APPENDIX B

FAMILY-FOCUSED TREATMENT MANUAL

FFT-HR:

Clinicians' Manual

for the Family-Focused Treatment of Children and Adolescents at

High Risk for Bipolar Disorder

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Plus Supplements: Attention Deficit Disorder, Oppositional Defiant Disorder, Comorbid Anxiety Disorders, and Suicidal Ideation and Self-Injurious Behaviors

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Introduction

The purpose of this manual is to explain an early intervention treatment for children and adolescents who may be at risk for developing bipolar disorder. We have developed an early intervention Family Focused Treatment for children and adolescents who are at high risk for developing bipolar disorder and their families (FFT-HR). FFT-HR consists of 8 weekly and 4 biweekly active sessions. This treatment is adapted from Family Focused Treatment for Adolescents with bipolar disorder (FFT-A), a treatment developed for adolescent patients with bipolar disorder and their families (Miklowitz & George, 2004).The strongest difference between FFT-A and FFT-HR is that the former specifically addresses prevention of future episodes in an adolescent who already has the diagnosis of bipolar I or II disorder. FFT-HR is aimed at preventing the onset and/or worsening of mood symptoms that are not yet a diagnosable bipolar I or II disorder. Moreover, FFT-HR can be applied to children from age 9-17.

For a thorough understanding of FFT, we recommend that you become acquainted with the Miklowitz (2008) Bipolar Disorder: A Family-Focused Treatment Approach manual before proceeding to learn the FFT-HR method. In addition, The Bipolar Teen: What You Can Do to Help You and Your Family (Miklowitz and George, 2007) describes many of the strategies discussed in this manual and is a resource that is made available to families in the research program.

The overriding goal of the FFT of children and adolescents at risk for bipolar disorder is to educate about the symptomatic presentation of the illness and the tools to prevent its onset and worsening. There are six subsidiary goals: to assist families to (1) learn to recognize the incipient signs and symptoms of recurrent mood disorder, (2) recognize the index child's risk for the onset of BD, and develop strategies to minimize this risk, (3) accept the current or future role of psychopharmacology to manage the child's mood states, (4) distinguish mood-dysregulated behavior from healthy teen behavior, (5) identify triggers for mood-disordered behaviors and develop plans to prevent escalations or deteriorations, and (6) operate at a more effective level in family communication and problem-solving.

We will specifically address the at-risk child and family members' tendency toward mood dysregulation. Severe emotion dysregulation may be a precursor to the development of bipolar disorder in youth at risk. Emotion regulation involves the utilization of behavioral and cognitive strategies in efforts to modulate affective intensity and duration (Thompson, 1994). In each module of FFT-HR there are opportunities to train family members in emotion regulation strategies as will be described below.

In this manual, you will learn how to proceed with administering FFT-HR. The three modules of FFT will be covered in a modified form. Several attached supplements explain how FFT-HR can be adapted when there are comorbid disorders or complications like attention deficit disorder, oppositional defiant disorder, suicidality, or anxiety disorders. Case vignettes and typical therapy interchanges are included. All names and identifying information of clients and family members have been altered and disguised so that these persons cannot

be identified, consistent with guidelines for preserving the confidentiality of patients.

I: PSYCHOEDUCATION (Sessions 1-4)

Session 1 Goals
Preview FFT-HR
Acquaint family with goals, format and expectations of program
Begin to develop treatment alliance

In the first psychoeducation session, acquaint the family with the goals, format, and expectations of the family program. ***Handout 1*** (see Appendix)**, "*Family Focused Treatment: What we're going to do and what to expect"***, accompanies this first session. State that your goal is to coordinate the sessions and act as a "coach," guide the family through learning the skills, and assist them in applying the skills to their day-to-day life. Clarify that your role is to teach the family to be capable of solving family problems on their own such that, by the end of treatment, your assistance will no longer be necessary. It is important to go through each item on the list and make sure that the family members understand what they can expect of the clinician, and what in turn is expected of them. Offer them a rationale for the approach being proposed. For example, under Goals, you can say:

> "I have lots of goals I'd like to discuss with you. One of them, _____ (child), is to help you understand the challenges you have had with mood and/or attention and to help these difficulties be more manageable. The best way to make these challenges more manageable is to help things go more smoothly in your family. My experience has been that if you know more about what causes your mood swings and how best to manage these difficulties, if you're able to talk to each other about troubles that you have, and you're able to solve problems that come up in your family, things will be easier at home. How does this sound to you?"

Under "format" the clinician reminds the child and his/her family that there will be a research assessment every 4 months to check on the child's symptom status. Tell them that keeping track of the child's moods over time on a mood chart will be very helpful not only for prevention and treatment but also for these research follow-up meetings. The assessments are central to the research, because this is how we know whether we are being helpful or not, given that our goal is to ameliorate mood symptoms and prevent the presentation of bipolar I or II disorder. Continue to describe the format:

> "There will be approximately four sessions of education about mood disorders and how to prevention them, four sessions of communication skills training, and four sessions of problem solving. In problem solving the focus will be on specific problems that you want to solve. Some of

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these will be related directly to _____'s mood swings and some will be problems that all families have. My goal is to acquaint you with how to solve family problems rather than giving you my own opinions of how to solve them."

Clarifying Your Expectations and Addressing Early Resistances

It is very important to be clear with the participants about what you expect from them. There will invariably be a time when one or several members of the family resist the process of treatment. This is especially true when working with kids, who rarely see the need for family meetings and can be quite resistant. It is especially helpful to <u>normalize</u> resistance early on in treatment. For example, say, "I can understand if you (the child) have difficult feelings while we're going through our educational materials. Most kids do – it's hard to be here discussing your personal stuff with strangers and with your parents. So if you do feel upset at any time, tell us – we promise we'll listen to your point of view and try to help you feel more comfortable with what we're doing."

Introduce the notion that cooperation does not mean just going along with whatever is presented. Our definition of cooperation is being honest with the clinician about feelings related to treatment (whether positive or negative) and acceptance or disagreement with certain items or modules of the treatment. With kids it is tricky to strike a balance between inviting their thoughts about the treatment and making sure they understand that this does not mean that they are in control of the treatment. It's helpful to model for them how they can give you feedback about the sessions productively, as opposed to just preventing progress by forestalling efforts. Examples of such forestalling efforts in our child patients have included turning chairs around so that no one can talk to them, grabbing handouts out of people's hands, or refusing to talk but interrupting when others try to talk.

Children and adolescents typically state that they don't want to be in psychotherapy. They may say they won't come, or if they do come they won't participate. It is important to not become "rattled" by the child's (or other family members') resistance. Simply accept these statements for now and view them as an attempt to exert some control over what appears to be an uncontrollable situation. If the child can identify even one goal or reason to come to therapy it may be enough, in the beginning, to have the child attend and eventually engage in treatment.

Roles and Goals

Describe your role and answer any questions the family has about what you will be doing during FFT-HR treatment. Your role is dissimilar from that of clinicians in more traditional psychotherapy in that you are more like a teacher or a coach. Tell them you will be reasonably active and will help direct them when they are learning about the disorder and new skills for communication and problem solving. This will be more successful with youth, particularly boys, who like the idea of a coach better than a therapist.

Engage the family in a conversation about their goals. It is very important that there be an agreed-upon focus to the treatment. It is helpful to make things visual for kids and their family members. On an easel or chalkboard put the word GOALS at the top in colored pen (see **Figure 7**, **Goals**). Then, have each family member choose a different colored pen. As a means of engaging the child, ask him to record the identified goals on the flip chart. However, make clear that he doesn't have to do this; he may not feel ready to have his writing skills on display, or may not feel comfortable with taking a central role early in treatment. This is also a good role for a younger sibling if he or she is not feeling that treatment pertains to him or her.

To increase the child or adolescent's motivation, identify and work toward goals that he lists as important. We start by asking the child what he would like to see changed. Expect him to say something like, "for us to get along better," or "for me not to get in trouble so much." Give him positive reinforcement for even the most minor contribution, but also encourage him to expand (i.e., "that seems like a worthwhile goal, John. Can you say more about what you mean by getting along better?"). Include goals that may not seem directly relevant to the family or to the presenting problem, but that the child still views as important. "I want to get a skateboard," "to spend more time with my friends," "to do better in basketball" may all seem tangential to your main goals but list them so that the child feels like he is being heard. Later, you may be able to buttress your arguments for self-care skills by pointing out that they may make more likely the achievement of these goals (e.g., getting to sleep on time may improve sports performance).

Then, open up the question to the rest of the family. As each member of the family presents his or her goals, ask the child to write down the goal with that family member's pen. It is important for the clinician to validate everyone's viewpoint. Often the issues presented in the goals section may lead to identification of family problems. These are best addressed during later problem solving. The clinician may remind the family that there will be several sessions devoted to problem solving for specific problems and this problem can be addressed at that point. Then the clinician refocuses the discussion back to the task of goal setting.

When the list is complete, tell the family that you'll be taking the flip chart paper with you. During the next week, make an 8 ½ x 11 copy for each family member (using the same colors they have each designated) and refer to it as you introduce new sections of the treatment or if participants raise questions about the purposes of the treatment. These goals are also helpful in generating family problems during the problem-solving module if the family has a difficult time identifying specific problems.

Homework

At the end of each FFT-HR session the clinician gives the family a homework assignment. Homework can be quite simple, such as having the family think about how the education fits in their day-to-day life, or something more complex, for example, scheduling a family meeting to practice communication skills once these skills have been presented in treatment. Early

in treatment small assignments are given based on what educational information has been covered when the session is completed. For example, if the family hasn't finished identifying their goals in the first session the clinician will assign homework to generate additional goals to share in the next session. If the family has done a comprehensive job of listing goals the clinician can assign the at-risk youth the task of noticing how many different mood states he or she has in the coming week in preparation for constructing a mood chart. Other family members can be asked to notice if they have mood swings as well. Once the family is learning the communication and problem solving skills they will be assigned a family meeting for at least 30 minutes each week to practice the skills. It is an important part of the treatment for the clinician to assign homework each session and check in at the beginning of the next session to see if the homework was completed. The objective is to have all members of the family incorporating the information and skills learned in therapy into their home environment.

Pacing and Flexibility of Sessions

The benefit of Family Focused Therapy for at-risk youth is that the treatment can be tailored to the particular family you are working with. We strongly encourage families to complete all 12 sessions but the skills can be provided in a shorter format if the family is resistant to all 12 sessions or appears not to need all treatment sessions. Some families have read a lot about mood disorder and have learned many of the education skills through other venues. Some families even come in with mood charts that they are using. For the highly educated families or families who are resistant to a lot of education the clinician may not complete 4 sessions of education and may have more time for problem solving or communication. If a family proceeds quickly through the treatment and the youth has been clinically stable by session 9 or 10 the youth and family may no longer have the need or desire to meet regularly. If all of the treatment material has been covered the clinician may spread out the final sessions in a booster session format over the six-month treatment period.

Additionally, if the family appears to need more than 12 sessions there is the option of meeting weekly during the last two months rather than bi-weekly. Many families have never had family therapy and it may take a couple of sessions to navigate goals and expectations for family therapy. There are also times when the youth is very resistant to treatment and his or her resistance has to be appropriately addressed before the treatment can continue. For example, one child spent a whole session discussing how she didn't want to be involved in therapy because therapists always tried to make people feel better and she already felt fine. The clinician took the time to listen to her concerns and they agreed that they would continue with meeting (not doing therapy) with the goal to keep the child feeling well. In these cases the clinician may find him or herself at session 3 before the education truly begins and may need additional sessions. In addition, if the child continues to struggle or one of the other family members is having a lot of psychiatric symptoms there may be a need for extra sessions. FFT-HR has built in flexibility to meet additional family therapy needs.

Finally, there may be times when the clinician needs to stray from the structure of completing the education first, the communication skills module second, and the problem-solving module third. Often families enter treatment with some very large problems that need to be addressed right away. For example, if there are arguments in the household that have become physically aggressive the clinician may need to address this safety concern using some problem-solving strategies at the beginning of treatment.

Session 2 Goals
> **Acquaint family with symptoms and signs of mood disorder**
> **Create individualized self-rated mood chart**
> **Address child and family's questions, doubts, and concerns**

Adolescents and children with MDD and bipolar disorder NOS often have an irregular presentation of symptoms.   Thus, it is important to not get locked into a "discrete episode" model of mood symptomatology in which the parents and the child are asked to think in terms of identifiable prodromes, active phases, and residual phases. Instead, ask the family and child to use their own terminology to describe the child's mood states, changes in activity, and behavior problems. Several of our young clients have not been able to identify symptoms of depression if they are asked "what happens when you get sad?" They are much more likely to respond to questions regarding times when they felt "bored," or "wanted to get away from everybody and everything."

Clarifying the Symptoms of Prodromal and Early-Onset Bipolar Disorder
Once the child has listed the experienced mood states and identified what he or she feels accompanies each of his or her particular mood states, give the family **Handouts 2 a, b, and c** entitled "**Symptoms of Mania", "Symptoms of Depression", and "Other things that kids experience that may be related to having a mood disorder".** These lists are presented with pictures and simplified language to help children, adolescents and parents understand how symptoms present within mood states. This section of the education highlights the fact that a mood disorder has a developmental progression, and that it is often comorbid with other disorders. It is important for family members to be familiar with the presentation of bipolar disorder so they can talk with the clinician about how the child's mood states present. Since a goal of treatment is to prevent the presentation of bipolar I or II disorder it is important for family members to be able to tell the clinician if they feel that their child has moved from the category of prodromal bipolar disorder into a category of bipolar I or II disorder. Given that these children will not have bipolar disorder I or II it will be important to be very open and inclusive of what children and family members consider symptoms of mood, behavioral and/or attentional difficulties.
If a child has a diagnosis of Attention Deficit Disorder or other comorbid disorders the therapy team will present information about these disorders and gather a report of the child's symptoms. This information will be included on the mood/behavioral chart. The appendix section also includes information on

attention deficit/hyperactivity disorder, oppositional defiant disorder, the anxiety disorders, and suicidality and how to address these issues in treatment.

Creating an Individualized Self-Rated Mood and Behavior Chart

Early in treatment, try to get the child into the habit of tracking her moods. Mood charts are quite valuable in tracking the child's progress, identifying the emergent signs of worsening symptoms, identifying diurnal variations, recognizing the effect of stressors, and clarifying the role of sleep/wake cycle irregularities. They also make the child more self-aware and observant of her mood states and behavior. Self-awareness may be a skill that the child has never employed and is particularly important in managing a mood disorder. FFT-HR is a good place for the child and family to learn the value of self-monitoring.

Begin by asking the child to describe her mood states and what descriptors go along with each. If the child has a difficult time staying focused or appears to become easily distracted give her colored pens and ask her to circle or underline the words and pictures on the handout that go along with her mood states as those mood states are discussed in the family session. Stand by a flip chart and draw a horizontal line in the middle of the paper (see **Figure 1**, **How I Feel**). Ask the child first and one or more parents if the child is hesitant to give a label that describes the <u>absence</u> of symptoms (i.e., mellow, calm, normal, typical). Then, draw a line right above and below the middle line and ask the child what words she would use for mild ups and downs (e.g. "pretty good" versus "a bit sad" or "frustrated"). Explain that these fluctuations are representative of the normal moods that someone might experience if she felt like things were going well or not going well. Then, draw a line one step higher and one step lower than the lines you've just drawn. Ask the child to label each of these lines. For example, the top line might be labeled "excellent mood" or "really happy," whereas the bottom line might be labeled "really bored" or "bummed out." Then, use a separate line for anger and ask the child to place it on the graph where it most clearly fits for her. (Is it part of an up, active mood? Is it part of the down, depressive cluster? Or both?). You may want to have lines for anger in the up and down sections of the chart. Then ask the child if there are any other states that should be tracked (i.e., anxiety, suicidality, urges to use substances). Have the child determine where each of these lines should be placed on the chart.

Once the lines are in place and labeled, then each label is placed at the bottom of the page as a heading. The child begins listing symptoms that go along with each of the states (for example, 'excellent' may include giggling, talking loudly, or feeling more energetic; 'angry' may include cursing, kicking doors, or pushing or hitting). Of course, some children may not have had experiences of activated or angry states. Be sure to accept the child and family's input regarding presentation of symptoms. Encourage the parents to join in this process but take cues from the child. Try to keep an air of curiosity and levity in the room, recognizing that it can be difficult for the child to focus on her abnormal moods and behavior.

Once this chart has been created, the child can use it on an ongoing basis. Ask the child to complete a mood rating at least twice a day (e.g., best versus worst; morning versus evening) and even more frequently if she is willing. More specifically, ask her to put an X on the line that she felt characterized her mood at various points in the day. Finally, include two vertical spaces at the bottom of each day to record when she went to bed and when she woke up each day. The child can also record stressors for that week on the chart to start to recognize how stressors can affect mood. Give the child a template that can be dated and copied for each day of the week. It's easiest if a single sheet can be used to characterize the whole week. Typically parents are managing a child's daily living skills including sleep. This exercise is often empowering for the child in a move towards self-care skills and fledgling independence. If a child is resistant to monitoring mood and/or sleep the clinician can point out the inherent move toward independence and the privileges that accompany moving into more of an independent phase. Framing the mood chart in this way can increase the likelihood that the child or teen will begin the developmental process of becoming age appropriately independent/responsible, a trait that so often slows down or stops with the onset of mood swings.

Likewise, ask one parent to make a similar rating of the child's mood each day, or at various times of the day. This is helpful for three reasons: to keep the parent attuned to diurnal shifts in the child's mood states, to quickly identify a worsening of mood, and to make clear to the child that he or she is not the only one being given homework. Parents usually appreciate the chance to record the child's ongoing mood states. You can ask them to rate the same mood chart developed for the child. Some parents want to keep more detailed notes of the child's moods, outbursts, medication, and/or stressors (see **Figure 2**, **Daily Mood Chart,** for an example of a more detailed mood chart that parents may complete). Rating the chart may also help the parents confront the misperception that the child can control his mood swings and may generate more compassion toward the child with the diagnosis. The chart can be customized to each family's needs. Some families like to take this exercise and create their own chart. As long as all of the information is recorded, individualizing the chart further for the family or child is encouraged. The more the child and family feels the chart fits for them the more likely they will be to complete it.

We have found it to be very helpful to ask the child to post his or her "How I Feel" mood chart (see **Figure 1**) on the refrigerator so he or she is not likely to forget to make a daily mood rating. Alternatively, have the child keep his or her chart with evening medications (if taken) and rate moods then. If the child has many mood switches during the day and evening, then he can place any number of Xs on any of the lines corresponding to the times of the day listed. Try not to make the task too complicated, however. Use your clinical judgment in deciding what level of complexity will work best for the child and ensure his compliance with the task. Depending on the child's age and level of independence it may be helpful to do a modified problem solving around how the child can be the most involved in the monitoring of mood and daily activities. Obviously, the older the child, the more responsibility should be ascribed to him.

Additional mood chart ratings can be made for other behavioral difficulties or symptoms the child and family reports. Please see the Appendices on working with comorbid symptomatic presentations including other target symptoms and diagnoses.

Session 3 Goals
      Introduce the vulnerability/stress model
      Construct a list of family and individual stressors

Factors Affecting Health Problems
      It is very important for the child and family to become acquainted with which aspects of mood swings he or she has some degree of control over and how best to prevent the current mood swings from becoming more severe and chronic. The vulnerability-stress model provides this framework. With reference to the ***Handout no. 4, "Factors Affecting Health Problems",*** the clinician states:

> "I am going to explain to you what each of these words mean in the rectangles and in the arrows. We believe that the items in the rectangles are not something that we can change. For example, environmental stressors are a part of daily life. One might decide when to change schools or move but there is always some stress in a person's life. In addition, our biological vulnerabilities or genetic "predispositions" are things that we are born with that we are unable to change. For example, some people are genetically predisposed to having cavities, meaning that having cavities runs in their family. As a result, that person may brush her teeth just as often and eat the same amount of candy as her friend but she may have cavities and her friend may not. As you can see in the handout, we believe that events or situations that we experience as difficult or stressful can interact with our biological predispositions. This means that some people are more likely to have mood swings because of their genes or the chemistry of their brain.
>
> We know that mood swings run in families. However, just because your brain chemistry makes it more likely that you will have mood swings doesn't mean you will necessarily have them. We also think that stress plays a role. If a person learns to cope with the stress or other difficulties in her life then she will have much less trouble with mood swings. The way that we may cope with stress are called protective and risk factors. Protective factors – things we can do on a daily basis to manage difficulties so that we feel better – like eating regular meals and risk factors – things that we may do or not do on a daily basis that could have us feeling worse – like not getting enough sleep are things that are more in our control and we will discuss these in more detail later. Does this make sense?"

With younger children the clinician may need to explain what is meant by "stress" and "cope". Many children have experienced stress but usually use other words to describe this experience. Sometimes other family members can point out things that the child has shared with them that are stressful in helping to delineate this term. At this point ask each member of the family to give you examples of major life stressors that precipitated an episode of physical or mood problems (e.g., the ulcer came on after a large project at work was due, headaches developed after a period of interpersonal stress involving other family members, depression followed a geographical move). After this discussion it is helpful to ask a family member if they can describe the model back to you. This concept is a lot of family members to take in, thus reviewing the model in a number of different ways is helpful.

In addition to major stressors, daily stressors or hassles can also affect mood and behavior. In the following exercise have each member of the family identify daily or typical life stressors. Once each family member has identified stressors, each is asked to choose a symbol that represents them and to plot where these stressors land on a thermometer from a scale of 0, not at all stressful, to 100, the most stressful a person could imagine (See **Figure 3** entitled "**The Impact of Life Stressors**"). It helps each member of the family to prioritize the importance of his or her own stressors, and also to see how events that each might not find stressful may be disturbing to other family members. Stressful events can include major events (e.g., death or sickness in someone in the family) or minor events or "daily hassles" (e.g., my sister making noise in the next room).

At times, children struggle with this exercise. Sometimes they are not sure what is being asked of them or they are concerned about criticizing another family member and getting in trouble. The clinician may use an example to help get the ball rolling. For example, "When my friend is late that is very stressful for me - I would say that it is at a 75. When I realized that being late was so stressful for me I shared my frustration with my friend. She said that she had no idea that she was late so often and that it was upsetting to me. Now she is almost always on time and things go much better. So you see, even though it may be a little scary to talk about things that are upsetting often the person is not aware that what they are doing is upsetting and they usually work to change it." As added incentive the clinician may tell the family that the first one to give a stressor can choose the symbol that depicts that person's contributions. This also provides some levity to the task when invariably the child will try to test the clinician's drawing abilities with odd symbols.

Developing an individualized stress thermometer can help the child and family to decrease the effects of stressful events for the child. For example, one adolescent reported that one of the most stressful events for him was having his younger brother bothering him when he had a friend visiting. After completing the stress thermometer, the family was able to see in retrospect how many times the two boys fought in this situation. The parents decided from then on to keep the younger brother entertained while his big brother was playing with a friend.

They quickly noticed that the older son was less likely to fly into rages at his brother and that the overall level of family conflict diminished.

After explaining the impact of environmental factors on an individual's symptoms, turn to the discussion of biological vulnerability using *Handout 5*, *How Do People Get Mood Problems*? This handout is used to lead a discussion about the variables that influence expression of the biological bases of the disorder. Ask the family to identify variables that they think affect the milder form of cycling in the child's mood (example: conflicts with teachers, getting overstimulated by video games). Individually, these items may not influence the expression of the disorder, but collectively may build up and increase the probability that a biological predisposition will be reflected as symptoms of bipolar disorder. We have also used this handout as an entre for discussing prevention of using substances and the dangers associated with using substances for at-risk youth.

For homework give each member of the family **Handout 3 Recent Life Events**. Have each member of the family choose two stressors that they would like to work on developing coping strategies for over the coming week. Have them write the two stressors down on the left side of the page and then instruct them to come up with solutions for how to manage those stressors on the right side of the page. Ask the family to try out these solutions if they are able and then chart their stress level for the stress items that they chose. Usually, just by trying to change the stressor the individual feels a bit less impacted.

Session 4 Goals
> **Identify risk and protective factors**
> **Discuss how the family can help**
> **Mood episode prevention planning**

Begin session four by reviewing what was covered in the prior week. Remember that these concepts are new to children and are not easily integrated by them. A full week between sessions is usually optimal from the family and clinician's point of view, but the child may have trouble recalling information when they are simultaneously learning new things in school. A strategy for helping children and family members remember concepts from one session to the next is to have someone volunteer to summarize educational information at the end of the session. Then, at the beginning of the next session the clinician can present the sheet used in the last session and ask for a volunteer to summarize the material shared in the previous session. This strategy is particularly helpful with the vulnerability-stress model handout. Once the clinician is sure that the child and family members remember each concept on the stress vulnerability handout she can proceed with the next handout, **Handout 6**, on **Risk and Protective Factors**. Explain it as follows:

> "We believe that kids and adults are better able to manage their mood swings when they can identify what we call risk and protective factors. Risk and protective factors are things that a person does on a daily basis

that affect one's ability to handle stress and stay healthy. Risk factors are those things that increase the chances of having mood swings or other difficulties and protective factors are those things that keep you from having mood swings or other difficulties. For example, if I had diabetes, then skipping meals may increase my chances of getting sick whereas taking my medication may help keep me from getting sick. For a person with mood swings, missing a night's sleep could be a risk factor but keeping on a regular sleep/wake schedule could be a protective factor."

Ask each member of the family to identify things that they might consider risk and protective factors for their own mood stability (whether or not they have a mood disorder) or health in general. Having all family members engage in this activity is good basic education for the various members of the family on how to take care of themselves and manage their own stress. Then, explain to the family that, in research, certain triggers have been identified that are particularly likely to cause problems for people who have a predisposition for bipolar disorder. Review the list with them on **Handout 6** (e.g., the effects of poor sleep hygiene and irregular daily routines). Then, go through the same procedure with protective factors.

If the child is taking medication, the clinician can present **Handout 7**, **Medications Commonly Used to Treat Mood Problems**. This handout may generate a discussion around the ways in which medication is or is not a protective factor and options that individuals with mood difficulties have in regard to pharmacotherapy. If it appears that the family and/or child is struggling with side effects or do not feel that the medication is helpful then the clinician can help the family with a model for bringing up their concerns with the treating psychiatrist. A goal of treatment is for the family and child to become expert at understanding and discussing the medication that the child is taking and how to tell if the medication is producing the desired effects. We have also found that if the family perceives the clinician and psychiatrist to have a collaborative relationship there tends to be less resistance to the medication regimen.

Often family members will mention that it is difficult to incorporate protective factors during symptomatic periods or times of extreme stress. The clinician can help the family with developing "in the moment" coping strategies for mood dysregulation or very stressful times. Ask each member of the family to think of a time when he or she was struggling with a very difficult time. Ask each person to think about what he or she did to cope with that difficult time. Write Intellectual, Emotional, and Distracting on a white board and as members of the family give ways that they coped write them under the category that fits (i.e., venting to a friend may go under emotional coping; going to the movies may go under distracting). Once all of the family members are done you will hopefully have a nice list of various coping strategies to use in the midst of very difficult times. This also helps to lay the foundation for what to do during a period of more severe mood dysregulation as some of these strategies may be used first. If these initial coping strategies aren't effective then the family may need to move toward much stronger interventions (i.e., calling the doctor; hospitalization). On

one sheet present for the family the protective and risk factors they have identified for day-to-day mood management and the coping strategies for more difficult times (see *Figure 4, Protective/Risk/Coping Strategies*).

How the Family Can Help

A component of the fourth session is a discussion of how the family can help with mood problems. Walk through **Handout 8** "**How Can Your Family Help?**" with the family and ask the parent and each child (including siblings) to give examples of how well the family does on each bullet point. You may use a grading system, for example, A = family does an excellent job, no room for improvement, B = family does a fair job, could improve but doesn't have to, and C = family does not do as well as could, room for improvement. For any Cs the family can discuss how they could achieve those bullet points. For example, when discussing "maintain a tolerant and calm home atmosphere," possibilities include: be willing to walk away from arguments; institute the "three volley rule" where family members agree to terminate or derail discussions that have reached three negative back and forth interactions; use time outs as a way of helping family members calm down in intense situations. When you get to the last bullet point, "use good communication skills," lead the family into a discussion of what communication is like at home and ask whether the family uses specific skills like active listening or giving praise or acknowledgement. The family can supplement these discussions by reading Chapter 9, "Family Management and Coping in The Bipolar Teen (Miklowitz and George, 2007)."

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

Mood Episode Prevention Planning

At this point the groundwork has been laid for the family to understand each person's own particular presentation with mood and/or other health issues. In addition, each member of the family understands how high-risk mood spectrum disorders present symptomatically, and what we believe is most likely to make a person who is predisposed to the diagnosis more likely to develop the illness. Finally, there has been a discussion about the elements that will make life go more smoothly for each member of the family regardless of their mood or health issues. At this point, the family can more confidently talk about how they will know that a person in the family is starting to have more acute mood issues and how to appropriately respond.

Mood episode prevention is planning during periods of stability for how to intervene when moods begin to worsen. Given that many of the children will have milder mood swings and may not have had discrete episodes it is important

to describe prevention as keeping mood swings at a manageable level and also becoming expert at identifying when the mood is shifting to something much more concerning than a transient mood swing. Due to this difference in treatment with prodromal bipolar children and adolescents the procedures for prevention are done less formally, and are presented from the perspective that all people have "good" and "bad" days. The discussion focuses on what can be done to minimize damage to relationships and emotional wellbeing when a bad day is occurring. For each bad day (or bad mood experience, if it did not last all day), a sequence is defined consisting of *triggers, mood states,* and *palliative measures*.

On the flipchart, instruct the child to write "How Can You Tell I'm Having a Good Day" at the top of the page. Then he or she writes each person's name (including the clinician's) across the page in a different color (see ***Figure 5, Mood Episode Prevention Plan***). Each person gives at least two descriptors of what happens to him or her on a "good" day, and how others can tell the day is going well (e.g., more interactive, happy, smiling). Then the child writes "How Can You Tell I'm Having a Bad Day" below the descriptors of the "good" day and gathers at least two examples from each person describing his or her mood on a "bad" day and what others may observe (e.g., grumpy, irritable, withdrawn). Below this list, ask each person to give you "triggers" for his or her bad moods (e.g., having others in the family nag at him/her; being hungry or tired; family arguments). The stress thermometer may provide some examples for this exercise.

Next, ask the child to write "What To Do When We Are Having a Bad Day" (palliative measures). The whole family gives suggestions regarding things each person could do to help him/herself (e.g., ride my bike, take time away for yourself, do something fun together, meditate). The family may use some of the coping strategies that they identified previously, however, many families are able to come up with even more coping strategies during this exercise. The more possible effective coping strategies the family can generate, the better for all members of the family. The more options the child and family members have for coping, the more hopeful they may feel in effectively managing difficult times. At least some of these suggestions should come from the person whose mood is being discussed, particularly when the focus is on the child. If you notice that the family omits important suggestions (i.e., communicating together, listening to each other, working together on problems) then add these to the list yourself. Medication evaluation and/or management may be added to the list depending on the child's experience with psychopharmacology. In many cases, "having a bad day" may signal the onset of a new or more severe period of cycling that could be addressed with beginning a medication trial or modifying an existing medication regimen.

Because the families in this study will have children with prodromal forms of bipolar disorder it may feel important to them to have an easy way of deciding whether what they are seeing in their child is a worsening of the presentation or transient symptoms that are less concerning.

The clinician can convey to the family that there are four factors to assess when delineating how concerned to be about presentation of mood symptoms. It is important to note how often symptoms are occurring, if there are many symptoms that cluster together, if the symptoms are of noticeable intensity, and that the symptoms are lasting for some definable period of time. It is helpful to use the FIND acronym (F=frequency or how often the symptoms are occurring, I=intensity of symptoms, N=number of symptoms that co-occur in a syndromic presentation, D=duration of symptoms) in determining when to be concerned about symptom presentation. It is also important for the child and family members to identify which items are most likely to be precursors to a mood episode. For example, some children may miss a few hours of sleep and be fine within a day of getting enough sleep. For another child this type of event may set off a week of cycling. If the child and family have identified the symptoms that are most likely to occur before ongoing worsening of mood they will be more likely to accurately identify when they need to put a prevention plan in place. Considering these aspects when measuring symptoms often sets families at ease by thinking about risk for mood episodes in this manner.

It is also important to note that the child and family may be less concerned about mood disorder symptoms and more concerned about attention and behavior. The mood episode prevention plan makes it easy to incorporate any symptoms the family is interested in charting. Please use the appendix supplements for other illnesses (e.g., anxiety disorders, disruptive behavior disorders) to aid the family in identifying triggers, moods and/or behavior states, and palliative measures.

Once the child and other family members have agreed on a set of plans, type it up for them and present it in the next session. Include in your summary all information collected on each family member. Ask them if they want to make any changes to any of the three categories: triggers, moods, or palliative measures. If not, ask them each to sign the contract, with agreement to perform the necessary behaviors when the time comes. The main point to get across in this activity is that when the child or adolescent is having a difficult time, it helps to have a plan that includes (a) telling a trusted person (hopefully a parent) and enlisting that person's support, and (b) implementing various forms of self-management.

A child with prodromal symptoms may be less likely to need medication or hospital intervention. However, if the child has been hospitalized in the past or has had unsafe behavior that may warrant hospitalization it may be necessary to meet with the parents separately and develop a plan for when the child is no longer able to enlist his or her own coping strategies. These discussions are often more productive without the child involved as the parents may need to make decisions to keep the child safe without the child's consent. If safety issues are involved help the parents devise a safety contract that they feel comfortable implementing for when the child is unsafe or uncooperative with other prevention plans. Some strategies may include taking more medication, being evaluated at the hospital, and/or calling 911.

Addressing Emotion Dysregulation in the Psychoeducation Module
 The Psychoeducation module of FFT specifically addresses emotion regulation in various ways. The individualized, self-rated mood and behavior chart has each family member observe and track instances of dysregulation. Through tracking more extreme mood occurrences, family members are more likely to predict and prevent continued occurrences. We know that behavior changes simply by paying closer attention to it. In addition, identifying daily stressors and responses helps family members track the stressors that lead to the largest reactions. Family members are building awareness of emotion in everyday life in response to stressors. Finally, relapse prevention strategies allow executive planning for future triggers of dysregulated emotions.

II. COMMUNICATION ENHANCEMENT TRAINING (Sessions 5-8)

Session 5 Goals
 How to use the skills to prevent mood worsening
 Preview skills of Communication Enhancement Training
 Teach Skill #1: Expressing positive feelings

 Present **Handout 9, How to Use the Skills We Are Teaching You to Prevent Worsening of Mood Symptoms** to provide a nice segue way from the education to the communication and problem solving modules. By explaining to the family that good communication and problem solving about family problems leads to less family tension and fewer mood symptoms you are providing a rationale for being open to the upcoming, and potentially more challenging, FFT-HR modules. Families who have learned to avoid having any difficult conversations over time are now being asked to delve into uncomfortable territory. Through encouraging change to arrive at specific goals, the family may be more likely to tackle the difficult steps necessary for healthier interactions.
 The second module of FFT-HR, communication enhancement training (CET), runs for approximately 4 sessions (sessions 5 – 8). CET for the families of high-risk children is guided by two assumptions. First, destructive patterns of family communication reflect distress within the family due to family members' attempts to deal with the child's syndromal depressive, subsyndromal manic, or attentional symptoms. Second, these communication patterns can be improved through skill training. CET uses a role-playing format to teach children and their relatives four communication skills: *offering positive feedback, active listening, making positive requests for change in others' behavior, and giving negative feedback.*
 The first two skills, delivering positive feedback and active listening, generally foster a feeling of collaboration between members of a family. The second two, positive requests for change and giving negative feedback, are potentially more conflictual, and are only introduced once the child, parents, and siblings are used to the role-playing format. For each skill, the clinician gives the participants a handout listing its components (e.g., for active listening: making good eye contact, paraphrasing), and models the skill for the family. Then, the

participants practice the skills with each other, with coaching and shaping by the clinician. A homework assignment, in which the participants keep a log of their efforts to use the skills, facilitates generalization to the home setting.

The purpose of communication enhancement training with children is similar to that for adults: to create a home atmosphere that is facilitative of stability and protective against increased symptoms. However, adults and children communicate in different ways. Adults use larger words, use longer sentences, and are more abstract. Children are often much more concrete and can become frustrated by abstract questions and statements.

> *Case Example*
> Ben, an 11-year-old diagnosed with bipolar disorder, not otherwise specified and Attention Deficit Disorder (ADHD) began to experience frustration during the communication module. When the family was asked what they would like to improve in their communication, Ben's father, Richard, said that he would like for he and Ben to share more with each other. Ben asked him what he meant. His father said that he would like to know what Ben wanted out of life, what made him happy, and where he saw himself in the future. Ben, becoming increasingly frustrated, told his father that he still did not understand. The clinician tried to help Richard focus his request a little more but he had a very difficult time defining what he meant. Finally, Ben said, "Dad, I'll tell you about my day today, OK?" and proceeded to give his father a very detailed account of all he did at school and after school. This seemed to please Richard very much who thanked Ben by saying, "that helps me know what makes you happy and what is happening in your life". Luckily, Ben was able to intercept what was becoming an uncomfortable impasse by making a guess about what his father wanted. The clinician can help parents avoid abstract dialogue and focus on the concrete, specific communication to which the child will respond more positively.

Initiating the Communication Skills Module

The communication module begins with making sure that everyone in the family understands what the clinician means by good communication. For children, "communication" can seem like an adult word and it may be necessary to say to them "it means making sure you and another person understand each other." Once everyone understands what communication means, then each person in the family identifies communication methods he or she is already using. Graph each method on the flip chart as to its usefulness (see ***Figure 6, "Communication Skills"***). For example, a family may identify these different ways of communicating: using "I" statements, yelling, telling someone else how you feel, or kicking the door. Next, rate them based on how helpful each of these methods are (+100 being most helpful and –100 being least helpful). The family may decide jointly that telling someone how you feel is the most helpful and kicking the door is the least.

Give the family **Handout 10, "The Four Basic Communication Skills"**. Then, preview the skills that you intend to teach the family.

> "You are going to learn four communication skills. The skills are expressing positive feelings, active listening, making positive requests for change, and expressing negative feelings. Once you have learned the skill and used it over the week we will chart it on our graph. Then we'll be able to see how helpful the skill is compared to the other skills that you are already using."

One of the ways in which the family learns a new skill (such as active listening) is by role-playing with each other inside and outside of the session. It is important for the family to understand the role-playing process. Describe it by saying:

> "We'll have you do something in here that we call 'role-playing.' This means that we will be asking you to turn your chairs to each other and practice new ways of talking to each other. Some people find that it is a little uncomfortable at first but you'll be surprised at how quickly you get used to it."

Sometimes family members may be self-conscious about role-playing but with perseverance, typically all members of the family become involved. In fact, it can be fun for the family to engage in new ways of communicating through rehearsal. The child may like this phase of treatment best because the focus is no longer on his or her symptoms, as during education. Communication training involves much more interaction between family members.

Skill #1: Expressing Positive Feelings

After introducing the concept of communication, start to teach the four skills. First, present the skill of expressing positive feelings. This skill is taught first because it is an easy skill to learn and usually leads to a sense of connection and good feeling between family members. To begin, briefly summarize the nature and purpose of the skill: it is a direct way to make other members of the family feel valued and appreciated, and makes them want to reciprocate those good feelings in the future. It also feels really good to give others positive feedback and if one gives positive feedback he or she will be more likely to receive it. We tell families that it takes 5 positives to make up for one negative interaction to highlight how important positive feedback is in family relations. Then explain the components using **Handout 11, "Expressing Positive Feelings"**.

It is sometimes hard for children, and even for adults, to come up with "feeling words." For example, a family member might say, "It made me feel like you cared," which is really not a disclosure of his or her own feeling state. Help family members to find the right feeling that goes along with that experience, such as "happy", "appreciated", or "touched". Explain to the child and family that expressing positive feelings typically goes better if the praise is offered for a

relatively specific behavior instead of a generic attribute such as being a "terrific person". Finally, model the skill for them. For rapport building, direct your modeling to the child as the receiver. For example, say,

> "_____ (child), I really appreciate how you have come to every session and tried to participate even though it has been hard for you some days. Your involvement makes me feel encouraged that I may be helpful to you and your family."

It is important to read your audience in choosing to whom you will direct initial modeling of the skills. If the child has been particularly difficult to connect with, it may not be possible to join with him or her using positive communication, especially if he or she thinks this kind of communication is "canned." In these cases, you may wish to use the skill to draw out an otherwise silent member of the family like a less involved father or younger sibling. However, there are times when a seemingly resistant, withdrawn child comes to life when given a compliment, especially if he or she experiences the parents as highly critical.

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

Once it is clear that family members know the steps of positive communication, have them think of something specific and pleasing that someone else in the family did in the last week. Once a family member is ready to give feedback and has chosen a recipient, instruct the members of the dyad to turn their chairs toward each other, and talk directly to each other with the one giving the feedback designated the "speaker" and the one receiving the feedback the "listener". The clinician's role is to be "coach and fan." So, make sure that the family members feel supported but also give them feedback on how to do the skill correctly.

For example, one father told his son, "I am really glad that you were able to stay out of trouble this week. It made me happy." The clinician praised the father's efforts at coming up with a compliment for his son, and pointed out to him that another way to state his compliment would be to say what his son <u>did</u> that he appreciated, as opposed to what he did not do. The father tried again and stated, "Son, your behavior was really exceptional this week and it made me really happy to see you behave so well." At this point the clinician gave a lot of praise to the father for being flexible and performing the skill in the way it was intended. However, she still encouraged the father to try being more specific by giving examples of what he meant by "really exceptional behavior."

Sometimes, there will be resistance to replaying the skill in accordance with the therapist's feedback. If this occurs, you can share with the speaker that the skills are like trying on a new pair of shoes. If they do not fit, the speaker is welcome to take them off. However, he or she will only know whether they fit if they are "walked in awhile to see if you can break them in. It's the same way with

these skills – you've got to first learn the skills and then mold them to your particular style before they'll feel natural." Next, ask each member of the family to practice the skill while you praise and provide coaching. Though this skill may seem like the easiest of the four to have the family learn don't be surprised if it is very difficult for the family to practice this skill. Especially in high conflict families, there has been more practice around negative interchanges than positive. It may feel difficult for family members to break the cycle. You can normalize this with family members and talk about how often people can feel vulnerable when sharing positive feelings or giving compliments. If there is a great deal of resistance to the exercise you can assign **Handout 12** (see below) for homework and family members can share what they noticed at the next session when they feel more prepared. This assignment will offer a template for observing positive behaviors and you can then teach the skill using these observations in the next session.

Once you are fairly certain that each of the family members – including the child – is using the positive feedback skill in the correct manner, assign the homework sheet, "***Catch a Person Pleasing You Task" (Handout 12***). This assignment can be treated as a game. Each member of the family is assigned his or her own sheet. The goal is for each family member to try to do something every day that he or she perceives as pleasing to other family members. All family members record on their sheets when another member of the family did something pleasing for them. They also record how they expressed positive feelings about what was done. This can lead to a discussion of what family members "catch" and what they "miss".

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

Session 6 Goal: Teach Skill #2: Active listening
An essential building block for good communication is the ability to listen. Because it is in many ways the basis for other communication skills, active listening can be introduced before expressing positive feelings. However, active listening is a more difficult skill to learn and can be anxiety producing for family members, so expressing positive feelings can be an opportunity to begin communication training with a concrete skill that has a positive tone.

In this session, give **Handout 13** and describe "**Active Listening"** to the family by saying:

"This is a skill you are probably all familiar with, known as active listening. It's a skill that is useful anytime, but it is even more helpful when there is an argument or disagreement. It helps to slow things down because each person has to let the other person know that they heard what was said before responding. In addition, the listener has to make sure that they understand what the speaker is saying. Often times just having clear communication and having the other person feel like you're listening avoids a beginning conflict.

"There are a couple of parts to it. If you want to let a person know you are listening to them, look at them, nod your head, and ask some questions to make sure you understand, like 'When did that happen?' Finally try to repeat to the person what you heard them say."

After introducing the skill, model the skill for the family. That is, be the listener and ask a member of the family to talk to you. You may want to ask for a volunteer so that the child can choose whether or not to talk. Once you have modeled the listening skill, solicit input from family members as to their experience of the demonstration (e.g., "What did you see me doing just now? How did you know I was listening?" "How did I do?" "Did I get all of the information?"). Next ask for volunteers to try practicing the skill (a speaker and a listener). **It is important to start with low conflict topics for active listening, given that it is difficult to learn a skill in the face of anxiety and/or criticism. Also, practicing the skill should not provide an opportunity for a parent to give the child a lecture.**
As with the other skills, continue to model, coach, and give positive reinforcement for the family member's efforts, even if these efforts are only modest. There is often more coaching involved in the active listening skill than the others because of its difficulty and complexity. Continue the process of integrating communication skills into the family's daily life by assigning homework, the "**Communication Skills Assignment" (Handout 14)**, to all members of the family. Instruct the family to practice active listening with various people in their daily lives, and to describe each instance on the homework sheet.

Session 7 Goal
Teach Skill #3: Making positive requests for change
The two remaining communication skills, making positive requests for change and expressing negative feelings, address a family member's desire for change in another family member's behavior. "**Making Positive Requests"** (e.g., "I would appreciate it if you would take out the trash") is the first step in requesting behavior changes (see **Handout 15**). This skill involves requesting a behavior – not asking that a behavior be ceased or changed. "**Expressing Negative Feelings About Specific Behaviors"** (e.g., "When you ignore me, it hurts my feelings; what can we do about this?") is tried when positive requests

have not achieved their desired effects (see **Handout 16**) and can label specific negative behaviors that the family member wants stopped or changed.

There are two caveats to keep in mind when teaching positive requests. First, the request should be for another person to do something, rather than stop doing something. For example, if a member of the family says I would really appreciate it if you would quit kicking me, have her try to frame it in the positive. For example, I would really appreciate it if you would keep you legs still. Second, even if the skill is performed correctly, the person receiving the request is not under obligation to do what is being asked of him or her. The request may best be conceptualized as one of a number of solutions to a family problem that can be taken up further through the problem-solving venue (see Problem solving section).

To proceed with positive requests pass out **Handout 15**, and introduce the skill:

"The next skill is called making a positive request. As you can see in the handout there are a few parts to this skill – look at the person, tell what you would like him or her to do, and say how it would make you feel."

After presenting the skill, model the skill, either by asking for a volunteer or including someone in the family who has been "hanging back" during the treatment. Once you have modeled the skill, have all family members role-play the skill with each other.

Here is an example of a therapist coaching a young boy and his mother on positive requests for change:

Son: No matter what happens, you think it's my fault. Remember the other day, when you couldn't find the remote, you automatically thought that I left it somewhere. You don't even know what happened, but you think it's my fault.

Clinician: Can you turn that into a Positive Request for Change?

Son: I wish that when something goes wrong, or something is broken or something, you wouldn't always blame it on me.

Clinician: That's a good start, but can you turn it into a positive, and say what your mom should do instead?

Son: Well, she should not judge me, like she should withhold her judgment about how it got broken until she knows what happened.

Clinician: So you'd like her to withhold judgment when something goes wrong, until she knows more about what happened. Do you want to respond to that, Marilyn?

Mother: Well, maybe I could withhold judgment if you would stop lying to me.

Clinician: Whoa, that's a pretty critical statement. Sounds like you're basically calling him a liar.

Mother: I guess I didn't say that right.

Clinician: Maybe you felt like he was asking you for something, and you feel like it's only fair for you to get to ask him for something in return. Can you ask for what you want using a Positive Request?

Mother: I would really appreciate it if you would be honest with me. It would make me feel more trusting of you and more likely to withhold judgment until I get all of the facts.

As with the other skills, praise all members of the family for their efforts, and coach each to make sure the skill is being performed correctly. Finally, assign homework: ask them each to practice the positive request skill at home and record these requests. The **Communication Skills Assignment (Handout 14)** can again be used for this purpose.

Session 8 Goal: Teach Skill #4: Expressing negative feelings

In many ways, expressing negative feelings is the most difficult skill to learn because it involves delivering an unpleasant message. Specifically, it is a way to give another family member constructive criticism about his or her behavior. Family members need to express their frustration with each other from time to time and may not have a productive forum for sharing this type of feedback. This skill offers family members a useful alternative when positive requests have been ineffective. But criticism in any form is difficult to accept. Given that it can stir up disagreement, the expressing negative feedback skill is a potential gateway to problem solving.

To proceed with negative requests pass out **Handout 16**, and introduce the skill:

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

As with the other skills, facilitate a role-play with a family member. To alleviate the child's concern that he or she will be the primary target of negative messages, structure the first role-play so that family members practice as if they were speaking to *someone outside of the family*. This is probably more important to do with children in the family than with adults, since children have often felt that they were the target of disapproval from parents. The example of Mike (inset) illustrates the initial role-play of this skill.

> Clinician: Mike, tell me a behavior that either a teacher or kid at school does that really bugs you.
>
> Mike: Well I hate it when I have had my hand raised forever and the teacher doesn't call on me and keeps calling on the same nerdy kids over and over again. I told him about it before and he just ignores me.
>
> Clinician: So, what do you think you could say to your teacher?
>
> Mike: Nothing, I'd be scared that he would take it out on me when he was grading my next test.
>
> Clinician: Well, how do you think he would respond if you said after class, "Mr. _____, I often raise my hand in class and you don't call on me. I know there's lots of kids who want to talk but it kind of upsets me. What should I do differently when I think I have the answer?" What do you think he would say?
>
> Mike: I think he would be blown away, none of the kids ever talk to him that way, they usually just complain behind his back or are obnoxious in class. But I don't know, it might work.
>
> Clinician: Well, you know, those were just my words. Maybe there are better ways to say it. Why don't you pretend I'm your teacher and say it the way you'd do it?
>
> Mike: Um, Mr. _____, could you call on me more? Sometimes I have the answer but you always call on Jeff or Karen.
>
> Clinician: That's a real good start, Mike. Louise (mother), what else do you think Mike could say?

Once you feel that family members understand the skill, have them practice with each other once or twice. It is good to make family members aware of this skill but don't spend too much time on it. You want to avoid "throwing

gasoline on a fire and igniting old flames" that you have worked hard to extinguish in the last 7 sessions.

        Handout 17, the "Expressing Negative Feelings About Specific Behaviors" Assignment, is given to the family once each member has had a chance to practice the skill. Again, ask family members to practice it in the upcoming week (if relevant in their day-to-day lives) and record their efforts on the form.

        In this final session of communication training, if time permits, the family may be asked to role-play each skill one final time, to make sure that the skills have been retained and are being used correctly. After the skills have been practiced, ask each member of the family to rate the usefulness of each skill, using the graph (***Figure 6***) that was previously constructed. It is important for each member to individually critique the skills; some skills are more useful to one family member than another.

        Each person in the family describes what reasons went into his or her ratings of each skill. For example, one mother said that Active Listening was the most helpful skill because she often did not know (a) whether her son was listening and (b) whether he understood what she was trying to say to him. She admitted that she sometimes spoke abstractly. His learning to paraphrase made her more certain that he was hearing her, and also let her know when she needed to be clearer.

Addressing Emotion Dysregulation in the Communication Skills Module

        Learning to manage ones' own emotions when others are communicating difficult information is the hallmark of Communication Training and therefore Communication Enhancement Training is essentially a mood regulation technique. Each of the communication skills is meant to improve the speaker's and listener's emotional response. The asking clarifying questions skill within active listening allows for dialogue exchange about emotion. This skill generates awareness and understanding of ones own and others' emotions. Through being aware of emotions the speaker and listener can better gauge when communication is moving in a nonproductive and potentially overly emotional direction. Several specific skills can be taught to family members when emotion dysregulation is increasing to slow down the interaction and decrease the escalating emotion.

        For example, teach families to disengage based on their own or other family members' emotional "temperature". Use the image of a thermometer and help family members learn to gauge their own internal emotional escalation or temperature. Have family members decide at what point on a 1-10 escalation scale they want to cease with communication. A helpful example is to describe an anger model of 1-3 = feeling a bit annoyed but fine to continue a conversation, 4-6 = feeling more frustrated and realizing that the conversation may need to be stopped if the "temperature" starts to rise, 7-10 = disengage either by ceasing communication or physically leaving the conversation (i.e., taking a time out). When family members are more aware of their own and others' internal "temperatures" and are avoiding higher levels of emotion, communication goes

much better. If family members have success with this model the outcome will be reinforcing in and of itself.

At this point, the clinician leaves communication training and moves to the problem-solving module, directing the family to continue practicing the skills, given that they will be using them to discuss family problems in the upcoming sessions.

III. PROBLEM SOLVING SKILLS TRAINING (Sessions 9-11)

Sessions 9-11 Goals
  Introduce the problem-solving module
  Identify specific problems for problem solving
  Complete problem solving steps

Problem solving is one of the oldest methods for working with families (for a review, see Clarkin & Miklowitz, 1997). But it can be difficult for children with mood/attention problems to engage in problem solving. Sometimes, children become anxious when solving family problems. For example, when asked how he felt about learning the problem solving module, one child turned his chair to the wall and began saying, "I will just do it my way and everything will be fine,.. we don't have any problems".

When problem solving is with adults the focus is on collaboration. However, children do not have equal say in the decisions that get made in a family. It may be more appropriate for the parent to come up with two or three choices for the child, and then allow the child to help decide which choice seems to be the most appropriate. Alternatively, all members of the family may generate solutions but it is made clear before a solution is chosen that the parents have veto power if a certain solution isn't viable. For example, one child wanted to come up with solutions to her problem of feeling lonely. One of her solutions was to get a dog. The parents invoked their veto power and told her that they weren't allowed to have any pets in the apartments where they were living. This may be a particularly important adjustment for children who are at risk for bipolar disorder, who sometimes believe that they are their parents' equals if not their parents' superiors. When parents try to assert their authority over these children, the child feels an intense need to resist because he or she perceives that the parent is trying to dominate him or her. Sometimes a simple "no" can set off a rage reaction (Papolos & Papolos, 2000). In addition, it may be necessary to build in a reward and/or consequence system to ensure follow-through once a solution has been chosen. There will be times when the parent has to keep his or her expectations in check, because the child's mood and cognitive problems may interfere with his or her effective problem solving.

The purpose of the problem-solving module is to reduce the family distress and tension that develops in response to life events, including the ups and downs of living with a child with mood/attention problems. Other objectives are to (1) open up a dialogue in the family about difficult problem topics, (2) allow

a forum for expressing reactions to the issues raised and (3) offer children and family members a framework for solving problems.

The first step is to offer the family a rationale for problem solving.

"Up until now we have been talking about how you communicate or talk with each other. Now we would like to look at some of the things you think are problems in the family and work together to solve them. We are going to teach you a model for working as a team so that everybody is happy with the solution."

If you are working with older children it may be appropriate to give **Handout 18** entitled **Solving Problems**. However, this handout may be too complex for many younger children (e.g., ages 9 – 11). For younger kids, if it appears they will struggle with **Handout 18**, use a large pad of paper on an easel and several colorful markers (you can also use **Figure 8, Traffic Light Steps of Problem Solving**) and list the components of problem solving on the flip chart. The description below is a simplified version of the overview of problem solving given to adult bipolar patients.

"We think of problem solving as having several steps. These steps are a little like what we do in our heads automatically, but there are some tricks to doing it as a family that make it go better. First, you need to define the problem, spend some time trying to identify what the problem really is and all agree on it. In this step you'll use a lot of active listening because different people often have different ideas about what the problem is. The more specific you can be about defining the problem, the better. Next, you give as many different solutions as you can think of – what we call 'brainstorming'. Then together you decide what the advantages (or pluses) and disadvantages (or minuses) are. Then you pick one or more solutions that you think will work and decide when and how you will put them into practice. After trying the best solution it is important to give yourself and your family a 'high five' and figure out if you think the problem was solved or not."

Once you have explained the steps in problem solving to the family, help them identify a practice problem. Give each family member a copy of the goals that were identified in the first session of therapy (See **Figure 7 Goals,** for an example*).* Instruct the family to look through the goals and state whether they feel that each goal has been met or if it should be on the agenda for problem solving. Invite the child and family members to list any issues which are not on the goal sheet but which feel like problems to them.

As with communication training, problem solving works best when simple, rather nonconflictual problems are chosen first, saving the more difficult problems for when the parents and children have some mastery over the skill. With kids it may be beneficial to keep all problems as simple and concrete as possible. But whether you try to help the family choose simple or more complex problems, be

30

aware that even the simplest problem may be the "tip of the iceberg." A more central, global conflict may be underneath the surface. Of course, use your clinical skills in choosing problems and guiding the family through the problem solving process.

As was true in communication training, your role in problem solving is again that of coach and fan. It is important that you guide the family through the problem solving steps, keeping them on task and consistently praising them for their efforts, no matter how small. It is helpful to point out to families the importance of using the communication skills when defining problems or evaluating advantages and disadvantages. Family members can use active listening while defining the problem, or practice positive requests while generating solutions.

It may be that in the midst of brainstorming it becomes apparent that everyone has not agreed on the definition of the problem. You may need to stop the problem solving briefly to have the family return to active listening so that a clearer understanding of the problem can be achieved.

There are two situations that may necessitate having a problem solving session with the child or parents alone. First, there may be problems that the child would like help solving separately from his or her family, or that may involve him/her and the siblings rather than the parents. Second, the family may need to solve a more complex problem involving the child that would be best done by the parents alone or that is beyond the child's understanding (e.g., whether to switch psychiatrists; financial problems). This is not typical and certainly, most problem solving should be conducted with the whole family present.   However, this is an option in FFT-HR.

The Format of Problem Solving

Working through a specific problem is aided by the introduction of the "**Problem Solving Worksheet" (Handout 19** which consists of two pages and is typically displayed as double sided). Use your clinical judgment to determine if this worksheet is too complex for the child. If so, as mentioned, the same task can be accomplished on a large pad with markers, or through using **Figure 8**, "**Traffic Light Steps of Problem Solving".** Whether using the worksheet or easel, help the family go through problem definition, proposed solutions, advantages and disadvantages, and implementation strategies while recording each step on paper.

As the family becomes familiar with the problem-solving format, encourage them to begin to use this skill at home. Once they have solved a couple of problems in the sessions, ask them to take another small, specific problem and work on it outside of the session. If it seems like the process is not fully within their grasp, have them take a specific part of the problem solving process (e.g., brainstorming and evaluating solutions) to work on at home, after defining the problem in the session. Encourage them to record their efforts between sessions and bring their written notes to the next session.

Sometimes it is necessary for the family to record the various steps of problem solving and what they agree to in a contract format (**see Figure 9,**

"Problem Solving"). You may have the family list the agreed upon solution and have all members sign that they will follow the proposed solution.

Addressing Emotion Dysregulation in the Problem-Solving Module

The proposed mediating mechanism of the Problem-solving module is reducing family distress. Problem-solving indirectly helps with emotion regulation by allowing family members to express and exchange charged information. Problem solving is also used in a more direct manner by helping families develop solutions for managing family conflict that often include extreme displays of emotion (i.e., shouting, becoming physical). It may be necessary to remind family members of the "thermometer" skill that was taught in communication training to use with problem solving. If any member begins to reach a level of emotion that makes working together impossible instruct the family to put the problem to the side and incorporate some of the coping strategies developed during the education module. In this way, the family can continue to work on problem solution without having a negatively charged emotional experience.

Session 12 Goals
   Termination
   Review treatment objectives and prevention plans
   Encourage existing treatment adherence
   Make referrals for ongoing and future care

The FFT-HR treatment continues to integrate education, communication skills, and problem solving depending on what the family brings into each session. At this point in treatment you will most likely be meeting every other week, and much may have happened during the treatment interval. Keep stressing to the family that most of the work needs to be done outside of the session during these final phases. The sessions should be seen as "booster sessions" or "tune-ups" regarding using the problem solving skills (and where relevant, the communication enhancement skills). The clinician may also help the family get out of intractable conflicts that the members feel incapable of solving on their own. Try to get through one full problem-solving task, from problem definition to solution implementation, in each session. If you are unable to accomplish a complete problem solving exercise in a session you may assign the rest of the problem solution and implementation for homework. Often, it is most helpful to aid the family with problem definition and generating solutions as this is where most of the family conflict may arise.

During termination it is helpful to discuss the family's reactions to the treatment. During this session, ask questions of the form, "What did you like/not like about the treatment? How was it helpful? How could it have been more helpful? What was your reaction to the education? The communication training? The problem solving? If we were to do the program with you all over again, what would you want to do differently? Could the treatment be structured differently? How would you change it? (For parents): What else can we do to help your son/daughter, or you, personally? Your other children? (For children and

adolescents): Are there other things we could have done to make you feel better? To help your relationship with your parents/siblings?".

To the extent that you are comfortable, communicate your pleasure in having worked with the family in these final sessions. Underline the progress the child has made (if this is the case) and express optimism about the future. Encourage each member of the family to express their feelings, positive or negative, about treatment ending. Keep in mind that if the child or one or more family members is "happy we're done," this may be a good thing and indicative of growth.

Make clear that you are available in the future for crisis intervention sessions, consultations, or referrals, and make sure the family knows how to reach you. It is helpful to specify with the family under what conditions they should contact you. You may tailor this discussion to the family but there are typically three main reasons to call you after treatment has ended. First, the child starts to have worsening of mood symptoms that could be the beginning of more severe mood swings. Help the family with remembering the FIND acronym and what was discussed in the education portion of FFT-HR to decide whether to call or not. Second, there may be safety issues at play, for example, if the child is caught experimenting with substances, has become homicidal or suicidal, or is engaged in other dangerous behaviors. Instruct the family to consult their safety plan first but to call and let you know what has happened. Third, if the level of conflict in the family becomes really high, the family should call. You will have to judge this on a family-by-family basis but certainly if anyone in the family becomes very verbally abusive or physically abusive with another member then the family should come in for a consultation. You may offer a booster session of the skills or refer them for additional care dependent on the needs of the family.

Principal Investigator/Program Director: Miklowitz, David J.

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Handout # 1

Family-Focused Treatment: What we're going to do and what to expect

Our Goal is to:
- Help things go more smoothly in your family
- Increase understanding of what "mood disorder" means
- Help your family communicate better
- Help your family solve problems better

What we're going to do:
- Get to know each family member
- Learn about mood problems and and how to manage them
- Learn communication skills
- Learn how to solve problems that may happen in your family

Things will work best if everyone in the family:
- Comes to each session ready to try your best and share your thoughts
- Participates in learning the skills during the meetings
- Comes prepared with the assignments finished
- Cooperates with each other

The coach will:
- Will work with experts to provide the best treatment
- Make sure everyone's privacy is respected
  - Give you a comfortable place to say what's on your mind
  - Give you things to work on at home
  - Give you a chance to check in between sessions if you need to

Handout # 2a

Elated/Expansive mood

Decreased need for sleep

Increased energy and activity

Increased sexual thoughts

Symptoms of Mania

IRRITABILITY!

The world would be a better place if everybody just thought the way I do.

Being overconfident or unrealistic

I'm a speaker. Welcome to my content!

Talking fast

Loss of self-control

Easily distracted, Racing Thoughts, Lots of ideas

Handout # 2b

Low mood or sadness

Low self-esteem

Tearfulness

Symptoms of Depression

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

Trouble concentrating

Sleeping too much or too little

Increase or Decrease in Appetite
Crave Sweets or Carbohydrates

Loss of interest in activities/boredom

Handout # 2c
Other things kids experience that may be related to having a mood disorder

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

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

◆ Difficulty controlling your anger.

◆ Stressful things may upset you more than they upset other kids.

Handout # 3

Recent Life Events

STRESS Thermometer

Things that have stressed you out lately:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

RAGE

ANGRY

UPSET

SAD

HAPPY

VERY HAPPY

STOP !

CALM DOWN

RELAX

THINK ABOUT WHAT YOU REALLY WANT

THINK ABOUT SOMETHING GOOD

MAKE YOURSELF HAPPY

Things you did to help you feel better:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Handout # 4

Factors Affecting Health Problems

Genes

Daily Events

Protective Factors

Risk Factors

Possible Outcomes

Good   Okay   Poor
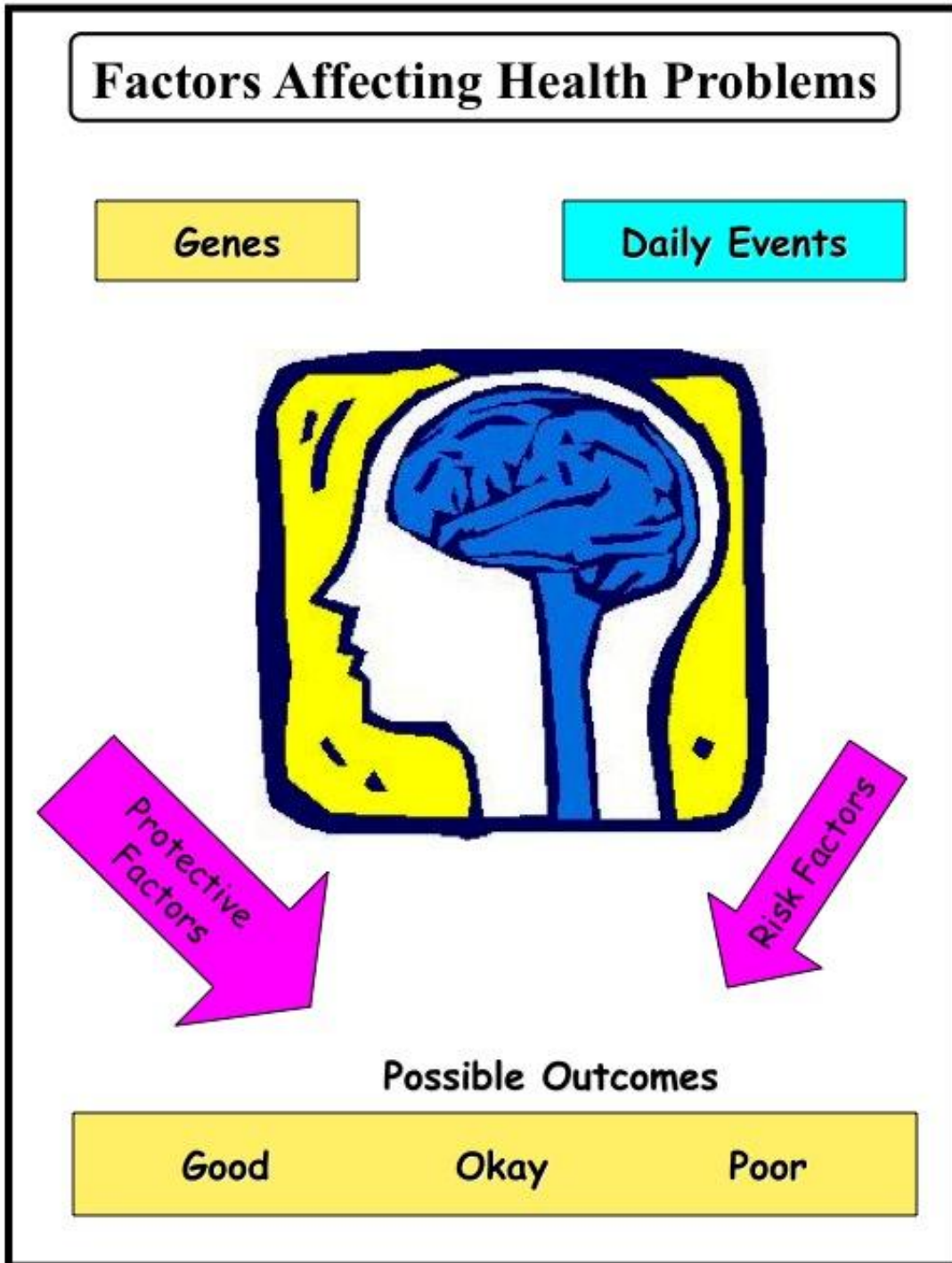
Handout # 5

How Do People Get Mood Problems?

Some people are born with a risk to develop mood disorder.

→ **their brain can get overactive under stress**
→ **their life can get stressful**
→ **their brain and life can both get stressed at the same time**
→ **the ways to deal with stress (like communicating well with others) may not be helpful all the time**

Some things that can make symptoms of mood disorder worse:

→ **Using street drugs**
→ **Not getting enough sleep**
→ **Changing typical daily schedules**

Handout # 6

Risk and Protective Factors For Mood Problems

Risk Factors

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

Protective Factors

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

Handout # 7

Medications Commonly Used to Treat Mood Problems

Generic Name	Brand Name

Mood-Stabilizers: Regulate ups & downs

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

Antidepressants: Improve mood

Serotonin-Reuptake Inhibitors:

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

Monoamine Oxidase Inhibitors:

Phenelzine	Nardil
Tranylcypromine	Parnate

Novel Agents:

Venlafaxine	Effexor
Bupropion	Wellbutrin
Trazodone	Desyrel
Nefazodone	Serzone
Mirtazapine	Remeron

Generic Name	Brand Name

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

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

Benzodiazepines: Control anxiety, improve sleep and induce calm

Lorazepam	Ativan
Clonazepam	Klonopin
Diazepam	Valium
Alprazolam	Xanax

Psychostimulants: Improve attention and concentration

Methylphenidate	Ritalin
	Adderal
	Concerta

Handout # 8

How Can Your Family Help?

• Help you get treatment and services

• Support taking your medication (if you take medication)

•Learn about mood swings so they can respond in a helpful manner

• Develop a plan as a family for managing angry feelings

• Help you have predictable and scheduled days and sleep

• Reduce expectations of what you can do when you are having a hard time with your moods

• Get help for other members of the family if needed

• Maintain a tolerant and calm home atmosphere

• Do fun things together

• Use good communication skills

Handout # 9

How to use the skills we are teaching you to prevent worsening of mood symptoms

Family Problem or Stressful Life Event

Lack of Communication about Problem

Good Family Communication about Problem

Problem doesn't get solved

Good problem solving

More mood symptoms

Fewer mood symptoms
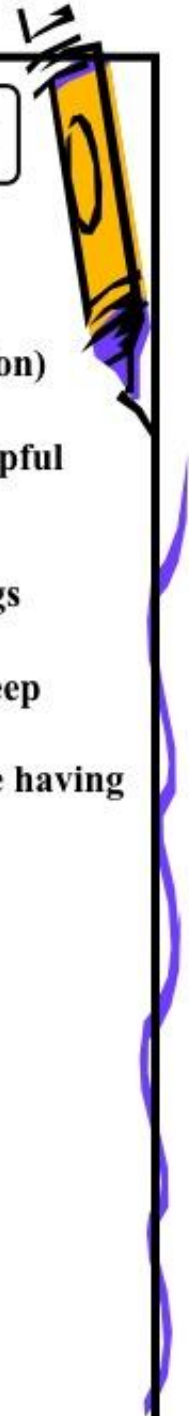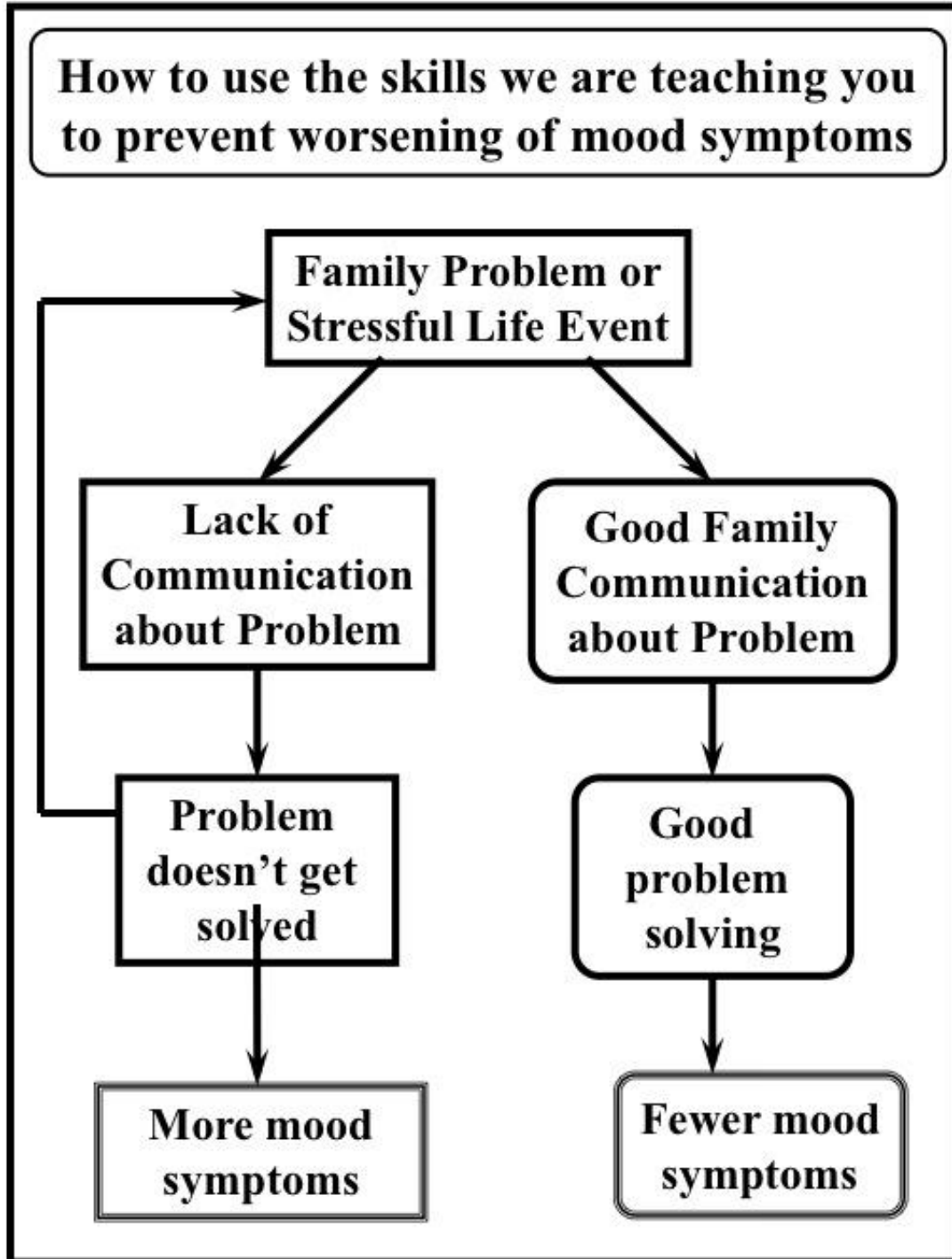
Handout # 10

The Four Basic Communication Skills

• **Expressing Positive Feelings**

• **Active Listening**

• **Making Positive Requests for Change**

• **Expressing Negative Feelings about <u>Specific</u> Behaviors**

Handout # 11

Expressing Positive Feelings

- **Look at the Person**

- **Say Exactly What S/He Did That Pleased You**

- **Tell Him/Her How <u>You</u> Felt When S/He Did That**

Handout # 12

Catch a Person Pleasing You

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

Examples

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

Handout # 13

Active Listening

• **Look at the Speaker**

• **Attend to What is Said (for example, nod your head, say "Uh-Huh")**

• **Ask Questions for Better Understanding**

• **Check Out What You Heard**

Handout # 14

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 Positive Requests for Change Did You Make?
Mon					
Tue					
Wed					
Thu					
Fri					
Sat					
Sun					

Handout # 15

Making a Positive Request

- **Look at the Person**

- **Say Exactly What You Would Like Him or Her to Do**

- **Tell Him or Her How You Would Feel When S/He Did That**

- **In Making Positive Requests, Use Phrases Like:**

  - "I would like you to _____ ."
  - "I would really appreciate it if you would _____ ."
  - "It's very important to me that you help me with _____ ."

Handout # 16

> ## Expressing Negative Feelings about <u>Specific</u> Behaviors

- **Look at the person; speak firmly**

- **Say exactly what he or she did that you did not like**

- **Tell him or her how you felt when s/he did that**

- **Suggest how the person might prevent this from happening in the future**

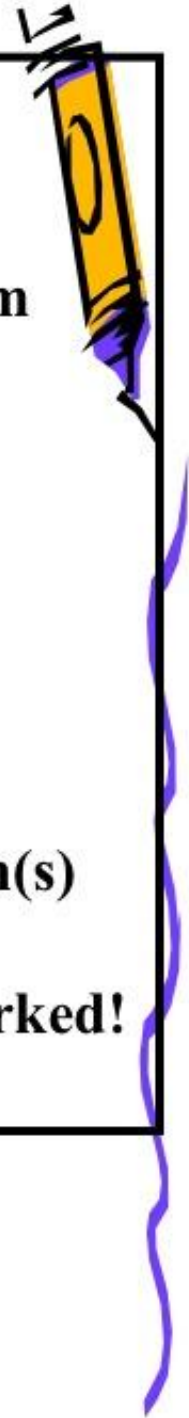## Handout # 17

Expressing Negative Feelings about Specific Behaviors Assignment

Day	Person Who Displeased You	What Exactly Did He or She Do That Displeased You?	How Did You Feel (angry, sad, etc.)?	What Did You Ask Him or Her to Do in the Future?
Mon				
Tue				
Wed				
Thu				
Fri				
Sat				
Sun				

Handout # 18

Solving Problems

- **Identify and Agree on the Problem**

- **Suggest Many Possible Solutions**

- **Discuss Pros and Cons**

- **Agree on Best Solutions**

- **Plan and Carry Out Best Solution(s)**

- **Praise Efforts; Check out if it worked!**

Handout # 19

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. Have everyone come up with at least one possible solution. DO NOT EVALUATE ANY SOLUTION AT THIS POINT.

(1) _____
(2) _____
(3) _____
(4) _____
(5) _____
(6) _____

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

Advantages (Pros)	Disadvantages (Cons)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Handout # 19 (continued)

Step 4: Choose the best possible solution OR solutions and list. (May be a combination of possible solutions.)

_____

_____

_____

Step 5: Plan how to carry out the chosen solutions AND set a date to carry it out. Date: _____

A. Specifically decide who will do what. List.

_____

_____

_____

B. Decide what resources will be needed; list and get them.

_____

_____

_____

C. Think about what can go wrong when you try it, and figure out how to overcome the problems.

_____

_____

_____

D. Practice carrying out the solution.

E. DO IT! (ON TIME)

Step 6: Review the solution and give positive feedback to all family members about their participation.

Step 7: If the plan didn't work, go back to Step 1 and try again. Do not become discouraged.

Week of _____

HOW I FEEL

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Super-Hyper							
Energized							
Balanced							
Down							
Crap/Angry							

I woke up at: _____

I went to bed at: _____

Super-Hyper	Down	Crap/Angry
Feel good about myself	Suicidal	Pissed off
Talk faster	No school	Hate my brother
Like being high	Short-tempered	Irritable
Lots of ideas	Stop eating or eat more	
Need less sleep	Wants to be alone	

Figure 2

DAILY MOOD CHART

For the week of[1] _____   **Name _____**

SLEEP

COMMENTS: (Awakenings, night terrors, etc.) _____

_____

ANGER

>50 min   --
50 min   --
40 min   --
≤30 min   --
Stressor   --
Strategies Implemented _____
COMMENTS: (Self-limiting behaviors, etc.) _____

_____

MEDICATIONS

Name	Dose/day	Times Taken	Changes/Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____
[1] Only unusual occurrences to be recorded on this chart

Hours of Sleep — — — — — — —

Rate Degree of Dysfunction:

	SEVERE	_____
Activated	**HIGH MODERATE**	_____
(Impulsive,	**LOW MODERATE**	_____
Aggressive) **MILD**		_____

Days of week 1 2 3 4 5 6 7

	MILD	_____
Withdrawn	**LOW MODERATE**	_____
(Anxious,	**HIGH MODERATE**	_____
Depressed)	**SEVERE**	_____

Number of switches per day — — — — — — —
Medication received (check if yes) — — — — — — —

LIFE EVENTS and PREDOMINANT SYMPTOMS (Life event impact –4 to +4)

  Day 1 (   ) _____

  Day 2 (   ) _____

  Day 3 (   ) _____

  Day 4 (   ) _____

  Day 5 (   ) _____

  Day 6 (   ) _____

  Day 7 (   ) _____

Figure 3

THE IMPACT OF LIFE STRESSORS

▲ STRESSOR 1

● STRESSOR 2

■ STRESSOR 3

▲ STRESSOR 4

● STRESSOR 5

■ STRESSOR 6

100

90

80

70

60

50

40

30

20

10
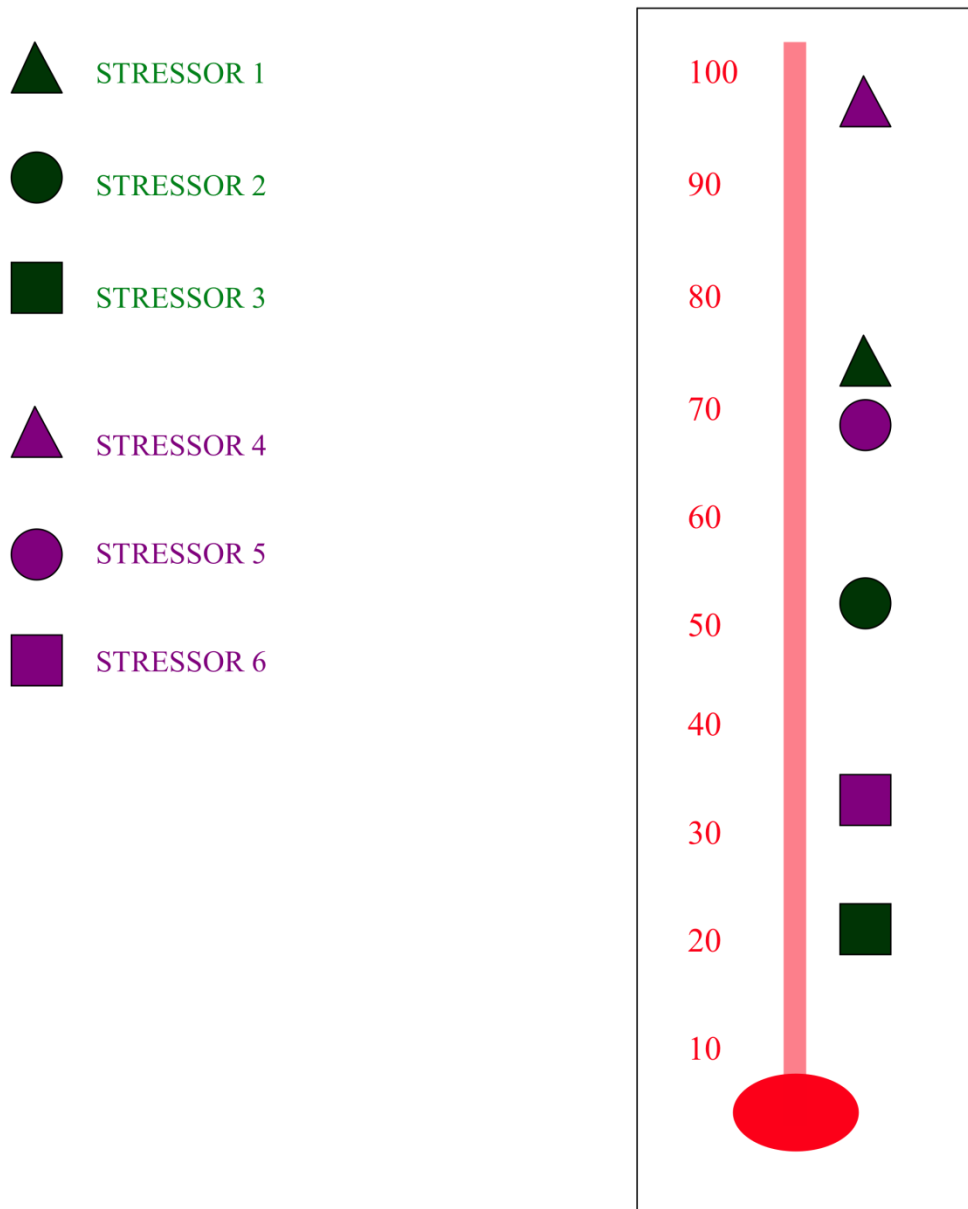
PROTECTIVE/RISK/COPING STRATEGIES

PROTECTIVE
Meds
Schedule
Personal hygiene
Take care of self
Prayer/scripture/study
Taking breaks
Exercise/swimming

RISK
Forgetting/not taking meds
Wrong meds/substances
Sugar
Screaming
Boredom
Unplanned shifts in the day
Overscheduled day
Not respecting each others' opinions
Spending a lot of time in the car

COPING

Emotional
Crying
Vent to someone
Communication

Intellectualize
Talk to someone – get ideas/tools
Tell yourself something to feel better
Problem solving
Prayer

Distractors
Shower
Movie – Lego or other
Calvin and Hobbes
Legos
Reading
Computer
Music
Work
Physical work
Pets
Talking about something else
Helping a friend
Play with mom's cell phone
Watch TV
Jump on tramp

Figure 5

MOOD EPISODE PREVENTION PLAN

HOW CAN YOU TELL I'M HAVING A GOOD DAY

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

HOW CAN YOU TELL I'M HAVING A BAD DAY

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

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

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

Figure 6

COMMUNICATION SKILLS
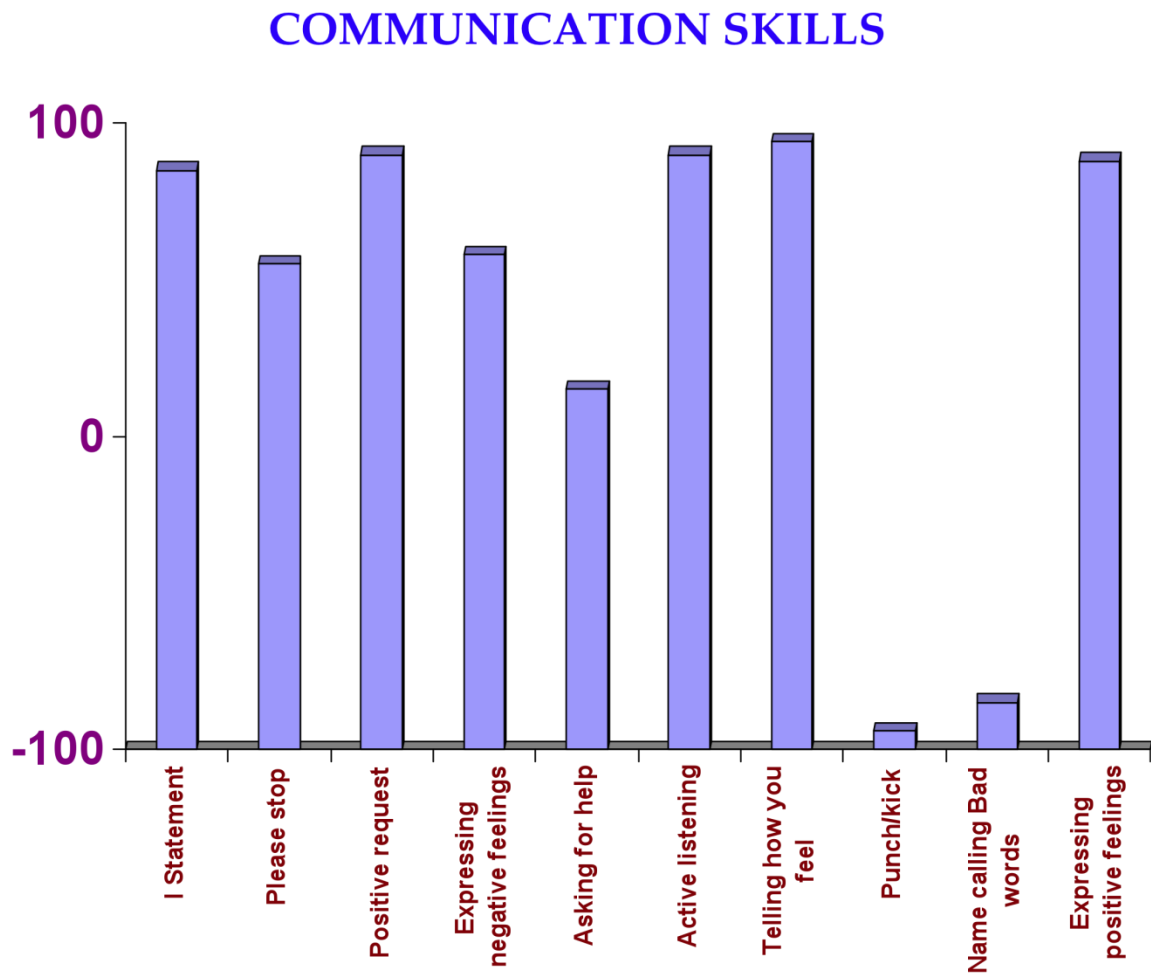
Fig. 7.

GOALS CHART

List your goals for the next 4 months. How would you like things to be different?

Child:

_____

_____

_____

_____

_____

Parent(s):

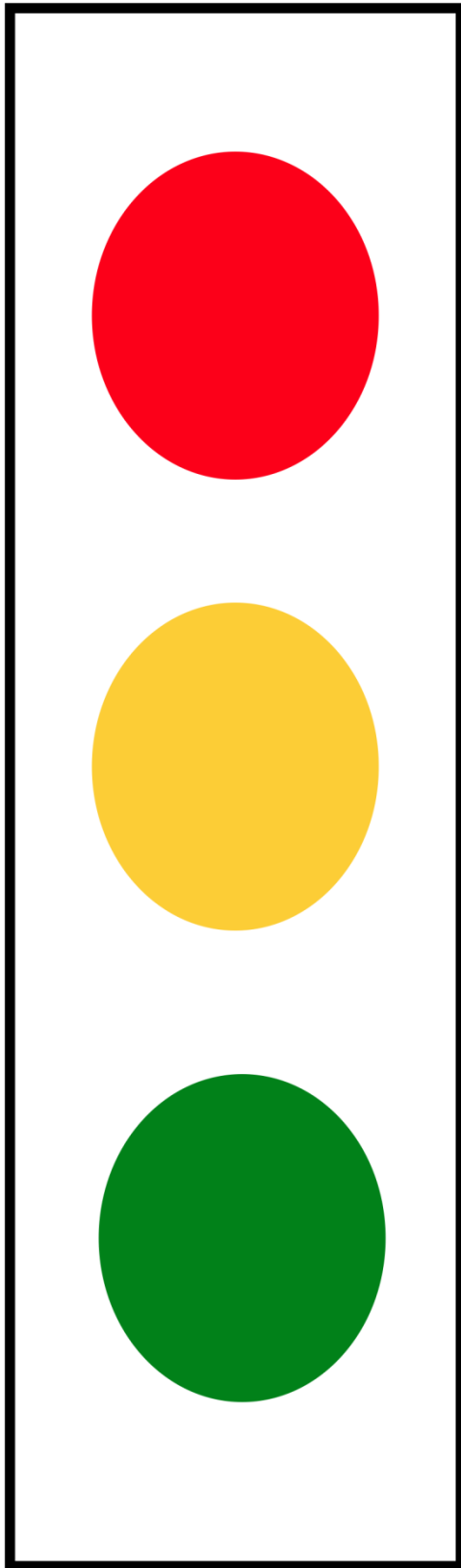_____

_____

_____

_____

_____

Sibling (s)

_____

_____

_____

_____

_____

Figure 8

STOP, CALM DOWN, THINK
BEFORE YOU ACT

SAY THE PROBLEM AND
HOW YOU FEEL
SET A POSITIVE GOAL
THINK OF LOTS OF
SOLUTIONS
THINK ABOUT THE
CONSEQUENCES

GO AHEAD AND TRY THE
BEST PLAN

Supplement to Clinicians' Treatment Manual for the Family-Focused

Therapy of Children and Adolescents at risk for Bipolar Disorder (FFT-HR)

Comorbidity with Attention Deficit/Hyperactivity Disorder

Kim Gallelli, Ph.D.

Stanford University, CA

Elizabeth L. George, Ph.D.

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Attention Deficit/Hyperactivity Disorder and Bipolar Disorder

Attention Deficit/Hyperactivity Disorder (ADHD) and Bipolar Disorder (BD) share some common symptoms such as hyperactivity, impulsivity, and inattention. However, these symptoms vary in intensity, duration and often require different treatment approaches depending upon the disorder they are associated with. ADHD primarily affects attention and activity, with a mild presentation of mood variability, but the extremes of "high" or "low" moods are generally not as extreme as in children with BD. A child with BD tends to have extreme mood states—such as mania and depression--and may also demonstrate much more aggression, irritability or uncontrollable rage in conjunction with these mood states.

Often children with ADHD or BD need to learn how to slow down, focus, and organize their thoughts and behaviors with the help of medication or behavioral treatments. In addition to these skills, children at risk for BD need to learn how to manage extreme mood shifts from destructive hypomania to severe depression with the help of more aggressive medical and behavioral treatment.

ADHD is highly comorbid with pediatric BD (Faraone et al., 1997; Wozniak et al., 1995). Recent research has suggested that the onset of childhood ADHD followed by later BD development might be a certain subtype of early-onset BD (Chang et al., 2003). ADHD, in combination with other factors such as a family history of mood disorders, may be a risk factor for future development of BD. Therefore, it is extremely important to identify the diagnostic criteria for ADHD as well as to delineate the differences between the two disorders. Distinguishing between ADHD and prodromal BD is crucial because there are extremely different medical and behavioral interventions, different parenting techniques that are appropriate, and often great differences in the course and outcome of each disorder.

What is ADHD?

The DSM-IV makes a distinction between three types of ADHD: a predominantly hyperactive-impulsive type, a predominantly inattentive type, and a combined type. The term attention-deficit/hyperactivity disorder (ADHD) is used to refer to all of the subtypes.

According to the DSM-IV (1994) ADHD is a "persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development … symptoms must have been present before age 7 years, … impairment from the symptoms must be present in at least two settings, … [and] there must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning. The symptoms of inattention include failure to give close attention to details or makes careless mistakes in schoolwork, has difficulty sustaining attention in tasks or play activities, doesn't seem to listen when spoken to directly, doesn't follow through on instructions and fails to finish various tasks, has difficulty organizing tasks and activities, avoids and/or dislikes tasks that require sustained mental effort, loses things necessary for tasks, is easily distracted by extraneous stimuli, and is often forgetful in daily activities."

Hyperactivity-impulsivity is defined by "often fidgets with hands or feet, squirms in seat and difficulty remaining seated, runs or climbs excessively or for adolescents a persistent feeling of restlessness, difficulty playing or engaging in activities quietly, appears "driven by a motor", talks excessively, blurts out answers, difficulty waiting turn, and often interrupts or intrudes on others."

Barkley (2000) proposes that attention deficit without hyperactivity may actually be a different disorder than the hyperactive-impulsive type and the combined type. Children with attention deficit disorder without hyperactivity (ADD) appear to be more passive and fearful than other children. They often appear more "spacey" or in a mental fog and not attentive to what is going on in their environment. They appear to be lethargic, sluggish, or slow moving, wandering through life only half-attending to things around them. They are likely to be quiet while working but that does not mean they are attending in an effective manner and often make errors due to the inability to sift out the relevant from the irrelevant material. On a positive note, these kids do not appear as aggressive and have less trouble with their peer relations. Whereas kids with ADHD show more problems with over-activity and impulsiveness, kids with ADD may have more problems with memory, perceptual-motor speed, and the speed with which the brain processes incoming information. Little is known about treatment for ADD though some reports suggest that a lower dose of stimulant medication is useful. However, research has shown that 30% or more of those with ADD do not respond at all to stimulants, compared to fewer than 10% of those with ADHD (Barkley, 2000).

How are Bipolar Disorder and ADHD different?

As mentioned above, many children with BD often first present with ADHD, and it is considered a risk factor for the development of a specific familial subtype of BD. Therefore it is essential that we delineate how the common symptoms differ with each illness.

- In children with ADHD, the symptoms of inattention, hyperactivity, and impulsivity are always prevalent. These same symptoms seem to wax and wane in children with BD depending upon their mood state.
- To obtain a diagnosis of ADHD, symptoms must onset before age 7. When these symptoms onset later in childhood and adolescents, they are more likely to be related to BD. However a child with ADHD may experience a worsening of symptoms later in life (usually closer to puberty). Although they still have baseline problems with attention and behavior, these problems escalate with more severity and duration.
- Children with ADHD may have problems with some mood swings, but they are often less intense than children with BD. Children with ADHD do not display the severely debilitating depressive as well as manic or euphoric features exhibited in children with BD.
- The duration of outbursts and/or tantrums usually differ. Children with ADHD may calm down within half an hour, whereas children with BD may rage for hours.

- Children with ADHD may be struggling in school and with peers but can often manage with interventions, whereas many BD children are unable to attend school and have minimal peer relationships.
- Children with BD typically engage in more risky, impulsive and dangerous behaviors. ADHD kids may engage in dangerous behaviors, often unaware of the dangers, whereas kids with BD can be extreme risk-takers. For example, a kid with ADHD may leave school with friends and get in trouble for ditching. In contrast, a 15 year old girl with bipolar disorder may be getting on the back of a 30 year olds' motorcycle to spend the night drinking with him in the mountains.
- Children with BD tend to have early sexual interest and behavior.

Here are seven proposed criteria for differentiating ADHD from bipolar disorder (Lynn, 2000):
1) Are mood shifts moderate or extreme? Are they characterized by depression, rage, or aggression?
2) Does the child have a first-degree family member diagnosed with bipolar or unipolar mood disorders?
3) Is the child's speech pressured, uninterruptible or hypomanic? Children with ADHD may speak quickly or loudly, but they can often be refocused and slowed down. Children with BD have little or no control over the propensity of their speech.
4) What is the typical nature of the dangerous or risky behaviors that are exhibited? The ADHD child often searches for stimulation in an impulsive manner—reacting to environmental cues. The child with BD often seeks out and engages in risk behaviors while being driven by enormous attention and energy, with minimal sleep—often unable to attend to anything else. As mentioned above, the nature of these risky behaviors are often more destructive and potentially life threatening.
5) Does the child rage (bipolar disorder) or get angry (ADHD)?
6) Does the child appear psychotic—with auditory or visual hallucinations, or unusual thoughts and beliefs? Does the child speak or tell stories that are completely unintelligible and/or illogical? ADHD children can be silly and creative and even tell tall tales, but tend not to have hallucinations, delusions, or thought disorder.
7) Does the child show a decreased need for sleep—able to function well (often like the "energizer bunny") without fatigue with only a few hours of sleep? ADHD children may be hyper or overactive during the day with multiple projects and/or games started and uncompleted, but tend to have more regular sleep habits.

Medication Issues

Typically, ADHD symptoms are successfully treated with medications referred to as stimulants. Commonly prescribed stimulants are Ritalin and Concerta. Other medications such as Strattera have also been used to treat ADHD. However prescribing stimulants can be dangerous if the problematic

symptoms are evident of BD, instead of ADHD. Although there exists conflicting research, it has been suggested that stimulants may trigger or exacerbate manic symptoms in children and adolescents with BD. Also, antidepressants such as Selective Serotonin Reuptake Inhibitors (SSRIs) have been implicated as exacerbating or triggering mania in children with BD, whereas they can be helpful in treating comorbid depressive symptoms in children with ADHD. Proper medication management of symptoms in children requires clinicians to thoroughly examine the nature of overlapping symptoms. However, in those cases where BD and ADHD co-occur, stimulants may help the BD child after his/her mood symptoms have been stabilized with other medications such as mood stabilizers or antipsychotic medications.

Addressing ADHD within the Education Module of FFT-HR

If it is apparent after the initial evaluation that the child has ADHD, the clinician reviews the symptoms of ADHD with the family during the discussion of mood symptoms using a handout of DSM-IV criteria. To delineate the differences between BD and ADHD the clinician shares the table below. It is helpful for parents to understand the difference between ADHD and BD given that ADHD is a suggested risk factor for BD. The family should be quite clear when they are continuing to observe symptoms of ADHD and when the illness has moved into a bipolar presentation.

Table for Psychoeducation Module

Differentiating between ADHD and Bipolar Behaviors and Characteristics

Bipolar	ADHD
Extreme variability in mood	Fairly consistent mood over time
Triggered by particular situations	Consistent across situations
Mood may be effected by time of year/season	Consistent all year
Skills and functioning vary—even when focused	Attention-concentration is key problem
When anger or rage presents, often cannot be redirected or soothed.	Supervision and guidance can help
Can argue for hours	Easily distracted, loses interest in fight
Unbelievable intensity/energy	Energized, but not as intense
Pressured speech	Talkative
Takes big risks/looks for danger or thrill	Does not intend to get into big trouble/eventually learns
Often does better at school	Often does better at home
Medication is often unwanted/seen as the enemy	Medication seen as a tool to help functioning
Internally distracted	Externally distracted
Self-destructive thoughts	Low self-esteem
High energy /inappropriate giggling	Normal laughing/fun
May be overly sexual	Sexuality not major issue

Stimulants may exacerbate or trigger mania	Stimulants improve symptoms
Extreme anxiety fears	Normal worries
Antidepressants may be harmful/trigger mania	Antidepressants can help with associated depressive symptoms
Symptoms worsen/ exacerbate with age	Symptoms improve with age

Many times you will hear parents ask, "How do I know if this bad behavior is due to his ADHD or to his mood disorder?" "Does the nature of the symptoms affect the way I intervene with my child's symptoms or problems?" Since the nature of the symptoms does affect the way the parent may structure an effective intervention or coping strategy, understanding the nature of symptoms is extremely helpful. Since ADHD symptoms are often present before the onset of the more extreme mood symptoms it is helpful to have the parent and child delineate the problems he/she had in elementary school. Problems that may have occurred associated with ADHD might include inability to concentrate, having to re-read chapters, and/or frequently getting out of his/her seat in school. It is helpful for the parents to note how and when these symptoms may have begun and worsened. For example, one child went from getting out of her seat 3-4 times in class, to being unable to sit still at all with continual pacing. Another example might be a mere difficulty in reading progressing to an inability to complete schoolwork at all.

At this point in the education you can help the family decide if they want to chart ADHD symptoms on a mood chart (see **Figure 1 How I Feel** or **Figure 2 Daily Mood Chart** for examples of mood charts that can be modified to chart ADHD symptoms). The family may have a line to delineate ADHD symptoms and mark an X when they have gotten worse or are causing significant difficulty in functioning. Alternatively, the parents may want to rate the ADHD on a 1-5 scale with 1 being no symptoms/no behavioral problems and 5 being very symptomatic/extreme behavioral issues. You and the family can decide how you want to chart ADHD symptoms in addition to mood and this chart can be customized to each family. A chart will help the parents with further delineation of mood versus ADHD symptoms and evaluation of medication effectiveness for each condition.

In addition to listing symptomatic onsets and worsening, it is also important to establish what the child's baseline of functioning has been in regard to attentional, cognitive, and impulsive capacities. Emphasizing the biological nature of ADHD and success of medication and behavior interventions will lessen parent's anxiety about their child's future academic and social functioning. However, parents will need to be wary of significant worsening from baseline functioning and attend to the possible onset of a mood disorder. Again, at this point it is helpful to review that if a mood disorder does develop, exacerbation of symptoms will wax and wane from the child's initial baseline level of functioning.

Parents are also often concerned about the impact different medications can have on their child's mood. It will be important to educate parents about the

efficacy of stimulant treatment in authentic ADHD. However, if mood symptoms are developing, treatment with stimulants may exacerbate the child's mood symptoms and it is possible that they will need to be temporarily removed from their stimulant medications until the mood symptoms are under control with mood stabilizing medications. **Handout 7, Medications Commonly Used to Treat Mood Problems,** will be provided to address various classes of medications used for each disorder. Parents will be encouraged to work collaboratively with their child's physician when changes in mood are detected.

Addressing ADHD within the Communication Module

The communication module of FFT-HR is designed to provide a neutral and nonthreatening framework for discussing family issues. Communication training is the first step to resolving problems that arise in the family. During the communication skills module the family's goal is to arrive at a better understanding of each person's position and feelings as they relate to a personal or family problem. Often, the behavior of a child with ADHD can be extremely frustrating and disruptive to the entire family. It is important to review that the child's "bad" behaviors may indicate a worsening or mismanagement of the illness. It is helpful to remind parents that the child is not a bad child—just exhibiting some difficult behaviors. Also, the child needs to be reminded that he can help control his behaviors with the help of parents and doctors. The child should be taught to note any changes in feelings or behaviors and communicate with parents about self-observations.

Barkley (2000) lists 14 guiding principles for managing ADHD that may be quite helpful in managing mood disorder symptoms as well.
1. Give your child more immediate feedback and consequences.
2. Give your child more frequent feedback.
3. Use larger and more powerful consequences.
4. Use incentives before punishment (positives before negatives).
5. Externalize time and bridge time where necessary.
6. Externalize the important information at the point of performance.
7. Externalize the source of motivation at the point of performance.
8. Make thinking and problem solving more physical.
9. Strive for consistency.
10. Act, don't yak!
11. Plan ahead for problem situations.
12. Keep a disability perspective.
13. Don't personalize your child's problems or disorder.
14. Practice forgiveness.

Many of these points are very similar to the principles of the communication skills module in FFT-HR. Specifically, the first skill taught, Expressing Positive Feedback is a direct reflection of principle 4 above (use incentives before punishment). We ask the family to spend a week or two, depending on whether they are meeting weekly or bi-weekly, catching each other doing positive things and giving positive feedback. It is only after sufficiently

spending time praising each other for positive behaviors that we move to changing behaviors through positive requests and expressing negative feelings about specific behaviors/problem-solving. Even during the portion of communication that addresses changing specific behaviors, we begin with the positive and then move to the negative.

Addressing ADHD within the Problem-Solving Module

The symptoms of ADHD can be distressing to both the child and the family. Most likely, families will focus on the child's poor academic and social functioning and cite numerous examples of missed appointments, lost and broken items, and impulsive and self-destructive behaviors. As mentioned earlier it is important to have the child note how she feels about these behaviors, which often induce feelings of shame, self-doubt, and low self-worth. At this point in treatment, the clinician helps the child and family to anticipate and respond better to problematic situations that will inevitably occur.

Case Example. The mom of a 10-year old became extremely frustrated because the child kept losing his coats and schoolbooks on the bus. There was a great deal of yelling around this topic. The child also acknowledged that he was quite upset because he most recently lost his "lucky" jacket. Also, he was getting upset because of getting "incompletes" on his lost/missing homework assignments.

> After briefly identifying feelings of all family members, the clinician helped the child to generate several possible solutions. The child suggested putting his name and phone number inside his clothing and books, and the mom suggested contacting the bus company to get their address and number to retrieve lost items the same day. The therapist suggested setting up a behavior management plan of rewards when the child remembered to bring home his belongings each day. The child and parent decided upon appropriate rewards. Also, the family was encouraged to examine whether certain illness parameters related to these frequent occurrences. For example, the child realized that by the end of the school day, his distractibility and inability to concentrate worsened significantly. This required a consult with the child's doctor to shift the time of his medication administration.

In addition to aiding the family in problem solving around symptom management, families often need time to discuss issues that have not gone well in the family in general. For example, 16 year-old Melissa who had comorbid diagnoses of prodromal BD and ADHD struggled with special occasions. Whether it was her birthday, someone else's birthday, Christmas, or any other occasion where presents were being received, she had a "meltdown" and in the words of the other family members, "ruined the time for all". We decided to address the problem by going through the problem solving worksheet and coming up with various solutions the family could use for the next special occasion. In this way the family was planning ahead for what they had identified as a problem situation. It is helpful for families to have a sense of mastery over

the various problems that occur given how taxing the symptoms of mood and attentional disorders can be.

Conclusion

In conclusion, FFT-HR for comorbid ADHD and prodromal BD contains specialized education regarding ADHD symptoms and medication. It is very important for clinicians to understand how ADHD and pre-onset BD differ and to be facile in helping the family with various strategies depending on what the family is presenting. Handouts that describe the differences between mood disorders and ADHD, and case examples of children with ADHD, BD, and both disorders are extremely helpful to families in developing behavioral plans for this difficult presentation.

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<u>Supplement to Clinicians' Treatment Manual for the Family-Focused</u>

<u>Therapy of Children and Adolescents at risk for Bipolar Disorder</u> (FFT-HR)

Comorbid Oppositional Defiant Disorder

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Oppositional Defiant Disorder and Bipolar Disorder

Oppositional defiant disorder (ODD) is frequently comorbid with bipolar disorder in children and adolescents (Geller & Delbello, 2003). Preliminary reports from the Stanley Foundation Childhood-onset Bipolar Disorder Consortium reported that 80 percent of children and adolescents with bipolar disorder met DSM-IV criteria for ODD (Post, et al., 2008). ODD is a disorder that puts parents and their children in an entrenched power struggle around what types of behaviors are acceptable or not. Typically, the child expects much more autonomy and freedom than the parent feels is appropriate for the child's chronological and/or developmental age. These children and adolescents tend to push appropriate limits that the parents have set and do not seem willing to compromise.

At times, the parents are responding to demands from the child or adolescent that would be considered age-normative. However, the parent may feel that, due to their own child's immaturity, the child must demonstrate more personal responsibility before more privileges will be granted. Herein lies the problem. Oppositional children have an inordinately difficult time taking responsibility for their behavior and compromising with others.

Given that increasing the child's freedom is contingent on the very behavior that is difficult for the child to display, the parents and child often find themselves in an immovable standoff. Due to the conflict around this pattern, issues related to oppositionality are typically at the forefront of family-focused therapy.

The DSM-IV identifies ODD as:

> A recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months and is characterized by the frequent occurrence of at least four of the following behaviors: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that will annoy other people, blaming others for his or her own mistakes or misbehavior, being touchy or easily annoyed by others, being angry and resentful, or being spiteful and vindictive. To qualify for ODD, the behaviors must occur more frequently than is typically observed in individuals of comparable age and developmental level and must lead to significant impairment in social, academic, or occupational functioning. The diagnosis is not made if the disturbance in behavior occurs exclusively during the course of a Psychotic or Mood Disorder or if criteria are met for Conduct Disorder or Antisocial Personality Disorder.

It is often difficult to look at a list of criteria in DSM-IV format and relate it to the aspects of the child's behavior that a parent may encounter on a day-to-day basis. For this reason Riley (1997) has come up with a practical list of the types of behaviors and attitudes a parent may observe in their child which might lead to suspicion of ODD (Table 1).

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Table 1. List of practical criteria for identifying ODD in a child or adolescent.

Oppositional Defiant Disorder
Source: Riley, 1997

How to tell if your child may have Oppositional Defiant Disorder (ODD).
- Rule 1: Oppositional children live in a fantasy land in which they are able to defeat all authority figures.
- Rule 2: Oppositional children are optimistic.
- Rule 3: Oppositional children fail to learn from experience.
- Rule 4: You must be fair to me, regardless of how I treat you.
- Rule 5: Oppositional children seek revenge when angered.
- Rule 6: Oppositional children need to feel tough.
- Rule 7: Oppositional children believe that if they ignore you long enough, you'll run out of moves.
- Rule 8: Oppositional children believe themselves to be equal to their parents.
- Rule 9: Oppositional children from middle-class homes emulate the behavior of their least-successful peers.
- Rule 10: Oppositional children and teenagers attempt to answer most questions with "I don't know".
- Rule 11: Oppositional logic revolves around denial of responsibility.

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There is inherent difficulty in diagnosing adolescents with bipolar disorder NOS and ODD. *If symptoms of ODD occur only during mood disorder episodes, then the child or adolescent is not diagnosed with ODD*. Given that many children with bipolar disorder are continuously cycling in and out of episodes of mood disorder it becomes very difficult to discern if the defiant behavior is part of the bipolar disorder or if ODD has become an additional piece of the diagnostic picture. Thus, despite the apparently non-overlapping criteria sets for ODD and bipolar NOS disorder, there is difficulty in diagnosing the comorbidity of these two disorders.

If the clinician and/or parents suspect that the child has ODD, the clinician reviews the symptoms of ODD during discussion of mood symptoms in the education portion of FFT-HR. It is quite helpful to parents to have a list of the criteria for ODD. Some parents are relieved because, although their child is oppositional, they realize that he or she does not appear to have the syndrome of ODD. Other parents are relieved to see that their child does meet the criteria for ODD because it helps them focus on how to understand and manage the

oppositional behavior. During this portion of the education the clinician may also inform the parents of the comorbidity rates of ODD and bipolar disorder, major depression, and ADHD in children and adolescents. Learning about the high prevalence rate of ODD in prodromal mood disorder populations may help parents to feel less isolated in their struggles with their child.

You may present this material with or without the child present depending on how defensive he or she may be. Some children who feel particularly labeled by having a mood disorder may feel quite resistant and disheartened by having another label tacked on to their behavior. On the other hand, some kids tend to feel unable to control their defiant behavior and hearing that this may be a condition which can be treated may make them feel more understood. If you are able to discuss the symptoms of ODD in a nonblaming, informative manner the child may be quite open to the discussion and even share some of the experiences he or she has had in the midst of a "defiant episode". It is of utmost importance to read the child's reaction to this material and be on the lookout for more labeling and blaming as a result of identification of the diagnosis by parents and/or siblings.

Contrasting Views on the Relation of ODD to Childhood-onset Bipolar Disorder or Prodromal Bipolar Disorder

Authors of popular books on bipolar disorder have different views on the relation of ODD and bipolar disorder. Unfortunately, none base their observations on empirical studies but rather, clinical observations. Nonetheless, their contrasting views are worth noting.

Papolos and Papolos (1999) do not view bipolar disorder and ODD as separate diagnoses, but instead identify oppositionality as a hallmark trait/behavior in children and adolescents with bipolar disorder or the bipolar spectrum. They have observed that the oppositional behavior frequently occurs in contexts that are stressful for children with bipolar disorder (i.e., transitions). According to these authors, oppositional behavior is not a separate diagnosis but rather an aspect of the bipolar condition.

In contrast, Waltz (2000) distinguishes the two disorders from each other. She gives three reasons for this distinction. First, in the case of ODD the child or adolescent usually has an easily articulated reason for his irritability, tantrums, or aggressive behavior whereas the bipolar spectrum child or adolescent may not have an understanding or even accurate memory of his or her angry or aggressive episodes. Second, children and adolescents with ODD often become oppositional under the influence of peers, which, according to Waltz, is less likely with bipolar children and adolescents. Finally, ODD children and adolescents do not display the elevated or irritable mood fluctuations that occur during the bipolar spectrum child's outbursts. The ODD child/adolescent is characterized as always angry and mean.

Given Waltz's distinction it can be illustrative to have parents rate oppositional behavior on the mood chart designed for children and adolescents with bipolar spectrum disorders. If the ODD symptoms co-occur with the mood disorder episodes then this oppositionality may be more appropriately coded as

part of the prodromal bipolar disorder. If the defiance is more pervasive then there may truly be a separate, comorbid ODD diagnosis. There are different strategies to use with children who only display oppositionality during mood disorder episodes and those with the more pervasive oppositionality characteristics of ODD, as will be discussed.

Ross Greene (1998) has a different conceptualization of children who are comorbid for ODD and bipolar disorder. He notes that besides being diagnosed with ODD, these children are likely to be diagnosed with ADHD, Tourette's disorder, anxiety disorders (particularly obsessive-compulsive disorder), language-processing impairments, sensory integration deficits, nonverbal learning disabilities, and Asperger's disorder. Greene refers to these children that don't fit a specific category in the DSM-IV, *inflexible-explosive*. He views their explosive behavior as "unplanned and unintentional and reflects a physiologically based developmental delay in the skills of flexibility and frustration tolerance" (Greene, 1998, pg. 14). The common characteristics of inflexible-explosive children are as follows:

1) A remarkably limited capacity for flexibility, adaptability and coherence in the midst of severe frustration;
2) An extremely low frustration threshold;
3) An extremely low tolerance for frustration;
4) The tendency to think in a concrete, rigid, black-and-white manner;
5) The persistence of inflexibility and poor response to frustration despite a high level of intrinsic or extrinsic motivation;
6) Inflexible episodes may have an out-of-the-blue quality;
7) The child may have one or several issues about which he or she is especially inflexible;
8) The child's inflexibility and difficulty responding to frustration in an adaptive manner may be fueled by behaviors – moodiness/irritability, hyperactivity/impulsivity, anxiety, obsessiveness, social impairment – commonly associated with other disorders; and
9) While other children are apt to become more irritable when tired or hungry, inflexible-explosive children may completely fall apart under such conditions.

Greene describes these types of explosive episodes as having three phases: vapor lock, crossroads, and meltdown. In the vapor lock phase, the child exhibits early warning signs that he is stuck. This early phase typically begins after a request from parents to "switch gears," to which the child responds with frustration due to cognitive and emotional deficits that inhibit him or her from being able to make these transitions easily. At this initial point, a child may still be capable of rational thought and catastrophe may still be prevented. The crossroads phase is the last chance that parents have to respond in a way that facilitates communication and problem resolution and prevents further deterioration. If the parents do not successfully navigate this phase, then meltdown begins. During meltdown, inflexible-explosive children display their

most destructive and aggressive behavior. During meltdowns kids are thinking irrationally, are not able to listen to parents, are not able to learn or reason, and do not respond well to punishment. In addition, punishment fails to prevent the child from having meltdowns in future frustrating conditions. Sadly, once the meltdown is over these children often express deep remorse for what they have said or done, although they may have difficulty recalling what actually occurred or why they became as upset as they did.

The therapist must show empathy for the parents' and siblings' frustration in dealing with these episodes of seemingly irrational oppositionality. Without acknowledgement of the pain associated with these aversive experiences, families move into an avoidant stance and eventually feel that they cannot continue to live with the oppositional child. Since often these explosions occur in the midst of mood episodes, the child can feel very hurt and rejected by the family once they begin to avoid him or her.

The position taken in FFT-HR is similar to Greene's: children at risk for bipolar disorder who are also oppositional are not seen as having two distinct disorders but rather as having poor emotional self-regulation or inflexibility. As this example illustrates, parents often must contend with hostility in their bipolar/oppositional child, and need to develop strategies for preventing these escalations from occurring. Education, communication and problem-solving skills training can be adapted to the needs of families coping with this combination of conditions in the child. The sections that follow describe these techniques in more detail.

Education Regarding ODD

As mentioned, it is quite helpful to cover the symptoms of ODD after discussing the symptoms of bipolar disorder NOS, cyclothymia, or major depression. Some of the symptoms of bipolar disorder NOS are similar to symptoms of ODD. Some parents wonder how anyone can ever tease these two disorders (as well as ADHD) apart. This often leads to a productive discussion around the importance of observing and being familiar with the child's risk factors and mood cycles so as to be able to anticipate and prepare for the episodes of oppositionality that may occur. Again, if therapeutic, the child may be involved in these discussions to help delineate the triggers for oppositional behavior and his or her particular experience of the defiant symptoms.

During the portion of the education section that covers medications (**Handout 7, Medications Commonly Used to Treat Mood Problems**), parents may ask questions about drugs for ODD. There are not specific medications designed to treat ODD. However, many of the medications that are prescribed for the symptoms of bipolar disorder may be helpful with the anger and rage attacks associated with ODD. For example, atypical antipsychotic medications (e.g., olanzapine [Zyprexa], quetiapine [Seroquel]) are commonly used for agitation, sleep problems, and hallucinations and/or delusions with bipolar disorder. These medications may help children who experience the uncontrollable rage and anger/irritability that go along with ODD to pause before "flying off the handle". In addition, the mood stabilizer Tegretol [carbamazepine]

is commonly used to treat the anger associated with bipolar spectrum disorder and may help with ODD symptoms as well. ODD is not hypothesized to have a relapse/remission course as it is viewed as a relatively consistent behavior pattern. Parents may therefore always be managing symptoms of ODD to one degree or another. However, most of the families in FFT-HR have noticed a remarkable decrease in ODD symptoms with the remission of mood disorder symptoms.

When ODD symptoms do diminish with remission of mood symptoms, it is likely that during a relapse of mood symptoms the child will also have a reemergence of defiant and oppositional behavior. For some families the parents and child identify defiant behavior as one of the initial symptoms of a mood episode relapse. One mother described being at the mall with her daughter who had been effectively treated with Lithium for months. One of the main symptoms that disappeared was the daughter's chronic irritability and oppositionality. While shopping for clothes the daughter snapped at her mother in a manner that was reminiscent of behavior before treatment. In the past, the mother would have seen this as further justification that she had a "bad, disrespectful" kid on her hands. This time she made a call to the psychiatrist and therapist to address a potential relapse of mood symptoms. The daughter had a Lithium level drawn and it was low. The psychiatrist was able to adjust the daughter's Lithium and the oppositional behavior disappeared. Through education about and charting mood symptoms and oppositionality the family was able to catch an early sign of relapse and avoid mood worsening.

As Greene describes families need to exercise their communication and problem solving skills to avert major meltdowns. Medical intervention by the psychiatrist may also be indicated when these oppositional symptoms begin to appear.

Empowering Parents in Learning to Manage Children at Risk for Bipolar Disorder With ODD

Many parents ask what can be done for their children who display noncompliant and defiant behavior in response to limit setting, requests, and family rules. As there are divergent theories about the comorbidity of bipolar disorder and ODD, there are discrepant theories on the treatment of ODD. There appear to be two primary schools of thought. The first proposes a behavioral response to the child's defiant behavior in the form of consequences. The second proposes more of a cognitive approach in working with the child to be able to problem solve and compromise around difficult issues in the family. We employ both of these methods in FFT-HR in different circumstances.

Behavioral Responses: Setting Up Contingencies for Good Behavior

The families we have treated have typically used the behavioral techniques of identifying undesirable behaviors and introducing consequences for those behaviors. There is much support for using consequences in the research literature (i.e., punishment or, at minimum, withdrawal of reinforcers), as outlined in Riley's book, <u>The Defiant Child: A parent's guide to oppositional</u>

<u>defiant disorder</u> (1997). Riley's perspective, based on his clinical experience, views the child as a conscious agent in his or her oppositional behavior. Given that he sees the child as at least to some degree in control of this behavior, it makes sense that his goal is to have the parent use techniques to shift the child's behavior. Some of the consequences designed to shift the child's behavior include but are not limited to:

- Time Out

Time out is a period the child must spend thinking about how his or her thoughts and behaviors have gotten him/her into trouble and how to replace those thoughts and behaviors with others that will not cause trouble. Time out should always begin with a brief, clear description from the parent of the behaviors that have gotten the child in trouble along with an explanation of how long the time out will be. It should end with a brief discussion of the decisions the child has come to about new behaviors, new thoughts, and how to stay out of trouble. This form of punishment may not be appropriate for children over the age of 12. However, adolescents vary in their maturity level and in what feels punitive to them. With a little creativity, a parent may be able to use time out to his or her advantage.

For example, for a 13-year old boy in one of our families, time out was the only intervention that worked during his defiant and aggressive phases. Separating the adolescent from the family appeared to serve two purposes: first, he felt that it was aversive to be isolated in his room; and second, it reduced the level of stimulation to which he was exposed, which helped him de-escalate.

His parents had tried many of the skills learned in FFT-HR (i.e., communication and problem solving) during these episodes. Unfortunately, use of clear communication skills seemed to provoke even more unreasonable and aggressive behavior from him. Removing him from the family seemed to calm him down, and then, after a period of time, the parents were able to return to the FFT-HR skills and come up with possible solutions to help prevent future defiant and aggressive behavior.

- Access to reinforcers and privileges

Privileges and reinforcers come in many forms. They may be favorite foods or drinks, activities, use of objects and devices (i.e., cell phones), designer clothes, and so on. Each adolescent's list is highly individual and it is up to each family to make a list that fits each child. In order to get control of an oppositional child or adolescent the parent must be willing to take control of the reinforcers that are specifically important to him or her, and make sure that he or she does not have access to them unless earned by appropriate behavior. In choosing reinforcers, parents should adopt the premise that everything in the home belongs to them. This includes things that the teen has purchased with his or her own money or items that others have given the teen as gifts.

A child's access to reinforcers should be in inverse proportion to his or her oppositional behavior. The general practice is to remove access to several of the most important ones for periods ranging from one hour to three hours, depending on circumstances. If less intense increments do

not work, the parent must be willing to take away access to <u>everything</u> for periods ranging from several hours to days – whatever is necessary to get the child to change his or her oppositional behavior.

Some of the families we have worked with have chosen to deny the child access to his or her cell phone, car, going out with friends, television and media, and computer access except for educational purposes. This strategy has proven to be quite effective if used in the appropriate way (see examples below).

The families we have worked with have made lists of egregious behaviors and the consequences for those behaviors in the form of lack of access to reinforcers combined with aversive tasks the child has had to perform (e.g., sweeping the garage).

- Level systems

The parent explains to his or her child that, at the end of the day, the parent will briefly give the child feedback on his or her behavior for that day. In the level system, the child's performance today determines the level he or she starts on tomorrow. The level the child is on determines how much or how little access she or he has to reinforcers. Someone on level III gets "usual" access to reinforcers. On level II everything is cut by at least two thirds. On level I everything is taken away.

This system can be overly complex for some families. Parents, however, appreciate having a number of options that they can refer to in times of conflict.

Special Issues in Setting Up Behavioral Contingencies with Children at Risk for Bipolar Disorder

Most families find that the more options and the more creative consequences they have available, the less helpless they feel. In the case of children at risk for bipolar disorder and disobedient behavior, start by empowering the parent through setting up a list of consequences that the parent can enforce. It is helpful to get the child's input on these consequences as they typically come up with better (and often, more stringent) punishments than their parents. However, the child should not construe this to mean that the parent is not the authority and it is important for the clinician to make it clear to the family that the parent has the final word.

It is ideal if the consequence is either a natural consequence of the "offense" or if it is related to the offense in some way (i.e., being physically aggressive to a sibling and then doing that sibling's chores as the consequence). The list of consequences made by each family will need to be individualized and flexible.

Remind parents that they may need to stick with certain plans for a time before abandoning them. Some parents are quick to drop a set of contingencies when the child stops responding. Of course, this teaches the child that all he or she needs to do to uproot a plan is simply to be uncooperative. It is important that the parents make a concerted effort for at least a month before deciding that imposing consequences (combined with rewarding good behavior) will not work.

However, as the clinician, you must keep in mind that if the child is not interested in engaging in this process even the most thoughtful plans will likely be ineffective.

"Time out" may not work with an adolescent. Parents and adolescents may feel it is a waste of time or the teenager may end up listening to music or looking through a magazine if the parent is not continually supervising. If the parents do view time out as useful, ask them to structure it in such a way that the teen spends time in his or her room doing something that he or she may not enjoy but that may be productive. For example, the adolescent may be asked to record on paper which aspects of his or her behavior resulted in receiving a "time out" and what he or she could do differently in the future. The act of journaling may help the adolescent to organize his or her thoughts and think preventatively. Again, each family needs to be creative and attuned to which consequences are appropriate for their teenaged child.

With any consequences for aversive behaviors it is important to monitor how the child is responding to the *duration of the punishment*. If the child perceives that he has no chance of regaining privileges, he may begin to act out due to a sense of unfairness and hopelessness. For example, one 15 year-old female client was grounded for a month and continued to act out in fairly extreme ways. The parents began to feel helpless because all they knew to do was increase the amount of time she was grounded. The girl said that she was continuing to act out because she did not think she would ever have a chance of not being grounded. Because she was being punished, she felt that she might as well behave in a manner deserving of punishment. When the family presented this difficulty to the FFT-HR clinician, she helped them devise a list of offenses and consequences. Table 2 presents the list of behaviors and consequences these parents and this adolescent devised.

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Table 2. Sample offenses and consequences from a family of an adolescent with bipolar disorder and ODD

Offense	Consequence
Borrowing without permission	Not allowed to borrow anything from that person for a week
Continuing to fight with sister when told to stop	Pick up trash bag full of trash
Not doing chores	$5.00 off allowance
Arguing and/or insults	Writing sentences, the worse the offense, the more to be written
Lying	Grounded from TV for two nights

Physical violence against sister	Do sister's chores for one week
Come home late without calling	Grounded next non-school day and/or night
Cussing at mom	Grounded from phone one night
Cussing at sister	Say sorry and give her a hug and do dishes for her
Ditching school	Go to bed one hour earlier for each class ditched

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Greene's Cognitive/Problem-Solving Approach

Although it can be helpful for parents and children to collaborate in creating a list of target behaviors and consequences, many parents report that when the at risk child gets into a particularly bad place, no consequence, threatened or real, makes a difference in his or her behavior. In observing the children and families in our clinic, we have concluded that many have the problems that Greene (1998) identifies in his description of chronically inflexible children. Due to mood swings and what appears to be uncontrollable behavior, even the best laid plans for consequences and reinforcers do not seem to work. These children are truly not in control of their behavior and need parental assistance and guidance at the point at which it is most difficult for the parents to help, due to the aversive nature of the child's behavior.

Greene argues that there are neurophysiological events that lead to oppositional behavior. He proposes that the parents work toward establishing what he calls a more "user-friendly environment" for the child. He uses the analogy that asking these children to navigate their current environments without modification is like asking someone who must use a wheelchair to go up a flight of stairs without a ramp. He recommends several techniques that parents can use to help their children navigate their environment. His framework is built around two basic themes: that it is of utmost importance that the number of meltdowns the child or adolescent has must be reduced, and that the child or adolescent must learn to maintain coherence in the midst of frustration. The parent must figure out ways to help the child establish and maintain coherence even in the most frustrating situations.

Greene lists eight steps toward a user-friendly environment. First, the parent must make sure that all adults in the child's environment have a clear understanding of the child's difficulties and what fuels his or her inflexibility-explosiveness. Second, the parent must carefully establish priorities in the goals they have for their child such that they reduce the expectations and demands for flexibility and frustration tolerance placed on the child. Third, parents need to identify in advance the triggers for inflexible-explosive episodes. Fourth, once the family has identified the warning signs of an episode, they need to have a

plan of action in place when they occur. Fifth, parents should not personalize or misinterpret incoherent behaviors as anything but what they are, incoherent behaviors. Sixth, it is important to understand the ways in which the child's inflexibility-explosiveness may be triggered by the parents and others in the child's environment. Seventh, it is helpful to use a more accurate language that everyone in the family understands to describe aspects of the inflexibility-explosiveness. Finally, parents are encouraged to come to have a more realistic view of whom the child is and what is likely for the child and in the parent-child relationship.

In addition to the items above, Greene proposes a system for reducing the number of meltdowns that occur. He suggests that if there are fewer meltdowns the child will be more coherent in his or her environment and will be more capable of displaying reasonable behaviors. Once enough time has passed, the child will be much more capable of functioning, problem solving, communicating, and relating to others in an adaptive manner. The technique Greene recommends is using a "basket framework" for handling conflict in the home. He proposes labeling behaviors as non-negotiable (basket A items); negotiable (basket B items); or not worth mentioning (basket C items).

The only items in basket A are safety items. These are behaviors about which the parent feels so strongly that they are willing to endure the child's meltdown to ensure their performance. For example, one of our parents decided that a basket A item was restricting her son from spending time with a peer who sold drugs and had spent time in jail. The mother noticed that her son seemed to have been using substances after spending time with this friend. Due to safety concerns, the mother decided that she would endure endless meltdowns in response to her decision to restrict her son's involvement with this peer. Due to the volatility of setting inflexible limits with these adolescents, Greene states that few things should go in basket A. The second basket, B, contains behaviors about which the parent and child must work out a compromise. This basket is quite important for children with oppositional behaviors because it teaches them to communicate with others, take another person's perspective, and problem solve in the midst of conflict. The parent has to be adept at keeping the child from melting down and remaining coherent in the midst of the conflict.

Children at risk for bipolar disorder with ODD often have poor negotiation skills and it may take time for them to learn to compromise. In the meantime, it means a lot of practice and in some particularly entrenched situations, foregoing the item in basket B and putting it into basket C. Basket C is full of behaviors that are not important enough to risk having a meltdown over and should not be mentioned to the child again. For example, if a parent decides that having the child's clothes match when he or she leaves the house is a basket C issue, then the parent should not bother to comment on the child's taste in clothes (unless to compliment, as long as that does not bring on a meltdown). Greene proposes that if the parents feel empowered to prevent a meltdown from occurring, the parent is in a much better position to respond to "vapor-lock" in a rational manner. The parent's response is one of the keys to a successful resolution of conflicts that otherwise would lead to a full-blown meltdown. When meltdowns

occur despite the parent's best efforts, the skills to use are "distraction, empathy, comforting, separating, suggesting an alternative activity – to defuse the situation, restore coherence, and ensure safety as quickly as possible" (pg. 158).

When children have mood disorders, and sometimes become irrational when thwarted, we have found that some of Greene's principles can be employed. How are these principles (as well as the principles of behavioral management discussed above) applied within FFT-HR? This is the topic of the next section.

Addressing Oppositionality Within the Education Module

In the treatment of these difficult children, medical intervention is sometimes the best approach. In other cases, Riley's "consequences" method seems most appropriate and with others, Greene's "problem-solving" approach. FFT-HR for children at risk for bipolar disorder who have ODD combines these three approaches. Through educating families about the cycling of symptoms of prodromal bipolar disorder (e.g., during medication changes, after stressful events) parents become better able to differentiate the defiant behavior that accompanies typical childhood/adolescence from ODD and from the type of defiance that occurs in the context of a mood disorder. Through using appropriate communication skills (e.g., negotiation), families may learn to anticipate when meltdowns are starting to occur and derail them. Through problem-solving, parents and children may be able to set up contingency contracts for preventing future conflicts involving oppositionality.

Addressing Oppositionality Within the Communication Module

The communication module of FFT-HR is specifically designed to provide a neutral format for discussing issues that arise in the family. This is the first step to resolving problems that may arise in the family. During the communication skills module the family's goal is to arrive at a better understanding of each person's position and feelings as they relate to the particular familial problem. This model is quite similar to Greene's proposed technique for averting meltdowns. If each family member is able to see the situation from the other's perspective the possibility of mutual understanding and compromise exists. Many of the oppositional children in the study have been able to describe to parents during communication exercises the negative impact of certain phrases the parents use. For example, one boy shared with his parents that when they threatened him with a punishment in the midst of an argument or if they said, "because I said so" in response to him asking them why he had to do something, a meltdown was imminent. He shared that he was unable to stay coherent once he heard either of these responses. The family worked, through communication, to come up with different ways the parents could respond that would keep the boy in a more coherent frame of mind.

Communication is also quite helpful during discussion of consequences for inappropriate behavior. Typically parents have consequences in place for the child's difficult behaviors but have not discussed with the child how he or she perceives the consequences. For example, one parent sent his child to his room when he became defiant and/or misbehaved in some way. The parent did not

notice a decrease in the child's problematic behavior as a result of this consequence. During communication skills the adolescent shared with his mother that he liked going to his room because his Nintendo was up there and that sometimes he misbehaved so that he would be sent to his room. This discussion led to a new framework for misbehavior and contingencies in the household.

A final benefit of communication skills training is that these children often have significant skill deficits in the areas of communication and compromise. For example, a 15 year-old girl in our program told us that if she budged at all from her position towards a compromise with her mother, even if her mother met her more than halfway, then she felt she was giving in to her mother's wishes. Through the communication exercises she became more practiced at the art of negotiation without feeling overly compromised. Another child, an 11 year-old boy, took charge in one session by introducing skills that the speaker needed to use to facilitate listening. This was his way of introducing structure for his parents who tended to be very verbose and vague in discussions with him. He often felt overwhelmed by the amount of information they gave him and by how unclear the messages were. He was able to empower himself by setting limits with his parents around aspects of their communication that he felt triggered meltdowns for him.

We have found that although communication is very helpful to maintain coherence and rationality in the face of oppositional behavior it is not complete without problem solving.

Addressing Oppositionality Within the Problem-Solving Module

As mentioned, communication skills are essential to the problem-solving process. Everyone in the family must understand and agree with the problem definition, which will require lots of active listening. If this step is not successful the rest of the exercise will not be effective.

When addressing behaviors and consequences the format for problem solving deviates from the traditional FFT-HR problem-solving model. With the FFT-HR model the problem is identified, solutions are brainstormed, pros and cons are delineated, and the best possible solution is chosen. In assignment of consequences for problematic behaviors the family lists the offensive behaviors and consequences are assigned to each behavior according to what seems fitting to all members of the family. As previously mentioned, the child often has the best suggestions for consequences in response to disruptive or problematic behaviors. If the child chooses the consequences he or she may be more likely to follow through with them after a transgression has occurred. It is important during the assignment of consequences to go through the last few steps of problem solving after choosing the best fit for each behavior. These include setting a date to implement the new contingency contract, anticipating what could go wrong during implementation, ideas about how to respond if the new contract is not effective, and reviewing how this set of consequences worked after a trial period. During assignment of consequences to particular behaviors it is imperative that the clinician gets a sense of whether the child buys into the

consequences and is willing to go along with the plan. As mentioned, a child who is unwilling to follow through with the agreed upon consequences can keep the most thoughtful plans from being successful.

FFT-HR problem solving is very helpful to families with an oppositional child. Typically the family becomes embroiled in power struggles with little movement and few options. Through this model the family is able to have a more fluid discussion and identify many options so that the problem does not seem immovable. Again, the child must be engaged and willing to discuss problems and solutions for this to be a collaborative effort. However, the model can be used with only the parent(s), sibling(s), and/or therapist(s) input. For example, a 16 year-old girl in our program was unwilling to discuss any options during problem solving. She would sit to the side and make disruptive noises during the brainstorming portion. The therapist made clear to her that she could choose not to be involved in brainstorming but that she was not allowed to disrupt the process and would need to leave the room if she continued to make noises. Her mother, father, and brother were generating solutions for a family problem. She was able to remain silent during the brainstorming portion and remained in the session. Though she did not offer any solutions, she became quite engaged during the evaluation phase and was able to feel as though she was contributing to the problem solving exercise.

Though oppositional children and adolescents are quite poor at generating workable solutions to problems, they are very skilled at refuting and criticizing potential solutions. These youth are typically not valued for their critical minds because they are typically seen as being negative and argumentative. The FFT-HR model for problem solving helps children learn in areas where they are deficient (i.e., generating hopeful solutions) and shows the family that the child can play an important role as trouble shooter in the process of identifying what can go wrong with proposed solutions. Typically the child has felt that he or she has no role in working with the family. With problem solving he or she may have the experience of being valued for finding what will not work in any scenario. It is often helpful to point out to these children that their keen insight about what can go wrong is invaluable and that they can learn from the other family members how to generate hopeful solutions.

During problem solving, though the child may seem resistant in the beginning, they often come around. Oppositional children have a very difficult time remaining disengaged. Unfortunately, if they are not engaged in the process, they are often engaged in disrupting the process. If the child insists on disrupting the process they may not stay in the room, and the therapist sets this limit the first time disruptive behavior occurs. Hopefully the child will respond to limit setting because it is very helpful to have him or her stay. Even if it appears that the child is tuned out, they are typically listening to everything and often have very good insight about the family process (in an "the emperor has no clothes" fashion). The other reason it is helpful to have the oppositional child in the process is that he or she may object to certain solutions. If the child is not willing to follow through with a proposed solution it is doomed to failure. For example, one family identified this problem: 'how can we keep the egg separator from

being ground up in the disposal again'. One of the solutions proposed was that family members would stick their hands down the drain to see if the egg separator was in there before they turned the disposal on. A 14 year-old boy said that he would never stick his hand down the disposal because he thought it was disgusting. The parents were in favor of this solution and continued to try to argue that this solution was preferable to all the others. The therapist pointed out that if their son was unwilling to follow through with this solution, it did not make sense to choose it. The family eventually chose a solution that everyone agreed to.

Conclusion

Oppositional children and adolescents are very difficult for the family to manage and usually very resistant and disruptive to the process of therapy. Because oppositional characteristics are part of the picture of bipolar disorder and there is such high comorbidity of oppositional defiant disorder (ODD) and bipolar disorder, it is imperative that anyone who works with youth at risk for bipolar disorder also understand and have training in working with ODD. By combining many different methods for addressing oppositional behavior and implementing a response plan in a structured environment, the therapist and family may achieve success in working with this group of disruptive children and adolescents.

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<u>Supplement to Clinicians' Treatment Manual for the Family-Focused</u>

<u>Therapy of Children and Adolescents at risk for Bipolar Disorder </u>(FFT-HR)

Youth with Comorbid Anxiety Disorders

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Anxiety Disorders and Prodromal Bipolar Disorder

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

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

Depending on the presentation of anxiety, managing this symptom cluster in the child can cause a lot of frustration for parents. Often the kids who struggle with anxiety are alternatively needy and defiant. Their anxiety may manifest in needing more support from parents at times and then switch to fear around being too needy and pushing the parents away. Parents often feel confused and frustrated in response to this push-pull from the child. Anxiety may also appear as temper tantrums, rage attacks, or withdrawal in the child making it even more confusing for parents to understand the origins of their child's difficult behavior. Kids with mood or attention symptoms and anxiety may be more likely to abuse substances and therefore complicate the treatment and familial relationship further. Many adolescents do not report feeling relief from anxiety with treatment of their mood. In fact, many report being more aware of their anxiety once the "noise" of the mood symptoms has subsided. They may turn to marijuana or harder drugs, believing that these substances relieve their symptoms of anxiety more effectively than any of their medications.

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

Addressing Anxiety Within the Education Module

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

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

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

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

When medication is covered (**Handout 7, Medications Commonly Used to Treat Mood Problems**), parents often ask questions about medication for anxiety disorders. There are several medications that can be used for managing anxiety. You can educate families on the medications that are addictive (i.e., Klonopin) or that may not be helpful given the at-risk child's vulnerability to mood cycling (e.g., Paxil). This discussion may prepare the family to discuss options

with the psychiatrist and not feel hopeless about addressing this cluster of symptoms.

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

Addressing Anxiety Within the Communication Module

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

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

Addressing Anxiety Within the Problem-Solving Module

Though the symptoms of anxiety are distressing, it is usually the child's maladaptive response to the anxiety that is the topic of discussion in problem solving. If a child has begun to experience extreme anxiety, the family may not be aware of what he or she is feeling. They may, however, notice that the child has begun to self-isolate and spend less time with the family. He or she may

spend time in compulsive ritualizing. This maladaptive coping puts a strain on family relations and becomes the focus of the problem-solving exercises.

For example, Marissa, a13 year-old with bipolar, NOS depression and anxiety, stopped going out to eat with her family. Until recently the family had gone to dinner at their favorite restaurant every Friday night. It was the most significant time they spent together as a family. During the communication module of treatment they learned that she was experiencing obsessions about germs and was beginning to engage in compulsive washing behavior. Though she missed spending time with the family, she felt that going to a restaurant would be very stressful for her.

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

FFT-HR and Specific Anxiety Disorders

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

FFT-HR and Separation Anxiety Disorder

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

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

In this family it was evident how the anxiety problems (fear of being alone) interacted with the mood dysregulation (raging when needs weren't met) in a maladaptive manner. It was very important for the clinician to provide education

about the two different disorders – how the separation anxiety manifested itself and precipitated the exacerbation of the mood symptoms. All agreed (his siblings and his parents) that they found Nate's symptoms stressful but did not know how to change their responses. We used the communication module for Nate to talk to his parents about his fears and concerns related to being separated from them. He also expressed how uncomfortable he found the anxiety. Through talking about the situation the family was able to identify the actual problem – his fears about the dissolution of his family and his difficulty soothing himself when certain anxiety-provoking thoughts arose.

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

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

FFT-HR and Generalized Anxiety Disorder

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

Sandy, a 17-year-old young woman with Bipolar Disorder NOS received a comorbid diagnosis of GAD during the administration of the K-SADS-PL. Her parents described her as "obsessing about things" and being preoccupied with "doom and gloom." They portrayed her as "constantly worried about how others see her," frequently second-guessing what she had said to friends that day and worrying about how it had been taken. They described an incident the previous week during which she had said something to an acquaintance, the acquaintance

had gotten upset, and Sandy became so distressed about having said the wrong thing that she left school for the day. Sandy saw herself as extremely self-conscious and stated that she worried a lot about her future, even thinking frequently that she would die young due to her health problems.

One of Sandy's mood problems involved extreme anger outbursts during which she lost complete control. She became verbally abusive toward her family at those times, threw objects, punched holes in walls and hit or kicked family members. Her parents reported that, at least in some instances, her anger outbursts were preceded by periods of worrying, feeling keyed up, and being unable to relax. In designing Sandy's mood chart, we decided that it would be important to track those periods of worrying and feeling physically keyed up to see how often the anxiety symptoms led to severe mood dysregulation. This proved to be helpful to Sandy as she was eventually able (sometimes) to see a "meltdown" coming in advance and to take steps to try to address the anxiety, rather than, in her parents' words, "Turning it into anger."

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

FFT-HR and Phobias
Specific phobias are commonly observed in the pediatric bipolar population. Sometimes, anxiety becomes associated with a specific stimulus, resulting in a severe anxiety response when confronted with that stimulus. The stimulus is then avoided or endured with significant distress. The patient generally understands that the intensity of the response is irrational and extreme. Rob, a 15-year-old with severe depression, had developed a phobic reaction to a character in a science fiction movie (E.T., the Extraterrestrial). The movie had originally come out when Rob was about five years old and had made a lasting impression on him. For years afterward, Rob was terrified of E.T. dolls, movie advertisements, and memorabilia and even refused to let family members mention the name. Our knowledge of the existence of the phobia emerged during the administration of the K-SADS. On the surface, it seemed that this phobia would not cause much difficulty in terms of Rob's current functioning, because it was a stimulus that could be easily avoided. However, the ten-year anniversary of the release of the film occurred during the course of FFT-HR, and there was quite a bit of media attention to the re-release. Rob's mother brought it up to his therapists before the anniversary date, in anticipation of an increase in the adolescent's stress and anxiety level. We discussed it using the problem-solving exercise when the adolescent was not present. The biggest decision was about whether to name it as a problem for the whole family to discuss or to maintain a more low-key approach to it. The concern was that by labeling it a potential problem and having the adolescent participate in the discussion, we

could be unnecessarily raising Rob's anxiety and creating a self-fulfilling prophecy.

After considering the advantages and disadvantages of both approaches, the mother decided to downplay the issue and see what happened. As it turned out, the re-release passed without any significant crisis. The family did not go to the theater to see it, and although the adolescent maintained his avoidance of talking about the movie and the character, and continued to insist that it was not to be mentioned at home, no further adverse psychological reactions ensued. It's probable that in this case, the severity of the phobic response had actually diminished over time, although the patient's maturity level and need for control over his anxiety level precluded him from being able to confront it directly.

FFT-HR and Obsessive-Compulsive Anxiety Disorder

Many of the youth in our program have components of obsessive-compulsive disorder. These symptoms are very distressing for the child and usually annoying for the family. Sue, a 12 year old with moderate depression, was, at times, immobilized by obsessions. She envisioned herself picking up a knife and slitting her mother's throat. These obsessions were so terrifying for her that she had begun to avoid her mother and spend most of her time in her bedroom. She had never heard of obsessions before and though she did not want to hurt or kill her mother she was very confused by these images and was scared that somewhere inside this was how she really felt. We spent a significant time during the symptom component of the education section discussing the difference between negative thoughts, delusions, and obsessions. We discussed how, though the obsessions were scary for Sue, they did not represent her real feelings about her mother. We also talked about options for managing the obsessions. One strategy was for her to use cognitive restructuring and remind herself when she had the obsessions that they were just part of her chemistry and did not represent her real feelings. We taught her relaxation techniques to use a couple of times during the day each day to hopefully help with the anxiety symptoms in general. We discussed her symptoms with the psychiatrist who recommended a low-dose SSRI. We taught her several distraction techniques. Some of the things that helped when she had the obsessions were playing video games, calling a friend on the phone, snapping a rubber band on her wrist, and riding her bicycle. Through the various techniques she learned in the program she was better able to manage the obsessions and began spending more time with her mother so that her fears of harming her diminished naturally (behavioral exposure). Though she learned to manage her anxiety, once the symptoms of depression lessened her obsessions decreased as well.

FFT-HR and Panic Disorder

Individuals with bipolar spectrum disorders often have panic attacks in addition to mood disorder symptoms. One of the main troubles with panic is that the response of the individual to the panic symptoms can exacerbate the original panic response, either in the moment of an attack or gradually over time. Panic

disorder can be extremely debilitating for the individual and the family. This illness can lead to the child being housebound. Often, the family must completely alter their lifestyle to address the needs and concerns of the child.

There are two parts to treating panic disorder with children. The first involves helping the child cope with the actual panic attack (e.g., learning not to catastrophize internal bodily sensations) and the second centers around helping the child resume typical activities that he or she has given up as a result of fear of having a panic attack. To address managing internal bodily sensations related to panic there is a wonderful 6 minute video of Sesame Street's Grover displaying the 9 easy steps to simulate the sensation of panic on youtube (www.youtube.com/watch?v=fengUNNoM04&feature=PlayList&p=D461D288901 493A3&playnext_from=PL&playnext=1&index=2). Even older teens have responded well to this video whether they want to use simulating panic as a technique or the video opens up lines of communication about symptoms they have experienced. One teenage girl shared that the video helped her feel like maybe her symptoms of panic weren't so weird if they made a video about it.

David, a 17 year-old boy with Bipolar NOS and many symptoms of depression and anxiety, had been having panic attacks for several years. He had become so fearful of having a panic attack in public that he was housebound and did not take part in any family activities. This was a huge loss for his parents and younger sister who missed his presence during their family outings. With appropriate medical treatment the panic attacks stopped but David's fears of leaving the home continued. Given that this problem was one of the most concerning for his family, the clinician addressed this issue early in the treatment using the problem-solving module. The family identified the problem as "not having enough mobility to do things together as a family." They were able to come up with several options to try. Part of the solution involved David trusting that though he may become anxious during an outing, he would be able to handle it with some relaxation techniques the therapist had taught him. The FFT-HR clinician created a relaxation tape that David could use at home twice a day. Once David had learned to self-relax, he worked with his family on imagining different anxiety provoking scenarios (i.e., going to the movies) and then used the relaxation techniques he learned on the tape. Later, when David became anxious, he was able to respond to cues from his mother to use his relaxation techniques. His family was instructed on gradual exposure exercises (e.g., gradual excursions outside of the home) and given reading materials on managing panic disorder using graded exposure techniques. In this manner he was able to manage his anxiety more effectively. He and his family were able to do more together.

Melissa, a 17 year-old girl, was having panic attacks in the morning several days a week. It appeared that she was having panic in response to going to school. Her parents were concerned that she was using panic to get out of going to class and began forcing her to go to school. She began to have even more panic attacks and if she made it to school either spent most of the day in the nurse's office or had to be picked up. We began charting her panic attacks on her mood chart. We added a line for how anxious she felt in the morning

when she woke up, if she felt rested or tired, if she felt like she could go to school or not, if she went to school, and if she had a panic attack. It became very clear from her chart that if she woke up feeling very anxious <u>and</u> tired then she immediately felt as if she couldn't go to school. She knew, however, that she would have to go to school and would end up having a panic attack whether she actually made it to school or not. We decided that our first priority was for her to quit having panic attacks even if that meant that she missed school. On days where she felt anxious and tired she was able to tell her parents that she couldn't go to school without any pressure to try. Within two weeks she wasn't having any panic attacks and was going to school 4 out of 5 days (a first for her in the last two years of school). It appeared that identifying the triggers for panic, charting her anxiety and panic, and having choices around coping strategies changed her pattern of panic.

FFT-HR and Posttraumatic Stress Disorder

Many children with bipolar disorder also have had traumatic experiences in their lives. In some cases, a parent with a mood and/or substance disorder has been abusive. These parents' own mood symptoms may have put their children in situations that are traumatic (i.e., suicide attempts, hospitalizations), or the parents may choose mates who become abusive or tormenting. Thus, the possibility of exposure to trauma is high in pediatric bipolar populations, and by extension, in children at risk for developing bipolar disorder.   Leverich, et al. (2002), found that those with bipolar disorder who endorsed a history of child or adolescent sexual or physical abuse had many more comorbid DSM-IV disorders, a more cycling presentation of the illness, more suicide attempts, and were more likely to have a psychosocial stressor set off an episode than those without early abuse. It is apparent from this research that traumatic experiences are problematic for the present and future course of the illness and for symptomatic outcome.

The triggers that set off a PTSD reaction put the child at risk for mood instability due to his or her extreme vulnerability to stress. This continuous symptomatic presentation is debilitating to familial and social relationships. Though it may be helpful for children to discuss their symptomatic response with family members, sometimes the most helpful response is to get professional support for the child if he or she continues to struggle with PTSD.

Kate, a 16 year old with depression, anxiety, and substance abuse had been quite distant throughout the FFT-HR treatment. She did not connect with the therapist and was very disengaged from her family. Her mother was concerned that Kate seemed distant and withdrawn and didn't show any initiative. Kate complained of extreme anxiety. The psychiatrist prescribed an anxiolytic medication but nothing seemed to alter the anxiety. Toward the end of the treatment Kate shared that the reason she had not engaged in treatment was because she couldn't let go of something she had done that was "horrible". One night while drunk she impulsively left a friend of hers with a boy nobody knew so that Kate could go off with some other friends. Her friend was raped and badly

beaten once Kate left. She said that she would never be able to get past feeling down and anxious because of her part in what happened to her friend.

We spent several sessions brainstorming different treatment options for helping Kate deal with this trauma. We considered medications, individual therapy, and group treatment. She was able to use the communication skills to express her guilt and frustration to her mother, and her mother expressed empathy and understanding toward her lapse in judgment. We also discussed ways in which she could make amends with her friend and how she might help her friend get access to the appropriate post-trauma treatments. Kate began work with an individual therapist who specialized in working with PTSD. She is making progress on managing her anxiety and depression.

Conclusion

Children at risk for bipolar disorder who have comorbid anxiety disorders can be a difficult group to treat. It is imperative that anyone who works with these at-risk youth also has training in working with anxiety disorders. In our FFT-HR study, there have been times when medical intervention has proven successful or the anxiety symptoms have abated when the mood symptoms were under better control. Other times medication has not proven to be as helpful and behavioral techniques taught by the therapist have helped with relief of symptoms. Generally the family and child benefit from using the communication and problem-solving skills to understand and manage the anxiety, regardless of the form it takes. By combining different methods of addressing anxiety and developing a plan to be used in case of symptom exacerbation, a therapist and family may have success in improving these complicated comorbid conditions.

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Supplement to Clinicians' Treatment Manual for the Family-Focused

Therapy of Children and Adolescents at risk for Bipolar Disorder (FFT-HR)

Handling Suicidal Crises

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Handling Suicidal Crises in FFT-HR

In the family-focused treatment of children at risk for bipolar disorder, suicidality may emerge as a concern. As experienced clinicians know, if this issue arises, it must take priority as an agenda. The communication and problem-solving skills can be used to help structure a discussion of this usually highly emotional topic. You will often need to depart from the treatment protocol in order to deal with a suicide-related crisis; you may need to increase the frequency of sessions, make them longer, switch from one module to another (e.g., education to communication skills) or have individual sessions with the child.

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

Assessing Suicide and Thinking Preventively

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

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

- What typically prevents the patient from acting on the suicidal ideation?

In comparing 120 consecutive youth suicides (younger than 20 years old) to 147 matched community controls in greater New York City, results showed that psychosocial factors had an effect size comparable to diagnostic factors in increasing suicide risk. The most notable risks were derived from school problems, a family history of suicidal behavior, poor parent-child communication, and stressful life events (Gould, Fisher, Parides, Flory, & Shaffer, 1996). These results underline the importance of working to improve family communication and bolster strategies for coping with stress in adolescents with mood problems.

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

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

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

Keeping the Child Safe

Several precautions must be taken with a highly suicidal child. You may need to have an emergency session with the child and/or an emergency family session. You must try to negotiate a no-suicide contract with the child. According to Brent & Poling (1997) the child must be able to agree 100% to the following.

1. That he/she will not attempt suicide/harm between now and the next outpatient appointment.
2. The child will inform an adult should he/she feel in danger of acting upon suicidal/aggressive thoughts.
3. Should there not be an adult available when the child feels in danger of acting upon suicidal/aggressive thoughts, he/she will phone or present himself/herself to the nearest emergency room.
4. The child will try to avoid activities and situations that may increase the chance of feeling suicidal/aggressive.

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

Addressing Suicidality Within the Communication Module

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

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

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

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

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

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

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

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

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

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

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

FATHER: You think I'm unhappy about coming to these meetings?
DOUGLAS: I know you've got better things to do. You never had to do this kind of stuff because of Dave.

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

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

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

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

Addressing Suicidality Within the Problem-Solving Module
There are at least two ways in which problem solving can be helpful for suicidal ideation. One is to help the child and family generate a list of alternative behaviors that the child can engage in when suicidal ideation becomes a problem. "Improving the moment" strategies might include relaxing, praying, meditating, going for a walk, taking a bath or a shower, talking to a friend or parent, fixing a meal, watching a favorite video, or reading a book. If there are indications that the child's potential for attempting suicide is high, problem solving can also be used to develop a plan to keep the child safe. This might involve the parents temporarily taking over responsibility for functions the child generally handles. Examples include monitoring medication if the suicide plan revolves around overdose of prescription drugs, or arranging transportation for an adolescent if he or she is deemed unsafe to drive.

Think of suicidal behavior as a problem to be solved. Suicidal ideation and attempts have antecedents and consequences. Determine if the child's suicidal feelings are reliably evoked by specific stimuli (e.g., arguments with certain family members, ups and downs in a romantic relationship). Examine any self-statements that intervene (e.g., "I'll show him (boyfriend) that he can't treat me that way"). A detailed discussion of the chain of events, thoughts, feelings, and behaviors that led up to the last suicide attempt may be quite helpful. The generation of solutions focuses on ways to alter this chain of events (e.g., talking to supportive family members, journaling, listening to music) to derail the self-destructive behavior.

Case example
Here is an example of using problem solving to respond to suicidal ideation in a 17-year-old chronically depressed adolescent. Clare thought about suicide almost daily, even when she wasn't depressed, but her family was unaware of this. She had actually made three somewhat ambivalent attempts, by overdosing on pain relievers and other medications she had found around the house, but these attempts had never come to the attention of her parents. Clare would get ill and vomit, or just sleep the effects of the medication off, and go on as if nothing had happened.

During the psychoeducation portion of FFT-HR, as suicidal ideation was being discussed as a symptom of depression, the family was surprised to learn the extent of Clare's preoccupation with suicide. Her mother denied the danger

of this thinking pattern but her father, who had experienced his own father's suicide, was quite concerned. The problem was defined as, "How to keep Clare safe". Clare's suicidal ideation was so habitual and ingrained that it seemed to have taken on a life of its own, making it hard to identify antecedents. During the generation of possible solutions, the clinician asked several key questions including:

1. Are you (Clare) willing to tell your parents if you become suicidal, and if so, how will you tell them?
2. What kinds of responses from your parents will you experience as supportive?
3. Is it safe for you to be alone when you are thinking this way? Is it safe for you to go out? Is it safe for you to drive?
4. At what point must action be taken? When that point arrives, what needs to happen and who is responsible for seeing that it happens?
5. At what point should the therapist, or physician, be called?
6. How else can your parents help? Where can you (the parents) get help if you are feeling frightened or unsure of how to proceed?

The family was able to agree on a comprehensive plan that enabled the parents to be more tuned in to when Clare was feeling unsafe, and to respond in ways that would reduce the danger. Both parents worked during the day, and Clare, who had left high school, was alone the majority of most days until 3:00pm, when her younger brother got home from school. Clare agreed to try to contact one of her parents when the suicidal thoughts were becoming excessively intrusive, i.e., when she could not put them out of her mind and focus on something else, despite numerous attempts. It was not always possible to reach either parent at work, so her father decided to start carrying a pager. If Clare could not reach either parent, she agreed to page her dad and he agreed to call her at home as soon as possible.

The hope was that brief, supportive contact with either parent would defuse the situation and help Clare engage in something more constructive, like doing her home schooling lessons or even watching TV. It was agreed that the plan would be re-evaluated in two weeks, as it was unclear that Clare would actually initiate contact when she needed to, and it also remained to be seen whether contact with a parent would be enough to derail Clare's suicidal obsessing. Nevertheless, Clare felt less alone with her disturbing thoughts and more protected by her parents.

Self-Injury

Self-injury is a pattern of behavior that can include cutting oneself, burning oneself, hitting or biting oneself, head-banging, interfering with the healing of wounds and even more severe methods of self-harm. According to Conterio, Lader, and Bloom (1999), this problem is appearing more frequently in childhood and adolescence. The self-injurer does not intend to kill herself (most self-injurers are female), but has developed this behavior as a method of coping.

Some of the youth we have worked with exhibit this behavior, so we present here some ideas (many of which are drawn from the book just cited) about how to understand and work with this problem in the context of FFT-HR.

Self-injurers describe many reasons for their behavior. These generally fall into two broad categories: 1) analgesic or palliative aims and 2) communicative aims. The first category includes the common report that cutting helps the self-injurer feel calmer in the face of overwhelming affect or to feel grounded or "real." There is often a sense of self-control that ensues. In this sense, self-injury is like an eating disorder. Although everything in the youth's environment may feel out of control, the eating or self-mutilating behavior is something over which she has exclusive control. Some self-injurers state that cutting helps them feel "cleansed," as if they have released something poisonous or contaminated from within themselves. A similar motive involves the self-injurer who feels excessively guilty and uses self-harm to punish herself for her imagined transgressions.

In terms of communication, many self-injurers say that by transforming their internal pain into observable wounds, they hope to express to others how badly they hurt. Some people cut when they are very angry and have no constructive way to express it. Some cut in the secret (or not so secret) hope of eliciting caring and concern from others.

The significant majority of patients who self-injure come from dysfunctional family systems where they experienced physical, sexual, or emotional abuse or neglect. In these cases, in addition to the aims noted above, the self-injury may represent a recreation of traumatic events from childhood. Nevertheless, it is important to keep in mind that people do develop a pattern of self-injury in the absence of these conditions and that not everyone who experienced a traumatic childhood will become a self-injurer. Conterio et al. (1999) also note that in their work with self-injurers, many patients come from families who "enforced strict and rigid codes of morality and behavior, codes that usually allowed little room for the expression of normal human emotions" (p.76).

There is some suggestion that self-injurers are more likely to be emotionally hypersensitive than non-self-injurers (e.g., negative emotions are too overwhelming to bear, certain sensations like noises or odors are experienced as extremely aversive). In the treatment model described in Bodily Harm, however, self-injury is conceptualized as neither a disease nor an addiction, but as a choice. In FFT-HR, the child is viewed as being challenged by a biologically-based condition that makes self-regulation difficult, but the child must be presented with choices about whether to use coping strategies that, although comfortable and familiar, ultimately do more harm than good. In FFT-HR, he or she can be acquainted with healthier methods of coping with negative affect.

The treatment model described in Bodily Harm involves four key elements. Initially, patients are required to sign a No-Harm Contract which spells out the expectations and responsibilities of both patient and therapist and describes how behaviors that threaten the treatment process will be handled. Designing the contract should be collaborative, with the therapist and patient deciding together what is reasonable behavior and what are fair consequences for stepping out of

bounds. For example, the therapist and patient may agree that self-injury on the day of a session is not acceptable. Both parties should agree on consequences that are therapeutic rather than punishing. In the example just mentioned, it may be agreed that if there is self-injury on the day of a session, the patient foregoes the session. The contract should not be so harsh that the treatment is terminated at the first violation, but the patient may be asked to undergo a period of probation.

The second treatment component is the Impulse Control Log. Patients are asked to keep a diary recording their self-harm urges. Each entry includes:

1. Self-injury thoughts
2. Time and date
3. Location
4. Situation
5. Feeling
6. What would be the result of self-injury?
7. What would I be trying to communicate?
8. Action taken
9. Outcome

The third component is referred to as "The Five Alternatives." This is simply a list of safe alternatives to self-injury. These can be comforting activities or temporary distractions. The fourth component is a series of writing assignments ranging from an autobiography to writing about the emotions surrounding self-injury to writing about "What I can't stand about the people in my life." Each assignment includes specific questions to help focus the patient. Special writing assignments can be designed to deal with specific situations. The authors make the point that, "any tool that helps you slow down, redirect your thinking, channel your energies, and articulate thoughts and feelings will help you navigate emotional distress more effectively" (p. 260). Please see Conterio et al. (1999) for more details on these techniques.

Addressing Self-Harm Within the Education Module
The FFT-HR clinician can use many of the above strategies in the education module. For example, the Impulse Control Log can be incorporated into the mood chart either with a separate line on the chart designated for self-injury or self-injury thoughts. Alternatively, the child can complete the Impulse Control Log in a separate space on the mood chart and then represent when those urges occurred by using an initial (i.e., S-I) on the chart with the mood state that the urges accompanied. When the clinician checks the mood chart he or she can also review any instances of self-injurious thoughts or behaviors. If the self-injurious thoughts are more likely to accompany certain moods then prevention plans can be put in place. "The Five Alternatives" can be generated during a discussion of coping strategies that the child can use when struggling with self-injury impulses. Given that a lot of kids report self-injuring after a fight or conflict with family members a discussion of how family members can help with self-injury can be added to the discussion of **Handout 8, How Can Your**

Family Help with mood problems. Finally, self-injury appears to have a relapse remission course so developing a specific relapse plan for self-injury will hopefully be a helpful addition to mood episode prevention planning.

Addressing Self-Harm Within the Communication Module

Although young self-injurers often harm themselves in an attempt to engage with others (e.g., to express anger or to invite rescue), their behavior often has the opposite effect on other people. Friends and family members are frequently repulsed by the self-mutilation, and may feel frustrated and helpless, with resulting withdrawal from the youth rather than engagement. Clearly, the family needs to play a central role in addressing self-injurious behavior in the child. Parents will need guidance from you in determining what is and isn't helpful.

For example, many parents try to keep the child safe by taking away all potential instruments of self-harm. This can be counterproductive with adolescents. It sends the message that the parents are in charge of controlling the maladaptive behavior and it may exacerbate struggles for control that are already going on between the parents and the adolescent.

Encourage the use of communication skills to help the child talk to her family about her experience of self-injury, including typical triggers, ways in which the behavior feels reinforcing to the child and in particular, ways in which the act is an attempt to communicate distress to others. One of the goals of treatment should be to help the child get beyond self-injury as a mode of communication and to use words to express her thoughts and feelings. Here is an example of an adolescent trying to explain to her family the emotional turmoil she experiences prior to cutting herself. Her parents were asked to use listening skills.

Joyce:	When I'm angry, I feel like I'm out of control. It builds up inside me and when I can't hold it any more, it explodes like a soda can when you shake it up and open it. All the pressure comes out. I feel like I want to kill the person I'm angry at. When I cut myself, it relieves all that. I'm not angry anymore.
Mother:	But doesn't it hurt?
Joyce:	Not really. I know that sounds weird, but it really doesn't.
Father:	So it seems like a better alternative than killing someone.
Joyce:	Well, that's what I think.
Father:	But you wouldn't really kill anyone. And what do you get so angry about anyway?

Joyce:	I get angry about lots of things. I just don't talk about it. I don't want to lose control.

Addressing Self-Harm Within the Problem-Solving Module

Problem-solving skills can be used to help clarify "who takes responsibility for what" in the family's attempts to prevent self-injury. As noted earlier, only the self-harmer can be accountable for the choice to self-harm or not, and the tools suggested by Conterio et al. may be useful in the solution-generation portion of problem solving. Because these tools are designed for the individual therapy context, the FFT-HR therapist may elect to schedule some individual sessions with the child to familiarize him/her with their use. The family, however, will also need guidance about how to respond to a cutting episode. In the case where the self-injury is an attempt to communicate, the family may elect to hold a family meeting after each self-injury episode, so that the child can be gently encouraged to express in words the message represented by the cutting.

Following is a vignette involving a 16-year-old girl with mild depression and ADHD, Alyson, who lived with her mother, her older brother and her mother's boyfriend. Alyson has recently had her first cutting experience and the family is describing it in a family session. Curt (mother's boyfriend) did not attend the session.

Mother:	We had just had a big blow-up about Alyson going over to Jason's (Alyson's boyfriend). It was 10:00 on a school night and Alyson wanted to go over to Jason's house and I said no. Alyson refused to take no for an answer and said she was going anyway. We started arguing and then Curt and Mike (Alyson's brother) chimed in too. We were all pretty much telling Alyson that she couldn't go and that it wasn't OK for her to be so headstrong or disobedient or whatever. It got pretty heated. Alyson charged up the stairs and into her room and I guess that's when she started cutting herself.
Clinician:	Alyson, what do you remember about that night?
Alyson:	Everybody was yelling at me and basically telling me I was a bad kid. When I went up to my room to try to get away from it, Mike had to grab me in the hall and make it worse. He asked me how I could do that to Mom and said she was too stressed out already without me making it worse. When I went in my room, I was really angry but also feeling guilty. I felt so upset, like I couldn't calm down. I kept pacing around. I felt like jumping out the window, like it might feel better to get really hurt and break my bones. I saw the scissors lying on my desk and I got the idea to cut myself. It hurt at first, but when I

	saw the blood coming out, it was calming or relaxing or something.
Mike:	So you're going to blame it on me, because of what I said.
Clinician:	Is that what you're saying Alyson?
Alyson:	No, I guess not, although that comment didn't help.
Clinician:	I guess my belief is that you were having a lot of intense feelings following the argument, and that would be hard for anyone to handle, and especially someone with a mood disorder. But you still have choices about how to handle intense feelings. If you had a chance to replay this scene, what could everyone, not just Alyson, have done differently?

The family went on to explore how things could have gone differently that night. They used that discussion to work through a problem-solving exercise focused on how to prevent future episodes of self-harm. Two solutions were chosen for trial. The therapist invited Alyson to call or e-mail if she felt another urge to cut, as a way to give more time to consider other options besides cutting. The family decided that after an intense argument, they would allow for a brief (half-hour) cooling-off period, and then have a family meeting to try to "debrief" after the argument. During the debriefing, everyone would get a chance to talk about how they were feeling as a result of the argument, but the issue that had prompted the argument would not be re-opened. If Alyson was feeling agitated, angry, upset or guilty after an argument, it would be better for her to communicate her feelings to her family than to try to dissociate from those feelings or to act them out in an indirect way like self-harm. Everyone agreed on this in principle, but whether the plan would work in practice still needed to be assessed. A date was set to re-evaluate the solutions.

The therapist did not opt for individual sessions with Alyson at this point to try to address the self-harm, because this was the first incident and a habitual pattern had not been established. Alyson herself was dismayed at what she had done and was motivated to use healthier coping strategies, so it was hoped that these solutions might address a developing problem.

Conclusion

Suicidality is, unfortunately, not unusual in the treatment of youth at risk for bipolar disorder. You must be knowledgeable about the appropriate questions to ask and what actions to take based on the answers to those questions. If you can obtain a suicide contract, you can proceed to implement some of the outpatient strategies outlined above, utilizing communication skills training and problem solving to deal with the acute crisis. Not all self-destructive behaviors are

motivated by a true intent to die. In those cases, it is most helpful to uncover the child's true intent: what he/she hopes to accomplish or communicate by the self-injury. Nevertheless, all suicidal ideation and self-injurious behaviors must be taken seriously.

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