Chapter 1

The Challenge of Treating Children with Mood Disorders

For all of us as therapists, work with children who have with complicated depression or bipolar spectrum disorders (BSD) can be confusing, difficult, and—most of all—humbling. These children push us to be at our very best, and yet very little research has been available until recently to help us determine what "our very best" is. Psychoeducational psychotherapy (PEP) is an evidence-based psychosocial intervention developed by Mary A. Fristad and her colleagues for children ages 8–12 with BSD or depression. The culmination of 25-plus years of clinical experience and research, PEP is an important part of an overall treatment program for these children and their families. This book is a PEP "how-to" guide for clinicians who are looking for a unique and empirically supported way of treating children with BSD or depressive disorders and their families. This book will provide the necessary tools to help such children and families.

What Is PEP?

PEP is the only evidence-based treatment designed for preadolescent children with BSD or complicated depression—the very children clinicians often struggle to treat. PEP combines psychoeducation with elements of family therapy and cognitive-behavioral therapy (CBT). The psychoeducational components give parents and children information about these disorders, as well as how they are diagnosed, treated, and managed. It starts with the basics—offering clear information about the symptoms and diagnosing of mood disorders, along with information about comorbid conditions and other factors that significantly complicate diagnosis. BSD and depression are biological illnesses, but their course is influenced by life stresses, family environment, and daily events. Thus children with these disorders need a wide range of interventions: biological, psychological, educational, and social. Therefore, PEP also provides information about these different types of treatment and gives parents guidelines for establishing a mental health treatment team. Given the challenges inherent in supporting children with mood disorders at school, PEP also provides parents with a better understanding of how school systems

work for special-needs children and how to develop and then work effectively with their child's school team.

This psychoeducation is coupled with CBT and other psychotherapeutic exercises practiced during and between PEP sessions. Children learn specific techniques to help them identify and manage difficult moods. Parents, as well as children, learn coping skills such as problem solving, better communication, crisis management, and ways to recognize and prevent or change negative family cycles. In sum, PEP provides information, support, and skills to children, their parents, their siblings, and other caretakers to enable them to manage these lifelong and often debilitating illnesses. Education, support, and new skills lead to better understanding, which in turn leads to better treatment, less family conflict, and ultimately a better outcome. The knowledge that families gain through PEP is only the beginning, and the skills they gain provide a starting point. PEP is designed to help the whole family approach these disorders in a new way—as chronic biological illnesses with a waxing and waning course that typically requires careful medication as well as a problem-solving focus. The skills taught through PEP build resiliency for the whole family.

How This Book Is Organized

Part I of this book offers background information on mood disorders in children, the treatment of these disorders, and practical considerations for implementing PEP. The rest of the present chapter describes the state of our knowledge about psychosocial treatments for children with mood disorders and compares PEP with other such treatments. The chapter concludes with a more detailed overview of PEP. The next three chapters in Part I provide the foundation for incorporating PEP into the treatment of these children and their families. Keep in mind that in order for you to teach families what they need to know about pediatric mood disorders, you will need a strong background in this area. Chapter 2 covers current scientific knowledge about mood disorders in children—the basis of the psychoeducation offered in PEP. Chapter 3 provides more practical details about conducting PEP in either a 20- to 24-week individual-family format (IF-PEP) or an 8-week multifamily group format (MF-PEP). Chapter 4 describes the complexities of diagnosing mood disorders in children.

Part II of this book (Chapters 5–22) provides you with the "nuts-and-bolts" information you need to conduct each PEP session—whether it is with an individual family or with a multifamily group of parents and a group of their children. In IF-PEP, sessions with the child alternate with those for the parents. The chapters in Part II follow the IF-PEP format, with alternating child and parent sessions. In MF-PEP, as explained in more detail in Chapter 3, a group for parents meets separately but (ideally) at the same time as the children's group.

Both formats make use of informational handouts and worksheets, to enable children and parents to practice new skills in session and to reinforce learning through between-session assignments. Part III of this book contains all handouts needed to conduct sessions; these materials may be reproduced and shared with families as needed.

It also includes reproducible materials for group games in MF-PEP. We turn next to an overview of empirically supported psychosocial treatments for mood disorders in children.

Evidence-Based Psychosocial Treatments for Depression in Children

Empirically supported psychosocial treatments are critical approaches for mild to moderate childhood depression, as well as important adjunctive treatments for more severe juvenile depression and BSD. Again, these are biological illnesses that are strongly influenced by psychosocial events (Post & Miklowitz, 2010).

Psychosocial treatments for depression include interventions targeting children at risk for depression (usually in a school-based group format) and therapy for youth diagnosed with depression and their families (in clinic-based group or family formats). The group interventions are based in CBT theory. Most groups include components addressing negative cognitions, negative explanatory style, relaxation, problem solving, coping strategies, positive activity scheduling, communication, and psychoeducation (Asarnow, Scott, & Mintz, 2002; David-Ferdon & Kaslow, 2008; Gillham, Hamilton, et al., 2006; Gillham et al., 2007; Gillham, Reivich, et al., 2006; Pfeffer, Jiang, Kakuma, & Metsch, 2002; Stark, Reynolds, & Kaslow, 1987; Stark et al., 2006; Weisz, Thurber, Sweeney, Proffitt, LeGagnoux, 1997; Yu & Seligman, 2002). The interventions seek to challenge negative cognitions about oneself, situations, other people's intentions, and the future (Abela & Hankin, 2008). Psychoeducational components of group programs teach about identifying feelings and negative thoughts; the relations among thoughts, feelings, and actions; and ways to regulate emotional reactions. These psychoeducational components are closely linked with cognitive strategies.

Studies have found that CBT psychodynamic, and interpersonal approaches to family therapy were effective for children at risk for depression (David-Ferdon & Kaslow, 2008). CBT with families targets many of the same topics covered in group models, with emphases on improving family communication and problem solving and on providing psychoeducation about depression to families (Kovacs et al., 2006; Nelson, Barnard, & Cain, 2003). Psychodynamic psychotherapy focuses on understanding the impact of early experiences on parents and parenting practices, recognizing a child's defensive style, and identifying dysfunctional attachments (Muratori, Picchi, Bruni, Patarnello, & Romagnoli, 2003; Trowell et al., 2007). Tompson et al. (2007) incorporated CBT and interpersonal approaches into a family-based treatment that decreased depressive symptoms and behavior problems. This study did not have a control group, however; thus the efficacy of the combined intervention remains uncertain.

Research on psychotherapeutic strategies for childhood depression supports several group interventions, including school-based CBT programs; a variety of theoretically diverse clinic-based interventions; and individual/family clinic-based interventions from psychodynamic, systems, stress–coping, and CBT perspectives. However, group therapy is not always available. No individual or family-based intervention for childhood depres-

sion has the support of a randomized controlled trial (RCT) (David-Ferdon & Kaslow, 2008). Practice parameters for treatment of depression in youth developed by the American Academy of Child and Adolescent Psychiatry (AACAP) state that the minimal standard of care should include "psychoeducation, supportive management, and family and school involvement" (Birmaher, Brent, & the AACAP Work Group on Quality Issues, 2007, p. 1510). PEP combines these elements with the CBT techniques that have proven helpful to groups of children in school-based interventions.

Evidence-Based Psychosocial Treatments for BSD in Children

Several groups of researchers have developed and examined psychosocial treatments for BSD in youth. Two groups have focused their efforts on adolescents. First, David Miklowitz and colleagues have developed an approach called family-focused treatment (FFT); this is described in *Bipolar Disorder: A Family-Focused Treatment Approach* (Miklowitz, 2008). Second, Tina Goldstein and colleagues have adapted dialectical behavior therapy and conducted a pilot trial with adolescents diagnosed with bipolar disorder (BD) (Goldstein, Axelson, Birmaher, & Brent, 2007).[1] Results look promising, but this treatment is still experimental. A third approach, child and family-focused CBT (CFF-CBT), is described in Mani Pavuluri's (2008) book, *What Works for Bipolar Kids: Help and Hope for Parents*; it is a therapeutic program for youth with BSD. Finally, we have developed PEP as described for clinicians in this book and for parents in *Raising a Moody Child: How to Cope with Depression and Bipolar Disorder* (Fristad & Goldberg-Arnold, 2004). All of these treatments are family-based and include four main sets of psychoeducational components: (1) They provide information about the etiology, course, prognosis, and treatments for mood disorders; (2) they emphasize that an affected youth is not at fault for his/her illness; (3) they separate the youth from his/her symptoms/diagnosis and minimize stigma; and (4) they stress the importance of both the patient's and family's responsibilities in managing the illness. In our discussion below of evidence-based treatments for BSD, we focus on those developed for preadolescents: CFF-CBT and PEP.

Child- and Family-Focused CBT

CFF-CBT is designed for for children ages 5–17 and their families (Pavuluri et al., 2004). The 12-session CFF-CBT intervention includes sessions with parents alone, children alone, and parents and children together, and is intended as an adjunctive intervention to medication. The treatment is organized around the acronym RAINBOW: Routine; Affect regulation; I can do it!; No negative thoughts and live in the Now; Be a good friend & Balanced lifestyle for parents; Oh, how can we solve the problem?; and Ways to get support.

[1]In this book, "bipolar disorder" (BD) generally refers to bipolar I disorder as defined by the American Psychiatric Association (1994), unless otherwise indicated (see especially the discussions of diagnoses in Chapters 4 and 6). "Bipolar spectrum disorders" (BSD), as the term indicates, refers to the entire range of bipolar disorders.

CFF-CBT uses psychoeducational and skill-building approaches to improve the psychosocial factors that affect the course of illness in children with BSD. These factors include "expressed emotion" (EE); stressful life events; and coping, communication, and problem-solving skills. EE refers to the intensity of critical feedback and emotional involvement of the family in the child's illness (Miklowitz, Goldstein, Nuechterlein, Snyder, & Mintz, 1988). Caregivers in families high in EE tend to direct hostility and negative comments toward, and to become emotionally overinvolved with, the affected children. High EE is associated with poorer outcomes in adults with BD (Butzlaff & Hooley, 1998) and in children with depression (Asarnow, Goldstein, Tompson, & Guthrie, 1993). Stressful life events can have a larger impact on affectively dysregulated children. Skills in coping, communication, and problem solving help decrease EE, improve family communication, improve social interactions, and reduce stress. Through psychoeducation and CBT strategies, families learn about the illness and ways to address symptoms. Therapists also offer to educate school personnel and conduct a session with siblings of affected children, focused on helping the sibling understand BSD and develop coping skills.

Psychoeducational Psychotherapy

PEP was tested in children ages 8–12 with mood disorders and their families. However, we have used these techniques clinically with children both younger and older than this age range. As noted earlier, PEP can be delivered in an individual-family format (IF-PEP) or a multifamily group format (MF-PEP). MF-PEP consists of eight weekly 90-minute sessions in which a parents' group and a separate children's group meet (ideally, at the same time). IF-PEP typically consists of 20–24 weekly 50-minute sessions, alternating between parent sessions and child sessions. Like FFT and CFF-CBT, PEP focuses on educating families about the children's illness and its treatment; decreasing EE; and improving symptom management, problem solving, and communication skills. PEP also provides parents with education about how to be effective and active members of a child's treatment team. Coping strategies for issues common to mood disorders—including emotion regulation, problem solving, and communication—are important foci of PEP. Family patterns are explored, along with ways to reduce negative cycles. PEP with individual families includes session time focused on helping children develop healthy eating, sleeping, and exercising habits, in addition to a sibling session when relevant.

Unlike FFT and CFF-CBT, PEP is designed for children with any mood disorder, including depressive disorders (i.e., major depressive disorder [MDD], dysthymic disorder [DD], and depressive disorder not otherwise specified) as well as BSD. This is important, because longitudinal studies suggest that one-quarter to one-half of children with prepubertal-onset depression will eventually develop BPD (Geller, Zimerman, Williams, Bolhofner, & Craney, 2001; Geller, Fox & Clark, 1994; Strober & Carlson, 1982); Therefore, learning about the warning signs of BSD, as well as about treating and coping with these disorders, may decrease delay in getting effective treatment for these children. IF-PEP and MF-PEP have both elicited clear consumer satisfaction from children and parents (Davidson & Fristad, 2008; Fristad, 2006; Goldberg Arnold, Fristad, & Gavazzi, 1999).

Efficacy of MF-PEP

The efficacy of MF-PEP has been demonstrated through a small RCT ($N = 35$) (Fristad, Gavazzi, & Soldano, 1998; Fristad, Goldberg Arnold, & Gavazzi, 2002, 2003; Goldberg Arnold et al., 1999), as well as through a larger RCT of 165 children ages 8–12 diagnosed with depressive disorders or BSD (Fristad, Verducci, Walters, & Young, 2009; Mendenhall, Fristad, & Early, 2009). In the latter study, MF-PEP plus treatment as usual (TAU) ($n = 78$) was compared to a wait-list condition ($n = 87$). Assessments occurred at baseline and at 6, 12, and 18 months. Intervention occurred between baseline and 6 months for the immediate-treatment group and between 12 and 18 months for the wait-list group. PEP was associated with lower Mood Severity Index (MSI) scores (the MSI combines scores from the Young Mania Rating Scale and the Children's Depression Rating Scale—Revised). The wait-list group showed a similar decrease in MSI scores 1 year later after treatment. In conclusion, MF-PEP is associated with improved outcome for children ages 8–12 with major mood disorders.

Given the documented efficacy of PEP, potential mediators of treatment outcome were investigated by Mendenhall et al. (2009). Participation in MF-PEP significantly improved quality of services utilized, which was mediated by parents' beliefs about treatment. Participation in MF-PEP also significantly decreased the severity of children's mood symptoms, which was mediated by quality of services utilized. As intended, MF-PEP appears to help parents become better consumers of the mental health system, leading them to access higher-quality services, which in turn lead to subsequent improvement in children's symptom severity.

Efficacy of IF-PEP

To meet the needs of varying clinical practice settings, an individualized version of MF-PEP (IF-PEP) was developed and tested. The original version of IF-PEP consisted of 16 sessions lasting 50 minutes each. Fifteen sessions dealt with specific issues associated with mood disorders (the same topics as in MF-PEP), while one flexible ("in-the-bank") session could be scheduled as needed for families to deal with crises and/or review previous material.

The efficacy of IF-PEP was tested in a small RCT of 20 children with BSD and their parents (Fristad, 2006). Children's mood improved immediately following treatment, with gains continuing 12 months after treatment. There was a trend toward improved family climate and treatment utilization, but a larger sample size would have been needed to find significance. Consumer evaluations from parents and children were positive.

Following completion of this study, we conducted a review of our treatment program. This review led to an increase in the number of IF-PEP sessions from 16 to 24, thereby matching the amount of therapist–family "face time" for IF-PEP with that for MF-PEP. The expanded IF-PEP includes 20 (vs. 15) content-specific sessions and 4 (vs. 1) flexible ("in-the-bank") sessions, to be used as needed to reinforce learning or manage crises. This is the version of IF-PEP described in detail in Part II of this book. Parent information on mental health services and school services, originally covered in one IF-PEP session, is now covered in two separate sessions; also added is a second child session

on developing healthy habits (i.e., sleep, exercise, and eating). A new parent session has been added for meeting with the child's school team; in another new session, siblings meet with the therapist. This expanded version of IF-PEP has been demonstrated to be associated with reduced mood symptoms and improved family climate in children with BD (Leffler, Fristad, & Klaus, 2010), and the session format is generally acceptable to families (Davidson & Fristad, 2008).

Overview of PEP Sessions and Interventions

A fundamental principle of PEP is reflected in its nonblaming motto: "It's not your fault, but it's your challenge!" In PEP, mood disorders are conceptualized as "no-fault" brain disorders with a biological foundation. Acknowledgment that the *cause* of mood disorders is often biological can decrease the blame and guilt parents feel for their children's problems. At the same time, psychosocial influences greatly affect the *course* of illness, which is part of the reason why an intervention like PEP is so important for overall recovery.

PEP not only educates parents and children about mood disorders and treatment, but also gives them tools for managing symptoms, for establishing a treatment team, and for effectively participating on the team. In both formats of PEP, child sessions and parent sessions follow the same general sequence; the topics build on each other as the program progresses. The early sessions are primarily (but not exclusively) psychoeducational, and they provide a foundation for the skills emphasis of later sessions. Take-home projects are assigned at the ends of both parent and child sessions to reinforce learning. Although some projects are primarily for either the parents or the child, several are family projects that require collaboration. These help to shift family interactions in a more positive direction.

The topics of IF-PEP sessions appear in Table 1.1 in their suggested order. The table also lists the corresponding chapter in Part II that covers each session's conduct and content. With one session per week, on average, child sessions alternate with parent sessions over the course of 20–24 weeks. As noted earlier, each session runs 45–50 minutes. There are important parent check-ins at the start and at the end of each child session, but the therapist and child spent most session time alone. The child does not attend parent sessions. IF-PEP offers more sessions and covers some topics not covered (or not covered as thoroughly) in MF-PEP. These include developing healthier habits, a meeting with the child's school team, and a session with siblings.

The topics of MF-PEP sessions appear in Table 1.2 in their suggested sequence along with the corresponding chapters in Part II. Over the course of 8 weeks, a group of children and a separate group of their parents meet (again, ideally at the same time) once a week. Sessions run for 90 minutes each. Parent session content in MF-PEP is generally similar to that in the corresponding IF-PEP sessions. Each children's MF-PEP session, however, includes a period of group games and activities not included in IF-PEP. These games and activities are explained further in Chapter 3.

In both formats of PEP, parents and children learn in their first two sessions about mood disorders, symptoms, and treatments, including medications (see Chapters 5–8).

TABLE 1.1. IF-PEP Session Order and Content

Week	Attendees Session no.	Session topic	Chapter
1	Child[a] Session 1	Mood disorders and symptoms	5
2	Parents Session 1	Mood disorders and symptoms	6
3	Child Session 2	Treatment, including medications	7
4	Parents Session 2	Treatment, including medications	8
5	Child Session 3	Healthy Habits	9
6	Parents Session 3	Mental health services/school services	10
7	Child Session 4	Building a coping Tool Kit	11
8	Parents Session 4	Negative family cycles and Thinking, Feeling, Doing	12
9	Child Session 5	Thinking, Feeling, Doing	13
10	Parents Session 5	Problem solving	14
11	Child Session 6	Problem solving	15
12	Parents Session 6	Revisiting mental health/school issues and services	10
13	Child Session 7	Healthy habits	9
14	Parents Session 7	School issues (meeting with school personnel)	16
15	Child Session 8	Nonverbal communication skills	17
16	Parents Session 8	Improving communication	18
17	Child Session 9	Verbal communication skills	19
18	Parents Session 9	Symptom management	20
19	Siblings	Sibling session	21
20	Child and parents Session 10	Wrap-up/graduation	22
	As needed[b]	In the bank	
	As needed	In the bank	
	As needed	In the bank	
	As needed	In the bank	

[a]Parents attend the beginning and ending of every child session.

[b]Therapists should use their discretion to determine when to hold an "in-the-bank" session, what its content will be, and who will participate. If a previous session's content is repeated, the handouts and projects for that topic should be used.

TABLE 1.2. MF-PEP Session Order and Content

Week	Attendees Session no.	Session topic	Chapter
1	Children[a] Session 1	Feelings and mood symptoms/ patterns	5
1	Parents Session 1	Mood disorders and symptoms	6
2	Children Session 2	Treatment, including medications	7
2	Parents Session 2	Treatment, including medications	8
3	Child Session 3	Building a coping Tool Kit	11
3	Parents Session 3	Mental health and school systems	10
4	Children Session 4	Thinking, Feeling, Doing	13
4	Parents Session 4	Negative family cycles	12
5	Children Session 5	Problem solving	15
5	Parents Session 5	Problem solving	14
6	Children Session 6	Nonverbal communication skills	17
6	Parents Session 6	Improving communication	18
7	Children Session 7	Verbal communication skills	19
7	Parents Session 7	Symptom management	20
8	Children and parents Session 8	Wrap-up/graduation	22

[a]Parents and children begin and end every session together.

For children, this is a basic introduction allowing them to understand more about their own specific disorders and symptoms, and helping them to distinguish symptoms from core features of personality. An exercise we call "Naming the Enemy" (see Chapter 7) is an example of what White and Epston (1990, p. 38) have referred to as "externalizing the symptom." This builds on the PEP motto, which is introduced in the first child session: "It's not your fault, but it's your challenge!" Parents receive more in-depth information in their sessions, including discussion of the etiology and course of these illnesses and the role of medication (Chapters 6, 8). Starting in their first and second sessions, parents also learn to chart their child's mood and, if relevant, medication regimen. The Mood Record or Mood–Medication Log is then briefly reviewed at the start of every child session, when parents check in with the therapist. These charts are crucial tools for track-

ing symptoms and evaluating what does and doesn't work to manage them. Families also collaboratively develop what we call a "Fix-It List" of realistic goals for the time they are in PEP.

Psychoeducation for parents in IF-PEP includes an overview of the types of mental health treatment, the range of professionals who may be on the child's treatment team, and the role of parents as team members (see Chapter 10). It also offers parents information on how school systems allocate services for special-needs children, the range of educational professionals who may be on the child's school team, and ways to build a coalition with the school (Chapters 10 and 16). In MF-PEP, mental health and school teams are discussed in one session.

The first child sessions also begin to teach emotion regulation and coping skills, including CBT. Developmental psychology suggests most children cannot distinguish thoughts, feelings, and actions until they possess metacognitive skills, which typically develop at about age 11 (Grave & Blissett, 2004). However, Vygotsky (1978) argued that a child can learn new skills by "scaffolding," a process by which a parent or therapist teaches the skill, provides input to help the child complete the task, and models or demonstrates the solution (Vygotsky, 1978). Children's understanding can be supported and raised through this social interaction; hence the term "scaffolding." In this way, the connections among thoughts, feelings, and behaviors can be taught to children who have not yet developed solid metacognitive skills (Fristad, Davidson, & Leffler, 2007).

PEP scaffolds cognitive content by teaching basic skills individually during early sessions, continually reinforcing them, and then connecting and building on them during later sessions. Starting with the first session (Chapter 5), children practice identifying their feelings, considering what events triggered those feelings, and rating the feelings' strength. These skills are particularly useful for mood-disordered children, given their emotion-processing deficits (see Chapter 2). Every subsequent child session begins with this brief three-step feelings exercise. As the program progresses, children become better able to recognize their emotions, to determine what triggers them, and to rate their feelings' strength; these are prerequisites for learning when and what kind of emotion regulation skill to use. The first emotion regulation skill, which we call "Belly Breathing," is taught at the end of the first child session. Deep breathing is probably the most universal calming and stress-relieving technique; it can be used any time, anywhere, and by anyone. Two other breathing techniques, "Bubble Breathing" and "Balloon Breathing," are introduced in subsequent sessions, and a breathing technique is practiced at the end of every session. We chose these names for the techniques because using imagery to which children can relate increases the likelihood that they will use the techniques, and therefore increases the likelihood of their success. We refer to them as the "three B's" in PEP. Practice of each breathing technique is assigned as a take-home project.

Better symptom management is a key purpose of two IF-PEP child sessions on developing healthy habits (Chapter 9). Sleep is often problematic for children with mood disorders, and pharmacological treatments for BD in particular are often associated with weight gain. Thus attention to eating and exercise becomes an important part of comprehensive care. Exercise also functions to alleviate depressive symptoms, and so increasing exercise can reduce a child's core symptoms. Children pick the area of greatest concern to them to work on first (selecting from among sleep, eating, and exercise). They revisit

healthy habits later in treatment. For children in MF-PEP, there is not a specific session focused on healthy habits, but related concepts are interwoven throughout the various sessions.

The session on building what we call a "Tool Kit" for coping (Chapter 11) builds on a child's previously learned skills. By this point, children should have some ability to identify feelings, including mood symptoms ("mad, sad, bad" feelings) and what events tend to trigger them. Children are next taught to recognize the physical sensations that can signal difficult emotions and to consider how they act in response. Children may not have a choice about how they feel ("It's not your fault … "), but they do have a choice about how they respond—with either hurtful or helpful actions (" … but it's your challenge!"). With help from the therapist and family, the child begins to develop a Tool Kit of helpful activities for responding to difficult emotions. Four categories of activity tools are discussed in this session: Creative, Active, Rest and relaxation, and Social (CARS). The breathing techniques taught early in the program can become some of the child's tools in the R category. Children go home after this session with the assignment of putting together a Tool Kit for taking charge of difficult feelings. This kit can be used across settings—at home, in school, or with peers.

The next child session, on what we call "Thinking, Feeling, Doing" (Chapter 13) connects thoughts to feelings and actions. It introduces a child to the idea that hurtful thoughts or actions increase hurtful feelings, and that these all lead to more problems. Changing hurtful thoughts and actions to more helpful ones can alter mood states. The exercise and worksheet on Thinking, Feeling, Doing helps the child see the relationships among a trigger situation and hurtful thoughts, emotions, and actions. Developing and using more helpful thoughts and actions can result in less difficult feelings.

Parents also learn the CBT-based linkage among thoughts, feelings, and actions as a way to begin changing negative family cycles (Chapter 12). With this parent session, the focus shifts from providing information to improving the internal workings of the family. As noted earlier, multiple studies have shown that high EE in families (patterns of critical comments, hostility, and emotional overinvolvement) predicts poorer outcome, and that EE can be changed (see Chapter 2 for a review of research). Joan Asarnow and her colleagues have focused on EE and childhood depression; they have shown that EE rates are higher in families of depressed children than in families of nondepressed children, and that high EE is associated with a more insidious onset of depression (Asarnow et al., 1993).

Helping parents understand negative family cycles is a first step to changing them, reducing EE, and improving family functioning. When parents' efforts fail to help their child feel better, they usually respond with frustration and anger, and may withdraw until guilt fuels further attempts to change the way the child feels. Empathy is crucial in conducting this parent session and in helping parents recognize how this or a similar negative cycle may play out in the family; at the same time, parents are taught that responding differently to the child can improve family interactions. To help parents catch negative interactions as they happen, they are asked to complete the same Thinking, Feeling, Doing exercise given to the child.

The next parent and child sessions (Chapters 14 and 15) each teach basic problem solving. The parent session also covers key coping skills and includes important dos and

don'ts for responding to a moody child. The goal for both parents and children is to view mood symptoms and challenging behaviors as problems to be solved by using the basic steps of problem solving. Children learn five steps: "Stop" (take a moment to calm down); "Think" (define the problem and brainstorm strategies); "Plan" (select and plan a strategy to use); "Do" (carry out the strategy); and "Check" (evaluate the outcome and decide on future action). For parents, problem solving is taught as an approach to symptom management and family conflicts. The importance of adequate problem definition is emphasized, and parents learn one additional step (deciding who needs to know about the problem). Parents are also taught to examine pros and cons as a way to pick which possible solution to try.

The parent session (Chapter 10) covering the school system and the child's school team is a useful foundation; however, many parents still struggle with how to work with their child's school. Therefore, in IF-PEP (but not MF-PEP), a meeting is scheduled for the parents, the therapist, and personnel at the child's school to discuss the child's particular school issues (Chapter 16). This is not a typical parent session, and it does not follow the usual session format. The therapist's goal for the meeting is to improve communication between the parents and the school staff. The therapist also assists in the development or enhancement of school services or accommodations. The meeting is typically scheduled after the parents have been taught problem-solving skills; these skills are helpful for planning, as well as during the meeting itself. In preparation, the therapist should help parents define the child's school problems and plan an agenda for the meeting. The parents typically arrange this meeting with school personnel.

Attention next shifts to communication skills and patterns. For children, there are two separate sessions, one for nonverbal communication (Chapter 17) and one for verbal communication (Chapter 19). Research suggests that children with mood disorders have difficulty reading nonverbal cues in others (see Chapter 2 for a summary). Therefore, children first learn about the communication cycle—sending, receiving, responding, and understanding the response. They then learn about the types of nonverbal communication (facial expression, gestures, posture, tone of voice, and personal space). Role play is used to help children practice sending and reading the emotional messages in nonverbal cues. The child session on verbal communication emphasizes ways to stop hurtful words and phrases and to replace them with more helpful expressions, including "I" statements. Parents receive one session on communication (Chapter 18), with an emphasis on making family interactions less stressful. Less daily stress and less EE help to reduce the frequency or severity of the child's symptoms and can significantly improve both child and family functioning. Parents are first counseled on general communication traps to avoid, as well as traps specific to mood disorders. They are then coached on how to communicate effectively with moody children. Next, family members are given the assignment to catch themselves using old, hurtful words, and to develop and use more helpful phrases as replacements.

The final parent-only session (Chapter 20) reinforces the skills learned in previous sessions and helps parents plan for the future regarding suicidal, manic, or other dangerous mood-related behavior. Being a "good enough" parent does not automatically equip one with the skills needed for these situations. This session emphasizes the importance of maintaining a Mood Record or Mood–Medication Log for catching symptoms early

to prevent crises, and reviews strategies for managing manic and depressive symptoms. Other issues covered include the need for a safety plan and guidelines for creating one; ways of responding to a child's suicide threats; and times when hospitalization may be needed. Techniques for parent stress management are reviewed.

Not all children with mood disorders have siblings, but when they do, the siblings can struggle under a heavy emotional burden. Sibling issues are an important part of managing a child's mood disorder within a family. When such issues are relevant, a session in IF-PEP is devoted to a meeting of therapist and siblings without the mood-disordered child (Chapter 21). The session allows siblings to speak freely, to voice their own concerns and issues, and to receive age-appropriate information about mood disorders. The therapist then helps siblings raise their issues with parents and facilitates family problem solving in regard to these. There is no sibling session in MF-PEP, but sibling issues are frequently discussed in both the parent and child group sessions.

The final session (Chapter 22) is devoted to a review of material learned over the course of treatment. Warning signs of relapse are reviewed, and transition plans are confirmed. In MF-PEP, a graduation ceremony is held. In some cases, after the end of IF-PEP, families will continue with the therapist for maintenance treatment; in such cases, goals are set and treatment continues.

As noted earlier, IF-PEP provides for four "in-the-bank" sessions to be used as needed at any time during the program. For example, some parents enter the program without a mental health team or school team in place and need additional help to establish them. The child or parents may need an additional session to consolidate such skills as problem solving, changing negative family cycles, making use of the coping Tool Kit, or crisis management.

In the next chapter, we review what current scientific research tells us about childhood mood disorders and their treatment. The information given to parents and children about mood disorders in PEP is based on this research. As also discussed in Chapter 2, many of the skills taught to children in PEP are designed to address cognitive deficits found in youth with mood disorders.

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