
Family Psychoeducation: An Adjunctive Intervention for Children with Bipolar Disorder

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Childhood onset bipolar disorder is associated with significant morbidity and mortality, yet effective treatment strategies have remained underdeveloped and understudied. While some headway is being made vis-a-vis pharmacologic treatments, empirical efforts have not focused on adjunctive psychosocial interventions for childhood bipolar disorder. In this review, we discuss psychoeducation, delivered via workshops, multifamily psychoeducation groups, or individual-family psychoeducation, as an adjunct to the ongoing pharmacotherapy, psychotherapy, and school-based interventions for children with bipolar disorder. We review the theoretical rationale for psychoeducation, including expressed emotion and caregiver concordance; summarize findings in the adult literature; and then describe our development and testing of psychoeducational interventions for mood-impaired children. Data from three pilot studies are reviewed, and progress on two studies currently underway is presented. We conclude with current limitations of psychoeducation and recommendations for future study to develop psychoeducation as an empirically supported adjunctive intervention for children with bipolar disorder. Biol Psychiatry 2003; 53:1000–1008 © 2003 Society of Biological Psychiatry

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Introduction

Efforts to develop empirically supported treatments for a variety of mental disorders (Chambless and Hollon 1998) have increased significantly in recent years. Considerable work has been done in the area of adolescent depression, including investigations of individual therapy (Mufson et al 1994), group therapy (Clarke et al 1992, 1995), and family therapy (Diamond and Siqueland 1995).

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While some studies have examined cognitive-behavioral therapy for elementary school-aged children with elevated depressive symptoms (Stark et al 1987; Weisz et al 1997; Kahn et al 1990) and some of these interventions have included a parent component (Stark et al 1994, 1996; Asarnow et al 2001), no published work to date has documented the efficacy of psychosocial interventions for elementary school-aged children with major depression (Kaslow et al 2002) or bipolar disorder (Fristad et al 2002). Hence, the creation and testing of efficacious treatments for children with mood disorders is needed (Burns et al 1999), especially for children with childhood bipolar disorder (Fristad et al 2002).

Our research group has initiated a series of coordinated efforts to develop and empirically validate psychoeducation as an effective treatment modality for families of children with mood disorders. In this review, we provide an overview of two theoretical constructs (expressed emotion and family concordance) relevant to psychoeducational interventions, review psychoeducation as a treatment strategy in adults and children, describe our clinical intervention, provide preliminary efficacy data for children with bipolar disorder, and describe two current studies. Finally, we summarize the role of psychoeducation in the comprehensive treatment of children with bipolar disorder and recommend future research studies to be conducted. Our goal is to introduce readers unfamiliar with psychoeducation for childhood bipolar disorder to the rationale for its use, describe possible mechanisms of change, explain its core components, introduce two ongoing studies, and encourage others to test it empirically.

Expressed Emotion

To understand the development of psychoeducation as an intervention strategy, a brief review of the concept of expressed emotion (EE) is in order. Expressed emotion emerged as a term from a series of studies that focused on relapse rates in adults diagnosed with schizophrenia (Brown et al 1958, 1962, 1972). Critical comments, hostility, and emotional overinvolvement (i.e., high EE) predicted relapse. While EE was studied initially in families of patients with schizophrenia, more recent studies have demonstrated that EE plays a similar role in

families of adults with mood disorders (Hooley 1998; Hooley et al 1986; Koenig et al 1997; Miklowitz et al 1988; Simoneau et al 1998). In the Butzlaff and Hooley (1998) recent meta-analysis of 27 studies, they concluded that 1) EE is a general predictor of poor outcome across diagnostic categories and 2) EE can be modified.

While the above-mentioned studies all focused on adults as the identified patients, studies by Asarnow et al (1987, 1993, 1994) have focused on EE and its relation to childhood depression. These researchers have demonstrated that EE rates are higher among families of depressed children compared to families of normal controls and children with schizophrenia spectrum disorders (Asarnow et al 1994). Additionally, high EE in families of depressed children is associated with a more insidious onset of major depressive disorder (MDD) (Asarnow et al 1987) and a slower recovery course (Asarnow et al 1993). Other studies have examined EE in different child populations. Schwartz et al (1990) examined 273 high-risk mother-child pairs. They found that high EE tripled the rate of children's diagnoses (major depression, substance abuse, and/or conduct disorder), so that the predicted rate of diagnosis for 15 to 19 year olds was 62.3% when maternal criticism and parental affective illness were present and only 6.5% when these two factors were absent. Goodman et al (1994) studied 20 depressed mother-child dyads and 19 never depressed mother-child dyads. They found that depressed mothers expressed the most affectively charged negative statements and that these statements were most associated with low self-worth and high child psychopathology rates. Presence of these negative statements modified the relationship between maternal depression and child psychopathology. Interestingly, the mother's current depressive symptoms were unrelated to her EE ratings.

There is no existing literature on EE rates in families of children with bipolar disorder; however, we can speculate, both from the adult literature and from the clinical manifestations of bipolar disorder in children, that these children would, if anything, respond with even more volatility to environmental stress (which EE can be construed to represent) than children with depression. Thus, the impact of reducing EE in families of children with bipolar disorder has the potential to significantly reduce symptom severity in these children.

Since high EE is associated with relapse, it follows that lowering EE in families might improve course of illness. As a result, several groups (Anderson et al 1986; Clarkin et al 1998; Falloon and Pederson 1985; Goldstein et al 1978; Honig et al 1997; McFarlane 1997) designed psychoeducational interventions to reduce EE in families with impaired adult family members.

Psychoeducation as a Treatment Strategy

While psychoeducation was first applied to families of patients with schizophrenia (see Goldstein and Miklowitz 1995 for a full review), this treatment strategy more recently has been applied to families containing members diagnosed with depression (Holder and Anderson 1990), bipolar disorder (Honig et al 1997; Miklowitz and Goldstein 1990), or any mood disorder (Clarkin et al 1988). In general, families participate in a program designed to teach them about the disorder, its course, prognosis, medications, and management.

Investigations of psychoeducational treatment for families with adult members having a mood disorder appear to hold promise. For example, Miklowitz et al (2000) reported that patients with bipolar disorder who received family psychoeducation as an adjunct to their pharmacotherapy had fewer relapses and longer delays before relapses during a 1-year interval than patients with bipolar disorder who received two family education sessions, pharmacotherapy, and crisis management. Psychoeducation has been linked to high patient retention rates as well (Goldstein and Miklowitz 1995). The adult psychoeducation literature has reached a relatively high level of sophistication regarding the use of treatment protocols, manualization of programmatic content, and use of randomized studies; attention now has shifted to how research findings can inform community-based treatment (Miklowitz and Hooley 1998).

The literature concerning psychoeducational interventions with families of impaired children and adolescents is not as sophisticated, despite clear evidence that parents of children with disabilities (as well as the children themselves) have many unmet needs and that assisting families to shift from "emotion focused coping" to "problem focused coping" is a useful strategy (Sloper 1999). Several authors have provided descriptive articles regarding psychoeducation programs they have developed for parents of psychiatrically hospitalized children (Dreier and Lewis 1991); for outpatient children and adolescents and their parents (Jordan et al 1999), and for parents of outpatient adolescents/young adults with schizophrenia (Sheridan and Moore 1991). Unfortunately, these articles provide limited, if any, family outcome data. One notable exception is the work of Brent et al (1993), who modified adult psychoeducation concepts to make them relevant for families of adolescents with mood disorders (Poling 1989). These researchers reported that parents significantly increased their knowledge of depression as the result of their participation in a 2-hour presentation about their adolescent's illness.

In summary, the EE literature has led to the development of psychoeducational interventions in an attempt to reduce symptom severity and duration. These have been

better developed for adults than children, although one might suspect that environmental influences are, if anything, even more important to children, who developmentally are expected to be dependent on their parents. An additional concern that comes to bear when dealing with children is concordance (i.e., do parents agree or disagree over their child's diagnosis and treatment plan?). This issue is discussed below.

Caregiver Concordance

Increased disagreement between parents/caregivers on child-rearing matters has been linked to higher rates of child problem behaviors (Jouriles et al 1991), poorer marital quality (Lamb et al 1989), lower levels of family problem-solving (Vuchinich et al 1993), and diminished parental effectiveness (Deal et al 1989). As individuals with bipolar disorder have a heightened sensitivity to conflict (Miklowitz and Goldstein 1997, p. 42), one might speculate that parental tension caused by disagreements over the most appropriate treatment and methods to manage symptoms of bipolar disorder, a condition that is very trying for families (Hellander et al 2003), would have a deleterious impact on a child's recovery from a manic or depressive episode. Additionally, Cole and Rehm (1986) found that fathers provided significantly less positive reinforcement for their children than did mothers during a challenging task, regardless of whether the child was depressed or nondepressed. This reinforces the findings that mothers and fathers approach parenting tasks differently and that fathers, in particular, may benefit from interventions designed to increase positive parent-child interactions.

Thus, therapeutic interventions intended to increase parental/caregiver concordance might be beneficial to a child with bipolar disorder and his or her family. As discussed below, our preliminary data suggest that fathers and mothers may experience differential gains through involvement in psychoeducational programs, both in terms of knowledge of and emotional response to their child's mood symptoms. If, following psychoeducational intervention, parents/caregivers think about and respond to their child and his/her problems in a more uniform (and presumably more accurate) and positive manner, one might anticipate improvement in parenting as well as family functioning that might lead to a healthier climate in which the child can recover from his or her current episode.

The Ohio State University Psychoeducation Program for Childhood Mood Disorders

Initially, we developed two versions of psychoeducational intervention. One was a 1½-hour workshop for parents of

children psychiatrically hospitalized for any major mood disorder. This brief format was conceptualized to cover the "basics" (i.e., long enough to provide meaningful information but brief enough that already stressed parents of acutely ill inpatients would find time to attend) (Fristad et al 1998a). The second version was multifamily psychoeducation groups (MFPG), designed for outpatient children with any major mood disorder and their parents. MFPG initially was administered in six 75-minute sessions in a manual-based, multifamily group format (Fristad et al 1996). Based on feedback received in our randomized, controlled pilot study, we expanded MFPG to eight 90-minute sessions. As most of our work to date has focused on MFPG, we will describe its therapeutic content in greater detail below.

MFPG Content

SESSION FORMAT. Each MFPG session begins and ends with a family component. During the middle portion of each group session, parents/caregivers and children meet separately, although their session content is thematically linked. Each of the eight sessions is highly formatted with specific content to be taught and skills to be practiced. Thus, MFPG is not the same as a support group, the focus of which is often more on exchanging stories of success and frustration.

The parent group leader is a psychologist and the child group leader is a postdoctoral psychology fellow. Prerequisites for running the group are clinical experience working with mood-impaired children, with families, and with groups. The child group leader has a clinical child psychology graduate student as a co-leader to assist with behavioral management.

Parents are given workbooks containing materials presented in the session, as well as copies of the children's activities and supplemental sections that describe educational interventions and medications in more detail. Children receive workbooks that include activities done in their sessions. Parents and children also receive family projects to complete during the week, designed to reinforce concepts taught during the session. These projects are reviewed at the beginning of every subsequent session.

Children earn points for their behavior during each session. These points are accumulated throughout the eight sessions and redeemed at the final session. Children spend a brief period in in vivo social skills rehearsal via structured, supervised play activities after each session's curriculum is adequately covered.

Detailed descriptions of session content, with examples of exercises used in and between sessions appear elsewhere (Fristad and Goldberg-Arnold 2003; Goldberg-Arnold and Fristad 2003). Most of the therapeutic tech-

niques utilized in MFPG are not unique to this intervention. What is unique, however, is the way in which teaching families about the child's illness and treatment options (including how to work effectively with the mental health system and school system), followed by training families in communication exercises, cognitive-behavioral interventions, and social problem-solving strategies focused on the children's mood symptom management is integrated. A summary of the eight session content for parents and children is outlined in Appendix 1.

Preliminary Efficacy Data

To determine the impact of psychoeducational interventions on increasing knowledge of mood disorders and reducing EE in families of children with mood disorders, we completed three pilot studies. We focused on these two variables because increased knowledge can be considered a necessary but not sufficient step in effective psychoeducation. That is, we must be able to measure our ability to impart new knowledge to parents if we intend to teach families about their child's condition; however, knowledge alone does not necessarily lead to behavior change. As there is a compelling literature that suggests reducing EE in families is related to improved child functioning, we chose to measure EE as a mechanism of change within families.

In each study, parents provided informed consent and children provided assent before study participation. All studies were approved by the Ohio State University (OSU) Biomedical Sciences Institutional Review Board.

First, we evaluated the impact of 1½-hour psychoeducational workshops presented to parents of psychiatrically hospitalized children and adolescents with mood disorders. Participants were 25 parents of 20 patients, 25% of whom had bipolar disorder. Parents completed the Expressed Emotion Adjective Checklist (EEAC) (Friedmann and Goldstein 1993) and the Understanding Mood Disorders Questionnaire (UMDQ) (Gavazzi et al 1997) before and after workshop attendance. We found that workshop participants, especially fathers, experienced significant knowledge gain after attending the 1½-hour workshop. Both mothers and fathers experienced a significant decrease in EE levels following workshop participation (Fristad et al 1998a). Interestingly, while pretest UMDQ scores differed between mothers and fathers, posttest scores were very similar for all parents. This suggests that workshop participation equalized parents' knowledge of mood disorders. Such equalization could potentially improve consistency in parenting within families. Regarding EEAC scores, mothers initially reported more positive and less negative emotions than fathers. Four months later, mothers and fathers achieved similar scores. If mothers and fathers understood the symptoms of and reacted more similarly to

their mood disordered child (particularly given the change to more positive and less negative interactions), these changes could potentially improve the child's home environment. As the subgroup of parents whose children had bipolar disorder was very small (25%), no further analyses were conducted to compare their outcome to those of parents whose children had depressive spectrum disorders (major depression, 45%; dysthymic disorder, 30%).

Second, we completed a small, nonrandomized program evaluation of the six-session MFPG program (Fristad et al 1998b) for nine parents and children, three of whom had bipolar disorder. Using the EEAC, all eight subscales improved in the predicted direction from pretreatment to posttreatment (mothers and fathers each reported increased positive attitudes and behaviors toward their children and decreased negative attitudes and behaviors toward their children; Wilcoxon sign ranked test, $p < .01$). Additionally, group evaluation data indicated highly favorable endorsement of the program by both parents and children (Fristad et al 1998b). No comparisons of families with children experiencing bipolar disorder versus depressive disorder were made, given the very small sample sizes involved.

Third, we conducted a small-scale randomized, controlled trial of the six-session MFPG (Fristad et al, in press) with 35 families of children aged 8 to 11 with mood disorders. Children were assessed using parent and child versions of the Children's Interview for Psychiatric Syndromes (ChIPS) (Weller et al 1999) to determine presence or absence of behavior, anxiety, mood, and other disorders (i.e., eating, elimination, and psychotic). The Children's Depression Rating Scale-Revised (CDRS-R) (Poznanski et al 1984) and the Mania Rating Scale (MRS) (Young et al 1978) were used to ascertain mood symptom severity. The Child and Adolescent Services Assessment (CASA) (Burns et al 1994) was used to determine service utilization, while the Harter (1985) Social Support Scale for children (SSS) determined children's perceived social support. The EEAC and UMDQ were also administered. Parents and children were interviewed separately by trained interviewers (a postdoctoral psychology fellow interviewed parents, a master's level clinical child psychology graduate student interviewed children). Following the assessment, all material was reviewed by the principal investigator, a clinical child psychologist experienced in assessing mood disorders in children, to determine eligibility, and a written report was prepared in which scoring was reviewed.

Eighteen families were enrolled into immediate treatment. Seventeen families experienced a 6-month wait and then participated in MFPG. While 35 families entered the treatment study, 29 families completed all assessments and treatment. Attrition occurred as follows: 16 out of 18

immediate treatment families completed all assessment and treatment sessions; 1 immediate treatment family dropped the study after two MFPG sessions due to a death in the family; 1 family completed all six sessions of the group but did not complete the third assessment due to increased family chaos following initiation of maternal employment. Thirteen out of 17 wait-list families completed treatment and all four assessments. Of the four noncompleter families, two completed the first and second assessments and then dropped out of the study before participating in treatment (one due to symptom reduction and scheduling conflicts; one due to increased family chaos). Two families completed the first three assessments and then dropped out before participating in treatment (one due to increased parental psychopathology; one due to a shift from mood symptoms to conduct disorder being the primary problem).

MFPG parents demonstrated significantly more knowledge than the wait-list control (WLC) families immediately after intervention, this gain was sustained at the 6-month follow-up. Multifamily psychoeducation group children reported a significant gain in social support from their parents and a trend toward increased gain from their peers at the 6-month follow-up, compared to WLC children. Finally, 6 months after study enrollment, 82% of the MFPG families reported an improvement in their ability to obtain appropriate services, compared to 20% of WLC families ($p < .01$). Pre-post intervention gains in knowledge and improvement in EE scores were similar for the two groups once WLC families completed treatment.

Anecdotal Observations—Caregiver Concordance

Our informal observations of parental concordance pre-post intervention in this small, randomized, controlled study caused us to subsequently develop a methodology to assess concordance in our ongoing trials (Holderle and Fristad 2001). Three family vignettes illustrate our belief that caregiver concordance is important to children's clinical outcome. At Family A's study entry, the parents' views of their child and his need for treatment were quite discordant. Only the mother attended group sessions. Based on her participation, she learned and implemented strategies that successfully increased her husband's awareness/involvement. In so doing, she gained, in her words, "a more active parenting partner." At study entry, the parents of Family B were experiencing considerable tension concerning their child's diagnosis and need for treatment. Both parents attended all group sessions. By the final session, the father's awareness of his son's treatment needs increased dramatically (and now corresponded with the views of his wife, school personnel, and study personnel). He began assuming responsibility for taking his son

to psychiatry/psychology appointments and was supportive of the unanimous recommendation for his son to have a medication trial. The parents of Family C varied considerably at study entry in their understanding of their daughter's mood symptoms and need for treatment. Both parents attended all group sessions. Following MFPG, the mother reported positive changes in the father's response to their child's symptoms. She perceived him to be more involved, and appropriately so, in his daughter's life.

These three vignettes suggest that providing parents with a uniform set of information about their child's disorder and its treatment, followed by skill building exercises introduced during group sessions and then practiced at home, can decrease disagreements, both over the factual understanding of their child's condition, as well as the parents' emotional and behavioral responses to their child's symptoms. We anticipate that increased concordance will, in turn, lead to a less stressed home environment that will contribute to a decrease in the child's symptoms.

Program Applicability for Families of Bipolar Children

We combined families of children with MDD and dysthymic disorder (DD), referring to them as "MDD/DD families" and families of children with bipolar disorder, referring to them as "BD families" in our MFPG sessions for two reasons. First, we wanted to enroll an adequate group size quickly and thus deliver services in a more timely fashion. Second, since approximately one third of depressed children will ultimately switch to BD (Birmaher et al 1996), teaching families of depressed children about mania and its management, as well as providing exposure to the experiences of families currently dealing with BD, may be useful for some MDD/DD families vis a vis early recognition, diagnosis, and treatment.

To investigate the issue of combined group membership, we further analyzed our randomized, controlled trial data to address the following two empirical questions: 1) Do BD families and MDD/DD families differ at baseline on variables pertinent to this treatment program? and 2) Do BD families and MDD/DD families benefit differentially from MFPG? We compared families of 16 children with bipolar disorders to families of 19 children with depressive disorders (Fristad et al 2002). These subgroups did not differ in the family's socioeconomic status, randomization to immediate or wait-list condition, treatment completion (86% overall), or single or two-parent family structure. Likewise, the child's age, sex, length of illness, and comorbid behavior (92%), anxiety (60%) and other (11%) disorders did not differ for the two subgroups.

At baseline, BD parents knew more about their child's mood disorder than did MDD/DD parents ($p < .04$).

Children with BD had a higher lifetime frequency of mental health service usage ($p < .02$) compared to children with MDD/DD, as well as greater mood symptom severity (current mood, $p < .05$; worst lifetime mood, $p < .001$) and greater overall functional impairment ($p < .02$). Following treatment, parents of children with BD and parents of children with MDD/DD had similar knowledge levels due to a greater increase in knowledge in the MDD/DD families compared to the BD families ($p < .03$).

Clinical observation suggested that having a minimum of two children with any particular diagnosis (i.e., depression or bipolar disorder) in a group is useful and often results in particularly supportive bonding, both in the children's and parents' groups. Given the pragmatic need to organize groups for families based on the child's age and developmental status, combining children with BD and MDD/DD increases the practicality of group initiation. It appears that combining families of children with BD and MDD/DD works.

Current Studies

We are expanding upon our previous work with two new, ongoing clinical trials.

MFPG. In our first study, we are recruiting families of 165 children aged 8 to 11 with mood disorders to participate in a controlled, randomized study of the efficacy of MFPG compared to a 12-month wait-list control (WLC) condition. As MFPG is an adjunctive intervention, all families are encouraged to continue treatment as usual during the study.

While participant enrollment and data collection are ongoing, some compelling program endorsements have been obtained from the MFPG children, who were asked in their eighth and final MFPG session to offer anonymous "words of wisdom" for the next group of children who will participate in MFPG. Samples of their quotes include:

"It helped you learn what to do if you were too upset or in a bad mood. And the fun part is every time we get to go down to the gym for 15 minutes."

"Astonishing and cool. You guys were really helpful."

"The teachers are very nice and they help you understand what is wrong with your body and understand what to do"

"This place is really great. You get to learn a lot and have fun doing it. Don't forget the gym because it's very fun, but class is even funner."

INDIVIDUAL FAMILY PSYCHOEDUCATION. In our second study, we have converted the 8-session MFPG materials into 16 sessions for "individual families." We have limited this study to the families of 20 children with

bipolar disorder, given the complete dearth of published clinical guidelines for treating these children. Content remains nearly identical, with one unit on "Healthy Habits" (i.e., diet, exercise, and sleep regimens) added for children and parents. Session attendance alternates between parents only and children (with parents joining the beginning and end of the child sessions). No outcome data are yet available from this study.

Individual family psychoeducation (IFP) was developed for three reasons. First, many clinicians do not work in settings conducive to running groups for single-diagnosis issues. Multifamily psychoeducation groups will probably be implemented most readily in a clinic setting, wherein large numbers of children can be referred to a time-limited group, then return to therapy with their primary clinician after the 8 weeks of group. Clinicians in solo practice will probably not find running groups feasible, yet will still require resources to assist families with young children diagnosed with mood disorders. Second, some families may not feel comfortable sharing personal information in a group setting (e.g., if one of the parents holds a more public position, such as a physician or teacher in the community). They may prefer more privacy to work on their clinical issues. Third, if clinics offer MFPG only once or twice a year, a family with a newly diagnosed child may not wish to wait that long for immediate, tailor-made assistance. In this case, the family could participate in IFP and then potentially participate again in MFPG to obtain the additional benefit of social support from meeting other parents and children in similar circumstances.

There are potential advantages and disadvantages of both MFPG and IFP. MFPG is expected to offer the very significant social benefit of meeting others who share problem content; however, IFP is expected to offer numerous pragmatic advantages, as outlined above.

Limitations

There are multiple limitations to psychoeducation as a proven intervention for children with bipolar disorder. First, our group is only now conducting the second randomized study of MFPG and the first randomized trial for IFP. Thus, neither of these treatments can be considered empirically supported as of yet. Additionally, participants have been primarily Caucasian and lower middle class to upper class. No participants have come from the lowest socioeconomic class. This intervention is probably less suited to families whose more immediate problems may center around basic requirements of food, shelter, and adequate daily provisions.

Summary

Childhood bipolar disorder is potentially devastating, both to the child and his or her family. Little research has been

conducted to date to develop empirical guidelines for treating these children. It is our position that pharmacologic interventions are the sine qua non for treatment, but that adjunctive psychosocial interventions are a critical component of comprehensive care. Our research group has developed psychoeducation as a response to the void of psychosocial treatment options. Psychoeducation can be delivered in several formats: single workshops for parents; 8-session outpatient multifamily psychoeducation groups (MFPG); and 16-session individual-family psychoeducation sessions (IFP). We have conducted several pilot studies, the results of which are encouraging and have led us to our two current clinical trials. We anticipate that knowledge of childhood mood disorders and caregiver concordance will increase, while expressed emotion will decrease if MFPG and IFP are found to be efficacious. To date, anecdotal evidence lends support to MFPG treatment. Individual family psychoeducation is too new to provide efficacy data.

Future studies should study the efficacy of IFP in a larger sample; determine the efficacy of MFPG and IFP in other settings, with other ethnic groups, and in studies conducted by other investigators; and develop psychoeducational materials for children of different age ranges (e.g., 6 to 8 year olds, adolescents).

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Appendix 1. MultiFamily Psychoeducation Group (MFPG) Curriculum

Session	Parent Core Content/Session Components	Child Core Content/Session Components
1	Mood disorders and their symptoms/ Introductions; treatment overview; group rules; myths and facts about mood disorders; risk factors; general philosophy (It's not your fault but it's your problem); comorbidity	Mood disorders and their symptoms/ Introductions; symptom review; discuss impact of symptoms on life
2	Medications/ The role of medication in treatment; monitoring safety and side effects; classes and names of medications	Medications; symptoms separate from child's personality/ Name their target symptoms and the medications they take for those symptoms
3	Mental health care system; educational system/ Learn who works in each system; how to access care; describe possible school-based interventions	"Mad/bad/sad" feelings management skills/ Build the "Tool Kit"; identify mood triggers; realize physical sensations of anger/sadness; develop prompts to use new coping techniques
4	Healthy and unhealthy responses to the disorder; review/ Outline common problems; acknowledge burden; consolidate learning from sessions 1–4	Connection between feelings, thoughts, and actions/ Introduction to cognitive-behavioral therapy
5	Problem-solving skills/ Negative behaviors to avoid; how to adjust expectations; create a balance; self-preservation; introduce steps of problem-solving	Impulse control training + problem-solving skills/ Introduce Stop-Think-Plan-Do-Check; learn to monitor efficacy
6	Effective communication skills/ Verbal and nonverbal communication	Nonverbal communication skills/ Charades-to teach nonverbal communication
7	Symptom management/ Manage manic symptoms, create a safety plan, handle suicidal concerns	Verbal communication skills/ Focus on speaking clearly and directly; avoid ineffective strategies (e.g. yelling)
8	Review and graduate/ Discuss members' remaining issues; provide resource information; share contact information for group members; graduate	Review and graduate/ Game-show review of previously learned material; trade in points for prizes; graduate
