# Depression Experience Journal: A Computer-Based Intervention for Families Facing Childhood Depression

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## ABSTRACT

**Objective:** This study tested the feasibility and safety of a computer-based application for families facing childhood depression. The Depression Experience Journal (EJ) is a psychoeducational intervention based on a narrative model involving the sharing of personal stories about childhood depression. **Method:** Semistructured interviews assessed Depression EJ feasibility and safety. Thirty-eight primary caretakers of children with depression (one caretaker per patient) used the EJ during a psychiatric hospitalization. Assessment of feasibility and safety was measured before EJ use and 2 to 4 weeks afterward. **Results:** Results revealed that the EJ was safe and useful for decreasing social isolation, increasing hope, increasing understanding of familial feelings about childhood depression, and fostering positive reactions in caretakers. **Conclusions:** Computer-based interventions hold significant promise in providing a new manner of psychosocial support to families facing child and adolescent psychiatric illnesses. *J. Am. Acad. Child Adolesc. Psychiatry,* 2006;45(2):158–165. **Key Words:** prevention, pediatric, computer, safety, depression.

Childhood depression is a serious public health problem (U.S. Department of Health and Human Services, 1999). Population studies show that at any one time, between 10% and 15% of the child and adolescent population have some symptoms of depression and by the age of 18, 20% to 25% of adolescents will have experienced a depressive episode (Lewinsohn et al., 1993; Smucker et al., 1986). Associated impairments, both during a depressive episode and after the acute depression has remitted, are substantial and include difficulties in school, problematic interpersonal relationships, substance abuse, and an increased risk of completed suicide

(Beasley and Beardslee, 1998; Institute of Medicine, 2002; President's New Freedom Commission on Mental Health, 2003). Parents of a child with depression are faced with the challenging, sometimes overwhelming, task of caring for such a child (U.S. Department of Health and Human Services, 1999).

Educating children and their families about depression has been shown to be effective in helping families deal with the illness (Beardslee et al., 2003). When this information is linked to a family's life experiences, these interventions have been effective in changing behaviors and attitudes, resulting in increased parental understanding of the children's experience, increased familial closeness, increased focus on their children's needs, and increased family communication (Beardslee et al., 1996, 1997, 2003).

Learning about depression may help parents identify affect, deal with stigmatization, and talk with others more effectively about their child's depression. Research suggests, however, that the design of an intervention for these parents goes beyond the expression of factual information about depression. Shapiro and Koocher (1996) have suggested that asking medical patients to tell the stories of their illnesses provides insights into each person's perceived losses and changes in functioning.

Research demonstrates positive effects in patients who have the opportunity either to tell or write their stories (Adler, 1997; Clark and Standard, 1997; McGihon, 1996; Suedfeld and Pennebaker, 1997). By heightening awareness and transforming unconscious thoughts, memories, and emotions into conscious ones, this narrative approach has been likened to mindfulness methods of stress reduction (Brody et al., 2004), and there is evidence that mindfulness and attentional control are effective therapies for preventing depression relapse (Teasdale et al., 1995).

It is notable that sharing one's story may be particularly useful within the context of childhood depression. Many patients and their families have few opportunities for emotional expression in a safe environment because of social isolation or efforts to protect family members and friends from illness-related topics (Shapiro and Koocher, 1996). In addition, clinicians often do not have time to help patients process losses. In one study, parents reported wishing that they had more support, particularly from healthcare providers, when their children were hospitalized on an inpatient psychiatric unit (Puotiniemi et al., 2002).

Many medically ill patients report some withdrawal from members of their support network (Lichtmann et al., 1987). Given the stigma of mental illness, the effect of a child's depression on the family's support network is likely to be even greater. This is of concern because when it is received, social support has powerful buffering effects and can improve quality of life (Shapiro and Koocher, 1996). In a national survey of parents of children with an emotional disorder, 72% indicated that emotional support was the most helpful aspect of family support services (Friesen and Koroloff, 1990). Benefits included improved problem-solving skills and more positive views about parenting and their children's behavior.

Perhaps to combat social withdrawal from family and friends, parents of children with pediatric illnesses often informally talk with other parents about their experiences, which can provide support and reduce isolation (Gonzalez-Heydrich et al., 1998). More formally, in medical crisis counseling for the parents of medically ill children, parent-to-parent support programs have become important services (Ireys et al., 2001). These programs can decrease stress, anxiety, and depression and increase social support (Ireys et al., 2001), as well as assist in coping with guilt and anger (Diehl et al., 1991).

In addition to family support groups, several computer-based interventions have been useful in providing support related to medical illnesses (e.g., Bucher and Houts, 1999). Although most of these interventions focused on presenting factual information (Lewis, 1999), some have begun to demonstrate the impact of more personal components. A study of the computer intervention of Gustafson et al. (1993), designed for breast cancer patients and their families, found that the discussion group was the most popular resource. In addition, the "personal stories" section grew as participants added their narratives, suggesting a desire for computer-based social support. Importantly, the majority of the study's participants preferred the online discussion group to face-to-face groups because of the online group's accessibility and anonymity and because it prevented participants from becoming overwhelmed by others' problems (Gustafson et al., 1993). Family members reported that the intervention helped them understand the medical condition and that it increased positive emotions (e.g., support, empathy) and decreased negative emotions (e.g., anger, worry).

The focus of the present study is the Depression Experience Journal (EJ), a computer-based intervention for families with children with depression. Grounded in theoretical research on preventive interventions, narrative therapy, and social support, the program makes the experiences of contributing children, parents, and health caregivers available via the Internet to families who may be facing similar issues and provides the opportunity for individuals to contribute their own narratives. It was designed to foster the creation of an electronic community that enhances self- and family understanding. This project is unique in its linking of personal experiences and information in a computer application that can be used by families facing childhood depression.

The present study is modeled after an earlier study conducted to assess the safety and feasibility of the first EJ prototype, the Cardiac EJ (DeMaso et al., 2000). Offord (1982) noted that it is essential to establish that a preventive intervention does more good than harm. In this context, the establishment of safety for participants using the EJ is important. Specifically, we explored the premise that the Depression EJ would be safe, feasible, and useful to primary caregivers of children facing childhood depression. Secondary goals included exploring whether primary caregivers would report finding the

EJ helpful in increasing their understanding of depression, increasing hopefulness, decreasing social isolation, generating ideas for the future, and improving communication with their child.

## METHOD

### Procedure

The Depression EJ was described to primary caretakers as a research project designed to facilitate the healthy coping of children and their families contending with childhood depression. Appropriate human subjects' permissions were obtained.

Participants were asked during the psychiatric hospitalization of their child to use the Depression EJ. Subjects underwent a semistructured interview about their child's depression before the use of the EJ. Following this interview, the Depression EJ was made available to each participant on a laptop computer. If participants were unable to view the Web site directly after the interview, they were allowed to view it later during their child's hospitalization or at home. Subjects were asked to explore the EJ application at their own direction for at least 30 minutes. Fourteen to 28 days after viewing the EJ, subjects completed a second 30-minute semistructured interview by telephone.

### Participants

Each participant was the primary caregiver of a youth (ages 8–19; mean = 15) psychiatrically hospitalized at Children's Hospital Boston. Only one caregiver per patient participated. Thirty-eight primary caregivers enrolled (ages 32–57; mean = 44). Although the majority of participants were parents (35 mothers, 2 fathers), nonparental caregivers who had served as the child's primary caregiver for a minimum of 2 years also participated when a parent was not available (n = 1).

The diagnosis of a *DSM-IV-TR* depressive disorder, a bipolar I or II disorder (depressed), adjustment disorder with depressed mood, or mood disorder (depressed) secondary to a general medical condition by either the case clinician (a staff social worker, child and adolescent psychiatry resident, or psychology intern) or attending child and adolescent psychiatrist at the time of admission was used to establish the presence of significant childhood depression (American Psychiatric Association, 2000). The clinician and psychiatrist conducted separate clinical psychiatric evaluations on each patient, which formed the basis for these diagnoses. There was 82% agreement between the clinician and the attending psychiatrist as to the presence of a depressive disorder. For those cases in which the clinician and the psychiatrist differed as to which depressive disorder they concluded was present, the psychiatrist's report was used. Inclusion criteria included sufficient English skills both to complete the semistructured interviews and to read the EJ narratives.

Of the 142 children who met the diagnostic criteria as outlined above for a depressive disorder, 73 were excluded from the study by unit staff. These families were not approached about participating in the study for the following reasons: no consistent primary caregiver available to complete the interviews (n = 21), hospital stay too short to contact caregiver (n = 19), caregiver's lack of adequate English speaking/reading skills (n = 10), and family in crisis or deemed inappropriate by the primary clinician (n = 23). The reasons that families in the final category were deemed inappropriate included

current child abuse or domestic violence investigations and caregiver resistance to their child's admission and/or diagnosis of depression.

On being asked to participate, 31 of the remaining 69 parents declined, resulting in a 55% rate of participation. Reasons for declining included being unable to come in for the initial interview (n = 11), lack of interest in participating in research (n = 8), feeling "overwhelmed" (n = 7), and health problems of the parent or another family member (n = 4). Of the 38 participants who enrolled in the study and completed the first interview, 25 (66%) viewed the EJ directly after the interview. Thirteen patients could not view the EJ directly after the interview and viewed it either later during their child's hospitalization (n = 9) and or at home (n = 4) an average of 6.5 days after the first interview. Thirty-five of the 38 participants (92%) also completed the second interview. These follow-up interviews occurred between 14 and 26 days after the caregivers' EJ viewings (mean = 19.8 days). At the time of the second interview, the majority of patients had been discharged from the hospital (n = 30); of those discharged, three had been readmitted.

Failure to complete the second interview was the result of the inability of the research team to reach the participants by telephone in the 2-week time frame following the Web site viewing (n = 2) and a reported lack of time to complete the second interview (n = 1). The majority of participants were white (n = 31) and married (n = 24). Nearly half (42%; n = 16) had completed a college education or more. Primary caregivers of more female (n = 26) than male (n = 12) children participated. Nearly all of the participants (n = 37) reported having access to a computer, and 89% (n = 34) reported having a working knowledge of computers.

The following diagnoses were given on admission: major depressive disorder (n = 18), depressive disorder not otherwise specified (n = 11), mood disorder not otherwise specified (n = 5), and mood disorder secondary to a general medical condition (n = 1). Comorbid admission diagnoses included eating disorder (26%), anxiety disorder (18%), disruptive behavior disorder (11%), substance abuse disorder (11%), learning disorder (8%), separation anxiety disorder (3%), and impulse control disorder (3%). Parents reported that the length of their children's depression ranged from 2 to 143 months (mean = 41 months, median = 26 months). Of the children, 32% had been hospitalized on a psychiatric inpatient unit previously, and 89% were receiving some form of outpatient therapy.

### Computer Application: Depression EJ

The Depression EJ is a psychoeducational intervention designed to facilitate the healthy coping of children and their families who must contend with significant childhood depression (DeMaso et al., 2003). This intervention is a Web-based application involving the sharing of personal stories about an illness (DeMaso et al., 2000, 2003). The EJ can be viewed at www.experiencejournal.com/depression.

The Depression EJ works by accepting descriptions from patients, parents, siblings, and hospital staff about what it has been like to live, cope, and work with pediatric depression (ranging from short written explanations of an experience to poems, stories, and video clips). Stories are grouped and saved so that they can be easily explored and revisited rather than depending on the "at the moment" experience of an online chat room. A hospital committee of 14 parents and 25 healthcare providers/hospital staff reviews all contributions for appropriateness (i.e., verifies that they are not potentially harmful or hurtful) before including them in the EJ. Children of different ages and genders are represented, and narratives concerning unipolar and bipolar depression are included. Release forms for the use of

information and materials for the EJs were developed in collaboration with the hospital's Office of General Counsel.

## Measures

Two different 30-minute semistructured EJ interviews were created for this study, based on the interviews used to evaluate the Cardiac EJ (DeMaso et al., 2000). The first interview assessed families' experiences with their child's depression, including primary caretaker ratings of the length and severity of their child's depression, history of other mental health problems, reason for the admission, and treatment history. Responses to these items were used to characterize this inpatient population and provide a context for caregivers' responses to the EJ.

The second interview elicited both qualitative data and quantitative ratings, with all nondichotomous quantitative data rated on a 7-point Likert scale ranging from 1 ("not at all") to 7 ("a great deal" or "extremely satisfied"). This interview included the following: (1) Satisfaction and Safety Scale, which examines parents' satisfaction with the way the EJ's factual and narrative information is presented, as well as parents' overall EJ satisfaction; (2) Concerns/Areas for Improvement Scale, which examines aspects of the EJ that parents found most and least helpful and explores how the EJ could be improved; (3) Specific Impacts Scale, which assesses parents' impressions of how the EJ has affected various facets of their lives, including their understanding of depression, sense of hope, sense of isolation, perspective taking, and ideas for the future; (4) Coping Response Scale, which assesses the effects of the EJ on parents' and children's perceived ability to cope with depression; and (5) Attitude Change Scale, which measures changes in how individuals feel about the concept of depression in general.

Parents were asked during both interviews to rate their own current depression level on a 7-point Likert scale. If a parent indicated that he or she was experiencing a high level of depression (defined as a self-reported score of ≥5) and was not in treatment, the interviewer conducted a brief screening to make sure the caregiver was not at risk and offered a mental health referral as indicated.

## Analysis of the Data

Descriptive statistics were calculated for each of the rating scales. Each of the responses to the open-ended questions in the coping response and concerns/areas for improvement categories was reviewed and coded based on frequency and similarity to other responses. Interrater reliability was then assessed for the coping responses by giving a second rater a randomly selected group of 25 caregiver responses to categorize under the headings generated in this review.

## RESULTS

### Satisfaction and Safety

Means and SDs for subjects' ratings of satisfaction and safety are reported in Table 1. Mean overall satisfaction with the Depression EJ was quite high (mean = 5.75), as was satisfaction with the way stories (mean = 6.19) and factual information (mean = 5.44) were presented. Parents assigned the EJ low ratings for hurtfulness (mean = 1.43) and potential harmfulness to children and adolescents (mean = 1.79). No parents reported

that they thought the EJ had any negative impact on their relationship with their child or their ability to talk to their family about depression. When asked whether the EJ caused them to have any thoughts or increased thoughts about hurting themselves, all of the parents answered no.

When asked if there were any aspects of the EJ that were not helpful, 27 parents answered no. Of the eight parents who said yes, two commented that there were aspects of the Web site's design that they would change, three indicated that some of the factual information was repetitive of what they knew already and/or that they wanted more detailed factual information, and three took issue with the inclusion of particular subject matter on the Web site, such as information on medications and bipolar disorder.

In the open-ended questions, personal stories were reported to be the most helpful. Specifically, 18 participants noted that the parent stories were most helpful to them, and 14 said that the child and adolescent stories were most helpful. More broadly, nine parents reported that the Web site's most helpful aspect was that it enabled them to hear that others have dealt with the same experiences and that they are not alone.

When asked whether they felt that any part of the EJ was hurtful at all, three subjects answered yes. These parents' responses included "sadness and worry" on realizing that their child was depressed and "hurtfulness" as a result of learning how many children have depression. One parent reported that she felt that the timing of the intervention (i.e., viewing the EJ during the child's hospitalization) was poor but noted that the experience did not have any lasting negative effects.

Parents offered several suggestions on how to improve the Depression EJ, emphasizing predominantly a desire for a greater number and range of narratives. Specifically, parents suggested the inclusion of stories from families beyond the hospitalization stage ($n = 3$), stories geared toward a younger audience (i.e., a younger sibling; $n = 2$), and narratives by siblings and extended family members ($n = 2$). Other parents indicated that they would like more information on medications ($n = 2$), more specific advice for parents ($n = 2$), and more information on community resources ($n = 2$). With regard to the Web site design and layout, participants' responses primarily focused on making the Web site more interactive (i.e., adding a question-and-answer forum with healthcare providers or a parent-to-parent forum; $n = 2$).

## TABLE 1
Mean Ratings and SDs for Satisfaction, Safety, and Specific Impact of the Depression Experience Journal

|  | Mean | SD |
|---|---|---|
| Satisfaction and safety |  |  |
| Overall, how satisfied are you with the EJ? | 5.75 | 1.66 |
| How satisfied are you with the way people's stories regarding depression were presented in the EJ? | 6.19 | 0.95 |
| How satisfied are you with the way factual information about depression was presented in the EJ? | 5.44 | 1.70 |
| Do you think the EJ would be harmful or hurtful to a child or an adolescent? | 1.79 | 1.14 |
| Overall, did you feel the EJ was hurtful at all? | 1.43 | 1.14 |
| Is your relationship with your child worse now that you have used the EJ? | 1.00 | 0.00 |
| Did the EJ make it more difficult to talk to your family about your child's depression? | 1.00 | 0.00 |
| Specific impact |  |  |
| Did the EJ give you any sense that there are others who also are facing the same issues of raising a child with depression? | 6.44 | 0.91 |
| Did you find it helpful to read about other families' experiences or stories about living with their child's depression? | 6.06 | 1.39 |
| Did the EJ decrease the extent to which you felt alone? | 5.83 | 1.51 |
| Did the EJ increase your sense of hope? | 5.44 | 1.42 |
| Did the EJ increase your understanding of your experience? | 5.40 | 1.38 |
| Did the EJ help you to gain perspective about your child's illness? | 5.26 | 1.56 |
| Did the EJ help you understand children with depression and their families? | 5.26 | 1.69 |
| Did the EJ relate to your own experiences? | 5.20 | 1.68 |
| How effective was the EJ in helping you understand your child's depression? | 4.97 | 1.67 |
| Did the EJ increase your understanding of your child's experience? | 4.77 | 1.80 |
| Did the EJ help you understand your own child's depression? | 4.60 | 1.85 |
| How effective was the EJ in helping you understand your child's reactions to his or her depression? | 4.49 | 1.56 |
| Did the EJ help you understand your child's feelings or behavior about his or her depression? | 4.43 | 1.95 |
| Did the EJ help prepare you for the future? | 4.34 | 1.85 |
| Did the EJ improve communication between you and your child? | 4.20 | 2.00 |

*Note:* Ratings were determined using a 7-point scale. The scales were anchored at one end by "1 = not at all," had a midpoint of "4 = moderately," and were anchored at the other end by "7 = a great deal" or "extremely satisfied." EJ = Experience Journal.

### Specific Impact

When asked to assess the EJ's specific impact, participants reported that the resource gave them a strong sense that there are others facing the same issues in raising a child with depression (mean = 6.44) and that they found it helpful to read about other families' experiences (mean = 6.06). Caregivers assigned the Web site high scores for decreasing their sense of isolation (mean = 5.83), increasing hope (mean = 5.44), increasing their understanding of their experience (mean = 5.40), and increasing their sense of perspective (mean = 5.26).

### Coping Response

Table 2 presents the coping responses that participants endorsed. In analyses of answers to the open-ended items on the Coping Response Scale, five main themes emerged. Twenty-nine (29) caregiver comments indicated that the EJ helped participants to understand the symptoms of pediatric depression, 24 comments revealed that the EJ gave parents a sense of how common pediatric depression is, 19 indicated that the site increased participants' understanding of their child's experience and feelings, 14 revealed that parents had obtained information on if/when they should seek help for a child, and 13 suggested that the site gave participants a perspective on or framework through which to understand their family's experiences. Among the 25 concerns also categorized by a second rater, there were two disagreements as to category, resulting in 92% agreement. Interrater reliability, calculated with Cohen's $\kappa$ coefficient, was 0.90.

### Attitude Change

Parents reported a moderate degree of attitude change. The mean rating parents gave in response to the question, "Did the EJ help you understand your

TABLE 2
Percentage of Subjects ($N = 35$) Responding in the Affirmative to the Open-Ended Coping Response
Questions Regarding the Depression Experience Journal

| Question | % Yes |
| --- | --- |
| Has the EJ affected how you think or feel about your child's depression? | 77.1 |
| Having used the EJ, do you think of yourself or your experience with childhood depression differently? | 77.1 |
| Has the EJ helped you to identify any warning signs in your child, that is, indications that he or she is having trouble coping or managing in response to his or her depression? | 60.0 |
| Did the EJ alert you to any specific issues about childhood depression? | 54.3 |
| Did the EJ help you to identify any skills, characteristics, or actions that help children or families cope well under stressful circumstances? | 45.7 |
| Did the EJ give you any ideas about what you might do if problems come up? | 41.2 |
| Have you obtained any new information from the EJ about your child regarding how he or she feels about his or her depression or how it has affected him or her? | 40.0 |

and/or your family's feelings about your child's depression?" on a 7-point Likert scale was 4.88, and the mean rating in response to the question, "Do you think the EJ had any effect on how supportive you and your family are of each other?" was 3.41.

## DISCUSSION

The Depression EJ appears to be safe, feasible, and useful to the primary caregivers of children facing childhood depression. Grounded in narrative therapy and social support research, this Web-based application had high satisfaction ratings and low ratings of harmfulness. The fact that nearly 80% of the caretakers in this study reported that the EJ affected the way they think or feel about their child's depression supports previous work suggesting that the computer is a viable medium for providing preventive interventions (DeMaso et al., 2000).

In developing this EJ, there had been concern initially about the potential adverse impact of stories about depression on a vulnerable population in which suicide is a significant problem. This concern was addressed by implementing a careful review by the editorial committee of all Web site contributions for any harmful or hurtful content and by targeting caretakers as the primary audience for the present research study. Although the EJ generated some sadness and worry in a few caretakers related to the awareness of the implications of child/adolescent depression, this study of a particularly vulnerable inpatient population found no increase in suicidal ideation among caretakers.

The Depression EJ specifically affected caregivers by providing them with a sense that others are facing the same issues, decreasing the extent to which they felt alone, giving them a sense of hope, and increasing their understanding of depression. These impacts paralleled the caretaker open-ended coping responses, in which the EJ was described as helpful in increasing parents' understanding of the symptoms of depression, increasing their understanding of their own child, increasing their understanding of how common childhood depression is, providing them with information on whom to seek for help, and expanding their perspective on their family's experience. Moderate increases in understanding of feelings about their child's depression and in intrafamily supportiveness lend further support to the use of the EJ as a resource for parents to evaluate their own families' experiences. All of these factors have been identified as important to successfully navigate medical crises (Shapiro and Koocher, 1996).

The application was less useful in helping caretakers improve communication with their children and preparing them for the future. Recommendations for improvement centered on increasing the breadth and number of stories and increasing the amount of factual information provided (i.e., medications, advice, and resources). The latter requests were expected, given that the EJ focuses primarily on personal experiences rather than factual information. Nevertheless, the caretakers were quite satisfied with the way factual information

was presented. A few caretakers were interested in a more interactive Web site with parent-to-parent or parent-to-healthcare forums, further supporting the importance of personal stories.

## Limitations

The caretakers in the sample were predominantly mothers, white, and married, and many were college educated. Thus, generalizations to other groups must be made with caution. In addition, caretakers' responses may have been positively biased because of social desirability. Although attempts (e.g., telephone interviews) were made to decrease this, caretakers may have felt pressure to rate the EJ positively because the interviewer was not an objective rater. In support of the validity of responses, ratings spanned the range of possible values (e.g., overall satisfaction scores ranged from 1 ($n = 2$) to 7 ($n = 15$) and ratings of how helpful it was to read about others' experiences or stories ranged from 2 ($n = 2$) to 7 ($n = 19$). In addition, caretakers rated the EJ low in several areas (e.g., on specific impact items asking whether the EJ helped to prepare parents for the future and whether it improved communication between parent and child, mean caregiver ratings were 4.34 and 4.20, respectively).

There were a number of families whose children met the diagnostic criteria for a depressive disorder but who did not participate in the study. The fact that nearly 15% of the children who met diagnostic criteria had no consistent primary caretaker likely speaks to the need for an intensive psychiatric intervention in the context of little or no family support. More than 20% of eligible families did not participate because of their clinician's or their own concern about being in crisis or being overwhelmed. Whether the clinicians were correct in their judgment was not challenged in this study, so the impact of the EJ on these caretakers could not be determined.

Although the initial EJ viewing was limited to 30 minutes, the amount of time spent viewing the EJ following this introduction is an unknown variable. In addition, caretakers read various stories within the EJ and therefore may have had quite distinct experiences. For example, some may have read contributions by healthcare providers regarding depression, whereas others may have only read other parents' personal experiences. The variations in amount and type of exposure to the EJ stories may have affected caretakers' EJ satisfaction

ratings and must be considered as variables to measure or control for in future computer-based intervention studies.

Although EJ content was reviewed by a hospital committee with older adolescents as a projected audience, this study focused specifically on parents and caretakers and did not examine the impact of the Web site on adolescents, an obvious area for future research. (At present, a disclaimer on the site states that young children should not view the EJ unless a parent or therapist is present.)

A child and adolescent inpatient population was selected for this study because it represents a group that would be particularly sensitive and vulnerable to potential adverse effects of the computer application. Although further study would be required, these findings support the EJ's applicability to outpatient settings, where the majority of youngsters with depression are diagnosed and treated.

## Clinical Implications

Providing a contribution to the EJ was an optional opportunity that was not assessed in this study. Given that previous studies have shown positive effects in patients who have the opportunity to write and tell their stories (Adler, 1997; Clark and Standard, 1997; McGihon, 1996; Suedfeld and Pennebaker, 1997), the impact of contributing one's own narrative to the EJ will be targeted as an area for future inquiry.

Interventions that focus on linking cognitive information to one's unique personal experiences appear critical to changing understanding and behavior (Beardslee et al., 1996, 1997, 2003; DeMaso et al., 2000). The creation of Web-based interventions presenting psychoeducational information closely connected to "one's own story" has the potential to supplement traditional interventions such as support groups or meetings with mental health professionals. This study demonstrates the significant promise that computer-based interventions hold in providing a new manner of psychosocial support to families facing child and adolescent psychiatric illnesses.

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The Evaluation of Sexual Abuse in Children N. Kellogg and the Committee on Child Abuse and Neglect

This clinical report serves to update the statement titled "Guidelines for the Evaluation of Sexual Abuse of Children," which was first published in 1991 and revised in 1999. The medical assessment of suspected sexual abuse is outlined with respect to obtaining a history, physical examination, and appropriate laboratory data. The role of the physician may include determining the need to report sexual abuse; assessment of the physical, emotional, and behavioral consequences of sexual abuse; and coordination with other professionals to provide comprehensive treatment and follow-up of victims. Pediatrics 2005;116:506–512.

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