J Contemp Psychother (2007) 37:157–164
DOI 10.1007/s10879-007-9050-4

ORIGINAL PAPER

Evidence Based Treatments for Bipolar Disorder in Children and Adolescents

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Published online: 26 April 2007

Abstract Limited research has been devoted to developing and testing psychosocial treatments for bipolar disorder (BPD) in children and adolescents, a chronic and impairing mental illness that has received increased attention in recent years. Existing treatments are intended as adjuncts to medication, and share a family-based psychoeducation approach. Components of four treatments are discussed: family-focused treatment (FFT), the RAINBOW Program, multi-family psychoeducation groups (MFPG), and individual family psychoeducation (IFP). Evidence supporting each approach is detailed. Selected components of MFPG are described. A flowchart provides suggestions for sequencing interventions to maximize effectiveness. To illustrate the use of evidence-based treatment for children with BPD, a case example is provided.

Keywords Bipolar disorder · Evidence-based treatment

Introduction

Bipolar disorder (BPD) is a serious and impairing mental illness characterized by distinct periods of elevated and depressed moods. In the past decade, bipolar disorder in children and adolescents has received increased research and clinical attention (Lofthouse & Fristad, 2004). In children, BPD is associated with significant morbidity and mortality (Geller & DelBello, 2003). If untreated, youth are at risk for academic underachievement, social impairment, psychiatric hospitalization, prolonged course of mood episodes, legal problems, and greater risk of substance abuse and suicide (Findling et al., 2001; Geller et al., 2003; Lewinsohn, Seeley, & Klein, 2003).

In children and adolescents, BPD frequently presents differently than in adults. Rather than clearly defined episodes separated by periods of euthymic mood, children and adolescents with BPD are more likely to experience mixed states, rapid cycling, and chronic mood states without periods of remission (Pavuluri, Birmaher, & Naylor, 2005). A prospective study of a group of children and adolescents with BPD (Birmaher et al., 2006) found high rates of mood episode recurrence and progression to bipolar I disorder from bipolar II or bipolar NOS. Compared to data on adults with BPD, this sample of youth spent significantly more time symptomatic and had more mixed or cycling episodes and switches in mood episodes.

No epidemiological studies of BPD in children exist at this time. However, a school-based survey of adolescents aged 14–18 found a lifetime prevalence of approximately 1% for BPD, plus an additional 5.7% of adolescents with distinct periods of manic symptoms that did not meet full symptom criteria for a manic episode (Lewinsohn, Klein, & Seeley, 1995). This study's findings are limited by the fact that parent informants were not included and only students functional enough to attend school on the days interviews were conducted were included in the study. Despite controversy about the prevalence of BPD in children and adolescents, it is clear this condition does occur in youth, and there is growing evidence to suggest it occurs more frequently than previously thought (Youngstrom, Findling, Youngstrom, & Calabrese, 2005).

A careful assessment is a necessary precondition before beginning any treatment for BPD in children and adolescents. This illness is difficult to diagnose in youth for a

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number of reasons. Some symptoms of BPD can be confused with symptoms of other conditions, such as oppositional defiant disorder (ODD), attention-deficit/hyperactivity disorder (ADHD), or anxiety disorders. If psychotic symptoms are present, BPD may be misdiagnosed as schizophrenia. To further complicate diagnosis, comorbidity is the rule, rather than the exception, in children and adolescents with BPD (Axelson et al., 2006; Lewinsohn et al., 1995). Because a family history of BPD is a risk factor for development of the disorder, and because self-report of symptoms is often insufficient to clarify diagnosis, it is essential to include collateral informants, especially parents or guardians, in the assessment process whenever possible (Youngstrom et al., 2005). Diagnosis can be assisted by the use of structured or semi-structured diagnostic interviews such as the Children's Interview for Psychiatric Syndromes (ChIPS: Weller, Weller, Rooney, & Fristad, 1999) or with symptom rating measures such as the K-SADS Mania Rating Scale (Axelson et al., 2003).

Components of Effective Treatment

BPD in children and adolescents cause significant impairment for youth and their families. In the majority of cases, this impairment necessitates the use of psychotropic medication. In fact, many children and adolescents with BPD are not good candidates for psychosocial interventions until they are stabilized on medication (Kowatch et al., 2005). However, this does not prevent parents from benefiting from psychosocial interventions. A thorough review of the evidence base related to medication treatment for child and adolescent bipolar disorder is beyond the scope of this article. The treatment guidelines published by the *Child Psychiatric Workgroup on Bipolar Disorder* (Kowatch et al., 2005) provide medication treatment algorithms based upon the available published evidence.

All empirically evaluated psychosocial treatments for children with BPD are family-based and include a psychoeducation component. Psychoeducation treatments combine psychotherapy and education to increase knowledge about a problem and foster skill building (Lukens & McFarlane, 2004). Psychoeducational treatments for BPD in children and adolescents provide families with information about the etiology, course, prognosis, and treatments for BPD. They reinforce the fact that BPD is not the affected youth's fault, and emphasize that is important to separate the individual from his or her symptoms. This approach minimizes the stigma associated with BPD while simultaneously stressing the patient's and family's responsibility in managing the illness (Fristad, 2006). Four psychosocial interventions have been developed for children with BPD. Although discussed separately below, it is important to note these interventions share several key features, such as a psychoeducation component and a focus on developing skills to improve coping with BPD.

Family-Focused Treatment (FFT)

Family-focused treatment (FFT) for adolescents with BPD was adapted from FFT for adults and is intended as an adjunct to pharmacotherapy (Miklowitz et al., 2004). The goals of FFT are to: increase adherence to medication regimens and therefore delay recurrence of mood episodes; enhance adolescents' knowledge of BPD; enhance their communication and coping skills; and minimize the psychosocial impairment caused by the illness. This treatment is focused on the family with the intention of improving caregivers' ability to understand and cope with their child's illness and to decrease caregivers' levels of expressed emotion (EE) (Miklowitz et al., 2004). Families high in EE are those in which caregiver's direct critical comments, hostility, and/or emotional overinvolvement toward the individual affected with an illness (e.g., a child with BPD). High-EE families are associated with poorer outcome for adults (Butzlaff & Hooley, 1998) and children with depression (e.g., Asarnow, Goldstein, Tompson, & Guthrie, 1993).

FFT consists of three components: psychoeducation, communication enhancement training, and problem-solving skills training, which are delivered over approximately 20 sessions with a therapist. During the psychoeducation component, the therapist teaches the family about adolescent BPD, encourages the adolescent to chart his or her mood, provides information about risk and protective factors, such as how psychosocial factors can affect the course of the illness (Miklowitz, Goldstein, Nuechterlein, Snyder, & Mintz, 1988; Geller et al., 2002), and develops a plan with the family for relapse prevention. During the communication enhancement training phase of FFT, families practice skills such as active listening with the goal of increasing the frequency of positive and effective communication among family members. The problem-solving component of FFT focuses on the use of cognitive-behavioral strategies to develop effective solutions to family conflicts. A sample of 20 adolescents who participated in FFT with their parents experienced an average of 38% reduction in manic symptoms and 46% improvement in manic symptoms at 12-month follow-up (Miklowitz et al., 2004).

RAINBOW Program

Another psychosocial intervention developed for youth with BPD is *Child and Family Focused Cognitive*

Behavioral Therapy for Pediatric Bipolar Disorder, also known as the *RAINBOW Program* (Pavuluri et al., 2004). This intervention was designed as an adaptation of the FFT model for children aged 8–12, and is a 12-session, protocol driven treatment that consists of sessions with the child alone, parents alone, child and parents together, and parents with siblings. The treatment is structured around the acronym RAINBOW *(Routine, Affect Regulation, I Can Do It!, No Negative Thoughts & Live in the Now, Be a Good Friend & Balanced Lifestyle for Parents, Oh, How Can We Solve the Problem?, and Ways to get Support)*, which helps families remember the themes of each session (Pavuluri et al., 2004).

The RAINBOW Program focuses on psychosocial factors that influence the course of BPD, similar to FFT, such as EE, stressful life events, coping and communication skills, and family problem solving. Also similar to FFT, the RAINBOW Program is based upon cognitive-behavioral and interpersonal psychotherapies, and utilizes psychoeducation. The RAINBOW Program incorporates a session for siblings to meet with the therapist and learn about the nature of BPD and its impact on their brother or sister. This session encourages siblings to develop empathy and coping skills. With parental permission, the therapist initiates contact with the child's school personnel, offering psychoeducation about BPD and suggestions for school-based interventions. In an open trial of the RAINBOW program, 34 children and adolescents 5–17 years old who had been stabilized on medication showed significant improvement in symptoms of bipolar disorder, aggression, ADHD symptoms, and global functioning (Pavuluri et al., 2004).

Multi-Family Psychoeducation Groups

Our research group has developed and evaluated the effectiveness of two additional psychoeducational psychotherapies for children with BPD. The first of these interventions is the multi-family psychoeducation group (MFPG). MFPG consists of eight 90-min sessions for parents, with concurrent sessions for children with another therapist (Fristad, Gavazzi, & Mackinaw-Koons, 2003). Similar to FFT and RAINBOW, MFPG is psychoeducational in nature and focuses on educating families about the child's illness and its treatment, decreasing EE, and improving symptom-management, problem solving, and communication. In contrast to FFT and the RAINBOW Program, MFPG is designed for children with BPD or a diagnosis of a depressive disorder (i.e., major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified). MFPG's group format allows parents to gain support by meeting other parents dealing with the unique stress of parenting a child with a mood disorder. For the children in an MFPG group, it is often their first opportunity to meet another child with a similar illness. Children are often surprised and relieved to discover they are ''not the only one'' (Goldberg-Arnold & Fristad, 2003). The group format also provides children with opportunities for in vivo practice of social skills and problem-solving strategies.

An important component of MFPG is educating parents to become more involved members of their child's treatment team, and identify areas in which their child may benefit from additional or modified services. Parents learn to advocate for the best care for their child, and are encouraged to become better consumers of mental health care. Parents are also provided with similar information about school services, special education options, and information about their child's educational rights (Klaus & Fristad, 2005).

The children's groups in MFPG include a number of interventions to teach children to more effectively cope with their illness. Table 1 summarizes the content of each MFPG parent and child session. One such component is called ''Naming the Enemy,'' in which children are asked to generate a list of their mood symptoms, plus symptoms of any other comorbid conditions they experience. In another column on the same page, children are instructed to list positive qualities about themselves (e.g., good baseball player, good sense of humor, loving). The therapist later demonstrates how the symptoms ''cover up'' the child's true self by folding the worksheet. The therapist further demonstrates how developing a plan to deal with the symptoms can figuratively (and literally, as the therapist folds the worksheet in the opposite way) ''put the symptoms behind them [the family].'' This exercise allows the child and family to externalize the child's symptoms, and agree on a common ''enemy,'' the child's mood disorder (Fristad, Gavazzi, & Soldano, 1999).

Another vital component of the MFPG child sessions is the ''Tool Kit,'' in which a child develops a variety of pleasant and relaxing activities to choose from in the event of a negative mood or interpersonal conflict. The child generates a list of activities in four categories (creative, physical, social, and rest and relaxation) that can be used in variety of settings, times of day, and alone or with others.

To successfully implement cognitive-behavioral therapy (CBT) techniques with children, it is necessary to keep in mind the fact that cognitive, language, information processing, and memory capabilities are less developed in children than they are in adults. Children are less skilled at many cognitive tasks, such as perspective-taking, understanding the connection between cognitions and behavior, and recognizing one's own emotional state (Grave & Blissett, 2004; Izard, 1994). The MFPG treatment contains a therapeutic technique called ''Thinking-Feeling-Doing'' (TFD) that was created with these developmental

Table 1 Content of MFPG parent and child sessions

Session	Parent group	Child group
1	Childhood mood disorders and their symptoms	Childhood mood disorders and their symptoms
2	Medications: Monitoring effectiveness and side effects, names and classes of medications	Medications: symptoms and the medications that target them; ''Naming the Enemy''
3	''Systems of Care:'' Mental health and educational services	''Tool Kit'' to manage symptoms and emotions
4	Learn about negative family cycle; Review first half of the program	Learn about the connection between thoughts, feelings, and actions; Thinking-Feeling-Doing
5	Develop problem solving and coping skills	Develop problem-solving skills ''Stop-Think-Plan-Do-Check''
6	Improve verbal and non-verbal communication coping skills	Improve non-verbal communication skills
7	Symptom management	Improve verbal communication skills
8	Review second half of the program; graduate	Review and graduate

considerations in mind. TFD is intended to increase the child's and parent's insight into the connection between their thoughts, feelings, and behavior. The first goal of this technique is to improve the parent's and child's awareness of their own negative mood states. The therapist then assists the child or parent to recognize negative thoughts and behaviors, which often accompany negative moods. This recognition leads to the final step of TFD: generating alternative thoughts and behaviors that can lead to positive mood states (Fristad, Davidson, & Leffler, in press).

Individual Family Psychoeducation

Individual Family Psychoeducation (IFP) was developed as a non-group form of the MFPG intervention. IFP was developed for use when MFPG is difficult to implement or undesirable to the family. For example, in geographically remote settings, group psychoeducation for a relatively uncommon diagnosis is likely to be impractical. Some families may not feel comfortable sharing personal experiences in a group setting, and would prefer individual treatment. IFP is also appropriate for families who do not wish to delay treatment until a group of other families is organized (Fristad, 2006). The original IFP protocol consisted of 16 50-min sessions, alternating between parent-only and child-only (with parent check-in at the beginning and end) sessions. To substitute for the in-session social skills practice included in MFPG which are not possible to implement in a single-family intervention, a *Healthy Habits* component was introduced, focusing on maintaining healthy sleep hygiene, improving nutrition, and increasing appropriate exercise activities. *Healthy Habits* was added because BPD is an illness that can be significantly affected by physical health and daily routines. Maintaining regular sleep habits can decrease the likelihood of triggering a manic episode (Malkoff-Schwartz et al., 1998). Some psychotropic medications for BPD are associated with a risk of significant weight gain, so improving diet and increasing exercise can combat this side effect (Kowatch et al., 2005). Also, the depressed phase of bipolar disorder is the most difficult component of BPD to adequately treat (Kowatch et al., 2005). With this in mind, *Healthy Habits* includes an exercise component, which has been shown to improve outcome in depression (Pollock, 2001), and behavioral activation, also proven beneficial for depression (Dimidjian et al., 2006). The original IFP protocol included one ''in the bank'' session to address a crisis, to be used at any time. Based on anonymous feedback from parents in a pilot study of IFP, the treatment protocol was expanded to 24 sessions. This extended protocol, IFP-24, includes 20 manual-driven sessions, plus four ''in the bank'' sessions to manage crises or reinforce a topic particularly relevant or difficult for the family. IFP-24 includes an additional session for parents to learn about diagnoses and symptoms, an extra session covering mental health treatments and educational interventions, an extra *Healthy Habits* session, a session devoted to school professionals, and a sibling session. In MFPG, IFP, and IFP-24, families are encouraged to continue mental health treatment as usual (TAU) throughout their participation.

Evidence Supporting MFPG and IFP

A pilot study of MFPG was conducted with 35 families (children age 8–11). Families were randomly assigned to either immediate treatment (IMM) in MFPG or a 6-month wait-list control (WLC) group. IMM parents demonstrated significantly more knowledge about mood disorders, improved family interactions, and improved ability to access appropriate services for their child at post-treatment follow-up, compared to WLC parents. Parents also reported positive consumer evaluations of MFPG. IMM children reported a significant increase in perceived social support from parents, and a trend toward increased perceived social support from peers that did not reach statistical significance. Children's mood symptom severity did not decrease significantly following treatment. Full results of this study have been reported elsewhere (Fristad, Goldberg-Arnold,

& Gavazzi, 2002, 2003; Goldberg-Arnold, Fristad, & Gavazzi, 1999).

Based on methodological constraints affecting this pilot study (e.g., small sample size, interviewers not consistently masked to randomization status of participants, 6-month wait-list meant MFPG groups occurred at different times of the year), and post-treatment parent and child evaluations, the MFPG protocol was modified. MFPG was expanded from six 75-min sessions to eight 90-min sessions. Increased session time is devoted to skill-building and providing information about accessing services. The wait-list duration was increased to 12-months so children would be compared during the same season of the year (and school calendar). Increased use of child and parent homework assignments was incorporated to provide increased opportunities for practice, and to allow non-attending parents/guardians to learn the group materials. A large scale (N = 165) randomized clinical trial of this MFPG format is being completed and results will be reported at a later date.

In the pilot study of IFP described above, 20 children with BPD and their parents completed the original 16-session format. Children were aged 8–11 at intake, and were randomized to IMM or WLC. Two IMM families completed treatment but did not return for post-treatment assessments. Two IMM families and three WLC families dropped out of the study before completing treatment. Therefore, the results of this trial are limited by small sample size. Children's mood symptoms improved significantly following treatment, and gains were maintained for 12 months after IFP treatment. EE scores improved significantly more for IMM families compared to WLC families, and a non-significant improvement in ratings of mental health and school services was observed. A full description of the subjects and more detailed results are published elsewhere (Fristad, 2006). A case series study of IFP-24 suggests it provides clinical benefit for children and families (Leffler, Fristad & Walters, 2006) and the format is acceptable to families (Davidson & Fristad, in press).

Summary

The four treatments for BPD in youth described above (FFT, RAINBOW, MFPG, and IFP/IFP-24) share many components in common. Most importantly, these interventions are based upon a psychoeducation format, and share a cognitive-behavioral foundation, and incorporate both parents and children as active partners in the management of BPD. Skill-building and problem solving strategies are present in each of these interventions as well. Regardless of whether medication is administered as part of the treatment, these four interventions share a common goal of increasing adherence to medication and other psychosocial treatments through education.

Despite the promising results reported in the investigations of these interventions, existing studies suffer from small sample sizes, and in some cases lack comparison groups. Results from multiple larger randomized clinical studies, such as the large trial of MFPG discussed above, will be necessary before any of these protocols can meet the definition of a ''well established'' treatment.

In addition, these treatments are all time-limited and designed to be adjuncts to TAU. In effect, they each represent a ''starter kit'' for coping with BPD in a child or adolescent. The question for clinicians remains, ''What do I do next?'' It is important to remember that BPD is a chronic condition and prepubertal BPD is associated with frequent relapses. Even if a child is stabilized on medication and his or her family environment is improved through one of the adjunctive treatments described above, relapse prevention will be a continuing treatment goal. Components of these four treatments can be utilized, such as mood monitoring, stress management skills, and maintaining healthy nutrition, sleep hygiene, and exercise habits. Clinicians can also help parents prepare a ''crisis plan'' to implement in case of a mood relapse.

In addition, children and adolescents with BPD frequently present with comorbid conditions. When mood symptoms have been stabilized, evidence-based treatments for the comorbid conditions can be implemented. Because BPD has a large genetic component, children and adolescents with BPD are more likely than other children to have a parent, sibling, or other family member with BPD or a mood disorder (Badner, 2003). Referring untreated family members for mental health services can have a positive benefit for all family members (Table 2).

Case Description

Tyler Smith[1], an 11-year-old Caucasian male, entered MFPG treatment with his parents. Initial assessment via structured interview and mood symptom rating scales indicated that Tyler met diagnostic criteria for bipolar I disorder and ADHD, combined type. At the pre-treatment assessment, Tyler was experiencing minimal symptoms of depression and mania, based upon parent and child report. However, he had a history of significant mood episodes, including a psychiatric hospitalization for mania. At the beginning of MFPG treatment, Tyler was seeing a child psychiatrist for medication management, and his family also regularly met with a social worker to work on coping with mood symptoms and parenting strategies. Tyler was

[1] This child's name has been changed and other personal details have been masked to protect confidentiality. The authors wish to thank the family for permitting us to share their information.

Table 2 Flowchart for treatment

Treatment phase	Sequence of interventions:		
1. Assessment and diagnosis	Careful evidence-based assessment of mood disorder and comorbid conditions	Identify parent and family mental illness	
2. Acute phase	Medication referral	Group or individual family psychoeducation	Treat comorbid conditions
3. Maintenance phase	Individual/family psychotherapy: focus on relapse prevention, medication adherence/monitoring side effects, and crisis management		
4. Developmental adjustments	Modify therapeutic techniques as child's cognitive, social, and emotional level develops with age		

treated with a mood stabilizer, an atypical antipsychotic, a low dose of a stimulant, and a medication to prevent nighttime enuresis. In sum, his existing treatment was of excellent quality.

Tyler lives with his biological parents, and has no siblings. Mr. and Mrs. Smith reported he ''gets along pretty well'' with them at home, but acknowledged they had significant difficulty controlling Tyler's behavior when he experiences periods of manic or depressed symptoms. At these times, Tyler would become intensely irritable and on occasion had become physically aggressive toward his parents. In the past, Tyler had been enrolled in a split day of mainstream and special education classes at school. The Smiths were concerned Tyler's grades did not reflect his true potential. Tyler got along well with his teachers but experienced teasing by peers. These conflicts often led to fights he called ''explosions.'' Mr. and Mrs. Smith reported Tyler had been arrested at school once for physical aggression. As a result, Tyler was restricted to half-days in school in special education classes, then was sent home daily at lunch time for the remainder of the school year. Tyler had no meaningful friendships, but spent some time playing with younger peers in his neighborhood because same-age peers rejected him. Tyler stated he has trouble keeping friends very long.

Mr. and Mrs. Smith attended all eight MFPG sessions, and were among the most vocal and involved parents each week. During the first session, Tyler's parents reported uncertainty about Tyler's diagnosis. They were ''100 percent sure'' Tyler had ADHD, but were unsure about his mood diagnosis, and noted that a previous treatment provider told them Tyler had ODD rather than a mood disorder. They asked many questions during the first session, which focused on educating families about mood symptoms and diagnoses, as well as common comorbid conditions. Over the course of the eight-week group, Tyler's parents became more confident that bipolar disorder was a correct diagnosis for their child. By week six, both parents spontaneously reported they could recognize warning signs of Tyler's depressed moods and meltdowns.

Mr. and Mrs. Smith also became active consumers of his mental health treatment. Tyler's mother was talkative during the session that focused on medication treatments. She was surprised to hear that tests of liver function were recommended for one of the medications Tyler was taking. She said Tyler had never had such tests. The following week, Tyler's parents told the group they had contacted his psychiatrist, and the liver function tests had been scheduled. A few weeks later, they asked the MFPG child group therapist to contact Tyler's psychiatrist to discuss his behavior and mood in group, because they felt the psychiatrist did not know Tyler well enough to treat him optimally. The MFPG therapist communicated via letter and telephone with Tyler's psychiatrist, providing helpful observations about Tyler's mood and behavior over the course of the MFPG group.

Tyler was extremely verbal and tangential at times during the first four sessions, often interrupting the therapist and his peers. However, he responded well to limit setting, and showed good insight into his mood symptoms (e.g., he was able to describe past suicidal ideation). Tyler showed above average compliance with MFPG homework assignments, and was better than most of his peers at recalling previous weeks' material when called upon. Tyler built a physical version of his ''Tool Kit,'' an optional assignment suggested by the child group therapist, by placing small reminders of each tool kit activity in a shoebox (e.g., picture of a basketball to remind him to calm himself by playing sports, cover of a CD to remember to relax while listening to music). He brought his Tool Kit to session four and showed it to his peers.

At session five, Tyler presented with an irritable mood, and often made negative or inappropriate comments to peers and the therapists. During the in vivo social skills practice at the end of the session, Tyler was tagged out while playing a ball game. Tyler became extremely angry, and refused to leave the game. Tyler was non-compliant with therapists' instructions, and refused to leave the gymnasium for over 45 min. Even when his parents came to get him at the end of their session, he could not be

consoled. Tyler was tearful and made repeated comments such as ''nobody believes me,'' ''everyone hates me now'' and ''I hate myself for feeling like this.'' He struck his parents when they initially tried to escort him out of the gym, but they were able to calm him down and bring him home after a few minutes.

At the next session, Tyler presented as his ''old self.'' He made positive contributions to group, showed good recall of previous material, and his mood was euthymic. In week seven, Tyler presented with an inappropriately elevated mood and rapid speech, and was not able to calm himself enough to participate appropriately. The MFPG therapist provided feedback to Tyler's parents after sessions five and seven regarding the observed fluctuations in his mood, and suggested they speak to his psychiatrist.

At the final MFPG session, Tyler was an active contributor to group, and showed good recall of previous weeks' material. He said he enjoyed the group and looked forward to practicing the skills he had learned. Shortly after group ended, Tyler's social worker sent the MFPG staff a letter stating Tyler continued to use his tool kit, and felt sad when the group ended. Tyler told her that he was better at setting goals for himself and was complaining less to his parents because of the skills he had learned in group, noting ''it's all paying off.''

A few weeks later, Tyler suffered a relapse of depression and rapid mood swings and was hospitalized. His parents attributed the change in mood to an adjustment in Tyler's medication. He was hospitalized for 5 days, and his medications were further adjusted. When Tyler returned for his MFPG study follow-up assessment (approximately 4 months after treatment ended), his moods had stabilized, and Tyler was attending a full day of school again. Tyler's father, who served as parental informant for the MFPG study, reported there was less arguing in the family, and said Tyler was ''doing well.'' He described Tyler as a ''good, smart, and complex kid.''

Data collected at the post-treatment assessment indicated Tyler was experiencing minimal mood symptoms. His father showed a significant decrease in EE and a small increase in his understanding of mood disorders, although his pre-treatment score indicated he had a very strong foundation of knowledge at baseline. Tyler continued to see his social worker and psychiatrist. Tyler made a new friend in his neighborhood, but still had some problems with older children who picked on him. He earned high grades in school, volunteered to work in the school store, and attended Bible study classes outside of school. Tyler described the MFPG group as a positive experience, and his parents noted it helped them cope with his mood symptoms and improve family relationships.

The MFPG intervention aided Mr. and Mrs. Smith in a number of ways. The pre-treatment evaluation and the education component of MFPG helped to clarify Tyler's diagnosis, so they could better cope with his symptoms. They were able to use the new information they gained about BPD to become better consumers of Tyler's mental health care, and implemented an effective crisis management plan when he required hospitalization. Meeting other families of children with mood disorders gave them the opportunity to increase their social support and de-stigmatize their child's illness. Further benefits of MFPG were seen in a post-treatment reduction in EE and increased knowledge of BPD.

Tyler also benefited from participating in MFPG treatment. During the sessions when his mood was euthymic, he was one of the most active participants in the group, and demonstrated excellent recall of previous sessions' material. His therapist's comments confirmed that he continued to use the skills learned in MFPG after treatment ended. These skills likely contributed to his improved functioning at home, in school, and with his peers.

Acknowledgment This paper was supported in part by a grant to the second author from the National Institute of Mental Health (NIMH: 1 RO1 MH61512-01A1).

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