations where scrutiny by others possible
- Fear of negative evaluation or acting in embarrassing/humiliating way
- Social situations almost always provoke fear/anxiety
- Social situations avoided or endured with intense fear/anxiety
- Fear/anxiety out of proportion to actual threat

- Duration: 6 months or more
- Significant distress or functional impairment

Panic Disorder:

- Recurrent unexpected panic attacks
- At least one attack followed by 1 month of persistent concern about additional attacks OR maladaptive behavior change
- Not attributable to substance use or medical condition
- Not better explained by another mental disorder

Specific Phobia:

- Marked fear/anxiety about specific object or situation
- Phobic object/situation almost always provokes immediate fear/anxiety
- Phobic object/situation actively avoided or endured with intense fear/anxiety
- Fear/anxiety out of proportion to actual danger
- Duration: 6 months or more (in individuals under 18 years)
- Significant distress or functional impairment

C. ASSESSMENT COMPONENTS

AACAP Practice Parameters¹ and AAP Guidelines² require comprehensive evaluation including:

1. Clinical Interview Standards

- Comprehensive psychiatric evaluation including developmental history
- Medical screening to rule out organic causes (hyperthyroidism, cardiac conditions)
- Substance use assessment (particularly important for ages 14-17)
- Suicide risk assessment using standardized tools
- Functional impairment assessment (school, social, family domains)
- New: Social media use assessment (cyberbullying, FOMO, validation-seeking) ¹³
- New: Previous or current COVID-19 impact assessment (social isolation, family stressors)¹²

2. Required Screening Instruments (AACAP Guidelines¹):

- **SCARED (Screen for Child Anxiety Related Disorders)**

- **PARS (Pediatric Anxiety Rating Scale)**
- **SPAI-C (Social Phobia and Anxiety Inventory for Children)**
- **GAD-7 (for ages 14-17)**
- **MASC-2 (Multidimensional Anxiety Scale for Children)**

3. Medical Evaluations Requirements:

- Complete medical history including medications, family history, and substance use
- Physical examination with vital signs, cardiovascular, thyroid, and neurological screening
- Laboratory screening (CBC, CMP, thyroid function, vitamins B12/D, toxicology)
- Specialized testing when clinically indicated (cardiac, neurological, autoimmune)

4. U.S. Preventive Services Task Force (USPSTF) Recommendations¹⁴:

- Screen for anxiety disorders in children 8 years and older
- Insufficient evidence for screening children younger than 8 years

II. EVIDENCE-BASED TREATMENT HIERARCHY

Evidence-Based Therapy Modalities for Anxiety in Youth Ages 11-17

Tier 1: First-Line Treatments

A. Cognitive Behavioral Therapy (CBT)

AACAP Recommendation Level: Strong¹ Evidence: First-line treatment for all anxiety disorders; 60-67% of youth free of primary diagnosis post-treatment¹⁵⁻¹⁶

Individual CBT

- **Duration:** 12-16 weekly sessions (3-4 months)
- **Session Length:** 50-60 minutes
- **Frequency:** Weekly
- **Core Components:** Psychoeducation, cognitive restructuring, exposure therapy, relapse prevention

Group CBT

- **Duration:** 12-16 weekly sessions
- **Session Length:** 90 minutes
- **Frequency:** Weekly
- **Group Size:** 6-8 participants

- **Special Advantage:** Particularly effective for social anxiety disorder³

Family-Involved CBT

- **Duration:** 10-14 weekly sessions
- **Session Length:** 60-90 minutes
- **Frequency:** Weekly
- **Recommended For:** Ages 11-14 (younger adolescents benefit more from family involvement)

Qualified CBT Providers:

- Licensed Clinical Psychologists (PhD/PsyD)
- Licensed Clinical Social Workers (LCSW/LMSW)
- Licensed Professional Counselors (LPC)
- Licensed Marriage and Family Therapists (LMFT)

Required Qualifications:

- Specialized training in evidence-based CBT for youth anxiety
- Minimum 3+ years clinical experience with adolescents
- Preferred: Certification in trauma-focused CBT (TF-CBT)

B. Dialectical Behavior Therapy (DBT)

Evidence Level: Effective for emotional dysregulation and comorbid conditions¹⁷ **Primary Use:** Adolescents with anxiety plus emotional dysregulation, self-harm, or suicidal behaviors¹⁷

Comprehensive DBT Program

- **Total Duration:** 20-24 weeks (6 months)
- **Components:**
 - Individual Therapy: Weekly, 50 minutes
 - Skills Groups: Weekly, 90 minutes
 - Parent/Family Training: Bi-weekly, 90 minutes
 - Phone Coaching: As needed between sessions

DBT Skills Training Only (for anxiety with emotional dysregulation)

- **Duration:** 16-20 weekly sessions
- **Session Length:** 90 minutes (group format)

- **Frequency:** Weekly
- **Four Skills Modules:** Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness

Qualified DBT Providers:

- Licensed Clinical Social Workers (LCSW)
- Licensed Professional Counselors (LPC)
- Licensed Clinical Psychologists (PhD/PsyD)

Required Qualifications:

- Intensive DBT training certification (minimum 40-hour training)
- Minimum 2+ years DBT experience
- Regular DBT consultation team participation
- Adherence to DBT treatment model

C. Acceptance and Commitment Therapy (ACT)

Evidence Level: Comparable efficacy to CBT for adolescent anxiety¹⁸ **Meta-analysis Results:** 27 RCTs (n=2,860) show ACT effective for anxiety and depression¹⁹

Individual ACT

- **Duration:** 12-16 weekly sessions
- **Session Length:** 50-60 minutes
- **Frequency:** Weekly

Group ACT

- **Duration:** 12-16 weekly sessions
- **Session Length:** 90 minutes
- **Frequency:** Weekly
- **Group Size:** 6-10 participants

Core ACT Components: Values clarification, mindfulness and acceptance training, cognitive defusion techniques, commitment to valued action

Qualified ACT Providers:

- Licensed Clinical Psychologists (PhD/PsyD)
- Licensed Clinical Social Workers (LCSW)

- Licensed Professional Counselors (LPC)

Required Qualifications:

- Specialized ACT training (minimum 20-hour workshop)
- Experience with acceptance-based therapies
- Understanding of psychological flexibility model

D. Mindfulness-Based Interventions (MBIs)

Evidence Level: Small to moderate effects for anxiety reduction²⁰ **Meta-analysis Results:** 33 RCTs (n=3,666) show effect sizes $d = 0.18-0.47$ for anxiety²¹

Mindfulness-Based Stress Reduction (MBSR) - Adapted for Youth

- **Duration:** 8-10 weekly sessions
- **Session Length:** 60-90 minutes
- **Frequency:** Weekly
- **Home Practice:** 20-30 minutes daily

Mindfulness-Based Cognitive Therapy for Children (MBCT-C)

- **Duration:** 8-12 weekly sessions
- **Session Length:** 60 minutes
- **Frequency:** Weekly
- **Format:** Individual or small group (4-6 participants)

Core Components: Breath awareness training, body scan meditation, mindful movement, present-moment awareness

Qualified Mindfulness Providers:

- Licensed Mental Health Professionals with mindfulness training
- Certified Mindfulness Instructors (with mental health background)

Required Qualifications:

- Personal mindfulness practice (minimum 2+ years)
- Formal mindfulness instructor training (40+ hours)
- Training in adapting mindfulness for youth
- Understanding of trauma-informed mindfulness

E. Family Therapy

Evidence Level: Effective as adjunct or primary treatment, especially for younger adolescents²²
Particularly Recommended For: Family accommodation of anxiety behaviors, high family conflict, ages 11-14

Family-Based Treatment for Anxiety

- **Duration:** 12-16 weekly sessions
- **Session Length:** 60-90 minutes
- **Frequency:** Weekly
- **Format:** Whole family sessions with some individual components

Parent Training Component

- **Duration:** 8-12 sessions (can be concurrent with youth therapy)
- **Session Length:** 60 minutes
- **Frequency:** Weekly or bi-weekly
- **Focus:** Reducing accommodation, supporting exposure

Core Components: Family psychoeducation about anxiety, accommodation reduction training, communication skills enhancement, problem-solving training

Qualified Family Therapy Providers:

- Licensed Marriage and Family Therapists (LMFT)
- Licensed Clinical Social Workers (LCSW) with family therapy training
- Licensed Clinical Psychologists (PhD/PsyD) with family therapy specialization
- Licensed Professional Counselors (LPC) with family therapy training

Required Qualifications:

- Graduate-level family therapy training
- Systemic therapy certification preferred
- Experience with adolescent family dynamics
- Training in anxiety-specific family interventions

B. Selective Serotonin Reuptake Inhibitors (SSRIs)

AACAP Recommendation Level: Strong¹ AAP Recommendation Level: Strong² NICE Guidance: Second-line after CBT, or first-line if severe impairment⁴

Evidence:

- SSRIs demonstrate significant efficacy in pediatric anxiety disorders²³

- Combined treatment response 58.1% vs. 31.5% placebo (NNT = 4)²⁴
- Higher doses within therapeutic range show greater benefit²⁵

First-Line SSRI Options:

Sertraline (Zoloft)

- Starting dose: 25mg daily
- Target dose: 50-200mg daily
- FDA Status: Approved for pediatric OCD (ages 6+)
- Efficacy Evidence: CAMS study showed 55% response rate vs. 24% placebo⁵; open-label studies show 36% response rates in social anxiety disorder²⁶
- Advantages: Good tolerability profile, extensive pediatric research base

Escitalopram (Lexapro)

- Starting dose: 5mg daily
- Target dose: 10-20mg daily
- Efficacy Evidence: Multicenter RCT (n=275) showed significant anxiety reduction (PARS score difference -5.13, p=0.005) vs. placebo²⁷; effective in both children (7-11) and adolescents (12-17)²⁸
- Pharmacogenetics: CYP2C19 phenotype influences response and pharmacokinetics²⁹
- Advantages: Fewer drug interactions, strong efficacy evidence

FDA-Approved SNRI Option:

Duloxetine (Cymbalta) - Only medication FDA-approved specifically for GAD in children ages 7-17³⁰

- **Starting dose: 30mg daily**
- **Target dose: 30-60mg daily**
- **Monitoring: Blood pressure due to noradrenergic activity**

Prescribing Guidelines:

- **Start low, go slow titration approach**
- **Monitor for activation symptoms first 4-6 weeks**
- **Full therapeutic trial: 8-12 weeks at therapeutic dose**
- **FDA Black Box Warning: Enhanced monitoring for suicidal ideation**
- **Higher SSRI doses more effective than lower doses²⁵**

Tier 2: Combination Treatment

Combined CBT + SSRI

AACAP Recommendation: Preferred for severe cases¹ NICE Guidance: Combined treatment may be more effective than either alone⁴

Evidence Base:

- CAMS study demonstrated superior outcomes with combination treatment⁵
- Most effective for youth with severe symptoms or multiple comorbidities
- 81% improvement rate with combination vs. 60% with monotherapy⁵

Indications:

- Severe functional impairment
- Partial response to monotherapy
- Comorbid depression
- Treatment-resistant anxiety

Implementation:

- Initiate both treatments simultaneously or sequentially
- Enhanced monitoring for first 12 weeks
- Coordinate care between therapist and prescriber

Tier 3: Second-Line Treatments

Alternative SSRIs

- **Citalopram (Celexa):** 10-40mg daily (monitor QTc)
- **Paroxetine (Paxil):** Generally avoided due to discontinuation syndrome

Alternative SNRIs (Serotonin-Norepinephrine Reuptake Inhibitors)

- **Venlafaxine (Effexor XR):** 37.5-225mg daily

III. PROFESSIONAL ORGANIZATION GUIDELINES

AACAP Practice Parameters¹

- Comprehensive diagnostic evaluation required
- Evidence-based treatment prioritization (CBT, SSRIs)
- Cultural considerations and family involvement
- Regular outcome monitoring using standardized measures

AAP Guidelines²

- Primary care screening and early identification
- Collaborative care models with mental health specialists
- Integration with pediatric medical home
- Family-centered approach to treatment

NICE Recommendations³⁻⁴

- **Generalized Anxiety and Panic Disorders:** CBT first-line, medication if CBT ineffective
- **Social Anxiety Disorder:** CBT preferred, medication not routinely offered
- **Stepped Care Model:** Begin with least intensive effective intervention
- **Combined Treatment:** Consider when individual treatments insufficient

IV. SPECIAL POPULATIONS

Developmental Considerations for Ages 11-17

Early Adolescence (11-14 years):

- Increased family involvement in treatment
- Focus on psychoeducation and concrete coping skills
- School-based interventions important
- Lower starting medication doses

Middle Adolescence (15-16 years):

- Transition to more individual-focused treatment
- Address identity formation and peer relationships
- Consider social media impact
- Standard medication dosing

Late Adolescence (17 years):

- Prepare for transition to adult care
- Focus on independence and self-advocacy
- Address academic and future planning stressors
- Full adult medication dosing considerations

Comorbid Conditions

Depression + Anxiety:

- Fluoxetine or sertraline preferred
- Address suicidal ideation first
- Consider combined treatment approach

ADHD + Anxiety:

- Treat anxiety first if primary
- Monitor stimulant-induced anxiety
- Consider atomoxetine for ADHD if significant anxiety

Autism Spectrum Disorder + Anxiety:

- Modified CBT approaches
- Sensory considerations
- Family involvement essential

Cultural and Diversity Considerations

Limited Evidence Base (AACAP Guidelines¹):

- Current research has insufficient representation of racial/ethnic minorities
- Treatment may need cultural adaptation
- Consider cultural factors in anxiety expression
- Family involvement varies by cultural background

V. MONITORING AND SAFETY

Initial Phase (Weeks 1-12)

Weekly to Bi-weekly Monitoring (FDA Requirements³¹):

- **Suicidal ideation assessment** using standardized tools (Columbia Suicide Severity Rating Scale)
- **Activation symptoms** (agitation, insomnia, disinhibition, increased energy)
- **Side effect monitoring** (GI upset, sleep changes, headaches)
- **Functional improvement tracking** using standardized measures (PARS, CGI-I)

Maintenance Phase

Monthly to Quarterly Monitoring:

- Symptom rating scales (PARS, SCARED)

- Functional assessment tools (CGAS, GAF)
- Medication adherence assessment
- Academic/social functioning evaluation

Safety Considerations

FDA Black Box Warning Compliance³¹:

- Enhanced monitoring for suicidal thoughts and behaviors
- Weekly contact first month, bi-weekly second month
- Clear documentation of safety assessments
- Parent/caregiver education about warning signs

Common Side Effects:

- **Sleep disturbances** (insomnia/sedation)
- **Gastrointestinal upset** (nausea, stomach pain)
- **Activation syndrome** (increased energy before mood improvement)
- **Headaches** and dizziness
- **Sexual dysfunction** (adolescents)

VI. TREATMENT RESISTANCE PROTOCOLS

Definition

Inadequate response after:

- 8-12 weeks of adequate CBT (12+ sessions with qualified provider)
- 8-12 weeks of therapeutic SSRI dose
- Or 12-16 weeks of combination treatment

Strategies

1. **Reassess diagnosis** (comorbidities, substance use)
2. **Optimize current treatment** (dose, adherence, therapy technique)
3. **Switch SSRI** to different class
4. **Augmentation strategies:** a. Add CBT to medication b. Add medication to CBT c. Consider buspirone augmentation
5. **Intensive treatments:** a. Intensive outpatient programs (IOP): i. Attend the program 3 hours per day for 3 to 5 days per week for approximately 3 to 6 weeks, depending on

specific needs. Each week, patients receive DBT and/or CBT 1-2 times a week. Patients meet with a psychiatrist for a comprehensive evaluation and medication management with follow-up every 1-4 weeks as indicated for specific patient needs. b. Partial hospitalization programs (PHP): i. More intensive intervention. Structured full-day treatment for 5+ hours or more for 5-7 days per week depending on then specific acuity. Patients go home in the evening. The duration of stay for anxiety disorders depends on the acuity of the presentation and can last 1-6 weeks. Daily scheduled therapies frequently include DBT, group therapy, and coping skills. Family therapy 1-2 times per week is essential. Evaluation by a child and adolescent psychiatrist followed by follow-up every 1-4 weeks as indicated for specific patient needs.

VII. OUTCOME MEASURES

Primary Endpoints (AACAP Guidelines¹)

- **Clinical Global Impression-Improvement (CGI-I):** Much or very much improved
- **Pediatric Anxiety Rating Scale (PARS):** $\geq 35\%$ reduction
- **Functional improvement:** School attendance, peer relationships, family functioning

Secondary Endpoints

- Standardized anxiety rating scales
- Quality of life measures
- Academic performance indicators
- Parent/family functioning measures

VIII. LONG-TERM MANAGEMENT

Continuation Phase (4-6 months)

- Maintain effective treatment
- Gradual therapy session spacing
- Medication continuation at effective dose

Maintenance Phase (6-12 months)

- Relapse prevention strategies
- Booster CBT sessions as needed
- Consider medication tapering trial

Discontinuation Considerations

- Minimum 6-12 months of stability

- Gradual medication taper over 2-4 months
- CBT skills reinforcement
- Relapse prevention planning

IX. FAMILY AND SCHOOL INTERVENTIONS

Family Component (NICE Recommendations³)

- **Psychoeducation** about anxiety disorders
- **Accommodation reduction** training
- **Communication skills** enhancement
- **Family therapy** when indicated

School Interventions (AAP Guidelines²)

- **504 Plans** or **IEP** modifications
- **Gradual school reentry** protocols
- **Teacher education** about anxiety
- **Peer support** facilitation

X. CRISIS INTERVENTION

Acute Anxiety/Panic Episodes

1. **Immediate safety assessment**
2. **Grounding techniques** and breathing exercises
3. **Short-term anxiolytic** if severe
4. **Emergency contacts** and safety planning
5. **Follow-up within 24-48 hours**

Suicidal Ideation

1. **Immediate risk assessment**
2. **Safety planning** and means restriction
3. **Enhanced monitoring** protocols
4. **Consider hospitalization** if high risk
5. **Family notification** and involvement

Evidence Base and References

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Treatment Protocol for Body Dysmorphic Disorder in Youth and Adolescents (11-17 Years)

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

Protocol Overview

This protocol provides evidence-based guidelines for the assessment, diagnosis, and treatment of Body Dysmorphic Disorder (BDD) in children and adolescents aged 11-17 years, based on NICE Clinical Guideline CG31¹ and current clinical best practices.

1. Disorder Overview

Definition and Diagnostic Codes

Body Dysmorphic Disorder (BDD) is characterized by¹:

- Preoccupation with an imagined defect in appearance
- In cases of slight physical anomaly, concern is markedly excessive
- Time-consuming behaviors including mirror gazing, comparing features, excessive camouflaging, skin picking, and reassurance seeking
- Significant functional impairment and/or distress

ICD-10 Classification³:

- **F45.2** - Hypochondriacal Disorder (includes Body Dysmorphic Disorder)
- **F42** - Obsessive-Compulsive Disorder (when BDD has delusional features)

DSM-5 Classification⁴:

- **300.7** - Body Dysmorphic Disorder
- **300.7** - Body Dysmorphic Disorder with muscle dysmorphia specifier
- **300.7** - Body Dysmorphic Disorder with good or fair insight
- **300.7** - Body Dysmorphic Disorder with poor insight
- **300.7** - Body Dysmorphic Disorder with absent insight/delusional beliefs

Prevalence and Impact

- Population prevalence: 0.5-0.7%¹
- Adolescent prevalence may be higher (1-2%)⁵
- Often unrecognized and underdiagnosed⁶
- High risk of suicide, particularly in adolescents⁷

- Significant impact on academic, social, and family functioning⁸

2. Recognition and Assessment

Initial Screening Questions

For young people at higher risk (depression, social phobia, alcohol/substance misuse, OCD, eating disorders) or seeking cosmetic/dermatological procedures¹:

1. "Do you worry a lot about the way you look and wish you could think about it less?"
2. "What specific concerns do you have about your appearance?"
3. "On a typical day, how many hours a day is your appearance on your mind?" (*More than 1 hour/day is excessive*)
4. "What effect does it have on your life?"
5. "Does it make it hard to do your work or be with friends?"

Comprehensive Assessment Components

Clinical Assessment

- **Symptom Profile:** Detailed exploration of appearance concerns, triggers, and behavioral responses⁹
- **Functional Impairment:** Academic performance, peer relationships, family dynamics¹⁰
- **Developmental Considerations:** Age-appropriate presentation and impact¹¹
- **Duration and Severity:** Timeline of symptoms and progression

Risk Assessment

- **Mandatory suicide risk assessment** for all children and young people with BDD¹
- Assessment of self-harm behaviors including skin picking or other self-injury¹²
- Risk of social isolation and academic decline
- Impact on family relationships and functioning

Comorbidity Screening

- Depression (high comorbidity rate)¹³
- Anxiety disorders (particularly social anxiety)¹⁴
- Obsessive-Compulsive Disorder¹⁵

- Eating disorders¹⁶
- Substance use disorders¹⁷

Psychosocial Factors

- Family dynamics and involvement in BDD behaviors¹⁸
- Peer relationships and bullying history¹⁹
- Academic or workplace performance
- Cultural and religious considerations¹

3. Treatment Framework

Stepped Care Approach

All Young People with BDD (Ages 11-17)

First-Line Treatment: Cognitive Behavioral Therapy (CBT) including Exposure and Response Prevention (ERP)¹

- Must involve family or carers
- Adapted to developmental age²⁰
- Individual or group format based on preference

Treatment Intensity by Functional Impairment

Mild Functional Impairment

- **Primary:** CBT (including ERP) addressing key BDD features¹
- Individual or group format jointly decided by patient and clinician
- Family/carers involvement essential

Moderate to Severe Functional Impairment

- **Primary:** CBT (including ERP) with family involvement¹
- **If inadequate response after 12 weeks:** Multidisciplinary review¹
- **Following review for ages 12-17:** Addition of SSRI to ongoing psychological treatment¹
- **Following review for age 11:** SSRI may be considered with enhanced monitoring¹
- Careful monitoring required, particularly at treatment initiation²¹
- **Children (11 years):** Consider guided self-help with family support¹

4. Psychological Interventions

Cognitive Behavioral Therapy (CBT) Protocol

Session Structure and Duration

Standard CBT for BDD (Moderate to Severe Impairment):

- **Total Sessions:** 16-20 individual sessions²²
- **Duration:** 50-60 minutes per session
- **Frequency:** Weekly sessions for 16-20 weeks
- **Total Therapist Hours:** 16-20 hours (classified as high-intensity treatment per NICE guidelines¹)

Low-Intensity CBT (Mild Impairment - primarily for age 11):

- **Total Sessions:** 6-10 sessions¹
- **Duration:** 30-45 minutes per session
- **Total Therapist Hours:** <10 hours (classified as low-intensity treatment¹)
- **Format Options:**
 - Brief individual CBT using structured self-help materials
 - Group CBT (patient may receive >10 hours total therapy time)

Family Sessions:

- **Frequency:** 4-6 separate family sessions integrated throughout treatment²³
- **Duration:** 60-90 minutes per family session
- **Purpose:** Psychoeducation, reducing accommodation, communication skills²⁴

Session Breakdown by Phase

Phase 1: Assessment and Engagement (Sessions 1-3)^{26, 28}

- Session 1: Comprehensive assessment, goal setting^{10, 33}
- Session 2: Psychoeducation about BDD, treatment rationale^{11, 19}
- Session 3: Formulation, treatment planning, family meeting^{24, 25}

Phase 2: Active Treatment (Sessions 4-14)^{22, 38}

- Sessions 4-6: Cognitive restructuring techniques^{11, 22}

- Sessions 7-10: Introduction and progression of ERP exercises^{11, 22}
- Sessions 11-14: Advanced ERP, behavioral experiments^{11, 22}
- Family sessions integrated throughout (2-3 sessions)^{24, 36}

Phase 3: Consolidation and Relapse Prevention (Sessions 15-20)^{34, 40}

- Sessions 15-17: Generalization of skills, lifestyle integration^{22, 26}
- Sessions 18-19: Relapse prevention planning, family consolidation^{34, 36}
- Session 20: Review of progress, discharge planning^{1, 33}

Core Components

1. **Psychoeducation:** Understanding BDD, normalizing experiences
2. **Cognitive Restructuring:** Challenging appearance-related beliefs
3. **Exposure and Response Prevention (ERP):**
 - Graduated exposure to avoided situations
 - Prevention of checking, camouflaging, and reassurance-seeking behaviors
4. **Behavioral Experiments:** Testing appearance-related beliefs
5. **Relapse Prevention:** Maintaining gains and managing setbacks

Developmental Adaptations for Children and Adolescents (11-17 years)

- **Therapeutic Alliance:** Building trust with both young person and family²⁵
- **Motivation Enhancement:** Using age-appropriate rewards and incentives¹
- **Collaborative Goal Setting:** Involving young person in treatment planning²⁶
- **Family Integration:** Training family members as co-therapists when appropriate¹
- **Peer Considerations:** Addressing social and academic impacts²⁷
- **Developmental Sensitivity:** Adapting interventions for cognitive and emotional development²⁸

Family Involvement Strategies

- **Assessment of Family Dynamics:** Understanding accommodation behaviors^{24, 36}
- **Family Psychoeducation:** Teaching about BDD and treatment rationale^{11, 24}
- **Reducing Accommodation:** Helping family members stop enabling behaviors^{24, 36}

- **Communication Skills:** Improving family interaction patterns^{25, 27}
- **Support for Caregivers:** Addressing family distress and burden^{24, 36}

Alternative Therapeutic Approaches

Group CBT (When Individual CBT Unavailable or Patient Preference)

- **Total Sessions:** 12-16 group sessions^{22, 25}
- **Duration:** 90-120 minutes per session^{22, 39}
- **Group Size:** 6-8 adolescents (age-matched groups preferred)^{25, 27}
- **Total Patient Hours:** 18-32 hours of therapy²²
- **Therapist Hours per Patient:** <10 hours (classified as low-intensity)¹
- **Structure**^{22, 25}:
 - Sessions 1-2: Group formation, psychoeducation
 - Sessions 3-10: CBT skills, ERP exercises
 - Sessions 11-16: Practice, relapse prevention
- **Family Component:** 3-4 separate family group sessions^{24, 36}

Guided Self-Help (Mild Impairment Only)

- **Total Sessions:** 4-6 brief support sessions^{1, 39}
- **Duration:** 30 minutes per session¹
- **Materials:** Age-appropriate self-help workbooks, online resources^{1, 39}
- **Total Therapist Time:** 2-3 hours¹
- **Support:** Regular check-ins, progress monitoring^{1, 41}
- **Family Involvement:** 2 family guidance sessions^{24, 36}

Intensive/Day Program (Severe Cases)

- **Duration:** 2-4 weeks intensive program^{1, 41}
- **Schedule:** 4-6 hours daily, 5 days per week^{39, 41}
- **Total Hours:** 40-120 therapy hours^{41, 43}
- **Components:** Individual CBT, group therapy, family work, academic support^{39, 41}
- **Staffing:** Multidisciplinary team approach^{1, 38}

Treatment Delivery Considerations

- **Total Treatment Duration:** 16-20 weeks for standard protocol^{22, 40}
- **Booster Sessions:** 2-4 sessions at 1, 3, and 6 months post-treatment^{34, 40}
- **Format:** Individual therapy preferred for BDD (group may be considered for mild cases)^{1, 22}
- **Setting:** Outpatient clinic, CAMHS services, specialized BDD clinics^{44, 45}
- **Therapist Qualifications:** Specialized training in BDD and adolescent CBT^{38, 40}
- **Supervision:** Weekly clinical supervision with BDD specialist^{40, 41}

5. Pharmacological Interventions

When to Consider Medication

- **Primary Indication:** Inadequate response to CBT after 12 weeks¹
- **Prerequisites:**
 - Multidisciplinary review completed¹
 - Continued psychological treatment¹
 - Assessment by child and adolescent psychiatrist¹

SSRI Protocol for Children and Adolescents (11-17 years)

First-Line Medication

Fluoxetine (specific recommendation for BDD in this age group)¹

- Evidence base strongest for BDD treatment²⁹
- Licensed for depression in adolescents (8+ years for some indications)³⁰
- Off-label use for BDD requires careful consideration¹

Age-Specific Considerations

Ages 11-12 years:

- SSRI addition "may be considered" with enhanced monitoring¹
- Requires specialist child psychiatrist assessment
- Weekly monitoring for first month mandatory¹

Ages 12-17 years:

- SSRI addition "should be offered" following multidisciplinary review¹
- Standard monitoring protocols apply
- Careful attention to developmental factors³¹

Prescribing Guidelines

- **Assessment:** Must be conducted by child and adolescent psychiatrist¹
- **Concurrent CBT:** Mandatory alongside medication¹
- **Starting Dose:** Low starting dose, potentially half normal adult dose¹
- **Monitoring:** Frequent, regular appointments with patient and family¹
- **Duration:** Minimum 6 months post-remission if effective¹

Safety Monitoring

- **Suicide Risk:** Enhanced monitoring for suicidal ideation and self-harm¹
- **Behavioral Changes:** Watch for hostility, agitation, akathisia³²
- **Side Effects:** Regular assessment and documentation¹
- **Family Education:** Training family to recognize warning signs¹

Alternative Medications

If fluoxetine ineffective or not tolerated:

- **Licensed SSRIs:** Sertraline (ages 6+) or fluvoxamine (ages 8+) for OCD indication¹
- **Clomipramine:** May be considered with careful monitoring¹
- **ECG Monitoring:** Required before clomipramine initiation¹

6. Multidisciplinary Team Approach

Core Team Members

- **Child and Adolescent Psychiatrist:** Medication management, risk assessment^{1, 30}
- **Clinical Psychologist:** CBT delivery, psychological assessment^{38, 39}
- **Mental Health Nurse:** Monitoring, family support, care coordination^{41, 45}
- **Social Worker:** Family support, school liaison when needed^{36, 37}

Collaborative Partners

- **School Personnel:** Teachers, counselors, educational psychologists^{37, 44}
- **Primary Care:** GP for ongoing medical care^{1, 44}
- **Dermatology/Plastic Surgery:** Screening and referral protocols^{1, 18}
- **Family Support Services:** When family dysfunction present^{36, 42}

Team Functions

- **Assessment Coordination:** Comprehensive evaluation across domains^{1, 39}
- **Treatment Planning:** Individualized, evidence-based interventions^{39, 40}
- **Risk Management:** Ongoing monitoring and response protocols^{1, 41}
- **Care Coordination:** Seamless service delivery and communication^{41, 45}

7. Special Considerations

Cosmetic Treatment Requests

- **Mandatory Assessment:** Mental health evaluation before any procedure
- **Specialist Consultation:** BDD expert involvement in decision-making
- **Treatment Sequencing:** Mental health treatment typically prioritized
- **Collaborative Care:** Partnership between mental health and cosmetic providers

Crisis Management

- **Suicide Risk:** Immediate psychiatric assessment and safety planning
- **Severe Self-Harm:** Medical evaluation and treatment
- **Family Crisis:** Support services and intensive case management
- **School Refusal:** Educational psychology involvement and graduated return

Cultural and Religious Considerations

- **Cultural Sensitivity:** Understanding diverse appearance standards
- **Religious Accommodation:** Respecting religious practices and beliefs
- **Community Resources:** Engaging cultural and religious leaders when appropriate
- **Language Services:** Ensuring effective communication with families

8. Monitoring and Review

Treatment Monitoring

- **Symptom Measures:**
 - Body Dysmorphic Disorder Examination (BDDE-A) - adolescent version
 - Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS)
 - Clinical Global Impression (CGI) scales
- **Functional Assessment:**
 - Children's Global Assessment Scale (CGAS)
 - Academic performance measures
 - Social and family functioning scales
- **Quality of Life:**
 - Pediatric Quality of Life Inventory (PedsQL)
 - Age-appropriate measures
- **Risk Assessment:**
 - Columbia Suicide Severity Rating Scale (C-SSRS)
 - Ongoing evaluation of safety concerns

Session Frequency and Monitoring Schedule

CBT Treatment Phase

- **Weeks 1-4:** Weekly CBT sessions + weekly risk monitoring
- **Weeks 5-16:** Weekly CBT sessions + bi-weekly progress review
- **Weeks 17-20:** Weekly CBT sessions + monthly comprehensive review

Medication Monitoring (if prescribed)

- **Week 1:** Daily contact for first 3 days, then alternate days
- **Weeks 2-4:** Weekly appointments with prescriber
- **Weeks 5-12:** Bi-weekly medication reviews
- **Ongoing:** Monthly medication monitoring

Crisis Response

- **Immediate availability:** 24/7 crisis response protocols

- **Urgent appointments:** Within 24-48 hours for significant deterioration
- **Safety planning:** Updated weekly during high-risk periods

Outcome Measures

- **Primary:** Reduction in BDD symptoms and functional improvement
- **Secondary:** Quality of life, family functioning, academic performance
- **Long-term:** Sustained improvement, prevention of relapse

9. Discharge and Follow-up

Remission Criteria

- Symptoms not clinically significant for 12 weeks minimum¹
- Full functional recovery in academic and social domains³³
- Sustained improvement in family relationships
- Age-appropriate social and developmental functioning

Discharge Planning

- **12-Month Review Period:** Regular monitoring by mental health professional¹
- **Primary Care Transition:** Gradual transfer of ongoing care¹
- **Relapse Prevention:** Education about warning signs and response strategies³⁴
- **Re-referral Protocol:** Fast-track access if symptoms return¹

Long-term Considerations

- **Developmental Transitions:** Support during key life changes (secondary school, college)³⁵
- **Adult Services:** Smooth transition planning when appropriate¹
- **Family Support:** Ongoing resources for caregivers³⁶
- **Educational Continuity:** Coordination with school services³⁷

10. Quality Assurance and Training

Staff Competencies

- **Specialized Training:** BDD-specific knowledge and skills³⁸

- **Child and Adolescent Expertise:** Developmental considerations and family work³⁹
- **Ongoing Supervision:** Regular clinical oversight and support¹
- **Professional Development:** Continuing education and skill updates⁴⁰

Service Standards

- **Evidence-Based Practice:** Adherence to NICE guidelines¹
- **Patient Safety:** Robust risk management protocols⁴¹
- **Family-Centered Care:** Involvement of families in all aspects¹
- **Cultural Competence:** Responsive to diverse community needs⁴²

Audit and Evaluation

- **Clinical Outcomes:** Regular review of treatment effectiveness⁴³
- **Service Accessibility:** Monitoring referral patterns and waiting times⁴⁴
- **Patient Satisfaction:** Feedback from young people and families⁴⁵
- **Professional Standards:** Compliance with regulatory requirements⁴⁶

Implementation Considerations

- **Service accessibility:** Protocols should ensure timely access to specialized BDD services^{44, 45}
- **Clinician training:** Specialized BDD knowledge essential for effective treatment^{38, 40}
- **Quality monitoring:** Regular audit of clinical outcomes and patient satisfaction^{41, 43}
- **Transition planning:** Smooth progression to adult services when appropriate³⁵

Evidence Base and References

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Treatment Protocol for Bullying in Youth and Adolescents (11-17 Years)

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

This protocol integrates evidence-based therapeutic interventions for adolescents (11-17 years) who have experienced bullying victimization. This comprehensive protocol combines individual therapeutic modalities with systemic approaches to address both immediate trauma symptoms and long-term psychological resilience.

Assessment and Screening Phase

Initial Assessment Components

1. Comprehensive Clinical Interview

- Detailed bullying history assessment
- Types of bullying experienced (physical, verbal, relational, cyberbullying)
- Duration, frequency, and severity of incidents
- Current symptoms and functional impairment
- Social support systems and protective factors
- Mental health screening for comorbid conditions

2. Standardized Assessment Tools

- **Child and Adolescent Trauma Screen (CATS)³:** A brief, freely accessible screening instrument based on DSM-5 criteria for PTSD, measuring traumatic events and posttraumatic stress symptoms (ages 7-17)
- **Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA-5)⁴:** A 30-item clinician-administered PTSD scale based upon DSM-5 criteria for children and adolescents ages seven and above
- **Child PTSD Symptom Scale for DSM-5 (CPSS-5)⁵:** Measures PTSD diagnosis and severity in children aged 8-18
- **Revised Child Anxiety and Depression Scale (RCADS)⁶:** Comprehensive assessment of anxiety and depression symptoms
- **Strength and Difficulties Questionnaire (SDQ)⁷:** Screening tool for emotional and behavioral problems
- **UCLA Child/Adolescent PTSD Reaction Index for DSM-5⁸:** Assesses trauma history and full range of DSM-5 PTSD diagnostic criteria

- **Bullying-specific questionnaires for comprehensive evaluation**

3. Risk Assessment

- Suicidal ideation screening
- Self-harm behaviors
- Substance use assessment
- Academic and social functioning evaluation

Primary Treatment Modalities

1. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Evidence Base: Multiple studies demonstrate TF-CBT effectiveness for bullying-related trauma, with approximately 35% of bullying victims developing PTSD symptoms⁹¹⁰. TF-CBT is recommended as a first-line treatment for youth with PTSD by international guidelines¹¹¹².

Treatment Duration: Weekly 12-20 sessions (typically 16 sessions), 60 minutes

Core Components:

- **Psychoeducation:** Understanding trauma responses and bullying impact
- **Cognitive Restructuring:** Identifying and challenging distorted thoughts
- **Exposure Therapy:** Gradual confrontation of avoided situations
- **Trauma Narrative Development:** Processing bullying experiences safely
- **Cognitive Processing:** Addressing self-blame and shame
- **Relapse Prevention:** Building coping strategies

Session Structure:

- Sessions 1-4: Stabilization and psychoeducation
- Sessions 5-12: Trauma processing and narrative development
- Sessions 13-16: Integration and relapse prevention

2. Bullying Victimization CBT (BV-CBT)

Evidence Base: Emerging specialized CBT approach specifically developed for bullying victims, addressing unique cognitive and behavioral patterns¹³¹⁴. Research supports CBT's effectiveness in reducing cognitive inflexibility, encouraging interpersonal interaction, and reducing avoidance behaviors¹⁵.

Key Interventions:

- **Evidence-Based Thinking:** Challenging catastrophic thoughts about bullying
- **Behavioral Activation:** Increasing positive activities and social engagement
- **Emotion Regulation:** Managing anxiety, depression, and anger responses
- **Social Skills Training:** Building assertiveness and communication skills
- **Cognitive Flexibility Enhancement:** Reducing rigid thinking patterns

Treatment Goals:

- Reduce PTSD symptoms by 50% or more
- Improve emotional regulation and coping strategies
- Restore sense of safety and self-efficacy
- Enhance peer relationships and social functioning

Adjunctive Interventions**1. Mindfulness-Based Interventions**

Evidence Base: School-based mindfulness interventions show significant reduction in bullying behaviors and improved self-control^{16,17}. Meta-analyses demonstrate mindfulness-based interventions improve emotional regulation and reduce anxiety and depression in adolescents^{18,19}.

Protocol Components:

- **Duration:** 8-10 weekly sessions (40-45 minutes each)
- **Content Areas:**
 - Introduction to mindfulness
 - Identifying worry and anxiety patterns
 - Acting thoughtfully vs. reactively
 - Taking perspective and stepping back
 - Making friends with difficult emotions
 - Practicing empathy and compassion
 - Daily mindfulness practice with journaling

Outcomes:

- 50% reduction in bullying-related stress
- Improved emotional regulation
- Enhanced self-control and decision-making
- Increased empathy and prosocial behavior

2. Social Skills Training

Evidence Base: Effective for younger adolescents and those with significant social deficits.²⁰. Studies demonstrate improvements in assertiveness, communication skills, and peer relationships²¹.

Core Skills Training:

- **Assertiveness Training:** Standing up for oneself appropriately
- **Communication Skills:** Expressing needs and boundaries clearly
- **Friendship Building:** Developing and maintaining peer relationships
- **Conflict Resolution:** Managing interpersonal disputes constructively
- **Empathy Development:** Understanding others' perspectives
- **Leadership Skills:** Taking positive roles in peer groups

Duration/Frequency Specifications:

- **Individual sessions:** 8-12 sessions of 45-60 minutes, allowing for personalized pace
- **Group format:** 8-10 weekly sessions of 90 minutes to accommodate group dynamics
- **Intensive options:** Workshop format for accelerated learning
- **Integration period:** 4-6 weeks for skill consolidation and real-world application

Delivery Format:

- Individual sessions integrated with primary therapy
- Small group training (3-5 participants)
- Role-playing and behavioral rehearsal
- Real-world practice assignments

3. Cognitive-Behavioral Group Therapy

Evidence Base: Group CBT effectively reduces anxiety, depression, and physical complaints in bullying victims^{22/23}. Research demonstrates significant improvements in coping strategies and psychological symptoms²⁴.

Group Structure:

- **Duration:** 10-12 weekly sessions (90 minutes each)
- **Group Size:** 6-8 adolescents
- **Age-Matched Groups:** Similar developmental stages

Core Elements:

- **Psychoeducation:** Understanding bullying and trauma responses
- **Cognitive Restructuring:** Group-based thought challenging
- **Coping Skills Training:** Stress management and emotion regulation
- **Peer Support:** Shared experiences and mutual encouragement
- **Behavioral Experiments:** Testing new behaviors in safe environment

Family and Systems Interventions

1. Parent/Caregiver Education and Support

Components:

- Understanding bullying impact and trauma responses
- Supporting adolescent's recovery process
- Communication strategies for difficult conversations
- Advocacy skills for school and community settings
- Family stress management

2. School Consultation and Collaboration

Evidence-Based School Interventions:

- **Whole-School Approaches:** Policy development and implementation²⁵
- **Bystander Training:** Empowering peers to intervene safely
- **Teacher Training:** Recognition and response protocols

- **Environmental Modifications:** Supervision and safety improvements

Consultation Services:

- Assessment of school climate and bullying policies
- Training for school personnel on trauma-informed approaches
- Development of individualized safety plans
- Coordination between therapy and school interventions

Specialized Considerations

1. Cyberbullying-Specific Interventions

Additional Components:

- Digital literacy and safety education
- Social media boundaries and management
- Documentation and reporting procedures
- Online reputation management
- Technology use agreements

Evidence Base: Specialized interventions address unique aspects of online victimization²⁷.

2. Cultural and Diversity Considerations

Culturally Responsive Adaptations:

- Language-appropriate materials and interpreters
- Cultural values integration in treatment planning
- Community and family involvement as culturally appropriate
- Addressing discrimination and bias-related bullying
- Culturally adapted mindfulness and coping practices

3. Trauma-Informed Care Principles

Core Principles:

- **Safety:** Physical and emotional safety throughout treatment
- **Trustworthiness:** Transparent and consistent therapeutic relationships

- **Collaboration:** Shared decision-making and empowerment
- **Choice:** Options and control over treatment decisions
- **Cultural Responsiveness:** Respect for identity and background

Treatment Outcome Measures

Primary Outcomes

- **PTSD Symptom Reduction:** 50% or greater reduction on CAPS-CA
- **Depression Improvement:** Clinically significant change on RCADS depression scale
- **Anxiety Reduction:** Meaningful decrease in anxiety symptoms
- **Functional Improvement:** Enhanced school and social functioning

Secondary Outcomes

- **Self-Esteem Enhancement:** Improved self-concept and confidence
- **Social Functioning:** Better peer relationships and social skills
- **Academic Performance:** Reduced impact on educational achievement
- **Quality of Life:** Overall improvement in daily functioning

Follow-Up Assessment Schedule

- **Post-treatment:** Immediate completion assessment
- **3-Month Follow-up:** Short-term maintenance evaluation
- **6-Month Follow-up:** Medium-term outcome assessment
- **12-Month Follow-up:** Long-term effectiveness evaluation

Treatment Implementation Guidelines

Phase 1: Stabilization and Safety (Sessions 1-4) weekly 60 min sessions^{11/12}.

- Establish therapeutic alliance and safety
- Complete comprehensive assessment
- Psychoeducation about bullying and trauma
- Develop coping and grounding techniques

- Create safety plan for ongoing situations

Phase 2: Trauma Processing (Sessions 5-12) weekly sessions^{11'12}.

- Process specific bullying incidents using chosen modality
- Address trauma-related beliefs and cognitions
- Work through avoidance behaviors
- Build emotion regulation skills
- Address shame and self-blame

Phase 3: Integration and Resilience Building (Sessions 13-20) weekly sessions^{11'12}.

- Consolidate therapeutic gains
- Develop relapse prevention strategies
- Practice new skills in real-world contexts
- Address future challenges and transitions
- Plan for treatment conclusion and follow-up

Concurrent Interventions Throughout Treatment weekly sessions^{11'12}.

- Family involvement and education
- School consultation and collaboration
- Crisis intervention as needed
- Coordination with other providers
- Community resource connection

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Additional Key Resources:

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Treatment Protocol for Depression in Adolescents (Ages 11-17 Years)

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

Protocol Overview

This treatment protocol incorporates evidence-based treatment recommendations from the most current American Academy of Child & Adolescent Psychiatry (AACAP) Clinical Practice Guidelines (2022)¹, American Academy of Pediatrics (AAP) Guidelines for Adolescent Depression in Primary Care (GLAD-PC) (2018)², and the U.S. Preventive Services Task Force recommendations (2022)³ for managing depressive disorders in adolescents aged 11-17 years.

Applicable Professional Standards

Primary Guideline Sources

1. AACAP Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Major and Persistent Depressive Disorders (2022)¹
2. AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I and II (2018)^{2,4}
3. U.S. Preventive Services Task Force Recommendation on Screening for Depression and Suicide Risk in Children and Adolescents (2022)³
4. FDA Safety Information on Suicidality in Children and Adolescents Being Treated with Antidepressant Medications (2004, ongoing monitoring)⁵
5. Joint Commission Standards for Behavioral Health Care⁶
6. DSM-5-TR Diagnostic Criteria (2022)⁷

1. DIAGNOSTIC CONSIDERATIONS

Depressive Disorders in Adolescents⁷

- **Major Depressive Disorder, Single Episode** - ICD-10: F32.0 (mild), F32.1 (moderate), F32.2 (severe without psychotic features), F32.3 (severe with psychotic features), F32.4 (in partial remission), F32.5 (in full remission), F32.9 (unspecified), DSM-5: 296.2x
- **Major Depressive Disorder, Recurrent** - ICD-10: F33.0 (mild), F33.1 (moderate), F33.2 (severe without psychotic features), F33.3 (severe with psychotic features), F33.41 (in partial remission), F33.42 (in full remission), F33.9 (unspecified), DSM-5: 296.3x
- **Persistent Depressive Disorder (Dysthymia)** - ICD-10: F34.1, DSM-5: 300.4
- **Disruptive Mood Dysregulation Disorder** - ICD-10: F34.81, DSM-5: 296.99
- **Premenstrual Dysphoric Disorder** - ICD-10: N94.3, DSM-5: 625.4
- **Other Specified Depressive Disorder** - ICD-10: F32.8, DSM-5: 311

- **Unspecified Depressive Disorder** - ICD-10: F32.9, DSM-5: 311

2. DIAGNOSTIC CRITERIA APPLICATION

Standard of care requires adherence to DSM-5-TR criteria⁷:

Major Depressive Disorder (Single or Recurrent Episode):

- At least 5 of 9 symptoms present during same 2-week period (at least one symptom must be depressed mood OR loss of interest/pleasure)
- Symptoms: depressed mood, markedly diminished interest/pleasure, significant weight loss/gain or appetite change, insomnia/hypersomnia, psychomotor agitation/retardation, fatigue/energy loss, feelings of worthlessness/inappropriate guilt, diminished concentration/indecisiveness, recurrent thoughts of death/suicidal ideation
- Symptoms cause significant distress or functional impairment
- Not attributable to substance use or medical condition
- No history of manic or hypomanic episode (unless substance/medically induced)

Persistent Depressive Disorder (Dysthymia) ⁷:

- Depressed mood for most of the day, more days than not, for at least 1 year in children/adolescents
- At least 2 of 6 symptoms: poor appetite/overeating, insomnia/hypersomnia, low energy/fatigue, low self-esteem, poor concentration/difficulty making decisions, feelings of hopelessness
- Never without symptoms for more than 2 months during 1-year period
- No major depressive episode during first year
- No history of manic or hypomanic episode
- Significant distress or functional impairment

Disruptive Mood Dysregulation Disorder⁷:

- Severe recurrent temper outbursts grossly out of proportion in intensity or duration
- Outbursts inconsistent with developmental level
- Outbursts occur 3 or more times per week on average
- Mood between outbursts is persistently irritable/angry most of the day, nearly every day
- Symptoms present for 12 months or more (never without symptoms for 3+ consecutive months)

- Onset before age 10 years
- Diagnosis should not be made before age 6 or after age 18
- Symptoms present in at least 2 settings

3. ASSESSMENT COMPONENTS

The standard of care requires comprehensive evaluation including:

1. Clinical Interview Standards:

- Detailed psychiatric history spanning minimum 60 minutes initial assessment
- Systematic review of DSM-5-TR criteria for Major Depressive Disorder
- Developmental history and psychosocial assessment
- Medical history and current medications
- Assessment of functional impairment across home, school, and peer settings¹

2. Required Screening Instruments:

- **PHQ-9: Modified for Teens or PHQ-A** - validated depression screening tool²
- **Columbia Suicide Severity Rating Scale (C-SSRS)** - mandatory for all cases⁹
- **SCARED or equivalent validated anxiety screening** (given high comorbidity)¹⁰
- **Substance use screening** (CRAFFT or equivalent)¹¹
- **Trauma screening** (ACEs, PC-PTSD-5, or UCLA PTSD-RI)¹²

3. Medical Evaluation Requirements:

- Complete medical history including medications, family history, substance use
- Complete blood count, comprehensive metabolic panel
- Thyroid function studies (TSH, Free T4), Vitamin D and B12 levels
- Pregnancy testing for sexually active females
- ECG if considering certain medications
- Sleep study referral if significant sleep disturbances present

4. Risk Assessment Documentation:

- Current suicide risk level with specific risk factors using C-SSRS
- Access to lethal means assessment

- Protective factors identification
- Safety planning documentation with patient and family involvement
- Assessment for non-suicidal self-injury (NSSI)

4. EVIDENCE-BASED TREATMENT HIERARCHY

MILD DEPRESSION (PHQ-A: 5-9)

ICD-10 Codes: F32.0 (single episode, mild), F33.0 (recurrent, current episode mild)

Standard First-Line Interventions (NICE/AACAP/AAP Consensus):^{24, 1, 2}

1. **Watchful waiting** for 2 weeks with follow-up assessment²⁴
2. **Psychoeducation** (patient and family) - mandatory component^{1, 2, 24}
3. **Choice of psychological therapies** (ages 12-17):²⁴
 - Digital CBT (computer/tablet/phone-based programs)
 - Group CBT
 - Group non-directive supportive therapy (NDST)
 - Group interpersonal psychotherapy (IPT)
4. **Individual therapies** if group options unsuitable:²⁴
 - Individual CBT (for ages 11-17)
 - Attachment-based family therapy
5. **Lifestyle interventions:**^{1, 24}
 - **Structured exercise program** (3 sessions/week, 45-60 minutes, 10-12 weeks)²⁴
 - **Sleep hygiene education**²⁴
 - **Nutritional counseling** and balanced diet advice²⁴
 - Academic accommodations as needed
6. **Active monitoring** with follow-up within 2 weeks initially, then 2-4 weeks^{2, 24}

Contraindication: Antidepressant medication should **NOT** be used for initial treatment of mild depression²⁴

MODERATE DEPRESSION (PHQ-A: 10-14)

ICD-10 Codes: F32.1 (single episode, moderate), F33.1 (recurrent, current episode moderate)

Standard First-Line Treatment (NICE/AACAP Consensus):

Ages 11-14 (Children):²⁴

- **Consider these options** adapted to developmental level:
 - Family-based IPT
 - Family therapy (family-focused treatment for childhood depression)
 - Psychodynamic psychotherapy
 - Individual CBT
- **With or without fluoxetine** (cautious consideration only after 4-6 therapy sessions if unresponsive)²⁴

Ages 15-17 (Adolescents):^{1, 24}

- **Offer individual CBT** for at least 3 months (12-16 weekly sessions, 45-60 minutes each)²⁴
- **Alternative options** if CBT unsuitable:²⁴
 - IPT-A (Interpersonal Therapy for Adolescents)
 - Family therapy (attachment-based or systemic)
 - Psychodynamic psychotherapy

NICE Combination Therapy Option:²⁴

- **Consider combined therapy** (fluoxetine + psychological therapy) as alternative to psychological therapy alone for ages 12-18

Monitoring Standards:

- Weekly sessions for minimum 8 weeks^{1, 2}
- Standardized outcome measures (PHQ-A, MFQ) every 2-4 weeks²⁴
- Safety assessment at each session using C-SSRS⁹
- Family involvement per clinical judgment and patient consent^{1, 24}

SEVERE DEPRESSION OR MODERATE WITH SUICIDAL IDEATION

ICD-10 Codes: F32.2 (single episode, severe without psychotic features), F32.3 (single episode, severe with psychotic features), F33.2 (recurrent, current episode severe without psychotic features)

ICD-10 Codes: F32.2 (single episode, severe without psychotic features), F32.3 (single episode, severe with psychotic features), F33.2 (recurrent, current episode severe without psychotic features)

Standard Combined Treatment (NICE/AACAP Consensus):

1. **Immediate psychiatric consultation** - same day for active suicidal ideation^{1, 2, 24}
2. **Combined psychotherapy and pharmacotherapy:**
 - **NICE mandates:** Do NOT offer antidepressants except in combination with concurrent psychological therapy²⁴
 - **AACAP suggests:** Combination treatment (CBT plus fluoxetine) for adolescents with major depressive disorder^{17, 18}
3. **Multidisciplinary review** after 4-6 therapy sessions if unresponsive²⁴
4. **Intensive safety monitoring** with weekly visits minimum^{1, 2, 24}
5. **Consideration of higher level of care:**^{1, 2, 24}
 - Intensive outpatient programs (IOP)
 - Partial hospitalization programs (PHP)
 - Inpatient psychiatric hospitalization

Key NICE Requirements:²⁴

- **Fluoxetine only antidepressant** where clinical trial evidence shows benefits outweigh risks
- **Assessment and diagnosis by child and adolescent psychiatrist** required before prescribing
- **Careful monitoring arrangements** including weekly contact for first 4 weeks
- **Close monitoring for suicidal behavior, self-harm, or hostility**

Monitoring Standards:

During Active Treatment:

- **Weekly visits** for first 4 weeks when starting antidepressant medication (FDA Black Box Warning compliance)^{5, 19, 24}
- **Biweekly visits** weeks 5-8, then weekly psychotherapy sessions^{1, 2}
- **Monthly visits** thereafter during acute phase (first 3 months)⁵

During Continuation Phase (6-12 months after acute treatment):

- **Monthly visits** minimum, frequency adjusted based on clinical status, family support, environmental stressors, and presence of comorbid conditions^{1, 2}

During Maintenance Phase (for recurrent/severe depression):

- **Monthly to quarterly visits** depending on clinical stability¹

- Duration typically 12+ months for recurrent depression; AACAP suggests continued fluoxetine alone or CBT plus continued fluoxetine to prevent relapse/recurrence¹⁷
- **NICE:** Continue medication for at least 6 months after remission (defined as no symptoms and full functioning for at least 8 weeks)²⁴

5. PHARMACOLOGICAL TREATMENT STANDARDS

FDA-Approved First-Line Medications (NICE/AACAP/AAP Consensus)

Fluoxetine (Prozac) - First Choice:^{24, 1, 2}

- **FDA-approved for Major Depressive Disorder ages 8+ and only antidepressant with established efficacy in youth^{5, 20, 21, 24}**
- **NICE:** Only antidepressant where clinical trial evidence shows benefits outweigh risks²⁴
- **Starting dose:** 10mg daily (consider lower in younger children or anxiety-prone patients)^{1, 20, 24}
- **Titration:** Can increase to 20mg daily after 1 week if necessary, though lower doses should be considered in children with lower body weight²⁴
- **Maximum dose:** 20mg daily recommended for most patients; higher doses may be considered in older adolescents with higher body weight²⁴
- **Black box monitoring required^{5, 19}**

Escitalopram (Lexapro) - Second Choice:²

- FDA-approved for Major Depressive Disorder ages 12+^{5, 21}
- **GLAD-PC:** Recommended second-line SSRI²
- Starting dose: 5-10mg daily²¹
- Maximum dose: 20mg daily²¹
- **Black box monitoring required^{5, 19}**

Second-Line Options (When Fluoxetine Unsuccessful):

NICE Recommendations:²⁴

- **Sertraline or Citalopram** only when specific criteria met:
 - Full discussion with patient/family about benefits and risks
 - Depression sufficiently severe to justify trial of another antidepressant
 - Clear evidence of fair trial of fluoxetine + psychological therapy
 - Reassessment of likely causes and treatment resistance

- Advice from senior child and adolescent psychiatrist
- Appropriate consent obtained

GLAD-PC Recommendations:²

- **Sertraline:** Starting 25mg daily (FDA-approved for OCD ages 6+)
- **Citalopram:** Use with caution due to QTc concerns

Contraindicated Medications:

NICE Contraindications:²⁴

- **Paroxetine:** Should NOT be used in children and young people
- **Venlafaxine:** Should NOT be used in children and young people
- **Tricyclic antidepressants:** Should NOT be used in children and young people

AACAP: Excludes paroxetine due to potential suicidal ideation¹

Mandatory Monitoring Requirements

NICE Monitoring Standards:²⁴

- **Weekly contact** with child/young person and parents/carers for first 4 weeks
- **Close monitoring** for suicidal behavior, self-harm, or hostility
- **Symptoms monitoring** for 7 days before prescribing unless immediate treatment needed
- **Urgent contact protocols** established for new concerning symptoms

FDA Black Box Warning Compliance:^{5, 19, 22}

- **Weekly face-to-face visits** for first 4 weeks after initiation or dose changes
- **Biweekly visits** for weeks 5-8
- **Monthly visits** thereafter for first 3 months
- **Specific documentation of suicidal ideation assessment** using validated tools (C-SSRS)
- **Patient and family education** about warning signs

Laboratory Monitoring:

- **Baseline:** CBC, CMP, TSH, pregnancy test for sexually active females
- **Follow-up:** As clinically indicated; repeat pregnancy testing quarterly for sexually active females
- **ECG:** If family history of cardiac disease, personal cardiac symptoms, or considering alternative medications

Side Effect Monitoring:

- **Activation syndrome assessment** (particularly crucial first 2-4 weeks)
- **Sleep and appetite changes** documentation
- **Sexual side effects** (age-appropriate inquiry for adolescents 14+)
- **Growth and weight monitoring** (height/weight at each visit)
- **Assessment for serotonin syndrome** symptoms

Duration of Treatment:^{23, 24}

- **NICE:** Continue for at least 6 months after remission (defined as no symptoms and full functioning for at least 8 weeks)²⁴
- **GLAD-PC:** 6 months to 1 year after symptoms fully resolved²
- **First episode:** 6-12 months following symptom remission
- **Recurrent episodes:** 12+ months following remission
- **Gradual taper** over 6-12 weeks when discontinuing to prevent withdrawal symptoms²⁴

6. PSYCHOTHERAPY STANDARDS

Cognitive Behavioral Therapy (CBT)^{1, 24, 23}

Treatment Requirements:

- Use of evidence-based manual (e.g., CWD-A, ACTION, CBT-T)^{14, 23}
- **NICE:** Individual CBT for at least 3 months for moderate-severe depression in ages 12-18²⁴
- Minimum 12-16 weekly sessions, 45-60 minutes each^{1, 2}
- Structured format with between-session assignments
- Parent/family involvement sessions (minimum 2-4 sessions)^{1, 24}

Core Components:^{1, 24}

- Psychoeducation about depression and adolescent development
- Cognitive restructuring techniques adapted for developmental stage
- Behavioral activation strategies including activity scheduling
- Problem-solving skills training
- Social skills training as indicated
- Relapse prevention planning

Interpersonal Therapy for Adolescents (IPT-A)^{1,23,24}

Treatment Requirements:

- 12-16 weekly 60 min sessions following IPT-A manual^{1,23}
- **NICE:** Evidence-based option for moderate-severe depression²⁴
- Focus on interpersonal problem areas:
 - Grief and loss
 - Interpersonal role disputes
 - Role transitions (particularly relevant for adolescents)
 - Interpersonal deficits

Family-Based Interventions^{1,24}

NICE Recommendations^{*24}

- **Family-based IPT** for ages 5-11 (10-12 weekly 60-90 min sessions) with moderate-severe depression
- **Attachment-based family therapy** (10-12 weekly 60-90 min sessions) for mild depression when group options unsuitable
- **Systemic family therapy** (10-14 weekly 60-90 min sessions) for treatment-resistant cases

Indications:^{1,2}

- High family conflict or dysfunction
- Family history of depression
- Treatment-resistant cases
- Younger adolescents (11-14 years)

Digital and Group Interventions²⁴

NICE Digital CBT Options:

- Computer, tablet, or phone-based CBT programs
- Examples include SPARX, Stressbusters, Grasp the Opportunity
- Some with healthcare professional support, others self-directed

Group Therapy Options:²⁴

- Group CBT

- Group non-directive supportive therapy (NDST)
- Group interpersonal psychotherapy (IPT)

Quality Standards^{1, 2, 24}

- **NICE:** Therapists must be trained in child and adolescent mental health²⁴
- **NICE:** Appropriate level of competence in specific therapy modality²⁴
- **AACAP:** Treatment alliance development with family¹
- **NICE:** Cultural competence and language considerations²⁴

7. CRISIS MANAGEMENT STANDARDS

Suicide Risk Assessment Protocol^{1, 2, 24}

Immediate Assessment Requirements:

1. **Columbia Suicide Severity Rating Scale (C-SSRS)** administration^{9, 24}
2. ****Risk factor evaluation:**^{1, 2, 24}**
 - Previous suicide attempts (strongest predictor)
 - Family history of suicide or depression
 - Access to lethal means
 - Recent stressful life events
 - Substance use
 - LGBTQ+ identity status
 - History of trauma or abuse
 - **NICE:** Bullying or abuse experiences²⁴
3. ****Protective factor assessment:**^{1, 2}**
 - Family support and connectedness
 - Religious/spiritual beliefs
 - Future orientation and goals
 - Problem-solving skills
 - Help-seeking behavior
4. **Mental status examination:** Psychosis, impulsivity, hopelessness, cognitive rigidity^{1, 2}

Safety Planning Standards^{1, 2, 24}

Required Elements (Stanley-Brown Safety Plan):

1. Warning sign identification (emotional, cognitive, behavioral, situational)
2. Internal coping strategies that can be used independently
3. Social contacts and settings for distraction and support
4. Family members or friends for help during crisis
5. Professional contacts including 24/7 crisis resources:
 - 988 Suicide & Crisis Lifeline
 - Local emergency services
 - Treating clinician contact information
6. Environmental safety measures (means restriction)
7. **Written plan with patient and family signatures^{1, 2, 24}**
8. **NICE: Regular review and updating of plan²⁴**

Hospitalization Criteria

Inpatient Admission Indicators (NICE/AACAP Consensus):

NICE Criteria:²⁴

- **High risk of suicide**
- **High risk of serious self-harm**
- **High risk of self-neglect**
- **Intensity of treatment/supervision not available elsewhere**
- **Intensive assessment indicated**

Additional AACAP/GLAD-PC Criteria:^{1, 2}

- Active suicidal ideation with plan and intent
- Severe psychotic symptoms with command hallucinations
- Inability to contract for safety or engage in safety planning
- Inadequate outpatient support system or family inability to provide supervision
- Previous high-lethality suicide attempt with continued risk factors
- Catatonic features

- Severe agitation or behavioral dyscontrol

NICE Considerations:²⁴

- **Balance benefits vs. detrimental effects** (e.g., loss of family and community support)
- **Involve child/young person and family** in admission process whenever possible
- **Age-appropriate facilities** with educational and recreational activities
- **Planning for aftercare** should begin before or early in admission

Current Evidence on Inpatient Length of Stay:

- Average minimum stay: 4-7 days for stabilization¹⁵
- Length determined by clinical need, safety assessment, and insurance authorization
- Focus on crisis stabilization, safety planning, and discharge planning

Documentation Requirements:^{1, 2, 6}

- Risk assessment rationale for disposition decision
- Family notification and involvement in safety planning
- Transition of care communication with complete medication reconciliation
- Follow-up appointment scheduling within 72 hours of discharge (within 24 hours for high-risk patients)

8.Treatment-Resistant Depression Standards

Definition and Criteria^{1, 2}

Standard Definition:

- Inadequate response to two adequate trials of evidence-based treatment
- Each trial minimum 8-12 weeks duration at therapeutic doses
- Documented treatment adherence >80%
- One trial should include combination psychotherapy and pharmacotherapy¹

Assessment Before Declaring Treatment Resistance:^{1, 24}

- Review diagnostic accuracy and comorbid conditions
- Assess treatment adherence and environmental factors
- Evaluate family engagement and support
- Consider developmental factors and trauma history
- **NICE:** Reassessment of possible individual, family and social causes²⁴

Next-Step Standards:^{1,2,24}

1. **Specialist Consultation:** Child and adolescent psychiatrist referral (mandatory)^{1,24}
2. NICE Medication Strategies:²⁴
 - **Sertraline or citalopram** only when specific criteria met
 - Requires senior child and adolescent psychiatrist advice
 - Full informed consent process required
3. Psychotherapy Modifications:^{1,24}
 - **NICE:** Alternative psychological therapy not previously tried²⁴
 - **NICE:** Systemic family therapy (at least 15 fortnightly sessions)²⁴
 - **NICE:** Psychodynamic psychotherapy (approximately 30 weekly sessions)²⁴
 - Increase session frequency to twice weekly
 - Switch therapeutic modalities (CBT to IPT-A or vice versa)
 - Add family-based interventions
 - Consider DBT-A for emotion dysregulation
4. Intensive Treatment Options:^{1,2}
 - Intensive outpatient programs
 - Partial hospitalization programs
 - Residential treatment for severe cases

9. SPECIAL CONSIDERATIONS FOR AGES 11-17

Developmental Considerations:^{1,2,24}

- **Early adolescence (11-14):**
 - **NICE:** Family-based approaches often preferred²⁴
 - Greater family involvement in treatment decisions^{1,24}
 - Concrete thinking approaches
 - Shorter sessions if needed for attention span
- **Middle adolescence (15-16):**
 - Balance independence with family support^{1,2}
 - Address identity development issues

- **NICE:** Individual CBT as first-line treatment²⁴
- **Late adolescence (17):**
 - Prepare for transition to adult care^{1, 2}
 - College/work planning considerations
 - Greater autonomy in treatment decisions

School-Based Interventions:^{2, 24}

- **504 Plan or IEP accommodations** as indicated
- **NICE:** Coordination with school and educational professionals²⁴
- Academic support and modifications during acute episodes
- Return-to-school planning after hospitalization
- **NICE:** Collaborative anti-bullying strategies when relevant²⁴

Family and Cultural Considerations:^{1, 2, 24}

- **NICE:** Cultural competence training for healthcare professionals²⁴
- **NICE:** Therapy in patient's first language when possible²⁴
- **NICE:** Assessment of parental depression and family mental health²⁴
- **GLAD-PC:** Family involvement in all phases of treatment²
- Cultural background impact on symptom presentation²

11. QUALITY METRICS AND OUTCOME MONITORING

Required Outcome Measures:^{1, 2, 24}

- **PHQ-A or CDRS-R** at baseline, 4 weeks, 8 weeks, 12 weeks, and quarterly²
- **NICE:** Mood and Feelings Questionnaire (MFQ) as adjunct to clinical judgment²⁴
- **C-SSRS** at each clinical contact⁹
- **Functional assessment** using CGAS or similar measure^{1, 2}
- **NICE:** HoNOSCA or Strengths and Difficulties Questionnaire (SDQ)²⁴
- Family satisfaction and engagement measures²

Treatment Response Criteria:^{1, 2, 23}

- **Response:** $\geq 50\%$ reduction in depression severity scores
- **Remission:** Depression severity scores in normal range (PHQ-A ≤ 4)

- **NICE:** Remission defined as fewer than 2 symptoms and full functioning for at least 8 weeks²⁴
- **Recovery:** Sustained remission for ≥ 6 months with good functional status

Follow-up and Monitoring Standards:²⁴

- **NICE:** Regular review for 12 months post-remission by experienced CAMHS professional²⁴
- **NICE:** 24-month follow-up for recurrent depression²⁴
- **GLAD-PC:** Track functioning in multiple settings (home, school, peer)²
- Documentation of treatment adherence and environmental factors²

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Treatment Protocol for Problematic Social Media Use in Youth and Adolescents (Ages 11-17 Years): Neurodevelopmental Vulnerabilities and Evidence-Based Interventions

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

1. INTRODUCTION

This comprehensive treatment protocol addresses problematic social media use (PSMU) among youth and adolescents aged 11-17 years, with particular emphasis on the unique neurodevelopmental vulnerabilities during this critical period.

The protocol integrates current neuroscience research demonstrating that the prefrontal cortex—responsible for impulse control and decision-making—continues developing until approximately age 25, while the limbic system governing emotions and reward-seeking matures earlier⁷. This developmental asynchrony leaves adolescents particularly susceptible to the immediate gratification and social validation mechanisms embedded in social media design⁸.

2. NEURODEVELOPMENTAL CONTEXT AND VULNERABILITIES

A. Critical Brain Development During Adolescence

Structural Brain Changes:

- **Prefrontal Cortex Maturation:** The prefrontal cortex, crucial for executive function, undergoes extensive pruning and myelination throughout adolescence⁵
- **Gray Matter Reduction:** Synaptic pruning leads to more efficient neural networks but temporary vulnerabilities in decision-making⁶
- **White Matter Increase:** Enhanced myelination improves neural communication but is incomplete during adolescence⁷
- **Developmental Asynchrony:** The limbic system (emotion/reward) matures before the prefrontal cortex (control/planning), creating an "imbalance" period⁸

Functional Brain Vulnerabilities:

- **Heightened Reward Sensitivity:** Adolescent brains show hyperactivation in the nucleus accumbens when anticipating rewards⁹
- **Reduced Inhibitory Control:** Immature prefrontal-striatal circuits result in difficulty resisting immediate gratification¹⁰
- **Enhanced Social Sensitivity:** The "social brain" networks show increased activation to peer feedback during adolescence¹¹
- **Dopaminergic System Changes:** Peak dopamine receptor density occurs during adolescence, amplifying reward-seeking behaviors¹²

B. Developmental Sensitivity Windows

Research has identified specific "windows of developmental sensitivity" to social media effects¹³:

- **Early Adolescence (11-13 years):** Greatest vulnerability to social comparison and identity confusion¹⁴
- **Mid-Adolescence (14-15 years):** Peak sensitivity to peer rejection and social feedback¹⁵
- **Late Adolescence (16-17 years):** Continued vulnerability despite emerging regulatory capacities¹⁶

C. Neurobiological Impact of Social Media

Dopamine and Reward Circuits:

- Social media "likes" activate the same neural reward pathways as addictive substances¹⁷
- Variable ratio reinforcement schedules (unpredictable rewards) create compulsive checking behaviors¹⁸
- Each notification triggers dopamine release, reinforcing platform engagement¹⁹
- The dorsolateral prefrontal cortex, responsible for judgment and reasoning, shows altered activation patterns in frequent users²⁰

Stress Response Systems:

- Chronic social media use dysregulates the hypothalamic-pituitary-adrenal (HPA) axis²¹
- Fear of missing out (FOMO) maintains elevated cortisol levels²²
- Sleep disruption further compromises stress regulation systems - problematic users show 3x higher rates of sleep problems²³

Documented Brain Changes from Heavy Use:

- **Structural Alterations:** Habitual social media checking associated with changes in brain regions controlling social rewards and punishment, particularly affecting the amygdala and dorsolateral prefrontal cortex³²
- **Cortical Thinning:** Accelerated thinning in lateral prefrontal cortex and temporal parietal junction among high users, patterns associated with depression in adolescents³³
- **Heightened Sensitivity:** Brain imaging shows increased sensitivity to social feedback over time, creating a neurobiological vulnerability to peer approval/rejection³⁴

3. DIAGNOSTIC FRAMEWORK WITH NEURODEVELOPMENTAL CONSIDERATIONS

A. Assessment Must Include Developmental Stage

Age-Specific Diagnostic Criteria:

1. **Early Adolescence (11-13):** Focus on identity disruption and peer comparison³⁵
2. **Mid-Adolescence (14-15):** Emphasis on social feedback sensitivity and mood regulation³⁶
3. **Late Adolescence (16-17):** Assessment of emerging independence and future planning interference³⁷

B. Neurodevelopmentally-Informed Symptoms

Core Symptoms Reflecting Brain Vulnerabilities:

1. **Impaired Executive Function:** Inability to limit use despite negative consequences (prefrontal cortex immaturity)³⁸
2. **Emotional Dysregulation:** Using social media for mood modification (limbic system dominance)³⁹
3. **Reward Dependency:** Tolerance and withdrawal symptoms (dopaminergic alterations)⁴⁰
4. **Social Brain Hyperactivation:** Extreme distress from negative social feedback⁴¹

C. Comprehensive Assessment Protocol

Neurodevelopmental Assessment Components:

1. **Developmental History:** Timing of social media initiation relative to pubertal stage⁴²
2. **Executive Function Evaluation:** Formal assessment of inhibitory control and planning⁴³
3. **Sleep Assessment:** Critical given sleep's role in adolescent brain development⁴⁴
4. **Family History:** Genetic vulnerabilities to addiction and mental health conditions⁴⁵

Validated Assessment Tools with Developmental Norms:

- Bergen Social Media Addiction Scale (adolescent-normed version)⁴⁶
- Social Media Disorder Scale (cross-culturally validated for adolescents)⁴⁷
- Developmental Assets Profile (protective factors assessment)⁴⁸

4. COMPREHENSIVE TREATMENT INTERVENTIONS

A. Neurodevelopmentally-Adapted Cognitive-Behavioral Therapy

Core Adaptations for Adolescent Brain:

1. **Concrete Skill Building:** Compensate for abstract reasoning limitations⁴⁹
2. **Peer-Based Elements:** Leverage social brain sensitivity positively⁵⁰

3. **Reward Restructuring:** Create alternative dopamine-releasing activities⁵¹
4. **Parent-Adolescent Sessions:** Support emerging autonomy while maintaining structure⁵²

Treatment Specifications:

- **Duration:** 12-16 weeks minimum (allowing for neural adaptation)⁵³
- **Frequency:** Weekly 45–60-minute sessions⁵⁴
- **Provider Requirements:** LCPC, LCSW, or LMFT with specialized adolescent CBT training⁵⁵

B. Mindset-Based Interventions for Developing Brains

Neuroscience-Informed Approaches:

- **Agency Development:** "I control technology" vs "technology controls me"⁵⁶
- **Neuroplasticity Education:** Teaching adolescents about their changing brains⁵⁷
- **Mindfulness Training:** Strengthening prefrontal control over limbic impulses⁵⁸

Treatment Specifications:

- **Duration:** 8 weeks bi-weekly sessions⁵⁹
- **Session Length:** 50 minutes⁶⁰
- **Group Size:** 6-8 adolescents (peer learning)⁶¹

C. Digital Detox with Neurodevelopmental Support

Brain Recovery Protocols:

- **Initial Detox:** 3-week period limiting use to 1 hour/day⁶²
- **Neurochemical Rebalancing:** Allow dopamine receptors to resensitize⁶³
- **Sleep Restoration:** Critical for adolescent brain development⁶⁴
- **Alternative Activities:** High-reward, low-tech activities (sports, arts, nature)⁶⁵

Critical Monitoring During Detox:

- Withdrawal symptoms (irritability, anxiety, depression)⁶⁶
- Sleep patterns normalization⁶⁷
- Attention and focus improvements⁶⁸
- Mood stabilization⁶⁹

D. Family-Based Interventions Supporting Brain Development

Parent Education on Adolescent Neurodevelopment:

1. **Brain Development Timeline:** Understanding the 11–25-year maturation process⁷⁰
2. **Vulnerability Windows:** Recognizing high-risk developmental periods⁷¹
3. **Supportive Scaffolding:** Providing external structure while brain develops⁷²

Family Treatment Specifications:

- **Duration:** 8-12 weekly sessions⁷³
- **Session Length:** 60-90 minutes⁷⁴
- **Provider Requirements:** LMFT or LCSW with family systems training⁷⁵

5. SPECIALIZED INTERVENTIONS FOR DEVELOPING BRAINS

A. Digital Media Literacy with Neuroscience Education

Core Curriculum Addressing Brain Vulnerabilities:

1. **Dopamine and Design:** How platforms exploit reward systems⁷⁶
2. **Attention Economy:** Understanding attention as finite resource⁷⁷
3. **Social Brain Manipulation:** How platforms leverage social needs⁷⁸
4. **Neuroplasticity:** Brain's ability to change with different inputs⁷⁹

Implementation Specifications:

- **Duration:** 6-8 week curriculum⁸⁰
- **Frequency:** Weekly 45-minute sessions⁸¹
- **Group Size:** 6-8 adolescents⁸²
- **Provider Requirements:** Digital literacy certification required⁸³

B. Peer-Based Interventions Leveraging Social Brain

Developmentally-Appropriate Group Approaches:

- **Positive Peer Modeling:** Harness social learning tendencies⁸⁴
- **Collective Problem-Solving:** Build prefrontal skills together⁸⁵
- **Social Support Networks:** Create offline peer connections⁸⁶

Group Treatment Specifications:

- **Duration:** 10-12 weeks⁸⁷

- **Session Length:** 90 minutes⁸⁸
- **Group Size:** 6-10 same-age adolescents⁸⁹
- **Provider Requirements:** LCPC or LCSW with group therapy expertise⁹⁰

C. Technology-Assisted Interventions Supporting Development

Brain-Friendly Digital Tools:

- **Attention Training Apps:** Strengthen prefrontal control⁹¹
- **Sleep Tracking:** Monitor critical brain restoration periods⁹²
- **Mood Monitoring:** Increase emotional awareness⁹³
- **Nature-Based VR:** Stress reduction without social media⁹⁴

6. INTENSIVE TREATMENT OPTIONS FOR SEVERE CASES

A. Intensive Outpatient Programs (IOP)

Neurodevelopmentally-Informed Structure:

- **Duration:** 12-16 weeks⁹⁵
- **Frequency:** 3-4 sessions weekly⁹⁶
- **Daily Structure:** Balances treatment with school/development⁹⁷
- **Peer Milieu:** Age-grouped for developmental appropriateness⁹⁸

B. Partial Hospitalization Programs (PHP)

When Brain Vulnerabilities Require Intensive Support:

- **Duration:** 4-8 weeks⁹⁹
- **Daily Programming:** 6-8 hours structured treatment¹⁰⁰
- **Multidisciplinary Team:** Including developmental specialists¹⁰¹
- **Family Integration:** Supporting home environment changes¹⁰²

C. Crisis Stabilization Services

Immediate Safety with Developmental Sensitivity:

- **Duration:** Usually <15 days¹⁰³
- **24-Hour Supervision:** When self-harm risk present¹⁰⁴
- **Developmental Assessment:** Age-appropriate crisis intervention¹⁰⁵

- **Transition Planning:** Step-down to appropriate level¹⁰⁶

7. PREVENTION THROUGH DEVELOPMENTAL LENS

A. Universal Prevention Targeting Vulnerable Periods

Age-Specific Prevention Strategies:

1. **Pre-Adolescence (9-11):** Digital citizenship before vulnerability peaks¹⁰⁷
2. **Early Adolescence (11-13):** Intensive support during highest risk¹⁰⁸
3. **Mid-Adolescence (14-16):** Peer-led prevention programs¹⁰⁹
4. **Late Adolescence (17-18):** Transition to self-management¹¹⁰

B. School-Based Brain-Aware Interventions

Educator Training on Neurodevelopment:

- **Recognizing Vulnerability Signs:** Brain-based understanding¹¹¹
- **Classroom Strategies:** Supporting attention and focus¹¹²
- **Peer Education Programs:** Student leaders teaching brain science¹¹³

Implementation Specifications:

- **Teacher Training:** 4-hour workshops on adolescent brain¹¹⁴
- **Student Programs:** Bi-weekly peer education sessions¹¹⁵
- **Parent Education:** Quarterly brain development updates¹¹⁶

8. CRISIS INTERVENTION WITH DEVELOPMENTAL SENSITIVITY

A. High-Risk Scenarios Unique to Developing Brains

Neurodevelopmental Crisis Factors:

- **Impulsivity + Suicidality:** Underdeveloped impulse control increases risk¹¹⁷
- **Social Rejection Sensitivity:** Amplified pain from cyberbullying¹¹⁸
- **Risk-Taking Behaviors:** Sharing inappropriate content without considering consequences¹¹⁹
- **Emotional Flooding:** Inability to regulate intense emotions¹²⁰

B. Developmentally Appropriate Crisis Response

Age-Adapted Interventions:

1. **Safety Planning:** Concrete, specific steps for adolescent comprehension¹²¹

2. **Parent Involvement:** Balancing autonomy with protection¹²²
3. **Peer Support Integration:** Leveraging positive peer influences¹²³
4. **School Coordination:** Maintaining educational stability¹²⁴

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Evidence-Based Treatment Protocol for Self-Harm in Youth and Adolescents (Ages 11-17)

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

This protocol provides evidence-based assessment and treatment approaches specifically tailored for youth aged 11-17 who engage in non-suicidal self-injury (NSSI) and/or self-harm with suicidal intent. The protocol emphasizes early intervention, family involvement, and developmentally appropriate care while recognizing the complex interplay of biological, psychological, and social factors that contribute to self-harm behaviors in this age group.

1. Introduction and Definitions

Self-harm among adolescents is a significant public health concern¹. This protocol provides evidence-based assessment and treatment approaches specifically tailored for youth aged 11-17 who engage in non-suicidal self-injury (NSSI) and/or self-harm with suicidal intent. The protocol emphasizes early intervention, family involvement, and developmentally appropriate care while recognizing the complex interplay of biological, psychological, and social factors that contribute to self-harm behaviors in this age group.

A. DSM-5-TR and ICD-10 Diagnostic Considerations

DSM-5-TR Classification^{9, 10}

- **Non-Suicidal Self-Injury (NSSI):** Listed as a "Condition for Further Study" requiring research for potential inclusion as a formal disorder
- **NSSI Diagnostic Criteria (proposed):**
 - Intentional self-inflicted damage to body tissue on 5 or more days in the past year
 - Expectation that injury will lead to only minor physical harm
 - Engaged in for one or more of the following: relief from negative feeling/cognitive state, resolution of interpersonal difficulty, or induction of positive feeling state
 - Associated with clinically significant distress or impairment
 - Not occurring exclusively during psychotic episodes, delirium, substance intoxication, or intellectual disability
 - Not better explained by another mental disorder or medical condition¹¹

ICD-10 Classification^{12, 13}

- **X84:** Intentional self-harm by unspecified means
- **Z91.5:** Personal history of self-harm
- **R45.851:** Suicidal ideations

- Self-harm behaviors are coded under "External causes of morbidity and mortality" rather than as primary mental health conditions

Clinical Diagnostic Considerations for Youth^{14, 15}

- **Developmental Context:** Consider normative vs. pathological self-injury in adolescent development
- **Function Assessment:** Distinguish between automatic (internal) vs. social (interpersonal) functions
- **Severity Specifiers:** Frequency, method severity, medical consequences, and functional impairment
- **Comorbidity Patterns:** High rates of co-occurring mood disorders (60-70%), anxiety disorders (50-60%), and trauma-related disorders (40-50%)^{16, 17}
- **Differential Diagnosis:**
 - Distinguish from suicidal behavior with intent to die
 - Rule out medical conditions causing self-injurious behavior
 - Consider autism spectrum disorders with repetitive self-injurious behavior
 - Assess for substance-induced self-harm^{18, 19}

2. Initial Assessment and screening protocol

A. Universal Screening (Ages 12+)

Recommended Tools:

1. **Ask Suicide-Screening Questions (ASQ)** - validated for pediatric populations⁹
2. **Patient Health Questionnaire-9 Adolescent (PHQ-9A)** - validated for adolescents aged 12-18^{10, 11}
3. **Combined PHQ-9A + ASQ** approach for comprehensive screening¹²

Screening Frequency:

- Annual screening at minimum for ages 12+¹³
- Additional screening during high-risk periods

Following significant life events or transition

B. Clinical Interview and Assessment

Core Assessment Areas:

1. **Current episode details:** method, intent, precipitants, frequency
2. **Self-harm history:** onset, patterns, functions, triggers
3. **Mental health status:** mood, anxiety, trauma symptoms, substance use
4. **Social context:** family dynamics, peer relationships, school functioning
5. **Protective factors:** coping skills, social support, reasons for living¹⁴

Developmental Considerations for Ages 11-17:

- Cognitive developmental stage and abstract reasoning capacity
- Identity formation and peer influence
- Family dependence vs. autonomy conflicts
- Academic and social pressures¹⁵

3. Risk Assessment and Safety Planning

A. Risk Formulation (Not Risk Stratification)

Move beyond traditional low/medium/high-risk categories to comprehensive risk formulation including:

- **Historical factors:** trauma, previous self-harm, family history
- **Current stressors:** school, family, peers, identity issues
- **Protective factors:** family support, coping skills, future orientation
- **Dynamic risk factors:** mood changes, substance use, social isolation¹⁶

B. Risk Stratification:

- **High Risk:** Recent severe injuries, escalating frequency, concurrent suicidal ideation, limited support
- **Moderate Risk:** Regular NSSI, some functional impairment, variable support
- **Lower Risk:** Infrequent episodes, good insight, strong support system

C. Safety Planning

****Evidence-Based Safety Planning Components:**¹⁷**

1. Recognition of warning signs and triggers
2. Internal coping strategies (distraction, self-soothing)
3. Social contacts for support and distraction

4. Family members/friends who can provide help
5. Professional contacts and crisis resources
6. Environmental safety (removal of means)

Youth-Specific Adaptations:

- Developmentally appropriate language
- Technology-based safety planning apps
- Family involvement in safety planning
- School-based supports and contacts¹⁸

4. Evidence-Based Treatment Approaches

A. Dialectical Behavior Therapy for Adolescents (DBT-A)

Strongest Evidence Base for High-Risk Youth^{19, 20, 21}

F Codes Commonly Addressed^{9, 10}: F32.x, F33.x, F41.1, F43.1, F60.3 (older adolescents)

Indication: First-line treatment for moderate to severe NSSI

Treatment Intensity^{19, 20, 21}:

- **Duration:** Typically 6-12 months (24-48 individual sessions)
- **Components:**
 - **Individual therapy:** 1 session per week (50 minutes)
 - **Multi-family skills group:** 1 session per week (90-120 minutes)
 - **Phone coaching:** As needed between sessions (5-10 minute calls)
 - **Therapist consultation team:** Weekly (for providers)
 - **Total weekly commitment:** 3-4 hours including group

Evidence Summary:

- Moderate to large effect sizes for reducing self-harm ($d = 0.44-1.68$)²²
- Superior to enhanced usual care for reducing self-harm, suicidal ideation, and depression¹⁹
- 49.3% of youth achieved self-harm remission during follow-up²³

- Long-term effectiveness maintained at 3-year follow-up²⁴

Key Skills Modules:

1. Mindfulness
2. Emotion regulation
3. Distress tolerance
4. Interpersonal effectiveness
5. Walking the middle path (adolescent-specific module)²⁵

B. Cognitive Behavioral Therapy (CBT) ^{26, 27}

Indication: Mild to moderate NSSI, especially with comorbid depression/anxiety

F Codes Commonly Addressed: F32.x, F33.x, F41.1, F41.9, F43.2 ^{9, 10}

- **Individual therapy:** 1 session per week (50 minutes)
- **Family sessions:** 1 session every 2-3 weeks (50 minutes)
- **Total weekly commitment:** 1-1.5 hours
- **Duration:** 12-20 sessions over 3-6 months

Evidence Summary:

- Small to moderate effect sizes for reducing self-harm ($d = 0.13-0.31$)²⁸
- Effective for reducing depression and suicidal ideation²⁹
- Can be delivered in brief formats for accessibility³⁰

Core Components:

- Psychoeducation about self-harm functions
- Cognitive restructuring of negative thought patterns
- Problem-solving skills training
- Behavioral activation and mood monitoring
- Relapse prevention planning³¹

C. Mentalization-Based Therapy for Adolescents (MBT-A)

Indication: NSSI with attachment difficulties or trauma history ^{9, 10}

F Codes Commonly Addressed: F43.1, F60.3 (older adolescents), F94.1, F94.2 ^{9, 10}

Treatment Structure ^{9, 10}:

- **Individual therapy:** 1 session per week (50 minutes)
- **Group therapy:** 1 session per week (75 minutes) - when available
- **Family sessions:** 1 session every 2-4 weeks (50 minutes)
- **Total weekly commitment:** 2-3 hours

Focus: Improving capacity to understand mental states underlying behavior

Duration: 12-18 months (48-72 individual sessions)

Evidence Summary:

- Moderate to large effect sizes for reducing self-harm ($g = -0.82$)³³
- Superior to treatment as usual for reducing self-harm and depression³⁴
- Improvements mediated through enhanced mentalization and reduced attachment avoidance³⁵

Promising results in group formats for adolescents³⁶

D. Family-Based Interventions^{37, 38}

F Codes Commonly Addressed: Z62.820 (Parent-child relational problem), Z62.891 (Sibling relational problem), Z63.0 (Relationship distress with spouse/partner) ^{9, 10}

- **Family therapy:** 1 session per week initially, then bi-weekly (50-75 minutes)
- **Parent skills training:** 1 session per week for 6-8 weeks (90 minutes group or 50 minutes individual)
- **Multi-family groups:** 1 session per week (90 minutes) - when available
- **Total weekly commitment:** 1.5-3 hours depending on phase

Components:

- Family therapy sessions focused on communication and problem-solving
- Parent skills training for managing adolescent self-harm behaviors
- Sibling support when appropriate
- Family crisis planning and safety management^{37, 38}

E. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) ³⁹

Indication: NSSI with history of trauma or abuse³⁹

F. Codes Commonly Addressed: F43.1, F43.10, F43.12, Z62.810 (Personal history of physical/sexual abuse in childhood) ^{9,10}

Treatment Structure:

- **Individual therapy:** 1 session per week (50 minutes)
- **Parent/caregiver sessions:** 1 session per week parallel to child session (50 minutes)
- **Joint sessions:** 2-4 sessions during treatment (50 minutes)
- **Total weekly commitment:** 1.5-2 hours
- **Duration:** 12-20 sessions over 3-6 months

Evidence Summary:

- Large effect sizes for PTSD symptoms⁴⁰
- Superior to control conditions for trauma-related symptoms⁴¹
- High level of evidence based on multiple RCTs⁴²
- Effective across different trauma types and cultural contexts⁴³

F. Acceptance and Commitment Therapy for Adolescents (ACT-A) ⁴⁴

Indication: NSSI with experiential avoidance and rigid thinking patterns⁴⁴ **F Codes Commonly Addressed:** F32.x, F33.x, F41.1, F93.0

Treatment Structure:

- **Individual therapy:** 1 session per week (50 minutes)
- **Skills groups:** 1 session per week (90 minutes) - when available
- **Total weekly commitment:** 1-2.5 hours
- **Duration:** 16-24 sessions over 4-6 months

Evidence Summary:

- Promising results for anxiety and depression in youth adolescents⁴⁵
- Effective in reducing avoidance behaviors and increasing psychological flexibility⁴⁶
- Limited but emerging evidence for self-harm and suicidal ideation⁴⁷
- Effective as school-based group intervention⁴⁸

G. Adjunctive Services (Additional Hours)

- Psychiatric consultation: 1 hour monthly (0.25 hours per week average)
- Case management (high-risk cases): 1-2 hours per week

- School coordination meetings: 1 hour monthly (0.25 hours per week average)
- Crisis intervention (as needed)

5. Treatment Phases and Intensity Guidelines

A. Phase 1: Stabilization (Weeks 1-4) ¹⁷

Treatment intensity: 2-4 hours per week depending on risk level

- **Individual therapy:** 1-2 sessions per week (50 minutes each)
- **Family sessions:** 1 session per week (50-75 minutes)
- **Crisis planning sessions:** 1-2 additional sessions (30-50 minutes)

Goals:

- Safety planning and crisis management
- Psychoeducation for adolescent and family
- Establish therapeutic alliance
- Begin skill building (basic distress tolerance)
- Address immediate safety concerns

B. Phase 2: Active Treatment (Months 2-6) ¹⁷

Treatment intensity: Maintains 2-4 hours per week based on chosen modality

- **DBT-A:** Individual (weekly) + skills group (weekly) + family sessions (bi-weekly)
- **CBT/MBT-A/TF-CBT:** Individual (weekly) + family sessions (bi-weekly to monthly)
- **Psychiatric consultation:** Monthly (30-50 minutes)

Goals:

- Intensive skills training
- Address underlying trauma or mental health conditions
- Family therapy and parent training
- School coordination
- Regular monitoring and assessment

C. Phase 3: Consolidation (Months 6-12) ¹⁷

Treatment intensity: Reduces to 1-2 hours per week

- **Individual therapy:** Bi-weekly then monthly (50 minutes)
- **Family sessions:** Monthly (50 minutes)
- **Booster sessions:** As needed

Goals:

- Relapse prevention planning
- Transition planning
- Continued skills practice
- Reduced frequency of sessions
- Long-term follow-up planning

6. Treatment Matching and Individualization

A. Treatment Selection Criteria

DBT-A Recommended for:

- Frequent self-harm episodes (multiple times per month)
- High emotional dysregulation
- Multiple previous treatment failures
- Co-occurring substance use or eating disorders^{19, 37}

CBT-Informed Interventions for:

- Less frequent self-harm
- Primary depression or anxiety
- Good cognitive functioning and insight
- Motivated for change²⁸

MBT-A Recommended for:

- Self-harm with attachment difficulties
- History of trauma or complex trauma
- Emerging borderline personality features
- Difficulties with emotion regulation and interpersonal relationships^{34, 35}

TF-CBT Recommended for:

- Clear trauma history (abuse, violence, disaster)
- PTSD symptoms alongside self-harm
- Need for caregiver involvement in trauma processing
- Single or multiple trauma exposures^{39, 42}

Family-Based Approaches When:

- Significant family dysfunction
- Multiple system involvement (school, legal)
- Younger adolescents (11-14 years)
- Cultural factors favor family involvement³⁸

B. Cultural and Diversity Considerations

- Adapt interventions for cultural background, language, and values
- Consider LGBTQ+ affirmative approaches for sexual and gender minority youth
- Address trauma-informed care principles
- Involve cultural liaisons or interpreters as needed^{39, 40}

7. Crisis Management and Acute Care

A. Immediate Safety Assessment

****When to Consider Hospitalization:**⁴¹**

- Active suicidal ideation with plan and intent
- Severe self-injury requiring medical attention
- Psychosis or severe mental state changes
- Inability to contract for safety despite interventions
- Lack of adequate family/social support

B. Emergency Department Protocols

- Every adolescent presenting with self-harm should receive mental health assessment⁴²
- Avoid punitive or judgmental approaches
- Engage family in safety planning
- Coordinate with outpatient providers for continuity⁴³

C. Aftercare Planning

- Follow-up within 48 hours for high-risk cases⁴⁴
- Bridge to ongoing treatment services
- Family psychoeducation and support

8. Special Populations and Considerations

A. Youth with Neurodevelopmental Conditions

- Autism spectrum disorders require modified approaches
- ADHD may impact treatment engagement and completion
- Learning disabilities need accommodated assessment and intervention⁴⁶

B. LGBTQ+ Youth

- Higher rates of self-harm and suicide risk
- Address minority stress and family acceptance
- Connect with LGBTQ+-affirming resources⁴⁷

C. Trauma-Exposed Youth

- High comorbidity with PTSD and complex trauma
- Trauma-informed care principles throughout treatment
- Consider trauma-specific interventions (TF-CBT, EMDR)⁴⁸

8. Treatment Monitoring and Outcomes

A. Assessment Measures

Self-Harm Specific:

- Deliberate Self-Harm Inventory (DSHI)
- Self-Harm Questionnaire (SHQ)
- Functions of Self-Injury Scale⁵¹

General Mental Health:

- PHQ-9A for depression
- GAD-7 for anxiety
- Strengths and Difficulties Questionnaire (SDQ)⁵²

B. Treatment Fidelity and Quality Assurance

- Regular supervision and consultation
- Adherence monitoring for evidence-based treatments
- Outcome tracking and quality improvement
- Staff training and competency maintenance⁵³

9. School-Based Interventions and Collaboration

A. School Mental Health Support

- Designated mental health leads in schools
- Staff training on identification and response
- Policies for managing self-harm disclosures
- Peer support programs and mental health literacy⁴⁹

B. Collaboration Protocols

- Information sharing with appropriate consent
- Academic accommodations during treatment
- Return-to-school planning after hospitalization
- Prevention programming and early intervention⁵⁰

10. Treatment Monitoring and Outcomes

A. Assessment Measures

Self-Harm Specific:

- Deliberate Self-Harm Inventory (DSHI)
- Self-Harm Questionnaire (SHQ)
- Functions of Self-Injury Scale⁵¹

General Mental Health:

- PHQ-9A for depression
- GAD-7 for anxiety
- Strengths and Difficulties Questionnaire (SDQ)⁵²

B. Treatment Fidelity and Quality Assurance

- Regular supervision and consultation
- Adherence monitoring for evidence-based treatments
- Outcome tracking and quality improvement
- Staff training and competency maintenance⁵³

11. Medication Considerations

A. General Principles

- No medications specifically approved for self-harm treatment⁵⁴
- Treat underlying mental health conditions (depression, anxiety, trauma)
- Consider safety in overdose when prescribing
- Monitor for increased suicidal ideation, especially in early treatment⁵⁵

B. Special Considerations for Adolescents

- FDA black box warnings for antidepressants in youth
- Close monitoring during medication initiation
- Family involvement in medication management
- Coordination with therapy providers⁵⁶

12. Family Support and Psychoeducation

A. Family Psychoeducation Components

- Understanding self-harm functions and meanings
- Communication strategies and validation skills
- Crisis management and safety planning
- Self-care for family members
- Long-term recovery expectations⁵⁷

B. Support Resources

- Family support groups
- Educational materials and resources
- Online resources and apps

- Community mental health services⁵⁸

13. Prevention and Early Intervention

A. Primary Prevention

- Universal mental health screening in schools
- Social-emotional learning curricula
- Peer support and mentoring programs
- Media literacy and social media safety⁵⁹

B. Secondary Prevention

- Early identification of at-risk youth
- Brief intervention protocols
- Stepped care approaches
- Community-based prevention programs⁶⁰

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Treatment Protocol for Suicide Prevention in Youth and Adolescents (Ages 11-17 Years)

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

This comprehensive, evidence-based treatment protocol addresses suicide risk assessment, intervention, and ongoing care for adolescents aged 11-17 years. The protocol incorporates current clinical guidelines from the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), National Institute for Health and Care Excellence (NICE), World Health Organization (WHO), and the 2024 National Strategy for Suicide Prevention.

Key Guideline Integration:

- **AAP Blueprint for Youth Suicide Prevention (2024):** Multi-stakeholder approach emphasizing family, school, and community involvement
- **AACAP Practice Parameters:** Evidence-based assessment and treatment recommendations for children and adolescents with suicidal behavior
- **NICE Guidelines (NG225):** Self-harm assessment, management and preventing recurrence - comprehensive psychosocial assessment within 24 hours, person-centered collaborative care planning
- **NICE Depression Guidelines (NG134):** Identification and management of depression in children and young people with integrated suicide risk assessment
- **WHO LIVE LIFE Framework:** Evidence-based suicide prevention interventions and community engagement strategies
- **2024 National Strategy for Suicide Prevention:** Comprehensive whole-of-society approach with 15 strategic goals

I. Immediate Risk Assessment and Screening

A. Initial Safety Assessment

Time Frame: Within 15 minutes of presentation

Required Screening Tools:

- **Columbia Suicide Severity Rating Scale (C-SSRS) - current gold standard¹**
- **Ask Suicide-Screening Questions (ASQ) - validated for ages 10+²**
- **Comprehensive Mental Status Examination**
- **Assessment of protective factors and environmental supports**

AAP Recommendations:³

- **Primary care providers should screen for suicidal ideation in adolescents during routine visits**
- **Use of validated screening tools is essential for early identification**
- **Documentation of risk factors, protective factors, and safety planning is required**

1. B. Comprehensive Risk Factor Assessment Suicidal Ideation Evaluation

- a. Frequency, intensity, and duration of thoughts
- b. Specificity of plan and access to means
- c. Timeline and intent to act
- d. Previous attempts (strongest predictor of future attempts)⁴
- e. Protective factors and reasons for living

2. Clinical Risk Factor Assessment

High-Risk Factors:^{5, 6}

- a. Male gender (5.5:1 ratio for completed suicide in 15-19 year olds)
- b. Previous suicide attempt within past year (increases risk 30-fold)⁷
- c. Active suicidal ideation with specific plan and means⁸
- d. Comorbid mental health conditions:
 - Major depressive disorder with psychotic features^{9, 10}
 - Bipolar disorder with mixed states or rapid cycling^{11, 12}
 - Substance use disorders (particularly in males 16+)¹³
 - Conduct disorder with comorbid mood disorder^{14, 15}
 - PTSD and trauma-related disorders¹⁶
- e. Severe hopelessness or agitation¹⁷
- f. Social isolation without protective factors¹⁸
- g. Access to lethal means (firearms most common method)¹⁹

3. Developmental and Environmental Factors

Ages 11-14 Specific Considerations:²⁰

- Cognitive understanding of death permanence may be developing
- Higher prevalence of disruptive disorders as risk factors
- Family dynamics particularly important for intervention
- School-based stressors and peer relationships critical

Ages 15-17 Specific Considerations:

- Peak risk period for suicide attempts and completion

- Substance use becomes a significant risk factor
- Romantic relationships and identity formation stressors
- Increased independence may complicate family involvement

4. **Special Population Risk Factors**

LGBTQ+ Adolescents:²¹

- **Elevated Risk Statistics:**
 - 41% of LGBTQ+ young people seriously considered suicide in the past year²²
 - 3.5 times more likely to attempt suicide compared to heterosexual peers²³
 - Transgender and nonbinary youth: 2-2.5 times higher risk than cisgender LGBQ peers²⁴
 - 24% of suicides in ages 12-14 occur among LGBTQ+ youth²⁵
 - At least one LGBTQ+ youth (ages 13-24) attempts suicide every 45 seconds in the U.S.²⁶
- **Age-Specific Considerations (11-17 years):**
 - Middle school LGBTQ+ youth (ages 11-14) represent disproportionate suicide rates
 - 52% experience bullying (in-person or electronic), tripling suicide attempt odds²⁷
 - Peak vulnerability during identity formation and disclosure periods
- **Critical Risk:**
 - Multiple minority stressors increase risk 12-fold: physical harm, discrimination, housing instability, and parental change attempts²⁸
- **Assessment Priorities:**
 - Minority stress and family acceptance evaluation
 - School victimization and bullying assessment
 - Access to affirming care and support systems
 - Identity disclosure status and safety concerns

Trauma-Exposed Youth:

- Childhood sexual or physical abuse (15-20% attributable risk)²⁹

- Complex trauma and PTSD symptoms
- Disrupted attachment and emotional regulation
- Enhanced screening for all forms of maltreatment

Youth with Autism Spectrum Disorder:³⁰

- Increased anxiety and sensory regulation challenges
- Social communication difficulties affecting help-seeking
- Specialized assessment tools (ASC-ASD for children)
- Sensory triggers and coping strategies

NICE Guidelines for Assessment:³¹

- Comprehensive psychosocial assessment should be completed within 24 hours
- Assessment should include mental health history, current mental state, and social circumstances
- Risk assessment tools should not be used to predict suicide risk or determine access to treatment
- Person-centered approach emphasizing collaborative care planning

C. Risk Stratification and Immediate Interventions^{32, 33, 34}

Critical Risk (Immediate Intervention Required):³⁵

- Active suicidal ideation with plan, means, and intent³⁶
- Previous attempt with continued wish to die³⁷
- Psychotic symptoms with command hallucinations^{38, 3}
- Severe agitation or impaired reality testing⁴⁰
- Substance intoxication with suicidal ideation⁴¹

High Risk:³⁵

- Active suicidal ideation without specific plan³⁶
- Recent previous attempt (within 90 days) Severe depression with hopelessness³⁶
- Multiple risk factors with minimal protective factors⁴³

Moderate Risk:³⁵

- Passive suicidal ideation³⁶

- History of self-harm behaviors⁴⁴
- Moderate depression with some protective factors⁴²
- Family conflict with maintained relationships⁴⁵

Lower Risk:³⁵

- Thoughts of death without active suicidal ideation³⁶
- Strong protective factors present⁴⁶
- Good therapeutic alliance potential⁴⁷
- Stable support system⁴⁶

II. Immediate Intervention Protocols

A. High-Risk Interventions

Environment:

- Continuous 1:1 observation
- Remove all potential means of self-harm
- Secure, locked unit placement if necessary
- Family notification within 2 hours

Crisis Stabilization

- a. Medical clearance if needed
- b. Medication review and adjustment
- c. Safety planning intervention
- d. Possible hospitalization consideration
- e. Risk assessment

Family Involvement

- f. Psychoeducation about suicide risk
- g. Family safety planning
- h. Resource provision and crisis contacts
- i. Restriction of access to lethal means at home

B. Moderate-Risk Interventions

Environment:

- Enhanced observation (15-minute checks)
- Restriction of potentially harmful items
- Day treatment or intensive outpatient consideration
- Risk Assessment: Bi-weekly formal risk assessment

C. Lower Risk:

- Contact Frequency: Weekly, may transition to bi-weekly after 6-8 weeks
- Risk Assessment: Monthly formal risk reassessment

II. Evidence-Based Treatment Modalities

A. Primary Therapeutic Approaches

1. Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)⁴⁸

- **Session Structure: 16-20 individual sessions over 6 months**
 - **Acute Phase: 12-16 weekly sessions (50-60 minutes each)**
 - **Continuation Phase: 4-8 bi-weekly sessions (50 minutes each)**
- **Frequency: Weekly sessions for 3-4 months, then bi-weekly**
- **Session Duration: 50-60 minutes per individual session**
- **Family Sessions: Up to 6 family sessions (60-90 minutes each) integrated throughout treatment**
- **Focus: Cognitive restructuring, problem-solving, emotion regulation**
- **Evidence Level: Strong empirical support for adolescent populations**
- **Provider Qualifications:⁴⁹**
 - **Licensed mental health professional (PhD, PsyD, LCSW, LMFT, LPC)**

2. Dialectical Behavior Therapy for Adolescents (DBT-A)⁵⁰

- **Session Structure: Comprehensive multi-modal treatment over 6-12 months**
- **Individual Therapy: Weekly sessions (45-60 minutes each)**
- **Skills Training Groups: Weekly group sessions (90-120 minutes each)**
- **Family Skills Training: Weekly family participation (90 minutes each)**

- **Crisis Coaching: Phone consultation as needed (15-30 minutes)**

Total Sessions: 24-48 individual sessions, 24-48 group sessions

Frequency: Weekly individual and group sessions concurrently

Target Population: Adolescents with emotion dysregulation, borderline traits

Provider Qualifications:⁵¹

- **Licensed mental health professional (master's degree minimum)**
- **DBT-Linehan Board Certification preferred (gold standard)**

3. Brief Cognitive Behavioral Therapy (BCBT)⁵²

- **Session Structure:** 10-12 sessions over 3-4 months
- **Frequency:** Weekly sessions for first 6-8 weeks, then bi-weekly
- **Session Duration:** 45-50 minutes per session
- **Crisis Sessions:** Additional sessions as needed (30-45 minutes)
- **Focus:** Rapid symptom reduction and crisis stabilization
- **Provider Qualifications:⁵³**
 - Licensed mental health professional (master's degree minimum)
- **Components:**
 - Safety planning (sessions 1-2)
 - Means restriction counseling (session 1)
 - Cognitive flexibility training (sessions 3-6)
 - Emotion regulation skills (sessions 4-8)
 - Crisis response preparation (sessions 9-12)
- **Booster Sessions:** 2-4 monthly follow-up sessions (30-45 minutes)

4. Family-Based Interventions

Attachment-Based Family Therapy (ABFT):⁵⁴

- **Session Structure:** 12-16 sessions over 4-6 months
- **Frequency:** Weekly sessions
- **Session Duration:** 60-90 minutes per family session
- **Individual Sessions:** 2-4 individual sessions with adolescent (50 minutes each)
- **Parent Sessions:** 2-4 individual parent sessions (50 minutes each)

- **Focus:** Improving family attachment and communication
- **Provider Qualifications:**⁵⁵
- Licensed family therapist (LMFT, LCSW, PhD/PsyD with family therapy training)

Interpersonal Therapy for Adolescents (IPT-A):⁵⁶

- **Session Structure:** 12-16 sessions over 3-4 months⁵⁷
- **Frequency:** Weekly sessions⁵⁸
- **Session Duration:** 45-50 minutes per session⁵⁹
- **Phone Contacts:** Brief check-ins between sessions (10-15 minutes)⁶⁰
- **Parent Sessions:** 2-4 parent sessions integrated (45 minutes each) 3-4 months⁶¹
- **Focus:** Interpersonal relationships and social context⁶²
- **Provider Qualifications:**⁶³
 - Licensed mental health professional

Technology Integration:

- Smartphone apps for safety planning and mood monitoring
- Text-based crisis support protocols
- Telehealth options for follow-up sessions (45-50 minutes)

B. Pharmacological Interventions⁶⁴

First-Line Medications:

- SSRIs: Fluoxetine, sertraline, escitalopram
- Monitoring: Weekly for first month, then bi-weekly
- FDA Black Box Warning considerations and enhanced monitoring

AAP Medication Guidelines:⁶⁵

- Shared decision-making with adolescent and family regarding medication
- Careful monitoring for side effects and suicidal ideation
- Medication should be part of comprehensive treatment plan
- Consider medication adherence and family supervision

NICE Medication Recommendations:⁶⁶

- Antidepressants should not be offered as first-line treatment for mild depression

- For moderate to severe depression, consider fluoxetine as first-line SSRI
- Close monitoring required, especially in the first 4 weeks of treatment
- Medication should be combined with psychological interventions

Mood Stabilizers (Bipolar Spectrum):

- Lithium: 8.6-fold reduction in suicide attempts (adult data)⁶⁷
- Requires careful monitoring and third-party supervision
- Valproate, carbamazepine for complex presentations

IV. Safety Planning Protocol

A. Collaborative Safety Planning Elements⁶⁸

- 1. Warning Sign Recognition**
 - a. Personal triggers and early warning signs
 - b. Escalation patterns
 - c. Physical and emotional cues
- 2. Coping Strategy Development**
 - a. Internal coping skills (breathing, grounding)
 - b. Environmental modifications
 - c. Distraction techniques
 - d. Self-soothing activities
- 3. Support Network Activation**
 - a. Trusted adults (family, friends, teachers)
 - b. Peer support identification
 - c. Professional contacts
- 4. Professional contacts with 24/7 availability**
 - a. Primary therapist
 - b. Psychiatrist
 - c. Crisis hotline numbers (988 Suicide & Crisis Lifeline)

- d. Emergency services protocol

5. Environmental Safety

- a. Lethal means restriction plan
- b. Safe spaces identification
- c. Removal of triggers when possible

V. Treatment Intensity and Monitoring Guidelines

Immediate Actions:

- Crisis hotline contacts (988 Suicide & Crisis Lifeline)
- Emergency contacts (parents, therapist, psychiatrist)
- Emergency services protocol (911)
- Nearest emergency department information

VI. Ongoing Treatment and Monitoring

A. Progress Monitoring Tools²⁰

Validated Instruments:

- Columbia Suicide Severity Rating Scale (C-SSRS) - each session
- Patient Health Questionnaire for Adolescents (PHQ-A) - weekly
- Pediatric Quality of Life Inventory (PedsQL)
- Strengths and Difficulties Questionnaire (SDQ)

C. Family Involvement Standards

- Regular family sessions (minimum monthly)
- Parent psychoeducation groups
- Sibling support when appropriate
- School collaboration and communication
- Integrated trauma-suicide treatment

VII. School and Community Integration

A. School-Based Interventions

AAP School Collaboration Guidelines⁶⁹

- Schools should have suicide prevention policies and procedures
- Staff training on recognition of warning signs and referral protocols
- Academic accommodations for students receiving mental health treatment
- Crisis response plans for suicide-related incidents

Universal Prevention:

- Mental health literacy programs
- Stigma reduction initiatives
- Peer support training
- Crisis response protocols

Targeted Interventions:

- School-based CBT programs
- Counselor training on suicide risk assessment
- Academic accommodation planning
- Transition support services

NICE School-Based Recommendations: ⁷⁰

- Schools should have clear policies for identifying and supporting students who self-harm
- Staff should receive training on appropriate responses to self-harm disclosures
- Referral pathways to mental health services should be established
- Support should be provided while awaiting specialist assessment

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Treatment Protocol for Trauma Disorders in Adolescents (Ages 11-17)

Evidence-Based Protocol for Assessment, Intervention, and Ongoing Care

This protocol synthesizes evidence-based recommendations from the National Child Traumatic Stress Network (NCTSN), American Academy of Child and Adolescent Psychiatry (AACAP), American Academy of Pediatrics (AAP), and current peer-reviewed research to provide a comprehensive framework for treating trauma in adolescents aged 11-17 years^{1,2}.

I. Assessment and Screening Framework

A. Diagnostic Criteria Application

Standard of care requires adherence to DSM-5-TR criteria and codes³

Primary Diagnostic Considerations:

- **309.81 (F43.10) Posttraumatic Stress Disorder** - requires exposure to actual or threatened death, serious injury, or sexual violence
- **309.9 (F43.9) Unspecified Trauma- and Stressor-Related Disorder** - for presentations that do not meet full criteria for specific trauma disorders but cause clinically significant distress or impairment
- **308.3 (F43.0) Acute Stress Disorder** - symptoms occurring within one month of trauma exposure
- **313.89 (F94.8) Disinhibited Social Engagement Disorder** - for adolescents with early caregiving disruption
- **313.89 (F94.1) Reactive Attachment Disorder** - severe attachment disruption in early childhood
- **300.15 (F44.81) Dissociative Identity Disorder** - may present in complex trauma cases
- **300.14 (F44.89) Other Specified Dissociative Disorder** - including partial DID presentations

Trauma and Stressor-Related Disorders Criteria³:

- **Criterion A (Exposure):** Direct experience, witnessing, learning of close family/friend exposure, or repeated/extreme exposure to aversive details
- **Criterion B (Intrusion):** Recurrent distressing memories, dreams, dissociative reactions, psychological/physiological distress
- **Criterion C (Avoidance):** Efforts to avoid trauma-related stimuli (thoughts, feelings, external reminders)

- **Criterion D (Negative Alterations):** Cognitions and mood changes including amnesia, negative beliefs, persistent negative emotions, diminished interest, detachment, inability to experience positive emotions
- **Criterion E (Arousal/Reactivity):** Hypervigilance, exaggerated startle, concentration problems, sleep disturbance, irritability/aggression, reckless/self-destructive behavior
- **Criterion F (Duration):** Symptoms persist for more than one month
- **Criterion G (Functional Impairment):** Clinically significant distress or impairment
- **Criterion H (Not Attributable):** Not due to substance use or medical condition

Developmental Considerations for Adolescents (11-17 years):

- Symptoms may manifest differently across developmental ages⁴
- Consider developmental trauma and its cumulative effects⁵
- Assess for delayed expression of symptoms
- Evaluate impact on identity formation and peer relationships
- Screen for risk-taking behaviors as trauma responses⁶

Differential Diagnosis Requirements:

- Rule out medical conditions that may mimic trauma symptoms
- Distinguish from primary mood, anxiety, or psychotic disorders
- Assess for substance-induced presentations
- Consider cultural and contextual factors in symptom interpretation

B. Initial Trauma Screening

Based on AAP and NCTSN recommendations for universal trauma-informed care⁷:

Primary Screening Tools:

- UCLA PTSD Reaction Index for DSM-5 (adolescent version)⁸
- Childhood Trauma Questionnaire (CTQ)
- Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA-5)⁹
- Adverse Childhood Experiences (ACE) Questionnaire³

Assessment Domains (NCTSN Standards):

- **Trauma exposure history** (type, frequency, duration, developmental timing)

- **Post-traumatic stress symptoms** (re-experiencing, avoidance, negative cognitions/mood, arousal)
- **Functional impairment** (academic, social, family functioning)
- **Comorbid conditions** (depression, anxiety, substance use, behavioral problems)
- **Protective factors** (family support, coping skills, resilience factors)
- **Cultural considerations** (ethnicity, language, religious/spiritual factors)

C. Complex Trauma Assessment

Per NCTSN guidelines for complex trauma identification¹⁰:

Complex Trauma Indicators:

- Multiple trauma exposures, particularly in caregiving relationships
- Disrupted attachment patterns
- Dysregulation across multiple domains (emotional, behavioral, cognitive, biological)
- Developmental disruptions in key areas

II. Evidence-Based Treatment Modalities

A. First-Line Treatments (Well-Established Evidence Base)

1. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Evidence Level: Well-established (28 RCTs, large effect sizes)^{11, 12}

Protocol Structure:

- **Duration:** 12-25 sessions (typically 16-20 sessions)
- **Session Length:** 45-60 minutes (typically 50 minutes)⁵⁰
- **Session Frequency:** Weekly⁵¹
- **Age Range:** Effective for adolescents 11-17 years^{13, 14}
- **Therapist Qualifications:** Licensed mental health professionals (clinical social workers, counselors, psychologists, psychiatrists) with TF-CBT certification including online training, 2-3 day in-person training, and 6-12 months of ongoing consultation^{52, 53}
- **Components (PRACTICE model):**
 - Psychoeducation and Parenting skills
 - Relaxation techniques

- Affective expression and modulation
- Cognitive coping and processing
- Trauma narrative and cognitive processing
- In vivo mastery of trauma reminders
- Conjoint child-parent sessions
- Enhancing safety and future development

Inclusion Criteria:

- PTSD or significant trauma symptoms in adolescents 11-17 years
- Cognitive capacity for CBT techniques
- Caregiver available for participation
- No active substance use disorder (treat concurrently if present)

Contraindications:

- Active psychosis
- Severe intellectual disability
- Immediate safety concerns requiring stabilization¹⁶.

2. Attachment, Regulation, and Competency (ARC) Framework

Evidence Level: Promising practice (NCTSN endorsed)³⁹

- **Age Range:** Birth through young adulthood (particularly effective for younger adolescents 11-12 years)⁴⁰
- **Target Population:** Children and adolescents with complex trauma and their caregiving systems⁴¹
- **Duration:** Flexible, typically 6-12 months
- **Session Length:** 45-60 minutes (following standard therapeutic hour)⁵⁴
- **Session Frequency:** Typically weekly, with flexibility based on clinical needs⁵⁵
- **Therapist Qualifications:** Licensed mental health professionals with specialized ARC training including foundational 2-day training and ongoing consultation (minimum 12 hours over one year)⁵⁶
- **Three Core Domains:**

- **Attachment:** Building safe, stable relationships and caregiver capacity
- **Regulation:** Developing awareness and management of emotions, thoughts, and physiological states
- **Competency:** Supporting identity development, executive functioning, and trauma integration⁴²

Evidence Base: Research demonstrates significant decreases in trauma-related symptoms across all three domains over time, with effectiveness maintained at 12-month follow-up⁴³. Particularly suitable for children with developmental trauma and attachment disruptions⁴⁴.

3. Child-Parent Psychotherapy (CPP)

Application: Adolescents with disrupted attachment (ages 11-15)²²

- **Focus:** Caregiver-adolescent relationship repair
- **Duration:** 12-24 months of weekly sessions
- **Session Length:** 60-90 minutes⁴⁶
- **Session Frequency:** Weekly⁴⁷
- **Therapist Qualifications:** Master's or doctoral-level mental health professionals (psychologists, social workers, counselors) with specialized CPP training including 18-month Learning Collaborative or equivalent certification^{48, 49}

B. Additional Interventions

4. Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)²³

- **Component-based approach** for complex trauma
- **Individual and family phases**
- **Duration:** 18-30 sessions
- **Age Range:** 12-21 years (includes 11-17 target population)

5. Eye Movement Desensitization and Reprocessing (EMDR)^{17, 18}

Protocol Structure:

- **Duration:** Variable (typically 8-20 sessions), 60 minutes weekly
- **Age Range:** Effective for children and adolescents with some adaptations¹⁹
- **Eight-Phase Protocol adapted for adolescents**²¹.

III. Treatment Planning and Case Formulation

A. Multi-Modal Assessment Integration

Following AACAP practice parameters²⁴:

Comprehensive Evaluation Components:

1. **Clinical interview** (adolescent and caregivers)
2. **Standardized trauma assessments**
3. **Functional assessment** (school, peer, family domains)
4. **Risk assessment** (suicide, self-harm, substance use)
5. **Strengths and resilience factors**
6. **Cultural formulation**

IV. Safety and Stabilization Protocols

A. Trauma-Informed Care Principles (SAMHSA Framework)²⁵

1. **Safety** (physical and psychological)
2. **Trustworthiness and transparency**
3. **Peer support** integration
4. **Collaboration and mutuality**
5. **Empowerment and choice**
6. **Cultural, historical, and gender considerations**

V. Family and Caregiver Involvement

A. Caregiver Treatment Components (NCTSN/AAP Standards)²⁶

The National Child Traumatic Stress Network (NCTSN) and the American Academy of Pediatrics (AAP) guidelines recommend a brief, early mental health intervention like Child and Family Traumatic Stress Intervention (CFTSI) for children, adolescents, and their caregivers after a recent traumatic event. CFTSI is typically a brief treatment, with a range of 5-8 sessions²⁶.

Essential Elements:

- **Psychoeducation** about trauma and adolescent development
- **Trauma-informed parenting** skills training
- **Communication** enhancement techniques
- **Behavioral management** strategies

- **Secondary trauma** assessment and intervention

B. Cultural Considerations

Per NCTSN cultural competency guidelines²⁷:

Assessment Areas:

- Cultural identity and affiliation
- Trauma-related cultural factors
- Help-seeking patterns and beliefs
- Language preferences and needs
- Religious/spiritual considerations
- Discrimination and oppression experiences

VI. Medication Considerations

A. AACAP Psychopharmacology Guidelines²⁸

First-Line Medications for Adolescent PTSD:

- **SSRIs** (sertraline, fluoxetine) for adolescents 11+
- **Evidence level:** Moderate support
- **Monitoring requirements:** Regular assessment for side effects, suicidality

Adjunctive Medications:

- **Prazosin** for trauma-related nightmares (limited pediatric data)
- **Mood stabilizers** for severe emotional dysregulation
- Regular monitoring and family psychoeducation essential

B. Contraindications and Special Considerations

- Substance use disorders (address concurrently)
- Bipolar disorder (mood stabilization first)
- Eating disorders (integrated treatment approach)

VII. Treatment Outcome Monitoring

A. Progress Measurement Protocol²⁸

Regular Assessment Schedule:

- **Baseline:** Comprehensive trauma and symptom assessment
- **Monthly:** Brief symptom monitoring (PTSD Checklist-5, mood scales)
- **Mid-treatment:** Full assessment battery repeat
- **Post-treatment:** Comprehensive outcome evaluation
- **Follow-up:** 3, 6, and 12-month assessments

Key Outcome Domains:

1. PTSD symptom reduction
2. Functional improvement (school, social, family)
3. Comorbid symptom changes
4. Coping skill development
5. Family relationship quality

B. Treatment Fidelity Standards

Following NCTSN implementation guidelines²⁹:

Therapist Qualifications:

- Licensed mental health professional
- Specialized trauma training in chosen modality
- Regular supervision and consultation
- Cultural competency training

VIII. Special Populations and Considerations

A. Adolescents in Foster Care

Per NCTSN foster care guidelines³⁰:

Enhanced Assessments:

- Placement history and stability
- Multiple caregiver relationships
- Educational disruptions
- Legal proceedings impact

Modified Treatment Approaches:

- Flexibility in caregiver involvement
- Coordination with caseworkers
- Placement-sensitive interventions
- Transition planning emphasis

B. LGBTQ+ Adolescents

Cultural competency requirements³¹:

Affirming Care Elements:

- Identity-affirming language and approaches
- Minority stress assessment
- Family acceptance evaluation
- Community resource connection

C. Substance-Using Adolescents

Integrated treatment approach³²:

Concurrent Interventions:

- Substance abuse treatment coordination
- Trauma-substance use connection exploration
- Motivational interviewing integration
- Family substance use assessment

Treatment Completion Benefits:

- NCTSN data shows significantly better outcomes for treatment completers³³
- Dose-response relationship documented
- Engagement strategies improve retention

B. Professional Organization Endorsements

AACAP Practice Parameters:

- TF-CBT as first-line treatment for adolescent PTSD³⁶
- EMDR as alternative evidence-based option
- Emphasis on caregiver involvement

- Cultural adaptation importance

AAP Trauma-Informed Care Guidelines:

- Universal screening recommendations³⁷
- Integration with pediatric care
- Family-centered approach emphasis
- Resilience and protective factor focus

NCTSN Standards:

- Evidence-based treatment prioritization³⁸
- Complex trauma recognition and treatment
- Cultural competency requirements
- Outcome monitoring standards

Professional Guidelines:

- American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters
- American Academy of Pediatrics (AAP) Trauma-Informed Care Guidelines
- National Child Traumatic Stress Network (NCTSN) Evidence-Based Treatment Standards
- International Society for Traumatic Stress Studies (ISTSS) Treatment Guidelines
- Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma-Informed Care Framework
- Current meta-analytic evidence and systematic reviews (2020-2024)

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Conclusion This protocol represents the current consensus of evidence-based practice for adolescent trauma treatment (ages 11-17), synthesizing recommendations from leading professional organizations and peer-reviewed research. The evidence strongly supports trauma-focused interventions, particularly TF-CBT, delivered within a trauma-informed care framework that emphasizes safety, cultural competency, and family involvement.