Family-Focused Treatment for Bipolar Disorder in Adults and Youth

▼

Chad D. Morris

University of Colorado at Denver and Health Sciences Center

▼

David J. Miklowitz

University of Colorado, Boulder and University of Colorado at Denver and Health Sciences Center

▼

Jeanette A. Waxmonsky

University of Colorado at Denver and Health Sciences Center

Levels of familial expressed emotion during an acute episode are consistently associated with rates of recurrence among bipolar patients. This article briefly reviews the evidence for expressed emotion (EE) as a prognostic indicator and then illustrates family-focused treatment (FFT) with adults and adolescents suffering from bipolar disorder. FFT is a time-limited, modularized treatment consisting of psychoeducation, communication enhancement training, and problem-solving skills. Controlled trials indicate that FFT is an efficacious adjunct to pharmacotherapy for patients with bipolar disorder. We describe its recent application to early onset bipolar patients and include a clinical vignette. © 2007 Wiley Periodicals, Inc. J Clin Psychol: In Session 63: 433–445, 2007.

Keywords: bipolar disorder; expressed emotion; psychosocial treatment; family-focused therapy; adolescents; psychoeducation

Introduction

Between 15 and 18% of patients suffering from bipolar disorder have their initial onset before the age of 13 years, and between 50 and 66% before the age of 19 years (e.g., Leverich et al., 2002). Thus, the onset of bipolar disorder typically occurs during critical

Correspondence concerning this article should be addressed to: Chad Morris, 4455 E. 12th Avenue, A011–11, Denver, CO 80220; e-mail: Chad.Morris@uchsc.edu

JOURNAL OF CLINICAL PSYCHOLOGY: IN SESSION, Vol. 63(5), 433–445 (2007)
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20359

developmental phases for acquiring physical independence and psychological autonomy, and has wide-ranging effects on a child's current functioning as well as his or her psychosocial developmental trajectory. The early onset form is characterized by frequent mixed episodes, continuous cycling, suicidality, psychosis, and comorbidity with disruptive, attention deficit hyperactivity, anxiety, and substance-misuse disorders. Developmental tasks such as identity consolidation, relationships, academic success, and autonomy are often interrupted (e.g., Miklowitz, Biuckians, & Richards, 2006).

The symptoms of bipolar disorder frequently lead to impairments that place emotional, economic, and pragmatic burdens on the family system. Given the degree of individual and interpersonal turmoil that bipolar symptoms can cause, it is not surprising that it is a major contributor to the worldwide disease burden of mental illness, second only to cardiovascular conditions in causing lost years of healthy life worldwide (Murray & Lopez, 1996).

Pharmacotherapy has widely been viewed as the treatment foundation for acute episodes, ongoing relapse prevention, and symptom control of bipolar disorder. Medications often decrease acute symptoms to levels where it is possible to effectively employ illness planning and enhance psychosocial skills. Unfortunately, 55 to 70% of adult and early onset patients have recurring illness episodes within a 2- to 4-year period even when maintained on pharmacotherapy (e.g., Geller, Tillman, Craney, & Bolhofner, 2004).

Bipolar patients—both young and old—are highly prone to medication nonadherence. In one study (Miklowitz, Goldstein, Nuechterlein, Snyder, & Mintz, 1988), only about 30% of young patients with recent-onset mania took their medications on a routinely scheduled basis during a 9-month follow-up. Unfortunately, relapse frequently occurs following the sudden discontinuation of medications. Some of the reasons bipolar individuals choose to discontinue medications are societal stigma, medication side effects, perceived loss of control, and the belief that they will not have another episode (Colom et al., 2000).

The psychosocial and systems aspects of bipolar disorder are not adequately addressed through medication alone. There is growing evidence, including data from randomized controlled trials, that psychosocial interventions play a significant role in enhancing patient outcomes (e.g., Jindal & Thase, 2003) and that the effectiveness of interventions appears to be maximized over several years (Vieta et al., 2005). This article describes and illustrates a family-based program for treating bipolar disorder across the life span: family-focused treatment (FFT).

Frameworks for Family-Focused Treatment

Biopsychosocial Framework

Utilizing a "biopsychosocial" framework, family-based approaches to bipolar disorder seek to balance protective and risk factors in the social and family environments. Family psychosocial treatments for early onset bipolar disorder attempt to catch families when conflict and criticism play their most influential role on the development of emotional competence. A family structure providing stable routines (e.g., sleep), consistency in caretaking, and external structure helps children develop internal controls and emotional self-regulation strategies. Through providing education about illness-management strategies, family psychoeducation may increase families' abilities to provide this structure, enhance patients' adherence to pharmacotherapy, and delay and reduce the number of relapses (e.g., Miklowitz, 2006).

Expressed Emotion Research

Past research strongly suggests that how family members relate to one another influences the course of schizophrenia, bipolar disorder, and other mental disorders (Butzlaff & Hooley, 1998). "Expressed emotion" (EE) is a measure of the emotional attitudes of caregivers/relatives toward a family member with a psychiatric disorder. Based on a clinical interview, a relative is considered "high EE" if he or she expresses a high number of critical comments, makes one or more statements of hostility, or shows emotional overinvolvement (i.e., overprotective, exaggerated emotional responses, or inordinate self-sacrifice) when describing interactions involving the patient.

Numerous studies have found that high-EE family environments are associated with poorer outcomes of schizophrenia, bipolar disorder, and other psychiatric disorders. A meta-analysis found that the EE construct had strong effect sizes for predicting recurrences of psychosis in schizophrenia, but that the mean effect size for EE as a predictor of recurrences in mood disorders was even greater (Butzlaff & Hooley, 1998). There is a clearly documented link between high-EE families and relapse among patients with bipolar disorder (e.g., Miklowitz et al., 1988; Miklowitz et al., 2000). Retrospective and prospective studies have found that risk for relapse and/or hospital admissions among patients in high-EE families is from five to nine times greater than the risk among patients in low EE families (e.g., Miklowitz et al., 1988; Priebe, Wildgrube, & Muller-Oerlinghausen, 1989).

During the post-episode period, high-EE caregiver–patient dyads are frequently embroiled in "attack–counterattack cycles" that are difficult for either member of the pair to bring to resolution (Simoneau, Miklowitz, & Saleem, 1998). Moreover, high-EE relatives are more likely than low-EE relatives to attribute negative patient-related events to personal and controllable factors of the patient (Wendel, Miklowitz, Richards, & George, 2000). These are two major foci of FFT: (a) decreasing negative interactions and (b) helping relatives and patients to agree on the likely causes of bipolar disorder, the limits imposed by the disorder, and the influential roles of risk and protective factors.

Clinical Methods of FFT

Treatment Structure and Content

The development of FFT was inspired by the consistent findings concerning EE in the course of mood disorders. The FFT model encourages use of all available tools, including medication, skills training, and self-management strategies. Treatment is presented in modules focusing on two interrelated themes: (a) the need for information to assist relatives and patients in understanding and coping with the disorder, and (b) communication and problem-solving skills training to modify unproductive cycles of family interaction. FFT also strives to make patients and their relatives "educated consumers" who can effectively advocate for appropriate treatment.

Table 1 outlines the core elements of FFT, which targets Bipolar I or Bipolar II patients who are actively ill or have begun to stabilize from an acute episode of mania, hypomania, mixed disorder, or depressive disorder (including rapid cycling). FFT allows flexibility in whom to involve in treatment, which may include parents, children, spouses, siblings, and other significant relatives or caregivers in a person's life. For example, in some cases a family friend might be considered critical to the care of the patient and to the functioning of the family. Unlike some multifamily group psychoeducation models (e.g., NAMI's Family-to-Family program; Dixon et al., 2001), FFT works with one family at a time and actively involves patients in the psychoeducational process.

Table 1
The Six Objectives of Family-Focused Treatment

Assist the patient and relatives in:
- Integrating the experiences associated with mood episodes in bipolar disorder
- Accepting the notion of a vulnerability to future episodes
- Accepting a dependency on mood-stabilizing medication for symptom control
- Distinguishing between the patient's personality and his/her bipolar disorder
- Recognizing and learning to cope with stressful life events that trigger recurrences of bipolar disorder
- Reestablishing functional relationships after a mood episode

FFT is typically administered in 21 sessions (weekly, biweekly, then monthly) over 9 months, although shorter models have been tested with younger patients (e.g., Miklowitz, Mullen, & Chang, in press; Pavuluri et al., 2004). In the first segment, families learn about the nature, symptoms, course, and treatment of bipolar disorder; the notion that episodes come about as an interaction between genetic, biological, familial, and social-environmental risk or protective factors at different phases of development; the importance of continued adherence to medications; and the role of stress management in reducing the likelihood of future episodes.

Collaborative Care Approach

In imparting this didactic information, the FFT clinician strives to develop a working alliance with the patient and family. The clinician helps families make sense of the interactive roles of biological predispositions, stress, functional impairments, and personal responsibility for change. Acceptance of the patient's and family's efforts to cope with their situation, even if dysfunctional, is critical to building a strong working alliance.

Strategies to promote "collaborative care" have been found to decrease patients' hopelessness and enhance life functioning over time (e.g., Morris et al., 2005). Collaborative care emphasizes training patients and families in self-management strategies and engaging relatives in joint patient–provider care planning. Attention to the therapeutic alliance—showing respect and acceptance, and giving the patient and family members the sense that their opinions are essential to the treatment plan—increases adherence to and the overall success of treatment. For example, the objectives of FFT do not contain any presumption that the family was "dysfunctional" prior to the onset of the illness. Rather, the core assumption is that when the family understands the disorder and its precipitants, learns skills to minimize family conflict, and follows an illness-management program, the short- and long-term outcomes of the disorder will be improved.

Relapse Prevention Planning

A key part in the initial psychoeducational sessions is the relapse-prevention drill. Patients and families are asked to identify contexts that historically have put the patient at heightened risk for relapse, such as travel, holiday visits, or alcohol and drug use. Clinicians coach patients and families to recognize individual prodromal signs of mania or depression, such as changes in mood, activity level, sociability, thought patterns, sexual drive, sleep, or appetite. Then, clinicians instruct families in creating a relapse plan documenting the concrete steps that the patient and family can take if the patient begins to experience increased symptoms. Planning becomes a "psychiatric advance directive" for specific

actions such as identifying who will call the clinician, the ways in which relatives should communicate with an increasingly symptomatic family member, and how to keep the environment structured and low in stress.

Skills Training

Communication enhancement training (CET), generally begun by Session 8 and continuing for 7 to 10 sessions, uses behavioral modeling and rehearsal to teach clear and direct communication of positive and negative feelings (i.e., praise or constructive criticism), active verbal and nonverbal listening strategies (e.g., nodding one's head, paraphrasing), and making positive requests for change in another family member's behavior. Families practice these skills (e.g., diplomatically asking another family member to talk in a softer tone of voice) between sessions. These techniques are directed at reducing levels of high EE and negative relative/patient interactional behaviors.

The last four to five sessions of FFT (Months 6–9) concentrate on engaging the families in problem solving. Treatment has been tapered to biweekly or monthly at this point. Families first agree on the definition of a problem, brainstorm several possible solutions, evaluate the advantages and disadvantages of each proposed solution, agree on one solution or a set of solutions, develop an implementation plan, and review the status of the original problem. Initially, problem topics that do not have a strong emotional charge (e.g., planning a vacation) are used in training exercises, allowing families to have a successful experience with problem solving before tackling more significant concerns.

The final sessions are devoted to termination and the review of goal achievement. If the family is still having significant difficulties, or the patient is still unstable and/or medically nonadherent, additional booster sessions are scheduled.

FFT for Bipolar Youth

The psychoeducational model is distinct from the traditional family systems view, which tends to pathologize family relationships and the attempts of caregivers to manage the disorder. Through its collaborative-care approach, FFT endeavors to avoid blame and strengthen the protective influences of family relationships. This collaboration is presumed to be especially important in the early course of the illness, when the balance of risk and protective factors can have significant long-term consequences for the child's developmental trajectory.

In FFT for adolescents (e.g., Miklowitz et al., 2006), families are provided education and skills training relevant to the unique characteristics and developmental problems of teenagers. These problems include rapid onsets and offsets of irritable and/or depressed moods, severe oppositionality, disturbances in sleep/wake cycles, and high levels of family conflict. Comorbidities with attention deficit hyperactivity, anxiety, and conduct disorders also can be important foci depending on the teen's clinical presentation.

Sessions with youth and their families include clarification of the boundaries between bipolar symptoms and the normal turmoil of adolescence. During adolescence, the stage-salient developmental tasks include the successful transition to high school, psychological autonomy, developing same- and opposite-sex friendships and romantic relationships, and developing a coherent sense of self. These tasks can be derailed by the onset of bipolar disorder during or prior to adolescence. The FFT clinician normalizes adolescent developmental struggles and helps distinguish them from the impairments associated with clinically significant mood swings.

Treatment sessions often include strategies to put parents back in charge of their teen's healthy development, with consideration of the level of functional capacity of the child and his or her mastery of developmental tasks. For example, parents of a stable, older teen are encouraged to negotiate with the teen about sleep and wake hours, when she or he should be back home for the night, and showing respect for others in the home. Parents of a younger teen who is unstable are encouraged to take a more active role in encouraging treatment adherence, enforcing household rules about bed- and wake times, and providing daily structure for the teen. Next, we illustrate the use of FFT for youth by presenting a treatment case of an adolescent suffering from bipolar disorder and her family.

Case Illustration: Jenna

Jenna, a 16-year-old patient with bipolar disorder, her mother Kathryn, and her 13-year-old brother Justin received FFT for 21 sessions over 9 months. The children's father had left the family before Justin's birth, and there had been no further contact. Based on the Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (KSADS-PL; Kaufman et al., 1997), a research diagnostician identified Jenna as having Bipolar I disorder, with an acute mixed episode in the prior 3 months, and comorbid oppositional defiant disorder. Two months prior to starting FFT, Jenna had been hospitalized following a rage episode in which she had caused household destruction, threatened violence to her mother and brother, and attempted to jump out of a moving car while on the way to a psychiatric appointment. At the beginning of FFT, Jenna had "dysphoric hypomania," marked by irritability, agitation, and subsyndromal symptoms of depression. Throughout the FFT sessions, Jenna was regularly seeing a psychiatrist and receiving a consistent regimen of mood stabilizers (Depakote and Seroquel).

During the initial three sessions, the two clinicians (a primary psychotherapist and a trainee) explained their view that bipolar disorder needs to be managed biopsychosocially. First, they encouraged Jenna's ongoing work with her psychiatrist for medication management. Second, they emphasized coming to understand the impact of bipolar disorder on Jenna and her family as a necessary precursor to developing realistic communication and problem-solving skills. The therapists provided didactic material about bipolar symptoms, diagnosis, expected course over time, distinctions between age-appropriate moodiness and bipolar disorder, the basic biology and genetics of the disorder, risk factors (e.g., disruptions in sleep/wake cycles, alcohol and drug abuse, family conflict), and protective factors (e.g., medication adherence, good family problem solving, regular daily routines), the role of stressful events in evoking symptoms, and how the family and school could help Jenna recover.

The family then worked toward identifying stress factors that played a role in triggering Jenna's mood episodes. Jenna's input was strongly encouraged during this less didactic segment. While Jenna was at first very reluctant to identify herself as having bipolar disorder, she could easily describe problematic family situations associated with her negative mood states. The family came to agreements about how the prodromal signs of Jenna's mania and depression presented themselves (e.g., increased irritability, decreased sleep) and some of her triggers (e.g., interpersonal difficulties with peers, high-intensity interactions with family members, school workload).

Discussions of family stressors allowed the therapist to concurrently assess the family's communication styles. Kathryn complained of having little control over Jenna's behavior, but was overly critical of her, often attributing Jenna's aversive behaviors to willfulness. Based on Jenna's past actions, Kathryn feared that Jenna would continue to make poor

life choices and, in response, had become overprotective. Kathryn frequently commented on her perceptions of Jenna's shortcomings and her inability to make good decisions. Kathryn had valid concerns about some of Jenna's school friends, but had perpetuated a power struggle with Jenna by demanding that she not see certain friends for fear that Jenna would copy their bad behaviors (e.g., school truancy). Kathryn's insistence increased Jenna's desire to see these friends. Kathryn's critical comments toward Jenna, in turn, led to caustic retorts from Jenna and her brother. Kathryn then felt that the kids were ganging up on her, and interactions quickly escalated into shouting matches.

The therapists encouraged the family to identify and reduce stress situations so that minor shifts in Jenna's mood symptoms did not always erupt into family crises. In general, we have observed that parents tend to overrespond and overreact to minor perturbations in their offspring's mood states, some of which are clinically significant but many of which are not. The therapists encouraged Kathryn to view some of Jenna's behaviors as due to an illness rather than willful disregard of her parental authority. At the same time, Jenna was asked to self-monitor her own mood states and associated behaviors through a mood chart. Starting at Session 5, Jenna tracked her daily ups and downs as well as her sleep and any noteworthy stressors. This charting enabled her to begin to identify what conditions may have contributed to negative family interactions and poor personal choices (e.g., criticism from her mother, lack of sleep, occasional low blood sugar). Jenna's willingness to undertake the mood charting helped to build some trust with her mother, who up to that point had felt that she was the only one being asked to make changes.

After establishing a common language and understanding of mood symptoms and family stressors, the family moved into communication skills and problem solving (Session 6), and continued this work over the next eight sessions. The therapists modeled effective verbal and nonverbal communication skills (e.g., active listening, paraphrasing, expressing negative feelings about specific behaviors, making positive requests for change). Kathryn was initially more hesitant than the children to engage in communication exercises, being much more apt to suggest how Jenna and Justin might improve their skills. The therapists slowly engaged Kathryn by first asking one of the children to role play Kathryn and the other to play him- or herself. The therapists then asked for feedback from Kathryn on how the children had played her role in the family, and how she would play it differently. She was then asked to model her own communication skills for the children.

The family continued to struggle with escalating verbal conflicts. In tandem with problem-solving strategies, the therapists provided modeling of expressing positive feelings. Each family member was directed to praise the other for some specific behavior the other had performed, and to say how this positive behavior made him/her feel. This was an extremely difficult task for Kathryn, who continued to resort to critical comments but developed an increased awareness of how this behavior exacerbated family tension.

As treatment progressed into its fourth and fifth months, the family became more comfortable with trying new in-session exercises. Kathryn experimented with communicating her requests for change in a productive fashion rather than making global criticisms of Jenna's character. In Sessions 14 to 18, the FFT problem-solving structure assisted the family in defining a hierarchy of family conflicts. The therapists encouraged the family to solve a problem of moderate significance to the family in terms of emotional intensity (e.g., keeping the house free of clutter) so that they could gain a sense of competency before tackling the more emotionally laden family issues (e.g., the disrespect Kathryn felt that her children expressed toward her).

Kathryn identified inappropriate use of the phone as a long-standing problem in the family, with Jenna and Justin readily agreeing that this was a contentious family issue.

Kathryn felt that she was unable to set limits about phone use because her children ignored her. In turn, Jenna and Justin complained of their mother's unreasonableness. The siblings accused each other of "hogging" the phone, and the mother noted that conflicts over the telephone increased Jenna's irritability. The FFT therapists coached the family to identify a range of solutions for when and how the phone would be used; for example, the phone could be used only for certain periods of time if someone else was waiting, and access to the phone was contingent on cooperativeness between the siblings. All family members were encouraged to brainstorm other ideas, and options were evaluated as to their advantages and disadvantages. Finally, they agreed on a specific solution: that the phone would be used only by each child for a maximum of 1 hr per night, before 10 p.m., and only after the day's chores and homework had been completed.

This issue was revisited in later problem-solving sessions to determine if progress was being made and if the problem's resolution had decreased Jenna's irritability. Kathryn's resolve on setting limits was tested multiple times by both Jenna and Justin, but she was able to maintain a firm stance and voiced that she felt she had more control as a parent. Kathryn, who was becoming more aware of triggers for her own and Jenna's mood swings, added the following contingency for use of the phone: Jenna and Justin were not allowed their hour of phone time if they had not been consistent with their agreed-upon bedtimes and wake times, a preventive measure against mood swings.

In experiencing some initial success in problem solving regarding the phone use, the family was able to move on to discussing more emotionally laden conflicts. The family had been renting a room to a young woman attending the local community college. At times, the renter was verbally inappropriate, chastising Jenna for perceived lack of consideration of her personal space. In several cases, these encounters had escalated into shouting matches with verbal obscenities between Jenna and the renter, which was stressful for the family as a whole. One of these interactions had been a precursor to Jenna's inpatient hospitalization 2 months prior. Although needing the extra income, the family was considering discontinuing the renter's lease.

Having begun to establish effective communication and problem-solving skills, the family utilized FFT sessions to help Jenna strategize how she might better respect the renter's personal boundaries while also working to de-escalate their potentially volatile encounters. At the same time, Kathryn made a request for positive change of the renter, asking that she refrain from any shouting matches or obscenities with Jenna. The mother and renter agreed that they would have family meetings to address any concerns the renter had with Jenna's behavior. Kathryn was able to demonstrate to the family her willingness to address a stressful situation while maintaining clear expectations of the children's behaviors. More generally, Kathryn had become much more proficient at making access to reinforcers (i.e., privileges) contingent on the children's appropriate behaviors. The FFT therapists reinforced the family members' awareness of the progress they were making and their ability to constructively and collaboratively overcome conflict.

The focus of later maintenance sessions was the creation of a relapse-prevention plan. Reporting peer stigma, Jenna continued to be resistant to the bipolar-illness label, but was adhering to her medication regimen, responding to Kathryn's limit setting, and not showing the inflexible explosiveness evident in her past interactions with family members. The family worked together to assist Jenna in identifying an updated list of risk and protective factors. They conjointly developed a relapse-prevention plan involving keeping emergency phone numbers handy, balanced diets, regular exercise and sleep, and avoiding high-stress, provocative interpersonal situations at home and at school.

FFT ended with an understanding that the family might contact the treatment team for booster sessions in the future. At the end of treatment, Jenna continued to have

subsyndromal symptoms of depression, but was clinically stable and remained on her medication regimen. Although she did not feel that she had gained full mastery over her tendency to resort to escalating criticisms and accusations when she felt that her parental authority was being challenged, Kathryn reported considerably less family conflict and greater self-efficacy as a parent.

FFT Outcome Research and Future Dissemination

Jenna's positive outcome and that of her family parallel the research findings on FFT. The efficacy of FFT was first demonstrated in a small, open trial of FFT involving 9 adults with bipolar disorder (Miklowitz & Goldstein, 1990). Treatment outcomes for FFT patients were compared to those of 23 patients from an earlier study who received standard pharmacotherapy and routine care, but no family treatment. After 9 months of treatment, rates of relapse were higher in control patients (61%) than those in the FFT patients (11%). These preliminary findings spurred the development of randomized controlled trials examining the efficacy of FFT.

Randomized Trials

The first of these randomized controlled trials was a 2-year study of 101 bipolar patients, the Colorado Treatment/Outcome Project (CTOP; Miklowitz, George, Richards, Simoneau, & Suddath, 2003; Miklowitz et al., 2000). Patients were adults enrolled shortly after the onset of a bipolar manic, mixed, or depressive episode, with the majority (80%) entering while in the hospital. Patients and their families were randomly assigned following hospitalization to 21 sessions of home-based FFT plus standard medications or to a crisis-management intervention plus medication maintenance. Crisis management consisted of two sessions of home-based family education plus crisis-intervention sessions as needed over 9 months. A case manager conducted monthly telephone calls to all control families.

Patients receiving FFT and pharmacotherapy had better symptomatic outcomes over 2 years than did patients receiving crisis management and pharmacotherapy, including significantly lower rates of illness recurrence and longer periods of remission prior to recurrences. Patients in high-EE families benefited the most from FFT, at least in regard to the stabilization of depressive symptoms (Miklowitz et al., 2000). Patients in FFT also had less severe depressive and manic symptoms over the 2-year follow-up, a treatment difference that emerged almost 9 months into the period of active treatment. Analysis of the 2-year outcome data revealed that the stabilization of mania symptoms was mediated by patients' medication adherence, with the patients randomized to FFT showing better compliance with their mood stabilizer regimen (Miklowitz, George, et al., 2003).

An ancillary CTOP study investigated changes in EE attitudes and family interactional behaviors in families who were tested in a laboratory setting before and after FFT or crisis management (Simoneau, Miklowitz, Richards, Saleem, & George, 1999). For both the FFT and crisis-management conditions, levels of EE criticism and overinvolvement (as measured in caregivers) declined, but no time-related changes were observed in EE or negative interactional behaviors. Relatives and patients who had frequent hostile interchanges were still hostile at the end of family treatment. However, families in FFT displayed increased frequency of positive interactional behaviors during direct interchanges (most notably, nonverbal communications such as smiling or

speaking in an encouraging tone of voice). Families in the crisis-management condition did not display the same level of improvement in positive communication. Additionally, the degree of improvement in the interactional behavior of patients predicted their degree of clinical improvement over the first year of treatment. Thus, enhanced positive communication mediated the effects of psychosocial treatment on the stabilization of mood-disorder symptoms.

A second randomized trial of FFT was conducted in an outpatient bipolar disorder specialty clinic at the University of California, Los Angeles (UCLA; e.g., Rea et al., 2003). The UCLA study improved upon the CTOP study design by including a comparison of equal frequency and intensity, addressing the possibility that any form of intensive psychosocial intervention—family or individual—would outperform routine care and crisis management. In the UCLA study, 53 adult patients who had been hospitalized for mania were randomized as outpatients to the 21-session, 9-month FFT and pharmacotherapy or a comparison 21-session individual therapy and pharmacotherapy. The individual therapy dealt with psychoeducational themes similar to those covered in FFT, such as relapse prevention, stress management, problem solving, and maximizing treatment adherence. Both treatment groups showed equivalent rates of relapse during the 9-month intervention period; however, during the second study year (a 1-year posttreatment follow-up), a difference in time-to-relapse rates emerged. Patients in the families who received FFT and medications were less likely to relapse (28%) or be rehospitalized (12%) than were patients in individual therapy and medication (60 and 60%, respectively). Patients in FFT also were less likely to require hospitalization when they did relapse than were patients in individual therapy (Rea et al., 2003).

Another study examined FFT in combination with individual therapy. Miklowitz, Richards, et al. (2003) examined the effects of "integrated family and individual therapy" (IFIT), a treatment that combined individual interpersonal and social rhythm therapy (IPSRT) sessions with FFT psychoeducational sessions. IPSRT trains individuals to regulate sleep and wake cycles and resolve important interpersonal problems that contribute to mood cycling (Frank, Swartz, & Kupfer, 2000). Thirty adult Bipolar I and II patients in a 12-month open trial of IFIT plus medications were compared to 70 adult "historical control" patients receiving crisis management plus medication in the aforementioned CTOP randomized trial. IFIT patients received individual IPSRT sessions alternating biweekly with sessions of FFT for up to 1 year. Patients undergoing IFIT had longer periods of remission prior to relapses than did patients in the crisis-management study arm. Even after statistically controlling for the effects of medication, patients in IFIT displayed greater improvement over time in symptoms of depression than did patients in the crisis-management group. There were no significant differences between the treatment conditions in the stabilization of mania symptoms over 1 year.

FFT also was studied in the multisite Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). This program examined the efficacy of various pharmacologic and psychosocial interventions in 15 treatment centers across the United States (Miklowitz, Otto, et al., in press). In the randomized portion of the STEP-BD, acutely depressed adult bipolar patients ($N = 293$) were assigned to medication and one of four psychosocial treatments: 30 sessions of FFT, IPSRT, or cognitive-behavioral therapy (CBT), or a three-session psychoeducational control treatment. All three intensive psychotherapies were associated with more rapid recoveries from depression than was the control treatment. Patients in intensive treatment also were more likely to remain well during any given month of the 1-year study than were patients in the control group. There were no significant differences in outcome across the three intensive psychosocial treatments, but the study was underpowered to detect differences between them.

A 2-year open trial of FFT and pharmacotherapy for 20 adolescent patients (mean age = 15 years) revealed significant improvements over 24 months in manic symptoms, depressive symptoms, and parent-rated problem behaviors (Miklowitz et al., 2006). Improvements were not linear, however: Some adolescents showed steady improvement in the first year and then had a rebound of symptoms by Month 18, and stabilized again by Month 24. Moreover, the adolescents' levels of symptom severity over time were associated with whether parents were rated high or low in EE at entry into the study, suggesting that EE may be a moderator of the effects of FFT on symptomatic outcomes.

Another research group (Pavuluri et al., 2004) combined FFT with CBT and pharmacotherapy for 34 school-aged children and adolescents with bipolar disorder. Examined from pretreatment to the end of the 12-session treatment, child- and family-focused CBT led to significant reductions in the severity of bipolar symptoms and increased functioning.

A two-site randomized trial of FFT and pharmacotherapy versus brief psychoeducation and pharmacotherapy ($N = 58$) is nearing completion (Miklowitz et al., 2006). Studies also are exploring whether an FFT-based intervention for children of bipolar parents who are already showing subsyndromal mood disturbances might help delay the onset of the disorder, reduce the severity of cycling, modify the negative cycles of affective communication that develop between parents and their emotionally dysregulated children, and enhance the longer term protective effects of the family context (Miklowitz, Mullen, & Chang, in press).

The results of the aforementioned studies are consistent in suggesting that FFT is an efficacious adjunct to pharmacotherapy for families containing an adult or an adolescent with bipolar disorder. The gains derived from FFT are most fully realized at the conclusion of the 9-month intervention and during the post-intervention year. FFT addresses the acute needs of patients and family members, but it appears that participants need time to fully integrate and employ the newly learned self-management, communication, and problem-solving strategies.

Dissemination

As researchers continue to determine what approaches have the best outcomes, they also must consider if effective interventions are amenable to widespread dissemination. Most family approaches have been developed in teaching hospitals or other academic settings. It remains to be seen if family psychoeducational approaches can make the transition to public and private sectors that serve diverse populations.

Psychosocial interventions not only need to be culturally competent but also perceived as "low burden" and economically feasible. Little attention has been paid to dissemination strategies in community mental health or integrated care settings where fiscal incentives dictate the form and duration of most treatments. Few studies have included cost–benefit analyses of psychosocial interventions. We know that research suggests that the most effective family interventions last 9 months or longer, and their effects are often delayed (Miklowitz, George, et al., 2003; Rea et al., 2003). The necessity for relatively lengthy and individualized family treatments will need to be clearly articulated in terms of reduced hospital days and other cost drivers.

Clinical Issues and Summary

The FFT approach to bipolar disorder has growing research support. Family approaches present an opportunity for patients to gain control over concurrent episodes while building

skills that might prevent or decrease the impact of future episodes. Research has shown FFT to be an effective adjunct to pharmacotherapy, and the combination of FFT with other promising methods may prove to be a strong match for specific populations of patients identified by age of onset, symptom severity, family structure, or comorbid features. EE research, family systems theory, developmental psychopathology, and psychoeducational treatments have been synthesized into coherent family interventions that address the biopsychosocial context within which bipolar disorder waxes and wanes. Future work will need to refine existing treatments and identify means of disseminating evidence-based practices to diverse families and contexts.

Select References/Recommended Readings

Butzlaff, R. L., & Hooley, J. M. (1998). Expressed emotion and psychiatric relapse: A meta-analysis. Archives of General Psychiatry, 55, 547–552.

Colom, F., Vieta, E., Martinez-Aran, A., Reinares, M., Benbarre, A., & Gasto, C. (2000). Clinical factors associated with treatment noncompliance in euthymic bipolar patients. Journal of Clinical Psychiatry, 61, 549–555.

Dixon, L., Steward, B., Burland, J., Delahunty, J., Luxted, A., & Hoffman, M. (2001). Pilot study of the effectiveness of the family-to-family education program. Psychiatric Services, 52, 965–967.

Frank, E., Swartz, H. A., & Kupfer, D. J. (2000). Interpersonal and Social Rhythm Therapy: Managing the chaos of bipolar disorder. Biological Psychiatry, 48, 593–604.

Geller, B., Tillman, R., Craney, J. L., & Bolhofner, K. (2004). Four-year prospective outcome and natural history of mania in children with a prepubertal and early adolescent bipolar disorder phenotype. Archives of General Psychiatry, 61, 459–467.

Jindal, R. D., & Thase, M. E. (2003). Integrating psychotherapy and pharmacotherapy to improve outcomes among patients with mood disorders. Psychiatric Services, 54, 1484–1490.

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., et al. (1997). Schedule for affective disorders and schizophrenia for school-age children—present and lifetime version (K-SADS-PL): Initial reliability and validity data. Journal of the American Academy of Child and Adolescent Psychiatry, 36, 980–988.

Leverich, G. S., McElroy, S. L., Suppes, T., Keck, P. E., Denicoff, K. D., Nolen, W. A., et al. (2002). Early physical and sexual abuse associated with an adverse course of bipolar illness. Biological Psychiatry, 51, 288–297.

Miklowitz, D. J. (2006). A review of evidence-based psychosocial interventions for bipolar disorder. Journal of Clinical Psychiatry, 67(Suppl. 11), 28–33.

Miklowitz, D. J., Biuckians, A., & Richards, J. A. (2006). Early-onset bipolar disorder: A family treatment perspective. Development and Psychopathology, 18, 1247–1265.

Miklowitz, D. J., George, E. L., Richards, J. A., Simoneau, T. L., & Suddath, R. L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. Archives of General Psychiatry, 60, 904–912.

Miklowitz, D. J., & Goldstein, M. J. (1990). Behavioral family treatment for patients with bipolar affective disorder. Behavior Modification, 14, 457–489.

Miklowitz, D. J., Goldstein, M. J., Nuechterlein, K. H., Snyder, K. S., & Mintz, J. (1988). Family factors and the course of bipolar affective disorder. Archives of General Psychiatry, 45, 225–231.

Miklowitz, D. J., Mullen, K., & Chang, K. (in press). Family-focused treatment for bipolar disorder in adolescence. In B. Geller & M. Delbello (Eds.), Treatment of child and adolescent bipolar disorder. New York: Guilford Press.

Miklowitz, D. J., Otto, M. W., Frank, E., Reilly-Harrington, N. A., Wisniewski, S. R., Kogan, J., et al. (in press). Psychosocial treatments for bipolar depression: A 1-year randomized trial from the Systematic Treatment Enhancement Program. Archives of General Psychiatry.

Miklowitz, D. J., Richards, J. A., George, E. L., Suddath, R. L., Frank, E., Powell, K., et al. (2003). Integrated family and individual therapy for bipolar disorder: Results of a treatment development study. Journal of Clinical Psychiatry, 64, 182–191.

Miklowitz, D. J., Simoneau, T. L., George, E. A., Richards, J. A., Kalbag, A., Sachs-Ericsson, N., et al. (2000). Family-focused treatment of bipolar disorder: One-year effects of a psychoeducational program in conjunction with pharmacotherapy. Biological Psychiatry, 48, 582–592.

Morris, C. M., Miklowitz, D. J., Wisniewski, S. R., Giese, A. A., Thomas, M. R., & Allen, M. H. (2005). Care satisfaction, hope, and life functioning among adults with bipolar disorder: Data from the first 1,000 participants in the systematic treatment enhancement program. Comprehensive Psychiatry, 46, 98–104.

Murray, C. J. L., & Lopez, A. D. (1996). The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, MA: Harvard University Press.

Pavuluri, M. N., Graczyk, P. A., Henry, D. B., Carbray, J. A., Heidenreich, J., & Miklowitz, D. J. (2004). Child and family-focused cognitive behavioral therapy for pediatric bipolar disorder: Development and preliminary results. Journal of the American Academy of Child & Adolescent Psychiatry, 43, 528–537.

Priebe, S., Wildgrube, C., & Muller-Oerlinghausen, B. (1989). Lithium prophylaxis and expressed emotion. British Journal of Psychiatry, 154, 396–399.

Rea, M. M., Tompson, M., Miklowitz, D. J., Goldstein, M. J., Hwang, S., & Mintz, J. (2003). Family focused treatment vs. individual treatment for bipolar disorder: Results of a randomized clinical trial. Journal of Consulting and Clinical Psychology, 71, 482–492.

Simoneau, T. L., Miklowitz, D. J., Richards, J. A., Saleem, R., & George, E. L. (1999). Bipolar disorder and family communication: Effects of a psychoeducational treatment program. Journal of Abnormal Psychology, 108, 588–597.

Simoneau, T. L., Miklowitz, D. J., & Saleem, R. (1998). Expressed emotion and interactional patterns in the families of bipolar patients. Journal of Abnormal Psychology, 107, 497–507.

Vieta, E., Pacchiarotti, T., Scott, J., Sanchez-Moreno, J., Di Marzo, S., & Colom, F. (2005). Evidence-based research on the efficacy of psychologic interventions in bipolar disorders: A critical review. Current Psychiatry Reports, 7, 449–455.

Wendel, J., Miklowitz, D. J., Richards, J. A., & George, E. G. (2000). Expressed emotion and attributions among the families of bipolar patients: An analysis of problem-solving interactions. Journal of Abnormal Psychology, 109, 792–796.