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Family-Focused Interventions for Children and Adolescents with Bipolar Disorder

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Family-Focused Interventions for Children and Adolescents with Bipolar Disorder

by

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Chapter 1: Introduction

In recent years, more children and adolescents are being diagnosed with bipolar disorder (Alvaro & Romero, 2011; Apps, Winkler, & Jandrisevits, 2008; Cosgrove, Roybal, & Chang, 2013; Singh, Ketter, & Chang, 2010). Traditionally, bipolar disorder was diagnosed only in older adolescents and young adults (Parens & Johnston, 2010), although current estimates indicate that as many as one-third of the 3.4 million children and adults with depression may have early onset of bipolar disorder (Bipolar Disorder Statistics, n.d.). Many professionals contend increased prevalence rates are due to misdiagnosis, especially given that bipolar symptoms are similar to Attention Deficit Hyperactivity Disorder (ADHD) and other conduct disorders (Apps et al., 2008; Scheeringa, Zeanah, & Cohen, 2010).

Children and youth with bipolar disorder experience unusually high and low emotional states that have been described as *mood episodes.* These episodes consist of abrupt mood swings, intense changes in energy level and sleep, and behavioral manifestations such as temper tantrums, frustration, and defiant behavior (Birmaher, 2013; Jones et al., 2015). According to the American Psychiatric Association (APA; 2013), these episodes differ from "the normal ups and downs in mood that occur in life" (p. 45). Although some children with ADHD manifest some of the same symptoms as children with bipolar disorder, the medication prescribed for treatment of ADHD may trigger manic symptoms in children with bipolar (Birmaher, 2013; Jones et al., 2015). Thus, appropriate diagnosis is critical.

Professionals acknowledge that medication is an essential part of the treatment regimen for children and adolescents with bipolar diagnosis. However, BD is a condition that requires multimodal interventions that include therapy as well as medications (Alvaro & Romero, 2011).

In the case of children and youth with bipolar disorders, it is recommended that any therapy approach include the family. Family systems therapy is based on the idea that individuals are best understood through assessing and treating the entire family and that changing any family member's behavior affects the way the entire family functions (Brown, 2008). Therefore, family therapists attempt to change patterns of relating to create more functional ways of interacting.

Family-Focused Therapy (FFT) interventions have been developed as a particular type of family approach to treatment of children and youth with bipolar disorders, which is part of a multimodal intervention that typically includes medication. The purpose of this paper was to examine the efficacy of FFT in alleviating symptoms associated with bipolar disorder in children and adolescents.

Bipolar Disorders: Diagnostic Criteria

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) identifies the primary symptoms of bipolar disorder (BD) as intense and fast-changing mood episodes. These episodes consist of mania and depression, which can switch back and forth frequently or rarely and vary with each individual (Apps et al., 2008). The average age for onset of either manic or depressive episodes is 18, although it can begin in childhood or adulthood (APA, 2013).

Major depressive episodes are diagnosed when individuals demonstrate depressive moods for many days and over a period of time. Fatigue or decreased energy levels is evident (Birmaher, 2013). There is a decreased interest in activities and events that the individual had previously found enjoyable. Weight loss or gain can be present, along with insomnia or excessive sleeping (APA, 2013). Agitation is present nearly every day, as well as a diminished

ability to think and make choices. Most diagnosed with BD will feel hopeless and some will

have suicidal ideation. Data suggest that the risk of suicide may be 15 times higher in students

with BD than the general population (Miklowitz & Taylor, 2006).

Manic episodes consist of various levels of elevated or irritable mood for at least 1 week

consistently (APA, 2013). To be diagnosed as having mania, the person will demonstrate some

of the symptoms of decreased need for sleep, excessive talking, or grandiosity. Unlike the

depressive episode, people in a manic state experience great pleasure in various activities.

Two types of BD are identified in the DSM-5: Bipolar I and Bipolar II. Bipolar I is

diagnosed when both depression and mania are present. Individuals may also experience

hypomanic episodes that are not as intense as manic episodes (Apps et al., 2008). Hypomanic

symptoms have a shorter duration than manic symptoms (Birmaher, 2013). When individuals

experience four or more major depressive, manic, or hypomanic episodes in the same year, it is

referred to as *lability* (APA, 2013).

Those with Bipolar I often engage in risky behaviors, such as spending large amounts of

money and participating in dangerous situations. Some may have gambling problems, struggle

with drug addiction, or manifest other behaviors that are not typical for that person (Birmaher,

2013; Singh et al., 2010).

The second type of bipolar disorder is Bipolar II. Bipolar II is diagnosed when

hypomania and major depressive episodes are present, or have been present in the past. It is

characterized by mood episodes that include one or more major depressive episodes and at least

one hypomanic episode (Apps et al., 2008). Another common feature of BD II is compulsive

behavior, which can lead to suicide or drug use (Birmaher, 2013). As with all major psychiatric

disorders, episodes must cause significantly negative affect one's performance in social, occupational, or other areas of functioning. Bipolar II is more chronic than Bipolar I, and individuals spend more time in the depressive state (APA, 2013).

The rates of diagnosis and treatment of pediatric bipolar disorder (PBD) have soared in recent years (Cosgrove et al., 2013). Between 1994-1995 and 2002-2003, a "40-fold increase" was reported in the number of PBD diagnoses (Insel, 2010). Morris, Miklowitz, and Waxmonsky (2007) reported that between 15 and 18% of patients with bipolar disorder have their initial onsets before the age of 13 years, and between 50% and 66% experience onset before the age of 19.

Pediatric bipolar disorder is defined as "a chronic and debilitating illness characterized by periods of episodic mood disturbance and pronounced impairments in social, academic, and family functioning" (Weinstein, Henry, Katz, Peters, & West, 2015, p. 116). Even though these criteria reflect adult criteria in that children and youth experience mixed episodes of mania and depression, psychosis, and suicidal thoughts, BD in children and adolescents has different characteristics when compared with adults (Alvaro & Romero, 2011; Cosgrove et al., 2010; Parens & Johnston, 2010). For example, depression is more common in children and adolescents than in adults, and they may experience more somatic symptoms and drug and alcohol abuse (Apps et al., 2008). Their manic symptoms are also likely to be exhibited as extreme irritability. Table 1 provides a description of major bipolar symptoms as they are manifested in children/youth and adults.

Table 1

Bipolar Symptoms in Adults versus Children and Youth

ADULTS	CHILDREN AND YOUTH
• Feelings of guilt, worthlessness, helplessness, or hopelessness • Loss of interest of pleasure in usual activities, including sex • Insomnia or oversleeping • Appetite changes, which may include weight gain or loss • Fatigue, lack of energy • Thoughts of suicide or death • Slow speech; slow movements	• Insomnia, fatigue, headache, stomachache, dizziness • Apathy, social withdrawal, weight loss • Drug abuse or alcohol abuse, a drop in school performance, difficulty concentrating • Isolation from family and friends • For dysthymia, symptoms are less intense and fewer in number, but last longer

Note. Adapted from WebMD. (n.d.). *Understanding depression: Symptoms.* Retrieved from http://www.webmd.com/depression/understanding-depression-symptoms.

It is important to understand the way in which individuals experience symptoms because health professionals use these symptoms to differentially diagnose psychiatric disorders and provide appropriate treatment. In the next section, I describe family-focused intervention as part of a treatment plan.

Family-Focused Interventions

Prior to 2007, few studies examined whether psychosocial interventions could reduce the associated risks of bipolar disorder for children and youth (Fristad & MacPherson, 2014; Goldstein, Axelson, Birmaher, & Brent, 2007; Mikowitz et al., 2011a). Professionals now agree that BD requires a multimodal treatment and should involve both medication and therapy—ideally family-focused therapy (Alvaro & Romero, 2011; Parens & Johnston, 2010; Singh et al., 2010; West, Henry, & Puvuluri, 2007). Long-term interventions should provide patients and their families with tools and strategies to manage and control symptoms (Miklowitz & Taylor, 2006; Parens & Johnston, 2010).

The FFT model includes medication, psychoeducation, skills training, and self-management strategies that are implemented in various phases (Fristad & MacPherson, 2014; Morris et al., 2007). Family-Focused Therapy is used as an adjunct to pharmacotherapy to manage the "expressed emotion" of caregivers and family members (Morris et al., 2007, p. 435). Expressed emotion (EE) is a measure of "the emotional attitudes of caregivers/relatives toward a family member with a psychiatric disorder" (Morris et al., 2007, p. 435). High EE might include excessive criticism or hostility, overprotectiveness, feelings of self-sacrifice, or other exaggerated emotional responses. Morris found that children and youth in these high-EE environments are more likely to experience poorer outcomes than children and youth in low-EE environments. Family-focused therapy addresses these issues.

Family-focused interventions also ensure a family structure that provides stable eating, sleeping routines consistency in caretaking, and external structure helps children develop internal controls and emotional self-regulation strategies. Morris et al. (2007) identified six core elements of FFT:

1. Integrating the experiences associated with mood episodes in bipolar disorder,
2. Accepting the notion of a vulnerability to future episodes,
3. Accepting dependency on mood-stabilizing medication for symptom control,
4. Distinguishing between the patient's personality and his/her bipolar disorder,
5. Recognizing and learning to cope with stressful life events that trigger recurrences of bipolar disorder.
6. Reestablishing functional relationships after a mood episode. (p. 436)

Therapists who administer FFT have been trained in Marriage and Family Therapies (MFT), which includes psychotherapy and family systems. They have completed graduate training and 2 have years of clinical experience (American Association for Marriage and Family Therapy, 2015).

FFT is most often administered in 21 sessions over 9 months. Sessions occur weekly,

then biweekly, and then once monthly as the family acquires new skills (Miklowitz et al.,

2011b). Table 2 provides a summary of the program structure.

Table 2

FFT Program Structure

Understanding Bipolar Disorder: Phase 1 (Education)	In the first segment, families learn about (a) the nature, symptoms, course, and treatment of bipolar disorder; (b) the goals, procedures, and expectations (Miklowitz et al., 2011b); (c) the importance of consistently taking medication as prescribed; and (d) triggers that make cause stress and vulnerability (Morris et al., 2007).
Relapse Prevention Training: Phase 1 continued	Family, patient, and health professional (a) discuss risk and study history of events or substance usage that caused relapse in the past; (b) identify how family, school, and other supports can be helpful; (c) assist families in the ability to see early signs in the patient, and (d) make a document with a plan with specific steps that youth, school and family can follow should a relapse begin (Morris et al., 2007).
Skills Training: Phase 2	The health professional educates the family and youth how to effectively communicate feelings without blaming or hurting others. Verbal and nonverbal skills are taught, including expressing positive feelings, listening actively, making positive requests, and expressing negative feelings or making constructive criticism (Miklowitz et al., 2011b).
Problem Solving: Phase 3	The problem-solving module is introduced, goals are reviewed, and family problems are identified (Miklowitz et al., 2011b). The professional incorporates problem-solving topics that will not provoke emotional situations (Morris, 2007).
Termination: end of Phase 3	During the final phase previously learned content and relapse prevention plans are reviewed (Miklowitz et al., 2011b). The professional once again encourages the patient to take medication as prescribed and schedules additional booster sessions if needed. Referrals for ongoing care can be made at this time.

Miklowitz et al. (2011b) asserted enhanced knowledge about emotional regulation

strategies, effective communication skills, and problem-solving strategies enable the student and

his or her family to work together more effectively to reduce stress and conflict. Families learn

to understand the differences between the stereotypic adolescent turmoil and symptoms of

bipolar disorder. In sum, FFT is designed to diminish the most profound negative effects of

bipolar disorder.

Research Question

One major question guides this review of the literature: Is Family Focused Therapy an effective means of alleviating the symptoms associated with Pediatric Bipolar Disorder?

Focus of the Paper

I reviewed studies in Chapter 2 if they included children and adolescents ages 3 to 18 who were diagnosed with PBD. Chapter 2 studies were typically implemented in clinical settings from 2004 to 2015. In the paper, I included only literature that used quantitative or qualitative designs to evaluate family interventions. Psychopharmacology interventions were excluded from review to limit the scope of the paper. Although participants in these studies were typically taking medications, the focus of the research was on the added dimension of FFT as a role in the treatment regimen.

To obtain research articles for my starred paper I examined electronic libraries, journals, professional websites, and databases using keywords and combination of keywords such as *bipolar, mood disorders, children, adolescents, interventions, Bipolar Disorder, diagnosis, family-focused therapy and family history.* I also reviewed the table of contents of several academic journals, including *Bipolar Disorders* and *the Journal of Child and Adolescent Psychiatric Nursing*. In Chapter 2, I discuss the findings of individual and group studies and the implications of these findings.

Importance of Topic

I spent my early adulthood attending colleges and obtaining degrees in psychology, Spanish, and special education (learning disabilities and autism). I served as a special education paraprofessional for 4½ years and I was a teacher of students with autism for 3 years. It was the

end of my third year of teaching that I was diagnosed with Bipolar Disorder-Mixed State, which is also known as Bipolar II.

Looking back through my childhood and development, I have discovered that I had many symptoms of BD as young as 5 years old. In retrospect, I wish that I could have received more help for my depression and anxiety long before I reached adulthood. I believe my prognosis would have been less devastating if I could have learned coping skills before I used maladaptive ways to live with Bipolar Disorder. It is my hope that other children and adolescents receive both the medication and psychosocial support they need to develop proactive coping skills. This paper may serve as a means of educating teachers and parents regarding the psychosocial interventions that are an important component of the treatment plan.

Definitions

A number of terms are used throughout this review of literature. Terms already defined in Chapter 1 are not included in this glossary.

Anhedonia is a lack of pleasure from activities that were enjoyed in the past (Psychology Dictionary, n.d).

Emotional over-involvement (EOI) is "typically defined as over concern, overprotectiveness, and an inordinate level of self-sacrifice" (George, Taylor, Goldstein, & Miklowitz, 2011).

Expressed emotion (EE). Parents with high EE are those who make significant sacrifices to improve outcomes; low EE parents make minor adjustments (Miklowitz et al., 2009).

Fatigue is a word to describe a time of extreme tiredness due to emotional or physical exhaustion or boredom and lack of sleep (Psychology Dictionary, n.d).

Grandiosity/grandiose delusions involve the belief that one has exceptional abilities, wealth, or fame (APA, 2015).

Hypersomnia is when a person has multiple naps, and a change in duration of sleep. Can be used to avoid unpleasant symptoms (Psychology Dictionary, n.d).

Lability/labile affect is the "pathological emotional expression, generally due to neurological degeneration or other complications; may or may not be mood-congruent." For example, the person may sob uncontrollably when upset (Grinnell, 2008, p. 1).

Multimodal refers to interventions that use combinations of approaches, typically medications and psychosocial therapy (Alvaro & Romero, 2011).

Pharmacotherapy refers to the psychiatrists and use of medication that may or may not be allowed in a study (Miklowitz et al., 2008, p. 1054)

Psychosis is defined as symptoms that make it very hard or impossible for a person to "know what is real; to think clearly; to communicate and relate with others; and to feel normal emotions" (APA, 2015, p. 29).

Suicide ideation is "suicidal ideas or overwhelming desire to commit suicide, usually happening during depressive episodes. Usually not followed by actually try to commit suicide. To plan out how to commit suicide in any bad situation" (Psychology Dictionary, n.d).

Chapter 2: Review of the Literature

Chapter 1 provided a brief overview of Family-Focused Therapy (FFT) as an intervention for children and adolescents with Bipolar Disorder. In this chapter, studies are reviewed that examine the effectiveness of FFT in reducing depressive and manic symptoms. Prior to the literature review, an overview of assessment measures is provided.

Assessment Measures

A number of studies in this chapter rely upon the same assessment tools to measure outcomes. To assist the reader, Table 3 describes the assessments that are used in multiple Chapter 2 studies.

Table 3

Overview of Chapter 2 Assessments

ASSESSMENT	PURPOSE
Adolescent Longitudinal Interview Follow-up Evaluation (A-LIFE; Grinnell, 2008)	A system for assessing the longitudinal span of psychiatric symptoms that includes an interview, an instruction book, a coding sheet, and training materials
Beck Depression Inventory II Second Edition (BDI-II; Lipman, Covi, Rickels, Uhlenhuth, & Lazar, 1968)	A self-report tool to assess the severity of symptoms of depression based on the DSM-IV
Camberwell Family Interview (CFI; Vaughn & Leff (1976)	An interview that examines parents' critical comments, hostility, and emotional over-involvement related to illness episodes and classified parents according to high or low EE
Children's Depression Rating Scale Revised (CDRS-R; Poznanski et al., 1995)	A scale for diagnosing depression and monitoring treatment response for children 6 to 12 years
The Children's Global Assessment Scale (C-GAS; Shaffer et al., 1983)	A clinician-rated measurement of child functioning based on impairment in the family, social, school, or work areas
Children's Global Impressions Scales for Bipolar Disorder (CGI-BP; Spearing, Post, Leverich, Brandt, & Nolen, 1997)	A clinician report of child's overall psychiatric illness severity
The Children's Interview for Psychiatric Syndromes-Child Form (ChIPS) and *Parent Form* (P-ChIPS) (Weller, Weller, Rooney, & Fristad, 1999)	Structured diagnostic interviews assessing psychopathology using DSM-IV criteria to assess 20 behavioral, anxiety, mood, and other syndromes and stressors in youth 6 to 18 years old

Table 2 (continued)

ASSESSMENT	PURPOSE
Depression Rating Scale (DRS; Chambers et al., 1985)	Semi-structured interviews to assess affective disorders
Family Adaptability and Cohesion Scale II and IV (FACES-II; Olson, Russel, & Sprenkle, 1989) (FACES-IV; Olson, 2011)	A self-report instrument that examines family relationships and their health outcomes
Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS; Endicott & Spitzer, 1978)	A version of the semi-structured Kiddie Schedules interview, but designed for school-aged youth for 6-18 years old
Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetimes Version (K-SADS-PL; Kaufman et al., 1997)	A semi-structured interview for parents and adolescents
Mania Rating Scales (MRS; Axelson et al., 2003); *Child Mania Rating Scale* (CMRS; Pavuluri et al., 2006)	AssessesAssessment of current and past symptoms on 1 to 6 scales of severity and impairment;. p Parents rate children's symptoms on the CMRS.
Psychiatric Status Ratings (PSRs; Keller et al., 1987)	A 6-point scale that assesses severity of mania, hypomania, MDD, patterns of cycling, and evidence of significant changes from baseline moods.
Washington University Schedule for Affective Disorders and Schizophrenia (WASH-U-KSADS; Geller, Williams, Zimmerman, & Frazier (1996)	Assesses active psychosis, active substance abuse, neurological and other medical problems
Young Mania Rating Scale (YMRS; Young, Biggs, Ziegler, & Meyer, 1978)	A scale to determine if youth have significant affective symptoms

Family-Focused Therapy

Unless otherwise specified, the studies reviewed in this chapter implemented the FFT intervention as outlined in Chapter 1. That is, 21 sessions were conducted over a 9-month period (12 weekly, 6 biweekly, 3 monthly) and addressed psychoeducation, communication enhancement, and problem-solving. The course of treatment begins by establishing a family-therapist relationship and then focusing on pharmacotherapy and relapse prevention. The final sessions focus on communication, listening, offering positive feedback, constructive criticism, and problem-solving. The studies in this chapter describe FFT programs that have been modified slightly to meet the needs of different treatment groups, although these programs

follow the same general procedures as just described. The traditional FFT model was implemented in one study; the remaining nine used Family-focused Therapy-Cognitive Behavioral Interventions (CFF-CBT), Family-focused Therapy-Adolescents (FFT-A), Family-Focused Therapy, High Risk (FFT-HR), or Multifamily Psychoeducational Psychotherapy (MF-PEP).

George et al. (2011) presented a case study of a 15-year-old White male whose parents referred him for FFT after a month of major depressive episode. Isaiah also experienced extreme fatigue, hypersomnia, and anhedonia. He was subsequently diagnosed with Bipolar Disorder II. Prior to FFT referral, Isaiah was prescribed lithium and quetiapine, which appeared to help him with acute hypomanic and depressive symptoms. However, he continued to struggle with symptoms of irritability and anhedonia. Subsequent to diagnosis, numerous questionnaires and inventories were administered to assess depressive and anxiety symptoms as well as substance abuse. These measures were again administered at follow up to assess symptoms. Parents' symptoms were also assessed using the BDI-II at intake and follow-up. Mom reported no current mood symptoms, whereas Dad reported he experienced periods of moderate depression.

The study followed FFT protocol as described at the beginning of this section. Isaiah and his parents participated in treatment, along with his 13-year-old sister and 9-year-old brother. At the beginning of the treatment, each family member—including Isaiah—described their individual goals for the therapy. During psychoeducation, family members were encouraged to describe their own mood swings and to record them using mood charts. These charts revealed that all but Henry had reported either depressive or bipolar episodes.

Mom brought Isaiah to every session and called between sessions with concerns about his symptoms. The rest of the family attended inconsistently, which appeared to be related to the parents' beliefs about the treatment. By the sixth session, Dad felt that Isaiah's medication was working well and he saw no reason for the family to continue with FFT. Isaiah became more irritable and less communicative than he had been in the past. At an individual session the eighth week, Mom reported serious concerns about the family's overall functioning and about Isaiah's functioning in particular.

Because most of the psychoeducation component was completed, the therapist decided to move on to communication skills training in an attempt to reconnect with the family. The family practiced active listening, and the therapist praised their efforts. The next session focused on problem-solving, and Mom shared that she was granting Isaiah more independence. The entire family attended the next several sessions together, and they completed the rest of the communication skills and problem-solving exercises. Family functioning was improved substantially, according to all family members.

Less than 2 weeks later, Mom called to report that Isaiah had attempted to overdose with his prescription medications and was in the hospital. His doctors found marijuana and cocaine in his system. Mom blamed the therapist for pushing her to provide him with more independence, and she terminated treatment. This FTT had failed Isaiah and his family.

George et al. (2011) identified three factors that contributed to FFT failure. The first factor was the characteristics of the adolescent and the family including therapist's alliance with the individuals. Isaiah and his Mom benefited moree than from the study than Isaiah's father, but the standard approach was not enough for the family because of Isaiah's struggling with

comorbid disorders. The adolescent exhibited disrespect, negativity and various other behaviors that made it difficult for the therapist to develop an alliance. At times, parents interacted inappropriately.

The second factor was the interaction of the therapist with parents, specifically the difficulty of working with parents who are emotionally overinvolved. When the therapist allowed Isaiah more freedom, the parents perceived this as the cause of Isaiah's substance abuse and his purposeful overdose.

The third factor that contributed to the therapy failing was Isaiah's hidden substance abuse. Comorbidity of substance abuse and bipolar disorder is associated with illness severity for all types of symptoms. For Isaiah, the comorbidity had adverse consequences. The alcohol led to mood episodes during the 12-month follow-up period and caused a misuse of medications, poor grades at school, and ultimately an attempted suicide. These three factors are what resulted in the failure of this study.

Family-Focused Therapy-Cognitive Behavioral Interventions (CFF-CBT)

CFF-CBT was developed in 2004 and was more developmentally sensitive to meet the needs of pediatric bipolar disorder (PBD) patients. This FFT approach incorporated cognitive-behavioral components in addition to family therapy (Pavuluri et al., 2004).

Pavuluri et al. (2004) studied the effects of a CFF-CBT intervention with 34 children and adolescents with pediatric bipolar disorder (PBD). Participants were being treated at a specialty clinic at the University of Illinois at Chicago and were stabilized on medication. Most participants were White and middle class.

The RAINBOW program is a 12-session CFF-CBT model that is an individual- and family-based approach for the treatment of PBD. During the first session, the RAINBOW model is explained; family members receive a card as a visual reminder to use RAINBOW therapy in daily activities:

- R = Routine

- A = Affect regulation

- I = I can do it!

- N = No negative thoughts and live in the "now"

- B = Be a good friend and balanced lifestyle for parents

- O = Oh, how can we solve the problem?

- W = Ways to get support

Routine was explained to families as being important because lessens reactions to situations and decreases intense moods. Affect Regulation allows patients to learn to read their own moods based on specific criteria listed in the categories of Major Depression, Dysthymia, Normal, Hypomania, and Mania. I Can Do It requires patients with families and therapist to write positive statements about themselves and give positive feedback to their children, which facilitates problem-solving. No Negative Thoughts and Live in the Now encourage families to communicate after a negative situation while learning positive ways to avoid unhelpful thoughts. Oh, How Can We Solve the Problem teaches families not to discuss things while someone is escalated, but instead to work together as a family to solve the problem after the problem occurred. As a part of the last step, Ways to get Support, support is viewed as strength and not a

weakness, and the family and therapist make a list of whom the patient can contact to obtain help if needed.

The CGI-BP was administered prior to treatment, at the end of each session, and at the end of the study to assess behavioral symptoms. The CGAS was administered at the beginning and the end of the study by a therapist. Parents or guardians of completed a satisfaction survey at the end of the session.

Paired comparison t tests revealed significant changes in CGI-BP scores from the beginning to the end of the intervention: ADHD ($p < .0001$), aggression ($p < .0001$), mania ($p < .0001$), psychosis ($p > .01$), depression ($p < .0001$), and sleep disturbance ($p < .0001$). Paired comparison t tests of CGAS scores also revealed participants were functioning significantly better at the end of the treatment than in the beginning ($t_{32} = 5.7, p > .0005$).

In this study, CFF-CBT demonstrated a new psychosocial approach for the treatment of PBD that allows interaction between children and families. The researchers assert it is a very flexible intervention that enhances family communication and assists families with applying what they have learned during therapy sessions. Unfortunately, the lack of a control group is a limitation. Another limitation is the timing of medication use in this study because improvements could have been attributed also to the success of the medication prescribed prior to the study.

West et al. (2014) tested the effect of child- and family-focused cognitive-behavioral therapy (CFF-CBT) as an adjunct to usual psychotherapy on the severity and functioning ability in children with diagnosed bipolar disorders. The 69 participants ranged in age from 7 to 13 and were required to be stabilized on medication, as assessed by two rating scales. Participants were

excluded if IQs were less than 70, had active psychosis, were engaged in current substance

abuse, had medical or neurological problems, or demonstrated active suicidal thoughts that were

dangerous. In addition, if the child's caretakers had depressed or manic symptoms; the child was

not allowed to participate.

Participants were randomly assigned to either CFF-CBT or the control group, which were

determined to be equivalent groups. Both groups participated in 12 weekly sessions that spanned

over 9 months and included 6 monthly booster sessions. Both groups attended the same facility

and had the same medication management. Assessments took place at baseline; weeks 4, 8, and

12; and at week 39 in a follow-up.

Parents completed the WASH-U-KSADS and the CMRS (Pavuluri et al., 2006). To

assess depressive symptoms, parents completed the authors' unpublished *Child Bipolar*

Depression Rating Scale (CBDRS). Subsequent to treatment, parent completed the *Treatment*

Satisfaction Scale (Pavuluri et al., 2004) to assess family's satisfaction with the therapy.

Therapists completed the C-GAS and the (CGI-BP).

Regression analyses, *t* tests, and chi-square analyses were used to assess therapy

outcomes. Results revealed that treatment completion differed by condition. Specifically, more

participants dropped out in the control group than in the treatment group ($\chi^2 = 13.46$, $p = .63$).

CFF-CBT participants attended more of the 12 sessions than the control session participants

($t_{66} = 4.10$, $p < .0001$). Participants in CFF-CBT completed slightly more maintenance sessions

than the control group ($t_{57} = .193$, $p = .059$).

CFF-CBT significantly reduced parent-reported mania at posttreatment ($F_{49} = 7.90$, $p = .007$) and decreased depressive symptoms at posttreatment ($F_{67} = 4.92$, $p = .03$). However, symptoms over time were not significant for depression. Families were significantly more satisfied with CFF-CBT than the control group ($t_{30} = 2.24$, $p = .30$).

Clinician-reported depression symptoms showed no significance between treatment or treatment over time, although clinicians reported fewer mania symptoms after treatment. Follow-up showed no significant differences between the two groups on either depression or mania. Changes in global functioning were not reported for either group in posttreatment, although CFF-CBT participants scored higher at follow-up. These results are consistent with FFT and CBT of adults with BD.

Several study limitations were cited. For example, participants were not blinded to the treatment condition, and the use of parent reports can result in biased outcomes. Although medications were changed during the study, enough data were not collected to determine its effects on the symptoms. Finally, West et al. (2014) acknowledged that results may have been skewed because of a loss of participants at the follow-up phase.

Weinstein et al. (2015) also examined the use of the RAINBOW program, which was described previously in the review of the Pavuluri et al. (2004) study. This CFF-CBT program was implemented with 69 children diagnosed with bipolar disorder in a large midwestern urban area. Participants were assigned to either the RAINBOW treatment group or the Therapy as Usual (TAU) group. The RAINBOW sessions focused on A (accepting parents tough feelings about child), I (building personality), N (improving parent negative thinking using mindfulness), B (increasing parent balance in life), and W (using positive supports). The TAU group focused

on sessions that were the same lengths of time as CFF-CBT but were unstructured. Sessions

were voice recorded to assess content. At the end of the study, 30 participants remained in the

CFF-CBT and 17 participants remained in the TAU group.

Both the CFF-CBT and TAU groups were scheduled for twelve 60- to 90-min weekly

sessions during the main phase and up to 6 monthly follow-up sessions over a 9-month period.

The same trained therapists conducted the therapy sessions for both the RAINBOW experimental

group and the TAU control group.

Baseline and post-treatment data were collected for parents using a variety of assessment

tools: the BDI-II, the FACES, and the *The Conners/March Development Questionnaire*

(CMDQ). This questionnaire assesses annual income, child age and sex (Conners and March,

1996). A trained professional who was blind to the study administered the children's

assessments at baseline that included the CMRS, the CDRS-R, the WASH-U-KSADS, the

C-SSRS, the PHSCS, and the CMDQ. Data were collected at the beginning of the study, after 4

weeks, 6 weeks, 12 weeks, 39 weeks, and 6 months. Mixed-effects regression models were used

to analyze data.

Youth in CFF-CBT had lower mania symptoms than TAU, making results significant for

those completing CFF-CBT ($\chi^2 = 13.46$, $p = < .001$). Depression symptoms and self-esteem

were not correlated. The 6-month assessment did not differ by condition, so these results were

not significant.

Data reflected that one-third of the CFF-CBT sessions focused on parent well-being.

This was not the case in the TAU sessions, which focused on child well-being. Children in the

CFF-CBT group from low-income families showed a stronger response to children in the TAU

group from low-income families. Children with parents having higher depression symptoms did better in CFF-CBT than TAU based upon their own depression symptoms.

Weinstein et al. (2015) highlighted the finding that parental symptoms affected treatment in TAU and future studies address this variable. Although this study addressed parents' mild depressive symptoms, it did not address severe depression nor did it address mania symptoms in an objective manner. As an outpatient clinic study, results may not relate to more severe cases of depression and mania versus if the study took place as inpatient.

Family-Focused Therapy-Adolescents
  (FFT-A)

In 2008, the FFT model used with adults was adapted for use with adolescents. Some assessments were changed or modified. The mood section of the K-SADS-PL assessment used K-SADS Depression and Mania Rating Scales (DRS and MRS), and both adolescent and parent filled them out. The CGAS was also given instead of an adult scale. Assessment results were compared between child and parent (Miklowitz et al., 2008).

Miklowitz et al. (2008) investigated the use of an FFT-A program with 58 adolescents with bipolar disorders from the University of Colorado and the University of Pittsburgh. Adolescents ranged in age from 12 to 17; were diagnosed with Bipolar I, II, or Not Otherwise Specified; and experienced an episode within the 3 months prior to the study. All participants received pharmacotherapy. The researchers hypothesized that adolescents who had FFT-A in addition to pharmacotherapy would have more success than those who had enhanced care (EC) in addition to pharmacotherapy. Adolescents at the University of Colorado were recruited through referral by the community psychiatrists or the inpatient units of Children's Hospital in

Denver. Once the family was approved for the study, participants were randomly assigned to the pharmacotherapy and FFT-A group or the pharmacotherapy and EC group. Thirty patients were in the FFT-A group, while 28 were in the EC group.

Multiple assessments were used as pretest measures, some of which were also used as eligibility screening measures. Prior to the 2-year study, adolescents and parents completed the K-SADS-PL, the K-SADS, the DRS, and the MRS. The CGAS evaluated behaviors during the 2 weeks prior to the study and the most severe past episode of symptoms.

Trained Pittsburgh and Colorado therapists conducted the FTT-A and EC sessions. Adolescents and families in the FTT-A condition participated in the FFT-A treatment as described at the beginning of this section. The adolescents in the EC condition completed three weekly 50-min sessions over the 2-year study. Adolescents and families could request more sessions over the 2-years. The sessions focused on relapse prevention, accurately taking medication, and low family conflict.

Results showed that patients in FFT-A recovered from their baseline depression faster than the patients in EC ($F_{(1, 5017)} = 7.49$, $p = .006$). Treatment over time was independent of what occurred in baseline ($F_{(1, 51)} = 12.90$, p < .001). Compared to baseline, mania or hypomania symptoms decreased, although results were not statistically significant. Youth in the FFT-A group had less depression over the duration of the sessions and at the end of the 2-year study.

The results of the FFT-A and pharmacotherapy intervention supported the hypothesis of the original FFT study conducted with adults. Adolescents in the FFT-A group recovered more quickly from depression and mania and had longer intervals between relapse than adolescents in the EC group. The FFT-A participants also reported less time in depressed or manic states.

Miklowitz et al. (2008) acknowledged patient variability may have affected outcomes and recommended this be considered in future studies. They also speculated that outcomes would have been enhanced by supplementing FTT-A with "collaborative care interventions" to stabilize mania (p. 1059).

Miklowitz et al. (2009) conducted a second study with the same 58 adolescents in order to compare FFT-A and EC groups with regard to the effects of parental expressed emotion (EE). The procedures are also the same described previously, although different assessments were administered.

Two pre-post assessments were used to evaluate parent and family functioning: the CFI and the FACES-II. Parents with high EE were those who made significant sacrifices to improve outcomes; low EE parents made minor adjustments. Interviews with adolescents and parents were conducted at baseline, every 3 months in the first year, and every 6 months in the second year using the A-LIFE. In addition, the adolescent and one parent completed A-LIFE scales to rate depression, mania, or hypomania symptoms.

ANOVAs and ANCOVAs were used to interpret findings. The A-LIFE depression scores showed a significant effect for time at follow-up ($F_{(1,5063)} = 94.78$, $p < .0001$), a significant two-way interaction between EE and time ($F_{(1,5076)} = 29.50$, $p < .0001$), and a 3-way interaction among treatment group, EE, and time ($F_{1,5075} = 7.89$, $p = .005$). In other words, treatment differences were significant for adolescents from high-EE versus low-EE families according to treatment group and over time.

Regression analyses were also employed to analyze treatment effects and were also significant for treatment and time interaction effects on mania and depression scores. That is,

mania and depression scores improved over the 2 years for adolescents in high EE families who received FFT.

Expressed emotion moderates the effects of family-focused treatment for adolescents with bipolar adolescents. The data from this study supported the hypothesis that FFT-A would be more effective than EC in reducing the depression and mania symptoms of adolescents in high-EE families. Strong FFT-A effects were not found for adolescents in low-EE families. Miklowitz et al. (2009) recommended that families' EE be assessed prior to intervention so that interventions can be better tailored for the adolescent. Family EE in this study was assessed only once, and the researchers viewed this as a limitation.

Sullivan, Judd, Axelson, and Miklowitz (2012) wanted to better understand how families function as adolescents go in and out of mood episodes, so they conducted a 2-year study to evaluate family functioning and relationships related to adolescents' bipolar symptoms. The 58 families in this study came from private and public in- and outpatient facilities in Boulder, Colorado, or Pittsburgh, Pennsylvania.   Adolescents and their families were randomly assigned to FFT-A or EC. Adolescents followed a pharmacological protocol monitored by a psychiatrist.

Baseline measures included the MRS and DRS, which focused on the most severe 1-2 weeks in the month prior to intake and the most severe 1-2 weeks over the adolescent's lifetime. Parents and adolescents completed the FACES-II and the *Conflict Behavior Questionnaire* (CBQ; Prinz, Foster, Kent, & O'Leary, 1979), a self-report that examines the relationship with offspring and parent. Post- and follow-up assessments using the same measures were conducted every 3 months during the first year and 6 months the second year. They focused on the most symptomatic 1-2 weeks in the month prior to the follow-up appointment.

Multilevel analyses were used to evaluate outcomes. Adolescent-reported scores for cohesion, adaptability, and conflict were lower than parent-reported scores, which meant that youth thought their families did not work as well together as the parents did. Across the 2-year study, parent-reported conflict levels dropped no matter if in FFT-A or EC. For parents who reported high levels of conflict at baseline, scores dropped in the FFT-A treatment ($F_{(1,9.53)} = 12.80$, $p = .005$), but were not significant in EC treatment. Teen-reported conflict levels decreased over time in high-conflict families ($F_{(1,14.1)} = 4.55$, $p = .05$) but were not significant in the low-conflict families.

Longitudinal ratings revealed family relationships were significantly related to adolescents' depression scores over time, according to parents ($F_{(1,148)} = 5.02$, $p = .03$) and adolescents ($F_{(1,156)} = 9.40$, $p = .003$). In other words, family relationship scores were significantly higher when adolescent depression scores were lower. Adaptability ratings were also significantly related to depression scores for both parents ($F_{(1,155)} = 3.21$, $p = .07$) and adolescents ($F_{(1,161)} = 5.76$, $p = .02$). Over time, parents and adolescents reported less family conflict, which significantly decreased depression in adolescents based on DRS scores. According to parent-reported MRS scores, decreases in conflict also decreased mania in adolescents ($F_{(1,96.2)} = 5.43$, $p = .02$).

The study examined the stability of family functioning over time and the relationship of family functioning and mood symptoms during FFT-A treatment. Sullivan et al. (2012) hypothesized that family functioning would improve over the course of the 2-year study. Although the results clearly showed family functioning was related to adolescents' symptoms over time, it did not show that family functioning improved. Furthermore, neither FFT-A nor EC

influenced family relationships and adaptability. The study did show that adolescents in FFT-A treatment from high-EE families had better depression and mania scores over the 2 years than adolescents in EC treatment.

Limited sample size and missing data were a limitation of the study. Another element missing in the study was lack of control over the medication regimens, which may have contributed to variabilities in medication dosage and timing.

Family-Focused Therapy, High Risk
  (FFT-HR)

FFT-HR was employed to see if it could stabilize symptoms in youth who were high risk for BD. Miklowitz et al. (2013) adapted the FTT model to a 4-month intervention versus the 9-month intervention in order to quickly stabilize youth.

Miklowitz et al. (2011a) conducted a 1-year open trial of FFT-HR, family-focused therapy for youth at high risk for bipolar disorder. The 13 children they recruited from Stanford University and University of Colorado clinics ranged in age from 9 to 17 years, 11 months. Eleven youth were Caucasian, 2 were Hispanic, and 1 was mixed race. Selection criteria included having a biological parent with Bipolar Disorder I or II, Bipolar Disorder-Not Otherwise Specified, major depressive disorder, or cyclothymic disorder. Those with BD-NOS had to meet stronger criteria with greater periods of abnormality, symptoms of mania, and so forth.

An independent evaluator administered the A-LIFE and the psychiatric status ratings (PSRs) 16 weeks prior to the first evaluation, and patients were rated each week of the follow-up condition. During baseline and every 4 months, the YMRS was administered. During intake,

the clinician used CDRS-R, which examined 17 depressive symptoms. Prior to intervention, participants completed the CDRS-R to obtain baseline depression data and the YMRS to obtain baseline on affective symptoms. After each research follow-up week, parents completed the BDI-II.

The FFT-HR sessions were conducted in 12 sessions over a 4-month period instead of 21 sessions over 9 months. The content was the same. In this study, however, therapists offered booster sessions over the entire year.

Regression formulas were used to analyze data. Results revealed significant improvement in depression PSR scores ($F_{(1,799)} = 315.62$, $p < 0.0001$) and hypomania PSR scores ($F_{(1,795)} = 21.10$, $p < 0.0001$). When medications were changed, significant improvements were still reported for depression scores ($F_{(1,798)} = 315.54$, $p < 0.0001$) and hypomania scores ($F_{(1,795)} = 21.26$, $p < 0.0001$) over the year.

Nine of the 11 participants' depression scores of 5 (severe) or 6 (extremely severe) decreased to scores of 3 (moderate), 2 (mild), or 1 (no symptoms). Two individuals began the study with moderate scores and ended with moderate/mild depression scores. Participants demonstrated moderate improvement on the CDRS-R scale ($F_{(1,40)} = 6.73$, $p = 0.013$) and more significant improvement on the YMRS ($F_{(1,33)} = 12.98$, $p < 0.001$). FFT-HR intervention resulted in significantly improved depression and hypomania ratings over the course of the 1-year study. In addition, the study had a high rate of participant retention (85%).

Miklowitz et al. (2011a) cited a number of limitations. Among these was the failure to assess the impact of psychosocial interventions on the social and academic functioning and the

precise impact of medication changes. It was also unclear whether treatment success was due to the presence of the family member being present or the intervention itself.

Miklowitz et al. (2013) conducted another study to examine FFT-HR's effect on the mood symptoms of youth who were at high risk for BD. The 40 English-speaking participants were recruited from the University of Colorado or the Stanford and ranged in age from 9-18. They all manifested a significant number of bipolar, depressive, and/or manic symptoms and had a first-degree relative with BD I or II. Youth were randomly assigned to either the FFT-HR group or the Family Education control group (EC). They were also placed into subgroups based upon baseline depressive or hypomanic symptoms. The FFT-HR program was modified for use with adolescents by simplifying handouts and flipcharts and by providing flexible 1-hr session formats conducted by parents instead of therapists. Trained therapists conducted 8 weekly and 4 bi-weekly FFT-HR sessions over a 4-month period. They also conducted one or two family sessions with the EC group that summarized the results of the diagnostic assessment, introduced daily monitoring of mood, and gave instructions for managing mood swings. The FFT-HR sessions were conducted in 12 sessions over a 4-month period instead of 21 sessions over 9 months. The content was the same.

Two assessments were used to evaluate parent findings. In addition to the K-SADS, parents completed the *Five-Minute Speech Sample* (FMSS). The FMSS measures the EE of parents and primary caregivers during a 5-min interval in which they are asked to describe their child, their relationship, and their feelings and thoughts about how they interact (Magana et al., 1986). If two parents were present, the test is taken individually. Following the test, it is determined if the family if the family is rated as low-EE.

Trained professionals (blind to the treatment) interviewed youth at baseline and again at 4, 8, and 12 months using the YMRS and the CDRS-R. Examiners then rated the severity of depression, mania, and hypomania symptoms using the A-LIFE and PSRs. The PSRs were checked weekly.

Significant differences were reported in recovery outcomes such as symptom severity and frequency, mood episodes, depression and manic episodes, and other changes between patients in the FFT-HR and EC treatment groups ($\chi^2 = 5.24$, $p = .022$). The average time to recover for the FFT-HR group was 13 weeks. In the subgroup of patients with depressive symptoms at baseline, FFT-HR was associated with faster recovery from depressed mood ($\chi^2 = 7.69$, $p = .006$). In both groups, patients in high-EE families took significantly longer to recover from their initial mood symptoms than patients in low-EE families and were more likely to remain with symptoms for the full follow-up ($\chi^2 = 9.62$, $p = .002$).

Scores on the YMRS and CDRS-R yielded mixed results. The YMRS revealed a mild but significant treatment x time interaction effect ($F_{(1,98)} = 4.55$, $p = .035$) that showed more improvement for youth in FFT-HR than those in EC. The CDRS-R scores were nonsignificant, with no effect of EE or time x treatment interaction. The youth in FFT-HR spent more weeks in remission over the year than youth in the EC group ($\chi^2 = 24.30$, $p < .0001$).

Youth in FFT-HR made a more rapid recovery than those in EC, had more weeks in remission, and manifested fewer symptoms. Miklowitz et al. (2013) contended these findings support the findings of other studies that family psychoeducation is an effective adjunct to pharmacotherapy in children or adolescents with bipolar disorders. The FFT-HR program was also more effective with youth in higher-EE families than in low-EE families.

The researchers noted that the results obtained here might not generalize because the families in this study voluntarily sought treatment help, which may have resulted in better program compliance. As with many studies, patients used medication, but in this study not all patients were prescribed mood stabilizers.

Multi-family Psychoeducational Psychotherapy (MF-PEP)

Children and youth with mood disorders such as BD often manifest disruptive behaviors and can often have comorbid diagnosis of ADHD, oppositional defiant disorder (ODD), and conduct disorder. The MF-PEP intervention was developed to target these behaviors (Boylan, MacPherson, & Fristad, 2013).

Boylan et al. (2013) evaluated the effects of MF-PEP on disruptive behavior of individuals with mood disorders. Disruptive behaviors include ADHD, ODD, and other disruptive behavior disorders (DBD). A total of 165 children with a mood disorder and their families were selected for participation in the study. Families were randomly placed in one of two conditions: (a) IMM +TAU, which was the MF-PEP immediate treatment (IMM) and treatment-as-usual group (TAU) or (b) WLC+TAU, which was the 1-year waitlist control (WLC) and treatment-as-usual (TAU) group. All TAU families used the same medication, school services, and therapies.

The MF-PEP intervention consisted of eight, 90-min sessions with parents and children. The sessions began and ended with parents and children together. At the beginning stages of the program the family was introduced to mood disorders, comorbid disorders, medications, and behavioral manifestations of the disorder. Parents were taught communication skills, problem-

solving, and symptom management. Adolescents were taught coping skills, communication skills, and skills for restructuring thought processes. The intervention lasted for 12 months.

At the 12-month follow-up, 18 families had dropped out of the IMM and TAU group, and 26 families had left the WLC and TAU group. Therefore, data were analyzed for 147 IMM-TAU participants and 139 WLC-TAU participants using paired t tests, correlation coefficients, and ANCOVAs. Baseline data were collected using the ChIPS , P-ChiPS, MRS, and the Mood Severity Index (MSI). The MSI combines the MRS and CDRS-R scores.

Significant differences were reported for mood at 12-month follow-up of IMM+TAU and WLC+TAU, as determined by MSI scores ($F_{(1,113)} = 6.32$, $p = .01$). In agreement with the authors' hypothesis, results were significant: ADHD ($F_{(1,112)} = 6.29$), ODD ($F_{(1,112)} = 6.54$), and DBD ($F_{(1,112)} = 6.25$) at less than the .01 level of significance. Data for CD were significant at the .02 level of significance ($F_{(1,112)} = 5.83$). Therefore, MF-PEP was effective in decreasing behaviors associated with ADHD, ODD, and DBD, but was not as effective in decreasing the symptoms associated with Conduct Disorder.

Boylan et al. (2013) learned that the worse the mood symptoms and impairments, the more likely adolescents were to exhibit disruptive behaviors. Therefore, they argued that programs such MF-PEP should be implemented as an important early intervention for patients with mood and disruptive behavior disorders.

Even though improvements were observed with the use of MF-PEP, between-group differences were of low significance. Boylan et al. (2013) speculated that findings could have been interpreted more clearly with the use of a placebo group rather than the WLC + TAU group. They also contended the P-CHIPS was not adequate to address specific disruptive behaviors.

The final limitation of this study is that pre-post data were collected only at baseline and at the end of the 12-month study.

Summary

In this chapter, I presented the findings of 10 research studies that investigated the effectiveness of different FFT approaches with adolescents and families. Table 4 provides a summary of major findings, which are discussed in Chapter 3.

Table 4

Summary of Chapter 2 Findings

AUTHOR(S)	PARTICIPANTS	PROCEDURE	FINDINGS
		FFT	
George, Taylor, Goldstein, & Miklowitz (2011)	After a month-long depressive state, 15-year-old white male was referred for FFT. He was referred to the research program by his pediatrician.	K-SADS-PL, KSADS and many other interview tools were given to family. At intake, the adolescent was taking lithium and quetiapine. During family discussion, Mom reported no mood problems while Dad reported he had times of depression. The family began the FFT-A process.	Youth had resistance to treatment at first. Dad started missing sessions due to work. Youth became more irritable ass sessions continued. Next, Mom reported his drug use, and her son had attempted suicide. The family arrived for a few more sessions before the family blamed the therapist for son's behavior. The family did not return for treatment.
		FFT-CBT	
Pavuluri et al. (2004)	34 children and adolescents with PBD receiving treatment of CFF-CBT and medication in a specialty clinic.	Using severity scales allowed the study to demonstrate if symptom severity and functioning had changed before and after CFF-CBT treatment.	Results revealed high levels of treatment integrity, adherence, and satisfaction. Compared to pretreatment results, severity scales demonstrated significant reductions in PBDs' symptoms.
West et al. (2014)	69 youth with BDI, II, or NOS were chosen for the study. They were between the ages of 7 to 13.	Youth were randomly assigned to CFF-CBT or control groups. Assessment took place at baseline, 4, 8, and 12 weeks, as well as again in a 39-week follow up.	CFF-CBT was effective in reducing mania and depression symptoms. Participants in CFF-CBT were more likely to attend sessions with fewer dropouts and reported more satisfaction than with control treatment.

Table 4 (continued)

AUTHOR(S)	PARTICIPANTS	PROCEDURE	FINDINGS
Weinstein, Henry, Katz, Peters, & West (2015)	69 youth ages 7-13 diagnosed bipolar I, II, NOS with DSM-IV-TR	Youth were randomly assigned to CFF-CBT or TAU with 12 weekly sessions and 6 booster sessions. Assessed at baseline, 4, 8, and 12 weeks.	CFF-CBT had greater effect for youth with depressive symptoms relative to TAU for parents with higher baseline depression. Youth with lower baseline depression and youth with higher self-esteem had less of a response to TAU versus CFF-CBT.
		FFT-A	
Miklowitz et al. (2008)	58 adolescents with a mood episode during the last 3 months with Bipolar I, II, or NOS.	Youth were randomly assigned to FFT-A or EC. Adolescents also had the opportunity to be chosen for pharmacotherapy.	No differences were reported over time to repetition of depression or mania, although youth showed that FFT-A allowed fewer weeks in depressive states. Adolescents had less intensity/duration of depressive symptoms for 2 years. Over the 2-year study, rates of recovery did not differ between FFT-A and EC outcomes.
Miklowitz et al. (2009)	58 referred adolescents with BD I, II or NOS were accepted after a mood episode to FFT-A or EC	Within 9 months, families had 21 psychoeducation, communication and problem-solving sessions, and in EC they had 3 sessions in psychoeducation. Families in EC had 3 psychoeducation sessions. In follow-up sessions, youth were assessed every 3-6 months over 2 years.	Parents who rated low in EE made parents who were high in EE feel less connected and adaptable. Adolescents in FFT-A demonstrated less depressive or manic symptoms as part of high-EE families than when they had EC. Effects were not demonstrated in youth with low-EE families.
Sullivan, Judd, Axelson, & Miklowitz (2012)	58 families and youth from private and public inpatient and outpatient facilities	Adolescents were randomly assigned to FFT-A or EC.	Results did not support the hypothesis that family functioning would improve over the 2-year study.
		FFT-HR	
Miklowitz et al. (2011a)	13 children with a diagnosis of depressive disorder, cyclothymic disorder or BD-NOS	Parents and their child participated in 12 sessions over 4 months. Psychotropic medications were used as needed. Depressive and hypomanic symptoms were assessed every 4 months for 1 year on severity and impairment.	Significant improvements in depression, hypomania and psychosocial function scores were found. Improvements were also demonstrated on other rating scales. Families were involved in therapy, as demonstrated by an 85% retention rate.

Table 4 (continued)

AUTHOR(S)	PARTICIPANTS	PROCEDURE	FINDINGS
Miklowitz et al. (2013)	40 youth with BD-NOS, major depressive disorder, or cyclothymic disorder	Adolescents were randomly assigned to FFT-HR or 12 sessions of psychoeducation, training in communication, problem solving, or EC. Benefits of FFT-HR children with high versus low EE were compared.	The results demonstrated higher effect of youth in high-EE versus low-EE families. Youth in FFT-HR had faster recovery from past mood symptoms than the youth in the EC group.
MF-PEP			
Boylan, MacPherson, & Fristad (2013)	165 children ages 8-11 with mood disorders were selected. Their parents were also included.	Families were randomly assigned to MF-PEP (IMM+TAU) or a 1-yr waitlist control (WLC+TAU). Medication, school services and therapies at home continued.	MF-PEP was linked to decreases in ADHD, ODD, and DBD, but not conduct disorder.

Chapter 3: Conclusions and Recommendations

Bipolar disorder (BD) is a serious mental health condition characterized by extreme mood swings from depression to mania. Although it was once thought only adults could be diagnosed with BD, the prevalence of BD in children and adolescents has grown over the past decade at an astonishing rate. Some professionals contend this increase may be due to misdiagnosis. Nonetheless, research suggests that symptoms of BD in children and adolescents may be more severe than in adults (Insel, 2010). Due to these severe symptoms, pediatric bipolar disorder (PBD) requires multimodal interventions that include therapy as well as medications (Alvaro & Romero, 2011).

The purpose of this paper was to review the literature that examines the effectiveness of Family Focused Therapy (FFT) as a therapeutic intervention for PBD in addition to medication. In Chapter 1, background information is provided about bipolar disorder and FFT. In Chapter 2, I reviewed 10 studies focusing on the different versions of FFT and their effects on children and adolescents as well as their families. This chapter presents conclusions and provides recommendations for future research and current practice.

Conclusions

I discovered a number of common themes in the 10 studies I reviewed. These themes related to overall intervention effectiveness, research design, study's number of sessions/time period, and expressed emotions.

FFT Interventions

The traditional FFT model was implemented in one study; the remaining nine used

Family-focused Therapy-Cognitive Behavioral Interventions (CFF-CBT), Family-focused

Therapy-Adolescents (FFT-A), Family-Focused Therapy, High Risk (FFT-HR), or Multifamily

Psychoeducational Psychotherapy (MF-PEP). Findings are discussed for each of these FFT

approaches.

Traditional FFT. George et al. (2011) used the traditional FFT format with a 15-year-

boy with BD. In this case study, FFT was not effective. In fact, parents terminated therapy after

their son attempted an overdose. The standard approach was not successful primarily because of

the severity of comorbid disorders and undisclosed substance abuse.

FFT-Cognitive Behavioral Therapy (FFT-CBT). Three studies examined the use of FFT-

CBT. Two studies reported significant findings at the end of the treatment, but not over time

(Weinstein et al., 2015; West et al., 2014). Pulvuluri et al. (2004) found significance at the end

and over time.

FFT-Adolescents (FFT-A). Three studies employed FFT-A. Two studies reported

significant findings (Miklowitz et al., 2008; Miklowitz et al., 2009). Sullivan et al. (2012)

reported significant decreases in depression and mania in family conflict, but not in the family

cohesion or adaptability.

FFT- High Risk (FFT-HR). The two studies applying FFT-HR reported significant

results. There was a decrease in depression, hypomania and psychosocial function. Once again,

youth in high-EE families had greater success (Miklowitz et al., 2011a; Miklowitz et al., 2013).

Multifamily Psychoeducational Psychotherapy (MF-PEP). Boylan et al. (2013)

employed MF-PEP and found it was successful in decreasing the behaviors associated with

Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and

Disruptive Behavior Disorder (DBD). However, it was not successful in reducing symptoms

associated with Conduct Disorder.

Research Design

The majority of the studies had some type of control or comparison group (Boylan et al.,

2013; Miklowitz et al., 2008; Miklowitz et al., 2009; Miklowitz et al., 2013; Sullivan et al., 2012;

West et al., 2014). In each of these studies, the BD symptoms of adolescents in the FFT

treatment groups decreased significantly. The use of a control or comparison group helps

determine that the gains are indeed a result of the FFT intervention and not other extraneous

variables.

Study's Number of Sessions/Time Period

Four studies followed the recommended FFT protocol of 21 sessions over a 9-month

period (George et al., 2011; Miklowitz et al., 2008; Milowitz et al., 2009; Sullivan et al., 2012).

Five studies completed 12 sessions (Miklowitz et al., 2011; Miklowitz et al., 2013; Pavuluri

et al., 2004; Weinstein et al., 2015; West et al., 2014). Puvuluri et al. (2004) did not specify for

how long. Two studies conducted 12 sessions in 9 months (Weinstein et al., 2015; West et al.,

2014), and two studies conducted 12 sessions over 4 months (Miklowitz et al., 2011; Miklowitz

et al., 2013). Boylan et al. (2013) conducted eight 90-min sessions over 12 months.

Studies with 21 sessions that lasted over 9 months had more significant results over a

longer period of time than 12-week sessions (Weinstein et al., 2015; West et al., 2014). Boylan

et al. (2013) had the study with the longest period of time, and although it had positive effects on mood symptoms, it was not significant with regard to disruptive behaviors. There are so many variables in each study that change is difficult to determine whether the treatment duration was the factor responsible for improvement.

Expressed Emotion (EE)

Expressed emotion is a measure of the family environment and is determined by how parents talk spontaneously about their child. Parents with high-EE are those who make significant sacrifices to improve outcomes, and parents with low-EE make minor adjustments (Miklowitz et al., 2009). Four studies examined EE in caregivers. In the George et al. (2011), EE was measured but the case study ended early due to therapy termination. Two studies found that high-EE contributed to significant results in their studies (Miklowitz et al., 2013; Sullivan et al., 2012). Miklowitz et al. (2009) found some inconsistencies in his study where assessments varied between high- and low-EE presenting successful results, nonetheless the overall study showed significance. These findings indicate FFT is more likely to be successful in high-EE families.

Summary

These studies support the use of FFT with adolescents who have BD. With the exception of the one case study in which treatment was terminated, all studies demonstrated improved outcomes.

Recommendations for Future Research

One aspect that should be considered in future studies is the role of medication. Although all participants took medication and were stabilized on the medication, it was unclear when medications changed whether outcomes were due to the intervention or the medication.

Miklowitz et al. (2009) recommended that families' EE be assessed prior to intervention so that therapy can be changed to suit the family. The finding that high-EE families were more likely to have successful FFT therapy outcomes suggests this as a future avenue of research that could yield interesting results. The sacrifice and attitude of the caretaker could change how the therapy is being understood and used in the home on a consistent basis, which is important for the decreasing BD symptoms.

It would be helpful to design a series of studies that used the same assessments to evaluate status and outcomes. I think FTT studies should be more consistent in when and how they assess increases and decreases in the participants' symptoms. This would allow greater understanding of FFT's impact.

Finally, it was difficult for me to determine distinct differences among the types of FFT models in these studies. If there are indeed substantial differences among these models, it would be important to compare models with adolescent populations.

Implications for Practice

My own experience inspired me to study the effectiveness of FFT on children and adolescents. I have struggled my entire life with depression and anxiety, but I never received any professional help. My symptoms escalated as an adult, and I was diagnosed with BD. I was unable to continue teaching, and I realized I could not continue to live my life in the same way as

I did prior to the diagnosis. I believe if I had received help earlier, I would have had experienced less devastation and suffering.

Because I am currently not able to work, I will use what I found to assist myself and my family to seek the best therapy and education available. This month we are currently trying a family therapy session. Thankfully, my insurance will pay for it, which is not the case with some insurance policies. Of course, the lack of parity for mental health insurance is a major problem in our society, and is one that our late Senator Paul Wellstone fought for valiantly. This must be addressed—family caretakers need support and education.

Someday I would love to be an advocate for those who are diagnosed with bipolar disorders. I now believe I will strongly support and promote Family-Focused Therapy Interventions as successful necessities for children and adolescents, as I am sure more will continue to be diagnosed.

Summary

More children and adolescents are being diagnosed with bipolar disorder than at any previous time. As many as one-third of 3.4 million children with depression may be considered to have symptoms that are indicative of early onset bipolar disorder (Bipolar Disorder Statistics, n.d.). The disorder's symptoms and mood episodes can severely affect the functioning of a family. Family therapy enables families to understand their adolescent and to change the way the family functions in order to enhance successful treatment outcomes.

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