

Family-Focused Therapy (FFT)

for Youth with Mood and Psychotic

Disorders: Clinicians' Treatment Manual

(CHAMP Version, 2020)

David J. Miklowitz, Ph.D.^{1,2}

Mary P. O'Brien, Ph.D.³

Aimee E. Sullivan, Ph.D.²

Elizabeth L. George, Ph.D.²

Dawn O. Taylor, Ph.D.²

¹*University of California at Los Angeles*

²*University of Colorado Boulder*

³*Yale University*

With special thanks to: Danielle A. Schlosser, Jamie L. Zinberg, Sandra De Silva, Tyrone Cannon, Sarah Marvin, Angus Strachan, and Michael Goldstein.

Draft Date: June 30, 2020

Please do not circulate without permission. For correspondence please contact Dr. Miklowitz at dmiklowitz@mednet.ucla.edu.

Table of Contents

I.	Introduction.....	3
	
II.	Psychoeducational Sessions.....	13
	Session 1: Goal Setting, Treatment Overview.....	13
	Session 2: Symptoms, Vulnerability Stress Model.....	26
	Session 3: Stress and Coping Skills.....	43
	Session 4: Optimizing Family Support; Prevention Plan.....	60
III.	Communication Enhancement Training.....	68
	Session 5: Expressing Positive Feelings.....	68
	Session 6: Active Listening.....	75
	Sessions 7 and 8: Making a Positive Request, Communication Clarity, Expressing Negative Feelings	80
IV.	Problem-Solving Sessions.....	90
	Session 9: Expressing Negative Feelings, Intro to Skills.....	90
	Session 10-12: Problem-Solving Skills and Termination Tasks.....	94
V.	Optional Treatment Exercises.....	98
VI.	References.....	103
VII.	Treatment Supplements.....	104
	Anxiety Disorders.....	104
	Suicidality.....	114
	Attention Deficit Hyperactivity	127
	Oppositional Defiant Disorder.....	136

I. INTRODUCTION

An Introduction to Working with Early-Onset Youth

The purpose of this manual is to explain an early intervention treatment for children, adolescents or young adults who may already have, or may be at risk for, developing bipolar disorder (BD), major depression (MDD) or psychosis (hereafter referred to as Early-Onset Youth, or EOY). Family-Focused Therapy for EOY and their families (FFT-EOY) consists of 8 weekly and 4 biweekly sessions (12 sessions over 4 months).

The relevant populations for FFT-EOY are age 9-25, with a recent onset of bipolar I or II disorder (mania, depression, mixed, or hypomanic episodes); an episode of MDD; a recent onset of psychosis (including first- or second-episode schizophrenia or schizophreniform disorder); and the relevant “prodromal” forms of these disorders (bipolar disorder, not otherwise specified; psychosis NOS; depression NOS; attenuated psychosis syndromes). They must have family members who are willing to come in regularly - parents, grandparents, or extended relatives who are in a caregiving role.

For the CHAMP training clinic, you will only be seeing youth between the ages of 9 and 17, most of whom will have mood disorders, often with comorbid anxiety, ADHD, oppositional defiant disorder, and other disorders. This manual is written to cover a broad range of populations (e.g., young adults with prodromal psychosis) which may not be relevant to the patients you see.

For a thorough understanding of FFT, we recommend that you become acquainted with the Miklowitz (2010) Bipolar Disorder: A Family-Focused Treatment Approach manual (2nd Ed) before applying the treatment with your patients. In addition, The Bipolar Teen: What You Can Do to Help You and Your Family (Miklowitz and George, 2008) or The Bipolar Disorder Survival Guide (Miklowitz, 2011) describes many of the strategies discussed in this manual and are resources that can be made available to families.

The overriding goal of FFT-EOY is to educate families about the symptomatic presentation of the illness and offer tools to prevent its onset and/or worsening. There are six subsidiary goals:

To assist patients and families to:

- (1) integrate the experiences associated with episodes of mood disorder or psychosis,**
- (2) assist the patient and relatives in accepting the patient’s vulnerability to future episodes,**
- (3) accept the current or future role of psychopharmacology to manage symptom states,**
- (4) enhance social and academic functioning,**

(5) recognize and learn to cope with stressful life events that trigger recurrences of mood disorder or psychosis,

(6) assist the family in reestablishing functional family relationships after an episode.

In this manual, you will learn how to proceed with administering FFT-EOY. The three modules of FFT will be covered in a modified form. Case vignettes and typical therapy interchanges are included. All names and identifying information of clients and family members have been altered and disguised so that these persons cannot be identified, consistent with guidelines for preserving the confidentiality of patients.

Note: In the sections that follow, “IP” refers to the “index patient” who is the focus of your treatment (the child, adolescent or young adult who has symptoms of mood disorder, psychosis, or prodromal symptoms). The IP is also called the youth, the young adult, the teen, or the “early-onset youth” (EOY). We wanted to mix up the terms so you wouldn’t get bored! Keep in mind the differences that age can make when planning these interventions.

Parents of Early-Onset Youth

The parents of early-onset individuals are resourceful and proactive enough to have found treatment, and so from the very first encounter we want to communicate that we value them, that their partnership with us is essential, and that we think that the efforts they are directing toward helping their son/daughter matter. In fact, we think that their son/daughter is very fortunate to have a parent in his/her life that is willing to put effort into helping him or her.

While invariably parents entering such programs have tremendous strengths, at the same time, parents first arriving tend to be feeling pretty overwhelmed. Often, they are just beginning to come to terms with the fact that their son/daughter could develop a serious mental illness. Because some of individuals you will see have not yet met diagnostic criteria for a mood disorder or psychotic illness yet are exhibiting some characteristic early warning signs, parents may feel confused and immobilized by this diagnostic ambiguity.

If their son or daughter is exhibiting a lot of trouble with motivation and social withdrawal, parents have a hard time knowing whether this is “typical teenage behavior” or something more, such as negative symptoms or depression. Parents may be feeling frustrated and fatigued by their son/daughter’s “refusal” or inability to step up and function more independently. It is not uncommon for parents of early-onset youth to spend a lot of time in the morning getting their son/daughter out of bed, urging him or her to shower and groom, and then driving him/her to school. At the same time, the parent may feel conflicted about subjecting him/her to academic and peer struggles that seem more intense for their son/daughter than for other individuals their age, and with which their son/daughter may seem less well equipped to cope. If

the IP has been spending an inordinate amount of time alone in his/her room, and is no longer calling or initiating fun activities with family and friends, parents are understandably concerned that their son/daughter may be lonely, disconnected, and at risk for self-harm. It may be painful for these parents to watch their son/daughter struggle, and they are often confused about what more they can do to help. At the same time, they often wonder if they are doing too much for their son/daughter. In short, they are trying to figure out how best to keep their son/daughter “on track” without over- or under- parenting.

These parents may feel isolated from other parents in the community who are having a very different parenting experience. Advice that works for parents of “normal teens” (e.g., “tell him he’s grounded if he won’t go to bed”) may not seem relevant to these parents. Most likely, these parents would like to be able to step back a bit at this stage of life, and let their son/daughter take greater control of his/her own life as is recommended in many parenting guidebooks. However, the price for backing off may be to watch their child flounder and fail. If parents find this price exorbitant and remain quite involved, they run the risk of getting branded “over-involved.” It is important that mental health professionals do not form opinions too quickly about a parent’s level of involvement in his/her young person’s life.

Because of ongoing hypomania/mixed symptoms, depression, negative symptoms and social skills deficits, many early-onset youth have attracted few friends and adult mentors into their life to share the task of providing growth-promoting experiences, so the burden of raising them falls more heavily on the shoulders of their parents. Parents realize that other teens or young adults are spending time with friends, perhaps dating, and engaging in a wide variety of extra-curricular activities. They realize that their son/daughter is missing out on the skill development that is a by-product of these activities. They see their son/daughter slipping further and further behind and are often searching for ways to decrease the gap that is being created between their son/daughter and his/her peers.

While other parents may be enjoying the fruits of years of labor as they watch their son/daughter succeed in a variety of arenas, parents of early-onset youth may be internalizing the message that they must have done something very wrong for their son/daughter to be so “off track.” These parents may be exceptionally skilled with their offspring, yet their parenting efforts may not be appreciated by extended family members, friends or neighbors who only see the adolescent’s school failure or social isolation. It may be easier for others to simply view school failure and social isolation as a reflection of failed parenting than to understand the patience and skill it takes to cope with and support an adolescent who is experiencing psychiatric symptoms. Of course, it can be quite tiring for parents to feel misunderstood.

If their son/daughter is experiencing mania or positive psychotic symptoms, such as elated mood, grandiose delusions, paranoia and unusual perceptual experiences, parents may be confused and frightened by the symptoms and their implications. While some empirical studies suggest that prodromal youth may benefit from the early introduction of anti-psychotic medications (McGlashan et al., 2006; McGorry et al., 2005), additional study is still required. Therefore, parents are asked to tolerate more ambiguity as they collaborate with psychiatrists and begin the process of figuring out whether medications make sense for their son/daughter.

In summary, parents often arrive at our doors in need of support and information. Hopefully we can help them to feel like they have found a resource that will join with them in their efforts to help their son/daughter.

Youth with or at High-Risk for Bipolar Disorder, Major Depression or Psychosis

We see a variety of young people in our programs. Some of them have bipolar disorder or MDD or schizophrenia already. Others have early “prodromal” symptoms that don’t yet meet the full DSM-IV criteria, like mood swings, brief and recurrent hypomanic periods, or mild psychotic symptoms. Most are in some distress and that is what has prompted their visit. Typically their grades are dropping or they are having trouble at work, they are becoming increasingly isolated, and they are starting to wonder about their own future. Our main goal with them initially is to connect. Often IPs express a sense of relief when they are able to talk frankly with a knowledgeable professional about the symptoms that they have been experiencing. They may be “testing the waters” with us before they are willing to fully disclose. They are often relieved to hear that we have worked with many individuals that have symptoms similar to what they are describing, and that we have some ideas about a variety of coping strategies that may be useful.

The youth or young adult may also feel demoralized and confused. We want to help these individuals reconnect with their strengths and interests, and learn how to cope with the symptoms they are experiencing so that they can achieve their goals in spite of the symptoms.

For patients under age 18, it is important that we are clear with them from the start regarding the limits of confidentiality/what we share with their parents. Although it is quite common for therapists who work with adolescents to keep information confidential from parents, often a more collaborative approach works well for the patients at our clinic and their families. We typically encourage the patient to share information about the symptoms he/she is experiencing with his/her parents so that parents can be as useful to the patient as possible. Parents are crucial in setting up (and paying for) appointments with psychiatrists, therapists, school interventions, etc. If parents know what is going on with their son/daughter, they have the opportunity to be empathic and supportive and to set appropriate limits to keep their son/daughter safe. When patients have been quite secretive regarding their symptoms and inform us that their parents are largely in the dark, we encourage greater openness.

In general, our initial goal is to get to know the patient as an individual. We are interested in hearing about symptoms and struggles, but also in hearing about strengths, hopes, and goals for the future. With a solid understanding of where our patients are developmentally, we can start to formulate a collaborative plan with them regarding how they can move on with their lives and make progress toward reaching their goals.

Objectives of FFT-EOY

FFT-EOY consists of three modules: psychoeducation sessions (4 sessions), communication enhancement training (4 sessions), and problem solving skills training (4 sessions). In total, participants will complete 12 sessions over a 4-month period (8 weekly, 4 biweekly). Additional sessions may be scheduled if necessary. In some cases, we may have a shorter treatment if the family and therapist are only available for a short period of time.

Pacing and Flexibility of Sessions

FFT can be tailored to the particular family you are working with. While it is ideal to have each family complete all 12 sessions, it might not fit the pace of the family you are working with. For instance, a family might require two sessions to cover one session's worth of material. In this case it is acceptable to stretch the session out to two sessions. In order to accommodate that change, you can skip a problem solving session. On the other hand, if a family is able to address two session's worth of material in one session, it is fine to do so. Furthermore, you might notice that some of the material may not be applicable to a particular family and it is fine to skip that session (for example, their communication is clear so the "communication clarity" handout is not needed).

You will find that each session has a structured outline indicating what you should try to cover. This is meant to be a guide rather than a rule. If you happen to spend more time working on some objectives and you don't get to all of the objectives because it doesn't seem appropriate for a particular family, that is okay.

Clinical Tip

The most important aspect of the educational material is that it is communicated to the family in a way that the family is able to understand and finds meaningful and useful. All of the handouts are simply tools to help convey information. If a particular handout does not support your efforts to provide information to a particular population or to facilitate constructive communication among family members, please feel free to drop or modify the handout. The goal is not to get through a certain set of handouts each session.

The manual can be thought of as a toolbox of techniques that the therapist can use with family members at ANY point in the therapy that those techniques seem relevant. For example, during the course of conducting a problem solving session, it may become clear that a discussion of pleasant events scheduling or relaxation techniques may help a family to get beyond an impasse in the problem solving process. This may be the ideal time to teach a skill that didn't seem relevant earlier in the treatment.

Emotional Tone of the Therapy

It is fairly common and understandable that a parent or other family member may become tearful when talking about the impact the patient's symptoms have had on him or her. Parents may experience a lot of grief over their son or daughter's sudden change in functioning and if symptoms are quite severe and precipitous parents may need to "mourn" the change. Alternatively, family members may express anger over how difficult it has become for them to work given the patient's difficulties going to school, or to invite friends over since the onset of the patient's symptoms of depression, reclusiveness, suspiciousness, and/or odd behavior.

It is very important to keep the sessions tolerable and low-key for the patient. Therapists should step in fairly quickly to redirect family interaction when emotions escalate during a session. In some instances it may make sense to spend time gathering information and developing a better understanding of the family members' emotions and what tends to provoke them. ***You always have the option of asking the family member who is expressing a lot of emotion to schedule a time to meet with you individually.*** During an individual meeting the therapist can discuss the family member's emotions further and provide some additional psychoeducation and/or recommendations for individual therapy as appropriate. Alternatively, it may make sense to work on some communication skills with the family earlier in the treatment so that psychoeducation can proceed more productively once family communication has improved. It may be useful to conduct problem-solving on ways in which family support could be optimized so that family members understand the importance of creating a low-key family environment.

Clinical Tip

With some families, you may find that the sessions have a stilted, overly didactic quality, that participants seem to be blithely going along with the tasks, looking blankly at the handouts, etc., but don't really seem to be aboard with your treatment goals. If so, take a step back. Think with them about their own treatment goals, and explain how the various tasks you've assigned them will help them meet these goals. If you feel like you are missing out on discussing important issues because of the treatment structure, depart from the manual to discuss what's on everyone's mind and then try to bring them back on task. Once you've brought them back on task, try to adjust the psychoeducational or skill-training tasks to be more consistent with their goals.

Pretreatment Sessions

Sometimes family members express reluctance about participating in family therapy. They may have misconceptions about what family therapy entails. For example, one father reported (somewhat in jest) that he envisioned using little foam boppers to hit family members over the head when discussing frustrating issues. He had never participated in family therapy before and was relying on an episode from a sitcom to help him form expectations of therapy. While many people may not be as forthcoming as this father, they often have concerns about what they may be getting themselves in to if they agree to family treatment. For those families that express some hesitation, it may be useful to use the first session to lead the family in a discussion of their concerns and get greater clarification regarding the content and process of this

approach to family therapy, and make an informed choice about whether they want to do it.

During the session it is important that you listen to family members' concerns and normalize them. Often parents are worried that they will be blamed by the therapist or by their youth for causing the youth's symptoms. Let them know that these concerns are quite common, nobody likes to be blamed, and that assigning blame isn't part of this therapy.

It is often helpful to give the family a sample of what the sessions will be like by presenting information that is relevant to a question they have raised. For example, often parents ask about what types of expectations they should be setting for their child. They may report that if the doctor says they should back off they will, but they don't want to just "let their child off the hook too easily" or "set different expectations for this child than they do for other children in the family." This is an excellent question, and there really isn't one standard set of expectations that applies to each and every youth that is experiencing symptoms. Symptoms differ across people and even within the same person over time. You can address the family member's question by saying something like the following.

"When there is a high level of stress in an individual's life and/or he or she is experiencing intense symptoms, one way to consider relieving that stress is to lower expectations temporarily. When symptoms remit or stress is reduced and/or coping strategies are supported, it may become possible to gradually raise expectations."

You should then ask the family members what they think about this approach to setting expectations. Does this make sense given their experiences with symptoms so far? Do they think this type of approach might help guide their efforts?

Throughout the therapy we will be presenting information and introducing skills and then talking with family members about their reactions to this information. If they find the skills useful we will think together about ways they can integrate the skills into their daily life.

Some adolescents or young adults have expressed reluctance to participate with their parents in therapy for fear that the therapist will disclose more information than the youth is ready to share. If this is the case, let the youth know that his/her concerns are common and understandable, and that you will be providing information to the family about symptoms in general, and then inviting the IP and family members to share their experiences with symptoms to the extent that they feel comfortable. However, you will respect the youth's boundaries, provided that the symptoms are not presenting a danger to him- or her-self or others. Youths are often relieved to hear that they will be given some control over the pace and content of disclosure about symptoms. Alternatively, you may want to meet with the youth individually to make sure s/he tells you what is off-limits for discussion (for example, her confusion about sexual orientation) before starting the family therapy.

IPs may worry that once they start talking with their parents about their symptoms they will be peppered with questions throughout the week and they will feel over-exposed

and overwhelmed. In these instances it may be useful to facilitate some negotiations between the parents and the youth regarding what amount of follow-up discussion would be tolerable between therapy sessions. Once boundaries have been established, the youth may feel more comfortable proceeding.

Some young adults express confusion about why they should participate in family therapy when their parents are pushing them so hard to become more independent. Why should their parents be interested in their business on the one hand, but want them to function more independently on the other? This is seen by some youths as contradictory.

Consider the following treatment vignette involving a 22-year old. Notice how the clinician weaves in information about the therapy while also validating the youth's concerns about communicating with his father.

Son: My dad is pushing me to finish school, pushing me to get a job, and pushing me to move out of the house. He keeps lecturing me about how I need to be more independent. Then he tells me he wants me to do this family therapy with him. Why would I do therapy together with my dad when he clearly just wants me to do things on my own?

Therapist: Sounds like you are feeling like you are being pushed a lot by your Dad. Dad, what do you think about what Brad just said?

Father: I have been pushing Brad a lot. He is my third child and I pushed the older two when they were his age and they thanked me for it later because they are now all functioning independently. If I change the rules for Brad now, his younger brother will expect the same type of leniency, and that could really mess up our household. I know that Brad may be going through something different than the others, but I'm not sure what that means and I really don't know how to parent any differently. I definitely need some more information.

Therapist: Dad, is there anything in addition to information that you are hoping to get out of the family therapy? Why do you want to do this with Brad?

Father: I am hoping that Brad will tell me more about what is going on with him so that I can have a better understanding and figure out how I can be more helpful to him. He and I used to be pretty close. We would go bicycling and hiking together. Now he and I barely talk and when we do talk it seems like all we do is argue.

Therapist: Sounds like you want to understand what Brad is going through and have a closer relationship with him?

Father: Yes.

Brad: He can't have it both ways. He is constantly pushing me out and then he wants me to talk to him about my business.

Therapist: Brad, what do you want for yourself? Are you interested in finishing high school or finding a job?

Brad: Yes, but it isn't that easy.

Therapist: No, it certainly isn't easy. In fact these types of transitions out of high school and into the work world are really hard for a lot of people and they can put a lot of stress on family relationships.

One thing that we would be interested in doing in the family therapy would be to get a better understanding of your goals so that we could think together about the best ways that everyone could support you in reaching those. How does that sound to you?

Brad: OK.

Therapist: Brad, it sounds like you have felt pushed by your Dad lately and that has sort of disrupted your relationship with him or left you feeling confused about how to relate to him. Did I hear that right?

Brad: Yes.

Father: I feel really badly about that. I think we are both confused at this point. I would like to have a close relationship with Brad throughout his life. I'm just not sure what approach I am supposed to be taking right now to help him.

Therapist: It may sound contradictory, but a close relationship, one in which people feel like they understand each other and can support each other, can actually help people to function more effectively and independently throughout their lives. Does that make sense?

Another thing we could work on in the family therapy would be opening up channels of communication so that you might be able to talk more directly and constructively about how to improve your relationship with each other. Is that something that you would be interested in?

In other words, you can tell the family that the therapy is fairly structured, with informational handouts provided at most sessions, but that the information will be tailored to try to best meet the needs of a particular family.

Questions about who to involve in the treatment

Family members wonder about who should participate in the therapy. We explain that when one person in the family is experiencing symptoms, all members of the family are typically affected, and in turn family members' reactions to those symptoms affect the person who is experiencing symptoms. Because of this, it is often useful to have everyone who is living in the family home participate in at least some portions of the therapy. If the youth/young adult objects to having certain people participate (i.e.

siblings, step-parents, etc.) it may be useful to allow him/her to begin the therapy with primary caregivers and then introduce additional members as he/she becomes more comfortable.

For example, some youths report that they will not discuss symptoms frankly with their parents if their younger siblings are in the room, explaining that it is embarrassing to them to discuss their “weaknesses” in front of their younger siblings. It makes sense to honor this boundary, and then after the educational sessions, to ask the question of whether the IP might be comfortable inviting the siblings to participate in some of the communication and problem solving sessions. Other youths, however, have welcomed the opportunity to have their siblings participate from the start. These contrasting examples highlight the importance of giving thoughtful consideration to whom to include in the various phases of therapy. This should be discussed and decided collaboratively with the IP and his/her primary caregiver(s) during the first session.

Remember that if additional family members join the therapy process after the beginning of the treatment, you will need to schedule some time with them to sign treatment or other informed consent documents. Also, you may find that adding a sibling, particularly a younger one, to sessions may be a hindrance more than a help. Consider the age of the sibling, his or her health status, and the nature of the relationship between the IP and the sibling before committing to including the younger sibling in each session.

Meeting with Patient/Parents Alone

Throughout the FFT protocol, there may be times when conducting a session without the IP present seems clinically advantageous. This is not typical and certainly, most education, communication skill and problem solving sessions should be conducted with the whole family present. An example of a problem that might be worked on without the patient could be a discussion of the family’s financial problems; the parents’ marital problems; or plans that affect the IP that have not been shared with him/her yet. In FFT-EOY, you may conduct sessions without the IP present, but the IP should agree to this arrangement. The overarching goal of treatment is to teach skills that the whole family can utilize. Nonetheless, there may be situations in which it makes sense to meet with the parents alone, just as there may be cases in which you will want to meet with the patient alone. Try to keep these alternative arrangements to a minimum. Be aware that some families will interpret your flexibility to mean “It doesn’t matter who comes as long as someone comes.”

II: PSYCHOEDUCATIONAL SESSIONS (Sessions 1-4)

Session 1: Goal Setting, Overview of Treatment

1. Joining
2. Acquaint family with goals, format and expectations of treatment.
3. Find out family members' goals for treatment
4. Build a bridge between family members' goals and the skills they will master in FFT
5. Assign Homework (set up a weekly family meeting; add to family goals).
6. Check-in with family members about their reactions to the session
7. Plan for next session; joining/closing

Handouts Needed:

- 1 (Family-Focused Therapy: What to Expect)
- *Possibly 2a-2e (Mania, ADHD, "Difficulty with Mood Swings," Depression, Positive Symptoms, Negative Symptoms, Anxiety Symptoms)*

In the first session you have several objectives, the most important of which is to join with the family and start to establish a therapeutic alliance. The second objective is to develop a treatment plan with the family. First, present the goals, format, and expectations of the FFT program, and then discuss each family member's goals for treatment. Then, build a bridge between what each family member wants from treatment and what we plan to provide. Finally, it is important to help them to establish the routine of doing some "practice" (i.e., homework) between sessions, plan for the next session, and gather their reactions to the first session.

Joining

The best way to build rapport at the beginning of treatment is through a process called "joining." Start the session by asking each family member to tell you something about him or herself, unrelated to symptoms (e.g. what they do for a living, favorite movies, hobbies, etc). You can introduce this process by saying something like the following:

"I would like to start our work together by getting to know you better as people. Of course there is much more to each of you than the current problems affecting you. I want to know about your interests and strengths so that I can try to make the therapy as relevant as possible to each of you and so that we can draw upon your strengths throughout the treatment."

Clinicians can model this by briefly introducing themselves (their role in the clinic, personal and professional interests). Avoid “cutesy” facts about yourself like your love of cats or your accomplishments in wind surfing. The goal is for the clinician to be friendly and personable while maintaining professional boundaries. Remember that the IP may have been struggling lately, and so avoid presenting a long list of achievements and successes. Here is a good example:

“I’ll start us off by telling you a bit about myself. As you know my name is _____. I have been a therapist (intern/fellow) here for the past year/ 2 years. I went to college in Boston and did my graduate work at the University of Southern California. I really enjoy working with young people and families and I am excited about doing prevention work.

Now, why don’t you each say a bit about yourselves?”

Once each family member has had a chance to talk about his/her interests and talk a bit about who they are, you can move the conversation to the goals of treatment.

Joining is an ongoing process that you will continue to work on throughout the treatment. Maintaining an air of friendliness and introducing some levity into the work can be very helpful. Also, be sure to chat with the family a bit about fun activities they may have participated in over the weekends, sports teams they follow, or upcoming plans they have for the weekend or other light topics (generally best at the beginning or end of the session). Once you know their interests, you can follow-up on those with brief questions to open or close later sessions.

Some therapists may feel that they are better able to connect with family members by asking the family members to introduce themselves first so that the therapist can get a feel for each person’s interests and add comments about him/herself that are relevant to family members’ interests. You can also ask each person to introduce someone else in the family (e.g., “can you tell me about your brother? Where does he go to school? What sorts of things is he into?”). Any of these approaches is fine. The goal is to make the family comfortable with you, and allay their fears that you will psychoanalyze them or expose uncomfortable secrets.

Tune in to the family members’ affective range and pace of communication early in the session so that you aren’t completely out of sync with the family. A family that is somewhat depressed may experience a very cheerful presentation as superficial. Establish a tone that is calm, low-key and mature.

The Goals of FFT-EOY

Once you have spent some time getting to know the family members, acquaint the family with the format, goals and expectations of the FFT-EOY treatment. **Handout 1, “Family-Focused Therapy: What to Expect,”** accompanies this first discussion. Go through each item on the list and let family members know what they can expect from the therapist and what in turn is expected of them. You may want to say something like the following:

“This is a fairly structured treatment. We have a lot of information that we would like to share with you, and a lot of skills that we would like to introduce to you over the next 4 months. We have 12 sessions planned. For the first 8 weeks we will be meeting every week, and then we will meet every other week for an additional 8 weeks. Does that sound manageable for all of you?”

Next week we would like to talk about (mood, thought disturbance, or other early onset) symptoms, what they are and how you might be able to reduce them. Then over the next few sessions we would like to focus on how to decrease stress, prevent symptoms from occurring, and how to cope at school, with friends, and at home.

In later sessions we plan to work on strengthening your family's communication skills, and working on solving family problems. We know that people's symptoms tend to stabilize when families take a calm, constructive, and structured approach to communication. We would like to teach everyone techniques that will help you to work together in this way. Can you imagine how this might be helpful?

Toward the end of our work together we will be integrating a lot of the skills that we have developed. How does this sound?”

Handout # 1

**Family-Focused Treatment:
What to Expect**

Our plan is to:

- Decrease friction between family members
- Improve communication skills
- Increase acceptance of mood/thinking problems
- Help the family solve problems better

We will meet:

- Weekly for sessions
- Biweekly for sessions
- Monthly for sessions
- months total

How we're going to do it:


- Get to know each family member
- Learn about mood/thought problems and the medicines used to treat them
- Learn communication skills
- Learn how to solve problems

Everyone in the family should:

- Help each other like any team would!
- Think about how others are feeling
- Come prepared with your homework finished

The therapist will:

- Help the family come up with ways to handle problems
- 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



Check in with the family while you are presenting this information. Avoid “talking at them” and pay particular attention to anyone who seems confused, bored, or annoyed. If so, ask them: “you seem like you’re having a reaction to this. Anything you’d like to talk about?”

Continuing on:

“Now let’s talk about what you can expect of me during this therapy. I will start sessions on time and make sure that we end in about 1 hr.

Therapy can be hard work so my job is to make sure to keep our work manageable. If you need to talk to me between sessions, you can reach me at this number (hand family card), and I will do my best to get back to you within 24 hours.

My role is basically that of a teacher or coach. My job is to teach you some skills and then to practice those with you so that by the end of treatment you can use the skills in your day-to-day life, and you no longer need my assistance. I’ll ask you to practice the skills at home in-between sessions.

Sometimes I will ask you to practice some of the skills we are learning at home or at school/work during the week. **We recommend that families schedule a family meeting every week to go over the therapy assignments.** Just like

with any skill, the more you practice, the easier the skill becomes. So, we will make better progress if you follow through with these assignments. Do you think this would be manageable? What questions/concerns do you have at this point?"

"Can you think of a time when you're all together when you could meet?"

When introducing educational sessions explain that "we're interested not only in giving you information but also in exploring your reactions to it and seeing how it fits your circumstances."

Note that we present this information about FFT *before* we ask family members about their personal goals. If you were to start with family members' goals, you may get confused silence; knowing that FFT addresses how to cope with mood or psychosis symptoms and communicate better as a family will help them hone in on what they want to accomplish.

Also, notice that the clinician refers to himself/herself as 'we'. This may indicate that you are seeing the family with a cotherapist, or that there is a supervision team watching. You can replace this with "I" if it makes more sense in your setting.

Tips for Practicing at UCLA: Clinic rules

The first session is the optimal time to address issues like the observation and tape recording of sessions:

"We are a training clinic, so every family session is observed by our supervisor, Dr. _____, and other trainees who are learning to work in this treatment modality. We may also tape the sessions so that we can go over them later with our supervisor and know what issues we want to follow up on. Do you have any concerns about this?"

OR: "We will be conducting the session by ZOOM, a video- and audio telehealth platform. Are you familiar with it? ZOOM is HIPAA-compliant. Are you and your family comfortable having sessions in your home, connected to us by ZOOM?"

If you are practicing at UCLA-CHAMP, there will be a treatment contract outlining when the 12 sessions will occur (or at least the first 6) – ask them to specify when they can come in weekly, and whether they anticipate anything getting in the way of regular sessions. They should sign and get a copy of this contract.

Remind them of the cancellation policy: minimum 24 hours, but they will be charged if they call that same morning and cancel. Give them the number of the clinic coordinator (Tannia Blanco or Georga Morgan-Fleming, 310-825-2836; Tannia can also be reached by a Google phone number, 323-405-7540) and emails (champ@mednet.ucla.edu for Tannia; gmorganfleming@mednet.ucla.edu for Georga).

Discuss your emergency contact/pager plans.

Family Members' Goals for Treatment

Once you feel you have begun to connect with each family member, let the family know that you are interested in hearing about what they hope to get out of the treatment. You want to convey to them that you are knowledgeable about their situation and that you have some ideas about what might be helpful to them, but what is most important first is to hear about what they are interested in getting out of therapy. You could say:

"I have a lot of ideas about what I think might be helpful to you in terms of treatment, but I would like to hear a bit more about what each of you wants to

get out of our work together. In what ways would your lives look different if the treatment were successful?"

In many cases it is useful to start with the IP when asking about treatment goals so that he/she has the first opportunity to express what he/she wants to change in his/her life. Youths are typically most interested in and motivated to achieve goals that they select themselves. Even if the parents express the very same goals, youths are likely to be less enthusiastic about the parents' stated goals because they are experienced as imposed upon them.

If the youth is new to therapy and is having a hard time understanding what you mean by goals, you could structure the process a bit more by posting a list (like the one below) of the various domains in life that one could think about setting goals. What is going well within each of these domains and what could be going better?

- Feelings about oneself (mood, self-esteem, hobbies and interests)
- Managing Symptoms
- Relationships:
 - with family members
 - Mom
 - Dad
 - Siblings
 - with friends
 - with classmates and teachers
- Functioning at school/work
 - ability to get up in the morning independently and get there on time
 - ability to get required work done
 - satisfaction with tasks
- Skills of independent living (grocery shopping, cooking, doing laundry, cleaning, managing finances)

Parents may be similarly confused about what types of goals you would like them to articulate: goals for themselves or for the youth? Since the focus of the therapy is on the IP, it would be helpful to hear the parents' thoughts about goals that relate to the youth. For example, are there particular symptoms that the IP is experiencing that the parents are concerned about or certain aspects of the youths' functioning at school, at work, with friends, or at home that they think merit further thought? In addition, parents might have goals involving their relationship with their son or daughter such as improved communication or reduced conflict. Perhaps parents would like to learn how to be more supportive of the IP. Alternatively, they may list goals that have nothing to do with the IP, but which you may be able to help them with anyway (e.g., "I get very nervous about job interviews. I'd like to know how to do better in them").

Most family members will appreciate being asked about their goals and having an opportunity to share their ideas. Some patients (or siblings) may tell you that they don't want to be here and that they were dragged to treatment by their parents. They have just been "real" with you and have given you an opportunity to connect with them. You could say something like:

“Thanks for being so honest with me. I appreciate that you are here tonight despite your reservations about treatment. Hopefully over time you and I can figure out how to make this work worth your time and effort. Is there anything that you would like to have going a little better in your life? What about with school/work? What about with friends? What about with your family?”

Some IP's may offer an unconventional treatment goal like “I want to get a car.” Although this goal may seem irrelevant, note that it indicates that they have some drive and motivation. The depression or negative symptoms must not be that bad for this IP. You could ask them a few questions about the type of car they are interested in, and then say something like:

“I can see why you would want a car like that. Has this been an ongoing discussion in your family? I'm interested in hearing some more about the kinds of conversations you've had with your parents about this.”

It would be interesting to learn more about the context of this particular goal since it might fit into a larger goal pertaining to autonomy/independence.

Another example might be an IP's goal of, “I want to get my parents off my back.” A strategy similar to the one used above of validating the IP's experience and contextualizing it a bit could be useful here. Something like:

“Yeah, a lot of teenagers/young adults raise the same goal in here. You are in good company. And I imagine that your parents might actually enjoy getting off your back as well? (Look at parents and see if they are agreeing with you). Do you think your parents know you feel this way? Tell me some about the kinds of things you think you could do without your parents' reminders?”

You can get back to this comment later in the session when you are “building bridges.” As you are outlining the FFT therapy, you can weave in the point that better communication and problem solving often helps both IP's and parents to find ways to work more comfortably and effectively together so that there is less nagging and less provoking.

In general, express a flexible attitude, knowing that the IP and/or parents' goals may not fit your therapeutic agenda.

This process of goal setting is very important and should not be rushed. These goals are essential to making the treatment relevant to the family members so that they feel that we are responding to their needs and not just imposing some pre-fabricated treatment upon them. You should write down each family member's treatment goal(s) because you will want to refer back to these goals frequently as you introduce new skills, making a connection whenever possible between the skill you are asking the family to develop and their treatment goals.

While some family members might bring up several clear goals, keep in mind that others might be unsure of what they want to get out of the treatment. They may be content to hear what you have to offer and that may stimulate some ideas for them regarding what they are most interested in learning. That is fine. It is important to

provide each family member with the opportunity to express his/her thoughts. Goal setting typically works best when it is a collaborative process.

Building Bridges

Now that you have listened to what each family member has identified as his/her treatment goals and outlined the FFT approach, you can make some clear connections between their goals and how the skills learned in FFT may help them to reach those goals. Pick out a few of the goals that each family member has stated and make some connection to the various skills that you will be working on and talk briefly about how those skills or those sessions will support each person in reaching his or her goals. For example, you could say something like,

“OK, now let’s make sure we are on the same page here. Joe, you mentioned that you wanted to understand more about these changes that have been going on with you. We will start with that in our next session. How does that sound? You also mentioned wanting to manage these changes better so that you feel a bit more in control at school and at home. That is something that we will get to fairly soon as well. We will spend sessions 3-4 talking about strategies for coping with various symptoms.

Mr. X you mentioned wanting to figure out how to get Joe to wake up and get ready in the morning more independently and to have him go to school more regularly, right? I think that first we need to develop a common understanding of the symptoms he is experiencing and how they play out at school and at home. We will be doing that over the next few sessions. Then we will be in a better position to think about strategies he can use to cope with the school environment and perhaps accommodations that could be made at school to help support him there.

Your desire to have Joe get up and out more independently in the morning is one of the most common requests we hear from parents at our clinic. That is something we will definitely take on during the problem solving sessions. How does that plan sound to you?

Mrs. X you mentioned that there has been a lot of arguing in your house lately and that you would like your son to know that you are on the same team and that you are really just trying to help him. Joe you also mentioned wanting to get your parents off your back. These are issues we deal with a lot here. Symptoms often make communication more difficult for families and they can put a lot of stress on relationships. At about session 5 we are going to work on some communication skills so that you have the best shot at working through some of the issues that have been coming up in a calm, constructive manner. Hopefully as we work on these communication skills all of you can feel a bit more like you are on the same team again. How does this sound to you?”

Make sure to check in with the youth and his/her parents every so often to assess whether they understand what you are saying. Are they reacting negatively to what is being discussed (e.g., rolling eyes, or looking angry or distressed)? If you notice these reactions, stop and ask about them. You could say something like:

Therapist: Tim, I think you may have been rolling your eyes when I mentioned the part about communication training? Did I get that right?

Youth: Yeah.

Therapist: Can you tell me more about your reaction?

Youth: Well, when I went to summer camp one year the counselors forced us to do some communication training. Every day we had to say something that we liked about each camper. It was ridiculous. We were inventing stuff that was completely insincere about kids that we actually hated. It just seemed really pointless.

Therapist: That does sound like a bad experience with communication training. I can understand why you might feel reluctant to put yourself in that type of situation again. Have you had any other experiences with communication training?

Youth: Not really.

Therapist: Well, hopefully the types of communication exercises that I have planned will be more helpful to you and your family and less contrived than the ones at summer camp. But, I will be very interested in your experiences of the training as we are going through it and I hope that you will continue to be honest with me about your reactions.

Avoid listing goals that cannot be achieved in this context

If family members have mentioned goals that really aren't appropriate for FFT it is important to be clear that you will not be working on those particular issues and to provide your rationale. For example, if one family member talks about early abuse that he/she experienced as a child and his/her desire to explore that because he/she thinks that is contributing to current problems, you could say something like:

"That certainly does sound like an important issue and I am glad that you brought it up. It is helpful for me to know that you have had some very difficult experiences in your life. What we have found is that the timing of discussing those types of issues is very important. While young people are experiencing significant symptoms like the ones you (the IP) have described (feeling on top of the world/depressed; feeling suspicious and uncomfortable around others) it is important to do some work that will support your ability to cope with those symptoms and to reduce anxiety. Talking about and revisiting those early abuse experiences can be make people very anxious, and we don't want to get into that type of work until (the IP's) symptoms have lessened and you are back functioning well at school and with friends. Once you are feeling better, then you can decide whether you would like to take on those early issues in a different therapy. Trying to do everything at once can be pretty overwhelming, so we think it is important to break therapy into different phases. Does that make sense?

A similar type of response would be important to use with parents who may have marital/couple issues that they want to focus on. You could let the family know that some of the communication and problem solving skills that we will be learning together may be helpful with those other issues, but that the main focus of the treatment will be on helping the IP to feel and to function better. If families try to change too much at once it becomes overwhelming.

Avoid starting to solve problems in the first session

Use this initial session as an opportunity for getting acquainted and information gathering. If the family starts arguing or insisting on talking about difficulties in school, etc., you can redirect them by saying something like,

“I know there are lots of pressing concerns that you have, and we will want to get to those as soon as possible. But, first we need to develop a plan for how we are going to work together. Tonight we are just taking the first step that lays the groundwork for all of our future work together. We will definitely get to the school issues, and many of the other concerns you have.”

Make sure to take note of potential communication pitfalls and ways in which the family may exacerbate problems or escalate conflict, although avoid mentioning them at this point. Also, take note of family strengths that you can highlight and build upon in future sessions.

Assigning a Practice (Homework)

Toward the end of the session, or even earlier if possible, give the family their first between-session practice assignment, which is to schedule a family meeting during which time they should discuss any questions/concerns that they have about what was discussed in the first therapy session. During the second session you will be discussing symptoms, so they could begin to think together in a low-key way about how various symptoms impact the family. Alternatively, they can discuss and solidify their goals for therapy.

Help the family schedule a regular between-session meeting.
--

Ask the family to identify a day and time for the family meeting. The first family meeting may be brief, perhaps only 10-20 minutes. This first meeting will help the family to establish a routine that you would like them to continue throughout the family treatment. The practice that you will assign will vary each week, but typically part of that practice will be completed during the family meeting. Make sure to check in at the beginning of session 2 to see if they did this assignment.

The IP in one family coined the term “FamChats” for these between-session meetings. The term caught on with the rest of the family, and became an easy way for the clinician to remind the family to schedule these chats. Note that we avoid using the term “Homework” with families, even if we use it among ourselves. “Practice” is a less onerous term.

Choice Point

At this point in session 1, you may be almost out of time and may feel like you've covered enough material for one day. If so, close out the session and summarize what you've said, and prep them for the next session (below). Alternatively, you may be only 35 minutes into the 50-minute session and may feel like they (and you) could do more! If so, move to "Facilitate a Family Discussion of the IP's symptoms" (usually covered in session 2). Go through one of the handouts, such as the handout on depression or mania. The instructions on conducting this exercise are below, for session 2.

Plan for the Next Session

If you have decided they've had enough for session 1, set up a date/time for the next meeting, and remind the family that you will be starting with some educational materials at the next session. Give the family an opportunity to ask any questions. They may have been asking questions along the way, and if they have no further questions that is fine. You could say something like:

"We have covered a lot of ground today. Questions may come up for you over the course of the week, and I would like to start our next session by addressing those questions."

Summarize and Reflect

If there is time, provide a brief summary of the session and then check-in with family members about their reactions to the session. You could say something like:

"Today was sort of an introductory session. We started to get to know each other a little bit. What was that like for you?"

"Then we talked about some goals. I plan to type out those goals and to distribute them to you next week so that we all have a clear reminder of what we want to address in our work together. If you think of additional goals during the week we will add them to our list next week. Anything else you want to put on our agenda?"

"I like the goals that you spelled out and it leaves me feeling hopeful and excited about our work. I think that there is a lot that we can accomplish together over the next several weeks."

Joining/Closing

With this discussion we are emphasizing the importance of reflecting on our experiences in therapy. As sensitive as we try to be, we cannot read the family members' minds and so it is important that we ask them regularly about their reactions to what is discussed in therapy. Hearing their honest feedback will enable us to try to pace and organize the therapy so that it is tolerable and meaningful for them. If the session has gone well and you are feeling hopeful and enthusiastic, it may be encouraging to the family to express that sentiment and to try to create an atmosphere of optimism.

Spend a few minutes chatting with the family about something light, perhaps fun plans they may have for the weekend, or current events that are relevant to your common interests with the family. It is probably most important to direct efforts toward connecting with the youth as you begin and end the first few therapy sessions. This is especially the case if you sense some reluctance in the youth to participate in the treatment. The more you can join with the youth, the better. If the parents don't have to drag the youth to treatment, the family will be more likely to attend regularly. Teens are particularly skilled at quickly detecting when an adult is trying too hard, so keep efforts low-key.

Use of Humor in FFT

Ideally, this therapy should involve a fair amount of shared low-key laughter. Often parents come in with high levels of distress. This is understandable in light of their circumstances. Of course, you won't be trivializing their concerns or the seriousness of their situation, but you can try to balance all of that with some light-hearted moments. This may prevent you and them from getting burned out. An underlying goal of the therapy is to help patients and families to get on with their lives despite symptoms. They can still work, have friends, and connect with each other in fun ways despite symptoms. It may be reassuring to them to be reminded of that implicitly or experientially by sharing some light moments together in therapy.

Have some fun with each of the family members. Some playful banter will remind them that you actually enjoy them despite some of the difficult conversations that may have just taken place. They may trust you more as they realize that you are going to help them cope with their more difficult emotions before they leave your office.

Good examples of humor are things that make fun of yourself or the setting:

"This is the first time I haven't bumped my head on the cameras."

"Let's see if I can find our next appointment on my iPhone without erasing all my pictures."

"You can call me Dr. Martin, or Alissa, or just Doc. The only name I don't respond to is 'dude'."

What Does “High Risk” Mean?

A common question that tends to come up in the first or second session is what is meant by the IP having “early onset” or being “at high risk” for bipolar disorder, major depression or psychosis. Consider including the following information in your response, pitched to the educational level and language of the family.

“A “high-risk” state is one in which individuals are experiencing a group of symptoms and changes in social and school/occupational functioning. It is the clustering of these symptoms rather than any one symptom in particular, as well as the frequency and intensity of the symptoms and the distress and disruption they create that suggests a high-risk syndrome.

Common high-risk symptoms can include experiences like feeling very moody (up or down, irritable), anxious, social withdrawal, a drop in grades, difficulty sleeping, uncharacteristic peculiar behavior, increasing difficulty with concentration, heightened sensitivity to signs, sounds, smells, touch, loss of motivation, exaggerated beliefs about personal powers or influences, and suspiciousness of others. We will be talking a lot more about these kinds of symptoms during our session next week.

A fever is said to be an early warning sign of measles. This means that a fever may be an indication that the measles are on their way. However, as you know, not everyone who has a fever goes on to develop the measles. Similarly, these early warning signs that I just described may or may not be the earliest phase of a mood or psychotic illness. When an illness does develop, there is typically a “build-up” phase of more mild symptoms that precede the most severe symptoms.

The available research suggests that less than 40% of people who meet criteria for a “high risk syndrome” will go on to develop a full bipolar or psychotic disorder within 2-5 years. This is good news indicating that less than half of the folks we have identified through our assessment procedures as having a high risk syndrome or as being in an at-risk state will go on to develop more severe problems. We would like to bring that rate down even further and for that reason are providing family treatment at a very early “high risk” stage. It is our hope that through our work together we will decrease your risk and create a more protective environment for you.”

Related to this issue is the question of what to call bipolar or psychosis symptoms. If the IP has well-established bipolar disorder, she may prefer the terms mania and depression. Some youth or young adults may prefer to talk about mood swings, highs and lows, or other proxies for mania and depression. Ask the youth what terms he or she prefers.

Likewise, the IP may object to the term psychosis. S/he may do better with a less charged term like “thought disorder” or even “thinking problems.” Once again, ask him how he would like you to refer to his symptoms.

Session 2: Discussion of Symptoms, Mood Charts and the Vulnerability-Stress Model

1. Joining/Check In: Ask whether the IP or family had any reactions to the first session.
2. Review homework (family meeting; additional family goals; questions about first meeting?)
3. Review the treatment goals that you discussed last week. Try to make a connection between some of their goals and the discussion of symptoms that is about to take place.
4. Family discussion of the IP's symptoms.
5. Guide youth and family through development of a mood chart.
6. (*If time permits*) Introduce the Vulnerability-Stress model, Risk and Protective Factors
7. Assign practice (family meeting, mood charts)
8. Plan for next session; Joining/Closing

Needed Handouts:

- 2a-2e (Mania, Depression, ADHD, Mood Swings, Positive, Negative, Anxiety Symptoms)
- 3 ("How I Feel": Mood Chart)
- 4 (Factors Affecting Health)
- 5 (Risk and Protective Factors for Mood Problems)

There are two main learning objectives during this session. The first is to facilitate an interactive exchange during which the IP and family members share their experiences of mood and psychosis symptoms and you provide additional information about those symptoms as needed. The second goal is to introduce the "Factors Affecting Health" model to the family to provide the theoretical basis for much of the treatment that follows and to highlight the influence that risk/protective factors and stress can have on symptoms and functioning.

Follow-up on the assigned practice

Ask them if they were able to have a family meeting and find out if they have any questions/concerns that might have come up during that meeting. If they didn't organize a family meeting last week, let them know that it will be helpful to the progress of the therapy if they get into the routine of meeting weekly between sessions. This will give them a chance to review some of the educational material that will be presented each week and practice some of the communication and problem-solving skills. Ask them to identify the best time for all of them to talk together as a

family. Since this may be a change in their family routine, how will they remember to meet during the specified time? Will they write the meeting time on the family calendar, or will someone take responsibility for gathering everyone together at the designated hour? It's often helpful to appoint the youth/young adult as the person responsible for making sure the family meeting occurs.

Review Treatment Goals

If there is a way to make a connection between one of their goals and the discussion of symptoms that is about to take place, do so.

For example, "Dad, you expressed an interest last week in developing a better understanding of X's symptoms, and X, you wanted to help your parents to understand what it is like for you to experience some of your symptoms. Those are the goals that we are going to focus on today."

Facilitate a Family Discussion of the IP's Symptoms

Whether the IP has bipolar disorder, depression, psychosis, or an early-onset "high-risk" type of each, it is important for you to review the medical records before sitting down to meet with the family for this second session. A thorough knowledge of the IP's symptoms will guide decisions regarding the order in which symptoms should be discussed. For example, imagine you are working with a youth who has some striking mania symptoms (for example, grandiose delusions) or positive psychotic symptoms (hearing voices, thinking that he can control other's thoughts at times). His parents, however, may be aggravated with his "laziness" and difficulty getting to school. In this case, it might be most productive to talk about the manic or psychotic symptoms first. Once the parents have a better understanding of some of the unusual symptoms that the youth is experiencing, they may be more receptive to thinking that the child has depression or negative symptoms rather than laziness.

A clear understanding of the youth's symptoms will help you to select handouts that are relevant to the family. For example, if the youth is experiencing comorbid anxiety, then the optional handout (2E) regarding those symptoms may be included in the discussion. Think about how best to pace the session, allocating most time to discussion of the symptoms that are most problematic, distressing, and/or disruptive to the youth and/or family. The goal is not to make sure every symptom gets discussed; it is for everyone on the family to be on the same page about the symptoms and disorder that is most relevant to the IP.

Before the session, you may want to consider whether the channels of communication within the family are open regarding the youth's symptoms. Some IPs are reluctant to share details about their symptoms with their parents and so questions aimed to draw them out will need to be asked with care. Other IPs seem quite oblivious to their symptoms or maintain an "everything is fine stance" while the parents provide striking examples (drop in school grades, staying up all night working on unrealistic projects, inexplicable shouting in their room in a way that suggests they may be answering back to voices, drop in attention to hygiene, etc.) These IPs may become angry and/or withdrawn when the parent attempts to describe these symptoms to you.

Ideally, this session will allow for family members to develop a greater understanding of each other's experience of the IP's symptoms. However, when there is a lot of sensitivity in the family about "putting the issues on the table," you can present the symptom information in more of a didactic format. Given that this is only the second session, we don't want to stress everyone out by trying to force openness. We want everyone to be "up to speed" on the various symptoms that we will be focusing on during our work together.

Fortunately, the most common situation is that parents and youths are willing to speak frankly about their experiences of symptoms when invited to do so. The IP is often more forthcoming when he or she is asked to speak first about his/her own experiences. Then, family members can add to this description or provide their own perspective. Remember, the IP is the "expert" on his or her own illness.

Clinical Tip:

Exploring the IP's symptoms should not feel like a repeat of the KSADS or other clinical assessment, with the family serving as an audience. Instead, the goal is to facilitate a deeper understanding on the part of family members of what it is like for the youth to experience these symptoms, and perhaps a deeper understanding by the youth of how his symptoms impact family members and family life. So, if you are feeling that you're just asking about symptoms and the IP is saying yes or no, then step back and encourage a discussion with open questions: What was that like for you, when your thoughts started racing (patient)? When did you first notice it? Mrs. X, what do you notice when Jim gets this way? Jim, what helps you to feel better? How do you know something is feeling different?

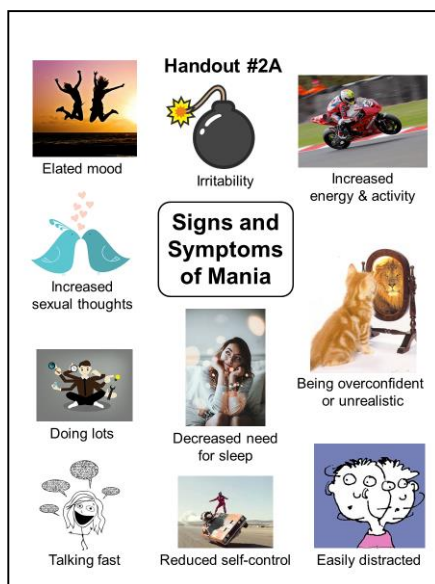
When this session is going well, you shouldn't have to do much; just ask the youth to describe his experiences of, for example, depression, mania, suspiciousness or apathy, and the family members should chime in with their own perceptions of his behavior. Intervene if differing perceptions lead to arguments: say, for example, "it's not unusual for people in families to disagree about these symptoms or how they affect others, but at this stage let's just get everyone's input on the table."

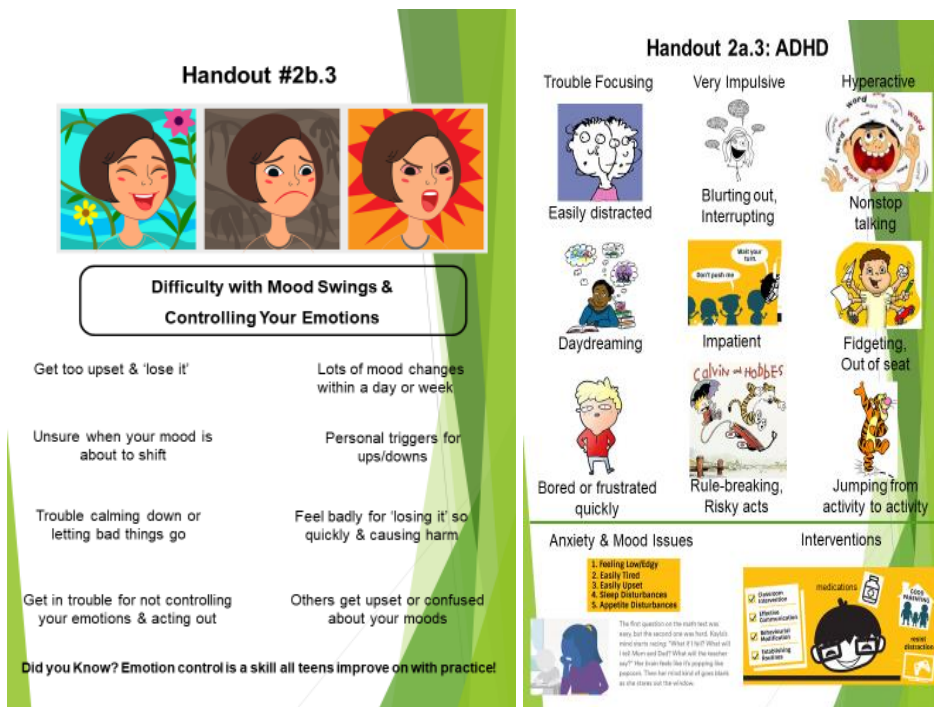
Avoid asking about symptoms in a yes/no or either/or format. Avoid asking "Have you ever had unusual ideas, or is that not something you've experienced? Or "Has it always been that way, or has it been only recently?" Instead, ask these questions openly, e.g., "Have you ever had unusual ideas? When did they start/worsen/get better? What was that like for you?"

Finally, if the IP has had full blown manic or depressive episodes, it is useful to find out what symptoms came first. That is, what was the first sign that a manic episode was developing - decreased need for sleep, racing thoughts, irritability? For depression, was it fatigue, negative thinking? Later, you will be able to use this information to construct the Prevention Action Plan, which requires thinking of illness episodes as a sequence of events.

Clarifying Manic or Hypomanic Symptoms in Youth with Bipolar Spectrum Disorders

If the IP has bipolar I or II disorder, or is on the bipolar spectrum (bipolar NOS), you will want to start by discussing manic (or hypomanic) and depressive symptoms. Give the family **Handouts 2a and 2b** entitled “**Symptoms of Mania**” and “**Symptoms of Depression**.” You may also find the alternative handouts on ADHD (2a.3) and “Difficulty with Mood Swings” (2b.3) useful. These lists are presented with pictures and simplified language to help adolescents and parents understand how symptoms present within mood states. This section of the education highlights the fact that a mood disorder has a developmental progression, and that it is often comorbid with other disorders. It is important for family members to be familiar with the presentation of bipolar disorder so they can talk with the clinician about the IP’s variable mood states. Be open and inclusive of what youth and family members consider symptoms of mood, behavioral and/or attention difficulties, even though you may suspect that some of these behaviors (e.g., manipulateness, argumentativeness, lack of follow-through) are developmentally normative or represent personality traits. If a child also has a diagnosis of Attention Deficit Disorder or another comorbid disorder, you may want to discuss these symptoms as well and talk about how they differ from manic symptoms.





Adolescents with bipolar disorder often do not have the same symptoms as DSM-5 adult bipolar disorder patients. For example, they may be characterized by short attention spans, anhedonia, low tolerance for frustration, sudden outbursts of anger followed by guilt, lengthy states of arousal in response to minor events, and disruptive behavior. Thus, it is important to not get locked into a “discrete episode” model of bipolar symptoms in which the parents and the adolescent are asked to think in terms of discrete build-up phases, active phases, and residual phases. Instead, ask the family and adolescent to use their own terminology to describe the adolescent’s mood swings, changes in activity, and behavior problems. Several of our adolescent patients have not been able to identify symptoms of depression if they are asked “what happens when you get sad?” They are much more likely to respond to questions regarding times when they felt “bored,” or “wanted to get away from everybody and everything.”

Most parents will want to talk about “raging,” which may or may not be a symptom of early-onset bipolar disorder. For a parent to begin to understand the IP’s oppositional and rageful behavior, they will need information about what is happening in the child’s mind. If you know the pathophysiology of manic states well, you can explain rage in terms the family can understand (e.g., over-activity of the amygdala and under-activity of the prefrontal cortex). **The important point is that the IP may have little, if any, control over these rages.** We have drawn parallels for families between the onset of these rage states and “a train leaving the station. Once it has taken off it follows its own tracks and at some point no one can jump off, not even the conductor. The trick is to try to keep the train from leaving the station in the first place.”

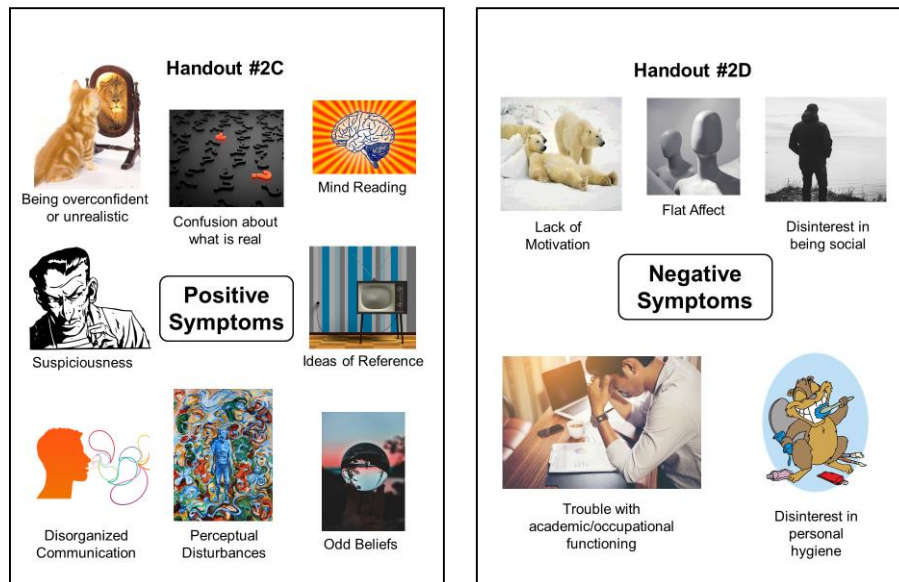
When the patient begins raging, the best laid plans for behavior management will usually be ineffective. The IP will not be moved by threats, explanations, promises of rewards or discipline. The consequences which the parent and IP have agreed upon can only be effective when the IP is in a state of mind to appreciate their meaning (Greene, 1998). Later, you can guide the family in planning how to proceed when the teen is symptomatic. They can be taught to implement behavior management plans to implement when the adolescent's mood is beginning to escalate.

Reactions to the Diagnosis: Jessica

Jessica was a 16 year-old female diagnosed with Bipolar I Disorder. She was chronically irritable during her manic or hypomanic stages with infrequent periods of depression. Jessica showed her resistance to the education phase by getting “revved up” during the sessions. When revved, she would become hypervocal, interrupt the clinician or her parents, and change the subject to unrelated topics. On many occasions it was difficult to keep her on task. Her mother would comment that she did not present this way just before the appointment. When asked, Jessica initially denied the observation. We pointed out to her how obvious the difference was to us, and she eventually acknowledged feeling “amped” but was unable to identify the cause. She did say that she was uncomfortable with sharing her feelings. She also said that she (like many teens) was afraid that admitting to her illness would make her parents “hold it against me” and limit her privileges (e.g., driving or outings with friends). She said that she struggled with seeing herself as different from others and “if I don’t talk or think about it then it won’t be true.” Admitting this discomfort opened the door for her to discuss her feelings about the diagnosis itself, within the context of the psychoeducation sessions.

Clarifying Psychosis (or Prodromal Psychosis) Symptoms in Youth

If the IP is being treated for prodromal psychosis (attenuated positive symptoms) you can start by giving the handouts on **Negative Symptoms** or **Positive Symptoms** (also labeled 2c and 2d) depending on which set of symptoms you believe best characterizes the IP and will lead to the most productive discussion. You can use these handouts flexibly to discuss symptoms in whatever order makes the most sense for a particular family.



Some family members are confused by the term “negative symptoms” and instead provide examples of their son or daughter’s “negative” or “oppositional” behavior. Likewise, some family members are confused by the term “positive” symptoms and they think that refers to pro-social behavior or signs of improvement. We explain that the term refers to cognitive or behavioral excesses. You may need to clarify that negative symptoms are really “deficit” symptoms, or instances where there is a lack of motivation or disinterest. For example, they may have noticed a change in their son or daughter’s interest in picking up the phone and calling friends and initiating social activities. The IP may be less interested in socializing, school or work activities.

If the IP has schizophrenia or another form of early-onset psychosis, family members may have difficulty telling negative symptoms from depression. We typically acknowledge this problem and use it as an opportunity to reinforce the importance of tracking symptoms over time. We may say something like:

“Yes, you are right. These could be symptoms of depression. There is a lot of overlap between symptoms of depression and the symptoms that accompany psychosis. That is why we would like to track these symptoms carefully over time to get a better handle on what is going on. Depression typically comes and goes, while negative symptoms are more chronic and occur even when someone isn’t feeling particularly sad.”

As family members offer examples, you can ask questions about the symptoms to draw out relevant information. For example, you may ask the youth to elaborate about what it is like for him/her to experience a particular symptom or may ask family members what it is like for them to see their son/daughter or brother/sister experiencing a particular symptom.

When describing unusual thinking, say something like:

“An example of confusion about what is real and what is imaginary might be when you wonder about whether something actually happened or was just a dream. Have you ever had that experience?”

After they respond you can say something like:

“Many people have this experience once or twice and it is brief and only momentarily confusing. When these types of experiences persist for long periods of time, occur frequently and are distressing, they are considered symptoms of unusual thinking.”

Below is an example of how to describe suspiciousness:

“Suspiciousness refers to the thought that people are not trustworthy and/or that someone is trying to harm you. Many of the young people that we see have this experience. Jane (patient), have you ever had this kind of symptom? What was it like?

At times it can interfere with being able to go to school or with making friends. Did you ever feel suspicious and not want to go to school because of worries that others at school would harm you in some way?

Mr. or Mrs. Hill (parent), are you aware that Jane is experiencing these symptoms of suspiciousness? How do you know when she is experiencing these symptoms? What is it like for you when she is experiencing these symptoms? What do you typically do when she is experiencing these symptoms? Jane, when your mom does X does that tend to help? (If Jane says no, then ask Jane what would be a more helpful reaction. Does Mom think she can respond in the way Jane proposed?)

Sometimes it is a good idea to also ask the other family members whether they have experienced any of the symptoms you are describing. This may help the IP feel less stigmatized and in the spotlight. It could also make the IP feel less alone in his/her experience of dealing with mood or psychosis symptoms. So, for example, ask the father if he has ever felt depressed or unusually suspicious of others, perhaps at work; ask the mother whether she has ever had the experience of things feeling like she was in a dream state.

When discussing symptoms of unusual thinking such as preoccupation with the supernatural, some IP's report that all of their friends must have psychosis because all of them are interested in Wicca and Witchcraft. We may say something like:

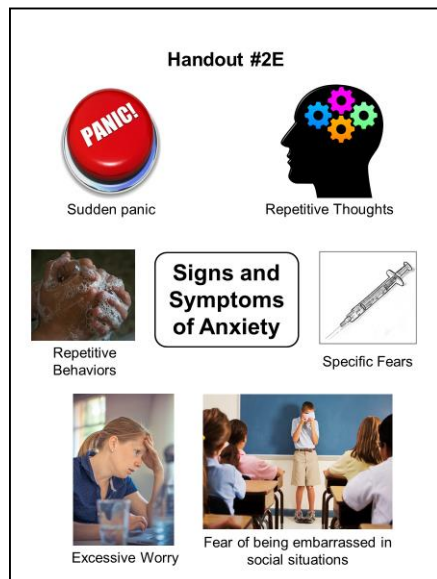
“Fair enough. Teenagers (or young adults) tend to be curious and open-minded and willing to consider a broad variety of ideas. This only becomes a cause for concern when a person becomes preoccupied with these thoughts (such as spotting UFOs) and those preoccupations become disruptive to their functioning at home, school, or work. Do you think any of these ideas have caused problems for you?”

It is important for family members to be familiar with these symptoms so they can better observe and understand what may be going on with the IP and talk with you about what they are observing. Since a goal of treatment is to prevent the onset of a manic/depressive episode or an episode of psychosis, it is important for family members to be able to tell clinicians if they feel that their son or daughter's symptoms are worsening. Create an open and low-key atmosphere so that the full range of symptoms can be discussed.

Guide each family through the handouts at a pace that is comfortable for them. At the end of the discussion of symptoms, ask each person to identify the symptoms they find most distressing, and which ones they would like help with first.

Exploring Anxiety Symptoms

If the youth is experiencing symptoms of anxiety, those symptoms should be discussed as well. **Handout 2e, “Symptoms of Anxiety,”** may be useful when describing these symptoms.



Help the family understand that anxiety can be a symptom of BD, MDD or psychosis, but can also be a separate “comorbid” disorder. Generally, severe anxiety symptoms may require adjunctive treatments such as exposure and response prevention, panic control treatment, or other forms of behavior therapy. SSRIs also have a significant role to play in managing anxiety symptoms. You may decide to supplement your treatment with adjunctive CBT techniques for anxiety, such as relaxation or mindfulness exercises. The difference in FFT is that you should involve the whole family in these exercises. A relaxation tape, for example, can be listened to conjointly.

If the child or teen has comorbid OCD, panic disorder, social anxiety disorder or GAD, consider whether you want to include CBT techniques such as exposure and response prevention in your sessions. When appropriate, you can recommend adjunctive individual or group CBT sessions if those are available in your setting. Avoid turning FFT into individual CBT. Our major objective is to help stabilize the IP's mood (or psychosis) symptoms, at which point the IP may be more amenable to CBT techniques.

If you decide to include CBT strategies, make sure to involve family members in implementing those strategies. For example, you can ask a parent to implement an exposure task. It may also be important to discuss the dangers of “accommodation” by the family to a patient's rituals or avoidance behavior.

Handling Tensions that Arise During Discussion of Symptoms

Sometimes during the discussion of symptoms, the IP becomes angry when he/she hears other family members describing his/her symptoms. Family members' descriptions may not hit the mark for the IP and may make him or her feel misunderstood or intruded upon, as if others are trying to tell him or her how he/she feels. If you notice this, explore these feelings and reactions with the family.

It may be useful to validate the IP's concerns and to remind everyone that the IP is the expert on what these symptoms are like for him/her. Everyone else can comment on their own experiences with similar types of symptoms, but they can only guess or imagine what the symptoms might be like for another person. The tone and language that family members use to share their experiences of the patient's symptoms can make a big difference in terms of how tolerable this information is for the IP to hear.

Clinical Tip Patient-as-expert

Tell the IP that "you are the expert in your own symptoms. We're going to depend on you to educate us about what this disorder is really all about. You're the one who's been through it, and you have a perspective that neither I (therapist) or your parents may share."

Typically when talking about someone else's internal experience, an attitude of curiosity from the clinician provokes less reactivity than an authoritarian stance. Phrases like "I imagine it might be X to experience Y" tend to work better than "You feel X when you experience Y." A statement like "I imagine it might be scary (X) to think that others at school are trying to harm you (Y)" tends to be better received than "You get scared when you think others are trying to harm you at school." When tensions arise the therapist may consider encouraging family members to ask questions so they can better understand the IP's experiences, or to start with "I imagine" or "I am guessing it might be..." to make any statement about the patient's experience.

At the same time, family members do have first-hand experiences with the IP's symptoms and the effects of these symptoms on family members. Understandably, family members may be perceiving the IP very differently from how he or she is experiencing him or herself because the family members may be most aware of the "externalizing" aspects of the syndrome, such as irritability, argumentativeness, or school truancy. The IP may be most aware of internalized experiences such as depression, feeling revved up, or distracting and perhaps anxiety provoking internal experiences (hearing voices, difficulty concentrating, etc.)

In summary, when one family member is experiencing symptoms, it is common for each family member to have a somewhat different experience of that complex event. Each person's perspective is helpful in understanding the impact of these symptoms on the individual and the family.

Creating an Individualized Self-Rated Mood and Behavior Chart

From the first or second session, try to get the IP into the habit of tracking his/her moods or other significant behaviors or thoughts. In this section, we focus on mood charting as applied to patients with bipolar spectrum disorders. Consider how you might adapt this assignment to a patient whose main problem is only depression, or paranoia/suspiciousness or auditory hallucinations.

Mood charts are quite valuable in tracking a patient's progress, identifying the emergent signs of an illness episode, identifying diurnal variations, recognizing the effect of stressors, and clarifying the role of sleep/wake cycle irregularities. They also make the IP more self-aware and observant of her mood states and behavior. Self-awareness is particularly important in managing a mood disorder. FFT is a good place for the patient and family to learn the value of self-monitoring.

Handout 3 Figure 1

HOW I FEEL

Week of _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. _____							
2. _____							
3. _____							
4. _____							
5. _____							

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

On the lines below, describe behaviors and feelings associated with each mood:

1. _____	2. _____	3. _____	4. _____	5. _____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Begin by asking the IP to describe her mood states and what descriptors go along with each. If you have a flip chart or a dry erase board, stand by it and draw a horizontal line in the middle (or give the IP **Handout 3: How I Feel** chart). Ask the IP first (or parents if the IP is hesitant) to give a label that describes the absence of symptoms (i.e., mellow, calm, normal, typical). Then, draw a line right above and below the middle line and ask the IP what words she would use for mild ups and downs (e.g. “pretty good” versus “a bit

sad” or “frustrated”). Explain that these fluctuations are representative of the normal moods that someone might experience if 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 IP 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, use a separate line for anger and ask the IP to place it on the graph where it most clearly fits for 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. Then ask the IP if there are any other states that should be tracked (i.e., anxiety, suicidality, urges to use substances). Ask the IP to determine where each of these lines should be placed on the chart.

Once the lines are in place and labeled, then each label is placed at the bottom of the page as a heading. The IP begins listing symptoms that go along with each of the states (for example, ‘excellent’ may include giggling, talking loudly, or feeling more energetic; ‘angry’ may include cursing, kicking doors, or pushing or hitting). Of course, some youth may not have had experiences of activated or angry states. Be sure to accept the IP and family’s input regarding presentation of symptoms. Encourage the parents to join in this process but take cues from the youth. Try to keep an air of

curiosity and levity in the room, recognizing that it can be difficult for the IP to focus on her abnormal moods and behavior.

Once this chart has been created, the IP can use it on an ongoing basis. Ask her to complete a mood rating at least twice a day (e.g., best versus worst; morning versus evening) and even more frequently if she is willing. More specifically, ask her to put an X on the line that she felt characterized her mood at various points in the day. Finally, include two vertical spaces at the bottom of each day to record when she went to bed and when she woke up each day. She can also record stressors for that week on the chart to start to recognize how stressors can affect mood.

Give the IP a template that can be dated and copied for each day of the week. It's easiest if a single sheet can be used to characterize the whole week. This exercise is often empowering for the youth in a move towards self-care skills and independence. If the youth is resistant to monitoring mood and/or sleep you can point out that "this is one of the few things you can do- other than just take medications – that puts you in charge of your moods."

Likewise, ask one parent to make a similar rating of the IP's mood each day, or at various times of the day. This is helpful for three reasons: to keep the parent attuned to diurnal shifts in the IP's mood states, to quickly identify a worsening of mood, and to make clear to the youth that he or she is not the only one being given homework. Parents usually appreciate the chance to record the youth's ongoing mood states. You can ask them to rate the same mood chart developed for the IP. Some parents want to keep more detailed notes of the IP's moods, rage outbursts, medications, and/or stressors. Rating the chart may also help the parents confront the misperception that the IP can control his mood swings and may generate more compassion toward him. The chart can be customized to each family's needs. Some families like to take this exercise and create their own chart. As long as all of the information is recorded, individualizing the chart for the family or patient is encouraged. The more the youth and family feels the chart fits for them the more likely they will be to complete it.

For some patients, you may want to suggest keeping the chart in an obvious place, such as in her backpack or on top of the dresser. Alternatively, the IP may decide to keep her chart with evening medications (if taken) and rate moods then.

If the IP has many mood switches during the day and evening, then he can place any number of Xs on any of the lines corresponding to the times of the day listed. Try not to make the task too complicated, however. Use your clinical judgment in deciding what level of complexity will work best for the youth and ensure his compliance with the task. Obviously, if the IP is an older adolescent or young adult, the more responsibility should be ascribed to him.

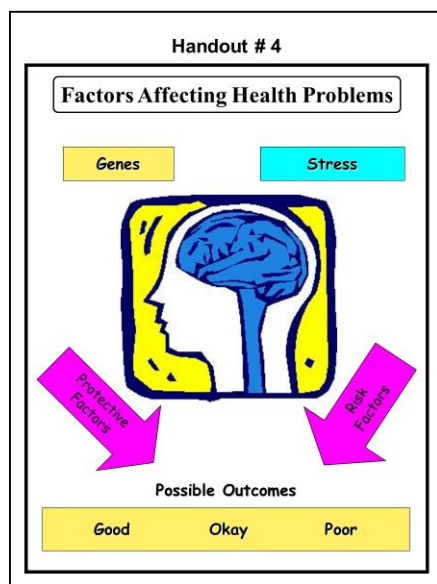
Additional chart ratings can be made for other behavioral difficulties or symptoms the patient and family reports. For example, you could ask a child with mild psychosis to keep track of his suspiciousness toward others, her level of apathy or depression, or her feelings of overstimulation.

Reflect

Pause for a moment and check-in with the family about the discussion you just had with them. Ask the youth what it was like for him to speak about his/her symptoms, and ask family members what it was like to hear what the youth said and to share some of their own experiences. If it feels genuine to you, compliment the family on the fact that they seem to have taken some risks and made some efforts to help each other understand what is going on. This process of opening up channels of communication is an important step in adapting to life with psychiatric disorders, and eventually managing symptoms more effectively.

How much time do you have left in the session? Is the family worn out? If you have twenty minutes and the family looks to be comfortable, transition to the next section on vulnerability and stress. If it took you a long time to get through the symptoms, and the family members look maxed out, then transition to planning for the next session and assigning practice (e.g., the mood chart; another family meeting) and start with vulnerability and stress at the next session.

If you have time and the family still looks fresh and engaged, ask them if they have the stamina to go through one more hand-out today or whether they would prefer to end now and save it for next week. Make sure that you aren't over-saturating the family with information, and that you are keeping sessions to approximately 50 minutes in length.



Vulnerability and Stress (How do People Get Mood or Thinking Problems?)

The “vulnerability-stress” theory states that mood or psychosis symptoms come about through an interaction of genetic, biological, and stress factors. This is a simple idea on the surface, but few of your family members have thought much beyond “it’s both genes and environment.” The objective is to help the IP and family understand what is meant by genetic predisposition and stress, without going into long and complicated explanations of gene and environment interactions.

The overriding goal is for the IP and family to recognize that mood swings (or psychosis symptoms) are not necessarily controllable by the IP, but that s/he may be able to maximize use of “protective factors” to prevent the current symptoms from becoming more severe and chronic.

With reference to the **Handout no. 4, “Factors Affecting Health Problems”**, you can say:

“We know that vulnerability (predisposition) to mood disorders and psychosis runs in families (“genetics”). We can’t change the genetic vulnerability that

each of has, but we can change the amount of stress in our life (to a certain extent) AND the way we cope with stress to try to keep ourselves healthy. Does this make sense?

"I am going to explain to you what each of these words mean in the rectangles and in the arrows. Environmental stressors are a part of daily life. One might decide when to change schools or move but there is always some stress in a person's life. In addition, our biological vulnerabilities or genetic predispositions are things that we are born with that we are unable to change."

"For example, some people are genetically predisposed to having cavities, meaning that having cavities runs in their family. As a result, that person may brush her teeth just as often and eat the same amount of candy as her friend but she may have cavities and her friend may not. As you can see in the handout, we believe that events or situations that we experience as difficult or stressful can interact with our biological predispositions. This means that some people are more likely to have mood swings even if they have only minor stress, because of their genes or the chemistry of their brain."

"We know that mood swings run in families. However, just because your brain chemistry makes it more likely that you will have mood swings (or thinking problems) doesn't mean you will necessarily have them. We also think that stress and other "risk factors" - things that make an illness worse - play a role. But 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. Things we do on a daily basis to manage difficulties so that we feel better - like getting regular sleep - are called "protective factors". Does this make sense?"

"Family members can be very useful with both of these tasks. They can help to create a low stress environment for a vulnerable person and they can help the person to cope effectively with daily stress."

Follow this up with some probes: "You've talked about how ____ may be genetically vulnerable because mood disorders run in your family. Can you say more about that?"

"What has caused you (the patient) stress in the past? Have you ever felt not in control of your feelings?"

You may need to explain further what is meant by "stress" and "cope". Many adolescents have experienced stress (for example, bullying, being sexually harassed by other teens) but may use other words to describe this experience (e.g., "lots of drama lately"). Other family members may point out things that the teen has found stressful. Ask each member of the family to give you examples of major life stressors that precipitated an episode of physical or mood problems (e.g., the ulcer came on after a large project at work was due, headaches developed after a period of interpersonal stress involving other family members, depression followed a geographical move).

Some family members react to the discussion of genetic vulnerability with guilt or shame. If you notice this, explore these feelings with the family. Remind the parents

that, “none of us have control over the genes we inherit or pass on to others.” You should also add that, “genes are only a part of the pathway by which a person develops a mood (or a thought) disorder.”

Clinical Tip

It is often useful after explaining these handouts to ask one of the family members to repeat back in his or her own words what he or she has heard you say. Asking them to put the material in their own words allows them to reach a deeper level of mastery of the material, and allows us to fill in any gaps in their understanding.

We don’t want to put them on the spot or to communicate that we don’t think they are bright enough to understand complex concepts. Phrasing it in the following way may avoid those miscommunications.

“I have been talking for a long time, and I don’t always say things as clearly as I might like, so I just want to stop and make sure that my message has gotten through. Would one of you please explain to me what your understanding is of how people get bipolar (psychosis, etc) symptoms so that I can be sure that I got my message across effectively?”

Handout # 5


Risk and Protective Factors

Risk Factors

- Drug or alcohol abuse
- Inconsistent sleeping habits
- Changing or stopping your medications suddenly
- Stressful life events
- Family conflict or distress

Protective Factors

- Following regular daily routines
- Social, family, & community support
- Communication & problem-solving skills
- Talking to your doctor or counselor
- Exercising regularly



Risk and Protective Factors

One way to help patients understand factors that affect their course of illness is to talk about Risk and Protective Factors. **Use Handout #5.**

Risk factors = anything that can make an illness more likely to occur, or get worse. Examples are drug and alcohol use, excessive amounts of stress, family conflicts, poor sleep habits, and negative self-talk.

Protective factors = anything that makes the person less likely to become ill if they are vulnerable to becoming ill. ***Protective factors are not just the inverse of risk factors*** - they are the activities, supports, or treatment resources that make people better when they are biologically predisposed to illness. Examples: consistent daily routines and

sleep/wake cycles, taking medicines, becoming educated about one’s illness and learning to identify early warning signs of recurrence, supportive family relationships, therapy or support groups. Ideally, we want to encourage the family to strike a balance in which risk factors are minimized and protective factors are maximized for the IP.

So, if the family is having trouble with terms like “coping strategies,” try asking, “what protects you from getting ill?” If they equate “stress” with “negative thinking,” then explain that negative thinking is a risk factor, but it is a reaction to stress.

Try to help people distinguish environmental stress from “when I get stressed out.” The latter usually means worrying excessively or getting irritable. The important issue is, what stressors are most likely to get you stressed out? Relationship problems, work problems, schoolwork, traffic? Having to wait in lines? Work with the family to identify those experiences that contribute to stress.

Addressing Marijuana use

Drug and alcohol abuse are classic examples of risk factors in mood and psychotic disorders. You will have multiple opportunities to address drug abuse throughout FFT, but none will be particularly effective with youth who have decided to keep using no matter what. In these cases, you may find it more effective to refer the youth for chemical dependency treatment or 12-Step programs.

If relevant to the youth you’re seeing, say:

“We are going to talk a lot more about stress next time, but I’d like to touch on the marijuana thing a bit more. Lots of kids wonder why we keep telling them not to smoke weed because they see other kids experimenting with using it and not having a lot of symptoms. Cannabis is a stressor to our biological system. Some folks with low genetic risk may be able to get away with smoking weed without experiencing symptoms, but once a person is experiencing symptoms, it can make them a lot worse. The same amount of weed can have a much more problematic impact.”

Avoid getting into discussions of whether marijuana is a good antidepressant or anxiolytic. Many kids (or even parents) will cite articles they’ve read about the wonders of CBD oil as a mood stabilizer. Some kids may even ask whether their treating psychiatrist can prescribe Cannabis for them. While not taking a moralistic stance against it, avoid encouraging Cannabis use. There is no evidence that children and teens with mood disorders benefit from regular use of any street drug.

Answer Questions

Give the family an opportunity to ask any questions. Say something like, “We have covered a lot of material today. What questions come to mind, or what reactions do you have to the material that we discussed? Pause and allow them to think for a moment. Make sure that you look interested in hearing what is on their mind.

Plan for Next Session and Assign Homework

Remind them of the headlines for the next sessions. You could say something like:

“Next session we are going to try to figure out what is causing the greatest amount of stress in your lives, We will begin to evaluate how you are coping and whether additional coping strategies might be useful to you.”

If there is a tie in to family members' goals, you should mention it by saying something like:

"Manuel, I remember that you were particularly interested in hearing about some additional ways to cope with symptoms and with stress, so next week we will start getting in to that important material. How does that sound?"

Remind the IP to keep his mood or thinking chart.

Ask the family to schedule a family meeting between sessions to review the material you've presented and to talk about any questions they may have or any reactions to the material. Ask them to share some of those questions or reactions with you at the beginning of next week's session. Also, ask them to notice sources of stress in their lives, as this will be the focus of next week's session.

Set up the next meeting time.

Sessions 3-4 Overview: Development of The Prevention Plan

In the psychoeducational sessions that follow, you'll find specific strategies for managing symptoms among teens and young adults with bipolar or psychosis symptoms. The overarching goal of these psychoeducation sessions is to develop a *Prevention Plan*, which identifies:

- Early warning signs of symptom intensification
- Stressors that may be provoking symptom intensification
- Coping skills the youth can use to manage the symptoms,
- Ways that family members can help the youth to reduce stress, and
- Strategies to overcome obstacles that can be undertaken by the youth and his or her relatives at key points in the symptom escalation.

The family will develop this plan over sessions 3-4. The specific sessions cover the following:

Stress

- Identification of relevant stressors that may elicit symptoms
- Identification of typical reactions to stress
- Development of the “stress thermometer” that will help IPs and family members communicate about their experiences of stress

Coping: Building a Tool Box

- Identification of coping skills the youth can use to manage symptoms, which may include sleep/wake cycle regulation, behavioral activation plans (e.g., pleasant events scheduling), relaxation training or mindfulness meditation, and maintaining consistency with a medication regimen.

Prevention Plan

- Pulling all of the strategies together into an action plan. The plan will be most successful if it is developed when the youth is less symptomatic, so that he or she has maximum ability to practice skills that will be needed should symptoms intensify.

Session 3: Identifying Stress and Coping Strategies

1. Joining/Check In
2. Review weekly practice assignment (family meeting; mood charts)
3. Stressors: Facilitate a discussion of the main stressors the IP and other family members are dealing with in their lives. Use the handouts to the extent that they are useful for a particular family in supporting this goal.
4. Stressors: Help family members to identify how they experience and express stress. Do family members differ in their expressions of stress? Do they know when they are starting to experience stress at a low level so they can catch it and cope with it early? (stress thermometer)
5. Coping Strategies (include medication information and adherence and sleep habits as indicated).
6. Assign homework (mood charts; stress or coping skill exercise)
7. Plan for next session; Joining/Closing

Handouts Needed:

- 6 (Sources of Stress)
- 7a (Stress and Coping Thermometer)
- 7b (Coping Ideas List)

Optional:

- 8 (*Medications Commonly Used in Outpatient Settings*)
- 9 (*Good Sleep Habits*)
- "*Pleasant Events*" Lists (*optional handouts*)

Goals of session 3

The first goal of this session is to help the IP and each family member to identify stressors from different domains of their lives, such as stress generated by the family, the school and the work contexts. Family members may be able to identify their own typical reactions when they are feeling "stressed out" (e.g. "I get angry, withdrawn, I reach for a cigarette, I get high"). The second goal is to develop a list of coping strategies that will become an important component of the prevention plan.

Review practice from last week

Check in with the IP: has s/he filled out and brought in the mood chart? If so, what has s/he learned from it so far? What are some of the connections between mood and sleep? How variable has her mood (or thinking patterns/paranoia) been?

Hopefully, she has brought it in and you can examine it with her: "sounds like you had some ups and downs last week. Why do you think you were so down on Thursday?" Or, "Have you noticed how much your sleep times change throughout the week? Do

you think that affects your mood (or your thinking processes)?" If the IP is complaining about paranoia: "Do you feel more/less suspiciousness when you've had a change in your sleep hours?" Review other family members' completed mood charts as well. Note any patterns you may see across the family as a whole, or between particular family members.

If they did have a family meeting, how did it go? Did they talk about any of the content of the sessions? Did they start to think about the various sources of stress in their lives?

Clinical Tip:
Addressing Homework Noncompliance

Many of your patients and family members will come in without having completed any of the practice assignments you recommended. *You will be less frustrated by this if you expect it to happen.* For example, assume that, even if you've explained the mood chart well, the IP will not have filled it out, and the family members may have no memory of it.

Take a low key approach to noncompliance. Say, "How about we try filling one out now?. How is your mood today? How high/low? Have you had any of the suspiciousness you described last week?"

"Let me explain again why I think this will be useful. A mood chart will help you see whether you have lots of ups and downs during the week, and whether these changes are related to your sleep. Later, we may be able to figure out how stress affects you, and for how long. Does this seem like it would be useful? Would it be good if your (mom, dad, sister) reminded you to do it?"

Likewise, if the family did not have a family meeting, normalize it (e.g., "lots of families have trouble finding a time when everyone can sit down for 15 minutes and have a discussion. It can be like herding cats. But is there a natural time when you're all together, like after dinner?"). Explain again how a family meeting will help them get more from the treatment. It will allow them to generate questions for you, practice skills, and learn to collaborate more effectively in the IP's problems.

If they did not have a family meeting, ask them why: was it a scheduling problem? Were they unclear why they were meeting? Briefly problem-solve with them regarding how they could make it happen in the upcoming week. We would like them to establish this routine while they are in FFT.

Do not rush through the review of the practice assignment. If we don't convey interest in what they have done between sessions, they will view the homework as unimportant. If they have engaged in practice assignments, praise them and ask them to show you the chart and talk about what they observed/learned.

Identifying Stressors

“As we talked about last week, stressful experiences can lead to symptom intensification. A first step in containing stress is to identify the various sources of stress in our lives. When stress remains “invisible” and unidentified, it can wreak the most havoc. Once we know where stress is coming from, we can think about how to deal with it more effectively.”

Distribute **Handout #6, “Sources of Stress,”** to each family member.

“This handout shows the types of events that typically generate stress for people. There are **major life events** such as when someone in your family dies or you move to a different house.

Even positive events like the birth of a new brother or sister can also cause stress. Why do you think these positive events are considered stressful?” (They are emotional events and often require change in routines)

If you have a **sudden change in routines**, like when the school year starts or you start a new job, that can feel pretty stressful. Having a predictable routine helps to keep stress low.”



“**Daily hassles** such as driving in traffic or forgetting homework assignments can be stressful too. These are the small stressors that are often “invisible” in that we don’t stop and deal with them like we do with something big. We may not realize the toll they are actually taking because they pile up little by little. Have any of these experiences happened to any of you?”

“Conflicts with others, especially family members, but also friends or teachers can be very stressful. Isn’t it interesting that not enough activity, “boredom,” can generate stress as well? Humans seem to need a balance between too much and not enough activity to minimize stress.

Some may be surprised to hear that boredom or not having enough to do can generate stress, partly due to too much time left for rumination or worry. Sitting on the couch and watching TV for hours can seem like a “low stress” thing to do, but can generate stress when an individual starts to feel uncomfortable about not making more progress in their schoolwork or social life. Also, a lot of sedentary activity may throw off sleep wake cycles, such that it is hard to sleep at night and feel rested the next day.

The Stress Thermometer

Ask each family member to talk a bit about what his/her experience of being “stressed out” tends to be like. Do family members know they are stressed out because they feel irritable and they snap at others? Do they have a lot of negative or critical thoughts

whirling in their heads? Do their bodies feel tense and their shoulders hunch way up? Do they find themselves declining social invitations and shutting down?

It will be useful for the IP and family members to become aware when they are getting stressed out so they can catch it early, at a time when they can cope most effectively.

Also, it is helpful for each family member to become skillful at identifying other family members' signs of distress. Every person reacts to stress differently. While one person may get quiet when overwhelmed by stress another person may become very chatty and another argumentative. Once family members understand each other's signs of feeling stressed, they are more likely to be able to help each other more effectively by providing space or reducing expectations, or providing emotional or practical support during times of stress.

Distribute Handout #7a, “Stress and Coping Thermometer,” to the IP and each family member. Much as one might do in DBT, the purpose of this handout is to:

- 1. Identify Stressors:** Explore recent events, even minor ones that have led to mood swings, rage reactions, or periods of depression.
- 2. Identify different levels of distress.** Help them describe the feeling states (or bodily sensations) associated with different amounts of emotional distress. For example, high emotional distress may mean paranoia, intense anxiety, severe irritability, or severe depression. Medium distress might be “feeling overwhelmed”. Low distress may mean feeling jittery, “kind of bummed,” or “ticked off”.
- 3. Identify Coping Strategies.** Make an initial list of things the IP can do to make himself feel better, preferably activities that involve other family members or other persons who can introduce some balance into the situation.

Handout #7A
Stress & Coping Thermometer

	Stressor	Self-Coping	Family Coping
High Stress	Ex: Argument with friend	Ex: Take a walk, read a book	Ex: Watch a movie with me
Medium Stress			
Low Stress			

You can explain the following:

“In the next two sessions, we’re going to be developing a prevention plan to help you get better control over your mood swings (or thought problems). First, we’re going to figure out what causes distress for you. Then we can develop a plan to help you manage your distress levels. Sometimes just having a plan can provide some immediate relief.”

Start by asking the IP to imagine recent events that have been associated with feeling upset, angry, or enraged. Being told to stop playing a video game might make a teen feel annoyed or frustrated but not overtly angry (lower distress), whereas being grounded for a week might provoke a rage reaction (high distress). You can also identify events, including positive ones, associated with “happy” or “very happy” (i.e., hypomanic or manic) moods (e.g., getting accepted for a date). When discussing a

stressful event, ask the IP, “when that happens, how would you rate your mood, from 1-10?”

Family members may want to chime in about specific events that caused stress for the IP or for themselves (e.g., “when I got a call from her teacher”). The main purpose of this task is to begin to develop the Prevention Plan. Try not to get in to problem-solving just yet. Right now, we are only asking them to identify what it feels like in their body or how they behave and express themselves when they are under varying levels of stress.

Over time they will better understand what types of events are most stressful for the IP and other family members. Perhaps social situations provoke the strongest stress reactions for one family member while school tests or homework assignments provoke the strongest reactions for the IP. The stress thermometer may be a useful tool for individuals as they experience life events, implement coping strategies, and then reevaluate their distress level to see if their coping efforts have been effective.

Mobilizing Coping Efforts

The next step is to start to list efforts the IP and family can take to cope with stress and changes in mood.




The following strategies will likely be useful for the IP in coping with stress and the resulting symptomatic changes (see Handout 7b: Coping Ideas List, below):

- Talking to others, especially supportive interactions with family members or friends
- Positive self-talk
- Pleasant life events scheduling
- Staying on a regular medication regimen
- Using relaxation or meditation exercises

In the sections that follow, we will consider several of these coping options. There are other possibilities as well, as described in the Optional Topics below.

Coping with stress

Distribute **Handout # 7b: Coping Ideas List**. Explain that a coping strategy is really just a way of dealing with stress. Some strategies may help you to feel better or less upset about the problem, while other strategies may help to actually solve the problem directly. Ask the IP and other family members which of these strategies they've used at times of stress. Have they worked well? Do they feel could benefit from new strategies? What additional strategies do they think might be useful? This discussion will allow family members to learn about the types of coping strategies that each person tends to use now, and often leads to additional suggestions for coping.

Handout # 7B Coping Ideas List		
 Feeling	 Doing	 Others?
Communicate your feelings to your family members	Do jumping jacks, run up and down stairs, do push-ups, ride your bike	
Cuddle with your pet or favorite stuffed animal	Count breaths, count clouds, count sounds, count colors, count cars	
Put on your most comfy clothes and calm music	Take a cold shower, take a hot bath, hold some ice cubes, lay in the sun	
Do something nice for another person in your family	Listen to music, play music, dance to music, go to a concert	
Cry for a few minutes if needed	Hang out with a close friend	
Tell someone you love them	Play with your pet	
Homework: Try one of the above each day between sessions. Note which are most helpful.		

For example, consider a 19-year old with early-onset psychosis who says that he is having a hard time in math class. He sits in the front of the classroom and feels like everyone is staring at him, until it becomes “really distracting and uncomfortable.” The way the youth copes with those feelings during class is to imagine that he is somewhere else. While this helps with managing his feelings of self-consciousness, his math grade has been dropping. Family members suggested talking to the teacher and asking for a change in seat assignment. One of his parents was willing to assist him with this request. The clinician also suggested some brief mindfulness exercises before he goes into class.

Developing a Toolbox of Coping Strategies

At this point in the treatment, you are likely to have a much clearer sense of the stressors that are present in the individual, family, and school/work contexts for the IP, and of the strategies that s/he is currently using to cope with those stressors. During session 3, you have the opportunity to introduce the importance of **scheduling pleasant life events, medication adherence and sleep regulation** (often issues for young bipolar and psychosis patients) or one of the other coping strategies discussed in the Optional Handouts (school accommodations, relaxation training, mindfulness, social skills training). For example, you can let them know about relaxation techniques or mindfulness exercises that might be useful for reducing anxiety or getting to sleep at night; pleasant event scheduling if they are feeling down because there aren't enough rewarding interactions going on in their lives; social skills exercises if identifying potential friends and initiating contact have been stressful. If there is another stress-related issue and skill that might be relevant, this session provides you with the time to teach that skill.

In developing a list of coping strategies, consider whether you should introduce a new skill now or whether it belongs in another part of treatment. For example, consider a family who has raised the problem of the youth's medication inconsistency. You may want to address this issue now, in the context of education about symptoms, the vulnerability/stress model and the increased likelihood of recurrence with nonadherence. Alternatively, you may decide to wait until you've taught basic problem-solving skills, especially if the nonadherence has to do with concrete issues such as forgetting to take medications, for which there might be practical solutions.

Another example: Sleep-wake cycle regularity. For most youth, suggesting regular sleep/wake patterns is useful. However, the way in which the youth implements these skills varies widely: One patient may benefit from an earlier bedtime, and another from not “sleep-bingeing” during the weekends. If you want to address the issue now, you will probably need to enter problem-solving mode to help the youth generate a sleep plan, rather than just presenting regular sleep as a good thing to do.

Pleasant event scheduling, relaxation training, or social skills training may also be introduced later on, during a problem solving session. Basically, as opportunities arise throughout the therapy, you are helping the family to develop a “toolbox” of coping strategies that they may use as needed.

Optional Topic 1: Pleasant Events Scheduling

Often the IPs we see do not have enough enjoyable activities in their lives. They are isolated from peer and school/work satisfactions, and spend inordinate amounts of time with technology (computers, televisions, etc.) or sleeping. This may be due to depression, negative or positive psychosis symptoms, social anxiety, and/or medication side effects. Sometimes by talking about the patient's reasons for avoiding activities, the therapist and family can figure out strategies that may help the patient to re-engage. We typically ask family members about activities they enjoyed in the past, but that they aren't currently involved in, or anything they would like to do but haven't been able to get started for whatever reason. We may brainstorm regarding how they could get those activities back in their lives. Alternatively, consultation with the treating psychiatrist may lead to medication changes that alleviate the problem for the youth.

In other cases, however, the reason for the inertia is not clear, and youths may seem pretty stuck in very restricted lives. Enticing them back into engaging more actively with their community, family, and peers and helping them to find greater satisfaction are important steps on the road toward higher functioning. Explain to the family that it is difficult to cope with the many stressors one encounters in life if there isn't a "stock pile" of pleasant experiences to balance the situation. It would be great if the youth could start enjoying him/herself more.

Sometimes it is the case that families have become immobilized by the symptoms and have stopped enjoying pleasant activities together. It is difficult to communicate well if family members are not sharing some fun times together. So, the pleasant event list may support individuals and families in creating more pleasurable and collaborative experiences in their lives.

Pleasant Events	
1.	Go to a sporting event
2.	Go to a museum
3.	Play cards
4.	Talk on the phone
5.	Learn a new hobby
6.	Do an art project
7.	Go out to eat
8.	Take a bath
9.	Read a book or a magazine
10.	Cook/Bake something new
11.	Do a puzzle
12.	Go for a drive
13.	Take a fun class
14.	Go see a music show
15.	Go to a movie
16.	Go to the local dog park
17.	Shoot some pool
18.	Go to a coffee shop
19.	Go on a day trip
20.	_____
21.	_____
22.	_____
23.	_____
24.	_____
25.	_____



Pleasant Events	
1.	Listening to music/radio
2.	Sharing a new hobby (collecting something?)
3.	Drawing, doodling, or painting
4.	Taking a walk
5.	Going to the beach/lake
6.	Daycycling
7.	Cutting pictures from magazines or newspaper
8.	Reading a book, magazine, newspaper
9.	Going to the library and reading a newspaper in another language
10.	Looking through travel books in a library or a bookstore
11.	Cooking a nice meal
12.	Learning how to play an instrument
13.	Beginning a new physical fitness program
14.	Exercise (running, hiking, swimming, soccer?)
15.	Cleaning (rooms, kitchen, car)
16.	Taking care of pet (fish, dog, cat)
17.	Gardening
18.	Going shopping for food and trying new items
19.	Writing (a letter to someone, a poem, a story)
20.	Journaling
21.	Going out to eat
22.	Going for a drive
23.	Taking photographs
24.	Looking at pictures
25.	Making a gift for someone
26.	Doing a puzzle
27.	Playing cards
28.	Talking on the phone
29.	Going to a museum
30.	Going to a science center and/or IMAX
31.	Soaking in the bathtub or the hot tub
32.	Planning a family vacation
33.	Planning a fun and inexpensive outing with friends and then figuring out how to make it happen
34.	Going apple picking in the fall
35.	Going surfing, boogie boarding, or body surfing
36.	Saving money for a special trip or a new gadget
37.	Assembling a model car or airplane
38.	Organizing a game night with friends
39.	Joining a gym
40.	Going swimming at the Y or other local pool
41.	Taking Karate, judo, or yoga class
42.	Thinking about the people in your life who really care about you
43.	Making a list of things you would like to do during your life or places you would like to go
44.	Flying a kite
45.	Going on a picnic with a friend
46.	Having an interesting discussion with a friend
47.	Upping around the house
48.	Going camping
49.	Making a list of the things you like about yourself
50.	Ice skating
51.	Sailing
52.	Surprising your parents by making them breakfast
53.	Doing something kind for someone
54.	Playing tennis
55.	Going to a play or concert
56.	Going to a sporting event
57.	Playing with animals
58.	Dancing
59.	Doing crossword puzzles or Sudoku
60.	Roast marshmallows over a fire
61.	Go bowling
62.	Doing woodworking
63.	Read a joke book with friends
64.	Starting a notebook, in which you save your best papers, notes, and teacher's comments
65.	Thinking, "I did pretty well" after doing something
66.	Drinking an ice-cold glass of water
67.	Reflecting on how I have improved and ways I would like to continue to improve
68.	Working to develop a new skill of personal quality, such as patience, organization, flexibility, good humor, etc.
69.	At the end of each day, ask your family members to talk about the funniest thing that happened at school or work
70.	_____
71.	_____
72.	_____
73.	_____

We share with them one of the above lists of “Pleasant Events” which are modifications of the Adult Pleasant Event Schedule found in the Skills Training Manual for Borderline Personality Disorder by Marsha Linehan (1993). There are multiple versions of this list, so select the handout that you believe will be most appropriate for the family. The goal in using this list is to get them to broaden their thinking about possible events they can schedule into their lives.

Have family members take turns reading items from the list aloud, and ask each of them to circle the events that pique their interest. After the family has reviewed the list, you can invite them to add some ideas of their own to the list. Then you can ask that they spend a few minutes picking out a few of the activities they have circled that they would be willing to try over the next few weeks.

After they have each identified several activities they would be willing to try, spend some time developing an action plan with each of them regarding when and how they can make sure to follow-through with these activities. Help them schedule the events as clearly and specifically as possible.

This activities list is particularly useful when the parents have tried repeatedly to suggest activities, or require activities of the youth and this process of trying to get the youth to become more active has turned into a tension filled power struggle within the family and perhaps within the therapy room during a particular session. In these cases, one goal of introducing this “pleasant activities for families” list is to decrease the tension in the family and to change the dynamic in the room from one of the parents pushing and youth resisting to a process in which we encourage the IP to try something new. When the family members read through the list we want them to linger on items that may spark memories of particularly good times shared together, and to talk about those experiences. By reflecting on these pleasant events, we may create a different mood and atmosphere in which the youth feels a little more flexible and receptive. We would like to rekindle interest in some activities that he/she used to enjoy but has forgotten about, or entice the youth to try something novel that he/she hasn’t thought about before.

Also, we would like to support the family in having some enjoyable experiences together. Usually warmth and connection “grease the wheels” for all of the communication and problem solving training to follow. Do not be put off if the youth says that the items are stupid; instead, ask the parent(s) if they have better ideas. Allow them to laugh about the items together. For example, while reading through the list of pleasant family activities, one youth commented that the item about reading the newspaper in another language was totally ridiculous and should be on a list of homework assignments rather than of pleasant events. After everyone laughed, his mother reminded him that she routinely reads the newspaper in Spanish, and that in fact most of the family’s favorite recipes have come from that newspaper. The son asked her why they haven’t had paella in a while, and she reminded him that he is the best paella maker in the house. They decided to go shopping for ingredients together that weekend and to cook some other favorite dishes as well.

Another youth read the item about “drinking an ice cold glass of water” and laughed out loud mockingly. He thought that was a ridiculous pleasant event and couldn’t believe that we would have something that stupid on the list. We asked him if he ever

had the experience of drinking water after a long walk, and he agreed that it could actually be quite pleasant. That led to a discussion of all kinds of simple pleasant experiences that often get overlooked because we are too preoccupied to really pay attention to them. The family talked about how humans seem to be wired to focus on negative things that happen or problems that are unresolved rather than ruminating about all of the hundreds of pleasant little moments that occur every day. The family was encouraged to shift their focus for a week to appreciating small pleasant moments (see Mindfulness exercises).

Another youth and mother that were at an angry impasse during a session because the youth was refusing to do anything active. They read through the list and it stimulated a discussion of how they used to take their dog out for a walk together every evening. The mom started recounting stories about how the dog had stolen a gentleman's hat one time and led them on a merry chase, and the son remembered how the dog constantly chased rabbits and squirrels, but never actually managed to catch one.

They wondered about why they were able to enjoy walks together when the dog was alive, but had such difficulty now. The son suggested that it was because they had the dog to entertain them and they didn't have to talk. The son said "Now whenever we walk my mom asks me non-stop questions about how I'm doing in this class or that one, which is really annoying and I don't wanna go." They agreed to try taking a few walks during the week provided that conversation was held to a minimum (or the mother would save up entertaining stories to tell and would not ask the son any questions about school).

Optional Topic 2: Medication Nonadherence

(Address this issue if you have reason to believe the IP has been inconsistent with medications – whether these are mood stabilizers such as lithium, Depakote or Lamictal or atypical antipsychotics like Risperdal, Seroquel, Latuda, or Abilify).

Often, during the education component of FFT, the issue of medication nonadherence emerges. This is an important issue for individuals with psychiatric disorders in general, and is even more pertinent to adolescents and young adults. At one time or another, many of our adolescents or young adults have either forgotten doses of medication, "played with" the doses and times to take the medication, or ceased taking their medications altogether. In most cases the parents were unaware until they began noticing emergent/intensified symptoms in the adolescent or young adult.

FFT assumes that people are more likely to commit to a regimen of psychotropic medications if:

- (1) they receive information from mental health professionals about their symptoms and how the medications may help;
- (2) they are approached with compassion and with the position that taking medications doesn't change one's identity;
- (3) it is their own decision and not one foisted on them by others; and
- (4) dosages can be adjusted or other medications substituted to control side effects.

Clinical Tip:
How do you ask about medication adherence?

The most effective way to assess nonadherence is to ask about it directly:

- Do you have any difficulty taking all of your prescribed medications?
- How often do you try to cope on your own without the medication?
- Many people miss taking their medications from time to time; how has it been for you?
- In your opinion, will medications help you to attain your personal goals?
- How often have you missed your medications in the last week?

Sometimes it helps to give the family a handout summarizing the various medications he or she is taking (Handout 8). Use this handout if you think your patient and family would benefit from knowing what his or her medications are doing; which ones are meant to stabilize mood and which work on psychotic thinking or hallucinations (atypical or typical antipsychotics) and which are antidepressants, anxiolytics or sleep medicines.

Handout # 8																																											
Medications Commonly Used In Outpatient Settings																																											
Mood-Stabilizers: To regulate ups and downs <table> <tr><th>Generic Name</th><th>Brand Name</th></tr> <tr><td>Lithium Carbonate</td><td>Escalith, Lithonate</td></tr> <tr><td>Lamotrigine</td><td>Lamictal</td></tr> <tr><td>Divalproex Sodium</td><td>Depakote</td></tr> <tr><td>Carbamazepine</td><td>Tegretol, Carbetrol</td></tr> <tr><td>Oxcarbazepine</td><td>Trileptal</td></tr> </table>		Generic Name	Brand Name	Lithium Carbonate	Escalith, Lithonate	Lamotrigine	Lamictal	Divalproex Sodium	Depakote	Carbamazepine	Tegretol, Carbetrol	Oxcarbazepine	Trileptal																														
Generic Name	Brand Name																																										
Lithium Carbonate	Escalith, Lithonate																																										
Lamotrigine	Lamictal																																										
Divalproex Sodium	Depakote																																										
Carbamazepine	Tegretol, Carbetrol																																										
Oxcarbazepine	Trileptal																																										
Antidepressants: To improve mood, help with anxiety <table> <tr><th>Generic Name</th><th>Brand Name</th></tr> <tr><td colspan="2">Serotonin-Reuptake Inhibitors:</td></tr> <tr><td>Fluoxetine</td><td>Prozac</td></tr> <tr><td>Sertraline</td><td>Zoloft</td></tr> <tr><td>Paroxetine</td><td>Paxil</td></tr> <tr><td>Fluvoxamine</td><td>Luvox</td></tr> <tr><td>Citalopram</td><td>Cilexat</td></tr> <tr><td>Escitalopram</td><td>Lexapro</td></tr> <tr><td>Vilazodone</td><td>Vibryd</td></tr> <tr><td colspan="2">Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs):</td></tr> <tr><td>Venlafaxine</td><td>Effexor</td></tr> <tr><td>Desvenlafaxine</td><td>Pristiq</td></tr> <tr><td>Duloxetine</td><td>Cymbalta</td></tr> <tr><td>Levomefepiprin</td><td>Fetzima</td></tr> <tr><td colspan="2">Atypical Antidepressants:</td></tr> <tr><td>Bupropion</td><td>Wellbutrin</td></tr> <tr><td>Mirtazapine</td><td>Remeron</td></tr> <tr><td>Vortioxetine</td><td>Brintellix</td></tr> <tr><td>Desvenlafaxine</td><td>Pristiq</td></tr> <tr><td>Duloxetine</td><td>Cymbalta</td></tr> <tr><td>Levomefepiprin</td><td>Fetzima</td></tr> </table>		Generic Name	Brand Name	Serotonin-Reuptake Inhibitors:		Fluoxetine	Prozac	Sertraline	Zoloft	Paroxetine	Paxil	Fluvoxamine	Luvox	Citalopram	Cilexat	Escitalopram	Lexapro	Vilazodone	Vibryd	Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs):		Venlafaxine	Effexor	Desvenlafaxine	Pristiq	Duloxetine	Cymbalta	Levomefepiprin	Fetzima	Atypical Antidepressants:		Bupropion	Wellbutrin	Mirtazapine	Remeron	Vortioxetine	Brintellix	Desvenlafaxine	Pristiq	Duloxetine	Cymbalta	Levomefepiprin	Fetzima
Generic Name	Brand Name																																										
Serotonin-Reuptake Inhibitors:																																											
Fluoxetine	Prozac																																										
Sertraline	Zoloft																																										
Paroxetine	Paxil																																										
Fluvoxamine	Luvox																																										
Citalopram	Cilexat																																										
Escitalopram	Lexapro																																										
Vilazodone	Vibryd																																										
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs):																																											
Venlafaxine	Effexor																																										
Desvenlafaxine	Pristiq																																										
Duloxetine	Cymbalta																																										
Levomefepiprin	Fetzima																																										
Atypical Antidepressants:																																											
Bupropion	Wellbutrin																																										
Mirtazapine	Remeron																																										
Vortioxetine	Brintellix																																										
Desvenlafaxine	Pristiq																																										
Duloxetine	Cymbalta																																										
Levomefepiprin	Fetzima																																										
Antipsychotics: To provide mood stabilization, control agitation, hallucinations or distorted thinking; to help with sleep <table> <tr><th>Generic Name</th><th>Brand Name</th></tr> <tr><td>Olanzapine</td><td>Zyprexa</td></tr> <tr><td>Risperidone</td><td>Risperdal</td></tr> <tr><td>Quetiapine</td><td>Seroquel</td></tr> <tr><td>Ziprasidone</td><td>Geodon</td></tr> <tr><td>Aripiprazole</td><td>Abilify</td></tr> <tr><td>Lurasidone</td><td>Latuda</td></tr> <tr><td>Paliperidone</td><td>Invega</td></tr> <tr><td>Asenapine</td><td>Saphris</td></tr> </table>		Generic Name	Brand Name	Olanzapine	Zyprexa	Risperidone	Risperdal	Quetiapine	Seroquel	Ziprasidone	Geodon	Aripiprazole	Abilify	Lurasidone	Latuda	Paliperidone	Invega	Asenapine	Saphris																								
Generic Name	Brand Name																																										
Olanzapine	Zyprexa																																										
Risperidone	Risperdal																																										
Quetiapine	Seroquel																																										
Ziprasidone	Geodon																																										
Aripiprazole	Abilify																																										
Lurasidone	Latuda																																										
Paliperidone	Invega																																										
Asenapine	Saphris																																										
Medications to improve attention and concentration <table> <tr><th>Generic Name</th><th>Brand Name</th></tr> <tr><td>Methylphenidate</td><td>Ritalin, Concerta</td></tr> <tr><td>Dextroamphetamine</td><td>Focalin</td></tr> <tr><td>Mixed Amphetamine</td><td>Adderall</td></tr> <tr><td>Dextroamphetamine</td><td>Desoxine</td></tr> <tr><td>Lisdexamfetamine</td><td>Vyvanse</td></tr> <tr><td>Guafacine</td><td>Tenes, Intuniv</td></tr> <tr><td>Atomoxetine</td><td>Strattera</td></tr> </table>		Generic Name	Brand Name	Methylphenidate	Ritalin, Concerta	Dextroamphetamine	Focalin	Mixed Amphetamine	Adderall	Dextroamphetamine	Desoxine	Lisdexamfetamine	Vyvanse	Guafacine	Tenes, Intuniv	Atomoxetine	Strattera																										
Generic Name	Brand Name																																										
Methylphenidate	Ritalin, Concerta																																										
Dextroamphetamine	Focalin																																										
Mixed Amphetamine	Adderall																																										
Dextroamphetamine	Desoxine																																										
Lisdexamfetamine	Vyvanse																																										
Guafacine	Tenes, Intuniv																																										
Atomoxetine	Strattera																																										
Benzodiazepines: To control anxiety, improve sleep and induce calm <table> <tr><th>Generic Name</th><th>Brand Name</th></tr> <tr><td>Lorazepam</td><td>Ativan</td></tr> <tr><td>Clonazepam</td><td>Klonopin</td></tr> <tr><td>Diazepam</td><td>Valium</td></tr> <tr><td>Alprazolam</td><td>Xanax</td></tr> </table>		Generic Name	Brand Name	Lorazepam	Ativan	Clonazepam	Klonopin	Diazepam	Valium	Alprazolam	Xanax																																
Generic Name	Brand Name																																										
Lorazepam	Ativan																																										
Clonazepam	Klonopin																																										
Diazepam	Valium																																										
Alprazolam	Xanax																																										

Try not to get into a prolonged discussion with the IP or family about medication choices or side effects. If they have concerns about side effects (e.g., weight gain on antipsychotics; trembling hands on lithium) or dosages, refer them to their psychiatrist or GP. This is especially true for FFT clinicians who are also psychiatrists; the family may lean on you for information about the choice of medications or how to adjust them, and the focus of the sessions may get lost. Avoid stepping into the role of the pharmacologist. If you are seeing the patient in

consecutive meetings for FFT and medication management, ask them to hold their questions for the medication management session.

Note that when families start discussing medications, you may see dynamics emerge that you hadn't seen before. For example, a parent who has made a strong case that the diagnosis is stigmatizing may also give the child a mixed message about the necessity of medications. Two divorced or separated parents may give conflicting messages about the importance of sticking with the regimen. Treat these inconsistencies like you would any other family issue where one coalition of family members develops in opposition to another: by pointing out differences in opinion among parents or other family members, asking the youth whether he or she has found these varying opinions to be confusing, and encouraging an open discussion about the need for medications, diagnosis, or related issues. If the issues can be resolved (or at least clarified) with family education, communication training or problem solving, spend some time coaching the family accordingly.

Case Example: Alicia, age 17

One family called between sessions to talk about their concern about their 17 year-old daughter Alicia. They said that Alicia had become more defiant, impatient, silly, and had been sleeping less; she had also become irritable and withdrawn, and had received failing grades on two tests over the past week. They were unsure as to what they should attribute her change in behavior. After several days of this change in behavior she told her parents that she had not been taking her medications for the last seven days. Her parents called to make sure that we would spend time on this issue in the next session. This event provided an opportunity to educate the IP and family members about medication nonadherence and to talk about prevention.

Therapist: So, it sounds like there was a week where you stopped taking your lithium and Lamictal.

Alicia: Yeah.

Therapist: And are you back to taking it now?

Alicia: (pauses). Yeah, I guess.

Therapist: What made you decide to stop taking it? The last time we met you said that it was really helpful to you.

Dad: She quit taking her medicine because she wanted to drink on her birthday and the doctor told her that she couldn't drink and take her medicine too.

Alicia (*defensive*): That's not true! You always think the worst.

Mom: Well, why did you quit taking it?

Alicia: I was just feeling a lot better and I wanted to see if I still needed it. So obviously I do, and you win (*stated dejectedly*).

Therapist: Alicia, you have some feelings about having to take medications to make yourself feel better and I'd like to hear more about those. I'd also like to hear more about this increase in your symptoms and how your family dealt with it (*organizes discussion around prevention*)

Dad: Well, this time things certainly seemed to go a little better. We got into the same kind of conflicts we've gotten into before which led to Alicia moving out and all that stuff you know about. This time we just asked her what was going on and that she seemed like she was having more symptoms and that kind of diffused the situation, and she didn't just walk out.

Alicia: I almost did.

Therapist: (to Dad) So it sounds like you noticed that she was experiencing more symptoms, and this time you were able to talk about it instead of getting into a fight. (*reinforces family for coping efforts*)

Dad: Yes, it seemed to make a difference. But it's been hard.

Alicia: Hard for you???

Therapist (*ignores provocation*): It's difficult for parents when they see their kid doing so well and then they go off of their meds and things get really difficult again. But let's talk about why people quit taking their medication – Alicia, you're not alone in all of this. Are you OK with us talking about this?

Alicia (*noncommittal*): Yeah. Whatever.

Therapist: Let's talk about some of the reasons. First, medications have side effects and a person may quit taking them to reduce them. Or, when they start to feel better, as you did Alicia, they think they don't need the medicine anymore. They kind of think of it like aspirin, "I take it when I have a headache and then quit taking it when the headache goes away." And then some people just forget to take their medicines, which is very easy to do when you're busy. Do any of these fit for you, Alicia?

Alicia: The feeling better one. I didn't think I needed it or ever really needed it in the first place.

Therapist: I can understand that, but Alicia, taking your medications is one of the most protective things you can do against having more symptoms, even when you're feeling fine. It's like when people take blood pressure medications – they may feel fine but the meds keep their blood pressure from getting up to dangerous levels. Do you understand how you could be feeling well and you might have to take mood stabilizers to keep it that way?

Alicia: But it's a drag that I have to take medicine for the rest of my life. I hate it.

Therapist: I get that. In fact, that's the other issue I wanted to talk about today. Feeling frustrated with having to take medications is pretty normal. Let's talk about how you can manage that frustration.

Alicia: What's the big deal about going off it anyway? It was only for a few days. I can just take it again if my symptoms get worse.

Therapist: Well, it's actually a bit more complicated than that. Some people stop their medications and then all of a sudden things get much worse.

Mom: You mean it stops working?

Therapist: Yes, for some people that's the case.

Alicia (*pauses*): Look, it's not like I don't care about getting along with my parents, and yeah, it makes me feel more stable or less up and down. It's not bad, but *I just don't like the feeling of being different.*

Therapist: Good point. That's understandable. But you'd be surprised to find out how many of the kids at your school have to take some medication to manage their health. People don't necessarily talk about it.

Alicia: Yeah, I know, I talked about this with Stacy (friend) just yesterday. She takes Adderall and this guy Jeff she's going out with takes some drug called 'Saphrex' or something. I don't know anybody who takes bipolar drugs though.

In this section, the clinician has done several things: clarified Alicia's reasons for believing she doesn't need medication; normalizing those reasons; making analogies between the medical treatment of psychiatric disorders and the treatment of other medical disorders; and educating Alicia and her family about the hazards of nonadherence.

Key Themes in Medication Nonadherence

In our experience, medication adherence among adolescents and young adults can be facilitated by the following:

- Help the adolescent develop cues for pill storage and use (for example, pill boxes, watch alarms, post-it notes, telephone reminders from family members)
- Examine the role of medications in the patient's family or marital relationships;
- Examine subtle or overt pressures from family members to discontinue medications
- Clarify the "symbolic significance" of taking medications (e.g., loss of creativity, fears about giving up one's experiences of emotions, relationships, music, or other pleasures)

In some cases, the issue is "grieving over the lost healthy self," when adolescents or young adults fear that taking medication means giving up aspirations, goals, or their view of themselves as a person with a future. These and related issues are discussed in more depth in *Bipolar Disorder: A Family-Focused Treatment Approach*, 2nd ed. (Miklowitz, 2010).

Importantly, when discussing medications, take an exploratory and validating stance toward the youth. The IP may have already heard her parents (and perhaps her psychiatrist) drive home the point that she will have a recurrence if she stops medicines. It's important to empathize with the IP's feelings about being different. Teens are particularly apt to feel this way, and nonadherence can be a way of testing the waters to see if it's true. This is an opportunity to form a better alliance with the kid, showing that you have some idea of what it might be like to feel different and how those feelings may make you want to prove something to your parents or others.

Who Should be in Charge of the Adolescent's Medications?

While there are no hard and fast rules about this, use the following guidelines when helping a family decide to what extent to hand control over to the young person. These guidelines will be less relevant to young adults.

- If the youth is to take responsibility, he or she must buy into the clinical concerns and treatment plan
- The youth must be cognitively able to handle the dosing requirements
- Issue of boundaries: is the youth more or less likely to take medications if the parents play an active role?
- Older adolescents/young adults are more likely to be able to take responsibility than early adolescents
- Make sure that medications do not become the battleground in which autonomy battles are fought.

In many late adolescents or young adults, battles over medications is a stand-in for battles over autonomy and independence. The key here is to show the adolescent that his or her goals toward independence are more likely to be achieved if her mood is stable.

Optional Topic #3: Addressing Sleep Problems

(Address this issue with most adolescents and young adults – once again, you are in the section on coping strategies for stress, and getting regular sleep and keeping regular routines is a major way to fend off the effects of stress on mood and thinking).

Sleep problems are often a central complaint among IPs with mood disorders and their family members. Fortunately, you can acquaint the parents and IP about the options available to them when they have insomnia or restless sleep. For example, parents can encourage children or younger adolescents to structure their “bedtime ritual” with set times for turning off the television, brushing their teeth, reading, and finally, turning out the lights. Many families do not have a bedtime ritual or even an agreed-upon bedtime for their adolescents. This is not because they haven’t thought of doing this. Rather, the child has been quite resistant to following through.

Pass out Handout 9, “**Good Sleep Habits.**” Spend some time discussing each bullet point with the IP: does s/he have a regular bedtime? What does she do right before trying to sleep? How much do her sleep habits vary from the week to the weekends? If she has been keeping a mood chart and writing down sleep/wake times, you can refer back to these to develop some solutions to the problem of sleep disturbance.

We stress that having the same bedtime and awakening time for the adolescent or young adult may help with this problem. The list below offers many possible alternatives when coping with sleep problems. Specify whether the problem seems more biochemical (i.e., the IP lies in bed and feels too “revved” to fall asleep) or more behavioral (i.e., there are no consequences for the IP for failing to follow an agreed-upon bedtime routine). The solutions may also be quite different for younger and older adolescents or young adults.


One family brought in the bedtime routine as a topic for problem solving. The parents described how difficult it was to get their two adolescent boys (ages 12 and 13) in bed and have them keep the lights out and go to sleep. Once the kids were in bed with the lights out, they were able to fall asleep, but getting them to bed was a major hassle. As a family, they engaged in problem solving and came up with a solution generated by the boys. The all agreed that if the boys got in bed at the agreed upon time with

lights out that they received points toward later purchases (each point was worth \$.50). If they did not follow the agreed upon bedtime plan, their consequence was not having access to “screen time” the next day. This plan did not fully solve the conflict but went a long way toward having shared goals.

Handout # 9

Good Sleep Habits

- Establish a regular bedtime and wake time, even on weekends.
- Avoid caffeine, alcohol, illicit drugs, and other stimulants, especially at night.
- Exercise early in the day, not right before bed.
- Avoid emailing or texting in the bedroom.
- Have an hour-long “wind-down” time before bed.
- Avoid highly stimulating activities right before bedtime.
- Anticipate events that could de-stabilize daily routines.



For older adolescents and young adults, the reinforcers for maintaining a good sleep/wake cycle tend to have to do with access to peers or romantic partners and academics. So, for example, a 19-year old contracted with his parents to be in bed by 12 each night, and up by 8, in exchange for use of the car on weekends.

Try to determine why sleep problems are occurring: are they related to antecedent-behavior-consequence chains or are they highly correlated with other symptoms? Implement an intervention appropriate to the nature of the problem. There are cases where the sleep difficulties are related to unresolved symptoms and may require additional medications. Be sure to involve the treating psychiatrist in designing sleep plans with the family. **Avoid recommending certain sleeping**

pills (including melatonin) unless you are either the treating psychiatrist or you have discussed this with him/her.

Ending Session 3

Reflect

Summarize for the family what you’ve covered today, but do it in a “Socratic” format:

- What kinds of stress affects you most?
- What are the symptoms you experience when you’re under stress?
- What are some of the things you can do when you’re under stress?
 - Pleasant activity scheduling?
 - Sleep solutions?
 - Medication consistency?
- How can your family help you?

Answer Questions and Assign Homework

1. **Ask family members to complete mood charts over upcoming week.**
2. Design a stress/coping assignment that encourages them to think ahead to the next session and practice new skills you have taught them. There are several assignments you can give them:

- To parents and IP: keep having a family meeting, only this time everyone should make a list of stressors that have affected them this week, and how they coped with them. If you haven't completed the handout in session, you can ask them to use Handout 7A before next session.
- To IP: Keep your mood chart, only this time make sure to also track your sleep patterns (or an important stressor, such as homework load, family stress) and take notes.
- Ask family members to complete coping skill "experiments" – try out different coping skills in response to stressors during the upcoming week, and note what did or didn't work to reduce stress.

Try to determine what the IP and family can handle this week. If the session has gone smoothly, err on the side of expecting them to do more. ***Once you have given them an assignment, you may want to ask them to repeat it back to you. If they have not been consistent with homework so far, ask them: what could get in the way of getting this done?***

Session 4: Optimizing Family Support and Drafting the Prevention Plan

1. Joining/Check In
2. Review homework (mood charts; stress or coping assignment)
3. Introduce the role of the family environment
4. Talk with family about what family members do that is experienced as helpful by the IP, and what others do that makes stress worse for him/her. If time allows, ask other family members talk about what is helpful and difficult for them regarding what others do when they are stressed out.
5. Go over handout "How the family can help".
6. Develop a draft of the Prevention Plan, building on coping strategies you discussed in session 3.
7. Assign homework (mood charts; work on prevention plan)
8. Plan for next session; Joining/Closing

Needed Handouts:

- 10 (How the Family Can Help)
- 11 (Prevention Plan)

The main learning objectives during this fourth of four psychoeducation sessions are to (a) explain that the family environment can play a key role in improving the patient's symptoms by reducing the patient's experience of stress and supporting his/her efforts to cope with stress, and (b) help the IP and family develop a prevention plan.

Answer Questions and Review Practice Assignment Related to Coping

Ask the family whether they met and discussed stress and coping, and if they made a list, to show it to you. Review the IP's mood/thinking chart, and ask him if he had any thoughts about the content from last time. Did he/she have any insights into the role of stress in his or her disorder?

Nonadherence with Practice Assignments

If the family did not do their assignments from last week, spend some time discussing this. You are on the fourth session and if they haven't picked up the habit of having family meetings, mood charting, or practicing coping, you will need to explore with them whether they are getting as much as they can out of treatment. Consider the following interchange:

Mother: No, we didn't have a family meeting, and he forgot his mood chart again.

Clinician: So, it sounds like the assignments didn't get done this week.

Mother: Yeah, we were really busy. Holiday shopping, making vacation reservations, all that stuff. But he's been doing better with the Abilify.

Clinician (pauses and waits). (To youth): That's great that you're doing well with the Abilify, and I know this is a busy time of year. But what about that mood chart?

Youth: I don't know, I just decided it wasn't worth the time. My mood is fine and I'm not really changing up or down.

Father: How can you say that after Sunday? Your sister was practically hiding under the table!

Youth: She was not. We were just playing.

Mother: He was really manic. And days like Sunday make me wonder whether the Abilify is at the right dosage (*changing subject*).

(At this point, it would be very easy to slip into discussing medications and mania symptoms. Instead, the clinician forges ahead with discussing homework).

Clinician: Let me hold on this for a minute, because we're all talking about different things. I'm hearing that Carl had trouble getting his mood chart done, and the two of you think that his mood is unstable, but he doesn't agree. Have you discussed that as a family?

Mother: (*pause*) No.

Youth: There's nothing to talk about.

Clinician: So it sounds like family meetings have gone by the way-side.

Father: Well, not entirely. We talked on the way over here.

Clinician: Tell me more.

Father: We talked about what we wanted to talk about here (*laughs, grins at mother*).

Clinician : Such as?

Father: You know, how to communicate better and stuff.

Clinician: That's a start. But tell me, what gets in the way of doing assignments between sessions? I think you'd get a lot more out of this treatment if you did.

Mother: If you came over and organized everyone's schedule so we were all in the same place at the same time, that would help!

Clinician: Well, as you know, I can't come over to your house, but I'll meet you halfway- how about I help you schedule your family meetings? Let's talk about that next. Tell me, are the family meetings difficult in some way? Awkward?

The clinician here has not accepted the idea that the family is too busy. She explored what happens during the family meetings – in fact, there had only been one, right after the first session, and because no one was clear on what they were supposed to do during the meeting, they all went back to what they had been doing. The clinician clarified the purposes of the family meeting and helped them schedule the next one. She put the father in charge of making sure it happened.

She then explored what the kid disliked about the mood chart. Once she had a preliminary agreement from him to try again, she gave them the same set of assignments for the next week (mood chart, family meeting). The clinician ended the discussion with “I want you to get what you can from this treatment, rather than just during the treatment hour. I want you to feel like your time was well-spent,”

Introduce the Role of the Family Environment in Mood or Psychosis Symptoms

Introduce this topic:

“Today we are going to build off of what we have been working on in the past couple of sessions. Last week we talked about stressors and strategies that we can use to cope. Today we are going to focus on what each family member can do to help each other cope with stress, and in turn what each of us can do to make it easier for other family members to help us.”

Start by asking someone other than the IP to say what others in the family have done when s/he is under stress. Ideally, we’d like a husband to say “my wife gives me a back rub” or for the mom to say, “Curt (son) asks me what’s wrong and listens.” Try to redirect the discussion if the family’s first impulse is to blame the IP for making the world stressful for them. We want to know what others do that helps.

Next, ask the IP how each family member responds when he is under stress or has mood symptoms or psychosis symptoms. What do they do when you’re sad? How do they react when you’re irritable? How do those reactions impact the IP? What do family members do that is helpful? Ask the family to think about what would be most helpful to the IP when s/he is symptomatic. And how could the IP express his needs so that he has a better chance of getting support from family members?

If there is time, go through some of the other family members’ stressors as well (or mood problems) and ask them what others could do to be helpful to them in those situations. What do others do that tends to be helpful? What do others do that tends to make matters worse?

Try to work through a couple of examples during the session. At times, parents may have trouble responding to their son/daughter’s symptoms or problems with day-to-day functioning.

For instance, consider a patient that had listed “trouble with focus and attention related to increased sensitivity to sounds,” as one of her areas of concern. Due to the IP’s trouble with attention, she has not been getting her homework done. The patient is so far behind in her classes that she is at risk of failing. The IP,

wanting to do well but unable to focus enough to get her work done, is experiencing a high level of stress. The IP explained that her parents reacted to her poor academic performance by closely monitoring her time spent studying, but she noted that this has made her feel more stressed out and led to increased conflict.

The clinician should (1) ask the IP how she has experienced her family's reaction to this problem, (2) ask the family members if they believe their responses to the IP are working effectively. If not, facilitate a discussion of alternative responses. For instance, in reference to the above example, the patient identified that an alternative helpful response would be to study on her own and then show her parents her homework when she is done with it.

Make sure to encourage alternative responses, as appropriate. For the example being discussed, you might suggest that the parents talk with their daughter's teachers about allowing her to have more time to complete assignments in light of her recent troubles. In addition, you could suggest that the parents decrease their expectations during times of worsening symptoms. If there are two parents, emphasize the importance of "being on the same page" regarding how to address problems that involve their son/daughter. Keep in mind that such discussions are likely to continue throughout the course of treatment and that alternative responses will improve with practice.

No matter how well the discussion has gone, praise them for their openness to talking about what is helpful and not helpful with each other. Allow for them to reflect on the experience a little bit.

Let them know that their ability to listen and their willingness to try new strategies and experiment with various ways of helping each other is a real strength and often leads to more satisfying and effective solutions to problems. Remind them that you will be helping them with these issues more directly when you get to communication training.

Handout # 10

How Can The Family Help?

- Help get treatment and services
- Support use of medication
- Learn about your symptoms so they can respond helpfully
- Maintain a tolerant and low-key home atmosphere
- Help you have regular daily routines and sleep
- Reduce expectations when you are having a tough time with symptoms
- Encourage your participation in treatment
- Get help for other family members if needed
- Do fun things together!

How Can the Family Help?

Much of the material in **Handout 10: How Can the Family Help** has been discussed already, but your families will find it helpful to have it all in one place. Also, this material will be important in the prevention plan. You may need to explain some of these items. 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; or 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 in a discussion of what communication is like at home

and ask whether the family uses specific skills like active listening or praise or acknowledgement. The family can supplement these discussions by reading Chapter 9, “Family Management and Coping” in The Bipolar Teen (Miklowitz and George, 2008).

Concerns about a teenager’s school performance or behavior 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 teen being successful.

When explaining “structure and consistency,” point out that irregular bed times in teens can often be traced to irregularities in the family’s overall routines. For example, if no one in the house eats dinner together, the IP’s dinnertime is likely to vary from night to night. If there are no bedtime rules (for example, the internet is unavailable after 11; the TV goes off at 10; quiet is expected after a certain hour) then the youth is unlikely to get to bed on time. Although older teens and young adults may no longer be tied to the parents’ or younger siblings’ routines, it is not unreasonable to ask the parents to set time expectations such as the above to help the young person regulate his hours.

Tensions Arise During the Discussion of Family Support

Sometimes parents struggle with what they perceive to be a contradictory message. We tell them that they did not cause the symptoms, yet we also tell them that there are things they can do to decrease symptom severity. Some people think that if they have some control over symptoms, then they are essentially blameworthy for causing the symptoms to begin with. If parents start to look uncomfortable, or you suspect that the parents are starting to feel blamed, you can introduce the following material that does help them to see that although they aren’t responsible for causing the symptoms, they still can be helpful with reducing them.

Christopher Amenson, Ph.D of the Pacific Clinics explains that:

“If you are a family that likes to rearrange your house a lot and move the furniture around from room to room every few months to create a new experience of the house, this is not a problem. In fact, it may help keep things fresh and interesting and there is nothing problematic about being this way. However, if you suddenly have a child that gets an illness and becomes blind, you would need to rethink your redecorating habit. Your redecorating didn’t cause the blindness, but now that the situation with your child has changed, you will need to adapt and refrain from moving the furniture because that would cause your child some problems. Your family will need to adapt to the changed situation and find some other ways to have fun as a family.”

After this general explanation, get back to concretizing it for the particular the family, e.g., “In other words, just because Robert is extra-sensitive to loud voices, that doesn’t mean that talking to him loudly made him become that way. But it may suggest that he’ll adapt easier in an environment where people keep their voices down.”

Introduce the Prevention Plan

At this point you have the opportunity to integrate a lot of the material that has been covered into the development of a plan to help prevent symptoms from getting worse. You can draw from the discussion about symptoms, sources of stress, coping skills, and family support to develop an intervention strategy that the family can use if symptoms worsen.

The action plan consists of four steps (SECO):

- (1) identify relevant Stressors and triggers that may be affecting the IP or the family as a whole,
- (2) identify Early warning signs that moods or mental health functioning is deteriorating,
- (3) mobilize efforts to Cope with stressors and early warning signs, and
- (4) plan ways to overcome Obstacles.

In introducing the plan, you can explain that developing a prevention plan is indicated since research has shown that early interventions are much more effective than waiting until symptoms are at a more severe level. Explain to the youth that “this is a

Handout #11 Prevention Plan			
Stressors or Triggers	Early Warning Signs	Coping Skills	Overcoming Obstacles

way to maintain control over your life even when your thinking/mood/energy start to change.”

Provide the family with the **Prevention Plan (Handout #11)**. There are several optional forms of this handout included in the handout packet; select one of these options or generate your own, as appropriate for the family’s needs. Ask them to discuss what should go in each column. Ideally, the IP will be in charge of filling out the form as you go, although

you may also want to appoint a parent or sibling if the IP is resistant.

The following are instructions for completing the 4-column SECO version of the prevention plan. The first column is “Stressors or Triggers.” Invite the family members to pull from the prior discussions on identifying stress, or invite the IP to report on recent stressors from her mood chart. Remind them that stressors can change from week to week. You can also put “triggers” here, such as “my irregular sleep patterns,” “missing several days of medications,” or “fighting with my parents about my room.”

The next column, “Early Warning Signs,” should be familiar to everyone at this point. Remember that EWSs are different from symptoms – these are the first signs that a person is going into an episode of depression, mania, or psychosis, and that functioning is becoming harder. Examples of “Early Warning Signs” might include, “I have more trouble concentrating,” “I seem to need more (or less) sleep;” “my mood gets more irritable,” “it’s harder for me to get my responsibilities done,” or “I am feeling more suspicious of other people and haven’t wanted to go out with friends,” or “It’s harder to get up in the morning.” Family members can draw from the items that they listed in the first column. For instance, for an IP who put that things are going well for

him/her when he/she wants to spend more time with friends, an early warning sign could be, “avoiding seeing friends.”

Sometimes, EWSs are specific to the person. One parent said that her son “gets this wild look in his eyes.” Another parent said that his daughter “starts hiding food under her bed.” Another said that her daughter “gets these big movements, talks with her hands more – it’s like Broadway versus the small screen.” Once a number of EWSs have been listed, encourage the IP to record them on the Plan sheet.

Third, and most importantly, they should list coping/prevention skills. These can be pulled from the prior discussions, which may include some of the items on the “Protective Factors” list:

- Taking medications more regularly
- Sleeping more regularly
- Talking with others about difficult feelings
- Monitoring one’s mood more regularly
- Staying away from alcohol and drugs
- Keeping the household low-key
- Reducing conflicts (e.g., the three-volley rule)
- Engaging in pleasurable activities (e.g., hobbies)
- Exercise

The next column is “Overcoming Obstacles.” The clinician explains that sometimes when things aren’t going as well, it can be more difficult to utilize some of our coping skills. The goal with these columns is to proactively look ahead at obstacles to implementing coping skills that may come up when symptoms arise. These barriers can be overcome more easily if anticipated with an action plan already in place. For instance, when we are feeling healthy and happy, it may be easy to draw on our coping skills such as engaging in hobbies or spending time with friends. However, when we aren’t feeling as well, there can be obstacles to using these much-needed coping skills. A bipolar patient who is currently well and says, “when I’m getting manic and elated, my parents should tell me and bring me back to earth” is unlikely to be this insightful when actually getting manic and elated.

For example, Jonathan, age 23, relied on spending time with friends as a coping skill, but his tendency to withdraw when depressed was an obstacle to using this coping skill. An action plan that was set up ahead of time involved a discussion with his girlfriend when he was doing well. Jonathan informed his girlfriend that his early signs of depression included withdrawing and self-isolating, which inhibited him from reaching out to her or to friends. Together they decided that when Jonathan started to pull away, his girlfriend would take the initiative to draw him out more and become more active in making plans to see each other.

Ramon, age 25, enjoyed the euphoric feelings that came with getting hypomanic or manic. As a result, he did not want to take medications at those times, although he was usually very compliant. He said that “my parents should tell me I’m getting high, and remind me to take them. I won’t like it at the time, but they should do it anyway.”

Melissa, age 19, listed spending quiet time alone in her room as a coping skill. However, one of her early warning signs included a tendency to shut down and not communicate. Family members became concerned by Melissa's withdrawal and thought they were being helpful by constantly checking in and offering suggestions or inviting her to spend time together. This led Melissa to have difficulty communicating her need for alone time. The family developed a "signal" to relieve Melissa from having to explain her need for some space and time alone. In this case, the family decided to have Melissa put a note on her door stating, "Alone time 'til 6pm." This met both Melissa's need for her quiet time along with her parents' need to know that she was okay and that they could check in with her at a specific time.

Answer Questions and Assign Homework

At the end of the session, review the patient's prevention plan worksheet and allow time to answer questions. Be sure to give all participants praise for their efforts.

Remind the family to have a family meeting between sessions and review the materials that were introduced during this session. Encourage the IP to continue filling out his mood chart but also to think about what else could be added to the prevention plan.

Plan for/schedule next session

Let them know that you will be transitioning out of the psychoeducational segment of your work together and into communication enhancement training as a primary focus. You will revisit the prevention plan throughout treatment but the next focus will be on improving the emotional "climate" of the family.

III. COMMUNICATION ENHANCEMENT TRAINING (Sessions 5-8)

Session 5: Overview of Communication Skills; Expressing Positive Feelings

1. Joining/Check In
2. Review homework (mood charts; prevention plan)
3. Discuss Family Members' Current Communication Styles
4. Preview Skills of Communication Enhancement Training
5. Teach Skill #1: Expressing Positive Feelings
6. Assign Homework (mood charts; Catch a Person Pleasing You)
7. Plan for the Next Session; Joining/Closing

Handouts needed:

- 12 (The Five Basic Communication Skills)
- 13 (Expressing Positive Feelings)
- 14 (Catch a Person Pleasing You)

Prior to introducing the second module, review the prevention plan homework and answer any questions that might have come up between sessions. Review the IP's mood chart. If the IP or family are stuck on how to move forward with the Prevention Plan, spend some time discussing it and help them complete the plan.

Background Information Regarding the Communication Enhancement Training

The second module of FFT, communication enhancement training (CET), runs for approximately 4 sessions (sessions 5-8). These sessions are not as tightly structured as the prior sessions. Families learn at different paces, and there may be significant material from sessions 1-4 that needs further review. So, if you have not adequately covered all of the communication skills by session 9, use some of the problem-solving sessions to further practice the skills.

CET is guided by two assumptions. First, aversive family communication reflects distress within the family due to family members' attempts to deal with the IP's symptoms and trouble with functioning. Second, aversive communication patterns can be improved through skill training and practice. CET uses a role-playing format to teach patients and their relatives five communication skills: *giving positive feedback, active listening, making positive requests for change in others' behavior, communication clarity, and expressing negative feelings.*

The purpose of communication enhancement training is to create a home atmosphere that is protective against increased symptoms. These skills – if practiced earnestly - foster a feeling of collaboration between members of a family. However, it may take some time for family members to get used to the role-play format.

For each skill, the clinician gives the participants a handout listing its components (e.g., for active listening: making good eye contact, paraphrasing), and models the skill for the family. Then, the participants practice the skills with each other, with coaching and shaping by the clinician. A practice assignment, in which the participants keep a log of their efforts to use the skills, facilitates generalization to the home setting.

Evaluate Current Communication Style

The communication module begins with a discussion regarding the importance of using good communication skills to create an environment that is calm, clear, and supportive. Good communication skills are typically in each person's best interests: they are more likely to get what they want when they are able to listen to and address each other's concerns.

Ask the family: what currently goes well in your family's communication; what doesn't go so well? Is it any different when _____ has symptoms? How about when (mother or father) are under stress at work?

If someone in the family describes their tendency to get worked up or to yell when something is upsetting, normalize this: "most families do this to some degree. It can be especially difficult to listen to someone else's perspective when you feel like you've been wronged. People get wrapped up in how they're going to respond instead of how to connect with the other person."

Introducing the Communication Skills


Give the family **Handout 12, "Communication Enhancement Skills"**. Then, preview the skills that you intend to teach the family. The key task in CET is role-playing, both inside and outside of the session. It is important for the family to understand the role-playing process. Describe it by saying:

"You are going to learn five communication skills: expressing positive feelings, active listening, communication clarity, making positive requests for change, and expressing negative feelings about specific behaviors. You'll be learning the skills through role-playing. This means that we will be asking you to turn your chairs to each other and practice new ways of talking and listening. It may be a little awkward at first but you'll be surprised at how quickly you get used to it when everyone else is doing it too. In fact, it can be fun for the family to try out these new ways of talking to each other."

Handout # 12

The Five Basic Communication Skills

- Expressing Positive Feelings
- Active Listening
- Communication Clarity
- Making Positive Requests for Change
- Expressing Negative Feelings about Specific Behaviors



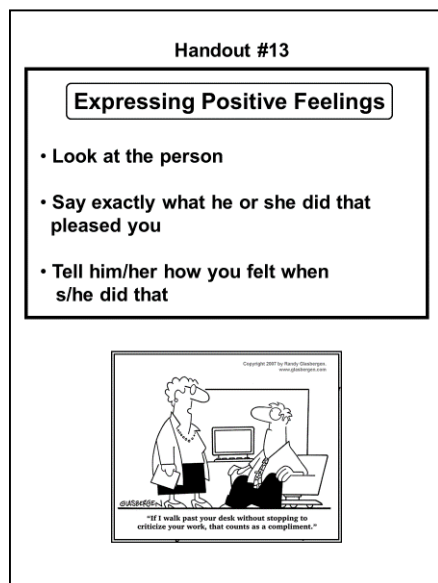
Briefly make connections between the ways they want to improve their communication and the skills on this handout. Then continue with the introduction:

“Good communication and problem solving leads to less family tension and fewer mood symptoms (psychosis symptoms). Having the skills makes it much easier to solve problems that may have been there for a long time.”

Make sure that everyone in the family understands what you mean by good communication. For younger adolescents, “communication” can seem like an adult word. It may be necessary to say to them “it means making sure you and another person understand each other.”

Introducing Skill #1: Expressing Positive Feelings

After introducing the concept of communication, start to teach the first of the five skills. First, present the skill of expressing positive feelings. This skill is taught first because it is an easy skill to learn and usually leads to a sense of connection and good feeling between family members. To begin, briefly summarize the nature and purpose of the skill: it is a direct way to make other members of the family feel valued and appreciated, and makes them want to reciprocate those good feelings in the future. Also, it helps to create a balanced approach to family life. It can be very easy to identify ways that other people irritate us, and we can easily take for granted the many things that others are doing each day to help us out. The most satisfied families tend to praise each other a lot more often than they ask for changes.



Then explain the components using **Handout 13, “Expressing Positive Feelings”**. It is sometimes hard for individuals to come up with “feeling words.” For example, a family member might say, “It made me feel like you cared,” which is really not a disclosure of his or her own feeling state. Help family members to find the right feeling that goes along with that experience, such as “happy”, “appreciated”, or “touched”. Don’t be satisfied with “good” for everything.

Explain to the participants that expressing positive feelings typically goes better if the praise is offered for a relatively specific behavior instead of a generic attribute such as being a “terrific person”. Finally, model the skill for them. For rapport-building, direct your modeling to the IP as the receiver.

For example, say,

“Keith, I really appreciate that you’ve been willing to talk about your school problems so openly. I’m glad that you’re using our time here so well.”

Or,

“Mr. Williams, I really appreciate how you have come to every session and tried to participate even though it has been hard for you some days. Your involvement makes me feel encouraged about our work together.”

If your attempt to model the compliment falls flat, try not to become defensive. Try to bring humor to the situation (e.g., “boy, that one went over like a lead balloon”). Your willingness to be vulnerable and persevere in the face of rejection may make family members and the IP feel less defensive themselves and more open to the process of positive communication.

Once it is clear that family members know the features of positive communication, have them think of something specific and pleasing that someone else in the family did in the last week. Once a family member is ready to give feedback and has chosen a recipient, instruct the members of the dyad to turn their chairs toward each other (unless they are already sitting such that they can easily talk to each other), and talk directly to each other with the one giving the feedback designated the “speaker” and the one receiving the feedback the “listener”. Your role is to direct the interaction, based on the dyad’s need for direction. Make sure that the family members feel supported but also give them feedback on how to do the skill correctly.

Consider the following example. A father agreed to compliment his 19-year old son on his attempts to stay out of trouble with the police. The father told his son,

“I am really glad that you didn’t get into any trouble this week. ”

The clinician praised the father’s efforts at coming up with a compliment for his son, and pointed out to him that another way to state his compliment was to say what his son did that he appreciated, as opposed to what he did not do.

The father tried again and stated,

“Son, your behavior was really exceptional this week and it made me really happy to see you behave so well.”

At this point the clinician gave a lot of praise to the father for being flexible and performing the skill in the way it was intended. However, she still encouraged the father to try again, giving examples of what he meant by “really exceptional behavior.”

Sometimes, there will be resistance to replaying the exchange (and in so doing, practicing the skill) in accordance with the therapist’s feedback. If this occurs, explain that the skills are like trying on a new pair of shoes. If they do not fit, the speaker is welcome to take them off. However, he or she will only know whether they fit if they are “walked in a while to see if you can break them in. It’s the same way with these skills – you’ve got to mold them to your particular style before they’ll feel natural.”

(But some families are concrete. They may come back with examples of problems they've had buying shoes lately).

Next, ask each member of the family to practice the skill while you praise and provide direction. Ideally, each member of the family will have practiced giving a compliment to someone else, and will have been the recipient of one as well. If one person is being left out (i.e., no one said that mom did anything well), encourage the family to do so (e.g., "No one has said anything about what Beth did this week. I imagine she must have done something nice for someone in here.").

Assign a Practice

Once you are fairly certain that each of the family members – including the IP – is using the positive feedback skill in the correct manner, assign the homework sheet, "**Catch a Person Pleasing You Task**" (**Handout 14**). This assignment (to be completed between sessions) can be treated as a game. Each member of the family is given one sheet. The goal is for each family member to try to do something every day that he or she perceives as pleasing to another member of the family (which can vary day by day). What they record on their sheets, however, is when something pleasant was done for them by another member of the family. They also record whether they acknowledged (i.e., expressed positive feelings) what was done. This can lead to a discussion of what family members "catch" (or notice) and what they miss.

Handout #14			
Catch a Person Pleasing You			
Day	Person Who Pleased You	Exactly What Did They Do That Pleased You?	What Did You Say to Him or Her?
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Examples:

- Looking Good	- Making Phone Call
- Making Bed	- Being Pleasant
- Having a chat	- Being considerate
- Being on Time	- Making a suggestion
- Going Out	- Offering to Help
- Helping at Home	- Going to Work
- Showing Interest	- Tidying up
- Cooking Meals	- Taking Medicines
- Working in Yard	- Attending Treatment

For example, in one family, the father brought a box of chocolates to the mother. He was very surprised when his gesture was not "caught" by her. She explained to him that she was actually offended because she was trying to decrease her sugar intake and recalled that he had commented earlier in the week that she had been gaining weight. She did express positive feelings about some other things he had done, however (i.e., rubbing her back, playing with the kids when he came home). He was surprised that these behaviors meant so much to her. Family members may realize that the efforts they expend to please each other are ineffective because they are not always in sync with the other person's desires. What better way to demonstrate the importance of direct communication!

Troubleshooting Expressing Positive Feelings

Most of the time family members will be receptive to this approach and perhaps even enjoy the exercise. However, if family members persist in expressing strong negative reactions, discuss their feelings and consider modifications. For example, one single-parent father and his son laughed out loud during this exercise and stated:

Dad: Doc, guys just don't talk like that. I don't mean any disrespect, but in my world it just won't happen this way. I just want to be honest with you

Therapist: I appreciate your honesty. Tell me some more about what's weird to you about this approach.

Dad: My son and I do nice things for each other, and I like to let him know that I appreciate what he does, but I would give him a high five and just say "thanks," or I might say "good job with the laundry, pound it (father puts up his fist)."

Therapist: So you are noticing what your son is doing and you are praising him for it in your own way. You have a briefer style that doesn't involve talking about how it makes you feel and so on.

Dad: Yeah. Those words just wouldn't be mine. It would feel really stilted.

Therapist: Ben, how do you tell your Dad when he has done something that you like?

Son: I just say "thanks for picking me up from school Dad, or thanks for cooking chicken tonight, that's my favorite."

Therapist: You know, I like the way that you communicated there and I'm glad that you brought this up because the whole point of this exercise is really just to remind us to focus on and comment on the good things that we are doing for each other. Sounds like you guys have your own way of doing that and it works for you.

Son and Dad: Yeah.

Therapist: OK, but you also said earlier that a lot of things you do that don't get noticed by each other. Do you think that there is room for you to be a bit more aware of what you are doing for each other day-to-day and to recognize it in your own way?

Dad: Yes, there is definitely room for that. I can see what you are saying about the need to keep a balance so that I'm not just always telling him to pick up his room and do his homework.

Therapist: What about you Ben? Do you think that your Dad knows when you appreciate something he did for you?

Son: I think so, but I'm not sure.

Therapist: Would you both be open to trying again but this time use whatever way feels comfortable for you to express positive feelings?

Son: OK.

Dad: Sure.

Alternatively, the clinician here might have accepted the family's way of expressing positive feelings, but assigned the Catch a Person Pleasing You task so that they could keep track of how often these exchanges occurred. Instead of writing down "What did you say to him or her" they could record an abbreviation like "pound it".

Ending Session 5

When wrapping up this session, summarize the skill the family has learned and why each is important. Ask them to repeat back to you what they're supposed to do with the ***"Catch a Person Pleasing You"*** assignment. Offer praise for their attempts to master the skills, even if very modest.

Mostly, encourage them to practice these skills at home, and with others. The skills will feel increasingly comfortable as they generalize to other settings.

Remind the family that, at session 9, you'll be switching to every other week. That is, the first 8 sessions are weekly, and then we switch to biweekly. This will not be a big issue for many families, but it will give them some time to prepare. Pair this statement with, "Because we'll be meeting less frequently, it will be extra important for you to have a family meeting and practice these skills between sessions. Are you still having a family meeting?"

Session 6: Active Listening

1. Joining/Check In
2. Review homework (mood charts; catch a person pleasing you)
3. Teach Skill #2: Active Listening
4. Assign Homework (mood charts; communication skills assignment)
5. Plan for the Next Session; Joining/Closing

Handouts needed:

- 15 (Active Listening)
- 16 (Communication Skills Assignment).

Review Homework

Start out session 6 by reviewing the “Catch a Person Pleasing You” homework from the previous week. Ask them how it felt to give each other more positive feedback during the week. What was it like for them to hear others noticing and commenting on some of the efforts that they made to be helpful or supportive? If they haven’t done the assignment, ask them each to come up with one positive thing another member of the family has done in the intervening week, and to express it now in a rehearsal within the session. Remember to coach them to be specific about the feeling they enjoyed (pleased, relieved, happy, touched) and also about the behavior the other person performed.


Introducing skill #2: Active Listening

An essential building block for good communication is the ability to listen. It is in many ways the basis for all of the other communication skills. However, active listening is a more difficult skill to learn and can be anxiety producing for family members, so expressing positive feelings is often an opportunity to begin communication training with a concrete skill that has a positive tone.

Handout #15

Active Listening

- Look at the speaker
- Attend to what is said
- Nod head, say “Uh-Huh”
- Ask clarifying questions
- Check out what you heard



Offer **Handout 15** and describe **Active Listening** to the family by saying: “This is a skill you are probably all familiar with, active listening. It’s a skill that is useful anytime, but it is really helpful when there is an argument or disagreement. It helps to slow things down because each person has to let the other person know that they heard what was said. That way, the other person feels like you’re listening. It’s a skill that can come in handy during an argument, because whoever is talking to you feels acknowledged, and then is often willing to do the same for you.

There are a couple of parts to it. If you want to let a person know you are listening to them, look at them, nod your head, and ask some questions to make sure you understand, like ‘When did that happen?’ It’s also a good idea to try to tell the

person what you heard them say, what we call “checking out what you heard.” Mrs. X, when someone listens to you and asks you questions, how does it feel?”

After introducing the skill, model the skill for the family. That is, be the listener and ask a member of the family to talk to you. You may want to ask for a volunteer. Once you have modeled the listening skill, solicit input from family members as to their experience of the demonstration (e.g., “What did you see me doing just now? How did you know I was listening?”). Next, ask for volunteers to try practicing the skill (a speaker and a listener).

It is important to start with low conflict topics for active listening, given that it is difficult to learn a skill in the face of anxiety and/or criticism. Practicing the skill should not provide an opportunity for a parent to give the patient a lecture.

As with the other skills, continue to model it, and give positive reinforcement for the family member’s efforts, even if these efforts are only modest. There is often more direction involved in the active listening skill than the others because of its difficulty and complexity.

Clinical Tip

Coach one person at a time

When teaching Active Listening, it can be tempting to coach the speaker and the listener simultaneously. For example, some clinicians try to get a parent to practice “Making a Positive Request” while the son or daughter listens actively. In our experience, this doesn’t work well. The speaker may bring up a topic that is hard for the listener to summarize, or that may make the listener feel defensive. Typically, coach the person who is learning the new skill only. For Active Listening, most of your coaching should concern the listener. The exception to this is when another family member, assigned the role of speaker, uses it as an opportunity to criticize the listener. Ask him or her to revise the topic to something more neutral, “like something that happened to you at work today, so ____ can practice listening.”

If there are more than two family members participating in the therapy, assign a speaker and a listener and give the other family members the job of observing to see if the listener is following all of the steps. Sometimes it is easier for people to learn the skills when they are not in the “hot seat.” After the role-play, ask the observers what they noticed. What did the listener do well? Did the listener follow all of the steps?

It is very common for family members in the listener role to answer back to the individual who is speaking by defending their own actions or expressing their own point of view on a particular topic. Let them know that while this is an expected response, it is not what we mean by active listening. Help them to summarize what the other person said or to ask follow-up questions to clarify the other person’s perspective. Let them know that they will have a chance to share their own perspective, but for now we are practicing listening skills. When everybody is talking and nobody is listening, there will be a breakdown in communication, and conflicts usually worsen.

Clinical Tip

Sometimes, families get confused about whether the goal of role-playing is to learn to listen or solve a specific problem. So, for example, a mother listened to her son talk about his difficulty with homework and responded appropriately, with statements of empathy such as “you get nervous when there’s a page full of math problems and you hear me or dad yelling at you to come to dinner.” However, when the father was asked about how his wife did with the listening skill, he said “I think if Rob started his homework earlier we wouldn’t have this problem.” Rob’s mother added, “but what about basketball practice?”

In this example the family has transitioned into problem-solving before active listening has been mastered. The clinician here reminded the family that “we’re not trying to solve the problem of his homework just yet. We’ll deal with that soon, but the goal here is to work on active listening, about any number of topics. Dad, what did you like about the way mom listened just now? Which of the elements on the handout did she use?”

If the IP is experiencing problems with memory or concentration/attention, he/she could consider jotting down notes while the other person is talking. That way, s/he will have an easier time reflecting back what was said and asking relevant follow-up questions.

Case Example: “Dad, You’re Getting Abstract Again”

Ben, a 13-year-old with both bipolar disorder and ADHD began to experience frustration during the communication module. When the family was asked what they would like to improve in their communication, Ben’s father, Richard, said that he would like for he and Ben to share more with each other. Ben asked him what he meant. His father said that he would like to “know what Ben wanted out of life, what made him happy, and where he saw himself in the future.” Ben, becoming increasingly frustrated, told his father that he still did not understand. The clinician tried to help Richard focus his request a little more but Richard had a very difficult time defining what he meant. Finally, Ben said, “Dad, I’ll tell you about my day today, OK?” and proceeded to give his father a very detailed account of all he did at school and after school. The clinician assigned Richard the task of listening and reflecting. This role seemed to please Richard very much who thanked Ben by saying, “that helps me know what makes you happy and what is happening in your life”. Ben was, understandably, less than enthused about his dad’s reaction.

In this vignette, Ben was able to intercept what was becoming an uncomfortable impasse by making a guess about what his father wanted. The clinician can help parents avoid abstract dialogue and focus on the concrete, specific communication to which the child will respond more positively.

Some youths will say: “it is obvious that I’m listening because I am sitting here. She doesn’t want me to just repeat back what he/she said.” Encourage them to consider that if they summarize the other person’s point, that person will feel understood and won’t have to keep trying to get a point across. This is a big shift for many youths who tend to have little experience with active listening (and who may wonder whether active listening means agreeing). Parents may be more familiar with the concept, but may still find it difficult to actually put into action.

Give a Practice Assignment

Continue the process of integrating communication skills into the family’s daily life by assigning homework. If you’ve already explained the “*Catch a Person Pleasing You*” assignment, you will have an easy time explaining the **Communication Skills Assignment (Handout 16)**. Explain that only the first two skills should be practiced (Expressing Positive Feedback and Active Listening) - they should not fill out the information regarding “communication clarity” or “positive

Handout #16						
Communication Skills Assignment						
	Person You Talked To	What You Talked About	What Positive Feedback Did you Give?	What Active Listening Skill Did You Use?	What Communication Clarity Skills Did You Use?	What Positive Requests for Change Did you Make?
Mon						
Tues						
Wed						
Thurs						
Fri						
Sat						
Sun						

Requests for change” until you review those skills. Instruct the family to practice active listening with various people in their daily lives, and to describe each instance on the practice sheet.

Troubleshooting the Active Listening Skill

Because of the importance and difficulty of mastering active listening techniques, it may take more than one session to practice this skill. You may want to make modifications to the active listening training based on the comprehension of a particular youth or family member. Feedback from the family and careful observation of the interactions are essential processes for ensuring that the teaching hits the mark.

“Angry Birds”

One 15 year-old boy had a very difficult time listening to his mother talk. His mother became aggravated with him during role-play exercises because he would stop making eye contact with her, which she felt was disrespectful and a sign that he wasn’t listening. He explained that it was hard for him to deal with people’s facial expressions, that he found them confusing and overwhelming, and that he could listen better when he could look away from their face, or could do something with his hands (e.g., play “Angry Birds” on his cell phone). He said that, far from distracting him, using his hands to play the game helped to ease his anxiety and helped him focus on another person’s message. The mother was surprised to hear this and became more understanding of his difficulty with eye contact. She proceeded to talk with him while he was looking at his cell phone, and he was consistently able to summarize what she had said. In fact, she discovered that he actually listened better when he was able to busy himself with his hands, especially when they were talking about emotionally charged topics.

This example serves to highlight that the goal of the listening exercise is to facilitate effective communication in a family. A therapist may need to modify the listening tasks to accommodate the needs of particular individuals with unique sensitivities and characteristics.

If you’d like more examples, consult pages 221-228 of *Bipolar Disorder: A Family-Focused Treatment Approach*.

Ending Session 6

When wrapping up this session, again summarize the skills the family has learned and why they’re important. Ask them to repeat back to you what they’re supposed to do with the **Communication Skills Handout** assignment. Offer praise for their attempts to master the skills, even if very modest.

Mostly, encourage them to practice these skills at home, and with others. The skills will feel increasingly comfortable as they generalize to other settings.

Sessions 7 and 8: Making Positive Requests for Change and Communication Clarity

1. Joining/Check In
2. Review homework (mood charts; communication skills assignment)
3. Teach Skills #3: Making A Positive Request
4. Teach Skill #4: Communication Clarity
5. Teach Skill #5: Expressing Negative Feelings about Specific Behaviors
6. Assign Homework (mood charts; family meeting focused on making a positive request, communication clarity, or expressing negative feelings)
7. Plan for the Next Session; Joining/Closing

Handouts Needed:

- 16 (Communication Skills Assignment)
- 17 (Making a Positive Request)
- 18 (Communication Clarity)
- 19 (Expressing Negative Feelings)
- 20 (Expressing Negative Feelings about Specific Behaviors practice sheet)

Review Practice

Ask the family whether they completed the Communication Skills assignment, and to describe their attempts at practicing active listening and what they observed about their conversations. Are they starting to get a feeling for what good listening feels like? Ask them to talk about the kinds of situations when they may want to use active listening in the future, and the kinds of situations when this wouldn't be feasible (e.g., when they are in a hurry and don't have time to open up a conversation). Often people are able to report that the listening skills deepened their conversations and that they felt more satisfied with the outcome of these discussions. If necessary, explore with them the reasons they did not complete the assignment (see above).

Change-Oriented Communication

Two communication skills, **making positive requests for change** and **expressing negative feelings**, address a family member's desire for change in another family member's behavior. Making positive requests (for example, "I would appreciate it if you would take out the trash") is the first step in requesting behavior changes from other people (see **Handout 18**). Communication clarity stands between these two skills, as it teaches a general method for being specific in one's messages to others. Finally, **Expressing negative feelings about specific behaviors** (e.g., "When you start rolling your eyes, it hurts my feelings; what can we do about this?") is

recommended when positive requests have not achieved their desired effects (**Handout 19**). There may be cases where it seems more appropriate to teach “Positive Requests” and “Negative Feelings” back to back.

Teach Skill: Making a Positive Request

There are two caveats to keep in mind when teaching positive requests:

- *First, the request should be for another person to do something, rather than stop doing something.*
- *Second, the person receiving the request is not under obligation to do what is being asked of him or her.*

The request may best be conceptualized as one of a number of solutions to a family problem that can be taken up further through the problem-solving venue (see Problem solving section).

Consider the contrast between these three ways of presenting feedback regarding a family member’s tone of voice:

- “I hate it when you use that negative tone of voice.” (criticism)
- “I would appreciate it if you’d use a more respectful tone of voice when we talk.” (positive request for change)
“I’ve asked you to speak to me in a respectful tone several times, but you haven’t followed through. What are we going to do about this? (expressing negative feelings about a specific behaviors)

To proceed with ‘positive requests,’ pass out the **“Making a Positive Request”** handout, and introduce the skill:

“The next skill is called making a positive request. This is a good skill to use when you want someone to do something differently. As you can see in the handout there are a few parts to this skill – look at the person, say what you would like him or her to do, and say how it would make you feel.”

Handout # 17

Making a Positive Request

- **Look at the Person**
- **Say Exactly What You Would Like Him or Her to Do**
- **Tell Him or Her How You Would Feel When S/He Did That**
- **In Making Positive Requests, Use Phrases Like:**

- “I would like you to ____.”
- “I would really appreciate it if you would ____.”
- “It’s very important to me that you help me with ____.”



After presenting the components of the skill, model the skill, either by asking for a volunteer or including someone in the family who has been “hanging back” during the treatment. If you feel you have a good relationship with the family, you can use this as an opportunity to address an issue that’s been bothering you as a clinician. For example, “Alan, I’d appreciate it if you’d let me know if you need to cancel by calling me the day before. I understand there are things that can get in the way of attending, but it’d be easier for me – and I think I could give you better care - because I could plan around it.”

Once you have modeled the skill, ask all family members to make a request of another family

member (or of you) and then role-play the skill in pairs. As with the other skills, praise all members of the family for their efforts, and provide feedback to each family member to make sure the skill is being performed correctly. If you are working with an unusually large family, it may make sense to break into pairs of two and ask different pairs to practice simultaneously.

Once the family has practiced this skill for a while, you can introduce some variety into the work. Ask the family to think about phrases that they hear a lot around the house.

For example,

Between siblings:

“Stop being such a pain;”

“Don’t touch my stuff.”

“Why do you keep taking my phone?”

From parents to youth:

“How can you live in that room of yours, it’s so gross?”

“Why are you watching TV when you have homework to do?”

“What are your dishes still doing in the living room?”

From youth to parents:

“Get off my case.”

“I took out the garbage yesterday, it’s Karla’s (sister’s) turn today.”

“I’ll walk the dog later.....why are you always nagging me?”

Next, how could each of these statements be rephrased so that they are expressed as positive requests for change? Ask them to role-play these new approaches to communication. Remember to coach the family member through these exercises. Examples of how we’d like them to express the above might include:

“I’d really appreciate it if you’d ask me first if you want to borrow my clothes. It would make me want to share them with you more often.”

“I’d appreciate your getting your homework done before you watch another TV program. That way, I wouldn’t have to worry about whether it’s getting done.”

“Sometimes I’m in the middle of something when you ask me to do a chore. How about we work out a deadline when these things are supposed to get done. That way I’d feel like I have some control over my free time.”

Summarizing Positive Request Skill

Ask each member of the family to discuss the usefulness of the Positive Request skill. Some skills are more useful to one family member than another. Ask the family to practice making positive requests over the next week and to track their efforts on the “**Communication Skills Assignment**” (Handout 16).

Teach Skill: Communication Clarity

Throughout treatment the clinician may have encouraged family members to use concrete and brief statements instead of abstract and lengthy statements (see the example of Ben and his father, above). The goal of ‘Communication Clarity’ is to help the IP or family members stay on track and direct their statements toward the goal of sharing a topic of conversation.

Provide the family with **Handout #18, “Communication Clarity.”** Go through and explain the purpose of each item.

Handout # 18

Communication Clarity

- Think about what you want to say
- Consider how your listener might feel
- Talk about only one topic at a time
- Be specific
- Use short sentences
- Stop and check in to make sure that your listener understood you



Figure out what you want to say:

Getting to the main point quickly will result in fewer misunderstandings. Organize your thinking so that you communicate the most important points. Oftentimes we can get caught up in providing too much detail and our point can get lost.

Use short sentences to highlight the main points:

Short statements are easier to understand and respond to than lengthier statements.

Be specific rather than abstract:

Using language that is specific is less confusing than abstract and/or general statements. For instance, making the statement, "I noticed you have been spending more time alone lately, is there something wrong?" is a clearer statement than "What's wrong with you? You seem

to be in the clouds lately."

Bring up one topic at a time: Attempting to discuss many topics at once can be confusing and overwhelming. For instance, making the statements "You have been sleeping constantly, I don't think you've been taking your meds, and you haven't been spending time with your friends," could be overwhelming. Instead, it would be more effective to prioritize and convey one point at a time, such as, "I've noticed that you have not taken your medications for the past 2 days and I want to talk with you about it." Leave the other issues for another time.

Once you have reviewed the handout; it's time to practice. Ask family members to think of one problem they would like to discuss. Ask them to take turns in the speaker and listener roles with any additional family members serving as observers to coach the speaker. Ask the speaker to try to follow the guidelines and to discuss the one problem he/she has selected briefly, getting to the main points and then stopping.

Ask the observers to comment on whether the speaker followed the guidelines on the handout, and ask the family members to change roles and continue practicing.

Below is a case example of a possible scenario in which the clinician could intervene and educate the family regarding the importance of more focused communication.

Case Examples

During sessions the clinician noticed that Anthony, a 15 year-old, was having difficulty getting his point across and appeared confused. During today's session Maria, Anthony's mother, tried to help Anthony by explaining what had been covered so far in the session, "Anthony, we are talking about how to get better at communicating and (Ms. Alvarez, the clinician) wants to know what we are doing now. I think it would be better if you shared more." Anthony asked her what she meant. Mark, Anthony's father, stated, "It's not that difficult, we just want to hear from you more." The clinician intervened and suggested that Maria and Mark provide more specific, concrete, requests for what they mean by "sharing more" or "hearing from you more." Anthony's parents tried again and stated, "We want you to talk with us if you are having a bad day and tell us how we can help." Anthony, responded, "Well sometimes it's hard to talk about things, but I'll try." Anthony was able to follow the content being discussed once it was presented in a brief and specific manner.

Dusty, a 14-year old, very strongly believed that she had bipolar disorder, even though her diagnostic evaluation suggested that she had major depression (with mood instability) but not bipolar disorder. During the communication clarity task, Dusty chose to tell her father how hard it was to focus "when I'm manic, which is like, all the time." In explaining this state, she illustrated jumped from one topic to another, and spoke in vague generalities such as "when I'm elated, my mind is really, like, stylin', and I have so many ideas and I want to get them all out." The clinician asked her to explain the same issue to her father in one sentence. She had considerable trouble at first, and then questioned why she should have to do this: "My parents say they want to know what's going on with me, so why should I short-cut it?"

After much coaching, Dusty was able to pare down her explanation to, "Dad, sometimes my mind gets all frenzied and I can't focus. When I do that you should slow me down by signaling me or something, or tell me to take a breath. I promise I won't get mad." The clinician gave her much positive encouragement for following through with the task, and she admitted that, at least for this issue, it had helped her focus.

Mrs. Watkins used the "positive request" skill to remind her son James of everything she wanted him to do from the moment he got home from school to the moment he went to bed: "James, I want you to put your book bag where you can find it later, wash the dishes after you've had your snack, bring your dirty clothes downstairs and put them in the hamper, check to see if the dog has been fed, get ready for dinner...." James, who was 14 and had ADHD, would tune her out after the first request. In sessions focused on communication clarity, we asked Mrs. W to break her requests down to one at a time and let James respond, and then to move on to the second most important request, rather than stringing them all together. Giving him "bite-sized" requests with clear beginnings and endings helped James to process the information and remember it later.

Introduce Communication Skills #5: Expressing Negative Feelings About Specific Behaviors

There is one more communication skill to learn - *expressing negative feelings about specific behaviors* - which can be difficult for people because it involves negative


emotional content. This skill sets you up to transition into the problem-solving module. “Negative Feelings” can be introduced toward the end of session 8 or the beginning of session 9, depending on whether you think the family is ready for discussing more affectively-laden topics.

In many ways, expressing negative feelings is the most difficult skill to learn because it involves delivering an unpleasant message. Specifically, it is a way to give another family member **constructive criticism** about his or her behavior. Family members need to express their frustration with each other from time to time and may not have a productive forum for sharing this type of feedback. This skill offers family members a useful alternative when positive requests have been ineffective. Explain to the family that expressing negative feelings is a recommended step *only as a last resort if other attempts (i.e., positive requests) have failed*. But criticism in any form is difficult to accept. Given that it can stir up disagreement, the expressing negative feedback skill should be used as a segue into problem solving.

Handout #19

**Expressing Negative Feelings
about Specific Behaviors**

- Look at the person; speak firmly
- Say exactly what he or she did that you did not like
- Tell him or her how you felt when s/he did that
- Suggest how the person might prevent this from happening in the future



Pass out **Handout 19, “Expressing Negative Feelings about Specific Behaviors,”** and introduce the skill:

“What do you do if you’ve made a positive request for change and you don’t feel that anything has been accomplished? The final communication skill we want to teach you to is ‘expressing negative feelings about specific behaviors.’ It is useful when someone is doing something that bugs you, and you want that person to stop or to do it differently. Our handout shows you one way to do this. When someone is doing something that bothers you, look at the person, say exactly what he or she did that upset you, how it made you feel, and suggest a way he or she could prevent it from happening in the future.”

As with the other skills, facilitate a role-play with a family member. To alleviate the IP’s concern that he or she will be the primary target of negative messages, structure the first role-play so that family members practice as if they were speaking to *someone outside of the family*. Often, adolescents feel that they are a continual target of parental disapproval. The example of Kevin (inset), a 16-year old with bipolar I disorder, illustrates the initial role-play of this skill.

“Don’t Copy my Homework”

CLINICIAN: Kevin, tell me about something annoying that someone you know does, other than your parents.

KEVIN: A friend of mine has been asking to copy off my school work. It really pisses me off. He’s like... whatever.

CLINICIAN: What bothers you about it?

KEVIN: He’s like, a moocher. He always wants something, like your homework, or your money, or food, whatever.

CLINICIAN: So, what do you think you could you say to your friend?

KEVIN: Nothing. I don’t want him to stop hanging out with me but I don’t wanna hand him my homework either cause I could get in trouble.

CLINICIAN: I understand. That’s a hard one. How do you think he would respond if you said, “(Name of friend), you’ve been asking to copy my work. I know you’ve been having a hard time with some of the assignments, but I don’t want to get in trouble if we get caught. It makes me uncomfortable to say this ‘cause you’re my friend.” What do you think he would say? (*Clinician models skill*);

KEVIN: (*thinks*) It was pretty long, and I think he might get ticked off, but I don’t know. It might work.

CLINICIAN: Well, you know, those were just my words. Maybe there are better ways to say it. Why don’t you pretend I’m your friend and say it the way you’d do it?

KEVIN (*thinking*): Um, Nate, I am not down with you copying off of me anymore. I want to help you out but I don’t want us both to get in trouble again. Umm.... how about we hang out and I can show you how to do some of the stuff for math or something.

CLINICIAN: That’s a really good effort, Kevin. Richard (father), how did you like the way Ben just said that? What else do you think he could say?

The next example (Ben) also illustrates the initial role-play of this skill.

Call on Me!

CLINICIAN: Ben, tell me a behavior that either a teacher or kid at school does that really bugs you.

BEN: Well I hate it when I’ve had my hand like raised forever and the teacher doesn’t call on me and keeps calling on the same nerdy kids over and over again. I told him about it before and he just ignores me.

CLINICIAN: So, what do you think you could you say to your teacher?

BEN: Nothing, I’d be scared that he would take it out on me when he was grading my next test.

CLINICIAN: Mom, how do you think Ben should handle this?

MOM: I think I should talk to Mr. Evans.

CLINICIAN: Well, that may be needed later, but let’s use this as an opportunity for Ben to do t on his own. Ben, how do you think Mr Evans would respond if you said after class, “I often raise my hand in class and you don’t call on me, which kinda hurts my feelings. I know there’s lots of kids who want to talk. But what

should I do differently when I think I have the answer?" What do you think he would say?

BEN: I dunno maybe. I think he'd be blown away, none of the kids ever talk to him that way, they usually just complain behind his back or act obnoxious in class.

CLINICIAN: Why don't you pretend I'm your teacher and say it the way you'd say it?

BEN (thinking): Um, Mr. Evans, could you call on me more? Sometimes I have the answer but you always call on Jeff or Karen.

CLINICIAN: That's a real good start, Ben. Richard (father), what else do you think Ben could say?

Once you feel that family members understand the skill, ask them to practice with each other. Start with problems that seem to be at the forefront of their minds (e.g., disagreements over homework or screen time) but that they haven't made much traction in solving. Make sure that the IP has an experience with being both speaker and listener. Again, the recipient of negative feelings is not obligated to change their behavior in response to this expression.

Handout 20, the "Expressing Negative Feelings About Specific Behaviors" Assignment, is given to the family once each member has practiced the skill. Ask family members to practice it in the upcoming week (if relevant in their day-to-day lives) and record their efforts on the form.

Summarize the Skills

Handout #20				
Expressing Negative Feelings About Specific Behaviors Assignment				
	Person Who Displeased You	What Exactly Did He/She Do That Displeased You?	How Did You Feel? (Angry, Sad, Upset, etc.)	What Did You Ask Him/Her To Do In The Future?
Mon				
Tues				
Wed				
Thurs				
Fri				
Sat				
Sun				

In this final session of communication training, the family may be asked to role-play each skill one final time, to make sure that the skills have been retained and are being used correctly. After the skills have been practiced, ask each member of the family to discuss which skill was the most useful to their family.

One mother said that Active Listening was the most helpful skill because she often did not know (a) whether her son was listening and (b)

whether he understood what she was trying to say to him. She admitted that she sometimes spoke abstractly. His learning to paraphrase made her more certain that he was comprehending her, and also reminded her when she needed to be clearer.

After this discussion, the clinician moves to the problem solving module. He or she reminds the family periodically that they should continue to practice the skills, given that they will be using them to discuss family problems in the upcoming sessions.

Ending Session 8:

Assign a Practice, Answer Questions, and Plan for Next Session

Ask the family to practice communication clarity and expressing negative feelings over the next week, and track their efforts on the "Communication Skills Assignment"

(Handout 16) and the “Expressing Negative Feelings about Specific Behaviors” (20) chart.

Ask the family if there are other communication skills that they think would be useful to learn. Dusty’s parents mentioned that they wanted the atmosphere at home to be “lighter”; everyone took things too seriously. The clinician spent some time talking about ways they might introduce more levity into their family meetings, or how, during the skill practices, they could allow more spontaneity. For example, all of their meetings had been held in the living room; could they switch rooms or hold one meeting outside? Dusty was asked to choose a music CD to play in the background while the family talked and practiced.

Remind the family that session 9 will be in two weeks, not one.

IV. PROBLEM-SOLVING SESSIONS (Sessions 9-12)

Session 9: Introduce Problem-Solving Skills

1. Joining/Check In
2. Review homework (mood charts; relevant communication skills assignments)
3. Review Skill #5: Expressing Negative Feelings about Specific Behaviors (if necessary)
4. Review the Prevention Action Plan (if needed)
4. Introduce Problem-Solving Skills
5. Assign Homework (Mood chart; Family meeting focused on Problem-Solving (handout 22))
6. Plan for the Next Session; Joining/Closing

Handouts Needed:

- 19 (Expressing Negative Feelings About Specific Behaviors),
- 20 (Expressing Negative Feelings About Specific Behaviors Assignment)
- 21 (Solving Problems)
- 22 (Problem Solving Worksheet)

Review Practice

Ask the family whether they completed the Communication Skills assignments above, and if they did, what they observed about their interactions.

- Was it hard for people to make clear specific positive requests during the week? This is a skill that takes some thought and some practice. How did it go? Did the requestor get more cooperation when making the effort to phrase things this way?
- Did anyone try to communicate more succinctly? Did anyone else notice?
- Were they able to express negative feelings when specific situations came up? What difficulties were encountered?

- If necessary, explore with them the reasons they did not complete the assignment (see above).

Rehearse Expressing Negative Feelings

Spend the first 10-15 minutes going through Expressing Negative Feelings (or other skills taught in session 8 that you feel have not been fully processed). Consider this vignette:

“A Bicycle Built for One”

Derek, a 21 year old, had a difficult yet highly dependent relationship with his wife, Gabrielle. He complained about her behavior frequently, but his complaints were vague (e.g., “She’s not there for me”).

Clinician: Derek, would you go over again what bothered you, only follow the steps on the handout involving expressing negative feelings? Turn toward Gabrielle and tell her what she did that displeased you, how it made you feel, and what you would like her to do differently in the future. Try to be as specific as you can.

Derek: Well, Gabrielle, I was really hurting at the end of that race, I was waiting for water or Gatorade or something. I was mad because, just like last time, you weren’t there at the end.

Clinician: OK, anything else about how you felt? Or what she could do differently?

Derek: Just annoyed. Not like burning angry or anything.

Clinician (pauses, waits to see if there is more content): OK, Gabrielle, can you say how you felt being the listener?

Gabrielle (tearing up): It sucked.

Clinician: Can you tell him what sucked about it?

Gabrielle (gathering herself): I know I let you down, but you don’t have to get all wiggly about it. And like it says on the sheet, tell me what you want me to do next time, not just what I did wrong.

Derek: Isn’t that obvious? Bring me some water!

Gabrielle: No, it’s not that obvious. I didn’t know whether I was on the right street or when you would come across that point. Plus there’s like a million bicycles going by.

Derek: I don’t mean you should’ve run out into the street and handed me water while I cycled by. I meant meet me at the end.

Clinician: Derek, can you be more specific about what she might do next time?

Derek: Well, any number of things, like come earlier, or get to the end at the same time as me. And ... after the race while I'm rehydrating maybe we could spend a few minutes together.

Clinician: Ok, could you try it again, only this time try to get all the components in, like what exactly Gabrielle could do differently, and why it's important to you?

Derek: Gabrielle, I was really hurting at the end of that race, I was waiting for water, and you never arrived. Do you think you could get there earlier next time and wait 'till I get to the finish line?

Clinician: Good. Gabrielle, what was your reaction this time? Was it useful feedback?

Gabrielle: Yeah, that was better. To be honest, even though I got defensive before, I kind of felt bad about leaving him hanging like that.

It's best to have each dyadic pair practice expressing a negative feeling to each other at least once, with coaching from you and the other family members. **Knowing how to deliver constructive criticism – either through making a positive request or expressing a negative feeling, followed by problem-solving – is key in the changes we hope to achieve in high expressed emotion families.**

Introduce Problem Solving Skills

When family problem solving (Clarkin & Miklowitz, 1997) is conducted with adults, the focus is on collaboration. However, teens (and sometimes, young adults) do not necessarily have equal say in the decisions that get made in a family. It may be more appropriate for the parent to come up with two or three choices for the IP, and then allow the patient to help decide which choice seems to be the most appropriate. This may be a particularly important adjustment for younger people who sometimes believe that they are their parents' equals if not their parents' superiors. When parents try to assert their authority over their sons/daughters, the kid feels a strong need to resist, fearing domination.

It may be necessary to build in a reward and/or consequence system to ensure follow-through once a solution has been chosen, but only if the reward is developmentally appropriate. The rewards for a younger adolescent (e.g., access to a cell phone, computer time) will not be the same as for a late adolescent (use of the car, money, curfew times). Young adults may not be responsive to rewards from their parents at all.

The purpose of the problem-solving sessions is to reduce the family distress and tension that develops in response to life events, including the ups and downs of living with a son/daughter with functional impairment and distressing symptoms. Other objectives are to (1) open up a dialogue in the family about difficult problem topics, (2) allow a forum for expressing reactions to the issues raised and (3) offer youth and family members a framework for solving problems. The first step is to offer the family a rationale for problem solving.

"Up until now we have been talking about how you communicate or talk with each other. Now we would like to look at some of the problems you've


described and work together to solve them. We are going to teach you a model for working as a team.”

Provide the family with **Handout 21** entitled **Solving Problems**.

Handout #21

Solving Problems

- Identify and agree on the problem
- Suggest many possible solutions
- Discuss pros and cons
- Agree on best solutions
- Plan and carry out best solution(s)
- Praise efforts; check out if it worked!



“We think of problem solving as having several steps. These steps are a little like what we do in our heads automatically, but there are some tricks to doing it as a family that make it go better. First, you need to define the problem, which means identifying what the problem is and agreeing on it. In this step you’ll use a lot of active listening because different people often have different ideas about what the problem is. The more specific you can be about defining the problem, the better. Next, give as many different solutions as you can think of – what we call ‘brainstorming’. Then together you decide what the advantages and disadvantages (or pluses and minuses) are. Then you pick one or more solutions that you think will work and decide when and how you will put these solutions into practice.”

If time permits, ask the family to begin listing potential problems to be addressed with the Problem-Solving Skills in the upcoming sessions.

Assign Homework, Answer Questions, and Plan for Next Session

Remind the family to practice expressing negative feelings over the next week and to track their efforts on the “**Expressing Negative Feelings About Specific Behaviors**” assignment (**Handout 20**). Spend some time summarizing and reflecting upon the importance of this communication skill.

This is also a good time to check in with the family about the IP’s prevention plan. Has there been any opportunity to use it? Have any early warning signs emerged? Do they want to add anything to it? Make sure they are aware that they have a plan in case the IP’s symptoms get worse, and that they now have some communication skills to go with it.

Remind the family that session 10 will be in two weeks, not one.

Sessions 10-12: Problem-Solving Skills Practice; Treatment Termination

1. Joining/Check In
2. Review homework (mood charts; expressing negative feelings assignment or problem-solving assignments, as appropriate)
3. Identify a specific problem for problem solving
4. Complete problem-solving steps (*repeat in each session*)
5. Termination tasks (*as appropriate*):
 - Review skills learned
 - Ask family members to reflect on therapy
6. Assign Homework (mood charts; problem-solving steps)
7. Plan for the next session; Joining/Closing

Handouts Needed:

- 21 (Solving Problems)
- 22 (Problem Solving Worksheet)

Review Homework

How did the communication assignments go? Did they have opportunities to express negative feelings about specific behaviors? What did they notice while practicing the skill? How have they been doing with using the other communication skills at home (active listening, communication clarity, etc.).

Problem-Solving Skills

Review the steps in problem solving for the family (Handout 21), which were introduced at the end of the last session. Help them identify a practice problem. Summarize some of the goals the family stated at the beginning of treatment. Do they feel that each goal has been met or should it be on the agenda for problem solving? Invite the IP and family members to list additional issues that may be more pressing. For example, the youth may not have been in school at the beginning of FFT, but may be planning to go back for the next semester and needs help in planning her schedule.

As with communication training, problem solving works best when simple, relatively nonconflictual problems are chosen as illustrations first, saving the more difficult problems for when the parents and IPs have some mastery over the skill. Guide the family to start with more simple problems since even the simplest problem may be the “tip of the iceberg.” A more central, global conflict may be underneath the surface. Of course, use your clinical skills in choosing problems and

guiding the family through the problem-solving process. If your instinct is telling you that a certain problem is too “hot” to illustrate the problem-solving technique, you are probably correct.

As was true in communication training, your role in problem solving is that of an active facilitator or coach. Guide the family through the problem-solving steps, keeping them on task and consistently praising them for their efforts, no matter how small. It is helpful to point out to families the importance of using the communication skills when defining problems or evaluating advantages and disadvantages (e.g., practicing positive requests while generating solutions). Recommend that families try the problem-solving format (below) on their own at home as an exercise between sessions.

Often, in the midst of brainstorming it becomes apparent that the family has not agreed on the definition of the problem. Rather than forging ahead with generating solutions, return to active listening so that a clearer and more specific understanding of the problem can be achieved. Elicit the different perspectives that family members hold on how to define it. If necessary, facilitate the transition back to defining the problem by owning the mistake: “Looks like I jumped ahead too quickly in encouraging you to throw out solutions before I fully understood what the problem was. Let’s go back to defining it.”

The Format of Problem Solving

Working through a specific problem is aided by the introduction of the “**Problem Solving Worksheet**” (**Handout 22, two pages**). Whether using the worksheet or an easel or whiteboard, help the family generate a problem definition, several proposed solutions, advantages and disadvantages of each, and implementation strategies; record each step on paper.

Handout # 22	Handout # 22 (continued)												
<div style="text-align: center; border: 1px solid black; padding: 5px; margin-bottom: 10px;">Problem Solving Worksheet</div> <p>Step 1: Define “What is the problem?” Talk. Listen. Ask questions. Get everybody’s opinion.</p> <p>_____</p> <p>_____</p> <p>Step 2: List all possible solutions: “Brainstorm.” List all ideas, even “bad” ones. Have everyone come up with at least one possible solution. DO NOT EVALUATE ANY SOLUTION AT THIS POINT.</p> <p>(1) _____</p> <p>(2) _____</p> <p>(3) _____</p> <p>(4) _____</p> <p>(5) _____</p> <p>(6) _____</p> <p>Step 3: Discuss and list the advantages and disadvantages of each possible solution.</p> <table style="width: 100%; border-collapse: collapse;"><thead><tr><th style="text-align: center; border-bottom: 1px solid black; width: 50%;">Advantages (Pros)</th><th style="text-align: center; border-bottom: 1px solid black; width: 50%;">Disadvantages (Cons)</th></tr></thead><tbody><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr></tbody></table>	Advantages (Pros)	Disadvantages (Cons)	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	<p>Step 4: Choose the best possible solution OR solutions and list (may be a combination of possible solutions).</p> <p>_____</p> <p>_____</p> <p>Step 5: Plan how to carry out the chosen solutions AND set a date to carry it out.</p> <p>Date: _____</p> <p>A. Specifically decide who will do what. List.</p> <p>_____</p> <p>_____</p> <p>B. Decide what resources will be needed; list and get them.</p> <p>_____</p> <p>_____</p> <p>C. Think about what can go wrong when you try it, and figure out how to overcome the problems.</p> <p>_____</p> <p>_____</p> <p>D. Practice carrying out the solution.</p> <p>E. DO IT! (ON TIME)</p> <p>Step 6: Review the solution and give positive feedback to all family members about their participation.</p> <p>Step 7: If the plan didn’t work, go back to Step 1 and try again. Do not become discouraged.</p>
Advantages (Pros)	Disadvantages (Cons)												
_____	_____												
_____	_____												
_____	_____												
_____	_____												
_____	_____												

If you have a problem ready to submit to this method, choose one member of the family as the “secretary.” That is, one person writes down what everyone else has said and tries to keep everyone on task. Usually, this is done by the IP (who may

relish his/her role as the one who organizes the family's work on this task). But you can also encourage a parent who hasn't said much, or a quiet sibling.

Once the family has solved a couple of problems in the sessions, ask them to take another small, specific problem and work on it outside of the session. If it seems like the process is not fully within their grasp, ask them to take a specific part of the problem-solving process (e.g., brainstorming and evaluating solutions) to work on at home after defining the problem in the session. Encourage the family to implement one problem solving session on their own between sessions, using the Problem Solving Worksheet to record their efforts.

Transitioning from one Problem-Solving Session to the Next

Start off every session by asking how the problem-solving went (or whether they had an opportunity to practice new communication skills, such as expressing negative feelings). Ask to see any completed communication or problem-solving skill forms.

Be creative in how you integrate communication with problem-solving skills. For example, the family may be having a hard time defining the problem because one member is long-winded; this is an opportunity to practice communication clarity ("OK, let's talk one at a time, and try to keep your suggestions to a single sentence that _____ can write down on the form").

Recall that you are now meeting biweekly. When switching to biweekly sessions it is important to explain to the family that fewer sessions can help them implement the skills in their natural world.

Consider how to address the following: many events have occurred between the current session and the last, but there has been little effort to utilize the problem-solving skills. Keep emphasizing to the family that most of the work needs to be done outside of the session during these final phases. The sessions should be seen as "booster sessions" or "tune-ups" regarding use of the problem-solving skills (and where relevant, the communication skills) and a chance to help the family get out of intractable conflicts that the members have felt incapable of solving. Try to get through one full problem-solving task, from problem definition to solution implementation, in each of the final sessions. Continue to integrate education, communication skills, and problem solving depending on what the family brings into each session.

Typically, the therapist is most central in structuring and directing the problem solving process when introducing it to the family, but it is important to take a less active role over time and ask family members to lead the family through the various steps of problem-solving. Coach them to develop a well-articulated and feasible action plan by the end of the session.

Troubleshooting Use of the Communication and Problem-Solving Skills

It is not uncommon for a family member to complain that he or she is practicing the skills and trying to implement them into daily life, but others don't seem to be doing so. In sessions 10-12 (if not sooner), check in with family members about how they are doing with implementing stress management, communication, and problem-solving skills in their daily lives. If they are struggling with these, it may be helpful to have a

problem-solving discussion on this topic. How can family members implement the skills they have learned in therapy into their daily lives?

Termination

During the final sessions, discuss the family's reactions to the therapy. Ask questions of the form, What did you like/not like about the treatment? How was it helpful? How could it have been more helpful? What was your reaction to the education? The communication training? The problem solving? If we were to do the program with you all over again, what would you want to do differently? The issues described in the box below can guide the questions you pose to them.

You can also communicate your own reaction to working with the family. Underline the progress the IP and family have made (if this is the case) and express optimism about the future. Encourage each member of the family to express their feelings, positive or negative, about treatment ending. Keep in mind that if the patient or one or more family members is "happy we're done," this may be a good thing and indicative of growth.

Issues to Explore in the Final Sessions

Has the IP and parents made sense of their experiences of mood or psychotic disorder? Do they agree on what the symptoms and prodromal signs of episodes are?

Have they come to accept the notion of recurrence and vulnerability to future episodes?

Are they on the same page about the IP's need for medications?

Do the parents and IP have a clearer idea of what constitutes the illness and what are his or her personality attributes, or what are typical teenage behaviors?

What have they learned about stress and how to cope with it?

How has their family communication and problem-solving changed? How can they remember to use the skills and keep from "sliding back" into old habits?

Discuss the family's transition out of FFT and about their ongoing commitment to treatment (and, if relevant, research). If they want to continue with therapy, talk with them about treatment options either at your clinic or in the community.

Good luck in your implementation of FFT!

V. OPTIONAL TREATMENT EXERCISES

Optional Topic 1: School Accommodations

If the youth has a history of academic difficulties, you may wonder whether he has a learning disability. Or, the striking social and emotional problems and perhaps nearly psychotic symptoms that are exacerbated by school attendance may point to the importance of making changes in the school context. The family may not know that there are many services the youth can obtain through the public school system, and many changes that can be made within each classroom to support the youths' functioning.

How Can the School Help?

What can be expected from the school:

- Under the Individuals with Disabilities Act (IDEA; 1975), schools are responsible for identifying and evaluating students with disabilities who require special education and services and following through and providing them with an Individualized Education Program (IEP).
- These services are to be provided in the least restrictive environment appropriate to the child's needs and that children should be integrated with other children with and without disabilities, and still receive special services (inclusion).

Ways in which the school is helping thus far:

-
-
-
-

Ways in which the school could be more helpful:

-
-
-
-

The optional handout entitled “How the School Can Help” is very useful in educating families about what they can expect from the schools in general terms (for example, the right to learn within the least restrictive environment; the notion that school accommodations can serve to create a less stressful environment for the youth). This form is a useful tool for helping the therapist to focus family discussion on what is working well in the school environment and what may not be working well and require intervention.

Ask all members of the family to participate in the discussion with the eventual goal of generating a list of issues and a plan for addressing those issues with the school. Ideally, the family should be supported in taking responsibility for setting up meetings with teachers, and/or the school

counselor and/or the school psychologist. It is important that the family has control over the amount of information they feel comfortable sharing with the school. They may want to talk about the best way to phrase requests and about how much information is necessary to share within the school context to get the services that they need. Communicating with school officials is an ideal time for the parents to practice their communication skills!

Optional Topic 2: Relaxation Training

The goal in this lesson is to teach the IP and his/her family a behavioral technique that they can use to reduce anxiety in a variety of situations. We tend to use an abbreviated form of the “relaxation via tension-relaxation” technique described In Goldfried, M. R. and Davison, G. C. (1976) in their book entitled Clinical Behavior Therapy on pages 88 –89. Family members are told that after some practice, this is a technique that they can use inconspicuously in class, at work, or when out with friends. Usually we introduce the technique and help them to tense and relax several muscle groups, but do not go through all of the muscle groups described in the text.

For example, we instruct family members to sit back and relax and to close their eyes if they feel comfortable doing so. We then read the following from the Goldfried and Davison text:

“Direct your attention to your left hand. I’d like you to make a fist with your left hand and to squeeze that fist tightly. Study the tension in your left hand and arm (5 second pause). Now relax the left hand and let it rest. Notice the difference between the tension and the relaxation (5 second pause). Now squeeze your left hand into a fist again, tightly, and notice the tensions in your hand and arm. Study those tensions (5 second pause), and now let go. Let your fingers spread out and relax. Notice the difference between tension and relaxation.

Now let’s do the same thing with the right hand. Repeat the steps above with the right hand. Then invite the family to take note of the difference once again between the tension and the relaxation and enjoy the contrast.

Now clench both your hands into fists and bring them towards your shoulders. Feel the tension in your arm and shoulder muscles (pause 5 seconds). Now relax. Let your arms drop down to your sides, and notice the difference between the tension that was in your arms and the relative relaxation that you feel now (5 second pause). Let’s do that once again now. Clench both hands and bring them up toward your shoulders, trying to touch your shoulders with your fists. Study that tension. Hold it. Study it. And now relax. Once again, let the arms drop and study the feelings of relaxation, the contrast between tension and relaxation. Just keep letting go of those muscles further and further (5 second pause).

Now we can direct our attention to the shoulder area. Shrug your shoulders, bringing both shoulders up toward your ears, as if you wanted to touch your ears with your shoulders. And note the tension in your shoulders and up in your neck. Study that tension. Hold it. And now relax. Let both shoulders return to a resting position. Just keep letting go further and further. Once again, note the contrast between the tension and the relaxation that’s now spreading into your shoulder areas (5 second pause). Do that once again. Bring both shoulders up as if to touch the ears. Feel the tension in the shoulders, in the upper back, in the neck. Study the tension in these muscles. And now relax. Loosen those muscles. Let your shoulders come down to a resting position, and study the contrast once again between the tension and the relaxation (5 seconds).”

After this introduction, the IP may be better able to “tune in” to his/her body and describe what muscles they tend to clench when stressed. Then, those particular muscle groups can be targeted in further work. For example, if one adolescent says that he/she tends to furrow his/her brow, the family can practice wrinkling up their foreheads, creating tension in their foreheads, and then relaxing their foreheads. The therapist should continue tailoring the relaxation exercise to the habits/tendencies of the participants.

If some family members have difficulty falling asleep at night, they could try this muscle tension/relaxation technique, starting with the top of their head and working their way down to their toes, briefly tensing and relaxing all of the various muscle groups in their face, neck, shoulders, arms, stomach, back, legs, and feet. This type of focused relaxation may help them to calm their bodies and minds down enough to fall asleep.

Relaxation techniques may be particularly useful for people who experience distressing positive symptoms, such as perceptual abnormalities or paranoia. Relaxation techniques may help them to refocus their attention.

Optional Topic 3: Social Skills Enhancement

It is useful to start out this section by checking in with the youth and asking about his/her level of social functioning. You can say something like the following:

Clinician: Sara, I know in the first session you mentioned that you have not been spending much time with friends because you 'haven't felt like it.' What's it like for you when you are around your peers at school?

Sara: I don't know. I guess I've noticed that this whole school year I've just felt kind of awkward around people, like I don't know what to say. I get nervous and worry that people are going to make fun of me. I usually just spend time by myself when I'm at school.

Clinician: I've talked with many young adults in our program who have said the same thing; they don't know what to say to people and they feel nervous in social situations. Oftentimes this can be a stressful experience since so much of our day-to-day lives take place in social situations. Sara, if you are interested, I think it could be useful to talk some more about this.

Sara: Okay, that's fine with me.

Typically, it is difficult to figure out whether the patients we see in our program are experiencing social functioning impairments because they lack social skills, suffer from depression or negative symptoms, have some mild paranoia, have social anxiety and related social avoidance, or have co-morbid Asperger's or Pervasive Developmental Disorder NOS. Despite the difficulty discerning what factors are influencing the youth's social impairment, it is a good idea to introduce the potential relationship between symptoms and social functioning. For instance, you can explain that positive symptoms, such as suspiciousness and/or odd beliefs, can cause the patient to be ostracized or feel worried about taking social risks (e.g. meeting new people, initiating social contact, entering into a conversation, etc.). Ideally, it is best to tailor this discussion to the family you are working with. You can highlight the particular symptoms that you believe could be impacting the youth's functioning. Below is an example of how you might initiate this conversation,

Clinician: Many of the people we see in our program talk about having a hard time socially. Sometimes symptoms such as anxiety, depression, or feeling suspicious can make it difficult to be in social situations. Jonathan, have you noticed a change in your level of interest in being social?

Jonathan: Well I don't like to be around lots of people. It makes me nervous.

Clinician: Do you know what it is about being around people that makes you nervous?

Jonathan: I guess I think that people are talking about me. I know that sounds stupid since they probably aren't, but I still worry about it.

Clinician: I don't think that sounds stupid. It is actually really common for many of the young people we see in our program to have suspicious thoughts and to feel nervous around people. If you could learn strategies to make yourself feel more comfortable in social situation, do you think you would be more interested in being around people?

Jonathan: Yes, but it's hard to imagine not feeling nervous.

Clinician: Well perhaps we can spend some time talking about what kinds of goals you have in regards to being social. For instance, do you want to learn strategies to identify people that might be kind and supportive friends? Or would you like to brush up on some conversation starting skills? I bet your parents might have some ideas too.

Identifying Goals for Enhancing Social Skills

At this point in the session many concerns about social functioning might have already been brought up. You should draw from some of those concerns and facilitate a discussion aimed at defining the specific goals you plan to work on during the session. Examples could include,

1. I want to meet some new people.
2. I want to learn how to start a conversation with a new person.
3. I want to feel more comfortable in social situations.

You should write down some of the goals on a piece of paper with 2 columns (1 for goals and the other for social skills strategies). If the IP is having trouble generating ideas for particular goals you can offer up some of the above examples as common goals that individuals like to work on.

Develop and Practice Social Skills

Once you have listed about 3-4 goals you can work with the family to generate ideas to help develop social skills and coping strategies. It is a good idea to work through each goal one at a time.

Here is an example of working on the goal of learning how to initiate a conversation with a new person: Turn to the parent and ask,

“_____ (mother's name), how do you typically start a conversation with someone new?”

Write down some of her ideas. You can ask for more ideas from other family members. Be sure to create an idea-friendly atmosphere by not being too quick to criticize the suggestions. You can also add some ideas of your own once the family members have listed a number of suggestions.

Once you have listed a few strategies, it is a good idea to role-play some of them. It is normal for individuals to feel awkward and/or feel resistant to role-playing at first. Try turning to the IP and ask if he/she would be willing to practice some of the strategies with you. If he/she seems uncomfortable you can have one of the parents role-play the strategy with you first. Once a strategy has been practiced, you can encourage the patient to try it out with the person of their choice in the room.

If a goal is not conducive to role-playing that is fine. An example of a goal that might not warrant a role-play, at least initially, is if the IP stated that she wants to meet new people but she does not know how to go about finding someone to talk to. A good strategy for tackling this goal is to encourage the IP to identify her interests (music, videogames, skateboarding, etc). Next you can ask for ideas about where to find someone who shares those interests (e.g. music store, school club, skate park, etc). Once you have generated some ideas about where to find potential friends, you can ask the IP if he/she knows how to initiate a conversation with someone new. If he/she is uncertain about how to do that, then you can move on to a role play exercise.

VI. REFERENCES

- Amenson, C., Schizophrenia: A Family Education Curriculum, Pacific Clinics, 1998.
- Caspi, A. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science*, 301(5631), 386-389.
- Clarkin, J. F., & Miklowitz, D. J. (1997). Marital and family communication difficulties. In T. A. Widiger, A. J. Frances, H. A. Pincus, R. Ross, M. B. First, & W. Davis (Eds.), *DSM-IV sourcebook* (Vol. 3, pp. 631-672). Washington, D. C.: American Psychiatric Association.
- Greene, R. (1998). The explosive child. NY: Guilford.
- Goldfried, M R. (1976). Clinical behavior therapy New York: Holt Rinehart and Winston. Inc.
- McFarlane, W R. (2002). Multifamily groups in the treatment of severe psychiatric disorders.. New York, NY, US: Guilford Press.
- Mueser, K.T., Gingerich, S. (1994). Coping With Schizophrenia: A Guide for Families. Oakland, CA, US: New Harbinger Publications.
- Miklowitz, D. J. & George, E. L. (2004). Treatment Manual for the Family-Focused Therapy of Adolescents with Bipolar Disorder (FFT-A). University of Colorado, Boulder.
- Miklowitz, D. J. (2010). Bipolar Disorder: A Family-Focused Treatment Approach, 2nd Ed. New York: Guilford Press.
- Papolos, D. F., & Papolos, J. (2000). *The Bipolar Child*. Broadway Books.

TREATMENT SUPPLEMENTS

Supplement to Clinicians' Treatment Manual for FFT

Comorbid Anxiety Disorders

Elizabeth L. George, Ph.D.

University of Colorado at Boulder

David J. Miklowitz, Ph.D.

University of California, Los Angeles

Anxiety Disorders

Anxiety disorders are frequently comorbid with bipolar disorder or clinical high-risk conditions in teens and adolescents. Comorbidity of all anxiety disorders (i.e., separation anxiety, generalized anxiety, specific and social phobias, obsessive compulsive, panic, and posttraumatic stress disorders) ranges from 32% to 50% for adolescents with bipolar disorder depending upon the study (Geller & DelBello, 2003). When examining subsyndromal bipolar disorders, the comorbidity rate is 33.3%. In the broader adult population, rates of anxiety disorders among bipolar patients range from 10.6%-62.5% for panic disorder, 7.8-47.2% for social anxiety disorder, 7-40% for posttraumatic stress disorder, 3.2-35% for obsessive-compulsive disorder, and 7-32% for generalized anxiety disorder (e.g., Cassano et al., 1999; Chen et al., 1995; Dilsaver et al., 1997; Kessler et al., 1994; Kessler et al., 1997). Because anxiety is so common in adolescents and adults diagnosed with bipolar disorder, it is important to address anxiety disorders in working with kids at risk for developing bipolar disorder.

A typical clinically observed developmental path for teens is to have been diagnosed with many anxiety disorders before a bipolar or CHR syndrome is identified. For example, many clients initially receive a diagnosis of separation anxiety disorder in early childhood, go on to develop a “sensory integration disorder”, then an obsessive-compulsive disorder diagnosis, and finally a generalized anxiety disorder before a psychiatrist recognizes a subthreshold bipolar or psychotic condition. Given the duration of the anxiety symptomatology by the time the child becomes an adolescent, he or she may have developed many maladaptive behaviors in response to the anxiety that the family and clinician must address.

Depending on the presentation of anxiety, managing this symptom cluster in the child can cause a lot of frustration for parents. Often the kids who struggle with anxiety are alternatively needy and defiant. Their anxiety may manifest in needing more support from parents at times and then switch to fear around being too needy and pushing the parents away. Parents often feel confused and frustrated in response to this push-pull from the IP. Anxiety may also appear as temper tantrums, rage attacks, or withdrawal in the IP making it even more confusing for parents to understand the origins of their offspring’s difficult behavior.

Kids with mood or attention symptoms and anxiety may be more likely to abuse substances and therefore complicate the treatment and familial relationship further. Many adolescents do not report feeling relief from anxiety with treatment of their mood. In fact, many report being more aware of their anxiety once the “noise” of the mood symptoms has subsided. They may turn to marijuana or harder drugs, believing that these substances relieve their symptoms of anxiety more effectively than any of their medications.

Given the potential for maladaptive behaviors and family disconnection, FFT can be quite helpful for kids coping with anxiety disorders, as well as parents trying to cope with the offspring’s sometimes frustrating and irrational behavior. Through FFT the IP and family can learn more adaptive coping strategies for managing anxiety.

Addressing Anxiety Within the Education Module

If it is apparent from the initial evaluation that the IP has significant anxiety or a diagnosable anxiety disorder, the clinician reviews the symptoms of the anxiety disorder during the discussion of symptoms in the education portion of FFT. It is quite helpful to parents to have a description of how anxiety presents itself and the teen's or young adult's idiosyncratic response to anxiety. Due to lack of knowledge and extreme discomfort, children often choose maladaptive patterns for managing anxiety. Some kids isolate more when they are anxious, become more defiant due to the agitation driven by the anxiety, or self-medicate with alcohol or illicit substances. Through education, clinicians can help the family and the IP find more productive ways of managing the anxiety.

During this portion of the education the clinician may discuss the high rates of anxiety for individuals with mood or psychosis symptoms, and how these disorders can be distinguished from each other. Acquiring this information will decrease the IP's sense of being different and feeling isolated. The clinician may present a model for recording anxiety on the thought or mood chart. Some IPs record anxiety as a separate line with accompanying symptoms. Other children place an A on the mood line that anxiety accompanies. Anxiety may accompany hypomania and depression. For example, an IP may have more separation anxiety from parents when depressed and more panic attacks when hypomanic. We discuss FFT for each of the separate anxiety disorders below.

The discussion of anxiety symptoms often leads to productive discussions about the importance of observing and being familiar with the IP's risk factors and symptoms so as to be able to anticipate and prepare for episodes of anxiety. Anxiety is such a common experience that this may be an opportunity for other members of the family to talk about their own experience with anxiety and help the teen or young adult to feel less "in the hot seat." Often, family members have good suggestions for how they manage their anxiety. The IP can also feel some sense of competence in this discussion by sharing techniques for managing anxiety that may prove helpful to other family members.

It is quite helpful to explain various techniques (i.e., cognitive restructuring, relaxation techniques, exposure) that can be used for anxiety disorders and symptoms. Self-help books such as Mind Over Mood: Change how you feel by changing the way you think (Greenberger and Padesky, 1995) or Mastery of Your Anxiety and Panic: Workbook (Treatments that work; Barlow and Craske, 2007) can be recommended. Behavioral techniques will be discussed in more detail as we describe how FFT addresses each of the different anxiety disorders.

When medication is covered (**Handout 8, Medications Commonly Used to in Outpatient Treatment**), parents often ask questions about medication for anxiety disorders. There are several medications that can be used for managing anxiety. You can educate families on the medications that are addictive (i.e., Klonopin) or that may not be helpful given the at-risk person's vulnerability to mood cycling (e.g., Paxil). This discussion may prepare the family to discuss options with the psychiatrist and not feel hopeless about addressing this cluster of symptoms.

When you discuss prevention action plans, address worsening of symptoms of anxiety also. If the family and/or the IP notices an increase in anxiety symptoms, make sure they have a plan that includes using coping skills learned in FFT (e.g., talking to parents, reducing stress), calling the clinician, and/or calling the psychiatrist. Catching and treating these symptoms early may make them less debilitating, especially if kids are also taught adaptive behaviors to manage them.

Addressing Anxiety Within the Communication Module

The communication module of FFT is designed to provide a neutral and nonthreatening framework for discussing family issues. Communication training is the first step in resolving problems that arise in the family. At this point, the family's goal is to better understand each person's position and feelings as they relate to a personal or family problem.

Often, the IP's response to anxiety may seem quite irrational and out of context. The communication skills provide a forum for the IP to discuss how his or her frustrating behavior may be the best response he or she has for managing significant anxiety. For example, Kurt, a 16 year-old boy with Bipolar NOS, ADD and significant GAD, was caught smoking marijuana by his mother in his room. When we met as a family she was furious and considered finding an alternate living arrangement for Kurt. She stated that the family had a "no drug" policy in the home and that this behavior was unacceptable. Kurt began to cry and said, "You just don't get what I am going through". The FFT clinician, while holding firm on her stance that marijuana could ultimately worsen Kurt's anxiety problems, encouraged Kurt to describe to his parents how he felt and why he used marijuana. His parents were asked to use the active listening skill. He shared with his parents that he was frequently anxious, sick to his stomach, and suffered from muscular aches and headaches. He told them that the only relief he got was when he smoked marijuana. Though his parents were unhappy about his drug use, this discussion prompted a compassionate series of problem-solving exercises focused on how they could address the anxiety as a team. Kurt and his parents agreed to be more conscientious about using the relaxation techniques they had learned in FFT and getting a consultation with the psychiatrist to see what anxiolytic medications Kurt could take that might decrease his desire for Cannabis.

Addressing Anxiety Within the Problem-Solving Module

Though the symptoms of anxiety are distressing, it is usually the IP's maladaptive response to the anxiety that is the topic of discussion in problem solving. If a teen has begun to experience extreme anxiety, the family may not be aware of what he or she is feeling. They may, however, notice that the teen has begun to self-isolate and spend less time with the family. He or she may spend time in compulsive ritualizing. This maladaptive coping puts a strain on family relations and becomes the focus of the problem-solving exercises.

For example, Marissa, a 13 year-old, stopped going out to eat with her family. Until recently the family had gone to dinner at their favorite restaurant every Friday night. It was the most significant time they spent together as a family. During the communication module of treatment they learned that she was experiencing obsessions about germs and was beginning to engage in compulsive washing

behavior. Though she missed spending time with the family, she felt that going to a restaurant would be very stressful for her.

Once the family better understood the problem, they were able to generate several alternative ways they could spend time together as a family. Marissa began to feel less anxious when she no longer felt that her family was displeased with her. In addition, the family was able to feel less annoyed by Marissa's anxiety since they understood that it was not personal. This is an example of how effective problem resolution can make a positive shift in family tension and reduce or alleviate anxiety symptoms.

FFT and Specific Anxiety Disorders

Though the modules of FFT address the problem of anxiety in general, the specific anxiety disorders present in very different ways and must be addressed separately. In many of the cases discussed below, treatment was supplemented with anxiolytic medications. We also referred patients to individual cognitive-behavioral or group therapists who specialized in anxiety disorders when we felt that issues provoking anxiety could not be fully addressed in the family context.

➤ *FFT and Separation Anxiety Disorder*

Many of the kids we work with still have symptoms of separation anxiety. Separation anxiety may present as: a teen who does not want to go to school, a teen who at 14 has not yet spent the night away from home at another teen's house, or a teen who becomes belligerent when one or more parents takes a business trip.

Nate, a 13 year-old boy with psychosis NOS, described becoming terribly anxious when away from his parents. His fears were complicated by the fact that his parents both worked and had recently separated. The arrangement developed by the family to manage Nate's anxiety was taxing for the whole family. When Nate arrived home from school early in the day, he immediately called his mother to quell his anxiety. If she was unable to soothe him on the phone, he flew into rages and "meltdowns." She usually had to return home to assure his safety. This pattern put a burden on her ability to function at work. In the evening, Nate's father drove over to the house and put Nate to sleep every night, a process that took hours and was very draining for the father.

In this family it was evident how the anxiety problems (fear of being alone) interacted with the mood dysregulation (raging when needs weren't met) in a maladaptive manner. It was very important for the clinician to provide education about the two different disorders – how the separation anxiety manifested itself and precipitated the exacerbation of mood and psychosis symptoms. All agreed (his siblings and his parents) that they found Nate's symptoms stressful but did not know how to change their responses. We used the communication module for Nate to talk to his parents about his fears and concerns related to being separated from them. He also expressed how uncomfortable he found the anxiety. Through talking about the situation the family was able to identify the actual problem – his fears about the dissolution

of his family and his difficulty soothing himself when certain anxiety-provoking thoughts arose.

Once this set of problems was clarified, the family was able to proceed with the problem-solving module. His parents felt very bad about his difficulties with mood (which developed at an early age), were scared of what he would do if they did not meet his demands, and felt guilty because of their breakup. It did not occur to them that Nate could take some responsibility for his emotional reactions.

Fortunately, Nate was quite interested in having tools to manage his anxiety so that he did not have to be so dependent on his parents – a new and more age appropriate goal for him. There were several solutions proposed to help Nate soothe himself in the absence of his parents. He could play videogames, do homework, call a friend, spend time with his sister, do a chore to earn some money, or fix a snack. The family agreed that if he'd tried several of these solutions and was still anxious, he could then call his mother. His list was very effective and Nate only called his mother one day in a week (a day when there was a thunderstorm which frightened him). Overall, Nate took more responsibility for soothing himself, which reduced family tension and moved him into a more age appropriate role.

➤ *FFT and Generalized Anxiety Disorder*

Generalized anxiety disorder (GAD) involves excessive worrying and the physical symptoms that go along with that state of mind. Sufferers may worry about the future ("I'll never be able to pass the test tomorrow") or the past ("I bet Tracy thought what I wore to school today was really ugly"). They may be excessively self-conscious, even rehearsing what they plan to say before they say it. They may be overly concerned about their competence and worry about every possible mistake they have made or may make. They may frequently ask for reassurance that what they're doing is OK. This level of worrying often leads to somatic complaints (e.g., frequent headaches or stomachaches) and/or to physical symptoms of anxiety like muscle tension or aches, restlessness, fatigue, difficulty falling asleep, relaxing or concentrating.

Sandy, a 17-year-old young woman with Bipolar Disorder NOS received a comorbid diagnosis of GAD during the administration of the K-SADS-PL. Her parents described her as "obsessing about things" and being preoccupied with "doom and gloom." They portrayed her as "constantly worried about how others see her," frequently second-guessing what she had said to friends that day and worrying about how it had been taken. They described an incident the previous week during which she had said something to an acquaintance, the acquaintance had gotten upset, and Sandy became so distressed about having said the wrong thing that she left school for the day. Sandy saw herself as extremely self-conscious and stated that she worried a lot about her future, even thinking frequently that she would die young due to her health problems.

One of Sandy's mood problems involved extreme anger outbursts during which she lost complete control. She became verbally abusive toward her family at those times, threw objects, punched holes in walls and hit or kicked family

members. Her parents reported that, at least in some instances, her anger outbursts were preceded by periods of worrying, feeling keyed up, and being unable to relax. In designing Sandy's mood chart, we decided that it would be important to track those periods of worrying and feeling physically keyed up to see how often the anxiety symptoms led to severe mood dysregulation. This proved to be helpful to Sandy as she was eventually able (sometimes) to see a "meltdown" coming in advance and to take steps to try to address the anxiety, rather than, in her parents' words, "Turning it into anger."

The FFT therapist also taught Sandy and her parents the elements of cognitive restructuring, including keeping track of automatic thoughts and their triggers, rating anxiety states, evaluating the evidence for and against each thought, developing new, more balanced interpretations of events, and observing improvement in anxiety symptoms. Homework assignments using thought records helped generalize these skills to the home setting.

➤ *FFT and Phobias*

Specific phobias are commonly observed in these populations. Sometimes, anxiety becomes associated with a specific stimulus, resulting in a severe anxiety response when confronted with that stimulus. The stimulus is then avoided or endured with significant distress. The patient generally understands that the intensity of the response is irrational and extreme.

Rob, a 15-year-old with severe depression and early psychosis symptoms, had developed a phobic reaction to a character in a science fiction movie (E.T., the Extraterrestrial). The movie had originally come out when Rob was about five years old and had made a lasting impression on him. For years afterward, Rob was terrified of E.T. dolls, movie advertisements, and memorabilia and even refused to let family members mention the name. Our knowledge of the existence of the phobia emerged during the administration of the K-SADS. On the surface, it seemed that this phobia would not cause much difficulty in terms of Rob's current functioning, because it was a stimulus that could be easily avoided. However, the ten-year anniversary of the release of the film occurred during the course of FFT, and there was quite a bit of media attention to the re-release. Rob's mother brought it up to his therapists before the anniversary date, in anticipation of an increase in the adolescent's stress and anxiety level. We discussed it using the problem-solving exercise when the adolescent was not present. The biggest decision was about whether to name it as a problem for the whole family to discuss or to maintain a more low-key approach to it. The concern was that by labeling it a potential problem and having the adolescent participate in the discussion, we could be unnecessarily raising Rob's anxiety and creating a self-fulfilling prophecy.

After considering the advantages and disadvantages of both approaches, the mother decided to downplay the issue and see what happened. As it turned out, the re-release passed without any significant crisis. The family did not go to the theater to see it, and although the adolescent maintained his avoidance of talking about the movie and the character, and continued to insist that it was not to be mentioned at home, no further adverse psychological reactions ensued. It's probable that in this case, the severity of the phobic response had

actually diminished over time, although the patient's maturity level and need for control over his anxiety level precluded him from being able to confront it directly.

➤ *FFT and Obsessive-Compulsive Anxiety Disorder*

OCD symptoms are very distressing and impairing for the IP and can cause considerable conflict in the family. Sue, a 13 year old was, at times, immobilized by obsessions. She envisioned herself picking up a knife and slitting her mother's throat. These obsessions were so terrifying for her that she had begun to avoid her mother and spend most of her time in her bedroom. She had never heard of obsessions before and though she did not want to hurt or kill her mother she was very confused by these images and was scared that somewhere inside this was how she really felt. She did not report any compulsions.

We spent a significant time during the symptom component of the education section discussing the difference between negative thoughts, delusions, and obsessions. We discussed how, though the obsessions were scary for Sue, they did not represent her real feelings about her mother. We also talked about options for managing the obsessions. One strategy was for her to use cognitive restructuring and remind herself when she had the obsessions that they were just part of her chemistry and did not represent her real feelings. We taught her relaxation techniques to use a couple of times during the day each day, along with a 3-minute breathing space from mindfulness meditation. We discussed her symptoms with the psychiatrist who recommended a low-dose SSRI. We taught her several distraction techniques. Some of the things that helped when she had the obsessions were playing video games, calling a friend on the phone, snapping a rubber band on her wrist, and riding her bicycle. Through the various techniques she learned in the program she was better able to manage the obsessions and began spending more time with her mother so that her fears of harming her diminished naturally (behavioral exposure). Though she learned to manage her anxiety, once the symptoms of depression lessened her obsessions decreased as well.

➤ *FFT and Panic Disorder*

It is well known that in panic disorder, the response of the individual to the panic symptoms can exacerbate the original panic response, either in the moment of an attack or gradually over time. Panic disorder can be extremely debilitating for the individual and the family. This illness can lead to the IP being housebound. Often, the family must completely alter their lifestyle to address the needs and concerns of the individual.

There are two parts to treating panic disorder with children. The first involves helping the IP cope with the actual panic attack (e.g., learning not to catastrophize internal bodily sensations) and the second centers around helping the IP resume typical activities that he or she has given up as a result of fear of having a panic attack. To address managing internal bodily sensations related to panic, it is recommended that patients seek interoceptive exposure treatment.

David, a 17 year-old boy with Bipolar NOS and many symptoms of depression and anxiety, had been having panic attacks for several years. He had become so fearful of having a panic attack in public that he was housebound and did not take part in any family activities. This was a huge loss for his parents and younger sister who missed his presence during their family outings. With appropriate medical treatment the panic attacks stopped but David's fears of leaving the home continued. Given that this problem was one of the most concerning for his family, the clinician addressed this issue early in the treatment using the problem-solving module. The family identified the problem as "not having enough mobility to do things together as a family." They were able to come up with several options to try. Part of the solution involved David trusting that though he may become anxious during an outing, he would be able to handle it with some relaxation and meditative his therapist had taught him. The FFT clinician created a relaxation tape that David could use at home twice a day.

Once David had learned to self-relax, he worked with his family on imagining different anxiety provoking scenarios (i.e., going to the movies) and then used the relaxation techniques he learned on the tape. Later, when David became anxious, he was able to respond to cues from his mother to use his relaxation techniques. His family was instructed on gradual exposure exercises (e.g., gradual excursions outside of the home) and given reading materials on managing panic disorder using graded exposure techniques. In this manner he was able to manage his anxiety more effectively. He and his family were able to do more together.

Conclusion

In FFT studies, there have been times when medical intervention has proven successful or anxiety symptoms abate when the mood or psychosis symptoms were under better control. In other instances, behavioral techniques have helped with relief of symptoms. Generally the family and IP benefit from using the communication and problem-solving skills to understand and manage anxiety, regardless of the form it takes. By combining different methods of addressing anxiety and developing a plan to be used in case of symptom exacerbation, a therapist and family may have success in improving these complicated comorbid conditions.

References

- Barlow, D. H. & Craske, M. G. Mastery of Your Anxiety and Panic: Workbook (Treatments that work). NY: Oxford University Press, 2007.
- Cassano GB, Pini S, Sacttoni M, Dell'Osso L: Multiple anxiety disorder comorbidity in patients with mood spectrum disorders with psychotic features. *Am J Psychiatry* 1999; 156(3):474-6.
- Chen YW, Dilsaver SC: Comorbidity of panic disorder in bipolar illness: evidence from the Epidemiologic Catchment Area Survey. *Am J Psychiatry* 1995; 152(2):280-.
- Dilsaver SC, Chen YW, Swann AC, Shoaib AM, Tsai-Dilsaver Y, Krajewski KJ: Suicidality, panic disorder and psychosis in bipolar depression, depressive-manía and pure-manía. *Psychiatry Res* 1997; 73(1-2):47-56.
- Geller, B. & DelBello, M. *Bipolar Disorder in Childhood and Early Adolescence*. NY: Guilford Press, 2003.
- Greenberger, D. & Padesky, C. *Mind Over Mood: Change how you feel by changing the way you think*. NY: Guilford Press, 1995.
- Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Arch Gen Psychiatry* 1994; 51(1):8-19.
- Kessler RC, Rubinow DR, Holmes C, Abelson JM, Zhao S: The epidemiology of DSM-III-R bipolar I disorder in a general population survey. *Psychol Med* 1997; 27(5):1079-89.
- Leverich, G. S., McElroy, S. L., Suppes, T., Keck, P.E., Denicoff, K. D., Nolen, W. A., Altshuler, L. L., Rush, A. J., Kupka, R., Frye, M. A., Autio, K. A., Post, R. M.: Early physical and sexual abuse associated with an adverse course of bipolar illness. *Biol Psychiatry* 2002; 51; 288-297.

Supplement to Clinicians' Treatment Manual for FFT

Handling Suicidal Crises

Dawn O. Taylor, Ph.D.

Elizabeth L. George, Ph.D.

University of Colorado at Boulder

David J. Miklowitz, Ph.D.

University of California, Los Angeles

In treating youth at high risk for psychosis or bipolar disorder, suicidality may emerge as a concern. As experienced clinicians know, if this issue arises, it must take priority as an agenda. The communication and problem-solving skills can be used to help structure a discussion of this usually highly emotional topic. You will often need to depart from the treatment protocol in order to deal with a suicide-related crisis; you may need to increase the frequency of sessions, make them longer, switch from one module to another (e.g., education to communication skills) or have individual sessions with the IP. We have found that in children and teens at high risk for bipolar disorder, FFT is associated with reductions in suicidal ideation and behaviors. One of the mediating mechanisms of this treatment effect is through reducing family conflict (Miklowitz et al., 2020; Miklowitz & Taylor, 2006).

There is a distinction between suicidal behavior and self-injurious behavior without the intent to die. Suicidal behavior is driven by an express desire to end one's life. Self-injury [as defined in Bodily Harm (Conterio, Lader and Bloom, 1999)] is the deliberate mutilation of the body or a body part, not with the intent to commit suicide but as a way of managing emotions that seem too painful for words to express. This is a different problem in many ways. It tends to be part of an ongoing pattern of behavior rather than an acute condition and, although certainly to be taken seriously, is generally less lethal than suicidal behavior. We address suicidality and self-injury as separate topics.

Assessing Suicide and Thinking Preventively

You will have inquired about suicide in the assessment phase of treatment and will know whether (a) suicidal ideation has been a problem in the past and (b) there has been any history of suicide attempts. If the IP or family members bring up concerns about suicide, or if the IP is suffering from moderate to severe depression during the course of treatment, you must follow the standard clinical protocol for assessing the seriousness of the situation. Brent and Poling (Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth, 1997) list the following components of an assessment of suicidality: degree of suicidal intent, relationship to other psychiatric symptoms and syndromes (for example, a chronically depressed patient who has an exacerbation of suicidality following abuse of marijuana), the nature of the precipitant, and motivation. Motivation may be a true wish to die, but for about two-thirds of adolescent attempters, the motivations are different from this, and include a desire to escape, to gain attention, express hostility or induce guilt (Hawton, Cole, O'Grady & Osborn, 1982). Essential questions during the assessment include:

- When does the patient experience suicidal ideation?
- Are there identifiable triggers?
- Does he or she have a plan?
- How long does it take for the ideation to develop into active intent?
- How long have these thoughts been occurring?
- How frequent are they?
- What does the patient do when s/he has these thoughts?
- What typically prevents the patient from acting on the suicidal ideation?

In comparing 120 consecutive youth suicides (younger than 20 years old) to 147 matched community controls in greater New York City, results showed that psychosocial factors had an effect size comparable to diagnostic factors in increasing

suicide risk. The most notable risks were derived from school problems, a family history of suicidal behavior, poor parent-child communication, and stressful life events (Gould, Fisher, Parides, Flory, & Shaffer, 1996). These results underline the importance of working to improve family communication and bolster strategies for coping with stress in adolescents with mood problems.

In our work, we have observed another situation that often results in suicidal thoughts or actions. The IP who erupts into out-of-control rages often feels intense guilt afterwards. These frightening acting-out episodes have some similarities to seizures in that, once past a certain point, reining the behavior in appears beyond the IP's control. Nevertheless, the IP may feel great shame and remorse afterwards, and begin to think that he or she does not deserve to live. Regardless of whether an episode of rage occurs, conflict with parents is one of the most common precipitants for suicidality (Brent & Poling, 1997). This underscores the usefulness of adopting a family therapy approach to treating suicidal youth. If the family can learn less conflictual ways to solve problems, the incidence of suicidal episodes in general should hopefully be reduced.

Young people, true to their nature, seem to act more impulsively than adult suicide attempters and may make attempts that seem to come out of nowhere, with little warning. The thinking leading up to the attempt may seem irrational ("My best friend didn't talk to me in school today; she must hate me, I want to kill myself"), grandiose ("Once I'm gone, everyone will be sorry and know I was right") or psychotic ("My soul is empty and I have no right to continue to exist"). Suicide in general, and especially in adolescents, is difficult to predict. Given that the capacity to prevent will be imperfect, the importance of treating the conditions that lead to risk or that increase impulsiveness (e.g., depression, anxiety, psychosis, substance abuse) is enormous.

When the issue of suicide comes up, the reactions of parents can vary widely. Some parents seem to underreact, perhaps because it is too painful for them to think and talk about the possibility of their offspring's death. Sometimes parents see suicidal ideation as manipulative and respond by ignoring it so as not to reinforce the IP's attempt to "get attention." Other parents may overreact, sometimes becoming so distressed that it is hard to keep them focused on the precipitating problem of suicidal ideation. Your task is to try to facilitate the parents' attempts to listen empathically and respond calmly. As mental health professionals know, suicide is a very real possibility that must be taken seriously and that requires both the IP and those who care about him or her to take responsibility and make whatever effort is necessary to ensure the offspring's safety.

Keeping the IP Safe

Several precautions must be taken with a highly suicidal person. You may need to have an emergency session with the IP and/or an emergency family session. You must try to negotiate a no-suicide contract with the person. Ideally, the IP will agree to do the following:

1. That he/she will not attempt suicide/harm between now and the next outpatient appointment.

2. The teen will inform an adult should he/she feel in danger of acting upon suicidal/aggressive thoughts.
3. Should there not be an adult available when the IP feels in danger of acting upon suicidal/aggressive thoughts, he/she will contact the clinician and go to the nearest emergency room.
4. The IP will try to avoid activities and situations that may increase the chance of feeling suicidal/aggressive.

If the IP will not contract for safety or does not seem reliable enough to follow a safety plan, you may need to speak with the family about arranging for someone to be with the offspring 24 hours a day. Hospitalization may be necessary. Make sure you have a release of information form completed so that you can communicate with the patient's physician and make him or her aware of the situation. Sometimes, suicidal episodes can be handled with the addition or adjustment of medication.

Addressing Suicidality Within the Communication Module

The communication skills taught in FFT can help keep these highly charged discussions about suicide moving in a constructive direction. Consider the example of Douglas, a 17-year-old patient with recurrent major depressive disorder and subthreshold psychotic symptoms (moderate ideas of reference). He received FFT with his parents and older brother, Harlan. Douglas had never made a suicide attempt, but thoughts of suicide had become more frequent and more intense over the previous few months, as Douglas had slipped gradually from a moderate to a severe depression. He had avoided bringing the suicidal thoughts up with his family because he was anticipating that each would react in a way that would feel uncomfortable to him. He “knew” that his mother would overreact, cry, and become overprotective. He believed that his brother would not know what to say, but would think Douglas was “really crazy” now and distance himself even more. He was concerned that his father would be disappointed in him and perhaps think he was weak.

Previous psychoeducation sessions had described suicidality as part of the symptom complex of depression and bipolar disorder. Thus, suicide was not framed as a moral or family failure but rather, part of Douglas's condition. The therapist, putting the suicidal thoughts in the context of Douglas's other problems, told the family:

“Suicidal thoughts and impulses are in themselves symptoms of depression. As Douglas has been getting more depressed over the last few months, it is not surprising that he also began having these despairing feelings. Suicidal feelings are at least in part a product of his condition.”

The therapist then asked Douglas to try to communicate his thoughts and feelings to his family: his feelings about dying and the reasons why it was so hard for him to share those thoughts. She asked the family to listen actively, without interjecting advice or suggestions.

DOUGLAS: I just keep thinking that this is never gonna get any better, that this family would be normal if I wasn't in it.

MOTHER: But Doug, why haven't you told me you were feeling like this? How can I help you if I don't know what's wrong?

THERAPIST: Remember, Kate that your job right now is to listen without trying to solve his problem. See if you can help Doug express his thoughts by paraphrasing them.

MOTHER: So you think we'd be happier if you weren't here?

DOUGLAS: Yeah, basically. And I didn't want to tell you about it because I don't want you to get all upset. You worry too much about me anyway. I don't want you to be watching me all the time, like you think I'm gonna do something stupid.

FATHER: But Douglas, why would you think we'd be happier without you?

DOUGLAS: Oh, I don't know. You wouldn't have to be coming to these therapy sessions and trying to figure out what's wrong with me all the time if I wasn't here.

FATHER: You think I'm unhappy about coming to these meetings?

DOUGLAS: I know you've got better things to do. You never had to do this kind of stuff because of Harlan.

FATHER: Do you think I feel differently about you and Harlan because of that?

DOUGLAS: I guess not. I know you love us both. Sometimes it just seems like I'm so screwed up that no one would want to be around me. (To Harlan) I know you don't want me around you and your friends.

HARLAN: (tearful) So you think I'd really rather have you gone for good? That's crazy. I'd hate it if you were gone. You're my brother.

Although the parents in this family still had difficulty with just listening, the communication skill format helped Douglas express feelings and thoughts he had been unable to express previously. In so doing, he received feedback and support from his family. They communicated clearly that they cared for him and valued his membership in the family.

Addressing Suicidality Within the Problem-Solving Module

There are at least two ways in which problem solving can be helpful for suicidal ideation. One is to help the IP and family generate a list of alternative behaviors that the IP can engage in when suicidal ideation becomes a problem. "Improving the moment" strategies might include relaxing, praying, meditating, going for a walk, taking a bath or a shower, talking to a friend or parent, fixing a meal, watching a favorite video, or reading a book. If there are indications that the IP's potential for attempting

suicide is high, problem solving can also be used to develop a plan to keep the IP safe. This might involve the parents temporarily taking over responsibility for functions the IP generally handles. Examples include monitoring medication if the suicide plan revolves around overdose of prescription drugs, or arranging transportation for an adolescent if he or she is deemed unsafe to drive.

Think of suicidal behavior as a problem to be solved. Suicidal ideation and attempts have antecedents and consequences. Determine if the IP's suicidal feelings are reliably evoked by specific stimuli (e.g., arguments with certain family members, ups and downs in a romantic relationship). Examine any self-statements that intervene (e.g., "I'll show him (boyfriend) that he can't treat me that way"). A detailed discussion of the chain of events, thoughts, feelings, and behaviors that led up to the last suicide attempt may be quite helpful. The generation of solutions focuses on ways to alter this chain of events (e.g., talking to supportive family members, journaling, listening to music) to derail the self-destructive behavior.

Case example

Here is an example of using problem solving to respond to suicidal ideation in a 17-year-old chronically depressed adolescent. Clare thought about suicide almost daily, even when she wasn't depressed, but her family was unaware of this. She had made three somewhat ambivalent attempts, by overdosing on pain relievers and other medications she had found around the house, but these attempts had never come to the attention of her parents. Clare would get ill and vomit, or just sleep the effects of the medication off, and go on as if nothing had happened.

During psychoeducation, as suicidal ideation was being discussed as a symptom of depression, the family was surprised to learn the extent of Clare's preoccupation with suicide. Her mother denied the danger of this thinking pattern but her father, who had experienced his own father's suicide, was quite concerned. The problem was defined as, "How to keep Clare safe". Clare's suicidal ideation was so habitual and ingrained that it seemed to have taken on a life of its own, making it hard to identify antecedents. During the generation of possible solutions, the clinician asked several key questions including:

1. Are you (Clare) willing to tell your parents if you become suicidal, and if so, how will you tell them?
2. What kinds of responses from your parents will you experience as supportive?
3. Is it safe for you to be alone when you are thinking this way? Is it safe for you to go out? Is it safe for you to drive?
4. At what point must action be taken? When that point arrives, what needs to happen and who is responsible for seeing that it happens?
5. At what point should the therapist, or physician, be called?
6. How else can your parents help? Where can you (the parents) get help if you are feeling frightened or unsure of how to proceed?

The family was able to agree on a comprehensive plan that enabled the parents to be more tuned in to when Clare was feeling unsafe, and to respond in ways that would reduce the danger. Both parents worked during the day, and Clare, who had left high

school, was alone the majority of most days until 3:00pm, when her younger brother got home from school. Clare agreed to try to contact one of her parents when the suicidal thoughts were becoming excessively intrusive, i.e., when she could not put them out of her mind and focus on something else, despite numerous attempts. It was not always possible to reach either parent at work, so her father decided to start carrying a pager. If Clare could not reach either parent, she agreed to page her dad and he agreed to call her at home as soon as possible.

The hope was that brief, supportive contact with either parent would defuse the situation and help Clare engage in something more constructive, like doing her home schooling lessons or even watching TV. It was agreed that the plan would be re-evaluated in two weeks, as it was unclear that Clare would actually initiate contact when she needed to, and it also remained to be seen whether contact with a parent would be enough to derail Clare's suicidal obsessing. Nevertheless, Clare felt less alone with her disturbing thoughts and more protected by her parents.

Self-Injury

Self-injury is a pattern of behavior that can include cutting oneself, burning oneself, hitting or biting oneself, head-banging, interfering with the healing of wounds and even more severe methods of self-harm (Conterio, Lader, and Bloom, 1999). The self-injurer does not intend to kill herself (most self-injurers are female), but has developed this behavior as a method of coping. Some of the youth we have worked with exhibit this behavior, so we present here some ideas (many of which are drawn from the book just cited) about how to understand and work with this problem in the context of FFT.

Self-injurers describe many reasons for their behavior. These generally fall into two broad categories: 1) analgesic or palliative aims and 2) communicative aims. The first category includes the common report that cutting helps the self-injurer feel calmer in the face of overwhelming affect or to feel grounded or "real." There is often a sense of self-control that ensues. In this sense, self-injury is like an eating disorder. Although everything in the youth's environment may feel out of control, the eating or self-mutilating behavior is something over which she has exclusive control. Some self-injurers state that cutting helps them feel "cleansed," as if they have released something poisonous or contaminated from within themselves. A similar motive involves the self-injurer who feels excessively guilty and uses self-harm to punish herself for her imagined transgressions.

In terms of communication, many self-injurers say that by transforming their internal pain into observable wounds, they hope to express to others how badly they hurt. Some people cut when they are very angry and have no constructive way to express it. Some cut in the secret (or not so secret) hope of eliciting caring and concern from others.

The significant majority of patients who self-injure come from dysfunctional family systems where they experienced physical, sexual, or emotional abuse or neglect. In these cases, in addition to the aims noted above, the self-injury may represent a recreation of traumatic events from childhood. Nevertheless, it is important to keep in mind that people do develop a pattern of self-injury in the absence of these conditions and that not everyone who experienced a traumatic childhood will become a self-

injuror. Conterio et al. (1999) also note that in their work with self-injurers, many patients come from families who “enforced strict and rigid codes of morality and behavior, codes that usually allowed little room for the expression of normal human emotions” (p.76).

There is some suggestion that self-injurers are more likely to be emotionally hypersensitive than non-self-injurers (e.g., negative emotions are too overwhelming to bear, certain sensations like noises or odors are experienced as extremely aversive). In the treatment model described in Bodily Harm, self-injury is conceptualized as neither a disease nor an addiction, but as a choice. In FFT, the IP is viewed as being challenged by a biologically-based condition that makes self-regulation difficult, but he/she must be presented with choices about whether to use coping strategies that, although comfortable and familiar, ultimately do more harm than good. In FFT, he or she can be acquainted with healthier methods of coping with negative affect.

The treatment model described in Bodily Harm involves four key elements (readers familiar with DBT will note similarities in this model). Initially, patients are required to sign a No-Harm Contract which spells out the expectations and responsibilities of both patient and therapist and describes how behaviors that threaten the treatment process will be handled. Designing the contract should be collaborative, with the therapist and patient deciding together what is reasonable behavior and what are fair consequences for stepping out of bounds. For example, the therapist and patient may agree that self-injury on the day of a session is not acceptable. Both parties should agree on consequences that are therapeutic rather than punishing. In the example just mentioned, it may be agreed that if there is self-injury on the day of a session, the patient foregoes the session. The contract should not be so harsh that the treatment is terminated at the first violation, but the patient may be asked to undergo a period of probation.

The second treatment component is the Impulse Control Log. Patients are asked to keep a diary recording their self-harm urges. Each entry includes:

1. Self-injury thoughts
2. Time and date
3. Location
4. Situation
5. Feeling
6. What would be the result of self-injury?
7. What would I be trying to communicate?
8. Action taken
9. Outcome

The third component is referred to as “The Five Alternatives.” This is simply a list of safe alternatives to self-injury. These can be comforting activities or temporary distractions. The fourth component is a series of writing assignments ranging from an autobiography to writing about the emotions surrounding self-injury to writing about “What I can’t stand about the people in my life.” Each assignment includes specific questions to help focus the patient. Special writing assignments can be designed to deal with specific situations. The authors make the point that, “any tool that helps you slow down, redirect your thinking, channel your energies, and articulate thoughts and

feelings will help you navigate emotional distress more effectively” (p. 260). Please see Conterio et al. (1999) for more details on these techniques.

Addressing Self-Harm Within the Education Module

The FFT clinician can use many of the above strategies in the education module. For example, the Impulse Control Log can be incorporated into the thought or mood chart either with a separate line on the chart designated for self-injury or self-injury thoughts. Alternatively, the child can complete the Impulse Control Log in a separate space on the mood chart and then represent when those urges occurred by using an initial (i.e., S-I) on the chart with the mood state that the urges accompanied. When the clinician checks the mood chart he or she can also review any instances of self-injurious thoughts or behaviors. If the self-injurious thoughts are more likely to accompany certain moods then prevention plans can be put in place. “The Five Alternatives” can be generated during a discussion of coping strategies that the IP can use when struggling with self-injury impulses. Given that a lot of kids report self-injuring after a fight or conflict with family members a discussion of how family members can help with self-injury can be added to the discussion of **Handout 10, How Can Your Family Help** with mood problems. Finally, self-injury appears to have a relapse remission course so developing a specific relapse plan for self-injury will hopefully be a helpful addition to mood episode prevention planning.

Addressing Self-Harm Within the Communication Module

Although young self-injurers often harm themselves in an attempt to engage with others (e.g., to express anger or to invite rescue), their behavior often has the opposite effect on other people. Friends and family members are frequently repulsed by the self-mutilation, and may feel frustrated and helpless, with resulting withdrawal from the youth rather than engagement. Clearly, the family needs to play a central role in addressing self-injurious behavior in the IP. Parents will need guidance from you in determining what is and isn’t helpful.

For example, many parents try to keep the IP safe by taking away all potential instruments of self-harm. This can be counterproductive with adolescents. It sends the message that the parents are in charge of controlling the maladaptive behavior and it may exacerbate struggles for control that are already going on between the parents and the adolescent.

Encourage the use of communication skills to help the IP talk to her family about her experience of self-injury, including typical triggers, ways in which the behavior feels reinforcing to the IP and in particular, ways in which the act is an attempt to communicate distress to others. One of the goals of treatment should be to help the IP get beyond self-injury as a mode of communication and to use words to express her thoughts and feelings. Here is an example of an adolescent trying to explain to her family the emotional turmoil she experiences prior to cutting herself. Her parents were asked to use listening skills.

Joyce:	When I’m angry, I feel like I’m out of control. It builds up inside me and when I can’t hold it any more, it explodes like a soda can when you shake it up and open it. All the
--------	---

pressure comes out. I feel like I want to kill the person I'm angry at. When I cut myself, it relieves all that. I'm not angry anymore.

Mother: But doesn't it hurt?

Joyce: Not really. I know that sounds weird, but it really doesn't.

Father: So it seems like a better alternative than killing someone.

Joyce: Well, that's what I think.

Father: But you wouldn't really kill anyone. And what do you get so angry about anyway?

Joyce: I get angry about lots of things. I just don't talk about it. I don't want to lose control.

Addressing Self-Harm Within the Problem-Solving Module

Problem-solving skills can be used to help clarify "who takes responsibility for what" in the family's attempts to prevent self-injury. As noted earlier, only the self-harmer can be accountable for the choice to self-harm or not, and the tools suggested by Conterio et al. may be useful in the solution-generation portion of problem solving. Because these tools are designed for the individual therapy context, the FFT therapist may elect to schedule some individual sessions with the IP to familiarize him/her with their use. The family, however, will also need guidance about how to respond to a cutting episode. In the case where the self-injury is an attempt to communicate, the family may elect to hold a family meeting after each self-injury episode, so that the IP can be gently encouraged to express in words the message represented by the cutting.

Following is a vignette involving a 16-year-old girl with mild depression and ADHD, Alyson, who lived with her mother, her older brother and her mother's boyfriend. Alyson has recently had her first cutting experience and the family is describing it in a family session. Curt (mother's boyfriend) did not attend the session.

Mother: We had just had a big blow-up about Alyson going over to Jason's [Alyson's boyfriend]. It was 10:00 on a school night and Alyson wanted to go over to Jason's house and I said no. Alyson refused to take no for an answer and said she was going anyway. We started arguing and then Curt and Mike (Alyson's brother) chimed in too. We were all pretty much telling Alyson that she couldn't go and that it wasn't OK for her to be so headstrong or disobedient or whatever. It got pretty heated. Alyson charged up the stairs and into her room and I guess that's when she started cutting herself.

Clinician: Alyson, what do you remember about that night?

- Alyson: Everybody was yelling at me and basically telling me I was a bad kid. When I went up to my room to try to get away from it, Mike had to grab me in the hall and make it worse. He asked me how I could do that to Mom and said she was too stressed out already without me making it worse. When I went in my room, I was really angry but also feeling guilty. I felt so upset, like I couldn't calm down. I kept pacing around. I felt like jumping out the window, like it might feel better to get really hurt and break my bones. I saw the scissors lying on my desk and I got the idea to cut myself. It hurt at first, but when I saw the blood coming out, it was calming or relaxing or something.
- Mike: So you're going to blame it on me, because of what I said.
- Clinician: Is that what you're saying Alyson?
- Alyson: No, I guess not, although that comment didn't help.
- Clinician: I guess my belief is that you were having a lot of intense feelings following the argument, and that would be hard for anyone to handle. But you still have choices about how to handle intense feelings. If you had a chance to replay this scene, what could everyone, not just Alyson, have done differently?

The family went on to explore how things could have gone differently that night. They used that discussion to work through a problem-solving exercise focused on how to prevent future episodes of self-harm. Two solutions were chosen for trial. The therapist invited Alyson to call or e-mail if she felt another urge to cut, as a way to give more time to consider other options besides cutting. The family decided that after an intense argument, they would allow for a brief (half-hour) cooling-off period, and then have a family meeting to try to "debrief" after the argument. During the debriefing, everyone would get a chance to talk about how they were feeling as a result of the argument, but the issue that had prompted the argument would not be re-opened. If Alyson was feeling agitated, angry, upset or guilty after an argument, it would be better for her to communicate her feelings to her family than to try to dissociate from those feelings or to act them out in an indirect way like self-harm. Everyone agreed on this in principle, but whether the plan would work in practice still needed to be assessed. A date was set to re-evaluate the solutions.

The therapist did not opt for individual sessions with Alyson at this point to try to address the self-harm, because this was the first incident and a habitual pattern had not been established. Alyson herself was dismayed at what she had done and was motivated to use healthier coping strategies, so it was hoped that these solutions might address a developing problem.

Conclusion

Suicidality is, unfortunately, not unusual in the treatment of youth at high risk for psychosis or mood disorders. You must be knowledgeable about the appropriate

questions to ask and what actions to take based on the answers to those questions. If you can obtain a suicide contract, you can proceed to implement some of the outpatient strategies outlined above, utilizing communication skills training and problem solving to deal with the acute crisis. Not all self-destructive behaviors are motivated by a true intent to die. In those cases, it is most helpful to uncover the IP's true intent: what he/she hopes to accomplish or communicate by the self-injury. Nevertheless, all suicidal ideation and self-injurious behaviors must be taken seriously.

References

- Brent, D. A., & Poling, K. (1997). Cognitive therapy treatment manual for depressed and suicidal youth. Pittsburgh, PA: STAR Center Publications, University of Pittsburgh.
- Conterio, K., Lader, W., Bloom, J. K. (1999). Bodily Harm: The breakthrough healing program for self-injurers. Hyperion Press.
- Gould, M. S., Fisher, P., Parides, M., Flory, M., & Shaffer, D. (1996). Psychosocial risk factors of child and adolescent completed suicide. *Archives of General Psychiatry*, 53(12), 1155-1162.
- Hawton K, Cole D, O'Grady J, Osborn M. (1982). Motivational aspects of deliberate self-poisoning in adolescents. *British Journal of Psychiatry*, 141, 286-291.
- Miklowitz, D. J., J. A. Merranko, M. J. Weintraub, P. D. Walshaw, M. K. Singh, K. D. Chang, and C. D. Schneck (2020). Effects of family-focused therapy on suicidal ideation and behaviors in youth at high risk for bipolar disorder. *Journal of Affective Disorders*. Epub ahead of print, July 2020.
- Miklowitz, D. J., and D. O. Taylor. 2006. 'Family-focused treatment of the suicidal bipolar patient', *Bipolar Disorders*, 8: 64-651.

Supplement to Clinicians' Treatment Manual for FFT-EOY

Comorbidity with Attention Deficit/Hyperactivity Disorder

Kim Gallelli, Ph.D.

Stanford University, CA

Elizabeth L. George, Ph.D.

University of Colorado at Boulder

David J. Miklowitz, Ph.D.

University of California, Los Angeles

Attention Deficit/Hyperactivity Disorder and Bipolar Disorder

Attention Deficit/Hyperactivity Disorder (ADHD) and Bipolar Disorder (BD) share some common symptoms such as hyperactivity, impulsivity, and inattention. However, these symptoms vary in intensity, duration and often require different treatment approaches depending upon the disorder they are associated with. ADHD primarily affects attention and activity, with a mild presentation of mood variability, but the extremes of “high” or “low” moods are generally not as extreme as in children with BD. A child with BD tends to have extreme mood states—such as mania and depression--and may also demonstrate much more aggression, irritability or uncontrollable rage in conjunction with these mood states.

Often children with ADHD or BD need to learn how to slow down, focus, and organize their thoughts and behaviors with the help of medication or behavioral treatments. In addition to these skills, children at risk for BD need to learn how to manage extreme mood shifts from destructive hypomania to severe depression with the help of more aggressive medical and behavioral treatment.

ADHD is highly comorbid with pediatric BD (Faraone et al., 1997; Wozniak et al., 1995). Recent research has suggested that the onset of childhood ADHD followed by later BD development might be a certain subtype of early-onset BD (Chang et al., 2003). ADHD, in combination with other factors such as a family history of mood disorders, may be a risk factor for future development of BD. Therefore, it is extremely important to identify the diagnostic criteria for ADHD as well as to delineate the differences between the two disorders. Distinguishing between ADHD and prodromal BD is crucial because there are extremely different medical and behavioral interventions, different parenting techniques that are appropriate, and often great differences in the course and outcome of each disorder.

What is ADHD?

The DSM-IV makes a distinction between three types of ADHD: a predominantly hyperactive-impulsive type, a predominantly inattentive type, and a combined type. The term attention-deficit/hyperactivity disorder (ADHD) is used to refer to all of the subtypes.

According to the DSM-IV (1994) ADHD is a “persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development ... symptoms must have been present before age 7 years, ... impairment from the symptoms must be present in at least two settings, ... [and] there must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning. The symptoms of inattention include failure to give close attention to details or makes careless mistakes in schoolwork, has difficulty sustaining attention in tasks or play activities, doesn’t seem to listen when spoken to directly, doesn’t follow through on instructions and fails to finish various tasks, has difficulty organizing tasks and activities, avoids and/or dislikes tasks that require sustained mental effort, loses things necessary for tasks, is easily distracted by extraneous stimuli, and is often forgetful in daily activities.”

Hyperactivity-impulsivity is defined by “often fidgets with hands or feet, squirms in seat and difficulty remaining seated, runs or climbs excessively or for adolescents a persistent feeling of restlessness, difficulty playing or engaging in activities quietly, appears “driven by a motor”, talks excessively, blurts out answers, difficulty waiting turn, and often interrupts or intrudes on others.”

Barkley (2000) proposes that attention deficit without hyperactivity may actually be a different disorder than the hyperactive-impulsive type and the combined type. Children with attention deficit disorder without hyperactivity (ADD) appear to be more passive and fearful than other children. They often appear more “spacey” or in a mental fog

and not attentive to what is going on in their environment. They appear to be lethargic, sluggish, or slowmoving, wandering through life only half-attending to things around them. They are likely to be quiet while working but that does not mean they are attending in an effective manner and often make errors due to the inability to sift out the relevant from the irrelevant material. On a positive note, these kids do not appear as aggressive and have less trouble with their peer relations. Whereas kids with ADHD show more problems with over-activity and impulsiveness, kids with ADD may have more problems with memory, perceptual-motor speed, and the speed with which the brain processes incoming information. Little is known about treatment for ADD though some reports suggest that a lower dose of stimulant medication is useful. However, research has shown that 30% or more of those with ADD do not respond at all to stimulants, compared to fewer than 10% of those with ADHD (Barkley, 2000).

How are Bipolar Disorder and ADHD different?

As mentioned above, many children with BD often first present with ADHD, and it is considered a risk factor for the development of a specific familial subtype of BD. Therefore it is essential that we delineate how the common symptoms differ with each illness.

- In children with ADHD, the symptoms of inattention, hyperactivity, and impulsivity are always prevalent. These same symptoms seem to wax and wane in children with BD depending upon their mood state.
- To obtain a diagnosis of ADHD, symptoms must onset before age 7. When these symptoms onset later in childhood and adolescents, they are more likely to be related to BD. However, a child with ADHD may experience a worsening of symptoms later in life (usually closer to puberty). Although they still have baseline problems with attention and behavior, these problems escalate with more severity and duration.
- Children with ADHD may have problems with some mood swings, but they are often less intense than children with BD. Children with ADHD do not display the severely debilitating depressive as well as manic or euphoric features exhibited in children with BD.
- The duration of outbursts and/or tantrums usually differ. Children with ADHD may calm down within half an hour, whereas children with BD may rage for hours.
- Children with ADHD may be struggling in school and with peers but can often manage with interventions, whereas many BD children are unable to attend school and have minimal peer relationships.
- Children with BD typically engage in more risky, impulsive and dangerous behaviors. ADHD kids may engage in dangerous behaviors, often unaware of the dangers, whereas kids with BD can be extreme risk-takers. For example, a kid with ADHD may leave school with friends and get in trouble for ditching. In contrast, a 15 year old girl with bipolar disorder may be getting on the back of a 30 year olds' motorcycle to spend the night drinking with him in the mountains.
- Children with BD tend to have early sexual interest and behavior.

Here are seven proposed criteria for differentiating ADHD from bipolar disorder (Lynn, 2000):

- 1) Are mood shifts moderate or extreme? Are they characterized by depression, rage, or aggression?
- 2) Does the child have a first-degree family member diagnosed with bipolar or unipolar mood disorders?
- 3) Is the child's speech pressured, uninterruptible or hypomanic? Children with ADHD may speak quickly or loudly, but they can often be refocused and slowed down. Children with BD have little or no control over the propensity of their speech.
- 4) What is the typical nature of the dangerous or risky behaviors that are exhibited? The ADHD child often searches for stimulation in an impulsive manner—reacting to environmental cues. The child with BD often seeks out and engages in risk behaviors while being driven by enormous attention and energy, with minimal sleep—often unable to attend to anything else. As mentioned above, the nature of these risky behaviors are often more destructive and potentially lifethreatening.
- 5) Does the child rage (bipolar disorder) or get angry (ADHD)?
- 6) Does the child appear psychotic—with auditory or visual hallucinations, or unusual thoughts and beliefs? Does the child speak or tell stories that are completely unintelligible and/or illogical? ADHD children can be silly and creative and even tell tall tales, but tend not to have hallucinations, delusions, or thought disorder.
- 7) Does the child show a decreased need for sleep—able to function well (often like the “energizer bunny”) without fatigue with only a few hours of sleep? ADHD children may be hyper or overactive during the day with multiple projects and/or games started and uncompleted, but tend to have more regular sleep habits.

Medication Issues

Typically, ADHD symptoms are successfully treated with medications referred to as stimulants. Commonly prescribed stimulants are Ritalin and Concerta. Other medications such as Strattera have also been used to treat ADHD. However prescribing stimulants can be dangerous if the problematic symptoms are evident of BD, instead of ADHD. Although there exists conflicting research, it has been suggested that stimulants may trigger or exacerbate manic symptoms in children and adolescents with BD. Also, antidepressants such as Selective Serotonin Reuptake Inhibitors (SSRIs) have been implicated as exacerbating or triggering mania in children with BD, whereas they can be helpful in treating comorbid depressive symptoms in children with ADHD. Proper medication management of symptoms in children requires clinicians to thoroughly examine the nature of overlapping symptoms. However, in those cases where BD and ADHD co-occur, stimulants may help the BD child after his/her mood symptoms have been stabilized with other medications such as mood stabilizers or antipsychotic medications.

Addressing ADHD within the Education Module of FFT-EOY

If it is apparent after the initial evaluation that the child has ADHD, the clinician reviews the symptoms of ADHD with the family during the discussion of mood symptoms using

a handout of DSM-IV criteria. To delineate the differences between BD and ADHD the clinician shares the table below. It is helpful for parents to understand the difference between ADHD and BD given that ADHD is a suggested risk factor for BD. The family should be quite clear when they are continuing to observe symptoms of ADHD and when the illness has moved into a bipolar presentation.

Table for Psychoeducation Module

Differentiating between ADHD and Bipolar Behaviors and Characteristics

Bipolar	ADHD
Extreme variability in mood	Fairly consistent mood over time
Triggered by particular situations	Consistent across situations
Mood may be effected by time of year/season	Consistent all year
Skills and functioning vary—even when focused	Attention-concentration is key problem
When anger or rage presents, often cannot be redirected or soothed.	Supervision and guidance can help
Can argue for hours	Easily distracted, loses interest in fight
Unbelievable intensity/energy	Energized, but not as intense
Pressured speech	Talkative
Takes big risks/looks for danger or thrill	Does not intend to get into big trouble/eventually learns
Often does better at school	Often does better at home
Medication is often unwanted/seen as the enemy	Medication seen as a tool to help functioning
Internally distracted	Externally distracted
Self-destructive thoughts	Low self-esteem
High energy /inappropriate giggling	Normal laughing/fun
May be overly sexual	Sexuality not major issue
Stimulants may exacerbate or trigger mania	Stimulants improve symptoms
Extreme anxiety fears	Normal worries
Antidepressants may be harmful/trigger mania	Antidepressants can help with associated depressive symptoms
Symptoms worsen/ exacerbate with age	Symptoms improve with age

Many times you will hear parents ask, “How do I know if this bad behavior is due to his ADHD or to his mood disorder?” “Does the nature of the symptoms affect the way I intervene with my child’s symptoms or problems?” Since the nature of the symptoms does affect the way the parent may structure an effective intervention or coping strategy, understanding the nature of symptoms is extremely helpful. Since ADHD symptoms are often present before the onset of the more extreme mood symptoms it is helpful to have the parent and child delineate the problems he/she had in elementary school. Problems that may have occurred associated with ADHD might include inability to concentrate, having to re-read chapters, and/or frequently getting

out of his/her seat in school. It is helpful for the parents to note how and when these symptoms may have begun and worsened. For example, one child went from getting out of her seat 3-4 times in class, to being unable to sit still at all with continual pacing. Another example might be a mere difficulty in reading progressing to an inability to complete schoolwork at all.

At this point in the education you can help the family decide if they want to chart ADHD symptoms on a mood chart. The family may have a line to delineate ADHD symptoms and mark an X when they have gotten worse or are causing significant difficulty in functioning. Alternatively, the parents may want to rate the ADHD on a 1-5 scale with 1 being no symptoms/no behavioral problems and 5 being very symptomatic/extreme behavioral issues. You and the family can decide how you want to chart ADHD symptoms in addition to mood and this chart can be customized to each family. A chart will help the parents with further delineation of mood versus ADHD symptoms and evaluation of medication effectiveness for each condition.

In addition to listing symptomatic onsets and worsening, it is also important to establish what the child's baseline of functioning has been in regard to attentional, cognitive, and impulsive capacities. Emphasizing the biological nature of ADHD and success of medication and behavior interventions will lessen parent's anxiety about their child's future academic and social functioning. However, parents will need to be wary of significant worsening from baseline functioning and attend to the possible onset of a mood disorder. Again, at this point it is helpful to review that if a mood disorder does develop, exacerbation of symptoms will wax and wane from the child's initial baseline level of functioning.

Parents are also often concerned about the impact different medications can have on their child's mood. It will be important to educate parents about the efficacy of stimulant treatment in authentic ADHD. However, if mood symptoms are developing, treatment with stimulants may exacerbate the child's mood symptoms and it is possible that they will need to be temporarily removed from their stimulant medications until the mood symptoms are under control with mood stabilizing medications.

Handout 8, Medications Commonly Used to Treat Mood Problems, will be provided to address various classes of medications used for each disorder. Parents will be encouraged to work collaboratively with their child's physician when changes in mood are detected.

Addressing ADHD within the Communication Module

The communication module of FFT-EOY is designed to provide a neutral and nonthreatening framework for discussing family issues. Communication training is the first step to resolving problems that arise in the family. During the communication skills module the family's goal is to arrive at a better understanding of each person's position and feelings as they relate to a personal or family problem. Often, the behavior of a child with ADHD can be extremely frustrating and disruptive to the entire family. It is important to review that the child's "bad" behaviors may indicate a worsening or mismanagement of the illness. It is helpful to remind parents that the child is not a bad child—just exhibiting some difficult behaviors. Also, the child needs to be reminded that he can help control his behaviors with the help of parents and

doctors. The child should be taught to note any changes in feelings or behaviors and communicate with parents about self-observations.

Barkley (2000) lists 14 guiding principles for managing ADHD that may be quite helpful in managing mood disorder symptoms as well.

1. Give your child more immediate feedback and consequences.
2. Give your child more frequent feedback.
3. Use larger and more powerful consequences.
4. Use incentives before punishment (positives before negatives).
5. Externalize time and bridge time where necessary.
6. Externalize the important information at the point of performance.
7. Externalize the source of motivation at the point of performance.
8. Make thinking and problem solving more physical.
9. Strive for consistency.
10. Act, don't yak!
11. Plan ahead for problem situations.
12. Keep a disability perspective.
13. Don't personalize your child's problems or disorder.
14. Practice forgiveness.

Many of these points are very similar to the principles of the communication skills module in FFT-EOY. Specifically, the first skill taught, Expressing Positive Feedback is a direct reflection of principle 4 above (use incentives before punishment). We ask the family to spend a week or two, depending on whether they are meeting weekly or bi-weekly, catching each other doing positive things and giving positive feedback. It is only after sufficiently spending time praising each other for positive behaviors that we move to changing behaviors through positive requests and expressing negative feelings about specific behaviors/problem-solving. Even during the portion of communication that addresses changing specific behaviors, we begin with the positive and then move to the negative.

Addressing ADHD within the Problem-Solving Module

The symptoms of ADHD can be distressing to both the child and the family. Most likely, families will focus on the child's poor academic and social functioning and cite numerous examples of missed appointments, lost and broken items, and impulsive and self-destructive behaviors. As mentioned earlier it is important to have the child note how she feels about these behaviors, which often induce feelings of shame, self-doubt, and low self-worth. At this point in treatment, the clinician helps the child and family to anticipate and respond better to problematic situations that will inevitably occur.

Case Example. The mom of a 10-year old became extremely frustrated because the child kept losing his coats and schoolbooks on the bus. There was a great deal of yelling around this topic. The child also acknowledged that he was quite upset because he most recently lost his "lucky" jacket. Also, he was getting upset because of getting "incompletes" on his lost/missing homework assignments.

After briefly identifying feelings of all family members, the clinician helped the child to generate several possible solutions. The child suggested putting his name and phone number inside his clothing and books, and the mom suggested contacting the bus company to get their address and number to retrieve lost items the same day. The therapist suggested setting up a behavior management plan of rewards when the child remembered to bring home his belongings each day. The child and parent decided upon appropriate rewards. Also, the family was encouraged to examine whether certain illness parameters related to these frequent occurrences. For example, the child realized that by the end of the school day, his distractibility and inability to concentrate worsened significantly. This required a consult with the child's doctor to shift the time of his medication administration.

In addition to aiding the family in problem solving around symptom management, families often need time to discuss issues that have not gone well in the family in general. For example, 16 year-old Melissa who had comorbid diagnoses of prodromal BD and ADHD struggled with special occasions. Whether it was her birthday, someone else's birthday, Christmas, or any other occasion where presents were being received, she had a "meltdown" and in the words of the other family members, "ruined the time for all". We decided to address the problem by going through the problem solving worksheet and coming up with various solutions the family could use for the next special occasion. In this way the family was planning ahead for what they had identified as a problem situation. It is helpful for families to have a sense of mastery over the various problems that occur given how taxing the symptoms of mood and attentional disorders can be.

Conclusion

In conclusion, FFT-EOY for comorbid ADHD and prodromal BD contains specialized education regarding ADHD symptoms and medication. It is very important for clinicians to understand how ADHD and pre-onset BD differ and to be facile in helping the family with various strategies depending on what the family is presenting. Handouts that describe the differences between mood disorders and ADHD, and case examples of children with ADHD, BD, and both disorders are extremely helpful to families in developing behavioral plans for this difficult presentation.

References

- Barkley, R. A. (2000). *Taking Charge of ADHD: The complete Authoritative Guide for parents*. The Guilford Press: New York.
- Chang, K.D., Steiner, H., Dienes, K., Adleman, N., Ketter, T. (2003). Bipolar Offspring: A window into bipolar disorder evolution. *Biological Psychiatry*, 53, 945-951.
- Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV)*.(1994). American Psychiatric Association.
- Faraone, S.V., Biederman, J., Wozniak, J., Mundy, E., Mennin, D., O'Donnell, D. (1997). Is comorbidity with ADHD a marker for juvenile-onset mania? *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 1046-1055.
- Lynn, G. T. (2000). *Survival Strategies for Parenting Children with Bipolar Disorder*. Jessica Kingsley Publishers: London.
- Wozniak, J., Biederman, J., Kiely, K., Ablon, J.S., Faraone, S.V, Mundy, E., &Mennin, D. (1995). Mania-like symptoms suggestive of childhood-onset bipolar disorder in clinically referred children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 867-876.

Supplement to Clinicians' Treatment Manual for FFT-EOY

Comorbid Oppositional Defiant Disorder

Elizabeth L. George, Ph.D.

University of Colorado at Boulder

David J. Miklowitz, Ph.D.

University of California, Los Angeles

Oppositional Defiant Disorder and Bipolar Disorder

Oppositional defiant disorder (ODD) is frequently comorbid with bipolar disorder in children and adolescents (Geller & Delbello, 2003). Preliminary reports from the Stanley Foundation Childhood-onset Bipolar Disorder Consortium reported that 80 percent of children and adolescents with bipolar disorder met DSM-IV criteria for ODD (Post, et al., 2008). ODD is a disorder that puts parents and their children in an entrenched power struggle around what types of behaviors are acceptable or not. Typically, the child expects much more autonomy and freedom than the parent feels is appropriate for the child's chronological and/or developmental age. These children and adolescents tend to push appropriate limits that the parents have set and do not seem willing to compromise.

At times, the parents are responding to demands from the child or adolescent that would be considered age-normative. However, the parent may feel that, due to their own child's immaturity, the child must demonstrate more personal responsibility before more privileges will be granted. Herein lies the problem. Oppositional children have an inordinately difficult time taking responsibility for their behavior and compromising with others.

Given that increasing the child's freedom is contingent on the very behavior that is difficult for the child to display, the parents and child often find themselves in an immovable standoff. Due to the conflict around this pattern, issues related to oppositionality are typically at the forefront of family-focused therapy.

The DSM-5 identifies ODD as:

A recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months and is characterized by the frequent occurrence of at least four of the following behaviors: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that will annoy other people, blaming others for his or her own mistakes or misbehavior, being touchy or easily annoyed by others, being angry and resentful, or being spiteful and vindictive. To qualify for ODD, the behaviors must occur more frequently than is typically observed in individuals of comparable age and developmental level and must lead to significant impairment in social, academic, or occupational functioning. The diagnosis is not made if the disturbance in behavior occurs exclusively during the course of a Psychotic or Mood Disorder or if criteria are met for Conduct Disorder or Antisocial Personality Disorder.

It is often difficult to look at a list of criteria in DSM-5 format and relate it to the aspects of the child's behavior that a parent may encounter on a day-to-day basis. For this reason Riley (1997) has come up with a practical list of the types of behaviors and attitudes a parent may observe in their child which might lead to suspicion of ODD (Table 1).

Table 1. List of practical criteria for identifying ODD in a child or adolescent.

Oppositional Defiant Disorder

Source: Riley, 1997

How to tell if your child may have Oppositional Defiant Disorder (ODD).

- Rule 1: Oppositional children live in a fantasy land in which they are able to defeat all authority figures.
 - Rule 2: Oppositional children are optimistic.
 - Rule 3: Oppositional children fail to learn from experience.
 - Rule 4: You must be fair to me, regardless of how I treat you.
 - Rule 5: Oppositional children seek revenge when angered.
 - Rule 6: Oppositional children need to feel tough.
 - Rule 7: Oppositional children believe that if they ignore you long enough, you'll run out of moves.
 - Rule 8: Oppositional children believe themselves to be equal to their parents.
 - Rule 9: Oppositional children from middle-class homes emulate the behavior of their least-successful peers.
 - Rule 10: Oppositional children and teenagers attempt to answer most questions with "I don't know".
 - Rule 11: Oppositional logic revolves around denial of responsibility.
-

There is inherent difficulty in diagnosing adolescents with a mood disorder and ODD. ***If symptoms of ODD occur only during mood disorder episodes, then the child or adolescent is not diagnosed with ODD.*** Given that many children with bipolar disorder are continuously cycling in and out of episodes of mood disorder it becomes very difficult to discern if the defiant behavior is part of the bipolar disorder or if ODD has become an additional piece of the diagnostic picture. Thus, despite the apparently non-overlapping criteria sets for ODD and mood disorder, there is difficulty in diagnosing the comorbidity of these two disorders.

If the clinician and/or parents suspect that the child has ODD, the clinician reviews the symptoms of ODD during discussion of mood symptoms in the education portion of FFT-EOY. It is quite helpful to parents to have a list of the criteria for ODD. Some parents are relieved because, although their child is oppositional, they realize that he or she does not appear to have the syndrome of ODD. Other parents are relieved to see that their child does meet the criteria for ODD because it helps them focus on how to understand and manage the oppositional behavior. During this portion of the education the clinician may also inform the parents of the comorbidity rates of ODD and bipolar disorder, major depression, and ADHD in children and adolescents. Learning about the high prevalence rate of ODD in prodromal mood disorder populations may help parents to feel less isolated in their struggles with their child.

You may present this material with or without the child present depending on how defensive he or she may be. Some children who feel particularly labeled by having a mood disorder may feel quite resistant and disheartened by having another label tacked on to their behavior. On the other hand, some kids tend to feel unable to

control their defiant behavior and hearing that this may be a condition which can be treated may make them feel more understood. If you are able to discuss the symptoms of ODD in a non-blaming, informative manner the child may be quite open to the discussion and even share some of the experiences he or she has had in the midst of a “defiant episode”. It is of utmost importance to read the child’s reaction to this material and be on the lookout for more labeling and blaming as a result of identification of the diagnosis by parents and/or siblings.

Contrasting Views on the Relationship between ODD and Early-Onset BD

Authors of popular books on bipolar disorder have different views on the relation of ODD and bipolar disorder. Unfortunately, none base their observations on empirical studies but rather, clinical observations. Nonetheless, their contrasting views are worth noting.

Papolos and Papolos (1999) do not view bipolar disorder and ODD as separate diagnoses, but instead identify oppositionality as a hallmark trait/behavior in children and adolescents with bipolar disorder or the bipolar spectrum. They have observed that the oppositional behavior frequently occurs in contexts that are stressful for children with bipolar disorder (i.e., transitions). According to these authors, oppositional behavior is not a separate diagnosis but rather an aspect of the bipolar condition.

In contrast, Waltz (2000) distinguishes the two disorders from each other. She gives three reasons for this distinction. First, in the case of ODD the child or adolescent usually has an easily articulated reason for his irritability, tantrums, or aggressive behavior whereas the bipolar spectrum child or adolescent may not have an understanding or even accurate memory of his or her angry or aggressive episodes. Second, children and adolescents with ODD often become oppositional under the influence of peers, which, according to Waltz, is less likely with bipolar children and adolescents. Finally, ODD children and adolescents do not display the elevated or irritable mood fluctuations that occur during the bipolar spectrum child’s outbursts. The ODD child/adolescent is characterized as always angry and mean.

Given Waltz’s distinction it can be illustrative to have parents rate oppositional behavior on the mood chart designed for children and adolescents with bipolar spectrum disorders. If the ODD symptoms co-occur with the mood disorder episodes then this oppositionality may be more appropriately coded as part of the prodromal bipolar disorder. If the defiance is more pervasive then there may truly be a separate, comorbid ODD diagnosis. There are different strategies to use with children who only display oppositionality during mood disorder episodes and those with the more pervasive oppositionality characteristics of ODD, as will be discussed.

Ross Greene (1998) has a different conceptualization of children who are comorbid for ODD and bipolar disorder. He notes that besides being diagnosed with ODD, these children are likely to be diagnosed with ADHD, Tourette’s disorder, anxiety disorders (particularly obsessive-compulsive disorder), language-processing impairments, sensory integration deficits, nonverbal learning disabilities, and Asperger’s disorder. Greene refers to these children that don’t fit a specific category in the DSM-IV,

inflexible-explosive. He views their explosive behavior as “unplanned and unintentional and reflects a physiologically based developmental delay in the skills of flexibility and frustration tolerance” (Greene, 1998, pg. 14). The common characteristics of inflexible-explosive children are as follows:

- 1) A remarkably limited capacity for flexibility, adaptability and coherence in the midst of severe frustration;
- 2) An extremely low frustration threshold;
- 3) An extremely low tolerance for frustration;
- 4) The tendency to think in a concrete, rigid, black-and-white manner;
- 5) The persistence of inflexibility and poor response to frustration despite a high level of intrinsic or extrinsic motivation;
- 6) Inflexible episodes may have an out-of-the-blue quality;
- 7) The child may have one or several issues about which he or she is especially inflexible;
- 8) The child’s inflexibility and difficulty responding to frustration in an adaptive manner may be fueled by behaviors – moodiness/irritability, hyperactivity/impulsivity, anxiety, obsessiveness, social impairment – commonly associated with other disorders; and
- 9) While other children are apt to become more irritable when tired or hungry, inflexible-explosive children may completely fall apart under such conditions.

Greene describes these types of explosive episodes as having three phases: vapor lock, crossroads, and meltdown. In the vapor lock phase, the child exhibits early warning signs that he is stuck. This early phase typically begins after a request from parents to “switch gears,” to which the child responds with frustration due to cognitive and emotional deficits that inhibit him or her from being able to make these transitions easily. At this initial point, a child may still be capable of rational thought and catastrophe may still be prevented. The crossroads phase is the last chance that parents have to respond in a way that facilitates communication and problem resolution and prevents further deterioration. If the parents do not successfully navigate this phase, then meltdown begins. During meltdown, inflexible-explosive children display their most destructive and aggressive behavior. During meltdowns kids are thinking irrationally, are not able to listen to parents, are not able to learn or reason, and do not respond well to punishment. In addition, punishment fails to prevent the child from having meltdowns in future frustrating conditions. Sadly, once the meltdown is over these children often express deep remorse for what they have said or done, although they may have difficulty recalling what actually occurred or why they became as upset as they did.

The therapist must show empathy for the parents’ and siblings’ frustration in dealing with these episodes of seemingly irrational oppositionality. Without acknowledgement of the pain associated with these aversive experiences, families move into an avoidant stance and eventually feel that they cannot continue to live with the oppositional child. Since often these explosions occur in the midst of mood episodes, the child can feel very hurt and rejected by the family once they begin to avoid him or her.

The position taken in FFT-EOY is similar to Greene’s: children at risk for bipolar disorder who are also oppositional are not seen as having two distinct disorders but rather as having poor emotional self-regulation or inflexibility. As this example

illustrates, parents often must contend with hostility in their bipolar/oppositional child, and need to develop strategies for preventing these escalations from occurring. Education, communication and problem-solving skills training can be adapted to the needs of families coping with this combination of conditions in the child. The sections that follow describe these techniques in more detail.

Education Regarding ODD

As mentioned, it is quite helpful to cover the symptoms of ODD after discussing mood and/or thought symptoms. Some of the symptoms of bipolar disorder are similar to symptoms of ODD. Some parents wonder how anyone can ever tease these two disorders (as well as ADHD) apart. This often leads to a productive discussion around the importance of observing and being familiar with the child's risk factors and mood cycles so as to be able to anticipate and prepare for the episodes of oppositionality that may occur. Again, if therapeutic, the child may be involved in these discussions to help delineate the triggers for oppositional behavior and his or her particular experience of the defiant symptoms.

During the portion of the education section that covers medications (**Handout 8: Medications Commonly Used in Outpatient Settings**), parents may ask questions about drugs for ODD. There are not specific medications designed to treat ODD. However, many of the medications that are prescribed for the symptoms of bipolar disorder may be helpful with the anger and rage attacks associated with ODD. For example, atypical antipsychotic medications (e.g., olanzapine [Zyprexa], quetiapine [Seroquel]) are commonly used for agitation, sleep problems, and hallucinations and/or delusions with bipolar disorder. These medications may help children who experience the uncontrollable rage and anger/irritability that go along with ODD to pause before "flying off the handle". In addition, the mood stabilizer Tegretol [carbamazepine] is commonly used to treat the anger associated with bipolar spectrum disorder and may help with ODD symptoms as well. ODD is not hypothesized to have a relapse/remission course as it is viewed as a relatively consistent behavior pattern. Parents may therefore always be managing symptoms of ODD to one degree or another. However, most of the families in FFT-EOY have noticed a remarkable decrease in ODD symptoms with the remission of mood disorder symptoms.

When ODD symptoms do diminish with remission of mood symptoms, it is likely that during a relapse of mood symptoms the child will also have a reemergence of defiant and oppositional behavior. For some families the parents and child identify defiant behavior as one of the initial symptoms of a mood episode relapse. One mother described being at the mall with her daughter who had been effectively treated with Lithium for months. One of the main symptoms that disappeared was the daughter's chronic irritability and oppositionality. While shopping for clothes the daughter snapped at her mother in a manner that was reminiscent of behavior before treatment. In the past, the mother would have seen this as further justification that she had a "bad, disrespectful" kid on her hands. This time she made a call to the psychiatrist and therapist to address a potential relapse of mood symptoms. The daughter had a Lithium level drawn and it was low. The psychiatrist was able to adjust the daughter's Lithium and the oppositional behavior disappeared. Through education about and

charting mood symptoms and oppositionality the family was able to catch an early sign of relapse and avoid mood worsening.

As Greene describes families need to exercise their communication and problem solving skills to avert major meltdowns. Medical intervention by the psychiatrist may also be indicated when these oppositional symptoms begin to appear.

Empowering Parents in Learning to Manage Children at Risk for Bipolar Disorder With ODD

Many parents ask what can be done for their children who display noncompliant and defiant behavior in response to limit setting, requests, and family rules. As there are divergent theories about the comorbidity of bipolar disorder and ODD, there are discrepant theories on the treatment of ODD. There appear to be two primary schools of thought. The first proposes a behavioral response to the child's defiant behavior in the form of consequences. The second proposes more of a cognitive approach in working with the child to be able to problem solve and compromise around difficult issues in the family. We employ both of these methods in FFT-EOY in different circumstances.

Behavioral Responses: Setting Up Contingencies for Good Behavior

The families we have treated have typically used the behavioral techniques of identifying undesirable behaviors and introducing consequences for those behaviors. There is much support for using consequences in the research literature (i.e., punishment or, at minimum, withdrawal of reinforcers), as outlined in Riley's book, The Defiant Child: A parent's guide to oppositional defiant disorder (1997). Riley's perspective, based on his clinical experience, views the child as a conscious agent in his or her oppositional behavior. Given that he sees the child as at least to some degree in control of this behavior, it makes sense that his goal is to have the parent use techniques to shift the child's behavior. Some of the consequences designed to shift the child's behavior include but are not limited to:

➤ Time Out

Time out is a period the child must spend thinking about how his or her thoughts and behaviors have gotten him/her into trouble and how to replace those thoughts and behaviors with others that will not cause trouble. Time out should always begin with a brief, clear description from the parent of the behaviors that have gotten the child in trouble along with an explanation of how long the time out will be. It should end with a brief discussion of the decisions the child has come to about new behaviors, new thoughts, and how to stay out of trouble. This form of punishment may not be appropriate for children over the age of 12. However, adolescents vary in their maturity level and in what feels punitive to them. With a little creativity, a parent may be able to use time out to his or her advantage.

For example, for a 13-year old boy in one of our families, time out was the only intervention that worked during his defiant and aggressive phases. Separating the adolescent from the family appeared to serve two purposes: first, he felt that it was

aversive to be isolated in his room; and second, it reduced the level of stimulation to which he was exposed, which helped him de-escalate.

His parents had tried many of the skills learned in FFT-EOY (i.e., communication and problem solving) during these episodes. Unfortunately, use of clear communication skills seemed to provoke even more unreasonable and aggressive behavior from him. Removing him from the family seemed to calm him down, and then, after a period of time, the parents were able to return to the FFT-EOY skills and come up with possible solutions to help prevent future defiant and aggressive behavior.

➤ *Access to reinforcers and privileges*

Privileges and reinforcers come in many forms. They may be favorite foods or drinks, activities, use of objects and devices (i.e., cell phones), designer clothes, and so on. Each adolescent's list is highly individual and it is up to each family to make a list that fits each child. In order to get control of an oppositional child or adolescent the parent must be willing to take control of the reinforcers that are specifically important to him or her, and make sure that he or she does not have access to them unless earned by appropriate behavior. In choosing reinforcers, parents should adopt the premise that everything in the home belongs to them. This includes things that the teen has purchased with his or her own money or items that others have given the teen as gifts.

A child's access to reinforcers should be in inverse proportion to his or her oppositional behavior. The general practice is to remove access to several of the most important ones for periods ranging from one hour to three hours, depending on circumstances. If less intense increments do not work, the parent must be willing to take away access to everything for periods ranging from several hours to days – whatever is necessary to get the child to change his or her oppositional behavior.

Some of the families we have worked with have chosen to deny the child access to his or her cell phone, car, going out with friends, television and media, and computer access except for educational purposes. This strategy has proven to be quite effective if used in the appropriate way (see examples below).

The families we have worked with have made lists of egregious behaviors and the consequences for those behaviors in the form of lack of access to reinforcers combined with aversive tasks the child has had to perform (e.g., sweeping the garage).

➤ *Level systems*

The parent explains to his or her child that, at the end of the day, the parent will briefly give the child feedback on his or her behavior for that day. In the level system, the child's performance today determines the level he or she starts on tomorrow. The level the child is on determines how much or how little access she or he has to reinforcers. Someone on level III gets "usual" access to reinforcers. On level II everything is cut by at least two thirds. On level I everything is taken away.

This system can be overly complex for some families. Parents, however, appreciate having a number of options that they can refer to in times of conflict.

Special Issues in Setting Up Behavioral Contingencies with Children at Risk for Bipolar Disorder

Most families find that the more options and the more creative consequences they have available, the less helpless they feel. In the case of children at risk for bipolar disorder and disobedient behavior, start by empowering the parent through setting up a list of consequences that the parent can enforce. It is helpful to get the child's input on these consequences as they typically come up with better (and often, more stringent) punishments than their parents. However, the child should not construe this to mean that the parent is not the authority and it is important for the clinician to make it clear to the family that the parent has the final word.

It is ideal if the consequence is either a natural consequence of the "offense" or if it is related to the offense in some way (i.e., being physically aggressive to a sibling and then doing that sibling's chores as the consequence). The list of consequences made by each family will need to be individualized and flexible.

Remind parents that they may need to stick with certain plans for a time before abandoning them. Some parents are quick to drop a set of contingencies when the child stops responding. Of course, this teaches the child that all he or she needs to do to uproot a plan is simply to be uncooperative. It is important that the parents make a concerted effort for at least a month before deciding that imposing consequences (combined with rewarding good behavior) will not work. However, as the clinician, you must keep in mind that if the child is not interested in engaging in this process even the most thoughtful plans will likely be ineffective.

"Time out" may not work with an adolescent. Parents and adolescents may feel it is a waste of time or the teenager may end up listening to music or looking through a magazine if the parent is not continually supervising. If the parents do view time out as useful, ask them to structure it in such a way that the teen spends time in his or her room doing something that he or she may not enjoy but that may be productive. For example, the adolescent may be asked to record on paper which aspects of his or her behavior resulted in receiving a "time out" and what he or she could do differently in the future. The act of journaling may help the adolescent to organize his or her thoughts and think preventatively. Again, each family needs to be creative and attuned to which consequences are appropriate for their teenaged child.

With any consequences for aversive behaviors it is important to monitor how the child is responding to the *duration of the punishment*. If the child perceives that he has no chance of regaining privileges, he may begin to act out due to a sense of unfairness and hopelessness. For example, one 15 year-old female client was grounded for a month and continued to act out in fairly extreme ways. The parents began to feel helpless because all they knew to do was increase the amount of time she was grounded. The girl said that she was continuing to act out because she did not think she would ever have a chance of not being grounded. Because she was being

punished, she felt that she might as well behave in a manner deserving of punishment. When the family presented this difficulty to the FFT-EOY clinician, she helped them devise a list of offenses and consequences. Table 2 presents the list of behaviors and consequences these parents and this adolescent devised.

Table 2. Sample offenses and consequences from a family of an adolescent with bipolar disorder and ODD

<u>Offense</u>	<u>Consequence</u>
Borrowing without permission	Not allowed to borrow anything from that person for a week
Continuing to fight with sister when told to stop	Pick up trash bag full of trash
Not doing chores	\$5.00 off allowance
Arguing and/or insults	Writing sentences, the worse the offense, the more to be written
Lying	Grounded from TV for two nights
Physical violence against sister	Do sister's chores for one week
Come home late without calling	Grounded next non-school day and/or night
Cussing at mom	Grounded from phone one night
Cussing at sister	Say sorry and give her a hug and do dishes for her
Ditching school	Go to bed one hour earlier for each class ditched

Greene's Cognitive/Problem-Solving Approach

Although it can be helpful for parents and children to collaborate in creating a list of target behaviors and consequences, many parents report that when the at risk child gets into a particularly bad place, no consequence, threatened or real, makes a difference in his or her behavior. In observing the children and families in our clinic, we have concluded that many have the problems that Greene (1998) identifies in his description of chronically inflexible children. Due to mood swings and what appears to be uncontrollable behavior, even the best laid plans for consequences and reinforcers do not seem to work. These children are truly not in control of their behavior and need

parental assistance and guidance at the point at which it is most difficult for the parents to help, due to the aversive nature of the child's behavior.

Greene argues that there are neurophysiological events that lead to oppositional behavior. He proposes that the parents work toward establishing what he calls a more "user-friendly environment" for the child. He uses the analogy that asking these children to navigate their current environments without modification is like asking someone who must use a wheelchair to go up a flight of stairs without a ramp. He recommends several techniques that parents can use to help their children navigate their environment. His framework is built around two basic themes: that it is of utmost importance that the number of meltdowns the child or adolescent has must be reduced, and that the child or adolescent must learn to maintain coherence in the midst of frustration. The parent must figure out ways to help the child establish and maintain coherence even in the most frustrating situations.

Greene lists eight steps toward a user-friendly environment. First, the parent must make sure that all adults in the child's environment have a clear understanding of the child's difficulties and what fuels his or her inflexibility-explosiveness. Second, the parent must carefully establish priorities in the goals they have for their child such that they reduce the expectations and demands for flexibility and frustration tolerance placed on the child. Third, parents need to identify in advance the triggers for inflexible-explosive episodes. Fourth, once the family has identified the warning signs of an episode, they need to have a plan of action in place when they occur. Fifth, parents should not personalize or misinterpret incoherent behaviors as anything but what they are, incoherent behaviors. Sixth, it is important to understand the ways in which the child's inflexibility-explosiveness may be triggered by the parents and others in the child's environment. Seventh, it is helpful to use a more accurate language that everyone in the family understands to describe aspects of the inflexibility-explosiveness. Finally, parents are encouraged to come to have a more realistic view of whom the child is and what is likely for the child and in the parent-child relationship.

In addition to the items above, Greene proposes a system for reducing the number of meltdowns that occur. He suggests that if there are fewer meltdowns the child will be more coherent in his or her environment and will be more capable of displaying reasonable behaviors. Once enough time has passed, the child will be much more capable of functioning, problem solving, communicating, and relating to others in an adaptive manner. The technique Greene recommends is using a "basket framework" for handling conflict in the home. He proposes labeling behaviors as non-negotiable (basket A items); negotiable (basket B items); or not worth mentioning (basket C items).

The only items in basket A are safety items. These are behaviors about which the parent feels so strongly that they are willing to endure the child's meltdown to ensure their performance. For example, one of our parents decided that a basket A item was restricting her son from spending time with a peer who sold drugs and had spent time in jail. The mother noticed that her son seemed to have been using substances after spending time with this friend. Due to safety concerns, the mother decided that she would endure endless meltdowns in response to her decision to restrict her son's involvement with this peer. Due to the volatility of setting inflexible limits with these adolescents, Greene states that few things should go in basket A. The second basket,

B, contains behaviors about which the parent and child must work out a compromise. This basket is quite important for children with oppositional behaviors because it teaches them to communicate with others, take another person's perspective, and problem solve in the midst of conflict. The parent has to be adept at keeping the child from melting down and remaining coherent in the midst of the conflict.

Children at risk for bipolar disorder with ODD often have poor negotiation skills and it may take time for them to learn to compromise. In the meantime, it means a lot of practice and in some particularly entrenched situations, foregoing the item in basket B and putting it into basket C. Basket C is full of behaviors that are not important enough to risk having a meltdown over and should not be mentioned to the child again. For example, if a parent decides that having the child's clothes match when he or she leaves the house is a basket C issue, then the parent should not bother to comment on the child's taste in clothes (unless to compliment, as long as that does not bring on a meltdown). Greene proposes that if the parents feel empowered to prevent a meltdown from occurring, the parent is in a much better position to respond to "vapor-lock" in a rational manner. The parent's response is one of the keys to a successful resolution of conflicts that otherwise would lead to a full-blown meltdown. When meltdowns occur despite the parent's best efforts, the skills to use are "distraction, empathy, comforting, separating, suggesting an alternative activity – to defuse the situation, restore coherence, and ensure safety as quickly as possible" (pg. 158).

When children have mood disorders, and sometimes become irrational when thwarted, we have found that some of Greene's principles can be employed. How are these principles (as well as the principles of behavioral management discussed above) applied within FFT-EOY? This is the topic of the next section.

Addressing Oppositionality Within the Education Module

In the treatment of these difficult children, medical intervention is sometimes the best approach. In other cases, Riley's "consequences" method seems most appropriate and with others, Greene's "problem-solving" approach. FFT-EOY for children at risk for bipolar disorder who have ODD combines these three approaches. Through educating families about the cycling of symptoms of prodromal bipolar disorder (e.g., during medication changes, after stressful events) parents become better able to differentiate the defiant behavior that accompanies typical childhood/adolescence from ODD and from the type of defiance that occurs in the context of a mood disorder. Through using appropriate communication skills (e.g., negotiation), families may learn to anticipate when meltdowns are starting to occur and derail them. Through problem-solving, parents and children may be able to set up contingency contracts for preventing future conflicts involving oppositionality.

Addressing Oppositionality Within the Communication Module

The communication module of FFT-EOY is specifically designed to provide a neutral format for discussing issues that arise in the family. This is the first step to resolving problems that may arise in the family. During the communication skills module the family's goal is to arrive at a better understanding of each person's position and

feelings as they relate to the particular familial problem. This model is quite similar to Greene's proposed technique for averting meltdowns. If each family member is able to see the situation from the other's perspective the possibility of mutual understanding and compromise exists. Many of the oppositional children in the study have been able to describe to parents during communication exercises the negative impact of certain phrases the parents use. For example, one boy shared with his parents that when they threatened him with a punishment in the midst of an argument or if they said, "because I said so" in response to him asking them why he had to do something, a meltdown was imminent. He shared that he was unable to stay coherent once he heard either of these responses. The family worked, through communication, to come up with different ways the parents could respond that would keep the boy in a more coherent frame of mind.

Communication is also quite helpful during discussion of consequences for inappropriate behavior. Typically parents have consequences in place for the child's difficult behaviors but have not discussed with the child how he or she perceives the consequences. For example, one parent sent his child to his room when he became defiant and/or misbehaved in some way. The parent did not notice a decrease in the child's problematic behavior as a result of this consequence. During communication skills the adolescent shared with his mother that he liked going to his room because his Nintendo was up there and that sometimes he misbehaved so that he would be sent to his room. This discussion led to a new framework for misbehavior and contingencies in the household.

A final benefit of communication skills training is that these children often have significant skill deficits in the areas of communication and compromise. For example, a 15 year-old girl in our program told us that if she budged at all from her position towards a compromise with her mother, even if her mother met her more than halfway, then she felt she was giving in to her mother's wishes. Through the communication exercises she became more practiced at the art of negotiation without feeling overly compromised. Another child, an 11 year-old boy, took charge in one session by introducing skills that the speaker needed to use to facilitate listening. This was his way of introducing structure for his parents who tended to be very verbose and vague in discussions with him. He often felt overwhelmed by the amount of information they gave him and by how unclear the messages were. He was able to empower himself by setting limits with his parents around aspects of their communication that he felt triggered meltdowns for him.

We have found that although communication is very helpful to maintain coherence and rationality in the face of oppositional behavior it is not complete without problem solving.

Addressing Oppositionality Within the Problem-Solving Module

As mentioned, communication skills are essential to the problem-solving process. Everyone in the family must understand and agree with the problem definition, which will require lots of active listening. If this step is not successful the rest of the exercise will not be effective.

When addressing behaviors and consequences the format for problem solving deviates from the traditional FFT-EOY problem-solving model. With the FFT-EOY model the problem is identified, solutions are brainstormed, pros and cons are delineated, and the best possible solution is chosen. In assignment of consequences for problematic behaviors the family lists the offensive behaviors and consequences are assigned to each behavior according to what seems fitting to all members of the family. As previously mentioned, the child often has the best suggestions for consequences in response to disruptive or problematic behaviors. If the child chooses the consequences he or she may be more likely to follow through with them after a transgression has occurred. It is important during the assignment of consequences to go through the last few steps of problem solving after choosing the best fit for each behavior. These include setting a date to implement the new contingency contract, anticipating what could go wrong during implementation, ideas about how to respond if the new contract is not effective, and reviewing how this set of consequences worked after a trial period. During assignment of consequences to particular behaviors it is imperative that the clinician gets a sense of whether the child buys into the consequences and is willing to go along with the plan. As mentioned, a child who is unwilling to follow through with the agreed upon consequences can keep the most thoughtful plans from being successful.

FFT-EOY problem solving is very helpful to families with an oppositional child. Typically the family becomes embroiled in power struggles with little movement and few options. Through this model the family is able to have a more fluid discussion and identify many options so that the problem does not seem immovable. Again, the child must be engaged and willing to discuss problems and solutions for this to be a collaborative effort. However, the model can be used with only the parent(s), sibling(s), and/or therapist(s) input. For example, a 16 year-old girl in our program was unwilling to discuss any options during problem solving. She would sit to the side and make disruptive noises during the brainstorming portion. The therapist made clear to her that she could choose not to be involved in brainstorming but that she was not allowed to disrupt the process and would need to leave the room if she continued to make noises. Her mother, father, and brother were generating solutions for a family problem. She was able to remain silent during the brainstorming portion and remained in the session. Though she did not offer any solutions, she became quite engaged during the evaluation phase and was able to feel as though she was contributing to the problem solving exercise.

Though oppositional children and adolescents are quite poor at generating workable solutions to problems, they are very skilled at refuting and criticizing potential solutions. These youth are typically not valued for their critical minds because they are typically seen as being negative and argumentative. The FFT-EOY model for problem solving helps children learn in areas where they are deficient (i.e., generating hopeful solutions) and shows the family that the child can play an important role as trouble shooter in the process of identifying what can go wrong with proposed solutions. Typically the child has felt that he or she has no role in working with the family. With problem solving he or she may have the experience of being valued for finding what will not work in any scenario. It is often helpful to point out to these children that their keen insight about what can go wrong is invaluable and that they can learn from the other family members how to generate hopeful solutions.

During problem solving, though the child may seem resistant in the beginning, they often come around. Oppositional children have a very difficult time remaining disengaged. Unfortunately, if they are not engaged in the process, they are often engaged in disrupting the process. If the child insists on disrupting the process they may not stay in the room, and the therapist sets this limit the first time disruptive behavior occurs. Hopefully the child will respond to limit setting because it is very helpful to have him or her stay. Even if it appears that the child is tuned out, they are typically listening to everything and often have very good insight about the family process (in an “the emperor has no clothes” fashion). The other reason it is helpful to have the oppositional child in the process is that he or she may object to certain solutions. If the child is not willing to follow through with a proposed solution it is doomed to failure. For example, one family identified this problem: ‘how can we keep the egg separator from being ground up in the disposal again’. One of the solutions proposed was that family members would stick their hands down the drain to see if the egg separator was in there before they turned the disposal on. A 14 year-old boy said that he would never stick his hand down the disposal because he thought it was disgusting. The parents were in favor of this solution and continued to try to argue that this solution was preferable to all the others. The therapist pointed out that if their son was unwilling to follow through with this solution, it did not make sense to choose it. The family eventually chose a solution that everyone agreed to.

Conclusion

Oppositional children and adolescents are very difficult for the family to manage and usually very resistant and disruptive to the process of therapy. Because oppositional characteristics are part of the picture of bipolar disorder and there is such high comorbidity of oppositional defiant disorder (ODD) and bipolar disorder, it is imperative that anyone who works with youth at risk for bipolar disorder also understand and have training in working with ODD. By combining many different methods for addressing oppositional behavior and implementing a response plan in a structured environment, the therapist and family may achieve success in working with this group of disruptive children and adolescents.

References

- Barkley, R. A., Edwards, G. H., & Robin, A. L. (1999). *Defiant Teens: A clinician's manual for assessment and family intervention*. The Guilford Press: New York.
- Geller, B., & Delbello, M. P. (2003). *Bipolar disorder in childhood and early adolescence*. New York: Guilford.
- Greene, R. W. (1998). *The explosive child: A new approach for understanding and parenting easily frustrated, chronically inflexible children*. New York, N.Y.: HarperCollins.
- Papoulos, D. F., & Papoulos, J. (1999). *The Bipolar Child*. New York: Broadway Books.
- Post, R. M., et al. (2008). Incidence of childhood-onset bipolar illness in the USA and Europe. British Journal of Psychiatry 192, 150-151.
- Riley, D. (1997) *The defiant child: A parent's guide to oppositional defiant disorder*. Taylor Publishers.
- Waltz, M. (2000). *Bipolar Disorders: A Guide to Helping Children and Adolescents*. O'Reilly & Associates.