Bipolar Disorder: An Update on Psychosocial Interventions

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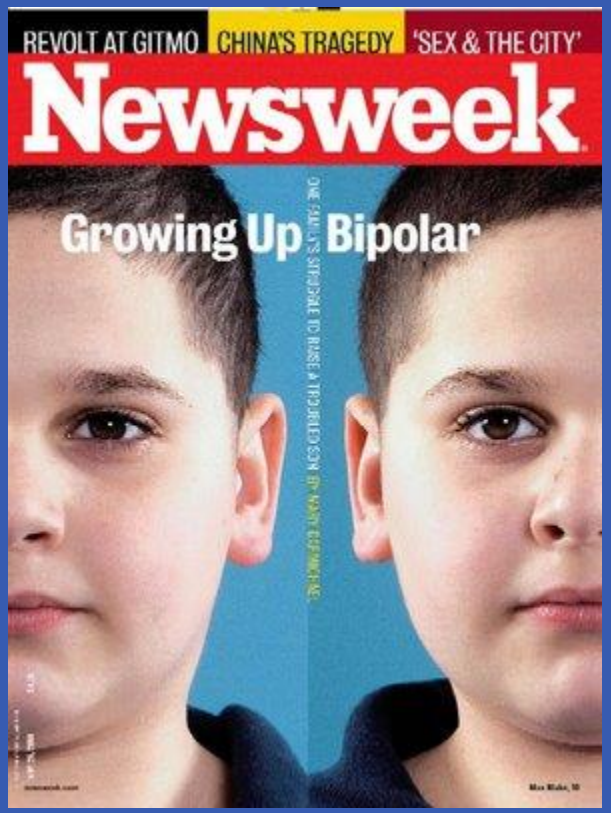
Objectives

- Describe family and life stressors that affect the course and outcome of bipolar disorder.
- Describe the three phases of family-focused therapy (FFT) and evidence for its efficacy in individuals who have (or are at risk for) bipolar disorder
- Learn the clinical strategies and techniques of FFT for adolescents and adults with BD.

Pediatric-Onset Bipolar Disorder

- 2% lifetime prevalence (< 18 years)[1]
- 9% lifetime prevalence of major depression (< 18)[1,2]
- At risk for the 4 S's[2]:
  - School problems
  - Substance abuse
  - Suicide
  - Social dysfunction
- High rate of familial transmission[3,4]
- High comorbidity rates
- Long delays (8-10 yrs) until treated
- Poorer prognosis, less time well[5]



[1] Van Meter et al, 2011, J Clin Psychiatry; [2]Goldberg et al., *J Nerv Ment Dis.*, 2004; [3]Goodwin and Jamison, *Manic-Depressive Illness*, 2007
[4]Faraone et al., *Biological Psychiatry*, 2003; [5]Leverich GS et al. (2007), J Pediatr 150(5):485-490

A 10-year Old Girl's Description of Bipolar Disorder

"When I feel happy, I get real bouncy… I'm hopping all over the place, and my mind seems to be focused on one thing for a short time. Sometimes, I don't necessarily feel bouncy, just kind of light and airy, like a butterfly. I sort of flit and float from place to place, physically and in my mind.

When I feel depressed, I'm like…dead. I just sit there lifelessly, and my body just sort of flops around, like a Beanie Baby. Also, my mind just sort of drifts away and wonders aimlessly into space."

Birmaher, 2004

Subtypes of BD

- Bipolar I: full manic episodes, usually alternating with major depressive episodes (1.2% prevalence)

- Bipolar II: hypomanic episodes alternating with major depression (prevalence 0.6%)
  - Hypomania: same symptoms as mania but can be as short as 4 days and *do not cause major impairment,* even though they are *noticeable to others*

Other Specified Bipolar Disorder (DSM-5) (formerly BP-NOS)

- Manic or hypomanic episodes that are recurrent but of insufficient duration for DSM-5 or hypomania
- Episodes of elation or irritability, but insufficient number of 'B' symptoms
- Major depressive episodes with subthreshold manic symptoms
- Over 5 years, 50% convert to BD I or II when a family history of BD is also present

Grandiose Delusions or Playful Fantasy?

- A five-year old girl is helped down from a roof at school. She appeared to be trying to wire a TV antenna. She explains that she has 500 brothers, half of them live on the moon, and that her teachers have told her it's OK to play on the roof at recess. "The moon talks to me sometimes."

GRANDIOSE OR BADASS?

A 10-year old boy jumps up in front of the classroom and claims he can teach the class better than any teacher, and then tells the class to ″turn to page 12″ in their book.

A 16-year old says he is developing a “live” version of Google Earth,, and that he intends to breed a ″phosphorescent horse″

Youth at High Risk for BD

- Child (ages 9-17) has an antecedent risk condition (lifetime history of major depressive disorder or unspecified BD)
- A first- or second-degree relative has bipolar I or II disorder (by interview)
- Child presents with depressive and/or (hypo)manic symptoms or significant mood instability
  - Probability of developing bipolar I or II disorder is 50% in 5 years (Birmaher et al., 2018)

Mood instability: A Childhood Risk Factor for Adult Bipolar Disorder

- Starts to cry for no reason
- Bursts of being affectionate, hugging, kissing without precipitant
- Sudden outbursts of rage (vs. irritability)
- Starts a frenetic period of activity and then says “I’m tired”
- Bursts of being nervous or fidgety: “I’ve gotta get outta here”
- Becomes overly familiar or intrusive with people s/he barely knows
- Laughs loudly or becomes silly about things others don’t find funny
- Rapid drops or increases in mood with quick return to baseline

Children’s Affective Lability Scale (CALS):Gerson AC et al., 1996, Psychiatry Research

Comorbidity in Large Samples of Bipolar Kids

	Axelson et al, 2006 N=438	Biederman et al, 2005 N=299	Findling et al, 2001 N=90	Geller et al, 2004 N=86
Mean age	12.7y	~10.7y	10.8y	10.8y
Female	47%	36%	~33%	38%
Anxiety	39%	49%	14%	17%
ADHD	60%	84%	68%	86%
ODD	40%	85%	47%	78%
Conduct	13%	42%	17%	13%
Substance	0%-16%	0%- 22%	0% - 18%	---

What's the diagnosis?

- 10-year old boy with explosive temper outbursts
- Has been violent at school and home
  - Hurt the family's cat
  - Broke a door
  - Threatened to kill siblings in their sleep
- Has expressed suicidal wishes
- Often seems silly and giddy, then angry or tearful
- Attentional and impulse control problems
- Poor social skills and physical hygiene
- Mood reactivity
- Poor school performance (attributes to bullying)

What else would you want to know?

What's the Diagnosis?

- 16 year old female
- Severe irritability exacerbated by menstrual period
- Recurrent depressive episodes that last < 2 weeks
- Starts laughing until cries
- Excessive cannabis use
- Suicidal ideation and self-harm
- Multiple sexual partners
- Rageful, violent
  - Attacked brother with knife
  - Broke a window
  - Caused fight at school

What else would you want to know?

Factors to Consider in Diagnosis:

- Family history of BD
- Evidence of elation or grandiosity
- Decreased need for sleep (vs. insomnia?)
- Neurodevelopmental history (e.g., FAS)
- Trauma reactions
- Cyclicity of mood and behavioral states
  - Are mood swings followed by return to baseline?

PSYCHOSOCIAL TREATMENTS FOR BIPOLAR DISORDER

Bipolar Disorder is Affected by Stress…

- Negative life events
  - Loss events often anticipate depressive episodes
- Positive life events
  - Events that trigger increased goal engagement and confidence may trigger mania
- Childhood trauma/adversity

  - History of physical abuse and sexual maltreatment may trigger episodes of mania in genetically vulnerable individuals
- Family stress
  - High expressed emotion in caregivers (criticism, over-protectiveness) is associated with high relapse risk

Miklowitz & Johnson, 2009; *Clinical Psychology: Science and Practice*; Gilman et al., 2014; *Mol Psychiatry*

Pharmacotherapies With Bipolar Disorder Indications

Therapy	Bipolar Mania	Bipolar Depress-ion	Maintenance
Lithium	Yes P	**No***	Yes P
Carbamazepine (Tegretol)	Yes	**No**	**No**
Valproate (Depakote)	Yes	**No**	**No**
Lamotrigine (Lamictal)	**No**	**No**	Yes
Aripiprazole (Abilify)	Yes P	**No**	Yes
Olanzapine (Zyprexa)	Yes P	**No**	Yes
Olanzapine+fluoxetine (OFC) (Symbiax)	**No**	**Yes P**	**No**
Quetiapine (Seroquel)	Yes P	**Yes**	**No**
Risperidone (Risperdal)	Yes P	**No**	**No**
Ziprasidone (Geodon)	Yes P	**No**	**No**
Asenapine (Saphris)	Yes P	**No**	**No**
Lurasidone (Latuda)	No	**Yes P**	**No**
Carpirazine (Vraylar)	Yes	**Yes**	**No**

P = Pediatric indication

Pharmacotherapy

- Pharmacotherapy is the first-line treatment option for mania in adolescents
- BUT……Even optimal pharmacotherapy is less than ideal in prevention of episodes
- When medications are the primary treatment, only 43% of teens recover in the year after a manic episode
- 54% of adolescents have recurrences and 35% are noncompliant with meds

DelBello M et al. 2007, *Am J Psychiatry*

Evidenced-based adjunctive psychotherapy for BD

- Cognitive-behavioral therapy (CBT)
- Family focused therapy (FFT)
- Interpersonal and social rhythm therapy (IPSRT)
- Dialectical behavioral therapy (DBT)

Family Focused therapy (FFT)

For persons with bipolar disorder

Bipolar disorder and the family: a bidirectional relationship

Individual's effect on family:

- Patient isolates in room and/or has explosive outbursts
- Withdrawal from family activities
- Argumentative and oppositional
- Impulsive behavior
- Siblings' adjustment is affected by BD in a brother or sister
- Parents develop depression, health problems
- Social embarrassment and stigma
- Financial problems

Family's effect on individual with BD:

- Mood symptoms can be triggered by negative interactions w/family
- Supportive family relationships can be protective in BD
- Parental education and buy-in is essential to compliance with medications

A mother's perspective….

"That's me on that string…my son is like a big baby puppeteer, keeping us all on a string with his vicious mood swings. Worst of all he seems delighted that he can do it."

Measuring Stress in the Family System: Parental Expressed Emotion (EE)

Family members' attitudes towards the patient as revealed in a clinical interview:

Critical comments:

"Does she even realize that her crying keeps the rest of us awake all night?"

"I resent her "poor me" attitude."

Hostility: *"The problem is I dislike the person he is."*

Emotional Overinvolvement:

"He said that math homework made him depressed, so I end up doing all the problems for him."

High levels of parental EE are associated with higher rates of recurrence in the 9 months after a hospitalization

Miklowitz et al., 1988; Vaughn & Leff, 1976

Family-Focused Treatment (FFT) of Bipolar Disorder

- 12 outpatient sessions over 4 months
- Assessment of patient and family
- **Engagement** phase
- **Psychoeducation** about BD: symptoms, early recognition, etiology, treatment, self-management
- **Communication enhancement training** (behavioral rehearsal of speaking and listening strategies)
- **Problem-solving** skills training

Miklowitz DJ. *Bipolar Disorder: A Family-Focused Treatment Approach, 2nd Ed*. NY: Guilford Press, 2008.

RANDOMIZED TRIALS OF FFT

Results of Ten Randomized Trials of FFT plus Medications for Adult and Adolescent Patients

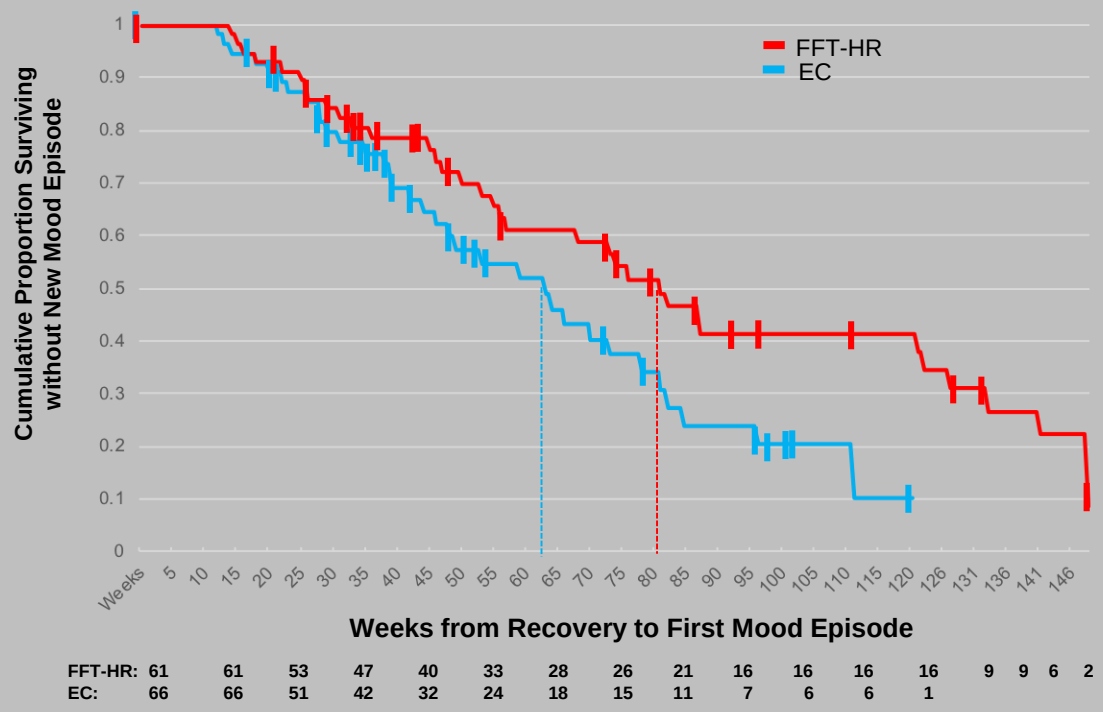
- FFT plus medications (4-9 months) vs. brief psychoeducation or individual therapy plus medications
- Total 1,140 patients
  - Five trials with bipolar adults (n= 523)
  - two with bipolar adolescents (n = 203)
  - Two with youth at high risk for BD (n = 285)
  - One with adolescents at risk for psychosis (n=129)

- Patients in FFT had greater benefits over 1-2 years in:
  - Depression stabilization (Cohen's d = 0.49 to 0.56)
  - Recurrence risk (RR= 0.79, 95% CI 0.54 - 1.15)
  - Psychosocial functioning/quality of life (d = .96)

- Meta-analysis: psychoeducation is more effective in a group or family setting than in an individual setting

Miklowitz et al., 2020, *JAMA Psychoatry*

Effects of FFT-HR vs. EC on Time to First Prospectively Observed Mood Episodes (N=127)



Treatment [FFT vs. EC]: $\chi 2$ (1)=4.44, *P*=.035; HR=.59

Miklowitz, Schneck et al., 2020, *JAMA Psychiatry*

Family-Focused Therapy: General Strategies

Tips on Zoom Sessions

- Arrange seating so they can talk to each other – e.g., chairs in semi-circle (avoid 4 on a couch facing you)
- Make sure you can hear everyone ("your point of view is important")
- If you can't hear someone, ask them to move closer
- Ask that devices and notifications are turned off during session
- Family should choose a room with few distractions and a good internet connection
- Avoid having family members connect from different locations
- Pets can be distracting

Overall Strategies for Working with Family Members

- Symptoms of bipolar disorder wax and wane, so all plans must be **flexible**
- Moods are not the same as manic or depressive episodes
- Not everything requires a medication adjustment.
- Distinguish who the person is from their disorder
- Cultural humility: curiosity about cultural beliefs, being open to alternative interpretations of illness, acknowledging one's own privilege

Family Engagement

- Be warm, approachable, genuine, and hopeful
- Use a Socratic rather than an overly didactic style
- Stance is one of nonjudgmental curiosity rather than knowledge– "I don't know so I'm asking."
- Show interest in patient and relatives as individuals
- Deal with emotional reactions at the moment
- Avoid technical jargon
- Use appropriate pacing- going too fast or too slow
- Distinguish current from prior negative experiences
- Identify patient as the expert on illness
- Recognize the patient's need for autonomy and control

Phase I: Psychoeducation

- 4 sessions of *psychoeducation*, covering:
  - Signs and symptoms of mood disorder
  - Mood charting
  - Gene x environment causation
  - Identifying precipitating stressors
  - Illness management strategies
  - Prevention action plan

DM

The Three Ps of Psychoeducation

- Provision of illness-related information and coping strategies
  - E.g., "bipolar people are exquisitely sensitive to changes to sleep/wake cycles"
- Personalization of didactic material to one's life
  - "The last two manic episodes I had came after periods when my sleep schedule got way off because of traveling"
- Practice of illness management strategies
  - Patient sets up sleep/wake plan and rates daily adherence to it and subsequent moods

Handout # 2

Increased energy and activity

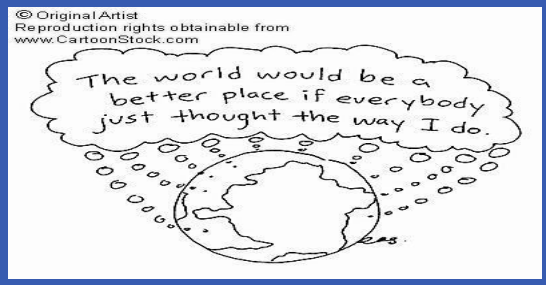
Decreased need for sleep

Elated mood

Symptoms of Mania

Increased sexual thoughts

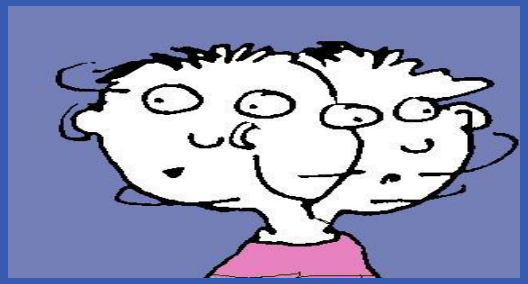
IRRITABILITY!



Being overconfident or unrealistic

Talking fast

Loss of self-control



Easily distracted, Racing Thoughts, Lots of ideas

Different angles on exploring mood symptoms

- Ask patient to describe symptoms of most recent manic or depressive episode (with aid of handout)
- To family: what did you first notice? How did you respond when he/she started doing that?
- To patient: how did you react when (family member) responded that way?

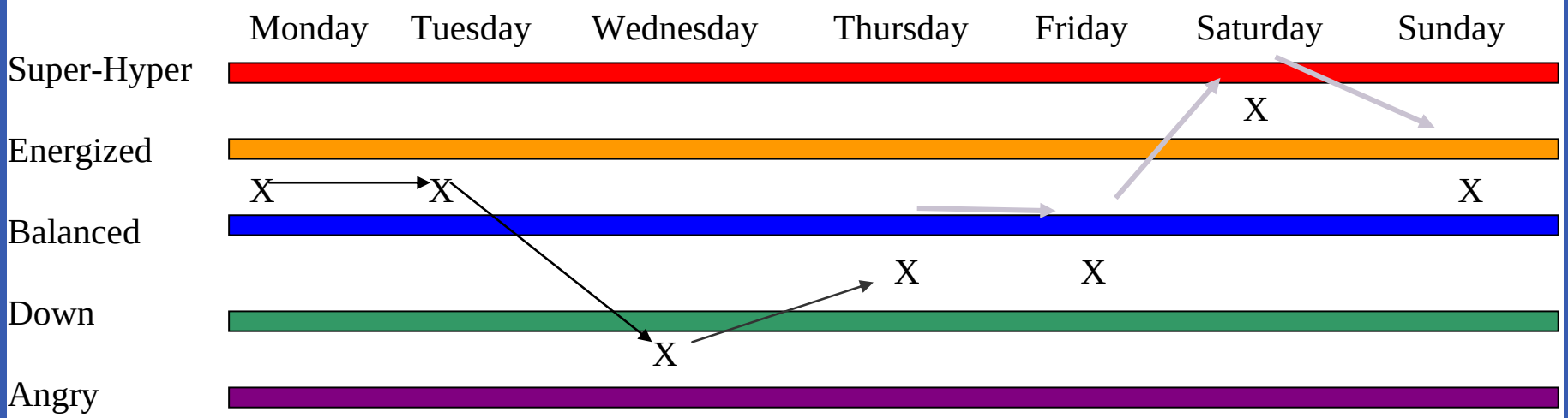
What emerges: a window into family dynamics

Daily Monitoring of Mood Symptoms

- Encourage the child or adolescent to keep a regular mood chart
- Explain that this is one of the things s/he can do in addition to taking medications to gain more control of the illness
- At the beginning of each session, examine patterns of moods in relation to stressors

Week of Mar 3

HOW I FEEL



I woke up at:	7	7	6	6	6	8	11
I went to bed at:	10	11	10:30	10:30	12	12	10

Examples of:

Super-Hyper
- Feel good about myself
- Talk faster
- Like being high
- Lots of ideas
- Need less sleep

Down
- Suicidal
- Don't want to go to school
- Short-tempered
- Stop eating or eat more
- Want to be alone
- Want to live in a bubble

Angry
- Pissed off
- Hate everyone
- Irritable
- Snap easily

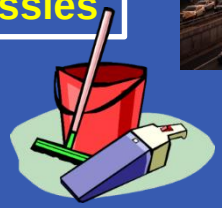
Handout # 6

Sources of Stress

Major Life Events

Routine Changes

School and Work Hassles



Conflicts

Boredom

Handout # 8

Examples of Coping Strategies

1. Exercise

2. Keeping regular sleep habits
3. Talking to your doctor/therapist
4. Getting your medications changed

5. Enjoying art and music

6. Talking openly with people you're close with

7. Relaxation or meditation

8. Spirituality
9. Helping someone else with their problems

10. Positive self-talk

11. Staying active

Promoting Good Sleep Hygiene

Enlist the help of parents so the kid can:

- Establish a regular bedtime and wake time
- Avoid caffeine and other stimulants
- Avoid alcohol, drugs, or activating over-the-counter meds
- Exercise early in the day, not right before bed
- Avoid working in bedroom
- Avoid highly stimulating activities before bedtime
- Anticipate stressors that could destabilize daily routines

- NEEDED: A good and predictable family routine

The Prevention Action Plan

- List prodromal signs
- List circumstances in which, historically, these have been most likely to occur
- What can parents do?
- What can the patient do?
- The psychiatrist? Therapist?
- Have emergency contact info in one place

Handout #11

Prevention Action Plan: Phil

	Stressors or Triggers	Early Warning Signs of Mania	Coping Skills	Overcoming Obstacles
1	Arguments with dad, brother	Sleeps less, gets up during night	Contact Dr. B for medication check	Find best phone number
2	Fired from after-school job	Irritable, picks fights, easily annoyed	Try to keep regular bedtime	Computer games may involve other people
3		Becomes obsessed with video games	Use iPhone at agreed-upon hours	
4		Talks loudly about ways to make money	Stay away from friends who make me want to smoke weed	
5				
6				
7				
8				

Early Response Plan for Escalating Mania

- Contact physician for an emergency appointment or have a supply of antipsychotic medication available
- Stay consistent with medications
- Keep consistent sleep habits
- For families: keep home environment structured and low key, reduce performance expectations
- Bring someone you trust with you when going out at night
- Get help managing money, give up car keys
- Avoid making major life decisions (use 2-person rule, 48-hour rule: “if it’s a good idea now, it’ll be a good idea then”)

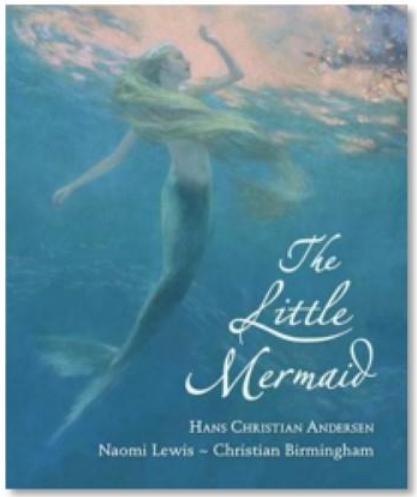
About that joint in your hand….

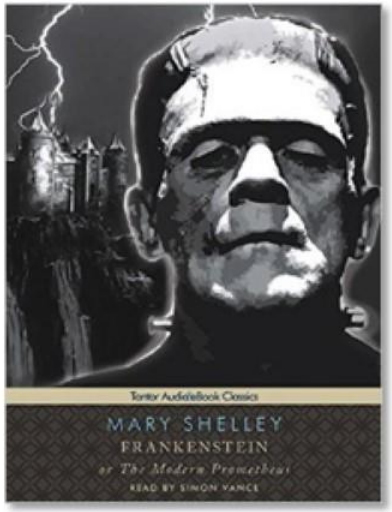
Why discourage marijuana use in young people with bipolar disorder?

- Medical marijuana is neither a mood stabilizer or an antidepressant.
- Cannabis use among adolescents is associated with suicidality and risky sexual behavior.

- Use is not always for "self-medicating"- people feel better when high, but overall the course of bipolar illness is worsened.
- Cannabis reduces learning, attention and memory recall by up to 50%.
- Increased gray matter volume in amygdala and hippocampus.
- We don't know what dosages or strengths are helpful for anxiety.
- What they're buying may not be just marijuana.
- It interferes with sleep and adherence to psychiatric medications.

Authors believed to have manic episodes (from Jamison, 1993)





- Hans Christian Andersen
- Honore de Balzac
- William Faulkner (H)
- F. Scott Fitzgerald (H)
- Graham Greene
- Ernest Hemingway (H, S)
- Hermann Hesse (H, SA)
- Henrik Ibsen
- Henry James
- William James
- Samuel Clemens (Mark Twain)
- Joseph Conrad (SA)
- Charles Dickens
- Theodore Roethke (H)
- Isak Dinesen (SA)
- Ralph Waldo Emerson
- Robert Lowell (H)
- Herman Melville
- Eugene O'Neill (H, SA)
- Francis Parkman
- John Ruskin (H)
- Mary Shelley
- Robert Louis Stevenson
- August Strindberg
- Leo Tolstoy
- Tennessee Williams (H)
- Virginia Woolf (H, S)
- Emile Zola

Johnson, Murray et al. (2012). Clinical Psychology Review

H = hospitalized, SA = suicide attempt, S = suicide

Creativity in BD

- Bipolar individuals are higher in creativity than non-psychiatric controls
- People in creative professions (e.g., writer, musician) are more likely to have BD than comparison professions
- Creativity is higher in relatives of people with BD
- Creativity is more linked to hypomania than mania
- Going off of meds does not lead to better art
- Meds can be adjusted to enable more energy and creative output

Sources: Johnson SL et al (2012), *Clin Psychol Review*; Kyaga et al. (2013), *J Psychiatric Research.* *Jamison, K., (1995), An Unquiet Mind.*

Family-Focused Therapy (FFT), Phase II: Communication Training

- 4-5 sessions of *communication enhancement training*, in which role-playing exercises focus on:
  - Expressing positive feelings
  - Active listening
  - Making positive requests for change in others' behaviors
  - Communication clarity
  - Expressing negative feelings

Handout # 13

Expressing Positive Feelings

- Look at the person
- Say exactly what they did that pleased you
- Tell him or her how it made you feel

Miklowitz DJ. *Bipolar Disorder: A Family-Focused Treatment Approach, 2nd Ed.* NY: Guilford Press, 2010.

Steps of Communication Skill Training (Part 1)

- Model the skill for the participants (e.g., active listening)
- Ask family members to turn chairs toward each other
- Ask one member to rehearse the skill with another
- Offer praise for his/her attempts

Steps of Communication Skill Training (Part 2)

- Encourage constructive feedback from other family members
- Summarize feedback and encourage him/her to practice again
- Assign homework to entire family

Handout # 13

Active Listening

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

Miklowitz DJ (2010) *Bipolar Disorder: A Family-Focused Treatment Approach. NY: Guilford Press.*

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 it would make you feel
- In making positive requests, use phrases like:
  - "I would like you to _____ ."
  - "I would really appreciate it if you would do _____ ."
  - "It's very important to me that you help me with the _____ ."

Miklowitz DJ (2010). *Bipolar Disorder: A Family-Focused Treatment Approach, 2nd Ed.* NY: Guilford Press.

Handout # 19

Expressing Negative Feelings About Specific Behaviors

- Look at the person; speak firmly
- Say exactly what he or she did that upset you
- Tell him or her how it made you feel
- Suggest how the person might prevent this from happening in the future

Miklowitz DJ. *Bipolar Disorder: A Family-Focused Treatment Approach, 2nd Ed.* NY: Guilford Press, 2010

Handout # 16

Communication Skills Assignment

Day	Person You Talked To	What You Talked About	What Positive Feedback Did You Give?	What Active Listening Skills Did You Use?	What Comm. Clarity Skills Did You Use?	What Positive Requests for Change Did You Make?
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						
Sun						

Empathic confronting strategy

Mom to ex-husband: "You know she is overweight. And you give her Doritos for lunch. What kind of father are you?"

Therapist: You're really concerned about your daughter's health. (Positive intention)

But the way you say it is critical and likely to make him defensive. (Inadvertent impact)

Try again. Tell him what you would like him to do. (Redirect with a positive request)

Communication Training Session with a High-EE Family: Teaching "Positive Requests for Change"

Family with father, mother, and 16 year old boy with BP I:

- Father (to son): I really resent the hours you keep. You always come in later than we've agreed on, and you're loud and you wake us all up. You don't take your illness seriously (*criticism, negative attribution*).
- Son (rolling eyes): Whatever.
- Father: You have to choose to get to sleep on time so you don't go wacko again. (*attribution)*

Step 1: Validate, reframe, challenge

- **Therapist**: Dad, I can see that it upsets you when Evan comes in late and wakes every one up. You're angry, but you're also concerned about his health and well-being. (*reframing – positive intention*)

- **Dad**: Of course.
- **Therapist**: But consider how you're delivering that message. You care and don't want him to get hurt, but I'm guessing he only hears the anger part. Evan? (*emphasizes inadvertent impact*)

- **Evan** (nodding): That's all I ever hear. One criticism after another, no matter what I do. He's like, always pissed off.

- **Therapist**: Dad, maybe you'd be more effective in getting your point across if you said it in a more positive way. (challenges dad; hands out 'Making a Positive Request')

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 it would make you feel
- In making positive requests, use phrases like:
  - "I would like you to _____ ."
  - "I would really appreciate it if you would do _____ ."
  - "It's very important to me that you help me with the _____ ."

Miklowitz DJ (2010). *Bipolar Disorder: A Family-Focused Treatment Approach, 2nd Ed.* NY: Guilford Press.

Step 2: Rehearsing and coaching

- Dad (eyeing handout): OK, Evan, I'd appreciate it if you would….come home earlier or at least let us know if you're held up somehow. (eyeing handout) That would make me feel … like you weren't just blowing me off as usual.

- Therapist: Good start. Evan, what did you think of what dad just said?

- **Evan** (to therapist): The first part was OK, but was that what he was supposed to do at the end?

- **Therapist**: Dad, can you try again, only this time add something positive about how you would feel?

Step 3: skill rehearsal, coaching, home practice

- **Dad**: OK, Evan, I'd appreciate it if you would….come home earlier or let us know if you're held up. Text me or something. That would make me feel … um… like I'm being respected.

- **Therapist**: Better! Evan, what did you think of how your dad said that?
- **Evan**: He said it a lot better. But I don't know if I'll do it.
- Dad: You'll do it if you want to keep using the car.

- **Therapist**: (*Redirecting*) Dad, nice job with that request. Now let's talk about how you both might practice this type of communication at home (*introduces homework sheet*).

Handout # 21

Solving Problems

- Agree on the problem
- Suggest several possible solutions
- Discuss pros and cons and agree on best solutions
- Plan and carry out best solution
- Praise efforts; review effectiveness

Miklowitz DJ. *Bipolar Disorder: A Family-Focused Treatment Approach, 2nd Ed.* NY: Guilford Press, 2010.

Handout # 22a

Problem Solving Worksheet

Step 1: Define "What is the problem?" Talk. Listen. Ask questions. Get everybody's opinion.

_____

_____

Step 2: List all possible solutions: "Brainstorm." List all ideas, even bad ones. Get everybody to come up with at least one possible solution. DO NOT EVALUATE ANY SOLUTION AT THIS POINT.

(1) _____
(2) _____
(3) _____
(4) _____

Step 3: Discuss and list the advantages and disadvantages of each possible solution.

Advantages	Disadvantages
_____	_____
_____	_____

How Do I Handle Irritability, Provocations? (II)

- Try to use "self-soothing" techniques yourself: self-talk, "mindful breathing", "giving self a time out"
- The "three volley rule" – your part of argument ends after 3 kid/parent exchanges
- Exit confrontations that are getting destructive
- "Creative consequences" – taking a ride, bringing over other relatives
- Call police/PET team if kid is danger to self or others

Summary - I

- Bipolar disorder is hard to diagnose in children; must be distinguished from other disorders
- Even optimal pharmacotherapy provides less than ideal prevention of mood recurrences
- Family intervention should be a key component of the outpatient management of bipolar disorder in both adults and kids
- Parents can help children and teens to learn to self-regulate emotions

Clinical Take Homes:
Psychosocial Management of Bipolar Disorder

1. Involve parents and siblings (or spouse) in some or all sessions
2. Encourage daily mood monitoring
3. Encourage an acceptance of the role of pharmacology

4. Develop mood management plan; clarify roles of family members
   a) Recognition of early warning signs of new episodes
   b) Managing stressors that may trigger symptoms
   c) Stabilization of sleep/wake rhythms

5. Enhance family communication and problem-solving
6. Encourage re-entry into school and work; address stigma

From: Miklowitz DJ & Gitlin, M. (2015). *Clinician's Guide to Bipolar Disorder*. NY: Guilford Press.

Adapting FFT or Other Psychotherapies to Your Setting

Problem	Adaptation
Fewer than 10 sessions available	Focus on only one module or personalize the skill-building
No diagnostic information available	Use symptom questionnaires; take first session for diagnostic eval.
No family assessments	Use 10-min problem-solving discussions; 10-pt Perceived Criticism Scale; Conflict Behavior Questionnaire
Patient is not taking meds	Is s/he stable enough to benefit from family sessions?
Patient denies illness	Don't force label; focus on aversive interaction patterns, interpersonal or work problems

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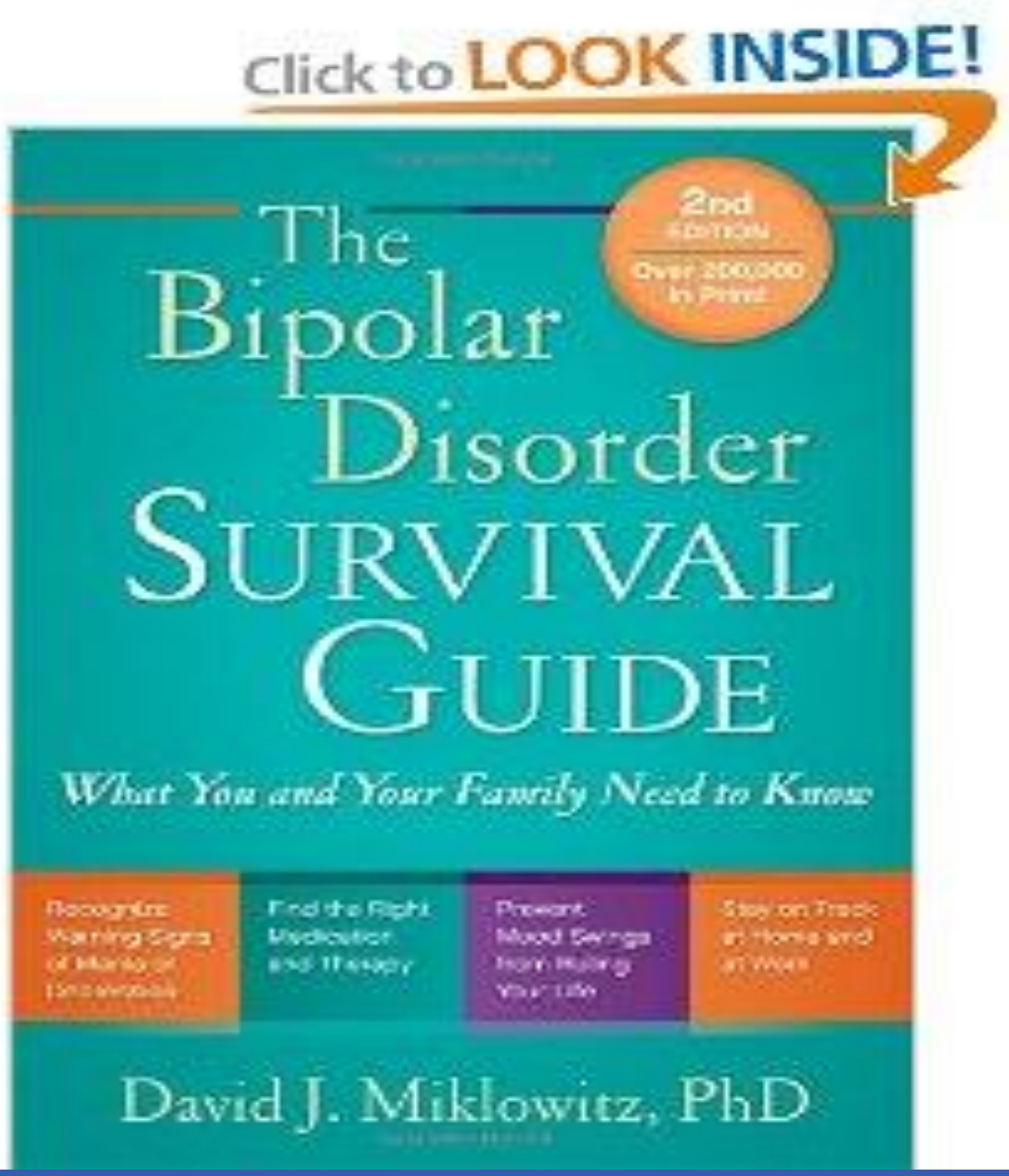
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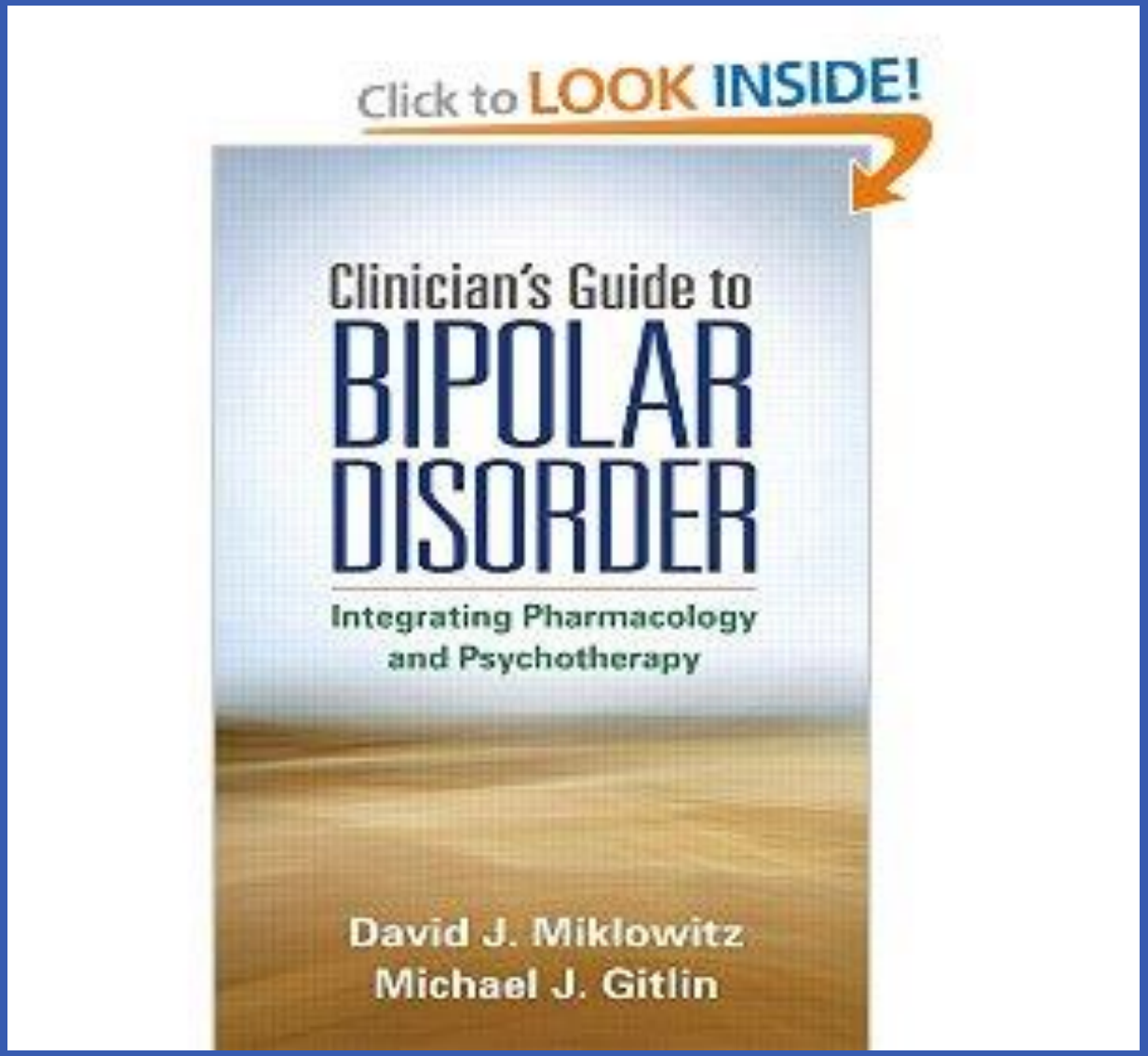
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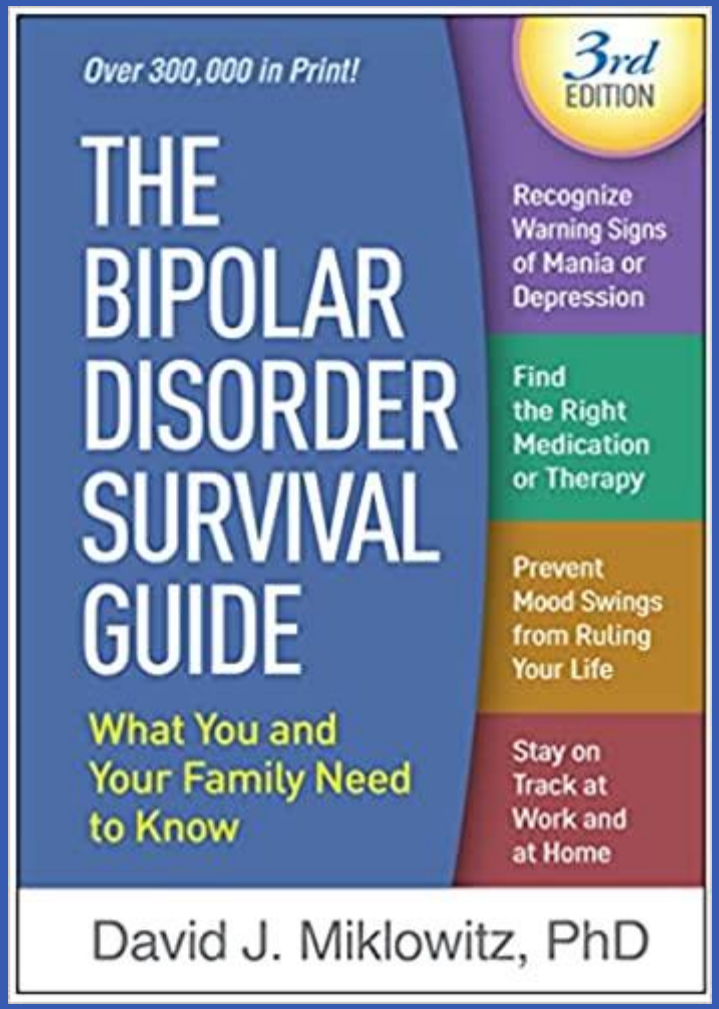
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