

Bipolar Disorder in Youth:
Learning to Cope as a Family

David J. Miklowitz, Ph.D.
Professor of Psychiatry
Division of Child and Adolescent Psychiatry
UCLA Semel Institute and
Department of Psychiatry, Oxford University

Upon Hearing the Diagnosis of
Bipolar Disorder...

"The endless questioning finally ended. My psychiatrist looked at me, there was no uncertainty in his voice. "Manic-depressive illness." I admired his bluntness. I wished him locusts on his lands and a pox upon his house. Silent, unbelievable rage. I smiled pleasantly. He smiled back. The war had just begun."

--Kay Redfield Jamison
"An Unquiet Mind" (1993)



BP in Youth is a Serious Illness

- ♦ Chronic or relapsing course, with high rates of:
 - ♦ mixed episodes or psychosis (~1/3)
 - ♦ suicide attempts (~1/3 – 1/2)
 - ♦ comorbid psychiatric illnesses (60%-90%)
 - ♦ hospitalization & functional impairment
- ♦ Onset in youth is a poor prognostic factor
- ♦ Significant rates of nonadherence with medications
- ♦ Highly stress-generating and stress-sensitive

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

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

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

Birmaher, 2004

Bipolar Versus ADHD

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> ♦ Bipolar: ♦ Cardinal manic symptoms ♦ Cyclic course ♦ Poor attention, distractible, impulsive when manic or mixed ♦ Rapid cycling moods, psychosis ♦ Family history of BP ♦ Depressive states ♦ Cycle acceleration on Ritalin | <ul style="list-style-type: none"> ♦ ADHD: ♦ Constant problems with distractibility, attention, organization regardless of mood state ♦ Age at onset younger ♦ Typically not seriously depressed ♦ Improved concentration and reduced impulsiveness on Ritalin |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Geller B et al. J Affect Disord. 1998;51:81-91

Bipolar Versus "Being a Normal Teenager"

Healthy Teen:

- Common to see increases in risk taking, mood instability, family conflict
- Excitement appropriate to context (e.g., Christmas, Senior prom)
- Has "bad days" but functioning generally stable
- "Grandiosity" appropriate to context
- Occasional has a mood disorder symptom without meeting duration or severity requirements
- Occasionally stays up too late, wakes up late, or has problems sleeping

Bipolar Teen:

- Same three factors but to greater degree and associated with school or social impairment
- Excitement/elation inappropriate to context
- Sudden deterioration in functioning
- Inappropriate grandiosity (e.g., "No one knows more than I do") or delusional or hallucinating
- Clusters of manic or depressed symptoms that cycle together
- Up most of the night for several nights in a row, sleeps most of the day

Optimal Treatment Combines Pharmacotherapy with Psychotherapy

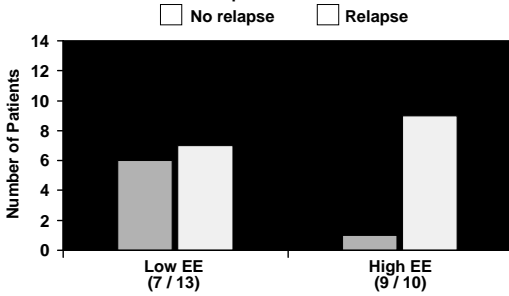
Source: Miklowitz, 2008; Am J Psychiatry

Family-Focused Treatment (FFT) of Bipolar Disorder

- 21 outpatient sessions over 9 months
- Assessment of patient and family
- Engagement phase
- Psychoeducation about bipolar disorder (*symptoms, early recognition, etiology, treatment, self-management*)
- Communication enhancement training (*behavioral rehearsal of effective speaking and listening strategies*)
- Problem-solving skills training

Miklowitz DJ & Goldstein M.J. *Bipolar Disorder: A Family-Focused Treatment Approach*. NY: Guilford Press, 1997.

High Levels of Family Expressed Emotion (EE)
Predict Relapses in a 9-Month Follow-Up of
Adult Bipolar Patients

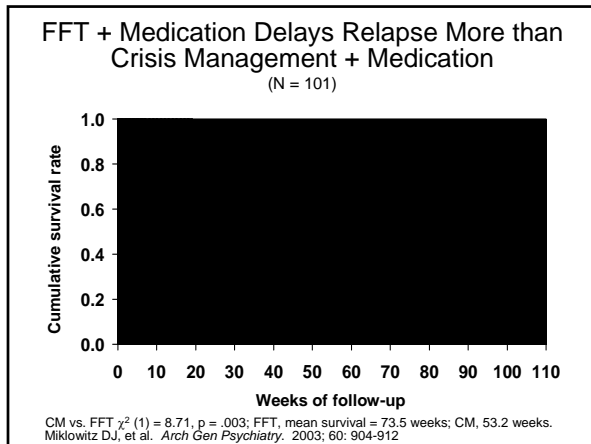


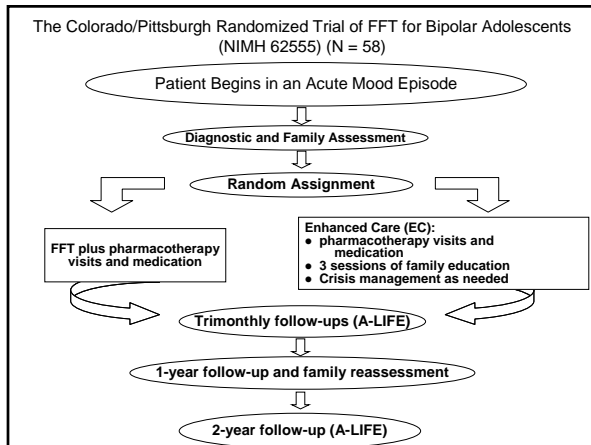
Miklowitz DJ, et al. *Arch Gen Psychiatry* 1988;45(3):225-231.



Is FFT Effective in Improving the
Course of Bipolar Disorder?

Results of Randomized Clinical
Trials

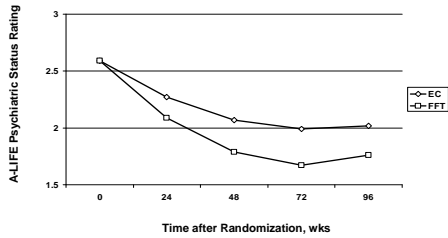




Baseline Patient Characteristics

	FFT N=30	EC N=28	TOTAL N=58
Age, mean (sd)	14.5 (1.6)	14.4 (1.6)	14.5 (1.6)
Female (%)	56.7	57.1	56.9
Non-Hispanic White	80.0	92.9	86.2
Live with both bio. parents (%)	46.7	42.9	44.8
Bipolar I, %	66.7	64.3	65.5
Bipolar II, %	10.0	10.7	10.3
Bipolar NOS, %	23.3	25.0	24.1
Baseline Depression	28.8 (9.3)	28.3 (9.7)	28.6 (9.4)
Baseline Mania	24.5 (9.9)	24.0 (9.2)	24.3 (9.5)

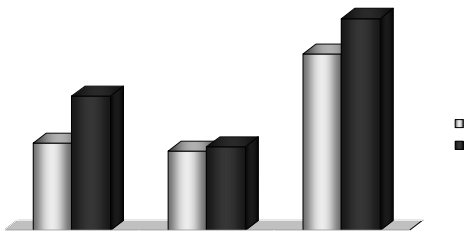
Adolescents With Bipolar Disorder in FFT:
Depression Scores Over Time



Treatment x time interaction, linear effect $F(1, 5014) = 9.15, P = 0.0025$

Miklowitz DJ, et al. Arch Gen Psychiatry 65(9):1053-1061, 2008.

Time in Episode



Depression: $p = .0003$; Mania: $p = .91$; Overall: $p = .07$

Miklowitz DJ, et al. Arch Gen Psychiatry 65(9):1053-1061, 2008.

*Methods of Family-Focused
Treatment*

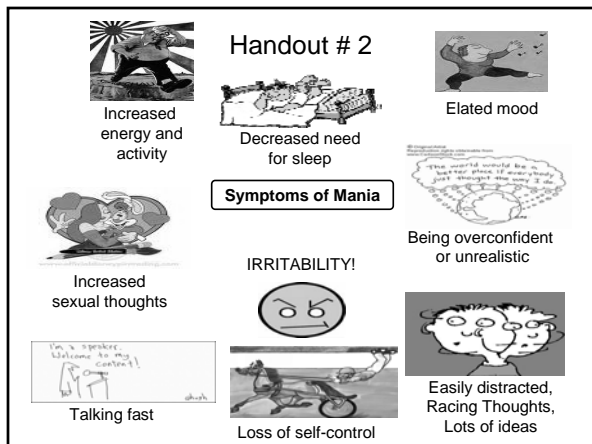
Phase II: Psychoeducation

- ♦ 7+ sessions of *psychoeducation*, covering:
 - ♦ Signs and symptoms of bipolar disorder
 - ♦ The vulnerability/stress model
 - ♦ Identifying precipitating life events

Psychoeducation (Continued)

- ♦ Encouraging medication adherence
- ♦ Keeping the family environment low-key
- ♦ Conducting a relapse prevention drill

Handout # 2



Increased energy and activity

Decreased need for sleep

Elated mood

Increased sexual thoughts

Talking fast

Loss of self-control


IRRITABILITY!

Being overconfident or unrealistic


Easily distracted, Racing Thoughts, Lots of ideas

Symptoms of Mania


Handout # 2b



Low self-esteem



Low mood or sadness




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 # 3

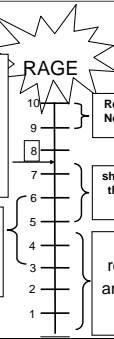
STRESS Thermometer

Things that have stressed you out lately:

Argument with brother

Problems with teacher

Argument with friend



RAGE

10
9
8
7
6
5
4
3
2
1

Things you did to help you feel better:

Self-talk

Isolating myself

Getting something to eat

Use listening skills

Angry – Not really thinking about friends or family (Levels 8-10)

Red Zone: No Control (Levels 8-10)

Irritable, Cranky, snappy... (Levels 4-7)

should tell family that something isn't right (Levels 4-7)

Normal: regular ups and downs... (Levels 1-3)

AWESOME

Handout # 6

Risk Factors in Bipolar Disorder

Risk factors

- ♦ Drug / alcohol abuse
- ♦ Poor sleep hygiene
- ♦ Irregular daily routines
- ♦ Stressful life events
- ♦ Family conflict or distress
- ♦ Provocative interpersonal situations

Miklowitz DJ & Goldstein M.J. *Bipolar Disorder: A Family-Focused Treatment Approach*. NY: Guilford Press, 1997. Permission to photocopy this handout is granted to purchasers of *Bipolar Disorder* for personal use.

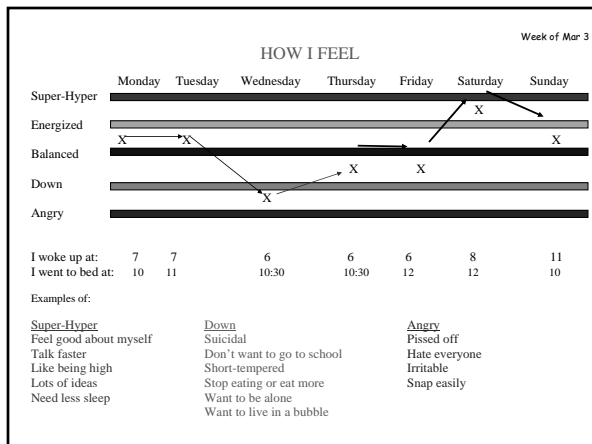
Handout: Siblings

Feelings that kids may have in response to their sibling's mood disorder (bipolar, depression)

- ◆ Trying to be the "good" kid
- ◆ Avoiding your brother/sister
- ◆ Avoiding the family/ Isolating yourself
- ◆ Anger
- ◆ Embarrassment
- ◆ Denying your own needs
- ◆ Taking on the role of holding the family together
- ◆ Being very quiet

Protective Factors and Self-Management Tools for Maintaining Mood Stability

- ◆ Staying consistent with medications
- ◆ Learning as much as possible about the disorder
- ◆ Keeping a mood chart
- ◆ Keeping regular sleep/wake routines
- ◆ Keeping environment low key and predictable
- ◆ Avoiding alcohol and street drugs
- ◆ Developing relapse prevention plans



Promoting Good Sleep Hygiene

Enlist the help of caregivers so the patient can:

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

Relapse-Prevention Contracting

- ♦ Develop plans when patient is euthymic
- ♦ Empower the patient: frame this as “a way to maintain control over your life even when your mood starts to change”
- ♦ Identify “agents of the plan” (relatives, friends, clinicians)
- ♦ Explain that there is a brief window of opportunity in which early intervention may prevent hospitalization
- ♦ Strategize about an early response plan: “What should others do if your mood starts to change?”

Elements of an Early Response Plan for Escalating Mania

- ♦ Contact physician for an emergency appointment or have a small supply of antipsychotic medication available
- ♦ Be aware of hospital resources and admission procedures
- ♦ Keep environment structured and low key
- ♦ Stay away from alcohol and drugs
- ♦ Keep consistent sleep/wake cycles

Elements of an Early Response
Plan for Escalating Mania (Continued)

- ♦ Bring someone you trust with you when you go out at night
- ♦ Get help managing money, give up car keys
- ♦ Avoid making major life decisions (use 2-person rule, 48-hour rule: "if it's a good idea now, it'll be a good idea then")¹

¹Newman CF, et al. *Bipolar Disorder: A Cognitive Therapy Approach*. Washington, DC: American Psychological Association, 2001.

Encouraging Medication Adherence

- ♦ Develop cues for pill storage and use
- ♦ Examine the role of medications in the patient's family or marital relationships
- ♦ Examine subtle or overt pressures from family members to discontinue medications
- ♦ Clarify the "symbolic significance" of taking medications (e.g., loss of creativity, giving up of emotions)¹
- ♦ Encourage "grieving over the lost healthy self"²

¹Miklowitz DJ & Goldstein MJ. *Bipolar Disorder: A Family-Focused Treatment Approach*. NYC: Guilford Press, 1997.
²Frank E, et al. *Biol Psychiatry* 48(6):593-604, 2000.

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

- ♦ If kid is to take responsibility, he or she must buy into the diagnosis and treatment plan
- ♦ The kid must be cognitively able to handle the dosing requirements
- ♦ Issue of boundaries - is kid more or less likely to take meds. if parents take a directive role?
- ♦ Older kids are more likely to be able to take responsibility than younger kids
- ♦ Make sure that medications do not become the battleground in which autonomy battles are fought

How Do I Handle Irritability, Provocations, Oppositionality? (I)

- ◆ Keep in mind the mantra: "Don't let your child's mood determine everyone else's mood in the family"
- ◆ Note difference between "process orientation" and "outcome orientation"
- ◆ Introduce collaborative problem-solving early in the escalation
- ◆ Use Ross Greene's "basket" approach: What are the issues I can let go, which do I strongly enforce, and which should be negotiated?

How Do I Handle Irritability, Provocations, Oppositionality? (II)

- ◆ Try to use "self-soothing" techniques: self-talk, breathing, giving yourself a time out
- ◆ Communication training and the "three volley rule" – your part of the argument ends after 3 volleys
- ◆ Exit confrontations that are getting destructive
- ◆ Impose consequences (if effective!)
- ◆ "Creative consequences" – taking a ride, bringing over other relatives
- ◆ Call police if necessary

How Much Should We Tell Others About What's Going On?

- ◆ What's the purpose of the disclosure? What do you expect to achieve? Are others affected by the kid's behavior?
- ◆ Who should be told - teacher? Parents' friends? What do you want them to do with the information? Does the kid need "reasonable accommodations?" in class?
- ◆ Is purpose primarily to alleviate parents' own distress? If so, consider support group as setting for disclosure
- ◆ Involve adolescent in this discussion so that he/she doesn't feel that confidentiality was violated

Summary - I

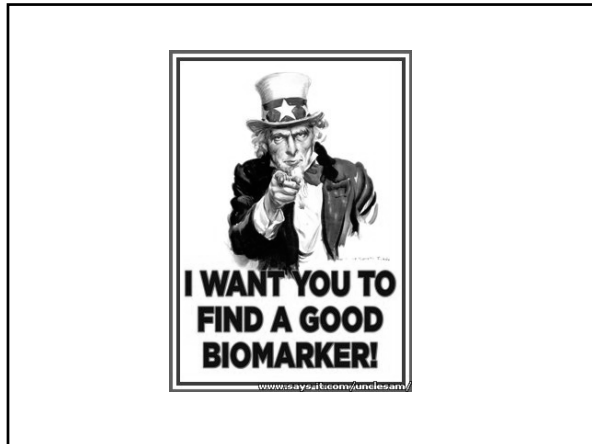
- ◆ Even optimal pharmacotherapy provides less than ideal prophylaxis in patients with bipolar I disorder
- ◆ Psychosocial treatment should be a key component of the outpatient management of bipolar patients

Summary - II

- ◆ FFT focuses on:
 - ◆ Building a strong alliance with the patient
 - ◆ Providing self-management tools
 - ◆ Enlisting the support of family members
 - ◆ Removing barriers to treatment adherence
 - ◆ Developing relapse prevention plans
 - ◆ Enhancing skills for communicating and solving problems

Self-Help Books on Bipolar Disorder

- ◆ *The Bipolar Disorder Survival Guide* – D. Miklowitz (2002)
- ◆ *The Bipolar Teen* – D. Miklowitz (2008)
- ◆ *The Bipolar Child* – D. Papolos & J. Papolos (2002)
- ◆ *New Hope for People with Bipolar Disorder* – J. Fawcett et al. (2000)



Research Collaborators: 1985–2010

Graduate Students

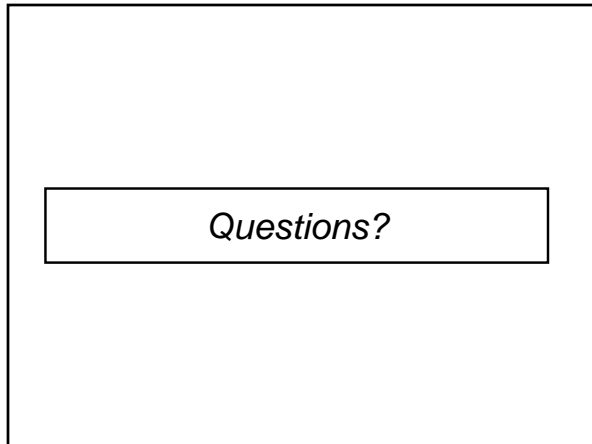
Eunice Kim, Ph.D.
 Elizabeth George, PhD
 Tina Goldstein, Ph.D.
 Kimberley Mullen, Ph.D.
 Adrine Biuckians, Ph.D.
 Aparna Kalbag, Ph.D.
 Jerold Phelps, Ph.D.
 Kristin Powell, Ph.D.
 Teri Simoneau, Ph.D.
 Victoria Cosgrove, Ph.D.
 Jennifer Sacher, Ph.D.
 Jeffrey Richards, M.A.
 Aimee Sullivan, M.A.
 Jedediah Bopp, M.A.
 Jessica Lunsford
 Chris Hawkey

Co-Investigators

Michael Goldstein, PhD
 Keith Nuechterlein, Ph.D.
 Ellen Frank, PhD
 Barbara Dausch, Ph.D.
 Natalie Sachs-Ericsson PhD
 Richard Suddath, MD
 Dawn Taylor, PhD
 Boris Birmaher, MD
 David Axelson, MD
 Chad Morris, PhD
 Chris Schneck, MD
 Cheryl Chessick, M.D.
 W. Ed Craighead, PhD
 Marianne Wamboldt, M.D.
 J. Mark Williams, Ph.D.
 Gary Sachs, M.D.
 Guy Goodwin, M.D.
 John Geddes, M.D.

Funding

NIMH Grants MH
 43931, 55101, 42556,
 62555, 073871, 077856
 NARSAD Distinguished
 Investigator Award,
 Young Investigator
 Award
 MacArthur Foundation
 Sutherland Foundation
 Alberts Foundation
 Univ. of Colorado



Questions?

Promoting Adherence to a Mood Stabilizer Regimen

- ◆ People with bipolar disorder are more likely to commit to a mood stabilizer regimen if
 - ◆ They receive information from mental health professionals about the disorder and how the medications will help
 - ◆ They are approached with compassion and with acknowledgement that taking medications doesn't change one's identity
 - ◆ It is their own decision and not one foisted on them by others
 - ◆ Dosages can be adjusted or other medications substituted to control side effects

Effective Ways to Inquire About Medication Adherence

- ◆ Ask the patient
 - ◆ Do you have any difficulty taking all your prescribed medication?
 - ◆ Do you ever try to cope on your own without the medication?
 - ◆ Many people miss taking their medications from time to time; how has it been for you?
 - ◆ In your opinion, will medications will help you to attain personal goals?

Scott J. Br J Psychiatry 178(Suppl 41):S164-S168, 2001.
Miklowitz DJ & Goldstein MJ. Bipolar Disorder: A Family-Focused Treatment Approach. NY: Guilford Press, 1997.

Reasons to Involve the Family in the Psychoeducational Treatment of Bipolar Children and Teens

- ◆ Adolescents and younger bipolar patients are usually living with their parents and siblings
- ◆ Often, more than one family member suffers from bipolar disorder
- ◆ Mood symptoms can be triggered by negative family interactions
- ◆ Supportive family relationships can positively affect the course of bipolar disorder
- ◆ Parental education and "buy-in" is essential to assuring the child's compliance with medications
- ◆ Siblings' adjustment is affected by BD in a brother or sister

Use of a Relapse Prevention Drill

Alexis, age 16, was diagnosed with bipolar NOS after a suicide attempt. She had frequent outbursts of rage that caused significant conflict in her family. In the third FFT session, the clinicians encouraged Alexis and her parents to identify the triggers, prodromal signs, and potential palliative strategies for her rage reactions. Her reactions were often precipitated by family arguments or multiple requests from parents that confused her and she could not prioritize. She developed a "stress thermometer" which clarified the stages of her negative escalation. Alexis and her parents were then encouraged to use a variety of emotional self-regulation techniques at the beginning of Alexis's rage escalation, including:

- Admitting that "something isn't feeling right"
- Paraphrasing each others' statements to slow down negative interactions
- Using calming self-talk
- Mindful breathing
- Exiting the situation or isolating oneself
