ENHANCED CARE MANUAL

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Clinicians' Manual for Brief Psychoeducational Treatment of Children and Adolescents at Risk for Bipolar Disorder

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Introduction

This manual provides instruction for a 4-month psychoeducational treatment, Enhanced Care (EC), for youth at risk for developing bipolar disorder. EC consists of six sessions with the following elements: (1) a thorough diagnostic assessment with a study evaluator, (2) a separate evaluation by a psychiatrist; (3) three family educational sessions (weekly to every other week) in which a mood chart is created, the primary risk and protective factors/coping strategies for mood disorders are reviewed, and a mood episode prevention plan is put in place; (4) ongoing medication management (if needed) from a study psychiatrist; (5) provision of reading materials pertinent to managing childhood mood disorders (The Bipolar Teen); and (6) three monthly individual sessions for the youth provided by the same clinician who conducted the initial educational sessions. The EC clinician's role includes being the point of contact for the family, handling telephone emergencies, and serving as a conduit of information between the child/family and the study psychiatrist.

Families in both the EC and FFT-HR conditions may request and receive extra sessions during clinical crises (e.g., suicidality, relapse) or family emergencies. We will document all extra-protocol contacts with the Child and Adolescent Services Assessment for later consideration in data analyses.

Overview of the EC Condition

The services provided in the EC condition are primarily educational. From a therapy perspective, they are adjunctive to medication (if needed) and limited in nature. EC serves the purpose of furnishing feedback regarding diagnostic assessments and providing education about mood disorders to children and their families. The three family sessions provide education regarding mood symptoms and episodes, risk and protective factors, the impact of stress, the importance of biological and social rhythm regulation, and the potential role of medications in mood and sleep stability. An individualized mood management plan is developed that includes discussions of how the family can help, how the school can help, and how to determine if the child's mood symptoms are worsening and what to do if that happens.

Although the child will not have a diagnosis of bipolar I or II, he or she may have early signs of the disorder, and in some cases will have a first or second degree relative with the disorder. The primary goal of EC is for families to recognize emergent symptoms and develop strategies for derailing the more severe progression of mood symptoms. We believe that having a frame of reference for mild mood swings versus more severe signs of the disorder will help families with early detection and prevention of the onset of bipolar I or II disorder.

The goals of the monthly individual sessions, conducted after the three family psychoeducation sessions, are threefold: 1) as "booster sessions" to further the use of concepts learned in the EC family sessions; 2) as a forum for problem-solving; and 3) as a preventative check-in to determine whether the youth is remaining stable.

Family Sessions

Session 1 Goals

- **Get to know the family**
- **Review the symptoms of mood disorder**
- **Explain the vulnerability-stress model**
- **Discuss risk and protective factors**
- **Build an individualized mood chart for the child**

Session	**Goals**	**Handouts**
EC 1	Get to know the family Review the symptoms of mood disorder Explain the vulnerability-stress model Discuss risk and protective factors Build a mood chart	#1 Goals #2 Mania #3 Depression #4 Other things #5 Factors affecting health #6 Risk and protective factors #7 Sample mood chart
EC 2	Review EC 1 and mood chart Discuss medication Do “What do I do if I’m having a bad day” exercise Develop guidelines for when to request a crisis session	#8 Medication #9 Mood Episode Prevention plan
EC 3	Review mood chart, prevention plans Discuss how the family and school can help Address unanswered questions	#10 How can your family help

Start by explaining that you will have three meetings with the family to teach

them about mood disorders and provide tools they can use to help manage mood symptoms. **Handout #1**, "**Enhanced Care"**, explains the goals for EC. Check in briefly with each family member about what they want to get out of the three sessions. Next, distribute **Handouts #2, #3, and #4 "Symptoms of Mania, Symptoms of Depression, and Other things".** Categorize the experience of symptoms from the child's perspective: what does he or she experience when activated/hypomanic and/or depressed? Try to get a sense from everyone's perspective of what the child's mood symptoms look like (e.g., mild changes in thinking, sleep, increased irritability, or changes in arousal). Ask other family members about their own experience of depression and mania. If the first-degree relative with bipolar disorder is a participant in treatment, that person's responses will be particularly relevant. Note whether the relative talks openly about having bipolar disorder or whether it is addressed vaguely or awkwardly in the family.

Move on to **Handout #5**, "**Factors Affecting Health Problems**." This handout illustrates how biological and genetic vulnerabilities interact with socio-environmental stress in bringing about mood symptoms (and other health problems). Introduce this handout as follows:

> "As you can see in the handout, we believe that things that we experience as difficult or stressful can interact with our biological vulnerabilities or "predispositions." Predisposition means that some people are more likely to have mood swings because of their genes or the chemistry of their brain. To give a different example, some people are genetically predisposed to being overweight, meaning that being overweight runs in their family. As a result, the person may not eat any more than the average person but has a physical system that makes it more likely that he'll gain weight.
> "We know that mood swings run in families. However, just because your brain chemistry makes it more likely that you will have mood swings doesn't mean you will necessarily have them. We also think that stress plays a role. If a person learns to cope with the stress or other difficulties in her life then she will have much less trouble with mood swings. Does this make sense?"

Explain that one reason that the child is in this study is that we believe that the child is having trouble with moods (and, if relevant, because he or she also has a family member who has trouble with moods). If the family member is present and is comfortable talking about his or her own experience with the disorder, you may be able to elicit some discussion of how this family member may have inherited a predisposition for mood problems and/or examples of how stress can exacerbate mood symptoms.

Ask the child what stressors tend to trigger his or her mood changes (for example, not getting what he or she wants; the teacher asking him or her to be quiet; arguments with siblings). If he or she says, "I don't know," ask him or her to recount the last time his or her mood escalated and the immediate precipitants of that escalation. Parents and siblings will probably want to have input here.

Handout #5 naturally leads to Handout #6, “Risk and Protective Factors For Mood Problems.” Introduce this handout by saying:

“We believe that individuals are better able to manage their mood swings when they can identify risk and protective factors. Risk factors are those things that may increase your chances of having mood swings. Protective factors are those things that you can do on a daily basis to make you less likely to have mood swings even if you’re vulnerable to them. For example, if I had diabetes, then skipping meals would increase my chances of getting sick whereas taking my medication would help keep me from getting sick. If I had mood regulation problems, missing a night’s sleep could be a risk factor but keeping on a regular sleep/wake schedule could be a protective factor.”

Go through each risk and protective factor and inquire as to whether that factor is present. Ask each member of the family to identify things that they might consider risk and protective factors for their own mood stability (whether or not they have a mood disorder). Having all family members engage in this activity takes the focus off of the child as being in the “sick role.” It is also good basic education for all members of the family on how to take care of themselves and manage their own stress.

Introducing the Mood Chart

Early in treatment, try to get the child into the habit of tracking his or her moods. Mood charts are quite valuable in tracking the child’s progress, identifying the emergent signs of worsening mood symptoms, identifying diurnal variations, and clarifying the role of sleep/wake cycle irregularities. They also make the child more self-aware and observant of his or her mood states.

Begin by asking the child to describe his or her mood states and what descriptors go along with each. Using a white board or flip chart, draw a horizontal line in the middle of the field (see Handout #7, “Sample Mood Chart” for an example). Ask the child to name his or her mood when no mood symptoms are present (i.e., mellow, calm, normal, typical). Then, draw a line right above and below the middle line and ask the child what words he or she would use for mild ups and downs (e.g. “pretty good” versus “pretty annoyed” or “frustrated”). Explain that these fluctuations are representative of the normal moods that someone might experience if he or she felt like things were going well or not going well. Then, draw a line one step higher and one step lower than the lines you’ve just drawn. Ask the child to label each of these lines. For example, the top line might be labeled “excellent mood” or “really happy,” whereas the bottom line might be labeled “really bored” or “bummed out.” Then, using a separate line for anger, ask the child to place it on the chart where it most clearly fits for him or her. (Is it part of an up, active mood? Is it part of the down, depressive cluster? Or both?) You may want to have lines for anger in the up and down sections of the chart. Alternatively, the child can put an “A” for anger each day on the line of the mood that it accompanies.

Once the lines are in place and labeled, each label is placed at the bottom of the page as a heading. The child begins listing descriptive terms that go along with each of the mood states. For example, 'excellent' may include giggling, talking loudly, or feeling more energetic; 'angry' may include cursing, kicking doors, or pushing and hitting. Encourage the parents to join in this process but take cues from the child. Try to keep an air of friendliness and levity in the room, recognizing that it can be difficult for the child to focus on his or her problematic moods and behavior.

Once this chart has been created, the therapist gives it to the family to be filled out by the child each day. Ask the child to complete a mood rating once or twice a day (e.g., best versus worst; morning versus evening) and more frequently if he or she is willing. More specifically, ask him or her to put an X on the line that he or she felt characterized his or her mood at various points in the day. Finally, include spaces at the bottom of each day to record when he or she went to bed and when he or she woke up each day. If there are other factors that seem to play a role in the child's mood (e.g., ate or didn't eat breakfast, menstrual cycle, marijuana use) these can be added and tracked also to try to parse out their effect on mood.

Ask one parent to make a rating based on the parent's impression of the child's mood each day, or at various times of the day. This is helpful for three reasons: to keep the parent attuned to shifts in the child's mood states; to make clear to the child that he or she is not the only one being given homework; and, by comparing charts, to get a sense of how self-aware the child is.

We have found it very helpful to ask the child to post his or her "How I Feel" mood chart on the refrigerator so he or she is not likely to forget to make a daily mood rating. Keeping the chart with evening medication (if taken) is also a helpful strategy for remembering to complete the chart. If the child has many mood switches during the day and evening, then he or she can place any number of Xs on any of the lines with corresponding times of day. Try not to make the task too complicated, however. Use your clinical judgment in deciding what level of complexity will work best for the child and ensure his or her compliance with the task.

At the end of session 1, ask the family to read Chapter 10 in The Bipolar Teen ("Tools and Tactics for Preventing Mood Episodes") and to find a time before the next session to discuss the material as a family.

Session 2 Goals

- **Review session 1**
- **Discuss medication and adherence**
- **Develop a prevention plan**

At the beginning of session 2, review the material covered in session 1 and ask if the family has any questions about what they read in The Bipolar Teen. Ask the child whether she has made progress on the mood charting. If she has not made

any effort, explain once again that the mood chart is an important source of information for her own management of moods. For example:

Therapist: Sounds like you didn't get a chance to do your mood chart. Was it clear why I wanted you to?

Child: Not really.

Therapist: The idea is for you to track your mood states and see how much they vary from day to day, and whether the changes are affected by your sleep.

Child: Oh, yeah.

Therapist: Can you say more about what got in the way of getting it done?

Child: I dunno.

Mother: Of course, this is always the problem. He has the same problem with his homework. He never does that either.

Child: Yes I do! You didn't notice the whole last week I got it done.

Therapist: Chris, I hadn't intended for this to end up with you feeling blamed. The mood chart is a tool that I think will help you and give you more control over your mood problems. Would it help if you had some reminders? Like an e-mail or a text from me?

Child: Maybe.

Therapist: How about I send you an email reminder this week. In return, can you try to get one of these charts done and bring it in next time?

Child: OK.

It's best to stop here and not get into a push/pull with the child about whether he will complete the task. You can go through the last few days with the child and ask him how he would have rated those days in retrospect. This exercise may make the child feel that the task is not as difficult as it first appeared.

Medications and Compliance

If the child takes medication, briefly review the child's medication regimen. You can use **Handout #8 "Medications Commonly Used To Treat Mood Problems"** to organize information about the medications the child is currently taking. This handout summarizes the major mood stabilizers, antipsychotics, and antidepressants. The family may have questions as to why the child is on so many different agents, and the child may complain about the side effects. Take

them through the section on medications in The Bipolar Teen (pp. 132-147) and review the major drug categories, purposes of each, and side effect profiles.

Emphasize the importance of consistency with medication regimens and explain the difference between meds that must be taken regularly and meds that are taken on an as-needed basis. Encourage the family to discuss the regimen with the physician so that adjustments can be made to limit side effects. For example, if a child is taking Zyprexa and is gaining a lot of weight, her physician may choose to substitute Geodon or Risperdal.

The Mood Episode Prevention Plan

Spend the bulk of the session on the mood episode prevention plan. Relapse prevention is a common concept used in the treatment of chronic, remitting/relapsing disorders like substance dependence, multiple sclerosis, and bipolar disorder. Since these youth have not developed bipolar I or II disorder, we don't use the term "relapse prevention". We help the family make plans during periods of relative stability for how to intervene if the child is having a particularly bad day. We also work on guidelines to help parents and their child determine when things are getting bad enough that a new strategy for mood management becomes essential.

The discussion begins from the perspective that all people have "good" and "bad" days and we want to think about what can be done to minimize damage to relationships and emotional wellbeing when a bad day is occurring. For each bad day (or bad mood experience, if it did not last all day), a sequence is defined consisting of *triggers, mood states,* and *coping strategies or things that might help*.

On the flipchart, write "How Can You Tell I'm Having a Bad Day" at the top of the page. Write each person's name (including the clinician's) across the page in a different color (see the sample Mood Episode Prevention Plan in Handout #9). Each person gives examples describing his or her mood on a bad day (e.g., grumpy, irritable, withdrawn). Below this section, you can record "triggers" for the bad moods (e.g., having others in the family nag at him/her; being hungry or tired; family arguments). If there is time, ask each participant to also describe moods on a good day, to make clear that the family member is not always feeling badly.

Next, write "What To Do When We Are Having a Bad Day." The whole family gives suggestions regarding things each person could do to help him/herself (e.g., take time away for yourself, do something fun together, meditate). At least some of these suggestions should come from the child. If you notice that the family omits important suggestions (e.g., listening to each other, working together to reach a compromise on a problem), add these to the list yourself.

Some children enjoy the task of being the recorder and writing down family members' ideas on the flip chart. If the child is uncomfortable with recording this information for everyone else in the family, share the task among several people, or do the recording yourself. The main point to get across in this

activity is that when the child is having a difficult time, it helps to have a plan that includes (a) telling a trusted person (hopefully a parent) and enlisting that person's support, and (b) implementing various forms of self-management. In addition to having a plan for handling bad days, spend some time clarifying when it would be important to call for a crisis visit. Criteria will depend on "red flags" the family has observed in the past or things that the parents would consider unacceptable and may include things such as: four "bad days" in a row, five or fewer hours of sleep per night for most days of a week, family arguments escalating to threats of violence or physical altercations, the child becomes more isolative and withdrawn, etc. If the child is taking medication, talk briefly about how people decide whether to call the doctor (i.e., the problem might be resolved with a change in medication) versus the therapist (i.e., the problem resolution seems to require a change in behavior or family interaction patterns). Once the child and other family members have agreed on a set of prevention plans, tell them that you will type it up for them and present it in the next session for their signatures. At the end of session 2, give the participants praise for their efforts. Suggest that the parents read Chapters 11 and 12 in The Bipolar Teen, on recognizing and preventing full-blown mood episodes, before the next session. Remind the child to fill out his or her mood chart.

Session 3 Goals

- **review the prevention plan**
- **discuss how the family and the school can help**
- **address any unanswered questions**
- **plan for the future**

At the beginning of the third session, hand the family your typewritten summary of their prevention plans (including information about other family members' bad days) and ask them if they want to make any changes to any of the three categories: triggers, moods, or coping strategies. If not, ask them to sign the contract to signify their commitment to try to manage their bad days as constructively as possible.

By this point, the child may have filled out one or more mood charts. Review the chart with the family and give the child much praise for even minor attempts to complete the task. Point out any patterns you observe: moods that worsen after nights of irregular sleep; moods that are better during weekends than weekdays; or moods that deteriorate in the late afternoon or early evening. Ask about any psychosocial stressors that may have contributed to the child's mood shifting. Finally, review strategies the family may have developed for managing the youth's mood escalation or deterioration.

How the Family Can Help

The bulk of the third session is spent on a discussion of how the family can help with mood problems. Walk through Handout 10 "How Can Your Family

Help?" with the family and ask the parent and each child (including siblings) to give examples of how the family might demonstrate each bullet point. For example, when discussing "maintain a tolerant and calm home atmosphere," possibilities include: be willing to walk away from arguments; institute the "three volley rule" where family members agree to terminate or derail discussions that have reached three negative back and forth interactions; use time outs as a way of helping family members calm down in intense situations. When you get to the last bullet point, "use good communication skills," lead the family into a discussion of what communication is like at home and ask whether the family uses specific skills like active listening or giving praise or acknowledgement. The family can supplement these discussions by reading Chapter 9, "Family Management and Coping."

The family may have concerns about the child's school performance or behavior. These issues are often at the forefront of parents' minds. If there are school problems, find out how much the parents know about getting help or accommodations from the school to increase the chances of their child being successful. If the parents need guidance in this area, refer them to Chapter 14, "Tackling the School Environment." The Child and Adolescent Bipolar Disorder website (www.bpkids.org) is another resource for information on the adjustment of school programs to fit the needs of mood-disordered children.

Addressing Unanswered Questions

When you begin the third and final session ask the family if they have any unanswered questions or unresolved issues. This will help you budget your time to cover the rest of the psychoeducation and remaining issues. If possible, field all remaining questions so that the family leaves feeling that their concerns were addressed.

The parents may ask informational questions (e.g., "What do we do about the side effects of Depakote?). In other cases the family will raise larger-scale issues that may not be resolvable within the limited time frame of Enhanced Care (e.g., "What do we do about his temper outbursts when he doesn't get what he wants?"). In many cases, you can refer the family back to strategies covered in previous education sessions, or reading materials such as The Bipolar Teen, Ross Greene's The Explosive Child, or the www.bpkids.org website.

Remind the parents and child that you will now be meeting with the child alone for the next three months on a monthly basis, and that the child and one parent will be contacted for face-to-face follow-up interviews every four months. Make it clear that you will be available by phone or email as a source of information and support for the four-year duration of the child's involvement with the study. Schedule the first of the three EC individual sessions. Encourage the child to keep a mood chart and to bring it to your first individual EC session.

Individual Sessions

Goals

The first goal of each individual session is to check in to see how

things have been going with the child or adolescent over the time since the last session. You can ask questions about each area of the youth's life (i.e., How are things at school? How are things with friends? How are things at home?). Be attuned to any mention of symptoms and/or stressors that have occurred in the intervening days or weeks. If the child discloses that he or she has experienced mood symptoms, then go through the mood chart (if s/he has completed one) and the mood management plan. If the child has been having symptoms of a comorbid disorder (i.e., ADHD, anxiety) then you will address strategies for these difficulties. You may refer to the appendices in the FFT-HR manual for education and information related to comorbid disorders. If you hear about future life changes that may be challenging (i.e., the youth is going to add a sport to an already rigorous academic schedule in a couple of months), you and the youth can discuss how to manage moods when dealing with the inevitable stress of new school activities.

The second goal of the session is to review protective and risk factors with the child. Ask about whether there were any changes in mood related to sleep since the last meeting. Ask about substance abuse (depending on the child's age) and consistency of medication (if prescribed). Ask whether there have been any protective factors (e.g., increased family support, better family routines) that may have contributed to mood stability.

Case example. A 15-year-old girl who had been reasonably stable came in for her first session. She described an incident in which she had cut school, gone to her friend's school, was caught by administrators at that school and ran away, prompting a chase by the school's resource officer. Her therapist expressed surprise. "Wow, that doesn't sound like you. What were you thinking that day?" The girl seemed truly puzzled about her behavior, saying, "I really don't know." Later in the session, the girl revealed that she had been skipping doses of her meds because, "They really don't do anything except make me tired." Her therapist drew a connection between the teen's recent acting out and her inconsistent medication adherence. Although the client was noncommittal about medications, she agrees to discuss ways in which she could remember to take them more consistently.

The third goal is for you to review recent stressors that have occurred since the last meeting. If the child mentions that a stressor occurred (i.e., difficult teachers, bullying), inquire about the details of the stressor: help the child identify whether this stressor is connected to a worsening of symptoms, and explore strategies that could have been used to cope with the stressor and accompanying symptoms. a

A 16 year-old boy talked about feeling much more distressed since basketball started. He said that his mood was stable but he was concerned about managing the additional stress so that he didn't get depressed. Before basketball started he was taking a 30 minute break each night to relax. Once basketball began he lost his "down time" and became concerned about having to push his bedtime later to get all of his homework completed. Luckily, this teen

realized that having some relaxation time and a regular bedtime schedule were protective factors for his mood. Through talking about his schedule it became clear that although he didn't want to do homework over the weekend, by spending an hour on homework each weekend day he would gain two hours during the school days, be able to have his 30 minute break and keep a regular bedtime. He left the meeting with a plan to start the following weekend. When he checked in at his next individual session the plan was working well. In addition to more time during the week for relaxation he felt that studying on the weekend was giving him continuity with his classes so that he felt more able to remember what happened from one week to the next.

If a difficult life event has occurred, you can use problem-solving to help the youth develop alternative responses to the event. In FFT, you teach the family a formal problem-solving model and go through the steps of the model one by one with the family. For example, you start with, "How would you define the problem?" and ask for each family member's input. In EC, the process is less structured and does not involve the use of a handout delineating the steps of problem solving. You can think of the process as more client-centered. If the child doesn't spontaneously come up with ideas, you can help him/her generate solutions for how to handle the problem. The youth can choose the solution or solutions that seem most helpful and set a time frame to put them into practice. At the next meeting you and the youth can discuss the solution's effectiveness and the outcome of the problem.

The fourth goal of each session is to review the mood management plan. Ask the child if he or she had any worsening of moods and if so, how he or she coped. Who did he tell? What strategies did she use? Did he follow the mood management plan? Was it helpful? What worked and what didn't? You and the child may agree to revise the plan within the context of the treatment protocol based on the answers to these questions.

In the following example, the therapist helped his client draw connections between positive mood changes and the child's own efforts. A 17-year-old boy came in for an individual session and was in a very positive mood. He proudly reported that he was passing all his classes in his new school. He also stated that he hadn't had a "meltdown" in over three months. (Previously, he had infrequent episodes during which he became so angry that he was unresponsive to his parents' attempts to calm him, and sometimes ended up hurting himself.) He went on to assert that the psychiatrist's diagnosis of this behavior as "Intermittent Explosive Disorder' was "a bunch of crap" and claimed that these episodes were simply the result of "all the stupid people in his world who eventually get me to go ballistic." This teen had consistently denied that his moods were anything out of the ordinary and rejected any suggestions that implied there were things he could do to improve his moods and functioning. Nevertheless, he seemed to enjoy talking to his therapist and was surprisingly open for a 17-year-old boy. His therapist gently suggested that surely he could take some credit for the protracted absence of meltdowns, but he insisted that he had done nothing differently. His therapist asked, "Have you had a meltdown since the time you got so angry, punched the wall, and broke your finger?" He

reflected on this and said, “No, I guess I haven’t. I even dropped my cell phone in the toilet and started to get really mad. I went to punch the wall but then I remembered that I didn’t want to break anything.” His therapist reminded him that he had a new girlfriend now, that his anger had been one thing that led his old girlfriend to break up with him, and that he didn’t want to scare his new girlfriend away. He hesitantly smiled and agreed.

Session	**Goals**	**Handouts**
Individual EC Sessions 1 – 3	Get an update from teen about time since last met Review the mood chart, protective and risk factors, and stressors Review mood management plan Provide homework, e.g., choose one ongoing issue/conflict with which to practice mood regulation strategies	Symptom list Individualized mood chart Risk and Protective Factors Stress thermometer work sheet

Troubleshooting Individual EC Sessions

<u>What if the child won’t talk?</u>

EC sessions can be beneficial even for withdrawn children. Generally, your role is to structure the sessions and be active. However, some children do not respond well to an overly directive approach. If you sense that the child is resisting your efforts, you may decide to switch to an in-session activity such as playing a game or working on a puzzle. Sometimes doing another activity will make it easier for the child to engage. If it is clear that the child really doesn’t want to talk and is becoming frustrated, and you feel you have done all you can to engage, it may be best to end the session early.

<u>What if the child only talks about family conflict?</u>

There will be times when the youth comes to therapy describing family conflicts. From a clinical standpoint, you might think about planning a family meeting to address the conflict, but in the second half of the EC protocol, the orientation is to offer individual sessions. You may listen to the youth's complaints and description of what happened, help the child to see family conflict as a stressor and link it to changes in mood, and support the youth in generating possible solutions for dealing with family conflict. Reserve the option of scheduling a family meeting only for those situations where it appears that family conflict has become significantly worse or is verging on abusive, or situations where the child's mood and behavior are deteriorating and the family needs to be involved to protect his or her health.

Should you give homework?

If you think that assigning homework will be helpful to the youth, then choose an activity related to the session for the youth to work on for the next meeting. Some examples of homework include:

- assigning the daily mood chart
- asking the youth to choose a stressor and complete handout #3 – The Stress Thermometer (see the FFT Manual for a description of this task)
- ask the youth to work on one protective influence before the next session. Examples include going to bed at the same time each night and waking up at the same time each morning, or disengaging from intense family interactions.

When you and the youth meet again you can review the homework. If the youth had difficulty with the homework you can help her finish it. Avoid responding to incomplete homework in a punitive manner; take a supportive, empathic stance (e.g., "Sounds like you had a lot of schoolwork to do; I can understand why this fell on the back burner").

Planning for the Future: Follow-Up Care

The child should be reminded that he or she will be contacted for face-to-face research follow-up interviews every four months. As with ending the family sessions, let the child know that you will continue to be available by phone or email as a source of information and support for the four-year duration of the study. Tell the child that you can schedule another session if things feel really difficult and efforts he or she makes to manage stress aren't helping, if he or she is having more symptoms, or if family conflict increases. Remind the child that he or she will be seeing his or her study psychiatrist regularly (if s/he is taking medications) and that his/her difficulties can also be discussed during those meetings.

Let the family know that you will schedule emergency sessions when the situation calls for it, especially if there is evidence of worsening symptoms, suicidality, safety concerns, drug abuse, or severe family conflict. Remind the

parents and youth that the study psychiatrist is available to meet with the family on an urgent basis in addition to the regular medication management sessions. You can also offer them additional referrals (e.g., an educational counselor, marital therapy) if they so request.

REFERENCES

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Handout # 1

Enhanced Care: What we're going to do and what to expect

Our Goal is to:

- Help things go more smoothly in your family
- Increase understanding of what "mood disorder" means and why we think you may have this challenge
- Provide tools to help you manage mood swings better

How we're going to do it:

- Get to know each family member
- Learn about mood problems and and how to manage them
- Explore the role of medication in managing mood problems
- Talk about how family and school can help

Everyone in the family should:

- Come to every session ready to try your best and share your thoughts
- Cooperation

The coach will:

- Provide thoughtful systematic intervention
- Make sure everyone's privacy is respected
- Give you a comfortable place to say what's on your mind
- Give you things to work on at home
- Give you a chance to check in between sessions if you need to

Handout # 2

Symptoms of Mania

Elated mood

Decreased need for sleep

Increased energy and activity

Increased sexual thoughts

IRRITABILITY!

Being overconfident or unrealistic

Talking fast

Loss of self-control

Easily distracted, Racing Thoughts, Lots of ideas

Handout # 3

Low self-esteem

Low mood or sadness

Tearfulness

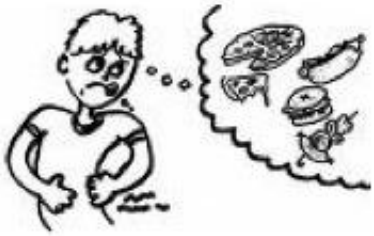
Symptoms of Depression

Trouble concentrating

Some people also:

- feel really tired or low in energy
- wish they weren't alive
- feel worthless or guilty
- talk or move slowly
- lack of thoughts

Sleeping too much or too little



Increase or Decrease in Appetite
Crave Sweets or Carbohydrates

Loss of interest in activities/boredom

Handout # 4
Other things kids experience that may be related to having a mood disorder

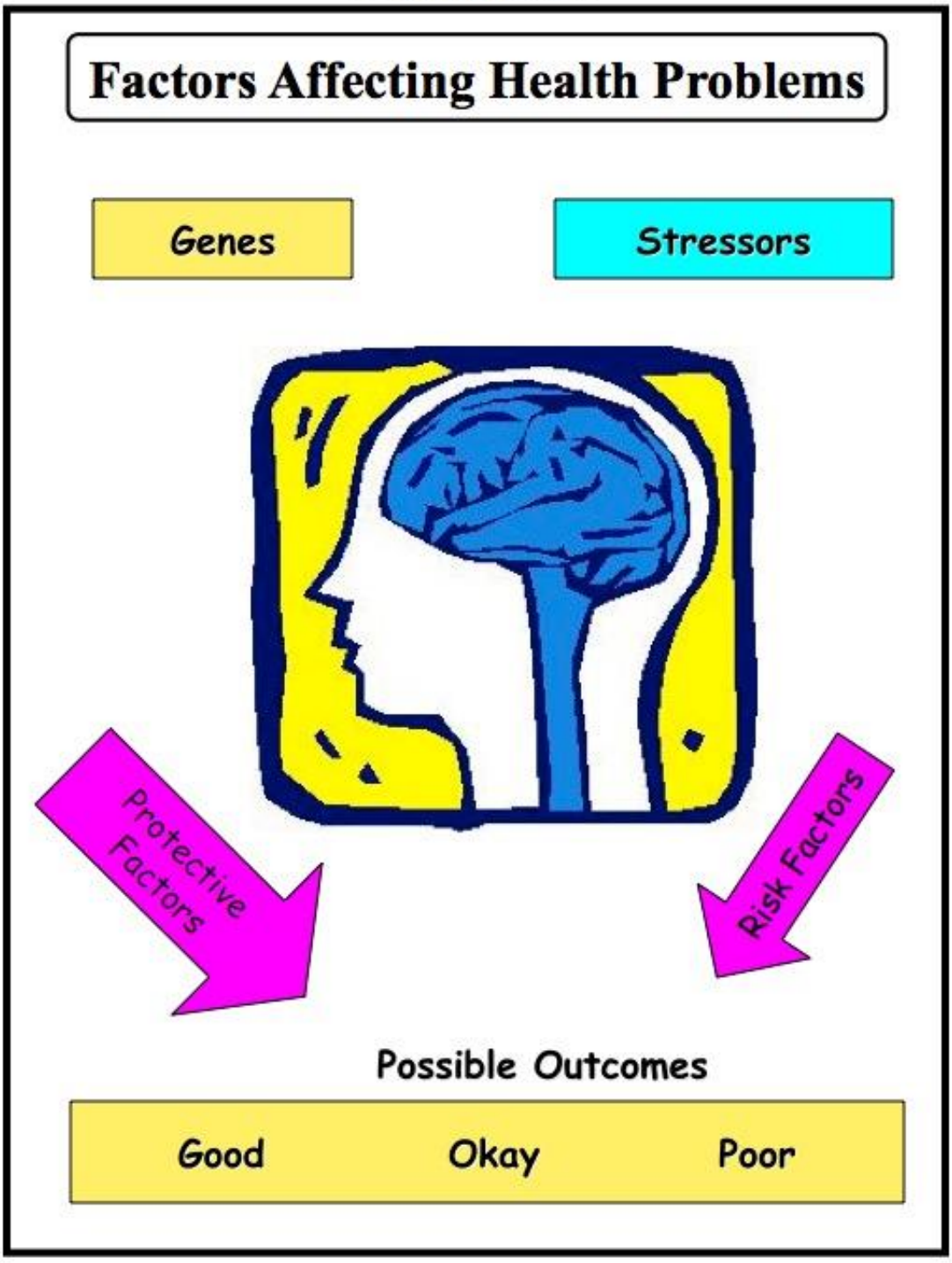
- **Problems that began when you were a baby (you probably won't remember this but your parents might) and then problems at other times of change (like going to kindergarten, middle school).**

- **Getting frustrated easily when you have to concentrate on one thing or when you have to wait when you want things right away.**

- **Difficulty controlling your anger.**

- **Stressful things may upset you more than they upset other kids.**

Handout # 5


Factors Affecting Health Problems
Genes
Stressors
Protective Factors
Risk Factors
Possible Outcomes
Good
Okay
Poor

Handout # 6

Risk and Protective Factors For Mood Problems

Risk Factors

- Drug / alcohol abuse
- Poor sleeping habits
- Irregular daily routines
- Stressful life events
- Family conflict or distress
- Conflict in interpersonal situations

Protective Factors

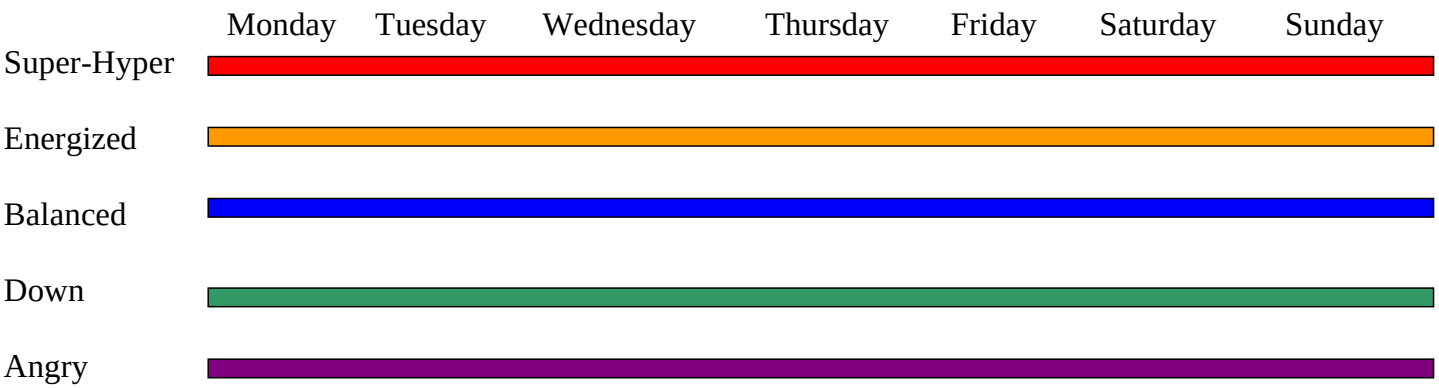
- Taking appropriate medicine
- Social / family / community supports
- Using communication & problem-solving skills
- Getting help when you need it

Handout #7

Figure 1

Week of _____

HOW I FEEL



I woke up at:_____
I went to bed at:_____

Examples of:

Super-Hyper	Down	Angry
Feel good about myself	Suicidal	Pissed off
Talk faster	Don't want to go to school	Hate everyone
Like being high	Short-tempered	Irritable
Lots of ideas	Stop eating or eat more	Snap easily
Need less sleep	Want to be alone	
	Want to live in a bubble	

Handout # 8

Medications Commonly Used to Treat Mood Problems

Mood-Stabilizers: Regulate ups & downs

Generic Name	*Brand Name*
Lithium Carbonate	Eskalith/Lithonate
Carbamazepine	Tegretol
Divalproex Sodium	Depakote
Lamotrigine	Lamictal
Oxcarbazepine	Trileptal
Topiramate	Topamax
Gabapentin	Neurontin

Antidepressants: Improve mood

Serotonin-Reuptake Inhibitors:

Fluoxetine	Prozac
Sertraline	Zoloft
Paroxetine	Paxil
Fluvoxamine	Luvox
Citalopram	Celexa
Escitalopram	Lexapro

Monoamine Oxidase Inhibitors:

Phenelzine	Nardil
Tranylcypromine	Parnate

Novel Agents:

Venlafaxine	Effexor
Bupropion	Wellbutrin
Trazodone	Desyrel
Nefazodone	Serzone
Mirtazapine	Remeron

Generic Name	*Brand Name*

Antipsychotics: Control agitation, hallucinations or distorted thinking; help with sleep

Olanzapine	Zyprexa
Risperidone	Risperdal
Quetiapine	Seroquel
Clozapine	Clozaril
Ziprasidone	Geodon, Zeldox
Aripiprizole	Abilify

Benzodiazepines: Control anxiety, improve sleep and induce calm

Lorazepam	Ativan
Clonazepam	Klonopin
Diazepam	Valium
Alprazolam	Xanax

Psychostimulants: Improve attention and concentration

Methylphenidate	Ritalin
	Adderal
	Concerta

Handout #9

Figure 4

MOOD PROBLEM PREVENTION

HOW CAN YOU TELL I'M HAVING A GOOD DAY

MOM	DAD	ME	SIBLING	THERAPIST
Easygoing	Calm	Happy	Sharing	Smiling
Nice	Funny	Friendly	Laughing	Relaxed

HOW CAN YOU TELL I'M HAVING A BAD DAY

MOM	DAD	ME	SIBLING	THERAPIST
Impatient	Quiet	Angry	Mean	Cranky
Yelling	Serious	Fighting	Hitting	Tired

WHAT DO WE DO WHEN WE ARE HAVING A BAD DAY?

Tell Mom	Draw	Communicate
Use I messages	Ride my bike	Work together on problems
Take time away for myself	Reduce stimulation	Do something fun together

Handout # 10

How Can Your Family Help?

- Help you get treatment and services
- Support taking your medication (if you take medication)
- Learn about mood swings so they can respond in a helpful manner
- Develop a plan as a family for managing angry feelings
- Help you have predictable and scheduled days and sleep
- Reduce expectations of what you can do when you are having a hard time with your moods
- Get help for other members of the family if needed
- Maintain a tolerant and calm home atmosphere
- Do fun things together
- Use good communication skills