Family-Based Interventions for Childhood Mood Disorders

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KEYWORDS

• Bipolar spectrum disorder • Depressive spectrum disorders • Children
• Adolescents • Psychosis • Psychotherapy • Evidence-based treatment
• Family-based treatment

KEY POINTS

- Family psychoeducation (FPE) plus skill building is the only psychotherapy identified as probably efficacious for childhood bipolar spectrum disorders (BPSDs), although none have been identified as well established.
- Cognitive behavioral therapy (CBT) is considered well established for childhood depressive spectrum disorders (DSDs).
- Few studies examine psychotherapy for young children in randomized controlled trials (RCTs).
- Family-based therapy has repeatedly demonstrated greater symptom improvement than treatment as usual among children with mood disorders in RCTs.
- Common components of efficacious family-based therapies include psychoeducation; problem-solving, communication, and social skills building; as well as cognitive reframing.
- The benefits of family-based therapy over individual therapy for childhood depression remain unclear.

OVERVIEW OF CHILDHOOD MOOD DISORDERS

Mood disorders (bipolar spectrum disorder [BPSD] and depressive spectrum disorder [DSD]) are debilitating psychiatric problems that affect both youth and adults. These disorders are associated with impaired functioning in relationships with family and

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Abbreviations

ABFT	Attachment-Based Family Therapy
ADHD	Attention-deficit/hyperactivity disorder
BD-I	Bipolar I disorder
BD-II	Bipolar II disorder
BPSD	Bipolar spectrum disorder
CBT	Cognitive behavioral therapy
CFF-CBT	Child- and family-focused CBT
DBT	Dialectical behavior therapy
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
DSD	Depressive spectrum disorder
FBPs	Family-based psychotherapies
FFT-A	Family-Focused Treatment for Adolescents
FFT-HR	Family-Focused Therapy-High Risk
FIPP	Focused Individual Psychodynamic Psychotherapy
FPE	Family psychoeducation
IF-PEP	Individual-Family Psychoeducational Psychotherapy
MDD	Major depressive disorder
MF-PEP	Multi-Family Psychoeducational Psychotherapy
PCIT	Parent-Child Interaction Therapy
PCIT-ED	Parent-Child Interaction Therapy-Emotion Development
RCTs	Randomized controlled trials
SIFT	Systems Integrative Family Therapy
SSRI	Selective serotonin reuptake inhibitor
TAU	Treatment as usual
WLC	Wait list control

peers, cognitive abilities, and performance at work and school. Onset of mood disorders in childhood can lead to long-term impairment and increased risk of mood symptoms in adulthood.[1,2]

PREVALENCE, PRESENTATION, AND COMORBIDITIES

Despite considerable debate regarding whether children can truly have a BPSD, substantial evidence now supports its presentation in youth.[2] Childhood BPSD has an estimated prevalence rate of 1.8%, and the prevalence in adolescents is 2.7%.[3] Prevalence of DSD is higher, with estimated rates of 2.8% in childhood and 5.7% in adolescence.[4]

Children with mood disorders often have a complex constellation of symptoms and are at high risk for future psychiatric problems. Childhood-onset major depressive disorder (MDD) is associated with greater risk for suicide, substance abuse, behavioral problems, and increased risk for having a DSD in adolescence and adulthood.[1,5] Childhood-onset MDD is associated with greater risk for later BPSD than is adult-onset MDD[6]; 20% to 40% of youth with MDD will have a BPSD later in life.[5]

Symptom presentation of MDD in youth is similar to that in adults in many ways; however, children are less likely to experience hypersomnia, decreased appetite, and delusions compared to adults.[6] While some youth do have a classic BD presentation (ie, sustained periods of irritable or elated mood lasting for days at a time), children with BPSD are more likely to exhibit rapid cycling, or shorter periods of extreme irritable or elated mood[7] and are at high risk for relapse after remission.[2,7] Kowatch and colleagues[8] found that estimated rates of manic symptoms in youth with BPSD are fairly similar across childhood BPSD studies, with the most common symptoms being increased energy, distractibility, pressured speech, and irritability. Among

children with subsyndromal bipolar disorder (bipolar disorder not otherwise specified [BD-NOS] in *Diagnostic and Statistical Manual of Mental Disorders* [Fourth Edition] [DSM-IV][9] or other specified bipolar and related disorder in DSM-V[10]), about one-third meet the criteria for bipolar I disorder (BD-I) or bipolar II disorder (BD-II) within 2 to 4 years.[11]

Most children with mood disorders have comorbid diagnoses. Common comorbidities for BPSD and DSD include attention-deficit/hyperactivity disorder (ADHD), disruptive behavior, anxiety, and (in adolescents) substance use disorders[5,6,8]; 42% of youth with BPSD experience psychosis.[8] A history of suicide attempts is reported in 22% of children with MDD and 44% of children with BD-I or BD-II.[2]

Family Functioning and Childhood Mood Disorders

Both BPSD and DSD are associated with significant functional impairment including problems with peers, family, and school.[1,2,12] Children with mood disorders experience greater tension between themselves and their parents and experience less maternal warmth than children without mood disorders; these differences may be due in part to parents being more likely to have a mood disorder themselves.[12,13] Family relationships and parenting factors including warmth/hostility, attachment, criticism, and parents' coping are possible contributors to children's mood symptoms.[5,13–16] High levels of criticism in parent-child relationships are associated with lower child social competence, depressive symptoms, and suicidal ideation.[15,16] Several psychotherapeutic interventions have been developed to address these factors.

FAMILY-BASED PSYCHOTHERAPY: A REVIEW OF THE EVIDENCE

As childhood BPSDs and DSDs are not uncommon and are clearly impairing for children and their families, identification of efficacious interventions could significantly benefit public health. Treatment guidelines for BPSD and DSD have been developed and published.[5,17,18] Psychotropic medications are commonly recommended and prescribed. Psychotherapy has also been established as an important component of mood disorder treatment. Psychotherapy provides support to patients and families; helps families to cope with mood disorders and their associated impairments; promotes medication compliance; supports psychological development; improves social, family, and academic functioning; and decreases mood symptoms and rates of relapse.[13,19–22]

With emerging data on the family-related impairments associated with mood disorders, efforts to develop family-based psychotherapies (FBPs) have increased. This article focuses specifically on FBPs for childhood mood disorders that have been examined in RCTs. For purposes of this review, FBP is defined as psychotherapy that regularly involves concurrent participation by a youth and one or more caregivers in therapy sessions. Only studies including children meeting DSM[9,10] mood disorder criteria were included (**Table 1**).

Cognitive Behavioral Therapy

Goodyer and colleagues[23] investigated the efficacy of CBT with parent involvement at the end of each session for adolescents with DSD. CBT components included the following:

- Engagement/goal setting
- Emotional recognition/self-monitoring
- Behavioral activation
- Cognitive restructuring
- Problem-solving and communication skills[23]

Table 1
Randomized controlled trials of family-based therapies for childhood mood disorders

Authors	Participants & Demographics	Diagnoses	Therapists	Measures	Treatment Conditions	Results
Diamond et al,[32] 2010	*N* = 66, age 12–17 y 17% adolescent boys 74.2% African American	39% MDD, 8% DD; participants selected for elevated depressive symptoms and suicidal ideation	Master's and doctoral level	BD-I, BD-II, SIQ-JR, SSI, DISC	ABFT (12 weekly 60- to 90-min adolescent-parent sessions) (*n* = 35) EUC (facilitated referrals with ongoing clinical monitoring) (*n* = 31)	ABFT: faster rate of improvement in suicidal ideation and depressive symptoms with benefits maintained at 3-mo follow-up
Diamond et al,[33] 2002	*N* = 32, age 13–17 y 22% adolescent boys 31% white, 69% African American	MDD	Master's and doctoral level	BDI, BHS, YSR, SRFF, STAIC, CBCL, HAM-D, K-SADS	ABFT (12 weekly 60- to 90-min adolescent-parent sessions) (*n* = 16) WLC (*n* = 16)	ABFT: greater improvement in depressive symptoms per clinician ratings, greater youth-reported improvement in anxiety and family conflict (*d*s = 0.64–1.3)
Fristad,[46] 2006	*N* = 20, age 8–11 y 85% boys 90% white	40% BD-I, 35% BD-II, 25% BD-NOS	Doctoral level	EEAC, therapy evaluation form, provider and medication usage grids, MSI	IF-PEP (16 alternating parent and child sessions 50 min each) + TAU (*n* = 10) WLC + TAU (*n* = 10)	IF-PEP: greater improvement in family interaction; positive consumer evaluations from parents and children Both groups demonstrated improvements in mood symptoms posttreatment and at 12-mo follow-up

Fristad et al,[41] 2002 Fristad et al,[42] 2003 Goldberg-Arnold et al,[43] 1999	*N* = 35, age 8–11 y 77% boys 88.5% white, 2.9% Hispanic, 2.9% African American, 2.9% Southeast Asian, 2.9% American Indian	11% BD-I, 34% BD-II, 17% DD, 37% MDD	Master's and doctoral level	UMDQ, EEAC, SSS, CASA	MF-PEP (6 parent and child group sessions 75 min each) + TAU (*n* = 18) WLC + TAU (*n* = 17)	MF-PEP: greater improvement in family interaction and parent knowledge of mood disorders at 2- and 6-mo follow-ups, improved service utilization at 6-mo follow-up; greater improvement in child-reported social support from parents at 6-mo follow-up
Fristad et al,[39] 2009	*N* = 165, age 8–11 y 73% boys 90.9% white, 6.7% African American, 1.8% bi/multiracial, 0.6% Hispanic	38% BD-I, 13% BD-II, 18% BD-NOS, 1% substance-induced mood disorder, 3% MDD, 3% MDD + DD, 3% DD, 1% mood disorder NOS	Master's- and doctoral-level therapists; 12 graduate students as cotherapists	MSI	MF-PEP (8 parent and child group sessions 90 min each) + TAU (*n* = 78) WLC + TAU (*n* = 87)	MF-PEP: greater mood symptom improvement at 1-y follow-up (*d* = 0.53)
Goldstein et al,[27] 2014	*N* = 20, age 12–18 y 25% adolescent boys 80% white, 10% African American, 10% multiracial	15% BD-I, 40% BD-II, 45% BD-NOS	Masters and doctoral level	K-SADS, A-LIFE, PSR, SIQ-Jr, LIFE, CALS	DBT (36 alternating individual child and family skills sessions 60 min each) (*n* =14) TAU (*n* = 6)	DBT: significantly fewer severe depressive symptoms over time (*d* = 0.98); more likely to demonstrate improvement in suicidal ideation; nonsignificant group differences in manic symptoms and emotional dysregulation

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Table 1
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Authors	Participants & Demographics	Diagnoses	Therapists	Measures	Treatment Conditions	Results
Goodyer et al,[23] 2007	*N* = 208, age 11–17 y 26% adolescent boys All living in Manchester or Cambridge, England (no race/ethnicity data reported)	MDD or probable MDD (4 rather than 5 symptoms of MDD with psychosocial impairment)	Doctoral level (psychiatrists and psychologists)	K-SADS, Health of the Nation outcome scale, CDRS-R	CBT (18 individual youth sessions 55 min each over 24 wk + 1 final session at 28 wk, each with parent participation at the end of the session) + SSRI (*n* = 105) SSRI alone (*n* = 103)	Both groups demonstrated improvement in depressive symptoms, overall functioning, and suicidality; no apparent group differences.
Luby et al,[29] 2012	*N* = 43, age 3–7 y 63% boys 86% white, 9% black, 5% other	MDD	Master's and doctoral level	PAPA, PFC-S, HBQ, KIDSEDF, BRIEF, PSI	PCIT-ED (14 parent-child sessions over 12 wk) (*n* = 25) DEPI (12 parent psychoeducational group sessions of 60 min over 12 wk) (*n* = 18)	Both groups showed significant declines in depressive severity and in internalizing, depression, and functional impairment domains PCIT-ED: greater improvement in emotion recognition skills (*d* = 0.83), executive functioning (*d*s = 0.33–0.50), and parenting stress in the child domain (*d* = 1.53) and total stress (*d* = 0.54)

Miklowitz et al,[35] 2008	*N* = 58, age 12–17 y 43.1% adolescent boys 89.7% white, 5.2% biracial, 1.7% African American, 1.7% American Indian, 1.7% Asian/Pacific Islander	65.5% BD-I, 10.3% BD-II, 24.1% BD-NOS	Not reported	K-SADS, A-LIFE	FFT-A (21 adolescent-only, parent-only, or family sessions of 50 min) + pharmacotherapy (*n* = 30) EC (3 family sessions of 50 min each) + pharmacotherapy (*n* = 28)	FFT-A: more rapid improvement in depressive symptoms, fewer weeks in depressive episodes, more time without depressive symptoms, and greater improvement in depressive symptoms over 2 y No group differences in rates of recovery from index episode or time to recurrence
Miklowitz et al,[36] 2013	*N* = 40, age 9–17 y 57.5% adolescent boys 90% white, 5% Hispanic ethnicity	42.5% MDD, 7.5% cyclothymic disorder, 50% BD-NOS	Not reported	YMRS, CDRS-R, A-LIFE, PSR, FMSS	FFT-HR (8 weekly + 4 biweekly adolescent-only, parent-only, or family sessions) + as-needed pharmacotherapy (*n* = 21) FEC (1–2 family sessions) + as-needed pharmacotherapy (*n* = 19)	FFT-HR: faster improvement of initial mood symptoms, more time in remission, less time with subthreshold mood symptoms, and greater improvement of manic symptoms over 1 y; FFT-HR was more effective in improving mood symptoms for children in more highly critical/ conflictual families

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Authors	Participants & Demographics	Diagnoses	Therapists	Measures	Treatment Conditions	Results
Sanford et al,[47] 2006	*N* = 31, age 13–18 y 35.5% adolescent boys All living in Canada (no race/ethnicity data reported)	MDD (12.9% MDD with psychosis)	Not reported	RADS, FAD, ACL, SSAI	FPE (12 sessions of 90 min each at home with all family members who agreed to participate) + TAU (*n* = 16) TAU (*n* = 15)	FPE: faster rates of improvement in family functioning, greater improvement in global social function (*d*s >0.9), depressive symptoms (*d* = 0.52, 0.64) at the 6- and 9-mo follow-ups
Trowell et al,[30] 2007	*N* = 72, age 9–15 y 62% boys 87% white, 6% Asian, 6% other	45% MDD, 8% DD, 47% MDD + DD	Not reported	CDI, K-SADS, MFQ, CGAS	SIFT (8–14 family sessions 90 min each) (*n* = 37) FIPP (16–30 individual child sessions 50 min each + 1 individual parent session for every 2 child sessions) (*n* = 35)	Both groups showed high response rates and did not differ SIFT: greater decline in child-reported depression at end of treatment but not at 6-mo follow-up

West et al,[24] 2014	*N* = 69, age 7–13 y 58% boys 52% white, 30% African American, 10% Hispanic, 5% American Indian/ Alaskan, 1% American Indian/ Pacific Islander	31.9% BD-I, 5.8% BD-II, 62.3% BD-NOS	Bachelor's, master's, + doctoral level	K-SADS, CDRS-R, CGI	CFF-CBT (12 weekly 60- to 90-min sessions with the parent, child, or family) + pharmacotherapy (*n* = 34) TAU + pharmacotherapy (*n* = 35)	CFF-CBT: reported greater treatment satisfaction, demonstrated greater reductions in parent-reported mania posttreatment (*d* = 0.69) and depression posttreatment (*d* = 0.55) and at 6-mo follow-up (*d* = 0.48); nonsignificant differences in global functioning

Abbreviations: ABFT, Attachment-Based Family Therapy; ACL, Adjective Checklist; A-LIFE, Adolescent Longitudinal Interval Follow-Up Evaluation; BDI, Beck Depression Inventory; BHS, Beck Hopelessness Scale; BRIEF, Behavior Rating Inventory of Executive Function; CALS, Children's Affective Lability Scale; CASA, Child and Adolescent Services Assessment; CBCL, Child Behavior Checklist; CDI, Child Depression Inventory; CDRS-R, Child Depression Rating Scale-Revised; CGAS, Children's Global Assessment Scale; CFF-CBT, child- and family-focused cognitive behavioral therapy; CGI, Children's Global Impressions scale; *d*, Cohen's d, a measure of effect size; DBT, dialectical behavior therapy; DD, dysthymic disorder; DEPI, Developmental Education and Parenting Intervention; DISC, Diagnostic Interview Schedule for Children; EC, educational control; EEAC, Expressed Emotion Adjective Checklist; EUC, enhanced usual care; FAD, Family Assessment Device; FEC, family educational control; FFT-A, family-focused therapy-adolescent; FFT-HR, family-focused therapy-high risk; FIPP, Focused Individual Psychodynamic Psychotherapy; FMSS, Five-Minute Speech Sample; HAM-D, Hamilton Depression Rating Scale; HBQ, Health and Behavior Questionnaire; IF-PEP, Individual-Family Psychoeducational Psychotherapy; KIDSEDF, Penn Emotion Differentiation Test; K-SADS, Kiddie Schedule for Affective Disorders and Schizophrenia; LIFE, Longitudinal Follow-Up Evaluation; MF-PEP, Multi-Family Psychoeducational Psychotherapy; MFQ, Mood and Feelings Questionnaire; MSI, Mood Severity Index; NOS, not otherwise specified; PAPA, Preschool Age Psychiatric Assessment; PCIT-ED, Parent-Child Interaction Therapy-Emotion Development; PFC-S, Preschool Feelings Checklist-Scale Version; PSI, Parenting Stress Index; PSR, Psychiatric Status Screening; RADS, Reynolds Adolescent Depression Scale; SIFT, Systems Integrative Family Therapy; SIQ-Jr, Suicidal Ideation Questionnaire-Junior; SRFF, Self-Report of Family Functioning; SSAI, Structured Social Adjustment Interview; SSI, Scale for Suicidal Ideation; SSRI, selective serotonin reuptake inhibitor; SSS, Social Support Scale; STAIC, State-Trait Anxiety Inventory for Children; TAU, treatment as usual; UMDQ, Understanding Mood Disorders Questionnaire; WLC, wait list control; YMRS, Young Mania Rating Scale; YSR, Youth Self-Report.

In a study of 208 adolescents who received a 28-week intervention of either 19 sessions of CBT of 55 minutes each plus a selective serotonin reuptake inhibitor (SSRI) or an SSRI alone, both groups showed significant improvements in depressive symptoms, overall functioning, and suicidality. CBT did not seem to provide benefit beyond that provided by SSRI alone.

Child- and family-focused CBT (CFF-CBT) was designed to address symptoms and impairment related to childhood BPSD. CFF-CBT includes 12 weekly 60- to 90-minute child, parent, or family sessions and 7 treatment components that spell "RAINBOW":

1. Routine: developing consistent daily routines
2. Affect regulation: mood identification, coping strategies
3. I can do it!: improving self-esteem
4. No negative thoughts/live in the now: cognitive restructuring and mindfulness
5. Be a good friend/balanced lifestyle: learning social skills and parent self-care
6. Oh how do we solve this problem?: learning problem-solving/communication skills
7. Ways to find support: enhancing social support[24]

In a study of 69 children with BPSD who received either CFF-CBT or treatment as usual (TAU), the CFF-CBT group attended more therapy sessions and reported greater satisfaction with treatment. CFF-CBT yielded greater reduction in parent-reported mania posttreatment and depressive symptoms posttreatment and at 6-month follow-up.[24] This result suggests that involving families in CBT-based therapy for BPSD may be efficacious in mood symptom reduction.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT), originally developed to treat adults with borderline personality disorder, has been modified to treat BPSD and suicidality in adolescents.[25] In the first 6 months of DBT for adolescent BPSD, adolescents attend 24 weekly 60-minute sessions alternating between family and individual sessions. In the last 6 months, adolescents attend 1 family session and 1 individual session monthly to review skills and consolidate gains.

- Family skills training: psychoeducation about DBT and BPSD; mindfulness, distress tolerance, emotion regulation, and social skills
- Adolescent individual therapy sessions: problem-solving strategies
- Skills coaching: therapist available by phone for skills coaching as needed[26]

Goldstein and colleagues[27] examined the efficacy of DBT for 20 adolescents with BPSD compared with TAU in ameliorating mood symptoms. Although both treatment groups demonstrated high acceptability, adolescents in DBT attended more sessions and demonstrated greater improvement in depressive (but not manic) symptoms and suicidal ideation.[27] Thus, DBT seems to be a promising treatment of adolescent BPSD, particularly for depressive symptoms.

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT), a therapy that uses modeling and in-session coaching to promote positive parent-child relationships and firm yet warm parenting, is an effective treatment for young children with disruptive behavior disorders.[28] Luby and colleagues[29] added a module addressing emotion recognition and regulation to the core PCIT to treat preschoolers with MDD (PCIT-Emotion Development

[PCIT-ED]). PCIT-ED is delivered in 14 sessions over 12 weeks and includes the following modules:

- Child-directed interaction: positive-play techniques to improve the parent-child relationship
- Parent-directed interaction: effective commands and firm, nonpunitive behavior management strategies
- Emotion development (novel): emotion competence and regulation strategies; coaching parent to help the child identify and regulate emotions

Luby and colleagues[29] examined the efficacy of PCIT-ED compared with Developmental Education and Parenting Intervention (12 weekly 60-minute parent group sessions focused on child social and emotional development) in 43 preschoolers with MDD. Both groups demonstrated improved depressive symptom severity; PCIT-ED, however, was more efficacious in improving executive functioning and emotion recognition skills. PCIT-ED was the only identified FBP for preschoolers with mood disorders.

Family Systems Therapy

Trowell and colleagues[30] tested the hypothesis that Focused Individual Psychodynamic Psychotherapy (FIPP) is more efficacious than Systems Integrative Family Therapy (SIFT) in treating childhood depression using a 9-month RCT including 72 youth aged 9 to 15 years.[30] FIPP focuses on relationships, life stresses, and dysfunctional attachments, whereas SIFT focuses on family dysfunction without explicit attention to unresolved intrapsychic conflicts. In the study,[30] FIPP included 16 to 30 individual child sessions of 50 minutes each with 1 parent session for every 2 child sessions. SIFT involved 8 to 14 family sessions of 90 minutes each. Youth in both groups demonstrated high response rates. Those in SIFT reported greater reduction of depressive symptoms posttreatment, although SIFT and FIPP were no longer significantly different at the 6-month follow-up assessment.[30] Thus, it is unclear whether systems-based family therapy might be more efficacious than individual psychodynamic therapy.

Attachment-Based Family Therapy (ABFT) is derived from theory suggesting that family relationships can precipitate, exacerbate, or serve as a protective factor for depression and suicide.[31] ABFT is a process-oriented, emotion-focused treatment[32] including 12 weekly 60- to 90-minute adolescent-parent sessions consisting of 5 tasks or phases:

1. Relational reframe: strengthening relationships
2. Adolescent alliance: 1 to 2 adolescent-only sessions identifying family conflicts that may have contributed to depressed mood
3. Parent alliance: 1 to 2 parent-only sessions teaching emotion-focused parenting skills to improve parents' empathy and insight
4. Reattachment: together, parent or parents and adolescent discuss identified problems and learn new communication, problem-solving, and coping skills
5. Competency: improving the adolescent's autonomy while maintaining a healthy relationship with parents.[32,33]

In an RCT, 32 adolescents with MDD were randomized into ABFT or wait list control (WLC). Those in ABFT demonstrated greater improvement in clinician-rated depressive symptoms and youth-reported anxiety and family conflict.[33] Another RCT examined the efficacy of ABFT compared with enhanced usual care (facilitated referrals with ongoing clinical monitoring) in treating 66 youth with depressive symptoms and suicidal ideation (47% had DSD). Youth in ABFT demonstrated faster rates of improvement in suicidal

ideation and depressive symptoms with benefits maintained at 3-month follow-up assessment.[32] Taken together, these results suggest that structured, goal-oriented family therapy may be efficacious in treating adolescent depression and suicidality.

Family Psychoeducation Plus Skill Building

Family-Focused Treatment for Adolescents (FFT-A) includes 21 (12 weekly, 6 biweekly, and 3 monthly) 50-minute adolescent, parent, or family sessions over 9 months.[34,35] FFT-A was developed to treat adolescent BPSD and includes involvement from the youth, parents, and siblings. The components are as follows:

- FPE about the nature and course of BPSD and evidence-based treatments
- Communication skill building
- Problem-solving skills training

A total of 58 families of adolescents with BPSD were randomized to FFT-A and pharmacotherapy or to enhanced care (3 weekly 50-minute family sessions) and pharmacotherapy. Youth whose families received FFT-A demonstrated faster improvement in depressive symptoms, spent less time in depressive episodes, and demonstrated greater reduction in depressive symptom severity over 2 years.[35] Miklowitz and colleagues[36,37] modified FFT to treat younger children at high risk for BD (children with diagnoses of MDD, BD-NOS, or cyclothymia with parents diagnosed with BD-I or BD-II; Family-Focused Therapy-High Risk [FFT-HR]). FFT-HR includes 12 (8 weekly, 4 biweekly) adolescent, parent, or family sessions conducted over 4 months. A total of 40 children were randomized to FFT-HR or a family education control (1–2 family sessions). Those in the FFT-HR arm recovered more quickly from their initial mood symptoms, spent more time in remission, and demonstrated greater reduction in manic symptoms over 1 year.[36]

Multi-Family Psychoeducational Psychotherapy (MF-PEP) is a group intervention including 8 concurrent parent and child sessions of 90 minutes each developed as an adjunctive treatment for children with DSD or BPSD.[38] This intervention incorporates psychoeducation, family systems concepts, and CBT techniques. Sessions begin with parents and children together to review between-session projects and end with children reviewing their session content with parents. Key components are the following:

- Parent and child psychoeducation about symptoms and evidence-based treatments
- Facilitated social support
- Emotion regulation skills training
- Strategies for navigating the mental health system
- Altering maladaptive family interaction patterns
- Cognitive restructuring
- Family problem-solving and communication skill building.[38]

MF-PEP plus TAU was compared with WLC plus TAU in 165 children with DSD or BPSD aged 8 to 11 years. The MF-PEP group demonstrated greater improvement in mood severity,[39,40] and participation in MF-PEP improved the quality of services that children received, mediated by parents' treatment beliefs.[41] In a pilot RCT, MF-PEP demonstrated greater improvements in family interactions and knowledge of mood disorders compared with WLC.[41–43] In addition, comorbid behavior and anxiety disorders did not impede improvement in mood,[44,45] and behavioral symptoms improved with treatment.[44] These findings suggests that MF-PEP is efficacious in treating mood disorders and improving service engagement. An individual-family

version of MF-PEP, called Individual-Family Psychoeducational Psychotherapy (IF-PEP),[38] has demonstrated a medium effect size in ameliorating mood symptom severity for children with BPSD.[46] The efficacy of IF-PEP among children with DSD is currently being evaluated in an RCT.

Sanford and colleagues[47] conducted a small pilot study of FPE involving 12 family sessions of 90 minutes each and 1 booster session conducted in the homes of 31 adolescents with MDD (aged 13–18 years). The following are the goals of FPE:

- Increasing family knowledge about depression and its impact on families
- Improving family communication
- Enhancing coping and problem-solving skills[47]

Adolescents were randomized to FPE plus TAU or TAU alone. FPE demonstrated faster rates of improvement in family functioning and greater improvement in social functioning and depressive symptoms.[47] FPE seems to be a promising treatment for youth with MDD; replication in a larger RCT would provide more support of its efficacy.

FFT, MF-PEP, and FPE each demonstrate efficacy in treating mood symptoms of youth with DSD or BPSD with FPE plus skill building.

TREATMENT COMPLICATIONS AND SUGGESTED ADAPTATIONS

Complex presentation and comorbidity is common among children with mood disorders. Suggestions for how to manage treatment complications are presented in Table 2.

The following case illustrates use of IF-PEP in the treatment of an 8-year-old girl, Anna (identifying information has been altered to protect confidentiality), in the context of a larger treatment study.

Table 2
Strategies for managing treatment complications

Complication	Suggested Strategies
Treatment resistance	• Per treatment guidelines, refer for a medication evaluation or consult with prescribing physician • Consult with school personnel to address symptom management at school • Assess adherence to psychotherapy and medication
Comorbidity	• Because evidence-based treatments for some common comorbid disorders use similar strategies as those discussed in this review, evidence-based treatments for mood disorders may ameliorate some comorbid symptoms as well • Supplement with evidence-based strategies to treat comorbid conditions as necessary (eg, medication management for ADHD, exposure-response prevention for anxiety disorders) • Consult with the prescribing physician or school personnel, as needed • If another disorder is primary, consider addressing those symptoms first • For substance and autism spectrum disorders, simultaneously begin treatment of those conditions • Develop safety/crisis plans early in treatment to manage suicidality
Relapse	• Conclude therapy with a thorough review of newly learned skills • Use booster sessions to review skills and prevent relapse • Provide psychoeducation to parents and youth about relapse early in treatment; coach them to notice warning signs and recognize when further treatment is needed

CLINICAL CASE EXAMPLE

Presentation

At intake, Anna presented with dysphoric and irritable mood, anhedonia, decreased concentration, and feelings of worthlessness (eg, saying that she was stupid or that she hated herself) and significant psychotic symptoms, including hallucinations, delusions, and disorganized speech. Anna commented that she could see people's organs and bad spirits. Anna's mother, Ms Jones, described Anna as sad and tearful all day, every day, and noted that Anna occasionally experienced passive suicidal ideation. Per Ms Jones, Anna had difficulty maintaining friendships and was often physically aggressive toward her younger brother. Anna often worried about her future as well as the health of her family members and finances. Anna's intelligence quotient was in the average range. The family was advised that pharmacotherapy is the first-line treatment of psychosis, but Ms Jones was adamantly opposed, preferring FBP instead.

Diagnoses

Thorough assessment of Anna's presenting concerns, history, and family functioning through parent and child interviews revealed symptoms consistent with schizoaffective disorder, depressive type, and generalized anxiety disorder. Parent- and child-reported inattention and hyperactivity were better accounted for by Anna's psychotic symptoms than by an independent ADHD diagnosis; treatment included a plan to monitor these symptoms to further clarify whether a separate ADHD diagnosis was warranted.

Developmental History

Anna was delivered vaginally at full term without complications and was reportedly healthy at birth. As an infant, Anna was diagnosed with reactive airway disease, and she had continued to use an inhaler as needed. Anna reportedly met all developmental milestones within healthy limits.

Treatment Summary

Anna and Ms Jones attended 10 child sessions and 10 parent sessions over 3 months. Rapport was easily established with Ms Jones. Although guarded initially, Anna quickly warmed up in therapy. With their therapist, Anna and Ms Jones developed 3 treatment goals: (1) reduction in the frequency and intensity of Anna's depressed and irritable moods and psychotic symptoms, (2) improvement in Anna's self-esteem, and (3) improvement in Anna's social relationships. The therapist met with Anna and Ms Jones together at the beginning of each child session to assess Anna's functioning and address any new concerns. The 3 also met at the end of each session for Anna to share with Ms Jones the content of that day's session and to aid Ms Jones in facilitating Anna's skills generalization.

Treatment began by providing psychoeducation regarding depression and psychosis to Anna and teaching her to identify and rate the intensity of her feelings in order to improve her ability to recognize and communicate her mood states. Anna practiced identifying her feelings at the beginning of each subsequent session. Next, to improve Anna's self-esteem, Anna learned to differentiate herself from her symptoms. In future sessions, Anna was encouraged to identify triggers of different feelings and to develop a "tool kit" of pleasant and fun activities she could use as coping strategies. She was asked to practice using these strategies and to note their effectiveness in improving her mood between sessions. There was additional focus on triggers of psychosis and

effective coping strategies. The therapist assisted Anna in identifying ways to communicate with Ms Jones and school staff about her mood and psychotic symptoms to elicit their support in coping. Anna was then taught to recognize the relationship among thoughts, feelings, and behaviors and was presented with age-appropriate examples of cognitive restructuring. With assistance from Ms Jones, Anna practiced identifying negative automatic thoughts, evaluating their accuracy, and developing more balanced thinking at home. Anna then learned problem-solving skills including concrete steps to solve interpersonal problems. Last, Anna was taught strategies to improve nonverbal and verbal communication.

Ms Jones' sessions began with psychoeducation about mood disorders, psychotic disorders, and their evidenced-based treatments. Throughout the course of therapy, there was a specific focus on pharmacotherapy for psychosis and frequent discussion of Anna's likely need for additional treatment. Ms Jones was encouraged to monitor, rate, and record Anna's moods and behaviors between sessions. The therapist discussed possible school-based interventions for Anna and provided guidance to Ms Jones in communicating Anna's mental health needs to Anna's school. Parent sessions then focused on parenting strategies to help manage Anna's mood and coping strategies for Ms Jones to use. The relationship between thoughts, feelings, and actions was discussed, and Ms Jones was encouraged to use cognitive reframing strategies. The therapist then reviewed family problem-solving and communication skills with Ms Jones.

The final parent and child session involved a review of skills learned in therapy, including strategies to prevent relapse. At the end of treatment, both Anna and Ms Jones reported feeling that they better understood Anna's symptoms and how to manage them. Ms Jones reported greater willingness to consider psychotropic medication and scheduled a medication consultation.

Over the course of treatment, Anna became better able to identify her feelings and recognize her psychotic symptoms. As part of treatment, the therapist provided Anna's school staff with information about her symptoms and diagnoses and, per Ms Jones and Anna, the staff responded to Anna's symptoms in a more supportive manner. Consequently, Anna was able to recognize psychotic symptoms earlier, notify a teacher, and use coping strategies to manage her mood. Ms Jones reported that Anna was also able to use these skills at home, resulting in fewer conflicts with her mother and siblings. Although Anna continued to experience psychotic symptoms, her depressive symptoms improved over the course of treatment. An independent evaluator rated Anna's depression as moderate at the beginning of treatment, decreasing to borderline at the end of treatment. To address remaining symptoms after completing IF-PEP sessions that were included in the treatment study, Anna was referred for medication management and ongoing therapy.

SUMMARY

Given the impairment and risks associated with childhood mood disorders, effective treatment is essential for child, family, and public health. Family-based interventions address family-related correlates of mood disorders and the impact mood symptoms can have on family functioning. Evidence is mounting for their benefit in treating children with DSD and BPSD. Research examining treatment moderators, benefit of family-focused treatment compared with individual approaches, family-focused treatment for younger children, and the effects of mood disorder treatments on comorbid diagnoses will further allow for effective, evidence-based yet individualized treatment for children with mood disorders.

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