Pilot Effectiveness and Transportability Trial of Multi-Family Psychoeducational Psychotherapy (MF-PEP) for Childhood Mood Disorders in a Community Behavioral Health Setting

Thesis

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Abstract

Limited research has examined the effectiveness, transportability, and dissemination of Evidence-Based Treatments [EBTs], especially for children and adolescents (APA Task Force on EBP for Children and Adolescents, 2008; Barlow, Levitt, & Bufka, 1999; Higa & Chorpita, 2008; Kendall & Beidas, 2007). Even when EBTs are implemented in the real-world, psychotherapy has stronger effects in university-based research studies than in community settings (Weersing & Weisz, 2002).

Multi-Family Psychoeducational Psychotherapy (MF-PEP) is an adjunctive, manual-driven, group-based EBT for children with mood disorders and their parents which has shown positive results in two randomized controlled efficacy trials (Fristad, Goldberg-Arnold, & Gavazzi, 2002, 2003; Fristad, Verducci, Walters, & Young, 2009; Goldberg-Arnold, Fristad, & Gavazzi, 1999; Mendenhall, Fristad, & Early 2009). The current study examined a pilot implementation of MF-PEP at two community behavioral health centers. Fifteen community therapists were trained in MF-PEP and completed questionnaires after sessions. Twenty community therapists self-selected to refer families and completed questionnaires following MF-PEP. Forty children aged 8 to 12 years ($M = 10.15, SD = 1.23$) with mood disorders and their parents were referred to MF-PEP and completed questionnaires pre- and post-treatment. Treatment effectiveness and response, consumer and provider satisfaction, and financial feasibility were examined.
Paired pre-post data were available for 22 parents and 20 children (9 children for depressive symptom report). Data were analyzed via two-tailed, dependent-measures $t$-tests. Upon completion of therapy, parents showed significant increases in knowledge of mood disorders, $t(21) = -3.36, p = .003, d = .60$. Though all measures showed shifts in the hypothesized directions, significant differences were not found for: parental treatment beliefs, $t(21) = -1.55, p = .14, d = .23$; children’s treatment beliefs, $t(19) = -0.84, p = .41, d = .22$; children’s depressive symptoms, $t(8) = 0.03, p = .98, d = .01$; or children’s manic symptoms, $t(21) = 0.36, p = .73, d = .08$.

Post-treatment satisfaction ratings were available for 26 parents and 24 children on a measure with a potential score range of 1 to 5 (5 indicated highest satisfaction). Parents ($M = 4.43, SD = 0.52$) and children ($M = 4.04, SD = 0.68$) reported high satisfaction with MF-PEP. Mean satisfaction scores were significantly larger than the neutral score of 3 for: parents, $t(25) = 13.99, p < .001, d = 2.75$; and children, $t(23) = 7.55, p < .001, d = 1.54$. Qualitative feedback from community therapists indicated high satisfaction with MF-PEP training and facilitation and as an adjunctive treatment. The agency did not break-even financially; however, MF-PEP is financially feasible given adequate number of therapists and families.

The small sample size, sub-optimal data collection, and different follow-up assessment times between efficacy and effectiveness investigations hindered the power to detect statistically or clinically significant results. Preliminary results support the
transportability and acceptability of the intervention. Future effectiveness trials using larger samples, a control comparison, and follow-up data are needed. Limitations of the current study and implications for effectiveness, transportability, and dissemination of MF-PEP are discussed.
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Chapter 1: Introduction

Pilot Effectiveness and Transportability Trial of Multi-Family Psychoeducational Psychotherapy (MF-PEP) for Childhood Mood Disorders in a Community Behavioral Health Setting

Government agencies, healthcare policymakers, and professional organizations have called for improved quality of care in clinical settings by promoting the increased use of treatments with empirical support (American Psychological Association [APA] Presidential Task Force on Evidence-Based Practice [EBP], 2006; Chambers, Ringeisen, & Hickman, 2005; Institute of Medicine [IOM], 2001). In the field of mental health in particular, transporting evidence-based treatments (EBTs) to clinical settings has been deemed a national priority in the United States (President’s New Freedom Commission on Mental Health, 2003). Similarly, the APA has commissioned task forces to define and identify empirically-supported treatments (ESTs: Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures [Task Force], 1995), treatment guidelines (APA, 2002), EBP (APA Presidential Task Force on EBP, 2006), and EBP for children and adolescents (APA Task Force on EBP for Children and Adolescents, 2008). Despite urges from professional and governmental agencies to implement interventions with empirical support in clinical settings, the science-practice gap persists due to various methodological, practical, and ethical challenges inherent in
the dissemination process (APA Task Force on EBP for Children and Adolescents, 2008; Barlow, Levitt, & Bufka, 1999; Higa & Chorpita, 2008; Kendall & Beidas, 2007).

Historically, progress on EBTs and EBP for youth has been under-funded and lagged behind advances in adult literature (APA Task Force on EBP for Children and Adolescents, 2008). Although recent advances have been made in terms of the development of EBTs for children and adolescents (Silverman & Hinshaw, 2008), evidence from a variety of sources suggests clinicians are not implementing these treatments in clinical practice (Kazdin, Siegel, & Bass, 1990; Nelson, Steele, & Mize, 2006; Sheehan, Walrath, & Holden, 2007; Weersing, Weisz, & Donenberg, 2002). Even when EBTs are implemented in real world settings, research suggests psychotherapy often has stronger effects in university-based research studies than in community clinical settings (Weersing & Weisz, 2002; Weiss, Catron, Harris, & Phung, 1999; Weiss & Weisz, 1995; Weisz, Donenberg, Han, & Weiss, 1995).

Childhood mood disorders, including depressive spectrum disorders (DSD: major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified [NOS]) and bipolar spectrum disorders (BPSD: bipolar I disorder, bipolar II disorder, cyclothymic disorder, and bipolar disorder NOS) are prevalent and serious conditions for which a variety of EBTs exist (Brown et al., 2008; David-Ferdon & Kaslow, 2008; West & Pavuluri, 2009; Young & Fristad, 2007). These disorders pose serious public health concerns, can have a devastating impact on current and future functioning, and have been linked to increased risk of disruptive behavior disorders, teen pregnancy, legal problems, substance abuse, and suicide (Birmaher & Axelson, 2006; Birmaher, Brent, & the American Academy of Child and Adolescent Psychiatry [AACAP] Work Group on
Quality Issues, 2007; Geller, Tillman, Bolhofner, & Zimerman, 2008; Goldstein et al., 2009; Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2003; Strober et al., 2006). Although once thought to be primarily disorders of adulthood, recent epidemiological studies have revealed DSD and BPSD in youth are common. Approximately 2% of children and 4% to 8% of adolescents experience DSD, and an additional 5 to 10% of youth experience significant symptoms of depression that do not meet diagnostic criteria (Birmaher et al., 2007; Birmaher, et al., 1996). Approximately 1% of adolescents meet criteria for bipolar disorders and an additional 5.7% experience significant manic symptoms (Lewinsohn, Klein, & Seeley, 1995). No epidemiological studies have examined the lifetime prevalence rates of bipolar disorder in children younger than 12 years.

High recurrence rates also are reported. For youth with DSD, 20% to 60% experience a recurrence within 1 to 2 years and 70% within 5 years (Birmaher, Arbelaez, & Brent, 2002; Costello et al., 2002). For BPSD, relapse rates of 29%, 55%, 64%, and 73% at 1, 2, 4, and 8 year follow-up, respectively, have been reported (Geller et al., 2008; Geller, Tillman, Craney, & Bolhofner, 2004). Thus, childhood mood disorders are serious and prevalent conditions characterized by significant impairment. Despite the existence of several EBTs for childhood mood disorders, limited research has evaluated the effectiveness, transportability, and utility of these treatments delivered in real-world settings.

In this literature review, I first outline the stages of treatment development and evaluation. Then, I discuss barriers and key factors in translational research and introduce several models of dissemination and diffusion. Next, I review influential movements that have inspired much of the current translational research: the EST
movement; the EBP movement; and the EBP movement for children and adolescents. Finally, I review the current evidence base for the efficacy, effectiveness, transportability, and dissemination of EBTs for children and adolescents at-risk for and diagnosed with DSD and BPSD.

**Stages of Treatment Development and Evaluation: Efficacy to Dissemination**

A hierarchy of clinical studies is necessary for the development, evaluation, and eventual dissemination of a treatment. Southam-Gerow, Marder, and Austin (2008) outline a spectrum of clinical studies utilized in treatment development, outcome research, and dissemination. They note the initial three stages are defined by traditional clinical trials terms and methodologies stemming from the EST movement (e.g., Chambless & Hollon, 1998; Task Force, 1995), whereas the latter two stages are reflective of work by Chorpita (2003), Schoenwald and Hoagwood (2001), and Weisz, Southam-Gerow, Gordis, and Connor-Smith (2003). These stages include: (1) early clinical studies; (2) efficacy studies; (3) effectiveness studies; (4) transportability studies; and (5) dissemination studies. Although these stages are presented separately, Southam-Gerow et al. note that progression through the stages is not necessarily linear, and findings at some stages along the continuum may require the investigator to revisit the treatment model and revaluate at an earlier stage. In addition, these stages are not mutually exclusive. Thus, studies can incorporate elements from different stages simultaneously when evaluating a treatment.

**Early Clinical Studies and Efficacy Studies**

In the first stage of early clinical studies, new interventions are tested using single-case and open-trial designs to establish the safety and preliminary positive effects
of the treatment (Southam-Gerow et al., 2008). In the second stage, efficacy studies evaluate how well a treatment works for one or more psychological disorders within a specified population under highly controlled conditions (Southam-Gerow et al., 2008). Efficacy research is primarily concerned with internal validity and thus conducted in well-controlled environments (Steele, Nelson, & Nelson, 2008). For example, most efficacy trials are conducted in university settings with highly trained clinicians who are very invested in the treatment (Weisz et al., 1995). Clinicians are often provided with a detailed treatment manual and treatment fidelity is monitored to ensure treatment is being implemented in a standardized fashion across clinicians (Steele et al., 2008).

Historically, efficacy trials have also employed strict inclusion/exclusion criteria so as to examine the effects of a treatment on a particular disorder (Steele et al., 2008). However, some researchers have noted this flaw and have since loosened such criteria (e.g., Feeny, Danielson, Schwartz, Youngstrom, & Findling, 2006; Fristad, Verducci, Walters, & Young, 2009; Goldstein, Axelson, Birmaher, & Brent, 2007; Miklowitz et al., 2004). Randomized Controlled Trials (RCTs) utilizing randomization of subjects and a control group comparison are the preferred methodology in efficacy trials (Southam-Gerow et al., 2008). Initially, a waitlist control condition or placebo serves as the control group and if the treatment proves efficacious then active treatments are used as the comparison condition (Southam-Gerow et al., 2008). In addition, outcome measures generally consist of self-report and clinician-rated measures of symptom severity (Steele et al., 2008). Thus, the primary goals of early clinical studies and efficacy studies are to determine the safety, feasibility, and efficacy of a particular treatment when delivered under optimal conditions.
Effectiveness Research

In the third stage, effectiveness research evaluates how well treatments perform in real-world settings (Southam-Gerow et al., 2008). Effectiveness research is primarily concerned with external validity and the generalizability of treatment effects across samples and settings (Steele et al., 2008). Most effectiveness trials are conducted in community settings with community therapists who have variable training and heavy caseloads (Steele et al., 2008). Community therapists often do not receive intensive training in the treatment prior to implementation, as is common in efficacy trials (Steele et al., 2008). As a result, treatment fidelity monitoring is recommended in effectiveness research to ensure the treatment is being implemented in a consistent manner across clinicians (Chambless & Hollon, 1998). Effectiveness trials also use very lax or limited inclusion/exclusion criteria to capture the heterogeneity of clients presenting for treatment in real-world environments (Steele et al., 2008).

Although RCTs can be used within effectiveness trials, other methodologies have also been proposed. For example, benchmarking strategies provide a cost-effective alternative to measuring treatment effectiveness (Southam-Gerow et al., 2008). In these procedures, outcome data and effects achieved in a well-conducted RCT examining treatment efficacy are used as benchmarks for outcomes achieved in a practice setting (Southam-Gerow et al., 2008; Weersing, 2005). To the extent that outcomes in the practice setting approach the benchmark, the treatment is considered effective (Southam-Gerow et al., 2008). Weersing (2005) noted composite benchmarks can also be obtained across multiple RCTs for broader comparisons in effectiveness research (e.g., Weersing & Weisz, 2002). Benchmarking strategies are cost-effective and easier to implement than
RCTs, as they do not require random assignment, training and supervision in two separate treatment protocols, and assessment of treatment differentiation (Southam-Gerow et al., 2008). However, benchmarking strategies have several shortcomings, such as the lack of control group or comparison to usual care and results are often subjective as statistical tests are not easily conducted between the benchmark and achieved effectiveness outcome data (Southam-Gerow et al., 2008). Other research designs can play an important role in effectiveness research at different stages of implementation, such as single-case designs, pre-post designs, correlational designs, or observational designs (Southam-Gerow et al., 2008).

Outcome measures in effectiveness research usually consist of self-report measures of symptom severity, global functioning across settings, consumer satisfaction, and provider satisfaction (Steele et al., 2008). Cost-effectiveness can also be examined at this stage of implementation (Steele et al., 2008). Moderating variables (for whom a treatment does and does not work) and mediating variables (factors leading to meaningful change) are also important steps in treatment evaluation, and have been emphasized recently in both efficacy and effectiveness research (La Greca, Silverman, & Lochman, 2009; Steele et al., 2008).

New stakeholder groups are also a novel component of effectiveness research, and these new groups continue to influence the research process through the transportability and dissemination stages (Southam-Gerow et al., 2008). These stakeholder groups become involved because they are attempting to implement the novel treatments in their respective settings or are referring clients to receive the novel treatment. Stakeholder groups include agencies and their staff, third-party payers, other systems such as juvenile
justice and child welfare, advocacy groups, and policymakers (Southam-Gerow et al., 2008). Integrating these stakeholders into the research process and building a collaborative, transparent relationship becomes vitally important (Southam-Gerow et al., 2008). Thus, the primary goal of effectiveness research is to evaluate if positive treatment effects found under highly-controlled conditions of efficacy trials will generalize when conducted in real-world settings while incorporating new methodologies, outcome measures, and stakeholder groups.

**Transportability Research**

In the fourth stage, transportability research identifies and evaluates processes involved in moving treatment into community settings (Southam-Gerow et al., 2008). During this stage, strategies are identified to encourage the adoption and implementation of new interventions. These strategies include: (1) identifying the appropriateness of settings; (2) securing and maintaining funding and referrals; (3) making needed changes at agency, administrative, and system levels; (4) establishing training and supervision procedures; and (5) creating administrative supports needed for outcome monitoring (Southam-Gerow et al., 2008). Transportability research involves an “implementation intervention,” or an evaluation of the procedures required to make a treatment work and persist in new settings (Southam-Gerow et al., 2008, p. 450). Indeed, implementation research has recently become a larger focus in the field of mental health (Proctor et al., 2009). This implementation intervention involves a shift in focus from client-level outcomes in efficacy and effectiveness research to provider, agency, and system variables (e.g., Southam-Gerow, Ringeisen, & Sherrill, 2006; Southam-Gerow et al., 2008). Thus,
the primary goal of transportability research is to evaluate processes involved in the adoption and implementation of EBTs in novel settings prior to large-scale dissemination.

**Dissemination Research**

In the final stage, dissemination research focuses on how to disseminate treatment and implementation strategies obtained through prior efficacy, effectiveness, and transportability trials to achieve widespread adoption of the treatment (Southam-Gerow et al., 2008). During this stage another type of intervention is developed and tested, a “dissemination intervention,” which is a set of procedures and methods that encourage the adoption of the treatment and implementation procedures (Southam-Gerow et al., 2008, p. 450). At this stage of research large-scale organizational, financial, and policy decisions and characteristics that affect service delivery are also evaluated (Steele et al., 2008). Broadly speaking, dissemination research directs how and what EBTs are implemented on a wide-spread level. The recent re-vamping of mental health services for children and adolescents in Hawaii (Chorpita et al., 2002; Daleiden & Chorpita, 2005) and the large-scale initiative for Improving Access to Psychological Therapies (IAPT) for adult depressive and anxiety disorders through a stepped-care approach and dissemination of cognitive-behavioral therapy (CBT) in the United Kingdom (Clark et al., 2009) provide recent examples of service system evaluation and dissemination of EBTs. Thus, the goal of dissemination research is to identify methods and procedures for the widespread adoption and persistence of EBTs.

**Summary**

A hierarchy of clinical studies from early clinical research to dissemination research is necessary for the development, evaluation, and eventual wide-spread
implementation of a treatment. Each stage is characterized by different settings, samples, methodological techniques, and outcomes of interest. Currently, early clinical studies and efficacy studies are most prominent in academic literature, with effectiveness research becoming more prevalent. Studies examining transportability and dissemination of EBTs are rarer, however, recent pushes from policy-makers and funding agencies have sparked some developments in these areas (e.g., Chambers et al., 2005; Chorpita et al., 2002; Clark et al., 2009; Daleiden & Chorpita, 2005). As the field heads in the direction of translational research, various barriers and key components unique to translational research must be considered and addressed.

**Barriers and Key Components in Translational Research**

Barriers and key components in effectiveness, transportability, and dissemination research must be identified and addressed in order to ensure successful implementation and adoption of EBTs. Barriers to translational research include knowledge barriers, attitude barriers, and practice barriers (Higa & Chorpita, 2008). Key components to translational research include the creation of user-friendly manuals, adequate training, and the creation of collaborative, transparent relationships among researchers, clinicians, systems of care, and stakeholders (Herschell, McNeil, & McNeil, 2004; Roberts & James, 2008). These barriers and key components must be addressed in order to facilitate the transport and dissemination of EBTs into practice settings.

**Barriers to Translational Research**

Although efforts have been made to transport and disseminate EBTs in practice settings, various barriers to the dissemination process cause complications and must be addressed. These barriers can be broadly organized into three categories: (1) knowledge
barriers; (2) attitude barriers; (3) and practice barriers (Higa & Chorpita, 2008). Knowledge barriers include inconsistencies in the definitions of EBTs among different organizations and the over-abundance of treatment manuals for some disorders and the lack thereof for other disorders (Higa & Chorpita, 2008). Other knowledge barriers include difficulties in practitioners’ awareness and identification of EBTs, practitioners’ lack of access to research, and the intensive training and supervision required to learn EBTs (Higa & Chorpita, 2008). Practitioner attitudes also pose barriers to translational research (Higa & Chorpita, 2008). Research suggests theoretical orientation and practice settings are related to practitioner attitudes towards manual-based treatments (Addis & Krasnow, 2000), whereas other studies have found internship status is associated with openness to change and favorable attitudes toward EBTs (Aarons, 2004). Addis, Wade, and Hatgis (1999) described other attitudinal concerns of practitioners, including: (1) unmet client needs; (2) restriction of clinical innovation and creativity; (3) feasibility of manual-based treatments; (4) effects on the therapeutic relationship; (5) treatment credibility; and (6) competence and job satisfaction. Other common practitioner apprehensions regarding manual-based treatments include concerns over the adaptability of treatments to individual clients and the applicability of treatments to clients with multiple problems or comorbidities. Lastly, practice barriers include few incentives to change (e.g., mental health services are not federally regulated) and many costs associated with change (e.g., training costs, purchasing of manuals, supervision; Higa & Chorpita, 2008). Thus, various knowledge, attitudinal, and practice barriers can complicate and decelerate the dissemination process.
Key Factors in Translational Research

While there are various barriers to effectiveness, transportability, and dissemination research, several key factors in this line of research can facilitate the eventual dissemination of EBTs to real-world settings. These key factors include the development of user-friendly manuals, training efforts, and the development of transparent, collaborative relationships with various systems and stakeholders.

One key factor in the dissemination of EBTs is the development of user-friendly manuals. Herschell et al. (2004) proposed the development of such manuals, and recommended including information on development, theory, therapeutic process factors, procedures for integrating various systems, and strategies for developing positive relationships with clients. Hershcell et al. (2004) also stressed the importance of treatment standardization and treatment fidelity. Kendall and Beidas (2007) proposed therapists implement EBTs with a “flexibility within fidelity” approach, such that therapists adhere to the description and principles outlined in a treatment manual, but also implement the treatment in such a way as to accommodate the client’s developmental level or other individual needs.

Another key factor in the dissemination of EBTs involves training. Ideally, training should start early in the graduate career, and continue via continuing education [CE] for community practitioners (Herschell et al., 2004). This could be accomplished via increased APA monitoring, opportunities for supervision in the training and implementation of EBTs, and use of technological advances in training (e.g., via videoconferencing, audiotapes, videotapes, or the Internet; Herschell et al., 2004).
Collaborations amongst various systems and stakeholders responsible for providing care are also vitally important in the dissemination of EBTs (Roberts & James, 2008; Weisz, Chu, & Polo, 2004). Researchers, clinicians, and policymakers must build and work within collaborative, transparent relationships (Chorpita & Mueller, 2008; Southam-Gerow, Hourigan, & Allin, 2009). Such relationships allow for: research to be informed by practice and vice versa; funding opportunities for translational research; and practice and public policy decisions to be grounded in empirical evidence (Roberts & James, 2008).

**Summary**

Barriers and key factors to effectiveness, transportability, and dissemination research are important to identify and address in order to ensure successful wide-spread implementation and adoption of EBTs. Though it is helpful to consider such barriers and key factors, theoretical models of dissemination and diffusion can also facilitate understanding of the process and help researchers design and conduct studies aimed at the successful transport and dissemination of EBTs. Below I review several theoretical models of dissemination and diffusion applicable to translational research.

**Theoretical Models of Dissemination and Diffusion**

Theoretical models of dissemination and diffusion can help researchers design and implement studies examining transportability and dissemination of EBTs. Although some use the terms “dissemination” and “diffusion” interchangeably, others have argued for the distinction of these two terms when speaking of treatment development and widespread deployment (Schoenwald & Hoagwood, 2001). Diffusion refers to the unplanned or spontaneous spread of ideas (Rogers, 2003) whereas dissemination refers to
the directed and planned distribution of materials or ideas (Chambers et al., 2005). In the area of mental health, researchers are only beginning to examine the mechanisms by which dissemination of treatments from research settings to wide-scale implementation occur. Most of this research has been influenced by models of behavioral change, the most influential being Rogers’ (2003) model of diffusion of innovations. Rogers’ (2003) model is discussed below, as well as several models which have arisen to explain dissemination in the field of mental health.

**Model of Diffusion of Innovations**

Rogers (2003) described diffusion as a process by which innovation is communicated through certain channels over time among members of a social system. The four main factors of Rogers’ model of diffusion of innovation include: (1) characteristics of the innovation; (2) communication channels; (3) passage of time; and (4) the social system.

Several characteristics of the innovation affect the rate of adoption of innovation (Rogers, 2003). These innovation characteristics include: (1) relative advantage over alternatives; (2) compatibility with existing values, past experiences, and needs of potential adopters; (3) complexity or degree of difficulty to understand and use; (4) trialability or ability to test out or try before completely adopting; and (5) observability or visibility to others (Rogers, 2003).

Communication channels within a system also affect the speed of transmission of information and the rate of adoption of innovation (Rogers, 2003). Mass media channels are effective at increasing knowledge and awareness within a system. However, interpersonal channels are more effective in persuading an individual to accept a new
idea because of their bidirectional nature, such that group members can exchange information rather than simply being told information. Individuals with similar socioeconomic status, education, and belief systems are most effective when exchanging information about an innovation (Rogers, 2003).

Time and the decision-making process by group members within a system also affect the rate of adoption of innovation (Rogers, 2003). Rogers calls this process the innovation-decision process, which consists of five stages: (1) knowledge; (2) persuasion; (3) decision; (4) implementation; and (5) confirmation. In the knowledge stage, consumers are provided with information about the product. There are three types of knowledge: (1) awareness knowledge provides information about the product or innovation; (2) principles knowledge informs consumers about principles underlying how a product works; and (3) how-to knowledge informs the consumers about how to use the product. In the persuasion stage, consumers examine the advantages and disadvantages of using the product and form an opinion. In the decision stage, the consumers engage in activities that lead to a choice to adopt or reject the innovation. During the implementation stage, the individual puts the innovation to use, and during the final confirmation stage the individual seeks reinforcement of the innovation-decision. If they are reinforced they will continue to use the product, however, if they are punished they will reject the innovation. Rogers notes individual differences in openness to innovation account for the differential speed of moving through the innovation-decision process. Individuals most likely to move rapidly through to adoption include those who are more educated, are able to cope with greater uncertainty, and have greater exposure to mass media (Rogers, 2003). Rogers described five categories of adopters: (1) innovators; (2)
early adopters; (3) early majority; (4) late majority; and (5) laggards. The number of individuals adopting an innovation follows an S-shaped curve over time, with only a few individuals, the innovators, quickly adopting an innovation, followed by increasing adoption rates as early adopters communicate their experiences to more members of the system, the early majority. The late majority individuals in a system will not adopt the innovation until they are able to observe consequences and hear descriptions about the costs and benefits associated with adopting the innovation. Once the majority of individuals have adopted the innovation, the rate of adoption slows until only the last few individuals in the system who are least likely to change, the laggards, make their decision to adopt or reject the innovation (Rogers, 2003).

Lastly, characteristics of the social system itself affect the speed of communication and adoption of innovation (Rogers, 2003). Opinion leaders are members of the community who are at the center of communication channels and to whom other people look to help make decisions about adoption of innovation (Rogers, 2003). Thus, opinion leaders are very influential in spreading information about an innovation. Collaborative relationships between innovators or change agents outside the social system of interest and opinion leaders within the system can facilitate the adoption process (Rogers, 2003). The decision-making structure of the social system can also affect the rate of adoption of innovation. If decisions are made by a single powerful group or group member, then adoption can happen quickly. If individual members can decide adoption at their own rate, then adoption happens more slowly and relies mostly on interpersonal communication and opinion leaders. If adoption relies on collective decision-making, then adoption happens even more slowly (Rogers, 2003).
Higa and Chorpita (2008) and Southam-Gerow et al. (2008) provided several recommendations for dissemination researchers based on Rogers’ diffusion of innovations theory. They noted dissemination of EBTs should emphasize: compatibility with community therapists’ values and experiences; congruence with community need; improvements on existing interventions; minimal complexity; trialability; and observability (Higa & Chorpita, 2008; Southam-Gerow et al., 2008). In addition, information should be conveyed via both mass media and interpersonal communications (Southam-Gerow et al., 2008). The identification of and collaboration with innovators and opinion leaders in the current system can also facilitate the adoption of EBTs (Southam-Gerow et al., 2008). These opinion leaders should have similar attributes to individuals within the system of interest (e.g., education level, training, theoretical orientation; Higa & Chorpita, 2008). Researchers should also hire staff similar to individuals within the system of interest to facilitate the rate of adoption (Higa & Chorpita, 2008). Lastly, Southam-Gerow et al. (2008) emphasized dissemination of EBTs as a shift in thinking of the whole system rather than of individual group members. Thus, attention to the characteristics of innovation, communication channels, time, and social system can facilitate the adoption of innovation, and these factors can be applied to the dissemination of EBTs in practice settings.

Models of Dissemination in Mental Health Systems

Rogers’ (2003) model of diffusion of innovations has been very influential in dissemination work in mental health systems. Several models have been developed to specifically address dissemination of EBTs in the mental health field, largely based on Rogers’ model. These models include: (1) mental health system ecological model
(Schoenwald & Hoagwood, 2001): (2) deployment-focused model (Weisz et al., 2003); (3) implementation research framework (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005); (4) availability, responsiveness, and continuity intervention strategy (Glisson & Schoenwald, 2005); (5) distillation and matching model (Chorpita, Daleiden, & Weisz, 2005); (6) model for the adoption of EBTs in community settings (Smith-Boydston & Nelson, 2008); and (7) conceptual model of implementation research (Proctor et al., 2009).

**Mental health system ecological model.** Schoenwald and Hoagwood’s (2001) mental health system ecological model emphasizes multilevel factors when planning to disseminate a treatment. These multilevel variables include: (1) intervention characteristics; (2) practitioner characteristics; (3) client characteristics; (4) service delivery characteristics; (5) organizational characteristics; and (6) service system characteristics. Schoenwald and Hoagwood emphasized the importance of a transportability step between effectiveness research and dissemination, and also considered the whole ecology involved in the mental health services system before initiating widespread dissemination (Southam-Gerow et al., 2008). While early research phases, such as early clinical studies, efficacy studies, and even effectiveness studies narrowly focus on symptom severity and diagnoses, transportability and dissemination research require a broader focus at the service delivery, organizational, and service system levels (Southam-Gerow, 2004).

**Deployment-focused model.** Weisz et al. (2003) outlined the deployment-focused model of dissemination as one way of addressing the gap between efficacy research and dissemination. They proposed six steps in the development and eventual
deployment of EBTs: (1) theoretically and clinically guided construction, refinement, and manual development of an intervention; (2) initial efficacy trial under controlled conditions; (3) single case applications in practice settings with adaptations to the intervention as needed; (4) partial effectiveness tests of one or more practice setting targets (e.g., referred youth, community setting, community practitioners); (5) full tests of effectiveness and dissemination; and (6) tests of goodness of fit and sustainability in practice contexts. Weisz et al. (2003) also argued other variables examined in research settings must be evaluated when the treatment is implemented in community settings, including: (1) necessary and sufficient components of treatment packages; (2) moderators of treatment outcome; (3) mediators of treatment outcome; (4) cost-benefit analyses; (5) organizational factors in “real-world” systems and settings; and (6) variations in treatment procedures, packaging, training, and delivery.

**Implementation research framework.** Fixsen et al. (2005) offered a comprehensive examination of the dissemination of EBTs in mental health services. Their conceptual framework included five essential components: (1) source, or program to be implemented; (2) destination, or the context in which the intervention will be implemented; (3) communication link, or a “purveyor” of individuals who will implement the program with fidelity; (4) feedback mechanism, or a flow of information about performance of individuals, teams, and organizations acted upon by relevant practitioners, managers, and purveyors; and (5) sphere of influence, such as social, economic, political, historical, and psychosocial factors. Fixsen et al. (2005) also defined stages of implementation, including: (1) exploration and adoption; (2) program installation; (3) initial implementation; (4) full operation; (5) innovation; and (6)
sustainability. Fixsen e al. (2005) also discussed core intervention components and core implementation components in their conceptual model. Core intervention components are vital elements, techniques, or principles within a treatment that are replicable and make a difference (Fixsen et al., 2005). Core implementation components are techniques or procedures which promote high fidelity among practitioners. These components include: (1) staff selection; (2) pre-service training; (3) consultation and coaching; (4) staff evaluation; (5) program evaluation; (6) facilitative administrative supports; and (6) systems interventions. Though little experimental research exists evaluating effective transportability and dissemination methods, Fixsen et al.’s (2005) review of the literature noted that passive training approaches, such as simply providing education or a manual, are ineffective (e.g., Sholomskas et al., 2005), and ongoing consultation and coaching programs, quality assurance programs, administrative and systems supports, and funding availability are critical for dissemination.

**Availability, responsiveness, and continuity (ARC) intervention strategy.**

Glisson and Schoenwald (2005) based their model largely on Rogers’ (2003) model of diffusion of innovation. The ARC intervention strategy is guided by three assumptions: (1) implementation of any core technology is a social and technical process; (2) mental health services are embedded in successive layers of social context that include the service provider, service organizer, and community; and (3) effectiveness is a function of how well the social context complements and supports the objectives of core service technology. ARC is designed to address barriers between the social context and the service technology, help focus organizational and community efforts on a specific population and problem, build community support for services that target the problem,
create alliances among service providers and community stakeholders, encourage the
desired service provider behavior, and develop a social context that fosters effective
services at organizational and community levels. ARC also identifies and uses change
agents (i.e., doctoral- and masters-level practitioners in clinical psychology, social work,
industrial organizational psychology, and counseling) to bridge the research-practice gap.
Glisson and Schoenwald (2005) identified a sequence of four phases: (1) identifying and
forming personal relationships with community opinion leaders, organizations, and key
stakeholders, and collecting data about the problem and its effect on the community; (2)
working with service providers and opinion leaders to come to a collective understanding
of how the community can better understand and address the targeted problem; (3)
ensuring that agreements are followed through; and (4) promoting self-regulation of the
system after the intervention has terminated.

**Distillation and matching model.** Chorpita et al. (2005) proposed a distillation
and matching model [DMM] approach to the dissemination of EBTs. Chorpita et al.
originally developed the model as a way of synthesizing and simplifying the literature on
EBTs. The methodology uses frequency patterns in practice techniques to guide the
empirical construction of a distillation tree that organizes the selected literature according
to any number of variables of interest (e.g., disorder, age, ethnicity, gender). Steps in the
process include: (1) development of an understanding of the domain of interest (e.g.,
practice elements); (2) creation, correction, and preparation of the study data set and
procedures data set; (3) application of data reduction algorithms; (4) application of data
mining algorithms; and (5) interpretation of the mined patterns by domain experts.
Chorpita et al. proposed DMM can be used to yield a decision tree for matching clients to
treatments, along with a profile of practice elements representing the average intervention for a particular client or circumstance, or techniques could be matched to specific targets via a modular assembly of practice elements.

**Model for the adoption of EBTs in community settings.** Smith-Boydston and Nelson (2008) offer a model for the adoption and dissemination of EBTs in community mental health settings. Their model contains four stages: (1) needs assessment; (2) implementation plan; (3) comprehensive training plan; and (4) evaluation and feedback. During the needs assessment phase, EBT acceptance and readiness to change among practitioners, current training needs, and barriers are assessed. Also during this phase, treatment developers market the new treatment to administrators, clinical staff, and the community, and problem-solve potential and identified barriers. During the second stage, the implementation plan should assess financial strengths and limitations, identify needs for staff incentives/disincentives, engage key opinion leaders or staff, assess internal and external resources to assist in implementation, and address sustainability. During the third stage, the comprehensive training plan should individualize the center’s needs, develop a short term and long term plan for sustainability (e.g., quarterly trainings), identify appropriate staff and teams for focus, develop relationships with external resources (e.g., academic or university partnerships), provide specialty training for supervisors, develop on-site specialists, and develop manuals. Finally, the evaluation and feedback stage consists of continuous examination of the strengths and weaknesses of the process, measurements of treatment fidelity, measurement of client outcomes, continual changes to fit ongoing needs or changes in EBTs, and continuous monitoring or sustainability.

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**Model of implementation research.** Proctor et al. (2009) recently proposed a draft conceptual model of implementation research. The authors based their model on stage/pipeline approaches, multi-level models of change, and models of health service use. Proctor et al. proposed a heuristic model that emphasizes nested levels and quality improvement perspectives and links implementation processes with outcomes. The model posits two core strategies: (1) intervention strategies (i.e., EBP); and (2) implementation strategies (i.e., systems environment, organizational, group/learning, supervision, individual providers/consumers). Also in this model, three distinct but interrelated types of outcomes are of interest: (1) implementation outcomes (i.e., feasibility, fidelity, penetration, acceptability, sustainability, uptake, costs); (2) service outcomes (i.e., efficiency, safety, effectiveness, equity, patient-centeredness, timeliness); and (3) client outcomes (i.e., satisfaction, function, symptomatology).

**Summary**

Several theoretical models have been developed to understand and guide dissemination research in the field of mental health. Many of these models emphasize the importance of collaborative relationships with community partners, initial efficacy testing leading to broader levels of investigation, training and systems changes in novel contexts, and refinement and revaluation of the intervention at various stages. While various models of dissemination exist, empirical research investigating the utility of each of these models is lacking in the academic literature. Several influential movements in the field of psychology have placed greater emphasis on transportability and dissemination of EBTs, and inspired researchers to investigate these processes. These influential movements are described below.
Influential Movements toward Translational Research in Psychology

The EST and EBP movements in the field of psychology were very influential in initiating the push for effectiveness, transportability, and dissemination research. A variety of forces initiated the movement of ESTs and EBP in the field of psychology. Psychologists adherent to the scientist-practitioner model rallied for a scientific base for clinical practice (Calhoun, Moras, Pilkonis, & Rehm, 1998; Davison, 1998). In addition, emphasis on accountability in practice and research and managed care treatment and reimbursement policies served as influential forces in the EST and EBP movements (Roberts & James, 2008).

Empirically Supported Treatments

In an effort to identify, define, and promote usage of ESTs, Division 12 of the APA first established a Task Force on Promotion and Dissemination of Psychological Procedures in 1993, headed by Diane Chambless. The Task Force broadly defined ESTs as interventions that have been found to be efficacious for particular psychological disorders within a given population. They examined ways in which information about ESTs were disseminated to clinical psychology students, clinical psychologists, insurance companies, and the general public.

In their initial report, the Task Force (1995) identified three categories and criteria for classifying treatments based on empirical evidence: (1) well-established treatments; (2) probably efficacious treatments; and (3) experimental treatments. Also in their initial report, the Task Force identified 25 ESTs which met their criteria for empirical support in treating children, adolescents, and adults. The task force surveyed clinical training directors and internship directors of APA-approved sites and found one in five APA-
approved clinical psychology programs failed to provide minimal coverage of ESTs. The Task Force defined minimal coverage of ESTs as teaching 25% of the 25 identified ESTs in didactic courses and at least two practica. This standard was purposefully set low because at the time the empirical evidence for some of the treatments was relatively recent. The Task Force also found most internships did not require competence in ESTs. As a result of these findings, the Task Force provided recommendations for the training in and dissemination of ESTs to clinical psychology students, interns, clinicians, third-party payers, and the general public (Task Force, 1995). The Task Force continued to review and evaluate treatments in subsequent years, providing updates and expanded lists of ESTs (Chambless et al., 1996; Chambless et al., 1998; Chambless & Ollendick, 2001).

The Task Force’s initial and subsequent reports sparked much interest in the development and evaluations of ESTs for youth. For example, special editions of the *Journal of Clinical Child and Adolescent Psychology* and the *Journal of Pediatric Psychology* have focused on the identification and evaluation of ESTs for children and adolescents with a variety of disorders. In addition, APA’s Division 53, Society of Clinical Child and Adolescent Psychology, in conjunction with the Association for Behavioral and Cognitive Therapy, have recently created a website for information on EBTs (see [http://www.abct.org/sccap/](http://www.abct.org/sccap/)).

**Evidence Based Practice**

The EBP movement followed shortly after the EST movement, and aimed to reconcile the objections some raised regarding the strict criteria for ESTs and more broadly address the research-practice gap. The Presidential Task Force on EBP of the APA was appointed to develop a position statement regarding the integration of science
and practice for health services provided by professional psychologists. APA’s definition of EBP was modeled after the definition of EBP adopted by the IOM (2001). APA defined EBP as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Task Force on EBP, 2006, p. 273). Unlike ESTs, which rely heavily on empirical support for specific psychological treatments, EBP highlights the importance and integration of empirical research, clinical expertise, and patient values in selecting and providing patient care.

**Evidence Based Practice for Children and Adolescents**

Following the policy statements regarding EBP, a second APA Task Force on EBP for Children and Adolescents was formed in 2006 to address unique challenges in the development and dissemination of EBTs for youth. The 2008 report built upon the definition and goals of EBP, while highlighting factors unique in the treatment of youth. The Task Force emphasized the importance of developmental considerations and cultural/contextual factors when working with youth and their families. They also emphasized a dynamic systems approach, based upon a social ecological understanding of children, which included multiple layers: (1) individuals (e.g., clinicians, supervisors, researchers); (2) settings (e.g., schools, health centers, community agencies); (3) delivery mechanisms (e.g., training, ongoing consultation, clinical decision making, assessment, and monitoring tools); (4) consumers (e.g., youths and their families); (5) culture; and (6) interactions among layers. The Task Force also emphasized the importance of ongoing assessment and prevention programs. Lastly, the report provided recommendations for implementation, dissemination, training, supervision, practice, and policy, and also identified challenges and key factors to each of these processes.
Summary

The EST and EBP movements have been very influential in the field of psychology in addressing the research-practice gap and inspiring investigators to initiate and evaluate translational research. These movements also sparked interest specifically in the dissemination of EBP for children and adolescents, since translational research for youth has historically been under-funded and lagged behind advances in adult literature (APA Task Force on EBP for Children and Adolescents, 2008). Childhood and adolescent mood disorders are prevalent and serious conditions for which a variety of EBTs have been developed and evaluated (Brown et al., 2008; David-Ferdon & Kaslow, 2008; West & Pavuluri, 2009; Young & Fristad, 2007). Despite the seriousness of these disorders and the existence of a variety of EBTs, limited research has examined their effectiveness, transportability, or dissemination in practice settings. EBTs for childhood and adolescent mood disorders are discussed below, followed by a review of the translational research for these EBTs.

Efficacy of Evidence-Based Treatments for Childhood and Adolescent Mood Disorders

Childhood and adolescent mood disorders are prevalent and impairing conditions associated with significant morbidity and mortality. Given the significance of these disorders, researchers have been seeking effective treatment strategies. Both pharmacological and psychosocial interventions have been developed and used to effectively treat childhood and adolescent mood disorders. For youth with DSD, current practice parameters established by AACAP recommend education, support, and case management for mild cases of depression, whereas specific psychotherapeutic
interventions are recommended for moderate depression, and antidepressants plus psychotherapy for severe depression (Birmaher et al., 2007). For youth with BPSD, AACAP practice parameters recommend a comprehensive treatment plan of pharmacotherapy plus adjunctive psychotherapeutic intervention (Kowatch et al. 2005; McClellan, Kowatch, Findling, & the Work Group on Quality Issues, 2007). Currently, APA does not have official practice parameters for the treatment of childhood disorders. However, a recent review of the evidence base produced by APA’s Working Group on Psychotropic Medications for Children and Adolescents revealed support for several psychosocial, pharmacological, and combined interventions in the treatment of youth DSD and BPSD (Brown et al., 2008). However, medication non-adherence is common and psychoactive medications used in the treatment of mood disorders are associated with significant side effects (e.g., Kowatch et al., 2005). Thus, psychosocial and psychoeducational interventions are needed to enhance treatment outcome through education about symptoms, medications, and treatment adherence, side effect management, and skill building (e.g., coping skills, communication skills, problem solving skills). Also, combination pharmacotherapy plus CBT are more effective in decreasing suicidal behavior and depressive symptoms than either intervention alone (Treatment for Adolescents with Depression Study [TADS] Team, 2004), further suggesting the need for adjunctive psychosocial interventions in treating childhood and adolescent mood disorders. Finally, some evidence suggests a durable treatment effect for psychosocial interventions in the treatment of youth with mood disorders (e.g., West, Henry, & Pavuluri, 2007; Fristad et al., 2009). Thus, while effective treatment of childhood and adolescent mood disorders often includes a pharmacological component,
psychosocial interventions are also needed to address environmental issues, educate families about signs and symptoms, and help children and parents develop skills to prevent relapses of the disorder (Birmaher et al., 2007; Brown et al., 2008; David-Ferdon & Kaslow, 2008; Kowatch et al., 2005; Young & Fristad, 2007).

**Evidence-Based Treatments for Childhood and Adolescent Depressive Spectrum Disorders**

David-Ferdon and Kaslow (2008) recently reviewed the empirical support for psychosocial EBTs for youth at-risk for developing or currently diagnosed with DSD. This review examined the evidence base for specific programs, treatment modalities, and broad theoretical orientations in accord with the guidelines proposed by the Task Force on the Promotion and Dissemination of Psychological Procedures (Chambless et al., 1996; Chambless et al., 1998; Chambless & Ollendick, 2001; Task Force, 1995). David-Ferdon and Kaslow (2008) identified a variety of EBTs for children and adolescents. Treatments with the most empirical support utilized cognitive-behavioral or interpersonal psychotherapeutic techniques. A variety of delivery methods were also used, ranging from individual therapy to group treatment. Despite the existence of many different treatments, no specific intervention met criteria for a well-established treatment at the time of this review (David-Ferdon & Kaslow, 2008).

**Evidence-based treatments for childhood depressive spectrum disorders.**

David-Ferdon and Kaslow’s review of EBTs for children with elevated depressive symptoms and/or DSD revealed some progress in research regarding the prevention and treatment of childhood DSD since the initial review by Kaslow and Thompson (1998). The majority of EBTs for children were prevention programs or used with children with
elevated depressive symptoms. In the initial review, Kaslow and Thompson (1998) identified seven RCTs for children, all of which were prevention programs or used for children with elevated depressive symptoms. In the current review, David-Ferdon and Kaslow (2008) identified ten new RCTs involving children; seven were prevention programs or for children with elevated depressive symptoms, two studied mixed age groups (children and adolescents) with diagnosed depression (Nelson, Barnard, & Cain, 2003; Trowell et al., 2007) and one studied children with depression or anxiety disorders (Muratori, Picchi, Bruni, Patarnello, & Romagnoli, 2003).

David-Ferdon and Kaslow (2008) concluded the specific programs of Self-Control Therapy (SCT) and the Penn Prevention Program (PPP) are probably efficacious for at-risk children. In addition, the treatment modalities of group CBT with or without parental component are well-established treatment modalities for at-risk children and children with DSD (David-Ferdon & Kaslow, 2008). In terms of theoretical orientation classification schema, CBT is a well-established theoretical approach, and behavior therapy is probably efficacious for at-risk children and children with DSD (David-Ferdon & Kaslow, 2008). A variety of other specific treatments, theoretical orientations, and treatment modalities for children with elevated depressive symptoms and/or DSD have been developed and proposed, however, only limited research has supported their use.

Of the three RCTs that included youth meeting criteria for DSD, only one (Nelson, Barnard, & Cain, 2003) utilized CBT, the only well-established theoretical orientation for children. However, the treatment modality used, parents and children together, was deemed experimental. In addition, that study included mixed age groups (ages 8 to 14). The other two RCTs utilized Systems Integrative Family Therapy
delivered via family sessions (SIFT: Trowell et al., 2007), Focused Individual Psychodynamic Psychotherapy delivered via individual child sessions plus individual parent sessions (FIPP: Trowell et al., 2007), and Psychodynamic Psychotherapy delivered via child individual sessions and child plus parent sessions (Muratori et al., 2003). Of these three treatments, only Systems Integrative Family Therapy was deemed experimental; the other two did not have enough empirical support to be considered experimental or promising interventions. Thus, although a variety of interventions for youth with elevated depressive symptoms have shown to be efficacious, none have focused exclusively on children aged 12 and under with diagnosed depression.

Described below are the efficacy trials for the two specific treatments with the most empirical support, SCT and PPP. Both of these programs are probably efficacious and were designed for use with children with elevated depressive symptoms. Also mentioned are other specific interventions with less empirical support.

**Self-control therapy.** SCT is a CBT-based, manual-driven, group treatment designed for 8- to 12-year olds with elevated depressive symptoms in school settings (Stark, Reynolds, & Kaslow, 1987; Stark, Rouse, & Livingston, 1991). The intervention is designed to teach children adaptive skills for self-monitoring, self-evaluating performance, attributing the cause of good and bad outcomes, and self-consequencing. Skills are taught and practiced through didactic presentations, group exercises, and behavioral homework assignments.

In a study of 29 children ages 9 to 12 who endorsed significant levels of depressive symptoms, children were randomized to SCT, Behavioral Problem-Solving Therapy (BPST), or a waitlist control group (WLC: Stark et al., 1987). Both therapies
were group-administered in 12 sessions and implemented by graduate students and a psychologist well-trained in and familiar with the treatment. At post-treatment, children in both active treatments reported fewer symptoms of depression and anxiety compared to the WLC on the Children’s Depression Inventory (CDI: Kovacs, 1981) and Revised Children’s Manifest Anxiety Scale (RCMAS: Reynolds & Richmond, 1978). At 8-week follow-up, gains were maintained in the SCT and BPST groups, but could not be compared with the WLC group who subsequently had received treatment. The SCT group also had greater scores on positive concept on the Coopersmith Self-Esteem Inventory (CSEI: Coopersmith, 1967, 1975) and the BPST group showed decreases in parent-rated social withdrawal and internalizing symptoms, as rated by mothers on the Child Behavior Checklist (CBCL: Achenbach & Edelbrock, 1979). Both interventions were successful in ameliorating depressive symptoms, however, neither SCT nor BPST was found to be clearly superior (Stark et al., 1987).

In a second study, 24 4th to 7th graders with elevated depressive symptoms were randomized to receive an expanded version of 24 to 26 sessions of SCT plus monthly family meetings/family session or traditional counseling (Stark et al., 1991). Both groups self-reported significantly fewer depressive symptoms post-treatment and at 7-month follow-up on the CDI. However, youth in the SCT group self-reported significantly fewer depressive symptoms and cognitions at post-treatment (Stark et al., 1991). Concepts from SCT and BPST have been incorporated into the ACTION Treatment Program (Stark, Hargrave, et al., 2006; Stark, Sander, et al., 2006) and Primary and Secondary Control Enhancement Training Program (PASCET: Weisz, Thurber, Sweeney, Proffitt, & LeGagnouz, 1997).
Penn prevention program. PPP (sometimes called the Penn Resiliency Program [PRP]) is a CBT-based, manual-driven, group treatment conducted in school settings with 10- to 15-year-olds at risk for depression based on elevated depressive symptoms and family conflict (Cardemil, Reivich, Beevers, Seligman, & James, 2007; Cardemil, Reivich, & Seligman, 2002; Gillham & Reivich, 1999; Gillham, Reivich, et al., 2006; Gillham, Reivich, Jaycox, & Seligman, 1995; Jaycox, Reivich, Gillham, & Seligman, 1994). The intervention includes cognitive and social problem-solving components. The cognitive component focuses on cognitive restructuring and attribution retraining. The social problem-solving component focuses on goal-setting, perspective taking, information gathering, generating alternatives for action, decision making, and self-instruction. The program also incorporates other skill building exercises and strategies, such as decatastrophising, distancing and distraction, relaxation training, and enhancing social support.

Numerous studies have investigated the efficacy of PPP/PRP. Jaycox et al. (1994) conducted a study of 143 children aged 10 to 13 with elevated depressive symptoms randomized to 12 sessions of PRP, facilitated by the treatment developers, or no treatment control. Jaycox et al. found PRP significantly reduced depressive symptoms and improved classroom behavior, and children self-reported fewer moderate and severe depressive symptoms on the CDI and Reynolds Child Depression Scale (Reynolds, 1989). Treatment gains were maintained at 6- and 24-month follow-ups (Gillham et al., 1995), but not 36-month follow-up (Gillham & Reivich, 1999). In addition, no differences in explanatory style and parent reports of internalizing and externalizing symptoms measured on the Children’s Attributional Style Questionnaire (CASQ:
Seligman et al., 1984) and CBCL emerged post-treatment, but these emerged at 6-month follow-up (Jaycox et al., 1994). Effects on explanatory style were maintained through 36-month follow-up (Gillham & Reivich, 1999).

PRP plus a parental component was compared to usual care in 44 6th and 7th graders with elevated depressive and anxiety symptoms (Gillham, Reivich et al., 2006). Treatment was implemented by trained undergraduate research assistants and a senior member of the research team. Although the groups did not differ post-treatment, intervention effects in terms of reduction in depressive and anxiety symptoms were observed at 6- and 12-month follow-ups on the CDI and RCMAS (Gillham, Reivich et al., 2006).

In a study examining prevention of depression in low-income, minority youth, 168 Latino and African-American 5th to 8th graders were randomized to PRP, facilitated by members of the research team, or no treatment control (Cardemil et al., 2007; Cardemil et al., 2002). Cardemil et al. (2007) and Cardemil et al. (2002) found that Latino children who received PRP reported fewer depressive symptoms on the CDI, fewer negative automatic thoughts on the Automatic Thought Questionnaire (ATQ: Kazdin, 1990), and less hopelessness on the Hopelessness Scale (H-Scale: Kazdin, Rodgers, & Colbus, 1986) at post-treatment, 6-month, and 24-month follow-up. In addition, PRP showed improved self-esteem in Latino children at 6-month follow-up on the Harter Self-Perception Profile for Children (SPPC: Harter, 1982, 1985). However, PRP was not effective for any outcome measures in African American youth (Cardemil et al., 2007; Cardemil et al., 2002).
A recent meta-analysis aggregating results from 17 controlled evaluations of PRP (N=2,498) found that PRP participants reported fewer depressive symptoms at post-intervention and follow-up assessments when compared to youth receiving no intervention, with effect sizes ranging from 0.11 to 0.21 (Brunwasser, Gillham, & Kim, 2009). Also, PRP’s effects were significant at one or more follow-up assessments among studies with both targeted and universal approaches, when group leaders were research team members and community providers, among participants with both low and elevated baseline symptoms, and among girls and boys. However, Brunwasser et al. (2009) noted PRP was not superior to active control conditions, and PRP’s effects on depressive disorders maybe smaller than those reported in larger meta-analyses of depression prevention programs for older adolescents and adults (e.g., Cuijpers, van Straten, Smit, Mihalopoulous, & Beekman, 2008). Brunwasser et al. (2009) concluded PRP significantly reduces depressive symptoms through at least 1-year follow-up.

**Other specific psychosocial evidence-based treatments.** Several other specific psychosocial interventions have been developed for the prevention and treatment of childhood DSD and appear promising. These treatments include: ACTION Treatment Program; Bereavement Group Intervention; Coping with Depression; Family Cognitive-Behavioral Prevention; PASCET Program; Stress-Busters; Systems Integrative Family Therapy; Taking Action; and Wisconsin Early Intervention. These interventions appear to be effective in reducing depressive symptoms relative to control conditions (Asarnow, Scott, & Mintz, 2002; Clarke, Lewinsohn, & Hops, 1990; Compas et al., 2009; De Cuypers, Timbremont, Braet, De Backer, & Wullaert, 2004; King & Kirschenbaum, 1990; Pfieffer, Jiang, Kakuma, Hwang, & Metsch, 2002; Stark, Hargrave, et al., 2006; Stark,
Sander, et al., 2006; Trowell et al., 2007; Weisz, et al., 1997). To date, most research examining specific childhood interventions have a CBT orientation, focus on prevention of DSD, are designed for youth with elevated depressive symptoms, and are delivered in school settings (Kaslow, Davis, & Oyeshiku Smith, 2009). Most of these interventions were deemed experimental in David-Ferdon and Kaslow’s (2008) review due to the limited extent of empirical investigations.

Evidence-based treatments for adolescent depressive spectrum disorders. 
David-Ferdon and Kaslow’s (2008) review of EBTs for adolescents with elevated depressive symptoms and/or DSD revealed much progress in research regarding the prevention and treatment of adolescent DSD since the initial review by Kaslow and Thompson (1998). Research on the prevention and treatment of adolescent DSD continues to be more prevalent than research on the prevention and treatment of childhood DSD. Unlike the RCTs for children which have mainly examined youth with elevated depressive symptoms, many RCTs for adolescents included youth meeting diagnostic criteria for DSD. In the initial review, Kaslow and Thompson (1998) identified seven RCTs for adolescents; two were prevention programs or for adolescents with elevated depressive symptoms, and five included adolescents who met diagnostic criteria for DSD. David-Ferdon and Kaslow’s (2008) review identified 18 new RCTs involving adolescents; six were conducted with at-risk adolescents with elevated depressive symptoms, and twelve included adolescents who met criteria for DSD.

Through their review, David-Ferdon and Kaslow (2008) concluded the specific programs of Coping with Depression-Adolescent (CWD-A) and Interpersonal Psychotherapy for Adolescents (IPT-A) are probably efficacious. Under the rubric of
CBT, the treatment modality of adolescent group only is well-established, and individual, individual plus parent/family component, and adolescent group plus parent component are probably efficacious. Under the rubric of IPT, the modality of individual treatment is well-established. In terms of theoretical orientation classification schema, CBT and IPT are well-established theoretical approaches. A variety of other specific treatments, theoretical orientations, and treatment modalities for adolescents with elevated depressive symptoms and/or DSD have been developed and proposed, however, only limited research has supported their use.

Of the 17 RCTs that have included adolescents meeting diagnostic criteria for DSD, eleven utilized the well-established theoretical orientation of CBT (Brent et al., 1997; Clarke et al., 2005; Clarke et al., 1995; Clarke et al., 2002; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Goodyer et al., 2007; Lewinsohn, Clarke, Hops, & Andrews, 1990; Lewinsohn, Clarke, Rohde, Hops, & Seeley, 1996; Melvin et al., 2006; Rohde, Clarke, Mace, Jorgensen, & Seeley, 2004; TADS Team, 2004), two utilized the well-established theoretical orientation of IPT (Mufson et al., 2004; Mufson, Weissman, Moreau, & Garfinkel, 1999), and one utilized both CBT and IPT (Rossello & Bernal, 1999). Three additional RCTs examined non-directed support delivered via adolescent group only (Fine, Forth, Gilbert, & Haley, 1991), Attachment-Based Family Therapy delivered to parents and adolescents together (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002), and Family Psychoeducation delivered to all family members (Sanford et al., 2006). Of these three treatments, only non-directed support and Attachment-Based Family Therapy were deemed experimental. Thus, a variety of interventions for
adolescents with elevated depressive symptoms and meeting diagnostic criteria for DSD have been developed and evaluated.

Described below are the efficacy trials for the two treatments with the most empirical support, CWD-A and IPT-A. Both of these programs are probably efficacious and were designed for use with children meeting diagnostic criteria for DSD, though they have since been adapted and evaluated for use in at-risk adolescents with elevated depressive symptoms. Also mentioned are other specific interventions with less empirical support.

**Coping with depression-adolescent.** CWD-A is an adolescent version of an earlier program designed for depressed adults (Clarke et al., 1995; Clarke et al., 1999; Lewinsohn et al., 1990; Lewinsohn et al., 1996). CWD-A was initially developed and tested in a research clinic but has since been implemented in a variety of settings and has been used with youth with elevated depressive symptoms, youth deemed at-risk for the development of DSD based on parental depressive diagnoses, and youth meeting diagnostic criteria for DSD. Although various versions of CWD-A currently exist, all contain relaxation training, cognitive restructuring, pleasant activity scheduling, communication training, and conflict resolution techniques. The program usually contains 15 to 16 sessions which can range in length from 45 minutes to 2 hours. Certain protocols also contain a parental component. CWD-A has also been used as a template for the development of other similar protocols (e.g., Asarnow et al., 2005; Clarke et al., 2005; Garber et al., 2009; TADS Team, 2004). CWD-A has been examined in numerous studies with largely efficacious results.
Lewinsohn et al. (1990) randomly assigned 59 adolescents aged 14 to 18 who met diagnostic criteria for Major Depressive Disorder (MDD) or minor intermittent depression to CWD-A adolescent group, CWD-A adolescent group plus parent component, or WLC. Treatment was facilitated by trained members of the research team. Both CWD-A conditions showed greater reductions in self-reported depressive symptoms on the Beck Depression Inventory (BDI: Beck, Steer, & Garbin, 1988) and Center for Epidemiologic Studies-Depression Scale (CES-D: Radloff, 1977), and in clinician-rated depressive symptoms on the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS: Chambers et al., 1985). Adolescents receiving CWD-A also reported greater reductions in maladaptive cognitions and evidenced more involvement in pleasurable events. In addition, adolescents in the CWD-A conditions were less likely to meet diagnostic criteria for MDD or minor intermittent depression post-treatment, and results were maintained at 24-month follow-up. No significant differences were noted between the two CWD-A conditions in terms of treatment response or outcome measures (Lewinsohn et al., 1990).

A replication of the original study (Lewinsohn et al., 1990) added two modifications to the protocol: skills training presented throughout the course and booster sessions (Clarke et al., 1999; Lewinsohn et al., 1996). This study included 123 adolescents who met diagnostic criteria for MDD or Dysthymia recruited from the community. Youth were randomly assigned to CWD-A, CWD-A plus parent component, or WLC. CWD-A groups were facilitated in a research clinic by advanced graduate psychology or social work students or mater’s- or doctoral-level clinicians who received extensive training and supervision from the treatment developers. Participants in CWD-
A conditions were also randomized to follow-up conditions of booster sessions plus assessment or assessment only. Both CWD-A conditions showed greater depression recovery rates and improvements in self-reported depressive symptoms on the BDI post-treatment. No differences in depressive symptoms were noted from parent-reports on the CBCL or clinician reports on the K-SADS Longitudinal Interval Follow-up Evaluation (LIFE: Shapiro & Keller, 1979), or Hamilton Depression Rating Scale (HAM-D: Hamilton, 1960) post-treatment. The addition of the parent group had no significant effect, while the addition of the booster sessions was associated with accelerated rates of recovery of youth still depressed at the end of the active treatment, but they had no impact on the rates of recurrence through 2-year follow-up (Clarke et al., 1999; Lewinsohn et al., 1996).

Interpersonal psychotherapy for adolescents. IPT-A, like CWD-A, is an earlier version of a program originally designed for depressed adults (Mufson et al., 1999). IPT-A is intended for use with adolescents meeting diagnostic criteria for DSD. IPT-A was originally developed and tested in hospital clinics, but has since been implemented in school settings. IPT-A addresses interpersonal issues specific to adolescence, such as changes in parent-adolescent relationships due to shifts in closeness and authority. The program relates adolescents’ difficulties to one of four primary interpersonal areas (i.e., grief, role disputes, role transitions, and interpersonal deficits). Effective strategies are taught and developed to deal with these interpersonal problems, including improved communication, expression of affect related to changes in relationship, and the development of a new and effective social support system. The treatment generally consists of 13 individual sessions, 30 to 60 minutes in length. Sessions are conducted
over the course of 12 to 16 weeks, and can also include weekly phone contact between adolescent and therapist for the first four weeks of treatment (Mufson et al., 1999).

Mufson et al. (1999) randomly assigned 48 adolescents aged 12 to 18 years who met criteria for MDD to IPT-A or clinical symptom monitoring, which consisted of monthly therapist contact. Treatment was facilitated by child psychiatrists, a licensed clinical psychologist, and a master’s level psychologist with 10 years of experience, all of whom received extensive training and supervision from the treatment developers. Adolescents in the IPT-A group showed greater improvements in self- and clinician-reported depressive symptoms on the BDI and HAM-D, respectively. Adolescents receiving IPT-A also showed greater improvements in social functioning and interpersonal problem solving on the Social Adjustment Scale-Self Report Version (SAS-SR: Weissman & Bothwell, 1976) and the Social Problem Solving Inventory Revised (D’Zurilla & Nezu, 1990). In addition, 74% of adolescents in the IPT-A group met recovery criteria compared with 46% in the control group (Mufson et al., 1999).

Rossello and Bernal (1999) conducted a study of 71 Puerto Rican adolescents aged 13 to 18 years who met diagnostic criteria for MDD, Dysthymia, or MDD plus Dysthymia. Youth were randomly assigned to IPT, CBT, or WLC. Treatment was facilitated by advanced clinical psychology graduate students with an average of three years of clinical experience. Therapists were trained and supervised by two PhD clinical psychologists experienced in each of the therapy approaches. Results indicated IPT and CBT significantly reduced self-reported depressive symptoms on the CDI compared to WLC. Also, 82% of IPT adolescents were below cutoff for depressive symptoms and 59% of CBT adolescents were below cutoff for depressive symptoms at post-treatment.
IPT was superior to WLC in increasing self-esteem and social adaptation on the Piers-Harris Children’s Self-Concept Scale (PHCSCS: Piers, 1972; Piers & Harris, 1984). Of note, Rosello and Bernal (1999) utilized a slightly different version of IPT than Mufson et al. (1999).

**Other specific psychosocial evidence-based treatments.** Several other specific psychosocial interventions have been developed for the prevention and treatment of adolescent DSD and appear promising. These treatments include: Adolescents Coping with Emotions; Attachment-Based Family Therapy; Depression Treatment Program; Feeling Good bibliotherapy; Time for a Future – Adolescent Depression Program; and Interpersonal Psychotherapy-Adolescent Skills Training. These interventions appear to be effective in reducing depressive symptoms relative to control conditions (Ackerson, Scogin, McKendree-Smith, & Lyman, 1998; Diamond et al., 2002; Diamond, Siqueland, & Diamond, 2003; Kowalenko et al., 2005; Melvin et al., 2006; Wood, Harrington, & Moore, 1996; Young, Mufson, & Davies, 2006). To date, most research examining specific adolescent interventions have a CBT or IPT theoretical orientation, focus on the treatment of adolescent DSD rather than the prevention of adolescents at-risk for DSD, are designed for adolescents meeting diagnostic criteria for DSD, and are delivered in research or hospital clinics. Most of these interventions were deemed experimental in David-Ferdon and Kaslow’s (2008) review due to the limited extent of empirical investigations.

**Summary.** Research on psychotherapeutic interventions for youth with DSD or at-risk for developing DSD reveals support for several specific programs, treatment modalities, and theoretical orientations (David-Ferdon & Kaslow, 2008). The specific
interventions of SCT and PPP for children and CWD-A and IPT-A for adolescents are probably efficacious. In terms of treatment modality, child group only and child group plus parent group under the theoretical rubric of CBT are well-established for children. The treatment modalities of adolescent group under CBT and individual treatment under IPT are well established. Other modalities under the CBT rubric for adolescents appear promising and are probably efficacious, including adolescent group plus parent component, individual, and individual plus parent/family component. Finally, in terms of theoretical perspectives, CBT for both children and adolescents and IPT for adolescents are well established, and behavior therapy for children is probably efficacious. David-Ferdon and Kaslow’s (2008) review revealed significant progress in the prevention and treatment of youth DSD since Kaslow and Thompson’s (1998) initial review. However, there are still no specific interventions for children or adolescents that are well-established. In addition, research examining adolescent DSD remains more prevalent than research examining childhood DSD, and the majority of RCTs for children were conducted with at-risk youth with elevated symptoms, rather than those meeting diagnostic criteria for DSD. No study focused exclusively on the treatment of children ages 12 and under with diagnosed DSD. Thus, future research is needed to continue the evaluation of specific childhood and adolescent interventions and to investigate EBTs for children meeting diagnostic criteria for DSD.

Evidence-Based Treatments for Childhood and Adolescent Bipolar Spectrum Disorders

Significantly less research has examined the efficacy of psychosocial interventions for children and adolescents with BPSD. Current treatment guidelines
recommend combined psychopharmacology and psychosocial interventions for the
treatment of youth with BPSD (McClellan at el., 2007). In addition, psychosocial
interventions should seek to improve children’s and parents’ understanding of the causes,
symptoms, and treatment options for BPSD via: psychoeducation; symptom
management; coping skills; communication skills; problem-solving skills; social and
family relationships; academic and occupational functioning; and relapse prevention
strategies (Lofthouse & Fristad, 2004; McClellan et al., 2007). Although several articles
have reviewed current psychosocial treatments for youth with BPSD (Young & Fristad,
2007; West & Pavuluri., 2009) a comprehensive review examining the evidence bases for
specific programs, treatment modalities, and broad theoretical orientations in accord with
the guidelines proposed by the Task Force on the Promotion and Dissemination of
Psychological Procedures has not been conducted (Chambless et al., 1998; Chambless &
Hollon, 1998; Chambless et al., 1996; Lonigan, Elbert, & Johnson, 1998; Silverman &
Group on Psychotropic Medications for Children and Adolescents revealed support for
several psychosocial, pharmacological, and combined interventions in the treatment of
youth BPSD (Brown et al., 2008). Essentially no psychosocial studies have been
conducted with youth with BPSD in absence of pharmacotherapy. This review noted the
most empirical support for psychosocial interventions with psychoeducational and
cognitive-behavioral components, including: Family-Focused Treatment for Adolescents
(FFT-A: Miklowitz et al., 2008; Miklowitz et al., 2004); Child- and Family-Focused
Cognitive-Behavioral Therapy for children (CFF-CBT: Pavuluri et al., 2004); Multi-
Family Psychoeducational Psychotherapy for children (MF-PEP: Fristad, Goldberg-
Psychosocial interventions for childhood bipolar spectrum disorders. To date, only two groups have developed and investigated the efficacy of psychosocial interventions for children with BPSD. These treatments include CFF-CBT, MF-PEP, and IF-PEP. These psychosocial interventions are designed as adjunctive to pharmacotherapy and involve psychoeducation, child and parent involvement, and skill building. CFF-CBT has been investigated via pilot open trials. MF-PEP and IF-PEP has been investigated via RCTs.

Child- and family-focused cognitive-behavioral therapy. CFF-CBT (Pavuluri et al., 2004) is intended as an adjunctive treatment to pharmacotherapy and was designed as an adaptation of FFT-A (Miklowitz et al., 2008; Miklowitz et al., 2004) for children ages 8 to 12. Treatment consists of 12 sessions with child alone, parents alone, child and parents together, and parents with siblings. CFF-CBT integrates psychoeducational, cognitive-behavioral, and interpersonal techniques, and focuses on psychosocial factors that influence the course of BPSD, such as expressed emotion and stressful life events. CFF-CBT also teaches skills in the domains of coping, communication, family problem-solving, interpersonal, and cognitive-behavioral. Psychoeducation is also provided for siblings and the child’s school. Treatment is structured around the acronym RAINBOW: Routine; Affect regulation; I can do it; No negative thoughts and live in the now; Be a
good friend and balanced lifestyle for parents; Oh, how can we solve the problem; and Ways to get support. The maintenance phase after 12 initial sessions consists of psychosocial booster sessions and medication management delivered in a systematic yet flexible way based on the patient’s mental status, level of functioning, and access to the clinic (West et al., 2007).

In an open trial of CFF-CBT, 34 adolescents 5 to 17 years old with BPSD who had been stabilized on medication showed significant improvement in symptoms of ADHD, aggression, mania, psychosis, depression, sleep disturbance, and global functioning on the Clinical Global Impressions Scale for Bipolar Disorder (CGI-BP: Spearing, Post, Leverich, Brandt, & Nolen, 1997) and The Children’s Global Assessment Scale (CGAS: Shaffer et al., 1983; Pavuluri et al., 2004). Participation in the maintenance model of CFF-CBT was associated with positive effects in symptoms and functioning over a three year follow-up period (West et al., 2007). There were no statistically significant differences in post acute-phase treatment scores and scores at years 1, 2, or 3 on any study measures (i.e. CGI-BP and CGAS), indicating the maintenance of clinically significant improvement (West et al., 2007).

A group adaptation of CFF-CBT provided to 26 families who had children aged 6 to 12 years with BPSD indicated CFF-CBT was feasible and acceptable to families (West et al., 2009). Group CFF-CBT also resulted in significant improvement in manic symptoms and children’s psychosocial functioning post-treatment, as measured on The Child Mania Rating Scale – Parent Version (CMRS-P: Pavuluri, Henry, Devineni, Carbray, & Birmaher, 2006) and The Strengths and Difficulties Questionnaire (SDQ: Goodman, Ford, Simmons, Gatward, & Meltzer, 2000). Significant improvement was
not found for depressive symptoms on the CDI. Parents also reported an increased ability to cope with their child’s illness, though this finding was not statistically significant (West et al., 2009). Thus, both individual-family and group adaptations of CFF-CBT appear to be efficacious in open trial investigations.

**Multi-family psychoeducational psychotherapy.** MF-PEP consists of eight 90 minute sessions for children with concurrent parent sessions with another therapist (Fristad, Gavazzi, Mackinaw-Koons, 2003). MF-PEP is designed as an adjunct to pharmacotherapy and treatment as usual, and is intended for children ages 8 to 12 with BPSD or DSD. Similar to CFF-CBT, MF-PEP focuses on psychoeducation about childhood mood disorders and available treatments, decreasing expressed emotion, and improving symptom management, communication skills, and problem solving skills. The group format of the treatment allows parents and children to gain support from other families with children with mood disorders and allows children an environment to practice newly learned social, communication, and problem solving skills. Features of MF-PEP include: educating parents about how to more effectively function as members of their child’s school and mental health treatment team; “Naming the Enemy” exercise to externalize the child’s symptoms and to help them realize they are separate from their mood symptoms (Fristad, Gavazzi, & Soldano, 1999); creation of a “Tool Kit” to manage symptoms and emotions; the “Thinking-Feeling-Doing” therapeutic technique which helps children learn the connection between thoughts, feelings, and behavior (Fristad, Davidson, & Leffler, 2007); as well as problem solving, symptom management, verbal and nonverbal communication skill building for parents and children.
In a RCT of 35 families with children ages 8 to 11 with DSD or BPSD, families were randomly assigned to immediate treatment (IMM) plus treatment as usual (TAU) or a 6-month WLC + TAU (Fristad et al., 2002, 2003; Goldberg-Arnold et al., 1999). Both groups were also encouraged to continue treatment as usual (TAU). Results revealed IMM parents showed increased knowledge of mood disorders on the Understanding Mood Disorder Questionnaire (UMDQ: Gavazzi, Fristad, & Law, 1997), improved family interactions on The Expressed Emotion Adjective Checklist (EEAC: Friedmann & Goldstein, 1993), improved ability to access services for children, and positive consumer evaluations. In addition, IMM children reported a significant increase in perceived social support from parents and a trend toward increased perceived social support from peers on The Social Support Scale (SSS: Harter, 1985). However, children’s mood symptom severity did not decrease significantly following treatment on The Children’s Depression Rating Scale-Revised (CDRS-R: Poznanski et al., 1984) and The Mania Rating Scale (MRS: Young, Biggs, Siegler, & Meyer, 1978; Fristad et al., 2002, 2003; Goldberg-Arnold et al., 1999).

In a RCT of 165 families comparing MF-PEP + TAU to a WLC + TAU, MF-PEP + TAU was associated with decreased mania and depressive symptoms on The Mood Severity Index (MSI: Fristad et al., 2009), which combines CDRS-R and MRS scores, over a one year follow-up, with improvements continuing through 18-month follow-up (Fristad et al., 2009). In addition, MF-PEP + TAU was also associated with a significant decrease in the variance in number of current medications (Cummings & Fristad, 2007). An analysis of treatment mediators revealed participation in MF-PEP significantly improved clinician-rated quality of services utilized, mediated by parents’ beliefs about
treatment on the Treatment Beliefs Questionnaire (TBQ: Davidson & Fristad, 2006), and participation in MF-PEP also significantly improved severity of child’s mood symptoms on the MSI, mediated by clinician-rated quality of services used (Mendenhall et al., 2009). Thus, MF-PEP helps parents become better consumers of mental health services, and access to higher-quality services results in decreased mood symptom severity (Fristad et al., 2009).

Individual-family psychoeducational psychotherapy. IF-PEP (Fristad, 2006) is a non-group form of MF-PEP when MF-PEP is difficult to implement or undesirable to the family. The original protocol consisted of 16 50-minute sessions alternating between parent-only and child-only sessions. A unique feature of IF-PEP separate from MF-PEP is a Healthy Habits component focusing on maintaining healthy sleep hygiene, improving nutrition, and increasing appropriate exercise. In addition, an “in the bank” session to address crises can be used at any time throughout treatment. Based on feedback from a pilot study, IF-PEP was expanded to 24 sessions with 20 manual-driven sessions and four “in the bank” sessions for crisis management. Additional sessions focus on building and refining school and mental health treatment teams, siblings, school planning with school professionals, two on Healthy Habits.

A pilot study of 20 children with BPSD and their parents randomized to IMM or WLC revealed children’s mood symptoms measured on the MSI improved significantly following treatment, and gains were maintained for 12 months after completion of IF-PEP (Fristad, 2006). Expressed emotion scores on the EEAC improved significantly more for IMM families, and non-significant improvement in clinician-rated quality of services utilized was observed (Fristad, 2006). Evaluation of consumer satisfaction
revealed positive evaluations from both parents and children. Parents and children felt they: (1) learned about symptoms and medications for mood disorders and ways to manage symptoms at home and at school; (2) were comfortable with and benefited from their work with the therapist; and (3) benefited from the materials and activities provided.

The expanded 24-session version of IF-PEP was trialed with two families, both of whom showed improvement following treatment. Three out of four mood scales improved from baseline to post-treatment and parental report of the child’s behavior toward family members demonstrated improvement (more positive and less negative interactions following treatment: Leffler, Fristad & Klaus, in press).

**Psychosocial interventions for adolescent bipolar spectrum disorders.** To date, four groups have developed and investigated the efficacy of psychosocial interventions for adolescents with BPSD. These treatments include FFT-A, CBT, Dialectical Behavior Therapy (DBT), and Interpersonal and Social Rhythm Therapy (IPSRT). These psychosocial interventions are designed as adjunctive to pharmacotherapy, and involve psychoeducation, child and parent involvement, and skill building. CBT, DBT, and IPSRT have been investigated in pilot open trials. Only FFT-A has been investigated in an RCT.

**Family-focused treatment for adolescents.** FFT-A (Miklowitz et al., 2008; Miklowitz et al., 2004) was adapted from FFT for adults and is intended as an adjunct to pharmacotherapy. The treatment consists of 20 sessions with a therapist, patient, parents, and siblings. The goals of FFT-A are: to enhance adolescents’ and families’ understanding of bipolar disorder and the risk, maintaining, and protective factors; develop relapse prevention plans; emphasize the importance of mood stabilizing
medications; promote adolescents’ acceptance of the illness alongside his/her strengths and abilities; and promote family environment of lower levels of expressed emotion, conducive to long-term mood stability. These goals are achieved through the three primary components of FFT-A: (1) psychoeducation; (2) communication enhancement training; and (3) problem solving skills training.

In an open trial of 20 adolescents with BPSD who received FFT-A, adolescents experienced an average of 38% improvement in depression symptoms and 46% improvement in manic symptoms on the K-SADS depression (Chambers et al., 1985; Ambrosini, Metz, Prabucki, & Lee, 1989) and mania (Axelson et al., 2003) rating scales at 12-month follow-up, respectively (Miklowitz et al., 2004). Parents also reported significant improvements in problem behavior on the CBCL at 12-month follow-up (Miklowitz et al., 2004).

Miklowitz et al. (2008) evaluated FFT-A in a RCT of 58 adolescents with BPSD. Adolescents were assigned to FFT-A and protocol pharmacotherapy or enhanced care (EC) and pharmacotherapy. Outcome measures included K-SADS mania and depression rating scales and the Adolescent Longitudinal Interval Follow-up Evaluation (A-LIFE; Keller et al., 1987). Results revealed no group differences in rates of recovery from the index episode, however, FFT-A patients recovered from baseline depressive symptoms faster than EC patients (Miklowitz et al., 2008). In addition, there was no difference in time to recurrence of depression or mania, but FFT-A patients spent fewer weeks in acute states of depression than EC patients. FFT-A adolescents also spent more time without symptoms of depression than EC patients, and FFT-A adolescents had greater overall reductions in mood severity scores and a more favorable trajectory of
depressive symptoms over 2 years (Miklowitz et al., 2008). An analysis of treatment moderators revealed parental expressed emotion measured on the Camberwell Family Interview for Expressed Emotion (Vaughn & Leff, 1976) moderated the impact of FFT-A on symptom trajectory in adolescents with BPSD (Miklowitz et al., 2009).

**Cognitive behavioral therapy.** CBT (Danielson, Feeny, Findling, & Youngstrom, 2004) for adolescents aged 11 to 18 with BPSD consists of 12 sessions of acute phase treatment, followed by a maintenance phase of three monthly sessions and biyearly booster sessions. CBT is designed as an adjunct to pharmacotherapy and contains individual therapy, two sessions with parents and child, one session with only parents, and an optional 15 minute parent check-in at the end of every session. Treatment components include: psychoeducation; medication compliance; mood monitoring; anticipating stressors and problem solving; identifying and modifying unhelpful thinking; sleep regulation and relaxation; family communication; and relapse prevention. Optional treatment modules are also available for substance abuse, social skills, anger management, and contingency management. Maintenance and booster sessions are intended for relapse prevention and to work on previously taught skills.

In a pilot study of 12-session acute-phase treatment with CBT, 8 participants with BPSD did not significantly differ from 8 control group participants on interviewer-assessed mood symptoms, (YMRS and Inventory of Depressive Symptoms: Rush et al., 1986) adolescent-reported mood symptoms (General Behavior Inventory: GBI; Depue & Fuhrman, 1987), or parent-reported mood symptoms (GBI: Feeny et al., 2006). However, the small sample size limited the power to detect statistically significant differences. Effect sizes comparing CBT and control group were large for depressive
symptoms and ranged from small to large for manic symptoms when compared following acute treatment and at 8-week follow-up, and when comparing interviewer-assessed, self-reported, and parent-reported symptoms (Feeny et al., 2006).

**Dialectical behavior therapy.** DBT (Goldstein et al., 2007) for adolescents ages 12 to 18 with bipolar disorder was adapted from DBT for adults with borderline personality disorder (Linehan, 1993) and suicidal adolescents (Miller, Rathus, Linehan, & 2007). DBT is designed as an adjunct to pharmacotherapy. Acute treatment consists of 24 one-hour weekly sessions alternating between family skills training and individual therapy. Twelve additional sessions are offered over 6 months, also alternating between family skills training and individual therapy. Family skills training includes: psychoeducation; mindfulness; distress tolerance; emotion regulation; and interpersonal effectiveness. Individual therapy includes: psychoeducation; changing target behaviors; mood charting; mood regulation skills; and problem-solving strategies (including construction of behavioral chain analyses for targeted problems to understand the function of the behavior, identify constructive alternative solutions, and develop techniques for avoiding future problem behaviors). DBT for adolescents with BPSD also contains skills coaching by telephone and diary cards to assess mood, sleep, suicidality, and medication adherence.

In a pilot study of DBT, nine adolescents with BPSD completed 1 year of treatment. Outcome measures included the K-SADS depression rating scale and mania rating scale, Modified Scale for Suicidal Ideation (MSSI: Miller, Norman, Bishop, & Dow, 1986), Children’s Affective Lability Scale (Gerson et al., 1996), and Matson Evaluation of Social Skills with Youngsters (MESSY: Matson, Rotatori, & Helsel, 1983).
Results indicated high consumer satisfaction and improvements in suicidality, non-suicidal self-injurious behaviors, mood dysregulation, and depressive symptoms (Goldstein et al., 2007). There were no significant improvements in manic symptoms or interpersonal functioning and no differences in number of medications prescribed (Goldstein et al., 2007).

**Interpersonal and social rhythm therapy.** IPSRT (Hlastala, Kotler, McClellan, & McCauley, 2010) for adolescents ages 12 to 18 with bipolar disorder was adapted from IPSRT for adults with bipolar disorder (Frank, 2005; Frank et al., 2005), interpersonal psychotherapy for adults with depression (Klerman, Weissman, Rounsaville, & Chevron, 1995), and IPT-A for adolescents with depression (Mufson et al., 1999). IPSRT is designed as an adjunct to pharmacotherapy. Treatment consists of 16 to 18 sessions delivered over 20 weeks. Most sessions are conducted with the adolescent alone; however, parents and other family members participate in two to three family psychoeducation sessions and are encouraged to be involved in additional therapy sessions depending on the cognitive/social developmental level of the adolescent and/or if the interpersonal problem area chosen as the focus of treatment involves interpersonal disputes with parents. IPSRT consists of three essential components: psychoeducation; interpersonal work; and social rhythm/sleep stabilization. The primary treatment targets include: interpersonal stress; medication nonadherence; and circadian rhythm dysregulation. Developmental modifications specific to teens are also included, such as interventions to target school functioning.

In a pilot open trial, 12 adolescents with BPSD participated in 16 to 18 sessions of IPSRT over 20 weeks. Results indicated feasibility and acceptability of IPSRT were
high: 11 of 12 participants completed treatment, 97% of sessions were attended, and adolescent-rated satisfaction scores were high. In addition, participants experienced significant decreases in manic symptoms on the MRS, depressive symptoms on the BDI, and general psychiatric symptoms on the Brief Psychiatric Rating Scale for Children (BPRS-C: Hughes, Rintelmann, Emslie, Lopez, & MacCabe, 2001) over the 20 weeks of treatment. Participants’ global functioning on the CGAS increased significantly as well. Effect sizes ranged from medium to large (Hlastala et al., 2010).

**Summary.** Limited research has examined the development and efficacy of psychosocial treatments for children and adolescents with BPSD. Current psychosocial treatments are considered adjunctive to pharmacotherapy and include child and parent involvement. Treatments containing psychoeducation, cognitive-behavioral techniques, interpersonal techniques, and/or dialectical-behavior techniques show promise. To date, only MF-PEP and IF-PEP for children and FFT-A for adolescents have been examined in RCTs. More research is needed to examine the development and efficacy of psychosocial interventions for youth with BPSD.

**Effectiveness, Transportability, and Dissemination of Evidence-Based Treatments for Childhood and Adolescent Mood Disorders**

Despite the existence of several EBTs for childhood and adolescent mood disorders, evidence suggests that these treatments are not being readily utilized in real-world settings (Weersing & Weisz, 2002). Most outcome research on interventions for child and adolescent mood disorders involves evaluations of efficacy rather than effectiveness, transportability, or dissemination. For childhood DSD, the majority of studies were conducted in schools by the treatment developers or school staff with non-
referred youth with elevated depressive symptoms. For adolescent DSD interventions and youth BPSD treatments, studies were often conducted in highly controlled research or hospital clinics with the treatment developers or highly trained members of the research team with youth meeting diagnostic criteria for a mood disorder. In addition, nearly all of the aforementioned efficacy trials focused predominantly on Caucasian youth. Thus, it is unclear whether findings from these efficacy studies will generalize across populations, settings, and clinician-experience level.

Despite the importance of testing the effectiveness, transportability, and dissemination of EBTs, relatively few studies have examined the implementation of psychosocial interventions for children and adolescents at-risk for developing or diagnosed with DSD in real world settings. To date, no studies have examined the implementation of child and adolescent BPSD interventions in real world settings. Reviewed below are studies examining the effectiveness, transportability, and dissemination of child and adolescent interventions for the prevention and treatment of DSD. Studies were included if the interventions were conducted by personnel not affiliated with the treatment developers or research team, implemented in practice settings, and/or utilized limited inclusion/exclusion criteria.

**Effectiveness and Transportability of Evidence-Based Treatments for Childhood Depressive Spectrum Disorders**

Several studies have examined the effectiveness and transportability of childhood interventions for the prevention and/or treatment of DSD under real-world conditions. Similar to the efficacy literature, most effectiveness and transportability trials for youth DSD have focused on adolescent interventions. In addition, most effectiveness and
transportability trials for children have examined prevention programs or were designed for youth with elevated depressive symptoms, rather than youth meeting diagnostic criteria for DSD. Reviewed below are several effectiveness and transportability trials examining the implementation of these psychosocial treatments under real-world conditions.

**Benchmarking comparison of community psychotherapy versus cognitive-behavioral therapy in efficacy trials.** Benchmarking procedures have been used to evaluate the effectiveness of community psychotherapy for depressed youth relative to EBTs in clinical trials. Weersing and Weisz (2002) compared symptom trajectories of depressed children and adolescents on the CDI treated in community mental health centers to symptom trajectories of youth treated with CBT in efficacy RCTs. Results revealed that treatment offered in community clinics, predominantly psychodynamic or eclectic treatment in this trial, is not as effective as CBT delivered in efficacy trials. Those treated with CBT saw steep declines in depressive symptoms over three months, whereas those treated with community care took one year to achieve the level of symptom improvement obtained by youth treated with CBT, and more closely resembled the trajectory of individuals in the control condition in efficacy trials of CBT (Weersing & Weisz, 2002). Weersing and Weisz (2002) noted the recovery of symptoms after one year may have also followed the natural course and remission rates of depressive episodes in youth (Kovacs, 1996). Also, in the community sample, ethnic minority status and low therapy dosage were related to worse outcomes. However, youth treated in the community who were Caucasian and received a larger dose of therapy still performed more poorly than youth treated with CBT. Though this study did not specifically test the
effectiveness of CBT implemented in community settings, it showed that current
treatment offered in community settings is generally not evidence-based, nor is it as
effective as CBT delivered in efficacy trials.

**Penn prevention program.** Several of the examinations of PPP/PRP can be
considered at least partial effectiveness and transportability studies because they were
conducted in various settings and/or facilitated by school staff or clinicians not part of the
research team. A culturally modified version of PRP, Penn Optimism Program (POP),
was effective for Chinese 8- to 15-year olds deemed “at-risk” for depression due to
elevated depressive symptoms or family conflict (Yu & Seligman, 2002). Treatment was
delivered by school teachers trained and supervised by the research team. Significant
reductions in depression scores on the CDI as well as improved optimistic explanatory
style on the CASQ were noted in the intervention group compared to a no-intervention
control group, with effects maintained at 3- and 6-month follow-up (Yu & Seligman,
significant effects were found for POP ($d$ in the 0.25 to 0.39 range), these were smaller
when compared to studies conducted by the treatment developers (e.g., Cardemil et al.
(2002) found large effects of $d \geq 0.79$; Gillham et al. (1995) found moderate to large
effects of $d \geq 0.57$).

Examinations of PPP in Australia conducted by school psychologists, nurses, or
other school staff who received training from the treatment developers yielded mixed
findings. Quayle, Dzuirawiecz, Roberts, Kane, and Ebsworthy (2001) conducted an RCT
of 47 7th grade girls and found the PPP group showed fewer depressive symptoms and
more positive self-worth compared to the control group at 6-month follow-up. Pattison
and Lynd-Stevenson (2001) conducted an RCT of 63 children aged 9 to 12 years randomly assigned to PPP or control group, and found no group differences post-treatment or at 8-week follow-up of depressive symptoms measured on the CDI or social skills measured on the Matson Evaluation of Social Skills. Roberts, Kane, Thomson, Bishop, and Hart (2003) compared PPP to usual care with 189 11- to 13-year olds with elevated depressive symptoms. Children in both conditions self-reported decreases in depressive symptoms post-treatment on the CDI. PPP also reduced internalizing symptoms via parent-report on the CBCL (Roberts et al., 2003). There were no group differences between self- and parent-report at 3- and 6-month follow-up (Roberts et al., 2003).

Gillham, Hamilton et al. (2006) evaluated the effectiveness of PRP when delivered by therapists in a primary care setting in a partial effectiveness trial. Though treatment was conducted by two child psychologists and one child social worker with 21 to 24 years of experience in the primary care setting, this study was considered a partial effectiveness trial because treatment facilitators received extensive training and supervision by the treatment developers. Two-hundred and seventy-one 11- and 12-year olds with elevated symptoms of depression were randomized to PRP or usual care. Results indicated PRP improved explanatory style for positive events on the CASQ over the 2-year follow-up. In addition, PRP’s effects on depressive symptoms, measured on the CDI, and explanatory style for negative events were moderated by sex, with girls benefiting more than boys. Stronger effects were also observed in groups in which the treatment was implemented with high fidelity. Finally, PRP did not significantly prevent depressive disorders. PRP’s effect on a broader range of disorders (cumulative
percentage of depression, anxiety, and adjustment disorders) was moderated by initial symptom level. A significant preventive effect was found among high-, but not low-, symptom participants for depression, anxiety, and adjustment disorders (when combined). These results indicate that PRP may not be easy to disseminate, or require intensive training. Indeed, the strongest findings for PRP with the largest effect sizes have been produced by the treatment developers and members of their research team (Cardemil et al., 2002; Gillham et al., 1995). Gillham, Hamilton et al. (2006) posited that differences in outcome from efficacy and effectiveness trials of PRP were also likely the result differences in samples, organization, and treatment providers.

Efforts have also been made to examine the effectiveness, transportability, and specificity of PRP by comparison to an active treatment, Penn Enhancement Program (PEP), which controls for nonspecific intervention effects (Gillham et al., 2007). In this study, group leaders were school teachers, school counselors, and graduate students in school psychology, education, and clinical psychology (not affiliated with the research team) who participated in a 30 hour training workshop and biweekly group supervision with the PRP and PEP developers. In this study, 697 middle school children were randomly assigned to PRP, PEP, or no-treatment control. PRP prevented the onset of elevated depressive symptoms measured on the CDI and CDRS-R relative to the no-treatment control but not relative to PEP. PRP did not reduce mean levels of depressive symptoms over the three-year follow-up and did not prevent high or clinical levels of symptoms relative to either comparison group. However, findings varied by school; in two schools PRP significantly reduced depressive symptoms across the follow-up when compared to PEP and control, but not in the third school (Gillham et al., 2007). This
study encountered several realistic and common obstacles in translational research, including: low recruitment rate (i.e., fewer than 25% of students enrolled in the study in each school); substantial attrition; incomplete assessment of clinical depression; and the inclusion of graduate students as group leaders. In addition, the study included all consented children rather than an at-risk sample of children with elevated depressive symptoms (Gillham et al., 2007). Nevertheless, the current study did not illustrate specificity or effectiveness of PRP.

**Primary and secondary control enhancement training.** Weisz et al. (2009) investigated the effectiveness and transportability of the CBT-based PASCET program versus usual clinical care (UC) for 57 youth aged 8 to 15 with DSD. Community clinic therapists were also used, and were randomized to brief training and supervision in CBT for youth depression or UC. Youth were randomized to CBT or UC and treated until normal termination. Treatment was delivered by community social work, master’s level, or doctoral level therapists in outpatient mental health clinics. Outcome measures included the Diagnostic Interview Schedule for Children (DISC: Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000), CDI, CDI-Parent Form (Kazdin, French, & Unis, 1983; Wierzbicki, 1987), CBCL, Expectations of Therapy Outcome Scale (ETOS: Bonner & Everett, 1982, 1986), Therapeutic Alliance Scale for Children (TASC: Shirk & Saiz, 1992), and SACA. Results indicated more use of CBT by CBT therapists and more psychodynamic and family approaches by UC therapists. At post-treatment, depressive symptoms in both groups were at subclinical levels, and 75% of youths had no remaining depressive disorders, however, CBT and UC groups did not differ. Despite this lack of difference, CBT was briefer (24 vs. 39 weeks), superior in parent-rated therapeutic
alliance, less likely to require additional services (including all psychotropics combined and depression medication in particular), and less costly. Weisz et al. (2009) posited that PASCET also led to faster speed of improvement. Although efficacy investigations of PASCET have yielded group differences between PASCET groups and control groups, this transportability trial illustrated that an EBT can be implemented in a real-world setting, and emphasized the consideration of sample characteristics, training, and level of skill of therapists. Weisz et al. (2009) also noted that the longer length of treatment for UC coincided with natural rates of remission of depressive episodes in youth. Thus, PASCET’s superiority in parent engagement, reduced use of medication and other services, overall cost, and possible speed of improvement over UC are promising results for the effectiveness and transportability of CBT-based programs in real-world settings.

**Systems integrative family therapy versus focused individual psychodynamic psychotherapy.** Trowell et al. (2007) conducted a RCT of 72 9- to 15-year olds meeting diagnostic criteria for DSD. Youth were randomized to SIFT or FIPP in community and hospital clinics. Treatment was delivered by individual and family therapists trained by the program developers. Children in both groups showed significant improvements in self-reported depressive symptoms on the CDI and Moods and Feelings Questionnaire (MDQ: Trowell et al., 2007) and clinician-rated functioning on the CGAS. Post-treatment, 75.7% of SIFT youth and 74.3% of FIPP youth were no longer clinically depressed. SIFT youth reported significantly better improvement on the CDI and MFQ compared to FIPP youth, however, there were no group differences on clinician-rated measures. At 6-month follow-up both groups continued to show improvements on all measures, and there were no group differences between measures (Trowell et al., 2007).
Summary. Several studies have examined the effectiveness and transportability of childhood interventions for the prevention and/or treatment of DSD in real-world settings. A benchmarking investigation revealed current community psychotherapy is often not evidence-based and produces lower treatment effects than CBT delivered in efficacy trials. Studies examining the effectiveness of PPP implemented in various settings and by various individuals yielded mixed results. Treatment effects were often larger when PPP was implemented by the treatment developers, as in the efficacy trials, or in high fidelity groups. An examination of PASCET implemented in an outpatient setting by community therapists yielded no group differences compared to UC, however, PASCET resulted in improved parent engagement, reduced use of medication and other services, reduced overall cost, and possible speed of improvement over UC. An examination of SIFT and FIPP implemented in community and hospital clinics by trained therapists yielded positive results for SIFT. However, SIFT is still deemed an experimental treatment, as this is the only RCT that has investigated its treatment effects. Thus, while some effectiveness and transportability trials show promise, most have involved prevention programs or were for youth with elevated depressive symptoms, and yielded mixed findings. Similar to the efficacy literature, no effectiveness trials have focused exclusively on the treatment of diagnosed depression in children 12 years and younger. Overall, these treatments appear to be more effective when delivered under the controlled conditions of efficacy trials.
Effectiveness and Transportability of Evidence-Based Treatments for Adolescent Depressive Spectrum Disorders

Several studies have examined the effectiveness and transportability of adolescent interventions for the prevention and/or treatment of DSD in real-world settings. More research has been devoted to the examination of effective adolescent interventions than child interventions in the DSD literature. In addition, most effectiveness and transportability trials for adolescents have included youth meeting diagnostic criteria for DSD, unlike effectiveness and transportability trials for children, which have included mostly youth with elevated depressive symptoms. Reviewed below are several effectiveness and transportability trials examining the implementation of psychosocial treatments under real-world conditions.

Benchmarking comparisons of cognitive-behavioral therapy. Several studies have used benchmarking techniques to compare CBT in efficacy versus effectiveness trials. Weersing, Iyengar, Kolko, Birmaher, & Brent (2006) examined the effectiveness of CBT for adolescent depression by comparing outcomes of 80 youth treated with CBT in an outpatient depression specialty clinic, the Services for Teens at Risk Center (STAR) to a gold standard CBT research benchmark (Brent et al., 1997). Results indicated youth treated with CBT in STAR experienced significant symptom improvement on the BDI, however, this symptom improvement was also significantly slower than youth in the CBT benchmark. Outcomes for STAR youth were more similar to the research benchmark when accounting for differences in referral source (i.e., clinical versus advertisement) between the datasets. Those treated at STAR were referred from other mental health providers, schools, or discharged from inpatient hospitalizations, whereas a third of those
treated in the RCT were largely recruited via newspaper advertisement. Analyses revealed STAR symptom trajectories more closely resembled those of clinically referred RCT youth.

Shirk, Kaplinski, and Gudmundsen (2009) utilized benchmarking strategies to examine school-based CBT for adolescent depression delivered in health clinics and counseling centers in four high schools. Outcomes were compared to a benchmark from prior efficacy studies of CBT. Fifty adolescents diagnosed with DSD were treated by eight doctoral-level psychologists who followed a manual-guided, 12-session, individual CBT protocol. Post-treatment response to CBT, measured as no longer meeting diagnostic criteria for a depressive disorder, was 64%, which was comparable to results obtained in efficacy trials. Symptom reduction on the BDI was similar to prior efficacy trials. In addition, symptom reduction exceeded results from an efficacy trial using the original manual (i.e., Reynolds & Coats, 1986) and exceeded results from a prior school-based CBT trial (i.e., Brent et al., 1997). Also, life stress, trauma history, and symptom severity were negatively associated with outcome.

**Coping with depression-adolescent.** Several examinations of CWD-A can be considered at least partial effectiveness studies because they were conducted in various settings and/or facilitated by school staff or clinicians not part of the research team. Clarke et al. (1995) conducted a school-based intervention study with 150 at-risk adolescents with elevated depressive symptoms on the CES-D and the K-SADS. Youth were randomly assigned to CWD-A or usual care. Treatment was facilitated by trained school psychologists and counselors who had a minimum of a master’s degree in either clinical, counseling, or educational psychology, and previous experience in conducting
psychoeductional groups with adolescents. Treatment facilitators also received training from the treatment developers. Youth receiving CWD-A showed greater improvements in depressive symptoms on CES-D and global functioning post-treatment, but between group differences were lessened at the 12-month follow-up. Nevertheless, there were significantly fewer cases of depressive diagnoses in the CWD-A group than usual care at 12-month follow-up (Clarke et al., 1995).

Clarke et al. (2001) compared CWD-A with parent component plus health maintenance organization (HMO) care versus usual HMO care in a HMO setting. This RCT included 94 at-risk adolescents ages 13 to 18. Adolescents were deemed at-risk if they had a depressed parent and elevated depressive symptoms. Treatment was facilitated by master’s-level therapists trained in the intervention. Results indicated the CWD-A plus HMO care group showed greater improvements in psychological functioning and self- and interviewer-reported depression on the CES-D and K-SADS, but not parent-reported symptoms on the CBCL. According to blinded assessors, all of whom had a master’s degree in psychology, CWD-A youth endorsed significantly fewer suicide items and had better global functioning. At the 12-month follow-up, there were significantly fewer cases of depressive disorders for youth who received CWD-A as compared to youth who received usual HMO care, with results maintained, but at declining levels, through the 18- and 24-month follow-ups (Clarke et al., 2001).

Clarke et al. (2002) conducted a RCT of CWD-A for adolescents meeting diagnostic criteria for DSD and who had a depressed parent in a HMO. Eighty-eight adolescents aged 13 to 18 with DSD were randomized to HMO usual care or HMO usual care plus CWD-A. Intent-to-treat analyses revealed no significant advantage of the CBT
program over usual care on any outcome measures (i.e., depression diagnoses on the K-SADS, continuous measures of depression on the CES-D and HAM-D, non-affective measures on the CBCL, or functioning outcomes on the GAF). Of note, this is the only study of CWD-A that has not found the treatment to be beneficial. Clarke et al. (2002) posited the lack of difference was likely due to effectiveness, rather than efficacy, qualities of the study, such as being conducted in the context of a large HMO, permitting comorbidities, and comparing CWD-A to usual care at the HMO (an active treatment). Clarke et al. (2002) recommended a more aggressive treatment approach, such as combined antidepressant medication and psychotherapy for this population.

In a partial effectiveness trial of CWD-A, Rohde et al. (2004) evaluated 93 adolescents ages 13 to 17 with MDD and conduct disorder. Adolescents were recruited from a county juvenile justice department and randomly assigned to CWD-A or a life skills/tutoring control. CWD-A was delivered in a research clinic by therapists with at least a master’s degree in the mental health field and trained in CWD-A and high school student assistants. The Life Skills/Tutoring control was facilitated by high school teachers and adult assistants. Results indicated MDD recovery rates were greater in CWD-A (39%) compared with the control condition (19%) at post-treatment. Post-treatment, CWD-A participants also reported greater reductions in depressive symptoms, as measured on the BDI-II (Beck, Steer, & Brown, 1996), HAM-D, and LIFE, and improved social functioning, as measured on the CGAS and Social Adjustment Scale—Self-report for Youth (Weissman, Orvaschel, & Padian, 1980). However, differences between the two groups in conduct disorders were not apparent post-treatment or through follow-up, and MDD recovery rates at 6- and 12-month follow-ups were not significant.
This trial was designed only as a partial effectiveness study. Researchers utilized minimal exclusion criteria, patients were referred from real-world settings, and patients were allowed to receive treatment as usual. However, treatment was provided by well-trained therapists and patients were randomly assigned to treatment. Nevertheless, this study provided important findings, and suggested CWD-A, which had previously been examined mainly in highly controlled research settings, could effectively treat MDD when delivered under less stringent conditions.

Garber et al. (2009) conducted a multicenter RCT of a Cognitive-Behavioral (CB) Prevention Program, based largely on CWD-A conducted in two previous trials (Clarke et al., 1995; Clarke et al., 2001) which consisted of 8 weekly and 6 monthly adolescent group sessions and two parent meetings. Three-hundred and sixteen youth aged 13 to 17 years who had a parent with a current or past depressive disorder and a past history of depression or current elevated depressive symptoms, or both, were randomized to the CB prevention program or usual care. The study was conducted at four sites (i.e., Vanderbilt University in Nashville, TN; University of Pittsburgh in Pittsburgh, PA; Kaiser Permanente Center for Health Research in Portland, OR; and Judge Baker Children’s Center/Children’s Hospital in Boston, MA). Treatment was delivered by therapists with at least a master’s degree in the mental health field who were trained and supervised by experienced clinicians. Results indicated youth receiving the CB prevention program showed a lower rate of depressive episodes than those receiving usual care, measured by the K-SADS, LIFE, and CDRS-R. Adolescents in the CB prevention program also showed significantly greater improvement in self-reported depressive symptoms on the CES-D than those in usual care. Parental depression at baseline acted as a treatment
moderator. Among adolescents whose parents were not depressed at baseline, the CB prevention program was more effective in preventing onset of depression than usual care. However, for adolescents with a depressed parent at baseline, the intervention was not more effective than usual care in preventing depression (Garber et al., 2009).

**Cognitive-behavioral therapy enhanced primary care services.** Asarnow et al. (2005) evaluated the effectiveness and transportability of a quality improvement intervention aimed at increasing access to EBTs for depression (i.e., CBT and antidepressant medication) relative to usual care among adolescents in primary care settings. The CBT used in this study was based on CWD-A. Four-hundred and eighteen primary care patients ages 13 to 21 with elevated depressive symptoms from five health care organizations (including managed care, public sector, and academic medical center clinics) were randomized to usual care or 6-month quality improvement intervention, which included expert leader teams at each site that adapted and implemented the intervention, care managers who supported primary care clinicians in evaluating and managing patients’ depression, training for care managers in manualized CBT for depression, and patient and clinician choice regarding treatment modality (CBT, medication, combined CBT and medication, care manager follow-up, or referral). Care managers were psychotherapists with master’s or PhD degrees in a mental health field or nursing who received training and regular consultation in the study, delivery, and evaluation of CBT. Participating clinicians also received education regarding depression evaluation, management, and pharmacological and psychosocial treatment. Results indicated participants receiving the quality improvement intervention reported significantly fewer depressive symptoms on the CES-D, higher mental health related
quality of life, greater satisfaction with mental health care, and higher rates of mental healthcare and psychotherapy and counseling when compared to patients receiving usual care. Asarnow et al. (2005) noted that although effect sizes were small compared to highly controlled efficacy trials of specific interventions for youth depression, the study had important implications for what can be added to primary care settings to increase access to EBTs, and can result in improved depressive symptoms, quality of life, and satisfaction with mental health care.

In an evaluation of the long-term effects of this quality improvement program, results revealed the quality improvement intervention lowered the likelihood of severe depression at 6 months, with a similar trend as 18-month follow-up that was not statistically different from the usual care group (Asarnow et al., 2009). However, over the 18-month follow-up period, Asarnow et al. (2009) noted a significant indirect intervention effect on rates of severe depression, depressive symptoms, and mental health-related quality of life due to the initial intervention improvement observed at 6-months. Thus, positive and lasting results can be obtained from a quality improvement intervention implemented in primary care settings.

Other cognitive-behavioral therapy programs. Several other studies have investigated the effectiveness and transportability of CBT conducted in various settings and/or facilitated by school staff or clinicians not part of a research team. Kerfoot, Harrington, Harrington, Rogers, and Verduyn (2004) examined the effectiveness and transportability of brief CBT delivered by trained social workers versus routine care. In this study, 86 social workers were randomized to receive training in brief CBT or delayed training by remote telephone randomization. Results indicated social workers’
perceptions of their knowledge and skills in dealing with adolescent depression were better after the training than before. However, intention to treat analyses revealed adolescents who received the brief CBT had similar levels of depression post-treatment as those receiving routine care on the Mood and Feelings Questionnaire (Angold, Costello, Messer, & Pickles 1995). There were also no significant differences between the groups on other outcomes on the K-SADS or The Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA: Gowers et al., 1999) post-treatment or at follow-up. The authors noted the small sample size limited the power of their study and thus their ability to detect statistically significant differences, and also noted a severely impaired sample. Nevertheless, training in CBT did not result in differences in symptom severity between the two groups.

Kowalenko et al. (2005) evaluated the effectiveness of the Adolescents Coping with Emotions (ACE) program with 82 females aged 13 to 16 with elevated depressive symptoms. The ACE program is an 8-week, early intervention, group-based program which aims to build resilience and increase positive coping in youth using psychoeducational, cognitive-behavioral, and interpersonal techniques. Females were randomized to receive ACE or WLC. ACE was conducted in a school setting and delivered by a school counselor and community adolescent mental health worker trained and supervised by the program developer. Following treatment, ACE females had significantly lower depression scores on the CDI and improved coping scores on the General Short Form of the Adolescent Coping Scale (ACS: Frydenberg & Lewis, 1993) compared with WLC females. ACE females were also significantly less likely to be above clinical cutoff on CDI (score of 20 and above) than WLC females. Positive results
for ACE were maintained through 6-month follow-up, though they could not be compared to control group, who had subsequently received treatment (Kowalenko et al., 2005).

Crisp, Gudmundsen, and Shirk (2006) described a study called the Adolescent Mood Project, which investigated the transport of CBT for adolescent depression from the university setting to a school-based setting. Preliminary results from the open trial revealed all adolescents’ BDI scores decreased, with an average reduction of 22 points. Of the 20 individuals for whom post-treatment data was available, 15 no longer met criteria for a depressive disorder. The project also received positive feedback from school personnel, administrators, research therapists, and participants.

Sheffield et al. (2006) conducted a cluster, stratified, randomized trial of CBT-based universal and indicated depression prevention programs for 2,479 youth aged 13 to 15 years, of whom 521 were deemed at-risk based on elevated depressive symptoms. Conditions consisted of: (1) a universal intervention delivered by teachers on a whole-classroom basis (i.e., at-risk students plus their class peers); (2) an indicated intervention delivered by trained school counselors or community or mental health professionals to at-risk students; (3) universal intervention followed by indicated intervention for at-risk students; and (4) a no intervention control condition containing at-risk students and their class peers. Outcome measures included the CDI, CES-D, Beck Hopelessness Scale (BHS: Beck, Steer, & Ranieri, 1988), Anxiety Disorders Interview Schedule for Children (ADIS-C: Silverman & Albano, 1996), LIFE, Spence Children’s Anxiety Scale (SCAS: Spence, 1998), Social Problem-Solving Inventory –Revised (SPSI-R: D’Zurilla, Nezu, & Maydeu-Olivares, 1997), Children’s Automatic Thoughts Scale (CATS: Schniering &
Rapee, 2002), and Child and Adolescent Social and Adaptive Functioning Scale (CASAFS: Price, Spence, Sheffield, & Donovan, 2002). Results indicated none of the intervention approaches differed significantly from the no intervention control or from each other on changes in depressive symptoms, anxiety symptoms, externalizing problems, coping skills, and social adjustment. All at-risk students showed a significant decline in depressive symptoms and improvement in emotional well-being over time, although they still demonstrated elevated levels of psychopathology compared with the general population of peers at 12-month follow-up. There were also no significant intervention effects for the universal intervention in comparison with no intervention for the total sample of students in those conditions (Sheffield et al., 2006).

**Cognitive-behavioral therapy plus antidepressant medication.** Many trials examining CBT plus antidepressant medication can be considered hybrid efficacy-effectiveness trials because most were conducted in practice settings with interventions administered by clinicians or therapists not affiliated with the treatment developers or research team, and/or utilized limited inclusion/exclusion criteria. However, treatment facilitators often received extensive training and supervision from the treatment developers.

The TADS team (2004) examined 439 12- to 17-year olds with MDD randomized to CBT alone plus two parent-only sessions, fluoxetine alone (10 mg to 40 mg daily), CBT plus fluoxetine, and placebo (same dosages as fluoxetine plus monitoring). The medication condition was double-blind (i.e., placebo or fluoxetine) whereas the psychotherapy condition was not (i.e., CBT alone or in combination with fluoxetine). Interventions were delivered at 13 U.S. academic and community clinics. Treatment was
delivered by adolescent psychiatrists and CBT therapists trained and supervised by the program developers. Results indicated the combined CBT plus fluoxetine intervention was more effective than placebo, fluoxetine alone, or CBT alone in reducing depressive symptoms and overall psychological difficulties according to clinician ratings on the CDRS-R and CGI. Suicidal ideation improved significantly in all four conditions, however, combined treatment was superior to other conditions in reducing youth-reported suicidal ideation on The Suicidal Ideation Questionnaire-Junior High School Version (SIQ-Jr: Reynolds, 1987). Also, fluoxetine alone was found to be superior to CBT alone (TADS Team, 2004). Long-term effectiveness across 36 weeks of randomized treatment revealed a significant time X treatment interaction (TADS Team, 2007). Rates of response were: 73% for combined treatment, 62% for fluoxetine alone, and 48% for CBT alone at week 12; 85% for combined treatment, 69% for fluoxetine alone, and 65% for CBT alone at week 18; and 86% for combined treatment, 81% for fluoxetine alone, and 81% for CBT alone at week 36. Suicidal ideation decreased with treatment, but less so with fluoxetine alone than with combination treatment. Suicidal events were more common in patients receiving fluoxetine than combination therapy or CBT. The authors concluded in adolescents with moderate to severe depression, treatment with fluoxetine alone or in combination with CBT accelerates the response, and adding CBT to medication enhances the safety of the medication (TADS Team, 2007). Combined treatment was still recommended as superior to either fluoxetine or CBT alone for the treatment of MDD in adolescents (TADS Team, 2007). Results from a one year naturalistic follow-up study revealed the benefits seen at the end of active treatment at
week 36 persisted during follow-up on all measures of depression and suicidality (TADS Team, 2009).

Clarke et al. (2005) tested a collaborative-care, brief CBT program, based on CWD-A, adjunctive to selective-serotonin reuptake inhibitor (SSRI) treatment in an HMO pediatric primary care clinic. One-hundred and fifty-two adolescents aged 12 to 18 with MDD were randomized to TAU or TAU plus brief CBT. In both groups, TAU consisted primarily of SSRI medication delivered outside of the experimental protocol. Brief CBT was facilitated by trained master’s-level therapists. TAU was provided by the HMO and/or outside providers. Through 1-year follow-up, CBT was advantageous in terms of general health perceptions, reductions in TAU outpatient visits, and days’ supply of all medications. However, no effects were detected for MDD recovery between the two groups. Only one non-significant trend on the CES-D was found to favor CBT. This trial showed the importance of length of treatment, and indicated a brief version of CBT delivered in an HMO setting may not add much benefit to well-delivered SSRI treatment (Clarke et al., 2005).

Melvin et al. (2006) examined CBT and antidepressant medication (i.e., sertraline) in the treatment of adolescent DSD. Seventy-three 12- to 18-year olds diagnosed with DSD were randomly assigned to CBT, antidepressant medication alone, and combined CBT plus antidepressant medication. The interventions were conducted at three community-based clinics and delivered by registered psychologists, a supervised probationary psychologist, general medical practitioners, and a social worker with 1 to 5 years experience in providing CBT for adolescent depression. Treatment facilitators received supervision with an expert therapist and peer supervision. Following acute-
treatment all treatment groups demonstrated statistically significant improvements in depressive diagnosis on the K-SADS, depressive symptoms on the Reynolds Depression Scale (Reynolds, 1986; Reynolds & Mazza, 1998), anxiety symptoms on the RCMAS, and suicidal ideation on the Suicidal Ideation Questionnaire (Reynolds, 1988). Improvements were maintained at 6-month follow-up. In contrast to the TADS study, Melvin et al. (2006) found combined CBT plus antidepressant medication was not superior to either treatment alone. Compared with antidepressant medication alone, adolescents receiving CBT demonstrated a superior acute treatment response. However, Melvin et al. (2006) noted the superiority of CBT may be a result of the low dose of sertraline used (i.e., 25mg to 100mg).

Goodyer et al. (2007) examined selective serotonin reuptake inhibitors (SSRIs), CBT, and clinical care versus SSRIs plus clinical care alone. Two-hundred and eight adolescents aged 11 to 17 years with moderate to severe DSD who had not responded to a brief initial intervention were randomized to receive an SSRI and routine care or SSRI, CBT, and routine care. The primary SSRI used was fluoxetine, with other SSRIs allowed, with doses ranging from 10mg to 60mg daily. Interventions were delivered by psychiatrists and therapists trained and experienced with CBT at outpatient mental health clinics. Outcome measures included the K-SADS, HoNOSCA, Mood and Feelings Questionnaire (Wood, Kroll, Moore, & Harrington, 1995), CDRS-R, CGAS, and CGI. Results indicated both groups showed improvement in depression, mood, functioning and suicidality. There was no significant advantage of CBT plus SSRI over SSRI care according to youth- and parent-reports (Goodyer et al., 2007)
**Interpersonal psychotherapy for adolescents.** Mufson et al. (2004) evaluated the effectiveness of IPT-A facilitated by school-based social workers and doctoral-level psychologists versus TAU delivered in a school-based health clinic. Sixty-three adolescents aged 12 to 18 years with DSD were randomized to receive IPT-A or TAU. Results indicated adolescents treated with IPT-A compared with TAU showed greater symptom reduction and improvement in overall functioning. Youth treated with IPT-A showed significantly fewer clinician-reported depression symptoms on the HAM-D, significantly better functioning on the CGAS, significantly better overall social functioning on the SAS-SR, significantly greater clinical improvement, and significantly greater decrease in clinical severity on the Clinical Global Impressions Scale. The larger treatment effects occurred in older and more severely depressed adolescents. This study demonstrated that an EBT could successfully be conducted in a school-based clinic with trained therapists.

**Summary.** Several studies have examined the effectiveness and transportability of adolescent interventions for the prevention and/or treatment of DSD in real-world settings. Benchmarking investigations revealed CBT delivered in school settings and an outpatient clinic yielded results comparable to efficacy trials, though overall symptom improvement in the outpatient clinic was slower than in efficacy trials of CBT, and clinically referred youth in the benchmark more closely resembled the symptom trajectories of those treated in the outpatient clinic. Studies examining the effectiveness of CWD-A implemented in various settings (e.g., schools, HMOs, outpatient clinics) and by various individuals (e.g., school staff, community therapists) for youth with elevated depressive symptoms and/or diagnosed with DSD yielded generally positive results.
Only one trial (Clarke et al., 2002) conducted in an HMO setting for youth with DSD failed to find a treatment effect. A CBT-based enhanced primary care model implemented at primary care settings yielded positive acute and follow-up treatment effects, however, effect sizes were smaller than those found in efficacy trials of CBT for depressed youth. Implementation of other CBT programs in various settings and by various individuals yielded mixed results. Trials examining CBT plus antidepressant medication have found positive effects for combined interventions, CBT alone, and antidepressant medications alone. Finally, a study examining the effectiveness of IPT-A delivered in a school-based setting also yielded positive results.

Thus, a considerable amount of research has yielded generally positive results for adolescent DSD interventions implemented in real-world settings. Much more research has examined the effectiveness and transportability of adolescent interventions than child interventions for elevated depressive symptoms and DSD. Unlike the child effectiveness and transportability studies, which have included mainly youth with elevated depressive symptoms, many adolescent effectiveness and transportability studies have included youth diagnosed with DSD. Although results from effectiveness and transportability trials of adolescent DSD interventions appear promising, more research is needed to investigate elements necessary in the successful transport and implementation of these EBTs in real-world settings, as treatment effects are often larger when delivered under the controlled conditions of efficacy trials.
Dissemination of Evidence-Based Treatments for Childhood and Adolescent Depressive Spectrum Disorders

Several initiates have examined the wide-spread dissemination of EBTs for youth with DSD. Two examples include the overhaul of mental health services for youth in the state of Hawaii and the Child System and Evaluation Treatment Enhancement Projects (Child STEPS). The state of Hawaii has implemented significant changes in the delivery of mental healthcare for children (Chorpita et al., 2002). In 1994, the State of Hawaii settled a class action lawsuit brought before Federal Court on behalf of children with special needs, which resulted in The Felix Consent Decree. The Felix Consent Decree required the State of Hawaii to provide sufficient services for children with mental health problems. The state of Hawaii agreed to develop a coordinated and comprehensive system of care for students ages 0 to 20 with mental health needs. The initial stages of the consent decree involved the development of services necessary to meet the growing population need. The state of Hawaii altered its approach to obtaining professional mental health services by contracting directly with private agencies specifically to address children’s mental health issues.

Subsequent initiatives of the consent decree involved increased attention to the quality of the services offered. Efforts involved improving the technology available to existing providers, providing a feedback loop about performance and outcomes, and implementing new and empirically-supported approaches to specific mental health challenges. These initiatives lead to the development of: a full-time service testing team to monitor the effects of service delivery; a dedicated training organization for clinicians; a child research, assessment, and treatment center cosponsored by the University of
Hawaii, the Department of Health, and the National Institutes of Mental Health; statewide implementation of Multisystemic Therapy for delinquent youth (Henggeler, 1999); and a school based-mental health delivery system on the island of Kauai (Chorpita et al., 2002). To improve the technology of services delivered within the mental health system, the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health established the CAMHD Empirical Basis to Services (EBS) Task Force in October 1999 to conduct a multidisciplinary evaluation of psychosocial treatments for common disorders in youth based on literature reviews, similar to efforts by APA’s Division 12 (Chorpita et al., 2002). The EBS Task Force reviewed empirical literature pertaining to the efficacy and effectiveness of treatments for anxiety disorders, ADHD, autistic and related disorders, depression, conduct disorder, and oppositional disorders. Following their review, the EBS Task Force recommended particular treatments for specific disorders based on empirical support.

Other initiatives in the state of Hawaii have included the development of mechanisms for case and system review based on current scientific knowledge (e.g., The Distillation and Matching Model; Chorpita et al., 2005), data-driven quality improvement procedures regarding evidence-based clinical decision making using causal mechanism research, general services research, local aggregate evidence, case-specific historical information (Daleiden & Chorpita, 2005), and routing reports about system functioning (e.g., Daleiden, Lee & Tolman, 2004; Daleiden & Tolman, 2005). The evidence-based clinical decision making model draws from the traditional individualized case conceptualization model (Daleiden & Chorpita, 2005). The model suggests an order to the decision making structure such that practice strategies be reviewed in the absence of
clinical progress. Thus, individual case results serve as the primary evidence-base, after which the larger evidence-base of the scientific literature is consulted. The model helped to establish accountability and verifiable results in treatment. EBP is seen as one set of tools to assist practitioners in their efforts to demonstrate success. The State of Hawaii has also implemented Research Evaluation and Training (RET) Programs, a health science and service learning partnership between the State of Hawaii and the University of Hawaii, with a goal to provide leadership on systems of care research and evaluation, create service-learning opportunities in behavioral health research and evaluation, and provide leadership and support for scientific literacy and data-driven decision making within CAMHD and across other child serving agencies (Chorpita & Mueller, 2008). Examination and reorganization of Hawaii’s services for youth with mental health problems is ongoing. Results thus far are promising and may serve as a model for future large-scale dissemination initiatives.

The MacArthur Foundation Research Network on Youth Mental Health recently initiated Child STEPS, which consists of sponsored activities and initiatives designed to evaluate and improve effective mental health delivery for children (J. R. Weisz, Ph.D., primary investigator—see www.childsteps.org/). Projects include four endeavors: (1) the Scientific Review; (2) the Clinic Systems Project; (3) the Clinic Treatment Project; and (4) the Dissemination and Implementation Study. The Scientific Review researches and reviews evidence for the strongest treatment approaches. The Clinic Systems Project involves a descriptive study of a sample of community mental health clinics serving a representative sample of counties in the U.S. across 38 states to assess service system and service provider organization characteristics pertinent to the adoption and implementation
of EBP (Schoenwald, Kelleher, Weisz, & The Research Network on Youth Mental Health, 2008). The Clinic Treatment Project focuses on children ages 8 to 13 referred to community-based mental health agencies for disruptive conduct, depression, anxiety, or combination in seven agencies in Honolulu, Hawaii and Boston, Massachusetts. Children are assigned to standard treatment or EBTs from the aforementioned Scientific Review. EBTs are tested in standard manual form using a full treatment manual or in modular manual form in which therapists learn all components of EBTs but individualize the use of components for each child using a guiding clinical algorithm. In the Clinic Treatment Project, client- and service-level outcomes are examined. Finally, The Dissemination and Implementation study qualitatively examines experiences associated with learning and applying EBP among participants and agencies in The Clinic Treatment Project, examines the impact of new procedures, and addresses barriers to translational research. Child STEPS projects are currently ongoing.

**Summary**

Despite urges from various government agencies, healthcare policymakers, and professional organizations, relatively little research has examined the effectiveness, transportability, and dissemination of EBTs. Historically, developments in EBTs, EBP, and translational research for youth have progressed slower than advances in adult literature. Although various models of dissemination and influential movements in the field of psychology have initiated progress in translational research, this area remains understudied, especially in the realm of childhood and adolescent disorders.

Childhood and adolescent mood disorders are significant public health concerns due to their prevalence and potential devastation on current and future functioning.
Though progress has been made in the development and evaluation of efficacy, effectiveness, transportability, and dissemination of interventions for youth DSD, the majority of these studies investigated adolescent DSD. Those studies including children primarily consisted of prevention programs for youth with elevated depressive symptoms. Also, no intervention has focused exclusively on the treatment of diagnosed depression in youth 12 years and younger.

To date, only six groups have investigated psychosocial interventions for childhood and adolescent BPSD, and of those only two groups have developed three interventions for children with BPSD. Of those three treatments for children, only IF-PEP and MF-PEP have been examined in RCTs. No studies to date have examined the implementation of psychosocial treatments for youth BPSD in real-world settings.

Thus, despite progress in the development and evaluation of EBTs for youth with mood disorders, studies examining the efficacy of interventions exclusively for children ages 12 and under meeting diagnostic criteria for DSD are nonexistent and for children with BPSD are relatively rare when compared to studies examining adolescent depression interventions. Similarly, few studies have examined the translation of childhood DSD interventions implemented in real-world settings when compared to translational research for adolescent DSD interventions, and none have examined the implementation of childhood or adolescent BPSD interventions.

Studies examining the efficacy, effectiveness, and transportability of interventions for youth mood disorders often contain pragmatic limitations concerning the amount of therapist training and supervision provided along with expectations of clientele. For example, most interventions in the DSD literature for children are preventative and
designed for children with elevated depressive symptoms or at-risk for DSD. However, youth without a diagnosis of DSD and only elevated depressive symptoms and their families would likely not commit to a weekly intervention, and reimbursement from insurance companies without a diagnosis would be extremely difficult to obtain. In addition, implementation of these interventions in school settings would likely prove difficult, as teachers or counselors would have to take on the added responsibility of training in and implementation of an intervention, in addition to their already busy schedules. Also, most efficacy studies and many of the effectiveness trials provided extensive therapist training and supervision, which would likely not be provided in a practice setting due to time and fiscal constraints. Finally, most youth receiving treatment in practice settings are clinically referred rather than recruited via advertisement; representing a different population and potentially more severe psychopathology. Thus, these pragmatic limitations must be considered and addressed when aiming to transport and implement efficacious treatments to real-world settings.

**Purpose of the Present Study**

This pilot effectiveness and transportability trial examined the feasibility and effectiveness of MF-PEP, an EBT for children ages 8 to 12 with DSD and/or BPSD, when implemented under real-world conditions. This trial was conducted in practice settings with community therapists with variable training and heavy caseloads and with clinically-referred youth. Pragmatic limitations of transporting EBTs out of highly controlled research conditions were assessed. In addition, analyses examined whether MF-PEP can be implemented in a practice setting with beneficial results for children and families. Results from this trial will be used to alter and improve training in, ongoing
supervision of, and implementation of MF-PEP to enhance its transportability to practice settings, and also lay the groundwork for undertaking future effectiveness investigations of MF-PEP on a larger scale.

The current study investigated the effectiveness and transportability of MF-PEP in a pilot implementation at two local community children’s behavioral health clinics. Data were collected from: (1) parents and children pre- and post-treatment; (2) community therapists who received training in and facilitated MF-PEP following each group session; and (3) community therapists who referred families to participate in MF-PEP following the families’ completion of MF-PEP.

Goals of the current study were to: (1) examine the effect of MF-PEP on parental knowledge of mood disorders, child and parent treatment beliefs, and child mood symptom severity; (2) examine consumer satisfaction with MF-PEP from parents and children; (3) examine provider satisfaction with MF-PEP from MF-PEP therapists and referring therapists; and (4) examine the financial feasibility of MF-PEP.

Eight MF-PEP groups were conducted at two Close to Home Behavioral Health Centers: four at the Westerville site and four at the Reynoldsburg site. Each group had a recruitment goal of up to eight children and at least one corresponding parent, at least three MF-PEP therapists (one therapist to facilitate the parent group and two therapists to facilitate the child group), and up to eight referring therapists. MF-PEP therapists could facilitate more than one group, and referring therapists could refer more than one family to participate in MF-PEP. Forty children aged 8 to 12 years with any mood diagnosis (DSD or BPSD) and their parents were recruited to participate in MF-PEP. Fifteen community therapists were recruited to receive training in MF-PEP and facilitate MF-
PEP. Twenty community therapists self-selected to refer families to participate in MF-PEP and subsequently agreed to complete a questionnaire regarding families’ participation in MF-PEP and their satisfaction with the treatment.

Parents and children completed self-report questionnaires pre- and post-treatment. MF-PEP therapists completed self-report questionnaires following each of eight MF-PEP sessions. Referring therapists completed one questionnaire following the families’ completion of MF-PEP.

I explored the following hypotheses for this open trial examining pilot implementation, effectiveness, and transportability of MF-PEP on parental knowledge, child and parent treatment beliefs, child mood symptom severity, consumer satisfaction, provider satisfaction, and financial feasibility. Although definitive inferences could not be made about treatment effectiveness and response due to the open trial design and small sample size, descriptive data were analyzed and tests of significance were completed to examine potential trends in treatment response. I tested the following eight hypotheses:

**Treatment Effectiveness and Response**

1. Parents’ knowledge of mood disorders will increase in accuracy following MF-PEP completion.
2. Parents’ favorable treatment beliefs will increase following MF-PEP completion.
3. Children’s favorable treatment beliefs will increase following MF-PEP completion.
4. Children’s depressive and manic symptoms will decrease in severity following MF-PEP completion.
Consumer Satisfaction

5. Parents and children will find participation in MF-PEP to be a satisfactory experience.

Provider Satisfaction

6. Community therapists will find training in and implementation of MF-PEP to be a satisfactory experience.

7. Referring therapists will find satisfaction with MF-PEP as an adjunctive treatment and families’ transition back to usual care.

Financial Feasibility

8. MF-PEP will be a cost-neutral or cost-advantageous program.
Chapter 2: Method

Participants

Parents and Children

Forty children and their parents were recruited to participate in MF-PEP. Families were referred to participate in MF-PEP by their individual or family therapists. Participants had to meet four inclusion criteria to participate: (1) aged 8 to 12 years (boys and girls); (2) diagnosis of any mood disorder (DSD or BPSD) as determined by referring therapist; (3) child and at least one parent must be interested in and agree to participate in MF-PEP when provided with a brief description of the group by their individual or family therapist; and (4) child and at least one parent must be willing to complete all questionnaires and self-report inventories. The two exclusion criteria for children and parents were: (1) inadequate verbal skill and intellectual functioning, per the judgment of the referring therapist; and (2) inability to communicate or write in English. Participants were allowed to continue any psychosocial or pharmacological interventions during the study. Families could also participate in MF-PEP without participating in the present study, which consisted of completing questionnaires. No referred families declined participation in the study.

Demographic information was reported by caregivers about their children. Thirty-two (80%) of the 40 participants reported their relationship to the child. Twenty-four biological mothers (75%), three adoptive mothers (9%), two biological fathers
(6%), two maternal biological grandmothers (6%), and one paternal biological grandmother (3%) reported demographic information about their children.

Children were between the ages of 8 and 12 at study entry ($M = 10.15, SD = 1.23$). The majority was male (21 males, 53%). Race was reported by 30 (75%) of the 40 participants. Twenty-three children were Caucasian (77%), four children were biracial (African American and Caucasian: 13%), two children were African American (7%), and one child was Asian (3%). Ethnicity was reported by 27 (68%) of the 40 participants. Twenty-four children were not Hispanic or Latino (89%) and three children were Hispanic or Latino (11%). Participation in and frequency of outpatient therapy appointments was reported by 30 (75%) of the 40 participants. All thirty participants reported receiving outpatient therapy. Twenty-six children received greater than ten appointments (87%), two children received five to ten appointments (7%), one child received one to four appointments (3%), and one child’s caregiver was unsure of the number of appointments they had received (3%). Additional types of treatment were reported by 30 (75%) of the 40 participants. Twenty-eight children received pharmacotherapy (93%), ten children received school-based therapy (33%), eight children received home-based therapy (27%), six children were taken to the emergency room for behavioral problems or suicidal ideation (20%), six children received inpatient psychiatric care (20%), two children participated in online support groups (7%), and one child received residential/day treatment (3%).

Forty children and their parents were referred by their individual or family therapists to one of eight MF-PEP groups at two local community children’s behavioral health clinics, the Westerville and Reynoldsburg Close to Home Behavioral Health
Centers. All MF-PEP groups were conducted once per week on weeknight evenings from 5:00pm to 6:30pm. Of the 40 families referred to MF-PEP, 30 completed the intervention. Eight families dropped out due to scheduling difficulties and the time commitment involved in MF-PEP. One family dropped out because the parents felt the topics and material covered in MF-PEP were not applicable to their child’s needs and mental health issues. One family discontinued treatment in MF-PEP after the child was placed in Juvenile Detention Center for behavioral problems. See Table 1 for start dates and rates of family enrollment, completion, and drop-out for each MF-PEP group.

<table>
<thead>
<tr>
<th>Groups Start Date</th>
<th>Enrolled</th>
<th>Completed</th>
<th>Dropped Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westerville</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>04/2008</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>03/2009</td>
<td>7</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>03/2010</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Reynoldsburg</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>01/2009</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>09/2009</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>04/2010</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>30</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 1. Family enrollment, completion, and drop-out per group.

**MF-PEP Therapists**

Fifteen community therapists were recruited through the Reynoldsburg and Westerville Close to Home Behavioral Health Centers. Therapists had to meet two inclusion criteria: (1) agree to participate in training via a workshop or with an experienced therapist; and (2) be willing to complete self-report inventories. There were
no exclusion criteria for MF-PEP therapists. Therapists were expected to continue to see other clients and fulfill their employment obligations in addition to facilitating MF-PEP. Therapists could also receive training in and facilitate MF-PEP without participating in the present study, which consisted of completion of questionnaires. No therapists declined participation in the study.

Fifteen therapists facilitated eight MF-PEP groups at the Westerville and Reynoldsburg Close to Home Behavioral Health Centers. Therapists could facilitate more than one group: one therapist facilitated four groups; two therapists facilitated three groups; five therapists facilitated two groups; and seven therapists facilitated one group. Regarding number of therapists per group: one Westerville group had five therapists (three child therapists and two parent therapists); one Reynoldsburg group had four therapists (two child therapists and two parent therapists); and the remaining six groups each had three therapists (two child therapists and one parent therapist). MF-PEP is intended to be facilitated by two child therapists and one parent therapist. More than three therapists conducted two groups for observation and training purposes. All fifteen therapists completed training in and facilitation of MF-PEP and none dropped out of the study.

Referring Therapists

Community therapists self-selected to refer eligible families to MF-PEP. All therapists at the community clinics were informed of the groups and were given the opportunity to refer any of their clients. Referring therapists were contacted for study participation if the family they referred completed MF-PEP. Referring therapists had to meet one inclusion criterion: they must be willing to complete self-report inventories.
There were no exclusion criteria for referring therapists. Therapists were expected to continue to see other clients and fulfill their employment obligations in addition to referring clients to MF-PEP. Therapists could also refer families to MF-PEP without participating in the present study, which consisted of questionnaire completion.

Therapists who referred the 30 families completing MF-PEP were contacted one month after the completion of MF-PEP. Therapists could refer more than one family to group. Of the therapists who referred families completing MF-PEP: one therapist referred five families; two therapists referred three families each; two therapists referred two families each; and fifteen therapists referred one family each. Thus, a total of 20 referring therapists referred the 30 families who completed MF-PEP. Some therapists referred more than one family and thus provided feedback on more than one occasion.

Of the 30 families who completed MF-PEP, 20 referring therapists agreed to participate and enrolled in the study. Four therapists declined participation in the study by not responding to email contact inquiring about interest in study participation or returning study questionnaires. Five therapists could not participate as the family they referred did not continue treatment with them following MF-PEP. One referring therapist was unknown and thus could not be contacted.

**Measures**

**Measures Completed by Parents**

**Demographics Form** is a 6-item questionnaire that assesses demographic information regarding child participants, completed by the parent. Items are to be self-completed or the appropriate categories are indicated by checking the corresponding boxes. The child’s birth date, sex, ethnic category, racial category, individual who
completed the demographic questionnaire, and the types of treatment and services the child has utilized are recorded. This questionnaire was created for use within the current study to gather demographic information on participants in outpatient settings. The Demographics Form was administered pre-treatment (see Appendix A).

The Understanding Mood Disorder Questionnaire (UMDQ: Gavazzi et al., 1997) is a self-report questionnaire completed by the parent containing 20 true/false questions assessing attributions about mood disorders and knowledge of symptoms, course, and treatment of the disorder. The UMDQ also contains a 19-item checklist to ascertain awareness of manic and depressive symptoms. Higher scores on each section reflect greater understanding of mood disorders. The UMDQ has good internal consistency ($\alpha = .73$), reliability, and is sensitive to increases in knowledge about mood disorders (Gavazzi et al., 1997). The UMDQ was administered pre- and post-treatment.

Parent-Completed General Behavior Inventory Mania Form (PGBI-10M: Youngstrom, Frazier, Demeter, Calabrese, & Findling, 2008) is a 10-item questionnaire adapted from the P-GBI (Youngstrom, Findling, Danielson & Calabrese, 2001). The P-GBI is an adaptation of a well-validated instrument designed to screen for mood disorders in adult populations, the GBI (Depue, 1987). Ten items assessing mania were extracted from the P-GBI to create the PGBI-10M. Item responses are Likert-style and range from 0 (never or hardly ever) to 3 (very often or almost constantly). Higher scores reflect increased amount and severity of manic symptoms. The PGBI-10M has good reliability ($\alpha = .92$). The PGBI-10M also demonstrated good convergent validity by correlating ($r = .95$) with a 28-item version of the P-GBI, and showed significantly better discrimination of bipolar disorders. The PGBI-10M also demonstrated good discriminant
validity by discriminating bipolar disorder from unipolar depression ($AUROC = .86$) and bipolar disorder from attention-deficit/hyperactivity disorder ($AUROC = .82$) cases. The PGBI-10M was administered pre- and post-treatment.

**Treatment Beliefs Questionnaire – Parent Form** (TBQ-P: Davidson & Fristad, 2006) is a 37-item scale that assesses parental favorable beliefs about pharmacologic and psychosocial treatments. Item responses are Likert-style and range from 1 (*strongly disagree*) to 5 (*strongly agree*) with an option of “not-applicable” if the question does not pertain to the child’s current treatment regimen. The TBQ-P consists of six subscales: (1) beliefs specific to the child (e.g., beliefs about the child’s current need for medication and therapy); (2) general beliefs about medicine (e.g., beliefs about the use and prescription of medication in general); (3) seriousness of illness (e.g., beliefs about the child’s illness severity and long-term outcomes); (4) costs and benefits of treatment (e.g., beliefs about whether treatment is worthwhile, given the high costs or medication side effects); (5) knowledge of treatment (e.g., respondents’ perception of their understanding of treatment and possible side effects); and (6) relationship with healthcare provider (e.g., whether the respondent trusts providers and feels included in the treatment planning). Higher scores indicate that the respondent believes the child would benefit from treatment and also suggest a favorable view of mental health treatment and treatment providers.

The TBQ-P had good internal consistency when completed by primary ($\alpha = .84$) and secondary parents ($\alpha = .85$) and high test-retest stability over a 6-month period for both primary and secondary parents (.80 and .70, respectively), with five of the six subscales demonstrating good test-retest stability (Davidson & Fristad, 2006). In addition, the TBQ-P illustrated satisfactory convergent validity, discriminant validity, and
predictive validity (Davidson & Fristad, 2006). However, inter-rater agreement was poor between the TBQ-P and TBQ-C (described below; Davidson & Fristad, 2006). This was not surprising, as past research has demonstrated that children and parents often fail to agree upon problem areas in the child’s functioning (Yeh & Weisz, 2001). The TBQ-P was administered pre- and post-treatment.

**Parent Group Evaluation Form** is a 16-item questionnaire that assesses the parents’ feedback and experience of MF-PEP. Item responses are Likert-style and range from 1 (*strongly disagree*) to 5 (*strongly agree*). The Parent Group Evaluation Form consists of four subscales: (1) knowledge (items ascertain change in parents’ understanding of symptoms, treatment, and management of childhood mood disorders); (2) group evaluation (items assess whether or not parents felt the group format was helpful); (3) component evaluation (items ascertain whether or not parents found specific activities/aspects of MF-PEP to be beneficial and/or informative); and (4) benefit (one item assesses whether or not parents felt their children benefited from MF-PEP). The questionnaire also contains two open-ended questions to obtain suggestions and additional feedback/comments. This questionnaire was created for use within the MF-PEP efficacy studies to gather information about parents’ satisfaction and feedback. In the current study, the Parent Group Evaluation Form demonstrated good internal consistency (α = .85). The Parent Group Evaluation Form was administered post-treatment (see Appendix B).

**Measures Completed by Children**

**Treatment Beliefs Questionnaire – Child Form** (TBQ-C: Davidson & Fristad, 2006) is a 19-item scale that assesses children’s favorable beliefs about pharmacologic
and psychosocial treatments. Item responses are Likert-style and range from 1 (strongly disagree) to 5 (strongly agree) with an option of “not-applicable” if the question does not pertain to the child’s current treatment regimen. The TBQ-C is comprised of the same categories of questions as the parent version, described above, but contains fewer items. Questions are slightly reworded to fit the child’s developmental level. The TBQ-C also contains the same six subscales in the TBQ-P. Responses on the TBQ-C are scored in the same manner as the TBQ-P. The TBQ-C had good internal consistency ($\alpha = .82$) but less test-rest stability (.43) than the TBQ-P over a 6-month period, with only two of the six subscales demonstrating test-retest stability (Davidson & Fristad, 2006). This finding was not surprising, as poor correlation between child and parent informants is typical. For example, Yeh and Weisz (2001) found that 63% of clinic-referred parent-child pairs failed to agree on even a single problem area in which the child was having difficulty. Furthermore, when problems were grouped into broader categories, more than one-third of parent-child pairs were still unable to agree on a single general problem area. Similarly, Hawley and Weisz (2003) found that more than three-fourths of child-parent-therapist triads began treatment without consensus on a single problem, and nearly half failed to agree on even one broad problem domain. The TBQ-C also illustrated satisfactory convergent validity, discriminant validity, and predictive validity (Davidson & Fristad, 2006). The TBQ-C was administered pre- and post-treatment.

Children’s Depression Inventory (CDI: Kovacs, 1992, 2003) is a 27-item youth self-report measure of depressive symptoms. Each item consists of three statements, and the child is asked to select the statement that best describes his or her feelings for the past two weeks. In clinical samples, Cronbach’s alphas for the CDI have ranged from .71 to
.89, and test-retest reliability coefficients have ranged from .50 to .87 (Kovacs, 2003). The CDI and several other measures of youth depression have been found to correlate at .5 and higher (e.g., McCauley, Mitchell, Burke, & Moss, 1988; Kovacs, 1992). The CDI was administered pre- and post-treatment.

**Child Group Evaluation Form** is a 16-item questionnaire that assesses the child’s feedback and experience of MF-PEP. Item responses are Likert-style and range from 1 (*strongly disagree*) to 5 (*strongly agree*). The Child Group Evaluation Form consists of four subscales: (1) knowledge (items ascertain change in children’s understanding of symptoms, treatment, and management of mood disorders, family and peer relationships, and coping skills); (2) group evaluation (items assess if children liked or disliked the group format); (3) component evaluation (items ascertain whether or not children found specific activities/aspects of MF-PEP to be beneficial, enjoyable, and/or informative); and (4) benefit (items assess whether or not children felt parental behavior toward them changed). The questionnaire also contains two open-ended questions to obtain suggestions and additional feedback/comments. This questionnaire was created for use within the MF-PEP efficacy studies in order to gather information about children’s satisfaction and feedback. In the current study, the Child Group Evaluation Form demonstrated good internal consistency ($\alpha = .83$). The Child Group Evaluation Form was administered post-treatment (see Appendix C).

**Measures Completed by MF-PEP Therapists**

**MF-PEP Therapist Session Evaluation Survey** is a 7-item questionnaire that assesses the therapist’s feedback and experience of each MF-PEP session. Questions address whether the training provided was adequate, if activities/ideas were
practical/useful, and obtains additional suggestions/comments. Item responses are open-ended. This questionnaire was created for use within the current study to gather information about community therapists’ satisfaction and feedback. The MF-PEP Therapist Session Evaluation Survey was completed after each MF-PEP session (see Appendix D).

**MF-PEP Therapist Post-Group Feedback Survey** is a 22-item questionnaire that asks therapists to report about their experiences during training and following the completion of MF-PEP. Item responses for 18 of the 22 questions are multiple choice; 4 questions are open-ended. The multiple-choice questions ask therapists about the type of training they received, the helpfulness of the training methods, whether training adequately prepared them to run MF-PEP, the time elapsed between training and running a group, any shortcomings of the training, if training was adequate regarding how to deal with clients’ behavior, and information regarding the therapists' professional licensure, training in manualized interventions, their experience treating other childhood disorders, and their interest in continuing to run MF-PEP groups. The four open-ended questions give therapists an opportunity to provide feedback about their concerns, suggestions, and satisfaction regarding the group training and the running of group. This questionnaire was created for use within the current study to gather information about community therapists’ satisfaction and feedback. The MF-PEP Therapist Post-Group Feedback Survey was administered post-treatment (see Appendix E).

**Measure Completed by Referring Therapists**

**Individual/Family Therapist Questionnaire about MF-PEP** is a 15-item questionnaire that assesses the impact of child and parent participation in MF-PEP on
individual/family therapy, the therapist’s perceptions regarding whether MF-PEP was
beneficial for the family, and whether he/she found the treatment beneficial overall. Item
responses for 14 of the 15 questions are multiple choice (only one answer is to be
selected per question), with 4 questions being yes/no answers and 10 having 4 to 6
possible answers. The questionnaire also contains one open-ended question to obtain
additional feedback/comments. Nine of the questions also have an open-ended
component allowing for clarification of response to the preceding multiple choice
question. This questionnaire was created for use within the current study to gather
information about referring therapists’ satisfaction and feedback. The Individual/Family
Therapist Questionnaire about MF-PEP was administered post-treatment (see Appendix
F).

**Procedures**

Project staff included the treatment developer, study coordinator, consultant at
Nationwide Children’s Hospital, and three MF-PEP therapists. All project staff
completed Nationwide Children’s Hospital’s IRB ethics training. The treatment
developer and study coordinator also completed The Ohio State University’s IRB ethics
training. All MF-PEP groups and trainings were conducted at the Reynoldsburg and
Westerville Close to Home Behavioral Health Centers. The current study examined data
collected from eight MF-PEP groups: four groups at Reynoldsburg and four groups at
Westerville. MF-PEP therapists, parents, and children completed all questionnaires at
Reynoldsburg and Westerville Close to Home Behavioral Health Centers or at their
respective residences, while referring therapists were mailed questionnaires to complete
at their convenience at their respective places of employment.
Parents and Children

Children between the ages of 8 to 12 years with any mood diagnosis (DSD or BPSD) and their parents were referred to MF-PEP by their treating clinician. As MF-PEP is an adjunctive treatment, families were encouraged to continue any psychosocial or pharmacologic treatment as usual. Parents first attended a prescreening interview with a MF-PEP therapist at one of the two Close to Home Behavioral Health Centers to assess eligibility, determine appropriateness and compatibility of the family with current group members, and improve buy-in, according to standard operating procedures for referrals to group therapy within the Close to Home Behavioral Health Centers. Parental consent and questionnaires could be completed at this meeting. If these were not completed during the prescreening interview, both parents and children completed consent and assent with MF-PEP therapists on project staff or the study coordinator at the first group session. Parents and children were provided with parent and child workbooks created by the treatment developer. Parents and children completed self-report questionnaires pre- and post-treatment. Parents and children were each sent a $10 gift card to compensate their time completing the study after both sets of study questionnaires were received.

MF-PEP Therapists

Therapists at the Close to Home Behavioral Health Centers were asked if they were interested in receiving training in and conducting MF-PEP. Informed consent was obtained by MF-PEP therapists on project staff or the study coordinator, and therapists were instructed to either attend a formal workshop or co-lead an MF-PEP group with an experienced MF-PEP therapist. MF-PEP therapists were provided with MF-PEP therapist manuals created by the treatment developer. Upon completion of each session,
therapists completed the MF-PEP Therapist Session Evaluation Survey. Following the
completion of MF-PEP, therapists completed the MF-PEP Therapist Post-Group
Feedback Survey. Therapists also attended a feedback meeting with the treatment
developer and study staff to provide suggestions for improvements and feedback
regarding MF-PEP. Therapists were sent a $25 gift card to compensate their time
completing the study.

**Referring Therapists**

Community therapists at the Reynoldsburg and Westerville sites were informed of
the MF-PEP groups via fliers and word-of-mouth and were encouraged to refer eligible
families to group. The referring therapists of families who completed MF-PEP were
asked if they were interested in providing feedback regarding their satisfaction with MF-
PEP as an adjunctive treatment to individual or family therapy. Consent was obtained by
MF-PEP therapists on project staff or the study coordinator. Approximately one-month
after MF-PEP ended, referring therapists were asked to complete the Individual/Family
Therapist Questionnaire about MF-PEP. The referring therapists were sent a $10 gift
card to compensate their time completing the study.

**Description of MF-PEP Treatment**

MF-PEP is a group-based EBT for children with mood disorders comprised of
three components: (1) psychoeducation; (2) support; and (3) skills development. Parents
and children each are supplied with a workbook and families receive project handouts at
the end of each session. MF-PEP therapists are provided with a therapist manual. MF-
PEP sessions begin with a brief check-in meeting of parents and children, during which
the previous week’s projects are discussed, except during Week 1, when introductions are
made. Children and parents then go to their respective groups to review that particular session’s topics. Children review session content for approximately 1 hour, and then spend 15 to 20 minutes engaging in *in vivo* social skills training. As these groups are conducted in the early evening after children typically have spent the day in school, these recreational activities meet group goals and respect the children’s developmental limitations on attention. Parents spend 75 minutes discussing session topics, then children and parents rejoin. The children explain their session’s topic, discuss that particular week’s projects, and demonstrate the weekly breathing exercise with the parent group.

Initial MF-PEP sessions are more didactic in nature, with topics yoked in parent and child groups. Families learn about: mood symptoms and comorbid conditions including ADHD, disruptive behavior disorders, anxiety disorders, and psychotic symptoms; how to differentiate the child from his/her symptoms using the “Naming the Enemy” exercise (Fristad et al., 1999); and medications and side-effect management. Families set unique treatment goals for themselves. In subsequent sessions, parents learn about mental-health, school, and community-based treatment teams and services, and how to work effectively with service providers. Then, treatment shifts to skill-building with a focus on communication and problem solving in regard to symptom management. Children’s sessions also address affect regulation, basic cognitive-behavioral principles (i.e., how thoughts, feelings, and behaviors are related and can be modified: Fristad et al., 2007), problem-solving, and verbal and nonverbal communication skills. The last session concludes with an interactive game for children reviewing all skills and topics taught during MF-PEP and a graduation ceremony.
Data Analysis

Treatment Effectiveness and Response

**Hypothesis one: Parental knowledge of mood disorders.** Parental knowledge of mood disorders was measured by composite UMDQ scores. A two-tailed, dependent-measures $t$-test was used to compare the mean score from pre-treatment to post-treatment. The mean UMDQ score was expected to increase pre- to post-treatment. A 95% confidence interval and effect size were also computed.

**Hypothesis two: Parental treatment beliefs.** Parental treatment beliefs were measured by composite TBQ-P scores. A two-tailed, dependent-measures $t$-test was used to compare the mean score from pre-treatment to post-treatment. The mean TBQ-P score was expected in increase pre- to post-treatment. A 95% confidence interval and effect size were also computed.

**Hypothesis three: Children’s treatment beliefs.** Children’s treatment beliefs were measured by composite TBQ-C scores. A two-tailed, dependent-measures $t$-test was used to compare the mean score from pre-treatment to post-treatment. The mean TBQ-C score was expected in increase pre- to post-treatment. A 95% confidence interval and effect size were also computed.

**Hypothesis four: Children’s depressive and manic symptom severity.** Children’s depressive symptoms were measured by composite CDI scores. A two-tailed, dependent-measures $t$-test was used to compare the mean score from pre-treatment to post-treatment. The mean CDI score was expected in decrease pre- to post-treatment. A 95% confidence interval and effect size were also computed.
Children’s manic symptoms were measured by composite PGBI-10M scores. A two-tailed, dependent-measures $t$-test was used to compare the mean score from pre-treatment to post-treatment. The mean PGBI-10M score was expected in decrease pre-to post-treatment. A 95% confidence interval and effect size were also computed.

**Consumer Satisfaction**

**Hypothesis five: Parents’ and children’s satisfaction.** Parents’ and children’s satisfaction with MF-PEP was measured by composite scores on the Parent Group Evaluation Form and Child Group Evaluation Form. Descriptive statistics and 95% confidence intervals were calculated for each measure post-treatment. Qualitative responses and feedback provided on the open-ended questions on the evaluation forms were also examined. Both parents’ and children were expected to report high satisfaction in MF-PEP and thus produce high mean satisfaction scores.

Specifically, I hypothesized that parents’ and children’s mean composite satisfaction scores would be rated higher than the neutral score of 3. Two two-tailed, one-sample $t$-tests were used to compare the mean composite scores on the Parent and Child Group Evaluation Forms to the hypothesized mean value of 3. I also hypothesized that the proportion of parents’ and children’s composite satisfaction scores would be $\geq 4$ more than would be expected by chance. Exact proportions and 95% confidence intervals were calculated for parents’ and children’s responses $\geq 4$ post-treatment. Two two-tailed binomial tests were used to compare the proportion of parents’ and children’s composite satisfaction scores to chance levels ($p = .5$). Responses to other open-ended questions on the Parent Group Evaluation Form and Child Group Evaluation Form were also reported.
Provider Satisfaction

Hypothesis six: MF-PEP therapists’ satisfaction. Community therapists’ satisfaction with training in and implementation of MF-PEP was evaluated through responses to multiple-choice and open-ended questions on the MF-PEP Therapist Session Evaluation Survey and the MF-PEP Therapist Post-Group Feedback Survey. Satisfaction was also evaluated by discussion and feedback provided by therapists at feedback meetings with the treatment developer. MF-PEP therapists were expected to report high satisfaction with training in and implementation of MF-PEP.

Specifically, I hypothesized that the proportion of therapists responding “yes” when asked if training provided was adequate on the MF-PEP Therapist Session Evaluation Survey would be more than would be expected by chance. I also hypothesized the proportion of therapists’ responses on the following questions on the MF-PEP Therapist Post-Group Feedback Survey would be more that would be expected by chance: (1) responding 4 (helpful) or 5 (very helpful) when asked about the helpfulness of six training methods; (2) responding “yes” when asked if training fully prepared them for running MF-PEP; (3) responding “yes” when asked if they were interested in continuing to run MF-PEP groups; and (4) responding “no” when asked if there were topics or skills in which training was insufficient. Exact proportions and 95% confidence intervals were calculated for the responses noted above. Ten two-tailed binomial tests were used to compare the proportion of responses noted above to chance levels \(p = .5\). Responses to other multiple-choice and open-ended questions on the MF-PEP Therapist Session Evaluation Survey and MF-PEP Therapist Post-Group Feedback Survey were also reported.
Hypothesis seven: Referring therapists’ satisfaction. Referring therapists’ satisfaction with families’ participation in MF-PEP as an adjunctive treatment was evaluated through responses to multiple-choice and open-ended questions on the Individual/Family Therapist Questionnaire about MF-PEP. Referring therapists were expected to report high satisfaction with MF-PEP as an adjunctive treatment.

Specifically, I hypothesized that the proportion of therapists’ responses on the following questions on the Individual/Family Therapist Questionnaire about MF-PEP would be more that would be expected by chance: (1) “some” or “a lot” of improvement in the therapeutic relationship; (2) “more accurate knowledge and a better understanding of mood disorders” from parents; (3) “some” or “significant” improvement in parent coping; (4) “some” or “significant” improvement in child coping; (5) “some” or “significant” improvement in family climate; (6) “some” or “a lot” more agreement among caregivers if there were two caregivers in the family; (7) “somewhat likely” or “very likely” to refer clients to MF-PEP in the future; (8) “yes” when asked if the MF-PEP motto had affected the family’s attitude; (9) “yes” when asked if the family discussed the content of MF-PEP; and (10) “no” when asked if there were goals or concepts of MF-PEP the therapist did not agree with. Exact proportions and 95% confidence intervals were calculated for the responses noted above. Ten two-tailed binomial tests were used to compare the proportion of responses noted above to chance levels ($p = .5$). Responses to other multiple-choice and open-ended questions on the Individual/Family Therapist Questionnaire about MF-PEP were also reported.
Financial Feasibility of MF-PEP

Hypothesis eight: Financial Feasibility. Financial feasibility of MF-PEP was evaluated through discussion with Nancy Cunningham, PsyD, Clinical Director of Community Behavioral Health and Jarrod Leffler, PhD, ABPP, Clinical Director of Quality and Training. Current financial and billing strategies utilized with MF-PEP at the Close to Home Behavioral Health Centers were reported. The total cost, revenue, and net result of each group was calculated. Also, the number of families per group required for Nationwide Children’s Hospital to break-even financially was computed, and the number of groups which were able to meet these standards was reported. MF-PEP was expected to be a cost-neutral or cost-advantageous treatment.

Missing Data

Of the 30 families who completed MF-PEP, paired pre- and post-treatment data was obtained from 22 parents and missing from 8 parents on the UMDQ, TBQ-P, and PGBI-10M. Paired pre- and post-treatment data was obtained from 20 children and missing from 10 children on the TBQ-C. Paired pre- and post-treatment data was obtained from 9 children and missing from 21 children on the CDI. Post-treatment data was obtained from 26 parents on the Parent Group Evaluation Form and 24 children on the Child Group Evaluation Form.

Of the 15 MF-PEP therapists who were trained in MF-PEP, data was obtained for 14 therapists and missing for 1 therapist on the MF-PEP Therapist Session Evaluation Survey. Data was obtained for 13 therapists and missing for 2 therapists on the MF-PEP Therapist Post-Group Feedback Survey. Of the 20 community therapists who referred 30
families completing MF-PEP, data was obtained for 20 therapists and missing for 10 therapists on the Individual/Family Therapist Questionnaire about MF-PEP.

Reasons for missing data from families are varied. First, the CDI was not added as a study measure until the third group at Reynoldsburg. Thus, this measure was only administered to children at the last three of the eight groups. Second, initial study procedures proved to be suboptimal for data collection. During the first MF-PEP group parents and children were expected to mail study questionnaires to the study coordinator. After data were not received by the study coordinator following the first group, community therapists collected all pre- and post-treatment data. Though this improved data collection somewhat, collection was still suboptimal. MF-PEP therapists are particularly busy during the first and last group meetings, thus ensuring questionnaire completion by families served as an additional responsibility and burden. In addition, MF-PEP therapists may not have been as invested in obtaining study questionnaires from families, but rather were likely more concerned and preoccupied with facilitating the group. Thus, I started attending the first and last sessions to aid with questionnaire completion, which greatly improved data collection.

Data collection was better for MF-PEP and referring therapists, likely for a variety of reasons. First, both MF-PEP and referring therapists had fewer questionnaires to complete than children and parents. Second, therapists seemed more interested in providing feedback. They were eager to improve aspects and delivery of MF-PEP and also provide feedback regarding families’ transition back to usual care. Therapists were likely more invested in completion of study questionnaires because MF-PEP was slated
to become a regularly offered treatment at the Close to Home Behavioral Health Centers, thus they were interested in helping to improve its delivery and provide feedback.
Chapter 3: Results

Treatment Effectiveness and Response

Hypothesis One: Parental Knowledge of Mood Disorders

A two-tailed, dependent-measures $t$-test was used to compare 22 parents’ knowledge of mood disorders from pre- to post-treatment via mean scores on the UMDQ with alpha set at .05. As hypothesized, parental knowledge of mood disorders showed a statistically significant increase from pre-treatment ($M = 33.27, SD = 7.72$) to post-treatment ($M = 36.86, SD = 3.30$), $t (21) = -3.36$, $p = .003$, $d = .60$, 95% CI [-5.82, -1.36]. The effect size $d$ of .60 indicated a medium effect.

Hypothesis Two: Parental Treatment Beliefs

A two-tailed, dependent-measures $t$-test was used to compare 22 parents’ favorable treatment beliefs from pre- to post-treatment via mean scores on the TBQ-P with alpha set at .05. It was hypothesized that parental favorable treatment beliefs would improve pre- to post-treatment. Although parents reported improved favorable treatment beliefs from pre-treatment ($M = 3.86, SD = 0.49$) to post-treatment ($M = 3.96, SD = 0.43$), this difference did not achieve statistical significance, $t (21) = -1.55$, $p = .14$, $d = .23$, 95% CI [-0.25, 0.04]. The effect size $d$ of .23 indicated a small effect.

Hypothesis Three: Children’s Treatment Beliefs

A two-tailed, dependent-measures $t$-test was used to compare 20 children’s favorable treatment beliefs from pre- to post-treatment via mean scores on the TBQ-C
with alpha set at .05. It was hypothesized that children’s favorable treatment beliefs would improve pre- to post-treatment. Although children reported improved favorable treatment beliefs from pre-treatment ($M = 3.74, SD = 0.55$) to post-treatment ($M = 3.89, SD = 0.76$), this difference did not achieve statistical significance, $t(19) = -0.84, p = .41, d = .22, 95\% CI [-0.50, 0.22]$. The effect size $d$ of .22 indicated a small effect.

**Hypothesis Four: Children’s Depressive and Manic Symptom Severity**

A two-tailed, dependent-measures $t$-test was used to compare 9 children’s self-reported depressive symptoms from pre- to post-treatment via raw mean scores on the CDI with alpha set at .05. It was hypothesized that children’s depressive symptoms would decrease pre- to post-treatment. Although children reported fewer depressive symptoms from pre-treatment ($M = 18.44, SD = 12.55$) to post-treatment ($M = 18.33, SD = 9.01$), this difference did not achieve statistical significance, $t(8) = 0.03, p = .98, d = .01, 95\% CI [-9.49, 9.72]$. The effect size $d$ of .01 indicated a small effect.

A two-tailed, dependent-measures $t$-test was used to compare 22 parents’ reports of children’s manic symptoms from pre- to post-treatment via mean scores on the PGBI-10M with alpha set at .05. It was hypothesized that children’s manic symptoms would decrease pre- to post-treatment. Although parents reported fewer manic symptoms for their children from pre-treatment ($M = 13.23, SD = 7.65$) to post-treatment ($M = 12.64, SD = 8.05$), this difference did not achieve statistical significance, $t(21) = 0.36, p = .73, d = .08, 95\% CI [-2.85, 4.04]$. The effect size $d$ of .08 indicated a small effect.
Consumer Satisfaction

**Hypothesis five: Parents’ and Children’s Satisfaction**

A two-tailed, one-sample *t*-test was used to compare 26 parents’ mean satisfaction score with MF-PEP to a hypothesized mean score on the Parent Group Evaluation Form with alpha set at .05. It was hypothesized that parents’ mean composite satisfaction score would be higher than the neutral score of 3. As hypothesized, parents reported high satisfaction with MF-PEP (*M* = 4.43, *SD* = 0.52), 95% CI [4.22, 4.64]. Parents’ mean composite satisfaction score was significantly larger than the hypothesized score of 3, *t* (25) = 13.99, *p* < .001, *d* = 2.75, 95% CI [1.22, 1.64]. The effect size *d* of 2.75 indicated a large effect.

A two-tailed, one-sample *t*-test was used to compare 24 children’s mean satisfaction score with MF-PEP to a hypothesized mean score on the Child Group Evaluation Form with alpha set at .05. It was hypothesized that children’s mean composite satisfaction score would be higher than the neutral score of 3. As hypothesized, children reported high satisfaction with MF-PEP (*M* = 4.04, *SD* = 0.68), 95% CI [3.76, 4.33]. Children’s mean composite satisfaction score was significantly larger than the hypothesized score of 3, *t* (23) = 7.55, *p* < .001, *d* = 1.54, 95% CI [0.76, 1.33]. The effect size *d* of 1.54 indicated a large effect.

Two two-tailed binomial tests were used to determine if the proportion of parents’ and children’s composite satisfaction scores rated ≥ 4 differed from chance (*p* = .5). It was hypothesized that the proportion of parents’ and children’s composite satisfaction scores would be ≥ 4 more than would be expected by chance. Twenty-one out of twenty-six parents (81%) had a composite satisfaction score ≥ 4, significantly more than would
be expected by chance, exact binomial $p = .002$, 95% CI $[0.61, 0.94]$. Fifteen out of twenty-four children (63%) had a composite satisfaction score $\geq 4$, which was not significantly more than would be expected by chance, exact binomial $p = .31$, 95% CI $[0.41, 0.81]$. Thus, parents’ but not children’s composite satisfaction scores were $\geq 4$ significantly more than would be expected by chance.

Responses to open-ended questions on the Parent Group Evaluation Form also indicated high satisfaction with MF-PEP. When parents were asked what could be done differently in future groups, common responses included: (1) allow more time for open discussion among parents; (2) provide more information regarding appropriate punishment; (3) ensure adequate number of families attend group; (4) extend number and length of sessions; (5) provide option for make-up sessions; (6) allow more time for collaboration between parent and child groups; (7) add a follow-up session or subsequent support group; (8) provide flexible options for start dates and times for groups; (9) reduce amount of homework; (10) pre-screen families for compatibility prior to the start of group; (11) provide more visual aids; (12) provide more community resource information; and (13) adapt group to knowledge-level of families.

Statements of thanks and appreciation were also written when parents were asked for additional feedback and comments. Many parents noted: (1) thanks and gratitude; (2) improved attitudes; (3) improved coping skills; (4) improved familial communication and relationships; (5) improved knowledge of mood disorders and treatment; and (6) support from therapists and other families with similar difficulties. See Table 11 in Appendix G for all responses on the Parent Group Evaluation Form.
Responses to open-ended questions on the Child Group Evaluation Form also indicated high satisfaction with MF-PEP. When children were asked what could be done differently in future groups, common responses included: (1) increase the number of children in group; (2) provide more snacks; (3) decrease the number of sessions; and (4) decrease repetition among session content. Other suggestions included: (1) increase the length of group; (2) provide a movie; (3) learn more about medications; and (4) continue teaching breathing exercises. See Table 12 in Appendix H for all responses on the Child Group Evaluation Form.

**Provider Satisfaction**

**Hypothesis Six: MF-PEP Therapists’ Satisfaction**

**Satisfaction measured on the MF-PEP Therapist Session Evaluation Survey.**

A two-tailed binomial test was used to determine if the proportion of therapists’ positive responses on the MF-PEP Therapist Session Evaluation Survey differed from chance ($p = .5$). It was hypothesized that the proportion of therapists’ positive responses would be more than expected by chance. Fourteen therapists completed 187 MF-PEP Therapist Session Evaluation Surveys following each MF-PEP session. One-hundred and fifty-eight (84%) of 187 responses were “yes” when asked if training provided was adequate, significantly more than would be expected by chance, exact binomial $p < .001$, 95% CI [0.78, 0.89].

Comments from the therapist feedback meeting with the treatment developer and responses to open-ended questions on the MF-PEP Therapist Session Evaluation Survey for child therapists also indicated high satisfaction with training in and implementation of MF-PEP. See Table 13 (Appendix I) for all child group therapists’ responses on the MF-
PEP Therapist Session Evaluation Survey. When asked which activities or ideas worked well, common child therapist responses included: (1) group rules; (2) MF-PEP motto “it’s not your fault, but it’s your challenge;” (3) point and food incentives for good behavior and group participation; (4) feelings thermometer; (5) definitions and symptoms of depression and mania; (6) fix-it list; (7) naming the enemy exercise; (8) medication review; (9) discussion and identification of triggers; (10) identification of bodily reactions; (11) tool kit; (12) ice-breaker and physical activities; (13) crossword puzzles; (14) breathing exercises; (15) Thinking-Feeling-Doing CBT exercises; (16) problem-solving exercises; (17) helpful/hurtful and verbal/nonverbal communication; (18) jeopardy review game and graduation ceremony; (19) family projects and worksheets; (20) visual aids; (21) use of large easel or dry-erase board; (22) use of two child therapists; and (23) review of previous session content at the beginning of each session.

When asked what activities/ideas were difficult to do or convey, common child therapist responses included: (1) completion of study questionnaires at first and last sessions; (2) comprehension of MF-PEP motto; (3) feelings thermometer; (4) symptoms and diagnosis of depression and mania; (5) discussion of medications and medication match game; (6) full body drawings; (7) identification of body signals for mad, sad, and bad feelings; (8) differentiating triggers from helpful/unhelpful responses; (9) differentiating thoughts from behaviors; (10) connect the dots game; (11) problem-solving discussion; (12) repetition of some material; (13) CBT exercises; (14) changing thoughts, feelings, and actions; (15) communication exercises and projects; (16) feelings charades; (17) physical activities; (18) children’s comprehension of session content; and (19) homework completion.
When asked what child therapists would do differently if running group again, common child therapist responses included: (1) spend more time defining “fault” and “challenge” in the MF-PEP motto; (2) create easier word search; (3) create harder maze activity; (4) simplify medication match game; (5) gather list of medications children in group take to tailor medication discussion; (6) spend more time on tool kit and processing; (7) spend more time talking about weekly projects; (8) start group with adequate number of families (at least 5); (9) shorten group to 6 or 7 weeks; (10) combine sessions 6 and 7; (11) include more games and physical activities; (12) do not administer study questionnaires during first and last group sessions; (13) better manage children’s behavior; (14) allot more time for session set-up and preparation; (15) better articulate session content and activities; and (16) spend more time with group content and discussion and less time with games.

When asked if there were any problems with the MF-PEP materials, common child therapist responses included: (1) medication cards were overwhelming; (2) connect the dots activity and crossword puzzle were difficult; (3) three-ring binder for therapist manual was not user-friendly; and (4) include breathing pages at the end of each session in the child workbook.

When asked if there were any new ideas or flexible additions to the manuals or handouts, common child therapist responses included: (1) have ice-breakers or other games options; (2) add additional feelings to feelings inventory (i.e., worried, manic depressed); (3) shorten discussion of medications; and (4) include weekly activities with each session.
Finally, when asked for additional feedback or other comments, common child therapist responses included: (1) difficult to cover all information during group; (2) children greatly enjoyed physical activities; (3) some sessions had extra time; (4) ensure adequate group size; (5) provide more time for processing group content; (6) provide different snack/food options; (7) group was a long commitment for some families; (8) some child concepts were complicated; and (9) ensure therapists have the most recent versions of child therapist manuals.

Comments from the therapist feedback meeting with the treatment developer and responses to open-ended questions on the MF-PEP Therapist Session Evaluation Survey for parent therapists also indicated high satisfaction with training in and implementation of MF-PEP. See Table 14 (Appendix J) for parent group therapists’ responses on the MF-PEP Therapist Session Evaluation Survey. When asked which activities/ideas worked well, common parent therapist responses included: (1) MF-PEP motto; (2) mood definitions and diagrams; (3) open, interactive discussions; (4) naming the enemy exercise; (5) normalizing parents’ feelings; (6) review of medications; (7) review of mental health providers, services, and treatment; (8) encouraging parents to be a part of their child’s treatment team; (9) review of school services; (10) helpful/hurtful communication; (11) problem-solving; (12) discussion of suicidal concerns/threats; (13) fix-it list; (14) tool kit; (15) breathing exercises; and (16) family projects.

When asked what activities/ideas were difficult to do or convey, common parent therapist responses included: (1) covering all session material in the time allotted; (2) discussion of comorbid disorders; (3) discussion of brain abnormalities; (4) medication
and side effect review; (5) discussion of treatment opportunities based on children’s needs; and (6) discussion of wrap-around services and respite care.

When asked what parent therapists would do differently if running group again, common parent therapist responses included: (1) ascertain children’s diagnoses prior to starting group and tailor content accordingly; (2) prescreen families to increase buy-in and ensure compatibility with group; (3) tailor medication discussion to medications group participants take; (4) provide crisis numbers; (5) reinforce importance of group attendance, family projects, and homework completion; and (6) lengthen group sessions or add sessions to cover all material and develop group cohesiveness.

When asked if there were any problems with the MF-PEP materials, common parent therapist responses included: (1) provide more information in therapist manual regarding medications and their interactions; (2) ensure therapists have the most recent version of the manual; (3) provide more detailed instructions for parent therapists; (4) add information about the school nurse; (5) include family projects at the end of each session; (6) combine information to decrease the length of group; and (7) correct minor spelling errors in manual and workbook.

When asked if there were any new ideas or flexible additions to the manual or handouts, common parent therapist responses included: (1) present topics initially by having parents share their experiences (e.g., with medications or mental health care providers); (2) provide CBT skills for parents; (3) provide special education resources where clients live; (4) provide statistics on the rate of suicide in children; and (5) include time for role-plays to practice skills and obtain group feedback.
Finally, when asked for additional feedback or other comments, common parent therapist responses included: (1) start group with adequate number of families; (2) allow families time to “tell their story;” (3) include guidance over appropriate punishment; (4) parents spontaneously shared contact information at the end of group; (5) study questionnaire completion cut into group time; (6) parents need time to process their concerns with their children’s medications; (7) parents shared resources and information; (8) some family projects were complicated; (9) homework was helpful for parents; (10) could combine sessions 7 and 8; (11) parents asked for a support group; and (12) sessions containing less curriculum allowed more time for discussion and family support.

**Satisfaction measured on the MF-PEP Therapist Post-Group Feedback Survey.** Responses to multiple-choice and open-ended questions on the MF-PEP Therapist Post-Group Feedback Survey also indicated high satisfaction with training in and implementation of MF-PEP. Thirteen therapists completed the MF-PEP Therapist Post-Group Feedback Survey; however, not all 13 therapists answered each question. Ten therapists reported the number of years they had been independently licensed: 4 (40%) were licensed for ≥ 12 years; 3 (30%) were licensed for 5 to 8 years; 2 (20%) were licensed for 1 to 4 years; and 1 (10%) was licensed for < 1 year. Ten therapists reported what their professional license was in: 7 (70%) were in social work; and 3 (30%) were in psychology. Seven of 13 therapists (54%) had been trained in other manualized interventions for children. Eleven therapists indicated the age ranges they felt most comfortable treating: 2 (18%) felt comfortable treating 2 to 6 year olds; 10 (91%) felt comfortable treating 7 to 12 year olds; and 5 (45%) felt comfortable treating 13 to 18 year olds. Thirteen therapists indicated which three disorders they felt most comfortable
treating: 10 (77%) felt comfortable treating depression; 7 (54%) felt comfortable treating oppositional defiant disorder; 7 (54%) felt comfortable treating anxiety; 6 (46%) felt comfortable treating ADHD; 6 (46%) felt comfortable treating bipolar disorder; 2 (15%) felt comfortable treating conduct disorder; and 2 (15%) felt comfortable treating other disorders not listed.

Ten out of 13 therapists (77%) reported receiving formal training in MF-PEP at the Close to Home Behavioral Health Centers. Two of the three therapists who did not receive formal training had worked previously with the treatment developer, Dr. Fristad, and had conducted groups during the efficacy trials. The remaining therapist who did not receive formal training was a social work practicum student who helped co-facilitate one of the child groups; this practicum student helped mainly with behavior management during group. Of the 10 therapists who received formal training, 5 (50%) received 2 to 4 hours of training, and the remaining 5 therapists received 5 to 8 hours of training. The number of weeks elapsed between training and the facilitation of group varied for the 10 therapists who received formal training: 6 (60%) had > 4 weeks elapse between training and the start of group; 1 (10%) had 4 weeks elapse; 1 (10%) had 3 weeks elapse; 1 (10%) had 2 weeks elapse; and 1 (10%) had 1 week elapse. Of the 10 therapists who received formal training: 10 (100%) reviewed the treatment manual; 10 (100%) received a verbal presentation by a trainer; 9 (90%) reviewed the clinician manual; 6 (60%) received a partial video presentation; 3 (30%) received an audio-visual presentation; and 2 (20%) received a partial audio presentation.

Nine two-tailed binomial tests were used to determine if the proportion of therapists’ responses on the following questions on the MF-PEP Therapist Post-Group
Feedback Survey were more than would be expected by chance: (1) responding 4 (helpful) or 5 (very helpful) when asked about the helpfulness of six training methods; (2) responding “yes” when asked if training fully prepared them for running MF-PEP; (3) responding “yes” when asked if they were interested in continuing to run MF-PEP groups; and (4) responding “no” when asked if there were topics or skills in which training was insufficient.

Three of the nine two-tailed binomial tests indicated statistically significant results: (1) 10 out of 10 therapists (100%) rated review of the treatment manual 4 (helpful) or 5 (very helpful) significantly more than would be expected by chance, exact binomial $p = .002$, 95% CI [0.69, 1.00]; (2) 9 out of 10 therapists (90%) rated the verbal presentation training method 4 (helpful) or 5 (very helpful) significantly more than would be expected by chance, exact binomial $p = .02$, 95% CI [0.56, 1.00]; and (3) 12 out of 13 therapists (92%) responded “yes” when asked if they were interested in continuing to run MF-PEP groups significantly more than would be expected by chance, exact binomial $p = .003$, 95% CI [0.64, 1.00]. The one therapist who responded “no” when asked if interested in continuing to run MF-PEP groups indicated timing constraints and scheduling difficulties impeded her ability to run future groups. See Table 2 for all binomial test results.
Questions | $n$ | Hypothesized Response | Observed Proportion | 95% CI | $p$
--- | --- | --- | --- | --- | ---
Helpfulness of Training | | | | | |
Treatment Manual | 10 | 10 | 1.00 | 0.69, 1.00 | .002
Verbal Presentation | 10 | 9 | 0.90 | 0.56, 1.00 | .02
Clinician Manual | 9 | 7 | 0.78 | 0.40, 0.97 | .18
Partial Video | 6 | 4 | 0.67 | 0.22, 0.96 | .69
Audio-Visual | 3 | 2 | 0.67 | 0.09, 0.99 | 1.0
Partial Audio | 2 | 1 | 0.50 | 0.01, 0.99 | 1.0
Prepared from Training | 10 | 8 | 0.80 | 0.44, 0.97 | .11
Insufficient Training | 10 | 8 | 0.80 | 0.44, 0.97 | .11
Interested in Future Groups | 13 | 12 | 0.92 | 0.64, 1.00 | .003

Table 2. Binomial test results for the MF-PEP Therapist Post-Group Feedback Survey compared to chance ($p = .5$).

Responses to other multiple-choice and open-ended questions on the MF-PEP Therapist Post-Group Feedback Survey also indicated high satisfaction with training in and implementation of MF-PEP. Specific situations which could have occurred during group and corresponding training received were asked about on the MF-PEP Therapist Post-Group Feedback Survey. Most therapists noted: (1) a client’s behavioral or emotional distress disrupted the group; and (2) some clients missed more than three sessions. Most therapists felt well-trained on how to intervene in the former, but not the latter, situation. Only one therapist noted a client’s behavior became unsafe to self or others during the course of group, though most therapists reported not being well-trained in how to intervene in this situation. Many therapists reported they would like additional training in the aforementioned situations. In addition, most therapists felt fairly compensated for the time it took to prepare, run, and document the group. Therapists who did not feel fairly compensated suggested providing 1 hour of administration, preparation, clean-up, and processing time instead of 30 minutes. See Table 3 for
responses to multiple-choice questions regarding specific situations and corresponding training on the MF-PEP Therapist Post-Group Feedback Survey.

<table>
<thead>
<tr>
<th>Questions</th>
<th>n</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients’ behavioral/emotional distress disrupted group?</td>
<td>13</td>
<td>9</td>
<td>69</td>
</tr>
<tr>
<td>Trained on how to intervene in this situation?</td>
<td>12</td>
<td>8</td>
<td>67</td>
</tr>
<tr>
<td>Would you like to have received this training?</td>
<td>4</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>Clients’ behavior became unsafe to self or others?</td>
<td>13</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Trained on how to intervene in this situation?</td>
<td>10</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Would you like to have received this training?</td>
<td>6</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td>Clients missed more than 3 sessions during group?</td>
<td>13</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Trained on how to respond to this situation?</td>
<td>11</td>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td>Would you like to have received this training?</td>
<td>8</td>
<td>6</td>
<td>75</td>
</tr>
<tr>
<td>Compensated fairly for preparing and running group?</td>
<td>13</td>
<td>11</td>
<td>85</td>
</tr>
</tbody>
</table>

Table 3. MF-PEP therapists’ multiple-choice responses regarding specific situations and training on the MF-PEP Therapist Post-Group Feedback Survey.

Responses to open-ended questions on the MF-PEP Therapist Post-Group Feedback Survey also indicated high satisfaction with training in and implementation of MF-PEP. When asked about concerns regarding the therapist group training, common responses included: (1) spend more time reviewing how to run parent groups; (2) provide more training on criteria for group selection and how to identify appropriate and compatible families; and (3) provide more video examples. When asked about concerns regarding the MF-PEP group format, common responses included: (1) group member retention; (2) formalize prescreening interview to identify compatible families; (3) start group with adequate number of families; (4) children lost motivation and attention; and (5) homework completion. When asked what they liked most about the therapist group training, common responses included: (1) dialogue and feedback from others who had
received training in and facilitated MF-PEP previously; (2) reviewing the therapist manual; and (3) interactions and structure for group. Finally, when asked what they liked most about the MF-PEP group format, common responses included: (1) enjoyable to watch friendships form as families supported one another; (2) provides families with support while removing feelings of stigma and isolation; (3) families and children learn from each other; (4) flexibility of group; (5) informative, entertaining, interactive, and helpful activities; (6) three therapists to discuss clinical concerns with; and (7) separate parent and child groups. See Table 15 (Appendix K) for all responses to open-ended questions on the MF-PEP Therapist Post-Group Feedback Survey.

**Hypothesis Seven: Community Therapists’ Satisfaction**

Responses to multiple-choice and open-ended questions on the Individual/Family Therapist Questionnaire about MF-PEP indicated high satisfaction with MF-PEP as an adjunctive treatment. Twenty therapists completed the Individual/Family Therapist Questionnaire about MF-PEP; however, not all 20 therapists answered each question. Seventeen therapists (85%) who completed the questionnaire had seen the family they referred in therapy prior to the start of MF-PEP. Of these 17 therapists: 9 (53%) reported the family temporarily stopped coming to therapy during MF-PEP; 5 (29%) scheduled fewer sessions; and 3 (18%) reported no changes in the frequency of therapy sessions. When asked if MF-PEP attendance changed how therapists’ scheduled sessions due to reduced insurance coverage: 12 (71%) reported attending MF-PEP did not impact the number of sessions scheduled; 2 (12%) discontinued therapy; 2 (12%) reported the family did not need as many sessions as a result of attending MF-PEP; and 1 (6%) was unsure. When asked if MF-PEP attendance changed how families utilized therapy sessions: 5
(29%) reported no change; 4 (24%) reported families brought specific questions or concerns to sessions more than they used to; 4 (24%) reported families were able to communicate better about symptoms and behaviors; 2 (12%) reported being unable to answer because the families ceased therapy; 1 (6%) reported the family had not needed to attend therapy as often; and 1 (6%) reported the family did not use their weekly sessions as well during weeks with MF-PEP because they seemed overwhelmed with treatment.

Ten two-tailed binomial tests were used to determine if the proportion of therapists’ responses to the following questions on the Individual/Family Therapist Questionnaire about MF-PEP were more than would be expected by chance: (1) “some” or “a lot” of improvement in the therapeutic relationship; (2) “more accurate knowledge and a better understanding of mood disorders” from parents; (3) “some” or “significant” improvement in parent coping; (4) “some” or “significant” improvement in child coping; (5) “some” or “significant” improvement in family climate; (6) “some” or “a lot” more agreement among caregivers if there were two caregivers in the family; (7) “somewhat likely” or “very likely” to refer clients to MF-PEP in the future; (8) “yes” when asked if the MF-PEP motto had affected the family’s attitude; (9) “yes” when asked if the family discussed the content of MF-PEP; and (10) “no” when asked if there were goals or concepts of MF-PEP the therapist did not agree with. Responses from the two therapists who noted the family did not continue therapy with them were eliminated for all above binomial tests except for the 7th test which asked how likely therapists were to refer future clients to MF-PEP.

Five of the ten two-tailed binomial tests indicated statistically significant results: (1) 18 out of 18 therapists (100%) responded “no” when asked if there were goals or
concepts of MF-PEP the therapist did not agree with significantly more than would be expected by chance, exact binomial \( p < .001, 95\% \text{ CI } [0.81, 1.00] \); (2) 15 out of 15 therapists (100\%) reported “more accurate knowledge and a better understanding of mood disorders” from parents significantly more than would be expected by chance, exact binomial \( p < .001, 95\% \text{ CI } [0.78, 1.00] \); (3) 14 out of 15 therapists (93\%) reported “some” or “significant” improvement in parent coping significantly more than would be expected by chance, exact binomial \( p < .001, 95\% \text{ CI } [0.68, 1.00] \); (4) 18 out of 20 therapists (90\%) were “somewhat likely” or “very likely” to refer clients to MF-PEP in the future significantly more than would be expected by chance, exact binomial \( p < .001, 95\% \text{ CI } [0.68, 0.99] \); and (5) 15 out of 18 therapists (83\%) responded “yes” when asked if the family discussed the content of MF-PEP significantly more than would be expected by chance, exact binomial \( p = .008, 95\% \text{ CI } [0.59, 0.96] \). See Table 4 for all binomial test results.

<table>
<thead>
<tr>
<th>Questions</th>
<th>( n )</th>
<th>Hypothesized Response</th>
<th>Observed Proportion</th>
<th>95% CI</th>
<th>( p )</th>
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</thead>
<tbody>
<tr>
<td>Therapeutic Relationship</td>
<td>15</td>
<td>11</td>
<td>0.73</td>
<td>0.45, 0.92</td>
<td>.12</td>
</tr>
<tr>
<td>Parental Knowledge</td>
<td>15</td>
<td>15</td>
<td>1.00</td>
<td>0.78, 1.00</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Parent Coping</td>
<td>15</td>
<td>14</td>
<td>0.93</td>
<td>0.68, 1.00</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Child Coping</td>
<td>15</td>
<td>11</td>
<td>0.73</td>
<td>0.45, 0.92</td>
<td>.12</td>
</tr>
<tr>
<td>Family Climate</td>
<td>15</td>
<td>10</td>
<td>0.67</td>
<td>0.38, 0.88</td>
<td>.30</td>
</tr>
<tr>
<td>Caregiver Concordance</td>
<td>10</td>
<td>4</td>
<td>0.40</td>
<td>0.12, 0.74</td>
<td>.75</td>
</tr>
<tr>
<td>Refer Clients to MF-PEP</td>
<td>20</td>
<td>18</td>
<td>0.90</td>
<td>0.68, 0.99</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Impact on Family Attitude</td>
<td>18</td>
<td>12</td>
<td>0.67</td>
<td>0.41, 0.87</td>
<td>.24</td>
</tr>
<tr>
<td>Discuss MF-PEP in Therapy</td>
<td>18</td>
<td>15</td>
<td>0.83</td>
<td>0.59, 0.96</td>
<td>.008</td>
</tr>
<tr>
<td>Disagree with MF-PEP Goals</td>
<td>18</td>
<td>18</td>
<td>1.00</td>
<td>0.81, 1.00</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Table 4. Binomial test results for the Individual/Family Therapist Questionnaire about MF-PEP compared to chance (\( p = .5 \)).
Responses to open-ended questions on the Individual/Family Therapist Questionnaire about MF-PEP also indicated high satisfaction with MF-PEP as an adjunctive treatment. When asked about effects of the MF-PEP motto on families’ attitude, common responses included: (1) decreased blame; (2) improved understanding of children’s mental health; (3) improved parental patience and understanding; (4) improved children’s knowledge of self and symptoms; (5) improved coping skills and confidence; (6) created empathy; and (7) empowered the family. When asked if families discussed the content of MF-PEP in therapy sessions, common responses included: (1) tool box; (2) education from group; (3) support of other parents; (4) gaining knowledge; (5) how to use skills in daily lives; (6) improved communication; (7) improved coping; and (8) breathing exercises. When asked for other comments about families’ participation in MF-PEP, common responses included: (1) group was a springboard to discuss issues previously not brought up by child; (2) start group with adequate amount of families; (3) children enjoyed group and helping other members; (4) feedback about weekly attendance and performance was helpful; (5) many parents benefited significantly from group; and (6) some children did not benefit as much from group. See Table 16 (Appendix L) for all responses to open-ended questions on the Individual/Family Therapist Questionnaire about MF-PEP.

Financial Feasibility of MF-PEP

Hypothesis Eight: Financial Feasibility

Financial Feasibility of MF-PEP was evaluated through discussion with Nancy Cunningham, PsyD, Clinical Director of Community Behavioral Health, and Jarrod
Leffler, PhD, ABPP, Clinical Director of Quality and Training. Current financial and billing strategies utilized with MF-PEP at the Close to Home Behavioral Health Centers were reported. The total cost, revenue, and net result of each group was reported. Also, the number of families per group required for Nationwide Children’s Hospital to break-even financially was computed, and the number of groups which were able to meet these standards was reported. MF-PEP was expected to be a cost-neutral or cost-advantageous treatment.

The child group was billed as group psychotherapy at a reimbursement rate of $45.00 per hour ($67.50 per 1.5 hours). The parent group was billed as Prevention, Consultation, and Education (PC&E: contract funds from local county Mental Health Board) at a reimbursement rate of $85.00 per hour ($128.00 per 1.5 hours). Reimbursement from PC&E funds are not based on the number of individuals or type of service provided.

On average, $100.00 per hour ($150.00 per 1.5 hours) is the cost for a clinician’s time spent providing various services at the Close to Home Behavioral Health Centers. Clinicians are expected to provide 5.5 clinical hours in an 8 hour day. For each clinical hour, 22 minutes of “back-out time” are built into the hour in order to complete other case related activities, leaving 38 minutes of face-to-face time. Thus, for 1.5 clinical hours 33 minutes of back-out time are provided. Administration time for preparation and clinical needs (i.e., set-up and room arrangement, process last session and discuss current session) costs the Close to Home Behavioral Health Centers $50.00 per 30 minutes. For a 1.5 hour group provided with 30 minutes of administration time, a total of 63 minutes
of preparation/back-out time is provided (30 minutes from administration time plus 33 minutes of back-out time from 1.5 clinical hours).

In the current billing model, two child therapists and one parent therapist cost $150.00 each per a 1.5 hour session. In addition, the two child therapists each factor in 30 minutes of administration time ($50.00) per session as the child group requires more set-up and process time than the parent group. Thus, the cost for three therapists is $550.00 per session. In addition, group materials costs must be taken into account, including: child workbooks ($8.00 per child); parent workbooks ($15.00 per parent); prizes and miscellaneous items like pencils, easel, paper, markers, tape (about $70.00 to $120.00 per group); and snacks (about $50.00 per group). For Nationwide Children’s Hospital to break-even financially using this billing structure, each group session must bill for 1.5 hours of PC&E funds ($128.00 per 1.5 hours) and contain at least seven children ($67.50 reimbursement per child for 1.5 hour sessions). Groups that contain less than seven children result in a financial deficit. See Table 5 for cost, revenue, and net result per session for MF-PEP groups containing 6, 7, or 8 children when billing for 1.5 hours of PC&E.
<table>
<thead>
<tr>
<th>Session Cost and Revenue</th>
<th>Children per Group</th>
<th>Six</th>
<th>Seven</th>
<th>Eight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Child Therapists</td>
<td>$400.00</td>
<td>$400.00</td>
<td>$400.00</td>
<td></td>
</tr>
<tr>
<td>1 Parent Therapist</td>
<td>$150.00</td>
<td>$150.00</td>
<td>$150.00</td>
<td></td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>$550.00</td>
<td>$550.00</td>
<td>$550.00</td>
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</tr>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 hours PC&amp;E</td>
<td>$128.00</td>
<td>$128.00</td>
<td>$128.00</td>
<td></td>
</tr>
<tr>
<td>Child Clients</td>
<td>$405.00</td>
<td>$472.50</td>
<td>$540.00</td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$533.00</td>
<td>$600.50</td>
<td>$668.00</td>
<td></td>
</tr>
<tr>
<td><strong>Session Net Result</strong></td>
<td>-$17.00</td>
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<td>+$118.00</td>
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<td><strong>Group Materials Cost</strong></td>
<td>$308.00</td>
<td>$331.00</td>
<td>$354.00</td>
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<tr>
<td><strong>Group Net Result (8 sessions)</strong></td>
<td>-$444.00</td>
<td>+$73.00</td>
<td>+$590.00</td>
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</table>

Table 5. Cost, revenue, and net result per session for MF-PEP groups containing 6, 7, or 8 children when billing for 1.5 hours PC&E and 3 therapists.

Moving forward, groups could bill for 2 hours of PC&E funds ($170.00) per session to reduce costs. Though seven children per group would still be required to break-even financially, the cost to Nationwide Children’s Hospital would decrease and the revenue obtained per group would increase. Billing for 2 hours of PC&E funds could help offset costs; however, PC&E funds are a limited resource and used for various other purposes and programs at the Close to Home Behavioral Health Centers. Thus, billing for 2 hours of PC&E funds for MF-PEP groups would reduce the amount of available funds for other programs. See Table 6 for cost, revenue, and net result per session for MF-PEP groups containing 6, 7, or 8 children when billing for 2 hours of PC&E.
<table>
<thead>
<tr>
<th>Session Cost and Revenue</th>
<th>Children per Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Six</td>
</tr>
<tr>
<td>Cost</td>
<td></td>
</tr>
<tr>
<td>2 Child Therapists</td>
<td>$400.00</td>
</tr>
<tr>
<td>1 Parent Therapist</td>
<td>$150.00</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$550.00</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
</tr>
<tr>
<td>2 hours PC&amp;E</td>
<td>$170.00</td>
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<tr>
<td>Child Clients</td>
<td>$405.00</td>
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<tr>
<td>Total Revenue</td>
<td>$575.00</td>
</tr>
<tr>
<td>Session Net Result</td>
<td>+$25.00</td>
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<tr>
<td>Group Materials Cost</td>
<td>$308.00</td>
</tr>
<tr>
<td>Group Net Result (8 sessions)</td>
<td>-$108.00</td>
</tr>
</tbody>
</table>

Table 6. Cost, revenue, and net result per session for MF-PEP groups containing 6, 7, or 8 children when billing for 2 hours PC&E and 3 therapists.

In efforts to further defray costs, a practicum student could be used to co-facilitate child groups. Practicum students are not responsible for billable clinical time and are not paid employees; thus, such a structure would only require two therapists’ time, which would substantially reduce costs. In fact, less children per group would be required for Nationwide Children’s Hospital to break-even financially. Specifically, only four children per group when billing for 1.5 hours of PC&E (+$48.00 session net result and +$122.00 group net result) or 2 hours of PC&E (+$90.00 session net result and +$458.00 group net result) would be required for Nationwide Children’s Hospital to break-even financially. However, such small groups would likely not be ideal for facilitating curriculum and group cohesion. See Table 7 for cost, revenue, and net result per session for MF-PEP groups containing 6, 7, or 8 children when billing for 1.5 hours of PC&E and 2 therapists. See Table 8 for cost, revenue, and net result per session for MF-PEP groups containing 6, 7, or 8 children when billing for 2 hours of PC&E and 2 therapists.
<table>
<thead>
<tr>
<th>Children per Group</th>
<th>Six</th>
<th>Seven</th>
<th>Eight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session Cost and Revenue</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Cost</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Child Therapist</td>
<td>$200.00</td>
<td>$200.00</td>
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<td>1 Parent Therapist</td>
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<td>Total Cost</td>
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<td>$350.00</td>
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<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 hours PC&amp;E</td>
<td>$128.00</td>
<td>$128.00</td>
<td>$128.00</td>
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<tr>
<td>Child Clients</td>
<td>$405.00</td>
<td>$472.50</td>
<td>$540.00</td>
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<tr>
<td>Total Revenue</td>
<td>$533.00</td>
<td>$600.50</td>
<td>$668.00</td>
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<tr>
<td><strong>Session Net Result</strong></td>
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<td>+$318.00</td>
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<td><strong>Group Materials Cost</strong></td>
<td>$308.00</td>
<td>$331.00</td>
<td>$354.00</td>
</tr>
<tr>
<td><strong>Group Net Result (8 sessions)</strong></td>
<td>+$1,156.00</td>
<td>+$1,673.00</td>
<td>+$2,190.00</td>
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</tbody>
</table>

Table 7. Cost, revenue, and net result per session for MF-PEP groups containing 6, 7, or 8 children when billing for 1.5 hours PC&E and 2 therapists.

<table>
<thead>
<tr>
<th>Children per Group</th>
<th>Six</th>
<th>Seven</th>
<th>Eight</th>
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<tr>
<td><strong>Session Cost and Revenue</strong></td>
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</tr>
<tr>
<td><strong>Cost</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1 Child Therapist</td>
<td>$200.00</td>
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<td>1 Parent Therapist</td>
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<td>Total Cost</td>
<td>$350.00</td>
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<td>$350.00</td>
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<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 hours PC&amp;E</td>
<td>$170.00</td>
<td>$170.00</td>
<td>$170.00</td>
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<td>Child Clients</td>
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<td>$540.00</td>
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<td>Total Revenue</td>
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<td><strong>Group Materials Cost</strong></td>
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<td>$354.00</td>
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<td><strong>Group Net Result (8 sessions)</strong></td>
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<td>+$2,009.00</td>
<td>+$2,526.00</td>
</tr>
</tbody>
</table>

Table 8. Cost, revenue, and net result per session for MF-PEP groups containing 6, 7, or 8 children when billing for 2 hours PC&E and 2 therapists.

Approximate cost, revenue, and net result per session for each of 8 MF-PEP groups conducted at Westerville and Reynoldsburg Close to Home Behavioral Health Centers were also calculated. The number of therapists conducting each group and the
number of children who completed each group were taken into account. Attendance at each specific group session was not collected; thus, the number of families completing group was used in calculations. In addition, parent and child workbooks were manufactured through grant funds obtained through The Ohio State University Center for Clinical and Translational Science Community Engagement Program; thus, these costs were not included in the below calculations. None of the Westerville or Reynoldsburg groups broke-even financially. The four Westerville groups showed approximate financial deficits per session of: $152.00; $219.50; $234.50; and $287.00. When these approximate financial deficits per session were multiplied by 8 sessions and group materials costs were taken into account, the approximate amount of money lost per group at Westerville was: $1,336.00; $1,876.00; $1,996.00; and $2,416.00. The four Reynoldsburg groups showed approximate financial deficits per session of: $17.00; $152.00; $287.00; and $302.00. When these approximate financial deficits per session were multiplied by 8 sessions and group materials costs were taken into account, the approximate amount of money lost per group at Reynoldsburg was: $256.00; $1,336.00; $2,416.00; and $2,536.00. Thus, the approximate total amount of money lost between Westerville and Reynoldsburg sites was $14,168.00.

The majority of groups utilized the optimal number of therapists: two child therapists and one parent therapist. Specifically, six groups utilized two child therapists and one parent therapist, while two groups utilized two child therapists and two parent therapists. Two parent therapists were used in these two instances for training purposes. The Westerville group starting 03/2010 utilized three child therapists; however, the third child therapist was a social work practicum student who was not responsible for billable
time or being paid, thus she was not included in calculations. As noted earlier, use of a practicum student to co-lead child groups would have substantially reduced costs.

While MF-PEP has the potential to break-even financially, as evidenced by aforementioned calculations, at least seven families are required to attend and complete group in order to do so when billing for 1.5 or 2 hours PC&E. If the Close to Home Behavioral Health Centers utilize practicum students to co-facilitate child groups in future implementations, then as few as four families would be required in order to break-even financially. None of the eight MF-PEP groups had seven or more families complete MF-PEP; five groups had four or more families complete MF-PEP. See Table 9 for cost, revenue, and net result per session for Westerville MF-PEP groups and Table 10 for cost, revenue, and net result per session for Reynoldsburg MF-PEP groups.

<table>
<thead>
<tr>
<th>Session Cost and Revenue</th>
<th>Westerville Groups Start Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>04/2008</td>
</tr>
<tr>
<td>Cost</td>
<td></td>
</tr>
<tr>
<td>Child Therapists $(n)$</td>
<td>$400.00 (2)</td>
</tr>
<tr>
<td>Parent Therapists $(n)$</td>
<td>$150.00 (1)</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$550.00</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
</tr>
<tr>
<td>1.5 hours PC&amp;E</td>
<td>$128.00</td>
</tr>
<tr>
<td>Child Clients $(n)$</td>
<td>$202.50 (3)</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$330.50</td>
</tr>
<tr>
<td>Session Net Result</td>
<td>-$219.50</td>
</tr>
<tr>
<td>Group Materials Cost</td>
<td>$120.00</td>
</tr>
<tr>
<td>Group Net Result</td>
<td>-$1,876.00</td>
</tr>
</tbody>
</table>

Table 9. Cost, revenue, and net result per session for Westerville MF-PEP groups.
<table>
<thead>
<tr>
<th>Session Cost and Revenue</th>
<th>Reynoldsburg Groups Start Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/2009</td>
</tr>
<tr>
<td>Cost</td>
<td></td>
</tr>
<tr>
<td>Child Therapists $(n)$</td>
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</tr>
<tr>
<td>Parent Therapists $(n)$</td>
<td>$150.00</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$550.00</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
</tr>
<tr>
<td>1.5 hours PC&amp;E</td>
<td>$128.00</td>
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<tr>
<td>Child Clients $(n)$</td>
<td>$135.00</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$263.00</td>
</tr>
<tr>
<td>Session Net Result</td>
<td>-$287.00</td>
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<tr>
<td>Group Materials Cost</td>
<td>$120.00</td>
</tr>
<tr>
<td>Group Net Result</td>
<td>-$2,416.00</td>
</tr>
</tbody>
</table>

Table 10. Cost, revenue, and net result per session for Reynoldsburg MF-PEP groups.

Training costs must also be considered when examining the financial feasibility of MF-PEP. Twelve therapists were trained in MF-PEP. As mentioned earlier, two therapists had previously worked with the treatment developer and facilitated groups during the efficacy trial and thus did not require training, and one therapist was a social work practicum student who did not attend training. Each therapist training manual costs $14.00 to produce; these were not included in current training costs calculations as grant funding was used to pay for these manuals.

Two training sessions were held: 2 trainers facilitated a 5-hour training for 7 therapists; and 1 trainer facilitated a 4-hour training for 5 therapists. For the 5-hour training, costs included 2 trainers at $500.00 each ($1,000.00 total) and 7 therapists’ clinical billable time at $500.00 each ($3,500.00 total). Thus, the total training costs for the 5 hour training was $4,500.00. For the 4-hour training, costs included one trainer at $400.00 and 5 therapists’ clinical billable time at $400.00 each ($2,000.00 total). Thus,
the total training costs for the 4-hour training was $2,400.00. Total training costs for both training sessions equaled $6,900.00.

Each therapist was also allotted 30 minutes of consultation at $50.00 per session ($400.00 per clinician per 8 session group). Fourteen therapists conducted eight MF-PEP groups: experienced therapists provided consultation while novice therapists received consultation. The social work practicum student was not included in these calculations. Based on the number of therapists per group noted above in Tables 9 and 10, $10,400.00 was spent on consultation.

The total training costs for both training sessions and consultation was $17,300.00. Had the cost of therapist manuals been included ($14.00 each) for these 14 therapists, the training costs would have increased by $196.00 to $17,496.00. Of note, $6,448.00 was provided to Nationwide Children’s Hospital through grant funding to defray some training costs, which reduced the training costs to $10,852.00. When adding the therapist training cost from the current trial ($10,852.00) to the approximate financial deficits from groups ($14,168.00), the amount of money invested in MF-PEP by Nationwide Children’s Hospital that was not compensated by insurance reimbursement or other means was $25,020.00.
Chapter 4: Discussion

Summary

Despite urges from various government agencies, healthcare policymakers, and professional organizations, relatively little research has examined the effectiveness, transportability, and dissemination of EBTs. Historically, developments in EBTs, EBP, and translational research for youth have progressed slower than advances in adult literature. Although various models of dissemination and influential movements in the field of psychology have initiated progress in translational research, this area remains understudied, especially in the realm of childhood and adolescent disorders.

Childhood and adolescent mood disorders are significant public health concerns due to their prevalence and potential devastation on current and future functioning. Though progress has been made in the development and evaluation of efficacy, effectiveness, transportability, and dissemination of interventions for youth DSD, the majority of these studies investigated adolescent DSD. Those studies including children primarily consisted of prevention programs for youth with elevated depressive symptoms. Also, no intervention has focused exclusively on the treatment of diagnosed depression in youth 12 years and younger.

To date, only six groups have investigated psychosocial interventions for childhood and adolescent BPSD, and of those only two groups have developed three interventions for children with BPSD. Of those three treatments for children, only IF-
PEP and MF-PEP have been examined in RCTs. No studies to date have examined the implementation of psychosocial treatments for youth BPSD in real-world settings.

Thus, despite progress in the development and evaluation of EBTs for youth with mood disorders, studies examining the efficacy of interventions exclusively for children ages 12 and under meeting diagnostic criteria for DSD are nonexistent and for children with BPSD are relatively rare when compared to studies examining adolescent depression interventions. Similarly, few studies have examined the translation of childhood DSD interventions implemented in real-world settings when compared to translational research for adolescent DSD interventions, and none have examined the implementation of childhood or adolescent BPSD interventions.

This pilot effectiveness and transportability trial examined the feasibility and effectiveness of MF-PEP, an EBT for children ages 8 to 12 with DSD and/or BPSD, when implemented under real-world conditions. This trial was conducted in practice settings with community therapists with variable training and heavy caseloads and with clinically-referred youth. Pragmatic limitations of transporting EBTs out of highly controlled research conditions were assessed. In addition, analyses examined whether MF-PEP could be implemented in a practice setting with beneficial results for children and families. Results from this trial will be used to alter and improve MF-PEP to enhance its transportability to practice settings, and also lay the groundwork for undertaking future effectiveness investigations of MF-PEP.
Treatment Effectiveness and Response

Hypothesis One: Parental Knowledge of Mood Disorders

Results from this open trial provide initial support for the feasibility and transportability of MF-PEP for children with mood disorders in community settings. A significant increase in parental knowledge of mood disorders was evident from pre- \((M = 33.27, SD = 7.72)\) to post-treatment \((M = 36.86, SD = 3.30)\). Similar significant increases in parental knowledge of mood disorders immediately post-treatment were found in efficacy investigations of MF-PEP. An initial efficacy investigation of MF-PEP reported IMM parents demonstrated significantly more knowledge than WLC parents pre-treatment \((M = 31.9, SD = 6.9)\) to post-treatment \((M = 36.3, SD = 4.1)\) and through 4-month follow-up \((M = 36.9, SD = 3.4;\) Fristad et al., 2003). Similar increases in UMDQ scores were noted for the WLC group from pre-treatment \((M = 34.6, SD = 5.1)\) to post-treatment \((M = 37.4, SD = 2.1;\) Fristad et al., 2003). The larger efficacy trial did not administer the UMDQ immediately post-treatment, but noted similar significant increases for IMM parents compared with WLC parents from pre-treatment \((M = 33.48, SD = 5.08)\) to 6-month follow-up \((M = 36.90, SD = 2.11)\) and through 12-month follow-up \((M = 37.25, SD = 2.78;\) Mendenhall et al., 2009). Similar mean pre- and post-treatment scores on the UMDQ obtained in efficacy and effectiveness investigations indicate both statistically and clinically significant change.

Long-term follow-up data from efficacy investigations of MF-PEP indicated increases in parental knowledge of mood disorders were maintained at 6-month follow-up through 12-month follow-up (Fristad et al., 2002, 2003; Goldberg-Arnold et al., 1999; Mendenhall et al., 2009). Efficacy RCTs also indicated parents receiving MF-PEP
demonstrated significantly greater improvements in knowledge of mood disorders than a WLC group. In addition, pre- and post-treatment gains in knowledge of mood disorders were similar for the IMM and WLC groups after completing MF-PEP (Fristad et al., 2002, 2003; Goldberg-Arnold et al., 1999; Mendenhall et al., 2009).

As the current study was an open investigation of MF-PEP with pre- and post-treatment questionnaires and no control group, conclusions regarding long-term outcomes and comparisons to a control condition were not possible. However, these initial findings indicate MF-PEP provides similar outcomes in parental knowledge as observed in efficacy investigations.

**Hypothesis Two: Parental Treatment Beliefs**

Improvement in parents’ favorable treatment beliefs pre-treatment ($M = 3.86, SD = 0.49$) to post-treatment ($M = 3.96, SD = 0.43$) was not significant. The small sample size and suboptimal data collection may have limited the ability to detect statistically significant results. Initial efficacy investigations of MF-PEP analyzing qualitative feedback from parents indicated few changes in parental attitudinal shifts immediately post-treatment; however, a statistically significant attitudinal shift was apparent at 6-month follow-up (Goldberg-Arnold et al., 1999). Parents’ favorable treatment beliefs measured on the TBQ-P was only utilized in one of the prior efficacy investigations of MF-PEP (Mendenhall et al., 2009). In this efficacy trial, assessments were not administered immediately post-treatment, but rather at 6-month and 12-month follow-up. IMM parents demonstrated significantly greater improvements in treatment beliefs than WLC parents from pre-treatment ($M = 3.74, SD = 0.40$) to 6-month follow-up ($M = 3.94, SD = 0.48$) and through 12-month follow-up ($M = 4.00, SD = 0.41$: Mendenhall et al., 2009).
While parents in the IMM group had greater improvement in favorable treatment beliefs than the WLC group, it may be that such differences do not emerge directly post-treatment, but rather have a delayed effect. Indeed, parental treatment beliefs were found to be an important mediator in MF-PEP efficacy investigations. An analysis of treatment mediators revealed participation in MF-PEP significantly improved clinician-rated quality of services utilized, mediated by parents’ beliefs about treatment, and participation in MF-PEP also significantly improved children’s mood symptom severity, mediated by clinician-rated quality of services used (Mendenhall et al., 2009). Thus, MF-PEP helps parents become better consumers of mental health services, and access to higher-quality services results in decreased mood symptom severity (Fristad et al., 2009).

Therefore, parents’ favorable treatment beliefs may show a larger shift after accessing higher-quality services following MF-PEP and observing improvements in their children’s mood symptoms. While parents showed a non-significant shift in favorable treatment beliefs post-treatment, attaining appropriate services and experiencing the benefit from higher-quality services may have a larger impact on improving favorable treatment beliefs, rather than simply learning about treatment options and how to advocate for their children in MF-PEP. In addition, the process of becoming active members of children’s treatment teams and advocating for children requires time. For example, parents must process and incorporate newly learned information, decide which treatment options would be most beneficial for their children, arrange and plan for school meetings and treatment appointments, and wait for school support to be initiated or for appointment openings with clinicians. Such changes in treatment utilization and subsequent treatment beliefs would likely not be apparent
immediately post-treatment; however, once supports have been put in place, attitudinal shifts may be evident.

As the current study was an open investigation of MF-PEP with pre- and post-treatment questionnaires and no control group, conclusions regarding long-term outcomes and comparisons to a control condition were not possible. Though initial findings were not significant, future research is warranted to investigate whether participation in MF-PEP is associated with similar outcomes in parental favorable treatment beliefs as observed in efficacy investigations.

**Hypothesis Three: Children’s Treatment Beliefs**

Improvement in children’s favorable treatment beliefs pre- to post-treatment was not significant. The small sample size and suboptimal data collection may have limited the ability to detect statistically significant results. Children’s favorable treatment beliefs measured on the TBQ-C were only analyzed in one of the prior efficacy investigations of MF-PEP. Also, the TBQ-C has only been analyzed in evaluations of psychometric properties, rather than in evaluations of pre- and post-treatment effects (Davidson & Fristad, 2006). Psychometric evaluations of the TBQ-C revealed satisfactory convergent validity, discriminant validity, and predictive validity (Davidson & Fristad, 2006). The TBQ-C also demonstrated good internal consistency but less test-rest stability than the TBQ-P over a 6-month period, with only two of the six subscales demonstrating test-retest stability (Davidson & Fristad, 2006). This finding was not surprising, as poor correlation between child and parent informants is typical (Hawley & Weisz, 2003; Yeh & Weisz, 2001). However, this indicates the TBC-C may not be as reliable or as sensitive to measuring change as the TBQ-P.
In addition, children’s favorable treatment beliefs may not increase pre- to post-treatment as a result of MF-PEP. In the parental MF-PEP curriculum, parents learn about symptoms and management of the disorder, coping and communication skills, and different treatment options and resources. Parents are encouraged to be an advocate for their child and to become an active member of their child’s treatment team. The same emphasis is not placed on learning treatment resources in the MF-PEP child curriculum. Rather, children learn about mood disorders and different tools for managing symptoms. Thus, it may be that parental treatment beliefs, but not children’s treatment beliefs, are positively affected by participation in MF-PEP.

It is also possible that children’s treatment beliefs function in a similar manner to parental treatment beliefs in the efficacy investigations of MF-PEP. Children’s favorable treatment beliefs could show a larger shift after accessing higher-quality services and experiencing improvements in mood symptom severity, rather than directly post-treatment. While children showed a non-significant shift in favorable treatment beliefs post-treatment, attaining appropriate services and experiencing the benefit from higher-quality services may have a larger impact on improving favorable treatment beliefs, rather than simply learning about mood disorders and coping skills in MF-PEP.

As the current study was an open investigation of MF-PEP with pre- and post-treatment questionnaires and no control group, conclusions regarding long-term outcomes and comparisons to a control condition were not possible. Though initial findings were not significant, future research is warranted to investigate whether participation in MF-PEP is associated with similar outcomes in children’s favorable treatment beliefs as observed in parental treatment beliefs in efficacy investigations.
Hypothesis Four: Children’s Depressive and Manic Symptom Severity

Improvements in children’s depressive and manic symptoms pre- to post-treatment were not significant. The small sample size and suboptimal data collection may have limited the ability to detect statistically significant results. Paired pre-post data from the CDI was particularly low because this measure was not added until the third group at Reynoldsburg. Thus, this measure was only administered to children at the last three of the eight groups.

While children’s depressive and manic symptoms were measured in past efficacy trials of MF-PEP, different primary outcome measures were utilized: the clinician-rated CDRS-R (Poznanski et al., 1984) for depressive symptoms; the clinician-rated MRS (Young et al., 1978) for manic symptoms; and The Mood Severity Index (MSI: Fristad et al., 2009) for composite depressive and manic symptoms. The CDRS-R, MRS, and MSI are clinician-rated measures which incorporate both parents’ and children’s reports of symptoms, whereas the CDI is a children’s self-report measure of depressive symptoms and the PGBI-10M is a parental self-report measure of children’s manic symptoms. While clinician-rated measures of symptom severity are common in efficacy trials, self-report measures are common in effectiveness trials in order to reduce burden on parents, children, and community therapists, and also to simulate real-world conditions (Steele et al., 2008). Differences in self-report versus clinician-rated primary outcome measures may contribute to differences in outcomes between efficacy and effectiveness investigations of MF-PEP. Also, both parental and children’s input and corroborating reports of symptoms are important to incorporate and consider when evaluating mood
symptoms. Future effectiveness investigations of MF-PEP should gather parental and children’s report of depressive and manic symptoms.

In addition to differences in primary outcome measures, a second consideration when interpreting non-significant findings in the current study compared with efficacy trials is that initial efficacy investigations of MF-PEP did not find significant reductions in depressive or manic symptoms following treatment (Fristad et al., 2002, 2003; Goldberg-Arnold et al., 1999). A subsequent efficacy study using a larger sample size found MF-PEP was associated with improvement in mood symptom severity compared with a WLC group over a 1-year follow-up with additional improvement through 18-month follow-up (Fristad et al., 2009). When WLC participants received treatment after 12 months, they showed a similar pattern of improved symptoms, with a trend approaching but not reaching statistical significance. This may be owing to the limited follow-up period (6 months) for the WLC after starting treatment. Therefore, MF-PEP treatment effects may be cumulative, taking longer than 6 months to reach statistical and clinical significance (Fristad et al., 2009). As aforementioned, an analysis of treatment mediators revealed MF-PEP helps parents become better consumers of mental health services, and access to higher-quality services results in decreased mood symptom severity (Fristad et al., 2009). Thus, similar to improvements in treatment beliefs, improvements in mood symptom severity may not be apparent immediately post-treatment, as measured in the current study, but rather have a delayed effect after parents become better consumers of mental health services and access higher-quality treatment.

Another consideration when interpreting non-significant findings in the current study separate from methodological differences in the efficacy trial is treatment
effectiveness when EBTs are implemented in community settings. Research suggests psychotherapy often has stronger effects in university-based research studies than in community clinical settings (Weersing & Weisz, 2002; Weiss et al., 1999; Weiss & Weisz, 1995; Weisz et al., 1995). Thus, even when the same treatment with demonstrated efficacy is implemented in the community, various factors can lead to decreased effectiveness. One factor is therapist training and level of experience (discussed in detail below). A second factor is treatment fidelity. Treatment fidelity monitoring is recommended in both efficacy and effectiveness research to ensure the treatment is being implemented in a consistent manner across clinicians (Chambless & Hollon, 1998). Treatment fidelity was not monitored in the current effectiveness trial; thus, it is uncertain whether the treatment was implemented as intended and as was done in prior efficacy investigations. If treatment fidelity was poor, then the same positive effects observed in the efficacy trial may not have been present in the current effectiveness trial because the treatment was delivered differently in the two investigations.

A third factor in efficacy and effectiveness investigations includes differences in clientele. Effectiveness trials use very lax or limited inclusion/exclusion criteria to capture the heterogeneity of clients presenting for treatment in real-world environments (Steele et al., 2008). Indeed, the current effectiveness trial had very few inclusion/exclusion criteria. While prior efficacy investigations of MF-PEP also offered few inclusion/exclusion criteria, the clientele presenting for treatment at a university-based research hospital and community behavioral health setting differ greatly. For example, Weersing and colleagues (2006) found youth treated with CBT in an outpatient
depression specialty clinic experienced significant symptom improvement; however, this symptom improvement was significantly slower than youth in the CBT benchmark. Depressed youth treated with CBT in the outpatient depression specialty clinic were more similar to the research benchmark when accounting for differences in referral source (i.e., clinical versus advertisement) between the datasets. Those treated at the specialty clinic were referred from other mental health providers, schools, or discharged from inpatient hospitalizations, whereas a third of those treated in the RCT benchmark were largely recruited via newspaper advertisement. Analyses revealed symptom trajectories for youth at the outpatient depression specialty clinic more closely resembled those of clinically referred RCT youth (Weersing et al., 2006).

Thus, clinically referred youth may present with more impairing and severe symptoms which were unable to be addressed by other mental health providers, whereas those responding to advertisements may not experience as much immediate impairment. A two-tailed, independent-samples $t$-test revealed the mean baseline CDI score from all participants (IMM and WLC) in the larger MF-PEP efficacy investigation ($M = 9.91, SD = 8.21$) was significantly lower than the mean baseline CDI score in the current effectiveness trial ($M = 18.44, SD = 12.55$), $t (167) = 2.94, p = .004, 95\% CI [2.80, 14.26]$. However, baseline CDI data from participants with diagnosed depression in the larger MF-PEP efficacy investigation did not reveal a significantly lower mean CDI score ($M = 11.92, SD = 9.25$) than the mean baseline CDI score reported in the current effectiveness trial ($M = 18.44, SD = 12.55$), $t (56) = 1.83, p = .07, 95\% CI [-0.61, 13.66]$. Specific mood diagnoses for participants in the effectiveness trial were not collected; thus, comparisons between baseline CDI scores in efficacy and effectiveness participants
with diagnosed depression could not be conducted. As noted earlier, these data should be interpreted with caution, as results from the effectiveness data are based on nine children’s self-report of depressive symptoms. While the majority of families in the larger MF-PEP efficacy trial were clinically referred, a notable amount were recruited via media coverage (local news stories, advertisements: 19%) and word of mouth or fliers (19%: Fristad et al., 2009). Thus, it is possible youth treated in the effectiveness trial presented with more complex and severe impairment than those recruited via media coverage, word of mouth, or fliers in the efficacy trial, and as a result did not experience a post-treatment decrease in mood symptom severity.

As the current study was an open investigation of MF-PEP with pre- and post-treatment questionnaires and no control group, conclusions regarding long-term outcomes and comparisons to a control condition were not possible. Though initial findings were not significant, future research is warranted to investigate whether participation in MF-PEP is associated with similar improvements in children’s mood symptom severity as observed in efficacy investigations.

**Consumer Satisfaction**

**Hypothesis five: Parents’ and Children’s Satisfaction**

Both quantitative and qualitative data from parents and children indicated high satisfaction with MF-PEP. Quantitative data indicated the mean parents’ and children’s satisfaction scores were significantly greater than a neutral score of 3. In addition, the majority of parents composite scores were 4 or 5 (*strongly agree*) significantly more than would be expected by chance. While the majority of children’s composite satisfaction
scores were also 4 or 5 (strongly agree), this proportion was not significantly more than would be expected by chance.

Qualitative feedback from parents and children also indicated high satisfaction with MF-PEP. Parents’ suggestions for future MF-PEP groups have been noted and can be used to improve future groups. For example, the Close to Home Behavioral Health Centers have already instituted a prescreening interview to assess potential families for compatibility with group and only start groups with an adequate number of families. Other parental suggestions could be flexibly incorporated into current procedures, such as: increasing the time for open discussion among parents; learning more about appropriate punishment; allowing more time for collaboration between parent and child groups; providing referrals for parental support groups; providing more visual aids; providing more community resource information; and adapting group to knowledge-level of families.

Statements of thanks and appreciation were also written when parents were asked for additional feedback and comments. These comments were similar to qualitative feedback from families participating in the efficacy trial. Evidence of improved knowledge, coping skills, support, and attitudinal shifts were apparent both in the current effectiveness study and efficacy investigations of MF-PEP (Fristad et al., 2002, 2003; Goldberg-Arnold et al., 1999). Children’s qualitative feedback also indicated high satisfaction with MF-PEP. Though suggestions for more snacks and less sessions were made, overall responses were positive, as similarly evidenced by high composite satisfaction scores.
Parents’ and children’s positive experience and satisfaction with MF-PEP provide evidence for its transportability to community settings. This feedback indicated the treatment is acceptable and helpful to families. It was received well by families, and anecdotal data indicate improvements in knowledge, coping skills, and support, similar to improvements noted in the efficacy trials. In addition, retention and treatment completion was high, with 30 out of 40 families (75%) completing MF-PEP. Failure to attend appointments poses a significant barrier to the implementation of effective interventions for child and adolescent mental health services (Watt & Dadds, 2007). Approximately 12% to 36% of initial appointments are not attended and about 1 in 3 subsequent appointments are not attended (Carr, McDonnel, & Owen, 1994; Conduit, Byrne, Court, & Stefanovic, 2004; McKay, McCadam, & Gonzales, 1996). The high attendance and completion rate of MF-PEP provide further evidence for its acceptability and transportability to community settings.

Provider Satisfaction

Hypothesis Six: MF-PEP Therapists’ Satisfaction

Both quantitative and qualitative data from MF-PEP therapists indicated high satisfaction with training in and facilitation of MF-PEP. The majority of MF-PEP therapists were licensed social workers. About half also noted training in other manualized treatments. In addition, a majority felt comfortable treating the age range and mood disorders for which MF-PEP was designed. Regarding MF-PEP training, half indicated 2 to 4 hours of training and half indicated 5 to 8 hours of training. Most found review of the treatment manual, review of the clinician manual, and verbal presentation helpful training modalities. In addition, a majority of therapists found training in MF-
PEP adequate and were interested in running future MF-PEP groups. Suggestions from therapists could be used to improve MF-PEP training efforts moving forward, such as providing more audio-visual examples of group, observing a group before facilitating a group, and providing ongoing supervision with the option for processing group and receiving direct feedback of skills.

Therapists facilitating MF-PEP in the current trial differed greatly in their experience and background from those who facilitated MF-PEP in prior efficacy investigations. Most effectiveness trials are conducted in community settings with community therapists who have variable training and heavy caseloads (Steele et al., 2008). Community therapists often do not receive intensive training in the treatment prior to implementation, as is common in efficacy trials (Steele et al., 2008). Indeed, most of the community therapists who implemented MF-PEP in the current effectiveness trial were licensed social workers who received a brief training in MF-PEP, whereas clinicians facilitating MF-PEP groups in the efficacy trials were experienced doctoral-level, post-doctoral, or advanced graduate student clinicians who received extensive training and weekly group supervision from the treatment developer (Fristad et al., 2009). As mentioned earlier, these differences in training and experience could lead to differences in treatment fidelity in the efficacy and effectiveness investigations of MF-PEP and subsequently affect clinical outcomes. Future effectiveness trials should monitor treatment fidelity.

Despite differences in training and experience level, MF-PEP therapists were satisfied with training in and implementation of MF-PEP. This provides support for the transportability of the intervention to community settings. Often, therapist knowledge,
attitudinal, and practice barriers pose obstacles when attempting to transport an EBT to a community setting (Higa & Chorpita, 2008). However, the fact that most therapists reported: (1) a positive experience with training in and facilitation of MF-PEP; (2) interest in running future MF-PEP groups; and (3) training in other manualized treatments suggest positive attitudes toward EBTs.

It should be noted that Nationwide Children’s Hospital’s Close to Home Behavioral Health Centers are particularly interested in transporting EBTs to their clinics. Also, Dr. Leffler, Clinical Director of Quality and Training at Nationwide Children’s Hospital, worked with Dr. Fristad as a post-doctoral student and facilitates other group-based EBTs at the Close to Home Behavioral Health Centers. Transport of MF-PEP may be more difficult in settings where individuals who previously worked with the treatment developer are not present, and where implementation of EBTs is not a priority. Research suggests practicing clinical psychologists support the development of EBTs, but often don’t use them in clinical practice (Plante, Andersen, & Boccaccini, 1999). Also, a survey of community practitioners revealed only 35% to 54% of agencies required therapists to implement EBTs: even when EBTs were utilized, the full treatment protocol often was not implemented (Sheehan, Walrath, & Holden, 2007). Nevertheless, positive evaluations of MF-PEP by community therapists lend support to the transportability of the treatment. Additionally, the development of user-friendly manuals, training efforts, and the development of transparent, collaborative relationships with various systems and stakeholders at the Close to Home Behavioral Health Centers aided in effectiveness and transportability efforts and will be important to incorporate in future studies.
Qualitative feedback from MF-PEP therapists also indicated high satisfaction with MF-PEP. For example, most therapists found many of the techniques and group content beneficial to families. Therapists’ suggestions for future MF-PEP groups have been noted and can be used to improve future groups. For example, many noted difficulty with study questionnaire completion and the medication match game. Suggestions and strategies for remedying both of these difficulties have been initiated: the study coordinator attended the first and last session to facilitate study questionnaire completion; and therapists were advised to tailor medication discussion to medications currently taken by group members. Other strategies will likely be tested moving forward to ease the transportability process. Therapists also provided feedback regarding minor spelling errors and suggestions for additions to the workbooks (e.g., adding additional feelings categories and including breathing worksheets), which have been added. In addition, the Close to Home Behavioral Health Centers initiated regular prescreening interviews to assess families’ compatibility with group and ensure adequate group size prior to starting group after obtaining feedback from therapists, as prescreening interviews were not conducted in initial groups.

Some child group therapists suggested shortening the number of sessions. In this case, treatment fidelity would be interesting to measure to determine whether the treatment was implemented as intended, as therapists in the efficacy trials did not suggest this, and parents in both the efficacy and effectiveness trials requested increasing the number and length of sessions. Therapists also noted difficulty with various activities and covering all session content. In response to some of these concerns, the treatment developer and supervisors at the Close to Home Behavioral Health Centers stressed to
therapists the “flexibility within fidelity” notion during therapist feedback meetings (Kendall & Beidas, 2007). Therapists should adhere to evidence-based principles outlined in the manual and workbooks while flexibly adapting content to the developmental level and unique needs of each group. This skill set likely comes with time and practice implementing groups. Moving forward, Close to Home Behavioral Health Center supervisors will hold bi-yearly meetings with all MF-PEP therapists to process group experience, gather feedback, and provide recommendations and suggestions for future groups. Nevertheless, overall consensus from therapists indicated high satisfaction with training in and implementation of MF-PEP.

**Hypothesis Seven: Referring Therapists’ Satisfaction**

Both quantitative and qualitative data from community therapists who referred eligible families to MF-PEP indicated high satisfaction with MF-PEP as an adjunctive treatment. The majority of referring therapists reported: agreement with goals and concepts outlined in MF-PEP; improved therapeutic relationship; improved parental knowledge of mood disorders; and improved parent and child coping. Additionally, a majority noted the family discussed MF-PEP content in individual therapy and were interested in referring future clients to MF-PEP. Qualitative feedback from referring therapists also indicated high satisfaction with MF-PEP as an adjunctive treatment. A majority noted positive changes in children and parents following completion of MF-PEP.

Thus, overall referring therapists reported high satisfaction with MF-PEP as an adjunctive treatment. The high satisfaction from both MF-PEP therapists and referring therapists speaks to the transportability of the intervention. These evaluations indicate
therapists enjoyed facilitating groups and are willing to refer future clients to MF-PEP groups since they view the intervention as beneficial to families. Indeed, important aspects of transportability research include: (1) identifying the appropriateness of settings; (2) securing and maintaining funding and referrals; (3) making needed changes at agency, administrative, and system levels; (4) establishing training and supervision procedures; and (5) creating administrative supports needed for outcome monitoring (Southam-Gerow et al., 2008). Results from this pilot effectiveness and transportability trial indicate such changes at systems levels are well underway, and support the continued dissemination of the treatment. As noted earlier, the Close to Home Behavioral Health Centers pose unique opportunities for investigating the effectiveness and transportability of MF-PEP as the treatment developer has strong connections with supervisors, staff are invested in the treatment, and staff are interested in transporting EBTs. Nevertheless, preliminary results from this trial indicate high satisfaction with the intervention from therapists facilitating the groups and referring clients, thus providing support for its transportability and widespread dissemination.

**Financial Feasibility of MF-PEP**

**Hypothesis Eight: Financial Feasibility**

When examining the average cost of clinician’s time, reimbursement per client, and current billing procedures, none of the eight MF-PEP groups broke-even financially. However, there are various other factors to consider when examining such outcomes. First, calculations indicate MF-PEP has the potential to be a financially feasible intervention. Given the optimal number of three therapists and at least seven families per group, MF-PEP can break-even financially. Other adaptations of current billing
strategies can also be tested in order to reduce costs and increase revenue. For example, a practicum student could be used to co-facilitate child groups. Practicum students do not bill for clinical time and are not paid employees; thus, such a structure would only require billing for two therapists’ time, which would substantially reduce costs. Results indicated only four children per group would be required for the agency to break-even financially when utilizing a practicum student to co-facilitate the child group. As the ideal number of families per group is five to seven, MF-PEP has the potential to be cost-advantageous program once referral sources and systems changes are finalized.

Second, financial feasibility calculations were based upon average costs and reimbursement rates for therapists, group materials, and clients. These figures vary depending on therapists’ level of training (e.g., doctoral versus master’s-level clinician), families’ type of insurance coverage, and the number of sessions attended by families. This specific information was not collected in the current trial.

Third, the Close to Home Behavioral Health Centers and behavioral health programs as a whole must be considered. MF-PEP has only recently been initiated at the Close to Home Behavioral Health Centers; thus, some groups had more than the optimal number of therapists for training purposes. In addition, the Close to Home Behavioral Health Centers conduct a variety of other group treatments and programs. If any of these programs produce profit, these excess funds could be used to compensate for funds lost in the initial phases of training in and facilitating MF-PEP in order for the organization as a whole to break-even financially.

Fourth, long-term outcomes must be considered. Supervisors at the Close to Home Behavioral Health Centers are aiming to identify families eligible for MF-PEP
early in the treatment process, ideally at intake. MF-PEP teaches families about symptoms and management of mood disorders and coping skills, and educates parents about how to become better mental health care consumers. Access to higher quality services in turn leads to reduced mood symptom severity (Fristad et al., 2009). Providing such knowledge and skills to families early in treatment may allow them to access appropriate services sooner in the treatment process, thus preventing trial-and-error of extraneous other services that may not be maximally beneficial or appropriate and which may not be cost-effective for families or the agency. It is also possible that accessing appropriate services earlier on in the treatment process may prevent inpatient hospitalizations, which are costly to agencies, families, and insurance companies.

Long-term data and treatment utilization information were not collected in this pilot effectiveness trial. However, efficacy investigations suggest MF-PEP may be cost-effective to a family and agency in the long-run by providing families with knowledge and skills to access appropriate services as soon as possible. Future investigations of MF-PEP should collect long-term outcome data and treatment utilization information. As currently provided, MF-PEP is not financially feasible; however, modifications in costs, billing models, group size, and/or therapists could be made to make this an ongoing, viable program in many settings.

**Limitations and Future Directions**

The current investigation provides preliminary positive results from which to build regarding continued examination of the effectiveness, transportability, and eventual dissemination of MF-PEP. However, there were several limitations in this pilot trial: they are discussed below. These limitations should be addressed in future effectiveness
and transportability investigations of MF-PEP utilizing larger samples and long-term follow-up data.

**Open Design**

The open design of this pilot effectiveness trial greatly limits what can be inferred from results. A significant increase in knowledge of mood disorders was apparent post-treatment; however, such improvement could not be compared to a control condition or treatment as usual. Significant improvements in treatment beliefs and mood symptom severity were not apparent. Results from efficacy data suggest significant differences in these variables would be apparent when compared to a control condition at long-term follow-up time points; however, such data were not collected. Nevertheless, all variables illustrated shifts in the hypothesized directions: it is unclear whether significant differences would be found with a larger sample and when compared to treatment as usual at follow-up time points. Despite lack of significant changes in outcome variables, MF-PEP therapists, referring therapists, parents, and children found MF-PEP to be a beneficial and satisfactory intervention. Overall, results from this trial support the transportability of MF-PEP to community settings. Future investigations utilizing a larger sample, exploring long-term outcomes, and comparing to a control condition or usual care in community settings are warranted.

**Sample Size and Suboptimal Data Collection**

The small sample size and suboptimal data collection greatly limited the types of analyses and interpretation of data in this study. As MF-PEP was a new treatment option at the Close to Home Behavioral Health Centers, not all therapists were immediately aware of the option to refer eligible clients to group. In addition, different strategies for
comprising groups were initiated before settling upon the use of prescreening interviews. Similarly, different strategies for data collection were trialed before discovering an effective method. Initial data collection procedures requested families to mail study questionnaires to the study coordinator. However, after questionnaires were not returned following the first group, MF-PEP therapists began administering and collecting all questionnaires at the first and last group sessions. While this slightly improved data collection, results remained suboptimal, likely because MF-PEP therapists were not highly invested in ensuring the return of study questionnaires and were more concerned with facilitating group sessions and covering all MF-PEP curriculum. Thus, I began attending all first and last group sessions in order to facilitate study questionnaire completion and return. Though this improved data collection, families sometimes arrived to group late or left group early and subsequently took questionnaires home and neglected to return them. In addition, not all families completed group, thus pre-treatment but not post-treatment data was available from some families.

As mentioned earlier, it is also possible the clientele who presented for treatment at the Close to Home Behavioral Health Centers differed from those in the efficacy trials. Families participating in the efficacy trial may have been more interested and invested in research aspects of the treatment study, while families presenting for treatment at the Close to Home Behavioral Health Centers were likely more interested in obtaining treatment and symptom relief for their children. Thus, families in the effectiveness trial may not have been as interested or invested in study questionnaire completion as those in the efficacy trial. Results from the current trial based on limited CDI data revealed children in the effectiveness trial reported more depressive symptoms than those in the
efficacy trial. However, significant differences were not apparent when comparing mean CDI scores from children with diagnosed depression in the efficacy trial and effectiveness trial participants. Future studies could compare clientele and symptom severity between efficacy and effectiveness investigations of MF-PEP using a larger effectiveness sample size. Future trials will also need to conduct power analyses to determine the sample size necessary to achieve adequate power in larger benchmarking or controlled trials.

**Mood Rating Methodology**

As noted earlier, while children’s depressive and manic symptoms were measured in past efficacy trials of MF-PEP, different primary outcome measures were utilized: the clinician-rated CDRS-R (Poznanski et al., 1984) for depressive symptoms; the clinician-rated MRS (Young et al., 1978) for manic symptoms; and The Mood Severity Index (MSI: Fristad et al., 2009) for composite depressive and manic symptoms. The CDRS-R, MRS, and MSI are clinician-rated measures that incorporate both parental and children’s reports of symptoms, whereas the CDI is a children’s self-report measure of depressive symptoms and the PGBI-10M is a parental self-report measure of children’s manic symptoms. While clinician-rated measures of symptom severity are common in efficacy trials, self-report measures are common in effectiveness trials in order to reduce burden on parents, children, and community therapists and also to simulate real-world conditions (Steele et al., 2008). Differences in self-report versus clinician-rated primary outcome measures may contribute to differences in outcomes between efficacy and effectiveness investigations of MF-PEP. In addition, both parental and children’s input and corroborating reports of symptoms are important to incorporate and consider when
evaluating mood symptoms. Future effectiveness investigations of MF-PEP should gather parents’ and children’s report of depressive and manic symptoms.

**Long-Term Outcome Data**

Long-term outcome data were not collected in the current pilot effectiveness and transportability trial. While a significant improvement in knowledge of mood disorders was noted immediately post-treatment, as has been noted in prior efficacy investigations of MF-PEP, improvements in treatments beliefs and mood symptom severity were not apparent immediately post-treatment. As noted earlier, initial efficacy investigations of MF-PEP did not find significant attitudinal shifts or significant reductions in depressive or manic symptoms following treatment (Fristad et al., 2002, 2003; Goldberg-Arnold et al., 1999). However, a subsequent efficacy study using a larger sample size found MF-PEP was associated with improvement in parental treatment beliefs compared with a WLC group over a 6-month through 1-year follow-up (Mendenhall et al., 2009). In addition, MF-PEP was associated with improvement in children’s mood symptom severity compared with a WLC group over a 1-year through 18-month follow-up (Fristad et al., 2009). Results indicated MF-PEP treatment effects on mood symptoms may be cumulative, taking longer than 6 months to reach statistical and clinical significance (Fristad et al., 2009). In addition, an analysis of treatment mediators revealed participation in MF-PEP helps parents become better consumers of mental health services, and access to higher-quality services results in decreased mood symptom severity (Fristad et al., 2009). Thus, improvements in treatment beliefs and mood symptom severity may not be apparent immediately post-treatment, as measured in the current study, but rather have a delayed effect after parents become better consumers of
mental services and access higher-quality treatment. Thus, future effectiveness investigations of MF-PEP should obtain long-term follow-up data in order to determine if the same long-term effects observed in efficacy trials are found when MF-PEP is conducted in community settings.

**Location of Study**

The Close to Home Behavioral Health Centers pose unique environments for investigating the effectiveness and transportability of MF-PEP as the treatment developer has strong connections with supervisors, staff are invested in the treatment, and staff are interested in transporting EBTs. Preliminary results from this trial indicate high satisfaction with the intervention from therapists facilitating the groups and referring clients, thus providing support for its transportability and widespread dissemination. However, this treatment should be piloted at other community settings to further test the dissemination power of MF-PEP. The treatment will likely be more difficult to transport if the agency is not invested in implementing the treatment and/or transporting EBTs to community settings. In future effectiveness investigations of MF-PEP at novel settings, the development of user-friendly manuals, training efforts, and transparent, collaborative relationships with various systems and stakeholders will be important to ease transportability efforts.

**Treatment Fidelity Monitoring**

Therapists facilitating MF-PEP in the current trial differed greatly in their experience, training, and background from those who facilitated MF-PEP in prior efficacy investigations. Most effectiveness trials are conducted in community settings with community therapists who have variable training and heavy caseloads (Steele et al.,
Community therapists often do not receive intensive training in the treatment prior to implementation, as is common in efficacy trials (Steele et al., 2008). Indeed, most of the community therapists who implemented MF-PEP were licensed social workers who received a brief training in MF-PEP, whereas clinicians facilitating MF-PEP groups in the efficacy trials were experienced doctoral-level, post-doctoral, or advanced graduate student clinicians who received extensive training and weekly group supervision from the treatment developer (Fristad et al., 2009). As mentioned earlier, these differences in training and experience could lead to differences in treatment fidelity in the efficacy and effectiveness investigations of MF-PEP. Future effectiveness trials should monitor treatment fidelity to ensure MF-PEP is being implemented consistently and the same as was done in efficacy investigations.

Specific Measures of Financial Feasibility

The current study found none of the eight MF-PEP groups conducted at the Close to Home Behavioral Health Centers broke-even financially; however, they have the potential to break-even financially given the implementation of new and creative billing strategies and given the optimal number of therapists and children per group. Future effectiveness investigations of MF-PEP should collect specific information about costs of each clinician and reimbursement from each client in order to compute exact costs and revenues per group. In addition, long-term data looking at treatment utilization should be examined: if MF-PEP helps families access higher-quality services early in the treatment process and avoid unhelpful treatment or inpatient hospitalizations, MF-PEP may prove to be cost-effective for agencies, insurance companies, and families in the long-run.
Conclusions

In summary, this pilot effectiveness and transportability trial of MF-PEP provided support for the implementation of this intervention in community settings. Significant improvements in parental knowledge of mood disorders were noted from pre- to post-treatment. Though shifts occurred in the hypothesized directions, significant improvements in treatment beliefs and mood symptom severity were not apparent. The small sample size and suboptimal data collection may have hindered the ability to detect statistically significant differences. Of note, such treatment effects when compared to a control condition were not apparent until at least 6-month follow-up time points in efficacy investigations of MF-PEP. Thus, future effectiveness and transportability trials of MF-PEP should collect long-term outcome data and use a control comparison or usual community treatment comparison.

Parents, children, MF-PEP therapists, and referring therapists reported high satisfaction with MF-PEP. Parents and children reported high satisfaction with MF-PEP and noted positive shifts in knowledge, coping skills, and perceived social support. Parents appeared more satisfied with MF-PEP than children. MF-PEP therapists also reported satisfaction with training in and implementation of MF-PEP. Suggestions for improving future training and MF-PEP groups have been incorporated into training methods and manuals. Referring therapists also reported satisfaction with MF-PEP as an adjunct to individual or family therapy. However, the Close to Home Behavioral Health Centers pose unique environments for testing the effectiveness of MF-PEP, as the treatment developer has close ties with supervisors and the agency is very invested in transporting EBTs to their clinics. Thus, future effectiveness investigations of MF-PEP
should attempt implementation at novel community settings. Nevertheless, high satisfaction ratings from families and therapists support the acceptability and transportability of the intervention.

Lastly, analyses revealed none of the eight MF-PEP groups conducted broke-even financially. However, MF-PEP has the potential to break-even financially given optimal number of therapists and families per group. In addition, creative billing strategies and use of practicum students may also help defray costs. Future financial investigations should examine the financial feasibility of MF-PEP in the agency as a whole (i.e., taking into account revenue from other programs), specific measures of cost and revenue per group (i.e., actual cost and revenue produced by each therapist and family in group, as opposed to average costs and revenue), and subsequent treatment utilization in the long-term.

Preliminary results from this pilot investigation of MF-PEP support the effectiveness and transportability of the intervention. Future studies utilizing a larger sample size, control comparison, long-term follow-up data, specific measures of financial feasibility, and treatment fidelity implemented at novel community settings will be important to conduct in order to supplement current effectiveness and transportability efforts and provide more definitive evidence for the effectiveness, transportability, and dissemination of MF-PEP in community settings.
References


Appendix A: Demographics Form

Parents’ phone number: _______________________________________

Information about the Child:

Birth Date:   _____   /   _____   /   _______
              Month       Day       Year

Sex:        □ Male       □ Female

Ethnic Category:  □ Hispanic or Latino
                 □ Not Hispanic or Latino

Racial Category:  □ American Indian/Alaska Native
                  □ Asian
                  □ Native Hawaiian or Other Pacific Islander
                  □ Black or African-American
                  □ White

Who completed this paperwork? (Check all that apply)

□ Biological Mother        □ Biological Mother’s significant other
□ Adoptive Mother        □ Biological Father’s significant other
□ Biological Father       □ Biological Grandmother – Maternal
□ Adoptive Father        □ Biological Grandmother – Paternal
□ Stepmother              □ Biological Grandfather – Maternal
□ Stepfather              □ Biological Grandfather – Paternal
□ Other Family Members:   ____________________________________________
□ Legal Guardian:         ____________________________________________
□ Other:                  ____________________________________________
Has your child been involved in the following type of treatment? (Check all that apply)

☐ Outpatient therapy
  ☐ 1 to 4 appointments
  ☐ 5 to 10 appointments
  ☐ More than 10 appointments
☐ Management of medications for behavior problems
☐ Home-based counseling/therapy
☐ School-based counseling/therapy
☐ Residential treatment, day treatment/partial hospitalization program
☐ Inpatient psychiatric hospital
☐ Emergency Room due to behavior problems/suicidal thoughts
☐ Online support groups
☐ Other: (please specify) ________________________________
Appendix B: Parent Group Evaluation Form

We are interested in your confidential feedback on this outpatient family group experience. **Please fill in the response that best describes your thoughts and feelings about this group.**

<table>
<thead>
<tr>
<th>ATTENDING THIS GROUP HELPED ME UNDERSTAND:</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My child’s symptoms</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. My child’s medication</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. How to obtain appropriate therapy</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. How to manage my child’s mood symptoms</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. What to do/not do at home to help my child</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. How to work with school to get the help my child needs</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. My child’s problems are not “my fault”</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEETING IN A GROUP FORMAT MADE ME FEEL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Uncomfortable sharing personal information</td>
</tr>
<tr>
<td>9. Supported – knowing I’m not the only parent dealing with these sorts of problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I BENEFITED FROM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. The slides/workbook</td>
</tr>
<tr>
<td>11. The group facilitator’s input</td>
</tr>
<tr>
<td>12. Other group member’s input</td>
</tr>
<tr>
<td>13. My child’s participation in his/her group</td>
</tr>
<tr>
<td>14. The family projects</td>
</tr>
<tr>
<td>15. The parent-only worksheets</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MY CHILD BENEFITED FROM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. His/her group participation</td>
</tr>
</tbody>
</table>

We want to learn from you. What do you think we should do differently the next time we run group? Please write your response below, and continue on the back side of this page if necessary.

Please feel free to add any other comments/feedback you have. Thank you!
Appendix C: Child Group Evaluation Form

We want your feedback on your group experience. Please answer the following questions. Fill in the response that best describes your thoughts and feelings:

<table>
<thead>
<tr>
<th>ATTENDING THIS GROUP HELPED ME:</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Learn about depression/bipolar disorder in people my age</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Learn about the medication I take</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Get along better in my family</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. Get along better with my friends</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Get along better at school</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. Deal with the problems that come with depression/bipolar disorder</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. Learn it’s not my fault that I have depression/bipolar disorder, but I can make choices that help me do my best</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEETING IN A GROUP FORMAT MADE ME FEEL:</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Uncomfortable talking about myself</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>9. Less alone, knowing I’m not the only one dealing with these sorts of problems</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I LIKED:</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Meeting with other people my age</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>11. Doing role plays</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>12. Other activities/discussions</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>13. Games</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>14. My group leader(s)</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MY PARENTS’ BEHAVIOR TOWARD ME IS:</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Better since we came to group</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
16.  Worse since we came to group  

We want to learn from you!

What do you think we should do differently the next time we run group?

Please feel free to add any other comments/ feedback you have. Thank you!
Appendix D: MF-PEP Therapist Session Evaluation Survey

Session # _____

Group: Children   Parents

- Did the training provided adequately prepare you to run this session?

- What activities/ideas worked well?

- What activities/ideas were difficult to do or convey?

- What would you do differently if you were running the group again?

- Were there any problems with the materials provided for this session (handouts, manual pages, games, etc.)?

- What were any new ideas or flexible additions to the manual or handouts you thought of?

- Other comments:
Appendix E: MF-PEP Therapist Post-Group Feedback Survey

1. Did you attend a formal training to learn MF-PEP?
   a. Yes
   b. No - If No, skip to item #7 (p. 2)

2. How many hours was the training?
   a. < 1
   b. 2-4
   c. 5-8
   d. 9-11
   e. 12+

3. What methods of training did you receive? (Circle all that apply)
   a. Reviewing the treatment manual
   b. Reviewing the clinician (how to) manual
   c. Verbal Presentation by trainer
   d. Audio Visual Presentation by trainer
   e. Live observation of partial MF-PEP group
   f. Audio presentation of partial MF-PEP group
   g. Video presentation of partial MF-PEP group
   h. Live observation of full MF-PEP sessions
   i. Audio presentation of full MF-PEP sessions
   j. Video presentation of full MF-PEP sessions

3a. Please rate the level of helpfulness of each method you received
   1: Not at all, 2: Slightly helpful, 3: Moderately helpful, 4: helpful, 5: Very helpful, n/r: did not receive this method

<table>
<thead>
<tr>
<th>Method</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>n/r</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reviewing the treatment manual</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>b. Reviewing the clinician (how to) manual</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Verbal Presentation by trainer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Audio Visual Presentation by trainer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>e. Live observation of partial MF-PEP group</td>
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<tr>
<td>f. Audio presentation of partial MF-PEP group</td>
<td></td>
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</tr>
<tr>
<td>g. Video presentation of partial MF-PEP group</td>
<td></td>
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</tr>
<tr>
<td>h. Live observation of full MF-PEP sessions</td>
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</tr>
<tr>
<td>i. Audio presentation of full MF-PEP sessions</td>
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<td></td>
</tr>
<tr>
<td>j. Video presentation of full MF-PEP sessions</td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

4. How many weeks elapsed between when you received training and when you started the group?
   a. < 1
   b. 2
   c. 3
   d. 4
   e. 4+
5. Did training fully prepare you for running the group?
   a. Yes  b. No

6. Looking back on the training, were there topics or skills you found you did not have enough training on?
   a. Yes  b. No

6a. If yes, what would have helped to address this? (circle all that apply)

   a. Longer training
   b. More training on specific topics/skills
   c. Seeing an MFPEP group run in person or via video
   d. More time between training and running the group
   e. On going supervision with the option for processing group and receiving direct feedback of skills

7. In group, did an event occur when a client’s level of behavioral or emotional distress disrupted the group?
   a. Yes  c. No

8. Were you fully trained on how to intervene when a client’s level of behavior or emotional distress disrupted the group?
   a. Yes  b. No

8a. If no, would you like to have received this type of training?
   a. Yes  b. No

9. In group, did an event occur when a client’s behavior became unsafe to him/herself or others?
   a. Yes  b. No

10. Were you fully trained on how to intervene when an unsafe event or crisis occurred?
    a. Yes  b. No

10a. If no, would you like to have received this type of training?
    a. Yes  b. No
11. Did any one client miss more than 3 sessions while you were running the group?
   a. Yes  b. No

11a. **If yes**, were you trained on how to respond to & work with the family on missing/dropping out of group?
   a. Yes  b. No

11b. **If you were not trained in handling this**, would you like to have received this training?
   a. Yes  b. No

12. Were you compensated fairly for the time it took to prepare for, run, and document the group?
   a. Yes  b. No

12a. **If no**, what alternatives would have been helpful?

______________________________________________________________________________
______________________________________________________________________________

13. What is your biggest concern about the group training and how could this be addressed?
______________________________________________________________________________
______________________________________________________________________________

14. What is your biggest concern about the group format and how could this be addressed?
______________________________________________________________________________
______________________________________________________________________________

15. What did you like most about the group training and why?
______________________________________________________________________________
______________________________________________________________________________

16. What did you like most about the group format and why?
______________________________________________________________________________
______________________________________________________________________________
17. How many years have you been independently licensed?
   a. <1   b. 1-4   c. 5-8   d. 9-11   e. 12+

18. What is your professional license in?

19. Have you been formally trained in any other manualized intervention for children?
   a. Yes   b. No

20. Are you interested in continuing to run MF-PEP groups?
   a. Yes   b. No
      20a. If no, what is the reason?
         a. Don’t like the treatment
         b. Not enough training
         c. No available time
         d. Not interested in this clinical population
         e. Other __________________________

21. What age range of client’s are you most comfortable treating?
   a. 2-6   b. 7-12   c. 13-18

22. Please circle the 3 disorders are you most comfortable treating?
   a. ADHD
   b. Anxiety (Specific, Separation, GAD, OCD)
   c. Bipolar (Mania/Hypomania)
   d. Conduct
   e. Depression
   f. Oppositional Defiant
   g. Pervasive Developmental
   h. Other

THANK YOU for your time and effort in using MF-PEP and completing this form!
Appendix F: Individual/Family Therapist Questionnaire about MF-PEP

1. Were you seeing the family you referred to MF-PEP in therapy before they started in MF-PEP?
   a. No. Please skip to question #11
   b. Yes. Please answer all of the following questions.

2. While the family attended MF-PEP, did they:
   a. Temporarily stop coming to therapy with you
   b. Schedule fewer sessions with you (e.g., previously came weekly, during MF-PEP came every other week)
   c. Stay in phone contact only
   d. Stop contact throughout the 8 weeks
   e. Never come back to therapy
   f. Other (specify):

3. Has MF-PEP attendance changed how you are scheduling sessions due to reduced insurance coverage?
   a. Yes, I only have a few remaining sessions I can bill
   b. No, but I had to get additional sessions recertified sooner than I normally would
   c. No, attending MF-PEP didn’t impact the number of sessions I intend to schedule
   d. No, because now the family doesn’t need as many sessions with me
   e. Other (specify):

4. Has MF-PEP attendance changed how families utilize their sessions with you: (Circle all that apply)
   a. No, I have not noticed any change in how the family utilizes their sessions
   b. Yes, the family brings specific questions or concerns to sessions more than they used to
   c. Yes, the family is able to communicate better about the symptoms and behaviors that occur
   d. Yes, they do not use their weekly sessions as well during weeks with MF-PEP because they seemed overwhelmed with treatment
   e. Yes, the parents are more active in treatment planning and advocating for their child
   f. Yes, in another way (specify):

5. How did the family’s participation in MF-PEP affect your therapeutic relationship with them?
   a. It interfered with the relationship a lot
   b. It interfered with the relationship somewhat
   c. It did not impact the relationship
   d. It reinforced the relationship somewhat
   e. It reinforced the relationship a lot
6. How did MF-PEP attendance affect parents’ knowledge about the child’s disorder? After being in MF-PEP:
   a. The parent(s) have more misconceptions and misunderstandings about mood disorders
   b. The parents’ knowledge about mood disorders did not change
   c. The parent(s) have more accurate knowledge and a better understanding of mood disorders
   d. Other (specify):

7. How did parent(s) respond to MF-PEP? Coping:
   a. Deteriorated significantly
   b. Deteriorated somewhat
   c. Remained the same
   d. Improved somewhat
   e. Improved significantly
   f. Other (specify):

8. How did the child respond to MF-PEP? Coping:
   a. Deteriorated significantly
   b. Deteriorated somewhat
   c. Remained the same
   d. Improved somewhat
   e. Improved significantly
   f. Other (specify):

9. How did participation in MF-PEP affect family climate? Family climate:
   a. Got much worse
   b. Got somewhat worse
   c. Did not change
   d. Got somewhat better
   e. Got a lot better

10. If there are two caregivers in the family, how did participation in MF-PEP affect their agreement about the child’s needs? Concerning treatment needs and goals:
    a. They disagree a lot more
    b. They disagree somewhat more
    c. Their agreement has not changed
    d. They agree somewhat more
    e. They agree a lot more
    f. There are not two caregivers in the family
11. How likely are you to refer your clients to MF-PEP in the future if it is available?
   a. Very unlikely
   b. Somewhat unlikely
   c. Undecided
   d. Somewhat likely
   e. Very likely

12. MF-PEP has a non-blaming and empowering motto “It’s not your fault, but it’s your challenge.” Have you noticed that this motto has affected the family’s attitude?
   a. No
   b. Yes (specify): __________________________________________________

13. Did the family discuss the content of MF-PEP with you in therapy sessions?
   a. No
   b. Yes (specify): __________________________________________________

14. Were there goals or concepts the family brought to you that you did not understand or agree with?
   a. No
   b. Yes (specify): __________________________________________________

15. Do you have any other comments about the family’s participation in MF-PEP you would like to share?
Appendix G: Parent’s Qualitative Feedback about MF-PEP on the Parent Group Evaluation Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you think we should do differently the next time we run group?</td>
<td>More time for discussion with other parents</td>
</tr>
<tr>
<td></td>
<td>Additional help dealing with outbursts, punishment</td>
</tr>
<tr>
<td></td>
<td>Ensure at least 5 families are dedicated to come consistently to group</td>
</tr>
<tr>
<td></td>
<td>Extend number and length of MF-PEP sessions</td>
</tr>
<tr>
<td></td>
<td>Provide make-up session for missed sessions</td>
</tr>
<tr>
<td></td>
<td>More time for collaboration between child and parent groups</td>
</tr>
<tr>
<td></td>
<td>Add Saturday sessions as option</td>
</tr>
<tr>
<td></td>
<td>Add follow-up session after MF-PEP</td>
</tr>
<tr>
<td></td>
<td>Start groups later than 5:00pm</td>
</tr>
<tr>
<td></td>
<td>Decrease amount of homework</td>
</tr>
<tr>
<td></td>
<td>Test family’s compatibility with MF-PEP prior to starting group</td>
</tr>
<tr>
<td></td>
<td>More visual aids (e.g., movies)</td>
</tr>
<tr>
<td></td>
<td>Provide more information about community resources, schools, and group meetings</td>
</tr>
<tr>
<td></td>
<td>Focus on situational issues brought up by parents</td>
</tr>
</tbody>
</table>

Table 11. Parent’s qualitative feedback from open-ended questions on the Parent Group Evaluation Form.
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other comments/feedback</td>
<td>Adapt group to knowledge level of families</td>
</tr>
<tr>
<td></td>
<td>Offer more group therapy for youth</td>
</tr>
<tr>
<td></td>
<td>Start a support group</td>
</tr>
<tr>
<td></td>
<td>“My son was happy to be part of the group and he wants to keep coming to more. His attitude changed for the better and we are able to communicate with each other much better than before.”</td>
</tr>
<tr>
<td></td>
<td>“This is wonderful, I am so thankful. We needed this more than I realized.”</td>
</tr>
<tr>
<td></td>
<td>“This was an excellent opportunity to be a part of. A very valuable learning experience”</td>
</tr>
<tr>
<td></td>
<td>“Appreciation of the help that was given to all.”</td>
</tr>
<tr>
<td></td>
<td>“Thank you! This has been very helpful and affirming.”</td>
</tr>
<tr>
<td></td>
<td>“Very helpful info – finding other parents with the same problem.”</td>
</tr>
<tr>
<td></td>
<td>“You were great – we’ll miss this group!”</td>
</tr>
<tr>
<td></td>
<td>“[My daughter] benefitted HUGELY from group. It made her feel better to know she’s not the only kid with issues. She also connected with the tools that were provided. Very, very helpful for her.”</td>
</tr>
<tr>
<td></td>
<td>“I am so happy we did this, it was truly very helpful. I noticed a change in [my daughter]!”</td>
</tr>
<tr>
<td></td>
<td>“Please write more books! We need new and current material.”</td>
</tr>
<tr>
<td></td>
<td>“Thank you so much.”</td>
</tr>
</tbody>
</table>

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Appendix H: Children’s Qualitative Feedback about MF-PEP on the Child Group Evaluation Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you think we should do differently the next time we run group?</td>
<td>Increase number of children in group</td>
</tr>
<tr>
<td></td>
<td>Provide more snacks</td>
</tr>
<tr>
<td></td>
<td>Decrease number of sessions</td>
</tr>
<tr>
<td></td>
<td>Decrease repetitiveness of group</td>
</tr>
<tr>
<td></td>
<td>“I think you should do the same things next time in your group.”</td>
</tr>
<tr>
<td></td>
<td>“Talk to kids when they have bad beliefs.”</td>
</tr>
<tr>
<td></td>
<td>“Have more fun stuff.”</td>
</tr>
</tbody>
</table>

Other comments/feedback

| “I think the group should last longer.”                                   |
| “Have a movie.”                                                           |
| “Learn about more medications.”                                           |
| “I really love how we did the breathing!”                                 |

Table 12. Children’s qualitative feedback from open-ended questions on the Child Group Evaluation Form.
Appendix I: Child Therapists’ Qualitative Feedback about MF-PEP on the Therapist Session Evaluation Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What activities/ideas worked well?</td>
<td>Group rules</td>
</tr>
<tr>
<td></td>
<td>Group motto: “It’s not your fault, but it’s your challenge”</td>
</tr>
<tr>
<td></td>
<td>Point and food (usually starburst) incentives for good behavior and group participation</td>
</tr>
<tr>
<td></td>
<td>Feelings thermometer</td>
</tr>
<tr>
<td></td>
<td>Definitions/symptoms of depression and mania</td>
</tr>
<tr>
<td></td>
<td>Fix-it list</td>
</tr>
<tr>
<td></td>
<td>Naming the enemy exercise: separating symptoms from self</td>
</tr>
<tr>
<td></td>
<td>Discussion and identification of medications and medication management</td>
</tr>
<tr>
<td></td>
<td>Discussion and identification of triggers for mad, sad, and bad feelings</td>
</tr>
<tr>
<td></td>
<td>Identifying bodily reactions</td>
</tr>
<tr>
<td></td>
<td>Tool kit: creation, discussion, and sharing</td>
</tr>
<tr>
<td></td>
<td>Physical activities</td>
</tr>
<tr>
<td></td>
<td>Ice-breaker activities at start of group</td>
</tr>
<tr>
<td></td>
<td>Crossword puzzles</td>
</tr>
</tbody>
</table>

Table 13. Child therapists’ qualitative feedback from open-ended questions on the MF-PEP Therapist Session Evaluation Survey.
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What activities/ideas worked well?</td>
<td>Breathing exercises</td>
</tr>
<tr>
<td></td>
<td>Thinking-Feeling-Doing exercise</td>
</tr>
<tr>
<td></td>
<td>Feelings charades</td>
</tr>
<tr>
<td></td>
<td>Problem-solving exercises</td>
</tr>
<tr>
<td></td>
<td>Discussion of communication cycle and hurtful/helpful communication</td>
</tr>
<tr>
<td></td>
<td>Discussion of verbal/nonverbal communication</td>
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<tr>
<td></td>
<td>Communication game and communication cards</td>
</tr>
<tr>
<td></td>
<td>Jeopardy review game</td>
</tr>
<tr>
<td></td>
<td>Graduation ceremony</td>
</tr>
<tr>
<td></td>
<td>Projects and worksheets</td>
</tr>
<tr>
<td></td>
<td>Visual aids</td>
</tr>
<tr>
<td></td>
<td>Writing examples or project directions on large easel or dry-erase board</td>
</tr>
<tr>
<td></td>
<td>Having two child therapists co-facilitate group: one therapist was able to lead group while the other was available for behavior management</td>
</tr>
<tr>
<td></td>
<td>Review of previous week’s lessons at the start of each session</td>
</tr>
<tr>
<td>What activities/ideas were difficult to do or convey?</td>
<td>Completion of study questionnaires at first and last sessions due to length and attention span</td>
</tr>
<tr>
<td></td>
<td>Group motto: some children objected “I can’t!”</td>
</tr>
<tr>
<td></td>
<td>Feelings thermometer and comprehension of severity of emotions</td>
</tr>
<tr>
<td></td>
<td>Symptoms and diagnosis of depression and mania</td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What activities/ideas were difficult to do or convey?</td>
<td>Discussion of medications, dosages, management</td>
</tr>
<tr>
<td></td>
<td>Medication match game</td>
</tr>
<tr>
<td></td>
<td>Full body drawings</td>
</tr>
<tr>
<td></td>
<td>Identification of “body signals” for feeling mad, sad, or bad</td>
</tr>
<tr>
<td></td>
<td>Differentiating triggers from helpful/unhelpful responses</td>
</tr>
<tr>
<td></td>
<td>Differentiating thoughts from behaviors</td>
</tr>
<tr>
<td></td>
<td>Connect the dots game</td>
</tr>
<tr>
<td></td>
<td>Problem-solving discussion: comprehension and ability to remember 6 steps</td>
</tr>
<tr>
<td></td>
<td>Repetition of some material</td>
</tr>
<tr>
<td></td>
<td>Thinking-Feeling-Doing exercise</td>
</tr>
<tr>
<td></td>
<td>Changing thoughts, feelings, and actions</td>
</tr>
<tr>
<td></td>
<td>Communication cycle</td>
</tr>
<tr>
<td></td>
<td>Nonverbal communication</td>
</tr>
<tr>
<td></td>
<td>Family communication project</td>
</tr>
<tr>
<td></td>
<td>Feelings charades</td>
</tr>
<tr>
<td></td>
<td>Physical activities due to space restrictions</td>
</tr>
<tr>
<td></td>
<td>Children’s comprehension and abstract thinking</td>
</tr>
<tr>
<td></td>
<td>Children’s boredom with session content</td>
</tr>
<tr>
<td></td>
<td>Homework completion</td>
</tr>
</tbody>
</table>
Table 13 Continued

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What would you do differently if you were running the group again?</td>
<td>Spend more time defining “fault” and “challenge”</td>
</tr>
<tr>
<td></td>
<td>Create easier word-search and harder maze</td>
</tr>
<tr>
<td></td>
<td>Simplify medication match game</td>
</tr>
<tr>
<td></td>
<td>Gather list of medications children were taking and use for medication discussion</td>
</tr>
<tr>
<td></td>
<td>Spend more time on tool kit and processing</td>
</tr>
<tr>
<td></td>
<td>Spend more time talking about weekly projects</td>
</tr>
<tr>
<td></td>
<td>Start group with more children (at least 5 families)</td>
</tr>
<tr>
<td></td>
<td>Shorten group to 6 or 7 weeks</td>
</tr>
<tr>
<td></td>
<td>Combine sessions 6 and 7</td>
</tr>
<tr>
<td></td>
<td>Include more physical activities</td>
</tr>
<tr>
<td></td>
<td>Don’t administer questionnaires during sessions</td>
</tr>
<tr>
<td></td>
<td>Better manage participants’ behavior</td>
</tr>
<tr>
<td></td>
<td>Allot more time for session set-up/preparation</td>
</tr>
<tr>
<td></td>
<td>Allot more time for communication card activity</td>
</tr>
<tr>
<td></td>
<td>Improve time management, especially regarding questionnaire completion and research component</td>
</tr>
<tr>
<td></td>
<td>Better articulate activities to clients</td>
</tr>
<tr>
<td></td>
<td>Spend more time with group content/discussion and not implement game</td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were there any problems with the materials provided (handouts, manual</td>
<td>Medication cards were overwhelming</td>
</tr>
<tr>
<td>pages, games, etc.)?</td>
<td>Similarity/repetitiveness of some material</td>
</tr>
<tr>
<td></td>
<td>Three-ring binder for therapist manual is not user-friendly for running</td>
</tr>
<tr>
<td></td>
<td>group</td>
</tr>
<tr>
<td></td>
<td>Include breathing pages in child workbook</td>
</tr>
<tr>
<td></td>
<td>Did not complete some games/physical activities because more time was</td>
</tr>
<tr>
<td></td>
<td>spent on processing content and breathing exercises</td>
</tr>
<tr>
<td>What were any new ideas or flexible additions to the manual or handouts</td>
<td>Have ice-breakers or other games options</td>
</tr>
<tr>
<td>you thought of?</td>
<td>Additional feelings to inventory (worried, manic, depressed)</td>
</tr>
<tr>
<td></td>
<td>Additional options for physical activities</td>
</tr>
<tr>
<td></td>
<td>Shorten discussion of medications</td>
</tr>
<tr>
<td></td>
<td>Play jeopardy two times (medium and hard level)</td>
</tr>
<tr>
<td></td>
<td>Include activities with each session</td>
</tr>
<tr>
<td></td>
<td>Use of telephone game during discussion of communication helped convey</td>
</tr>
<tr>
<td></td>
<td>key points</td>
</tr>
<tr>
<td></td>
<td>Problem-solving: have 3 checks (hurt self, others, get in trouble) on</td>
</tr>
<tr>
<td></td>
<td>sheet under “check” step</td>
</tr>
<tr>
<td>Other Comments</td>
<td>Difficult to cover all information</td>
</tr>
<tr>
<td></td>
<td>Kids really enjoyed physical activities; used extra activity handouts to</td>
</tr>
<tr>
<td></td>
<td>add in tool kits</td>
</tr>
<tr>
<td></td>
<td>Some sessions had extra time</td>
</tr>
<tr>
<td></td>
<td>Ensure adequate group size</td>
</tr>
</tbody>
</table>

Continued
Table 13 Continued

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Comments</td>
<td>Children want more time for processing group</td>
</tr>
<tr>
<td></td>
<td>Have options for snack/food incentives</td>
</tr>
<tr>
<td></td>
<td>Group was long for some families; shorten length</td>
</tr>
<tr>
<td></td>
<td>Some child concepts were complicated</td>
</tr>
<tr>
<td></td>
<td>Provide most recent versions of therapist manuals</td>
</tr>
</tbody>
</table>
## Appendix J: Parent Therapists’ Qualitative Feedback about MF-PEP on the MF-PEP Therapist Session Evaluation Survey

<table>
<thead>
<tr>
<th>Questions</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What activities/ideas worked well?</td>
<td>Discussion of MF-PEP motto</td>
</tr>
<tr>
<td></td>
<td>Mood definitions and diagrams</td>
</tr>
<tr>
<td></td>
<td>Open, interactive discussions</td>
</tr>
<tr>
<td></td>
<td>Tips for success</td>
</tr>
<tr>
<td></td>
<td>Mood myths</td>
</tr>
<tr>
<td></td>
<td>Naming the enemy exercise</td>
</tr>
<tr>
<td></td>
<td>Normalizing parent feelings</td>
</tr>
<tr>
<td></td>
<td>Discussion of medication pros/cons, management, strategies, and side effects</td>
</tr>
<tr>
<td></td>
<td>Mood and medication monitoring</td>
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<tr>
<td></td>
<td>Encouraging parents to be part of their child’s treatment team and advocate for their child</td>
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<td></td>
<td>Review of different mental health providers, services, and treatment</td>
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<td></td>
<td>Review of school services</td>
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<td></td>
<td>“Can’t” vs. “won’t” discussion</td>
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<tr>
<td></td>
<td>Discussion of coping skills</td>
</tr>
<tr>
<td></td>
<td>Helpful/hurtful communication</td>
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<tr>
<td>Question</td>
<td>Response</td>
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<tr>
<td>What activities/ideas worked well?</td>
<td>Negative communication cycle</td>
</tr>
<tr>
<td></td>
<td>Problem-solving as a family approach</td>
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<tr>
<td></td>
<td>Reviewing family members’ needs</td>
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<td></td>
<td>Discussion of suicidal concerns/threats</td>
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<tr>
<td></td>
<td>How to work with family as a unit</td>
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<td></td>
<td>Open discussion about unique differences in families and how to address them</td>
</tr>
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<td></td>
<td>Sharing what families learned from group at last session</td>
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<tr>
<td></td>
<td>Fix-it list with application to whole family</td>
</tr>
<tr>
<td></td>
<td>Tool kits</td>
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<td></td>
<td>Breathing exercises</td>
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<td></td>
<td>Family projects</td>
</tr>
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<td></td>
<td>Discussion of family challenges</td>
</tr>
<tr>
<td></td>
<td>Review of session content at the beginning and end of each session</td>
</tr>
<tr>
<td></td>
<td>Building a support system and safety plan</td>
</tr>
<tr>
<td>What activities/ideas were difficult to do or convey?</td>
<td>Much information to cover in the first session on background/definitions of mood disorders</td>
</tr>
<tr>
<td></td>
<td>Discussion of comorbid disorders (i.e., ADHD)</td>
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<td>Discussion of brain abnormalities</td>
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<td></td>
<td>Medication review becomes tedious/boring</td>
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<td></td>
<td>Medication log seemed unnecessary for parents whose children had been taking medication</td>
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<tr>
<td>Question</td>
<td>Response</td>
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<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>What activities/ideas were difficult to do or convey?</td>
<td>“Can’t” vs. “won’t” discussion</td>
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<tr>
<td></td>
<td>Decreasing expectations; some parents felt this was “giving in”</td>
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<td></td>
<td>Discussion of treatment opportunities based on children’s needs</td>
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<td></td>
<td>Discussion of wrap-around and respite services for families with newly diagnosed children</td>
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<td></td>
<td>Discussion of side effects; some parents were angry/concerned they had not been informed of side effects by providers</td>
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<td></td>
<td>How to break the negative family cycle; parents felt stuck, especially single parents</td>
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<td></td>
<td>Focusing/re-directing parents when off topic</td>
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<td></td>
<td>Discussion of suicidal thoughts/threats and manipulation</td>
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<tr>
<td>What would you do differently if you were running the group again?</td>
<td>Ascertain children’s diagnoses prior to starting group and tailor content accordingly</td>
</tr>
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<td></td>
<td>Prescreen families to increase buy-in and ensure compatibility/appropriateness of family for group</td>
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<td></td>
<td>Highlight impulsive piece of mood disorders before or during “can’t” vs. “won’t” discussion</td>
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<td></td>
<td>Limit amount of information on medications</td>
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<td>Tailor medication discussion to medication group participants take</td>
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<td></td>
<td>Provide more information regarding respite care</td>
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<td></td>
<td>Provide crisis numbers</td>
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<tr>
<td>Question</td>
<td>Response</td>
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<tr>
<td>What would you do differently if you were running the group again?</td>
<td>Reinforce importance of group attendance, family projects, and homework completion</td>
</tr>
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<td></td>
<td>Focus on treatment options for single parents</td>
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<td>Include more information for parents regarding coping skills (e.g., support system as resource for families)</td>
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<td>Encourage families to try in-group problem-solving for other members’ support/ideas</td>
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<td></td>
<td>Make group 9 weeks to ensure time to cover material and develop group cohesiveness</td>
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<td></td>
<td>Less curriculum in first three sessions to allow more time for open discussion, group bonding</td>
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<tr>
<td>Were there any problems with the materials provided (handouts, manual pages, games, etc.)?</td>
<td>Provide more information in therapist manual regarding reasons to avoid medication combinations and drug interactions</td>
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<td>Ensure therapists have most recent manuals</td>
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<td></td>
<td>Provide more instructions for parent therapists</td>
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<td></td>
<td>Mood diagrams were confusing</td>
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<td>Add information about school nurse and update educational terms</td>
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<td></td>
<td>Include positive feelings on “Paying attention to feelings” handout – parents shared that children have trouble identifying positive emotions</td>
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<td></td>
<td>Provide family projects at end of each session</td>
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<td>Combine information to decrease group length</td>
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<td>Minor spelling errors</td>
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Table 14 Continued

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>What were any new ideas or flexible additions to the manual or handouts</td>
<td>Present topics initially by having parents share their child’s medications and previous experiences with medications and providers</td>
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<tr>
<td>you thought of?</td>
<td>Discuss role of the school nurse</td>
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<td></td>
<td>Provide CBT skills for parents similar to Thinking-Feeling-Doing exercise for children</td>
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<td></td>
<td>Brainstormed ideas about how to use support system to break negative family cycles</td>
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<td></td>
<td>Provided resources on Ohio special education</td>
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<td></td>
<td>Provide statistics suicide rates in children/teens</td>
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<td>Include time for role-plays to practice skills and obtain group feedback</td>
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<tr>
<th>Other Comments</th>
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<tbody>
<tr>
<td>Start group with adequate number of families</td>
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<tr>
<td>Families wanted time to tell their stories</td>
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<tr>
<td>Include guidance on battles over video games</td>
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<td>Parents shared contact information after group</td>
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<tr>
<td>Some parents complained group was giving their children too much information about bipolar disorder; those parents dropped after first session</td>
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<tr>
<td>Consent and study questionnaire completion cut into time during first and last sessions; families should complete pre-tests during screening interview or before the start of group</td>
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</table>
### Table 15. MF-PEP therapists’ qualitative feedback from open-ended questions on the MF-PEP Therapist Post-Group Feedback Survey.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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</thead>
<tbody>
<tr>
<td>What is your biggest concern about the group training and how could this be addressed?</td>
<td>Did not spend enough time reviewing how to run the parent group&lt;br&gt;Provide more training on criteria for group selection and how to identify appropriate and compatible families&lt;br&gt;The training was extensive and time consuming; provide training via video&lt;br&gt;Provide video tapes for therapists to review for ongoing consultation&lt;br&gt;Provide video examples of issues/problems</td>
</tr>
<tr>
<td>What is your biggest concern about the group format and how could this be addressed?</td>
<td>Group member retention; continued focus and identification of compatible families in referral process should help&lt;br&gt;Formalize prescreening interview to identify compatible families early-on&lt;br&gt;Start group with adequate number of families&lt;br&gt;Group could be condensed to 6 weeks; seemed repetitive&lt;br&gt;Children losing attention&lt;br&gt;Children losing motivation by the 6&lt;sup&gt;th&lt;/sup&gt; group&lt;br&gt;Small group size impacts motivation</td>
</tr>
</tbody>
</table>
### Table 15 Continued

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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</table>
| **What is your biggest concern about the group format and how could this be addressed?** | Difficulty motivating parents to complete homework  
Important to have continuity in the age range; outliers may feel uncomfortable  
Parents wanted a support group to follow this group  
Concern parents would feel “read to” from parent workbook |
| **What did you like most about the group training and why?** | Dialogue with and feedback from others who received training in and facilitated MF-PEP  
Hearing about what occurred in other groups and how these things were handled  
Reviewing therapist manual  
Interactions and structure for the group: kids get to learn and practice skills in and out of group  
Small group was conducive to questions |
| **What did you like most about the group format and why?** | Enjoyable to watch friendships form as members supported one another  
It would be helpful to allow more time for stories and support  
Provides families with the support they need; removes some feelings of stigma and isolation  
Families and children can learn from each other  
Flexibility of the group (i.e., structured enough for learning, informal enough for support and development of group process)  
It was very helpful to families |

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Table 15 Continued

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>What did you like most about the group format and why?</td>
<td>It was very interactive</td>
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<td>Most activities were informative and entertaining</td>
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<td>Offers something different than one-on-one treatment</td>
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<td>Opportunity for peer feedback/examples</td>
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<td>Three therapists to discuss clinical concerns with</td>
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<td></td>
<td>Separate parent and child groups; this allows for the curriculum to be age-specific and for parents to learn and support on another</td>
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Appendix L: Community Therapists’ Qualitative Feedback on the Individual/Family Therapist Questionnaire about MF-PEP

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>MF-PEP has a non-blaming and empowering motto “It’s not your fault, but it’s your challenge.” Have you noticed that this motto has affected the family’s attitude?</td>
<td>A decrease in blame for child’s behavior and a greater understanding of child’s mental health Parents more patient and understanding with regards to negative behavior Less blame in home This helped the child understand most of the mood stuff is outside of his control Improved coping skills and confidence Holding client accountable more and creating more empathy Empowered the family They have repeated this motto one to two times, so apparently they have internalized this belief Parents and client appear to have patience and understanding It helps kids see they are not their diagnosis and families cannot allow it to be an excuse Mom attempts to be tolerant They use the motto at home</td>
</tr>
</tbody>
</table>

Table 16. Community therapists’ qualitative feedback from open-ended questions on the Individual/Family Therapist Questionnaire about MF-PEP.
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>Did the family discuss the content of MF-PEP with you in therapy sessions?</td>
<td>Tool box, education from group</td>
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<td></td>
<td>Support of other parents and gaining knowledge</td>
</tr>
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<td></td>
<td>Medication and symptom reduction</td>
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<td></td>
<td>Reviewed group content and how family is using skills in daily life</td>
</tr>
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<td></td>
<td>Child described peer interactions and tools</td>
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<td></td>
<td>Child brought binder to therapy</td>
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<td>Limited conversation about group content</td>
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<td></td>
<td>Improved communication between parent and client has been significant</td>
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<td></td>
<td>Communication skills</td>
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<td></td>
<td>Reviewed basic principles of group</td>
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<tr>
<td></td>
<td>Coping strategies</td>
</tr>
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<td></td>
<td>Breathing exercises</td>
</tr>
<tr>
<td>Do you have any other comments about the family’s participation in MF-PEP you would like to share?</td>
<td>“The family was very invested in group and attended all sessions. Group seemed to be a springboard for child to begin to discuss loss issues previously not brought up by child.”</td>
</tr>
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<td></td>
<td>“They have not attended therapy sessions with me since the end of group. They have broken many appointments.”</td>
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<td></td>
<td>“Start group with more clients (6-8) so that if one family cannot attend the group one week it will not reduce efficacy of the child/parent portions.”</td>
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<td></td>
<td>“Child benefitted from his attendance and reported that he enjoyed attending and liked “helping” other members.”</td>
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Table 16 Continued

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<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>Do you have any other comments about the family’s participation in MF-PEP you would like to share?</td>
<td>“Feedback about weekly attendance and performance was helpful.” “Family reports significant improvement for mom and child after group. I am now seeing them for continued counseling. Mom reports ‘I don’t know where we would be if we hadn’t attended group.’ The family benefitted greatly from the information, especially the mother. However, the child’s behaviors continued to worsen in the area of anxiety. Even though he had the skills to cope, he needed medication increased to help deal with his anxious behaviors.” “The child does not appear to have gained tools or information to help her progress. This could be due to conflict in the home during group (stepfather was in and out of the home setting). When Dad originally was removed from the home mom appeared to become more committed to the group. Mom has utilized some of the tools/information she had learned at the end of the group. We do at times refer back to information learned in the group and mom can explain the information taught to parents.” “The family seemed to benefit a great deal from group.”</td>
</tr>
</tbody>
</table>