

## Family Focused Therapy for Bipolar Adolescents: Lessons From a Difficult Treatment Case

Elizabeth L. George and Dawn O. Taylor, *University of Colorado, Boulder*

Benjamin I. Goldstein, *University of Toronto*

David J. Miklowitz, *UCLA School of Medicine*

*This paper examines obstacles and challenges encountered in the manualized Family Focused Therapy–A of an adolescent with bipolar disorder. We begin by describing adolescent bipolar disorder and some of the many complications that frequently accompany it. We summarize Family Focused Therapy (FFT-A), an empirically validated treatment approach for bipolar disorder, originally applied to the treatment of adults with bipolar disorder and modified for use with adolescents and their families. We present the details of a difficult treatment case, and examine the factors that led to its suboptimal outcome. We elaborate on ways in which this case would inform future iterations of FFT-A, and suggest future directions for research in this area.*

THERE has been a growing awareness that the onset of bipolar disorder (BD) often occurs in childhood or adolescence (Taylor & Miklowitz, 2009). Many children with BD present with short periods of euphoria and longer periods of irritability without a full return to euthymia, rather than classic euphoric mania (Findling et al., 2001; Geller et al., 2000; Wozniak et al., 1995). Comorbid diagnoses (e.g., ADHD, oppositional defiant disorder, conduct disorder, and anxiety disorders) are also common and complicate the diagnosis of BD (Goldstein et al., 2010).

Substance abuse and dependence occurs in about 20% of adolescents with BD in large-scale clinical studies (Biederman et al., 2005; Goldstein, Strober, et al., 2008). It greatly complicates the treatment of adolescent BD and plays a part in the case we describe here. Suicidal behaviors, although not a core symptom of BD, are more frequent in BD than in other psychiatric disorders (Baldessarini & Jamison, 1999), and comorbid substance abuse is a risk factor for suicide completion. Evidence shows that psychosocial interventions enhance the efficacy of pharmacotherapy in promoting stabilization in BD and should be a key component of the outpatient management of most bipolar patients (Miklowitz, 2006).

Family attitudes toward the illness (i.e., high criticism or overprotectiveness) have a significant impact on the patient's symptomatic outcome (Miklowitz, 2004).

### Family Focused Therapy

Family Focused Therapy (FFT) is a psychoeducational and skills-training treatment approach for families in which one (or more) member(s) has BD. The approach has been supported in several randomized trials of adult and adolescent bipolar patients. FFT grew out of research on expressed emotion (EE), a construct that has been applied in working with families of patients with schizophrenia, major depression, and other psychiatric conditions. EE refers to the expression of critical attitudes, hostility, or emotional overinvolvement (EOI; overprotectiveness, inordinate self-sacrifice) among the caregivers of patients with major psychiatric disorders (Vaughn & Leff, 1976). EE has consistently been shown to predict the likelihood of relapses of bipolar disorder over 9 month to 1 year periods of follow-up (Miklowitz, Biuckians, & Richards, 2006; Miklowitz et al., 1988; Miklowitz et al., 2000; O'Connell et al., 1991; Priebe, Wildgrube, & Muller-Oerlinghausen, 1989; Yan et al., 2004).

For bipolar disorder, the implications of EE research are several-fold: (a) modifying the emotionally charged environment of the family after a mood episode may hasten the patient's recovery and delay recurrences; (b) caregivers may benefit from psychoeducation oriented toward distinguishing what behaviors are controllable

(e.g., willful oppositionality) and not controllable (i.e., illness-driven) by the patient; and (c) families of patients with bipolar disorder often need assistance in communicating and solving problems effectively during the post-episode period.

### Content and Structure of FFT

FFT has been conducted with patients in a variety of family constellations: biological parents, step-parents, spouses, siblings, and grandparents. FFT, given with pharmacotherapy, consists of three stages: psychoeducation about the nature, etiology, treatment, and self-management of BD; communication enhancement training, in which patients and caregivers rehearse effective speaking and listening skills; and problem-solving skills training, in which patients and caregivers define problems, generate and evaluate solutions, and implement solutions to specific conflicts in the family. The treatment is given in 21 sessions (12 weekly, 6 biweekly, 3 monthly) over 9 months, and is often supplemented with booster sessions after formal treatment ends. Sometimes, the demands of a case require additional sessions during acute symptomatic phases, or reordering the communication and problem-solving modules so that they are presented earlier in the treatment.

#### *Psychoeducation (Sessions 1–7)*

The initial sessions of FFT are focused on educating the family about BD. Topics covered include symptoms of depression and mania (or hypomania), a model for understanding the development of BD in terms of genetic components and environmental stressors, discussion of protective (e.g., stable sleep-wake patterns, regular routines) and risk factors (e.g., escalating family conflict, substance abuse) for BD, and examination of ways in which the family and the school can be helpful to the adolescent with BD. The importance of medication in the management of BD is emphasized and the family's questions about effects and side effects of medications are addressed. A custom-designed mood and sleep chart is developed for each member of the family who is interested in using one, with mood states named and described in that family member's own language.

The final component of the psychoeducation module is the "relapse drill." This is a specific plan, developed with the family, covering signs of an impending episode (a list of what the initial "red flags" are likely to be) and what steps each family member can take to prevent a crisis. A modified version of this exercise, in the case where the adolescent's mood problems do not take the form of discrete, easily recognized episodes, consists of a discussion of "How can you tell that I'm having a bad day?" and "What can I (and other family members) do to improve the situation?"

#### *Communication Enhancement Training (Sessions 8–14)*

The goal in this part of the treatment is for the family to learn four specific communication skills: expressing positive feelings, listening, requesting a positive change, and expressing negative feelings (anger) constructively. Each skill is taught through the therapist modeling the skill, family members practicing the skill with the help of a handout that delineates the components of the skill, receiving feedback from the therapist and other family members about how the skill was performed, and trying again after incorporating the feedback. Once a skill has been introduced, the therapist will suggest using the skill in family discussions that are going awry, reminding the family, for example, "Let's try the listening skill here." After learning a skill, the family is given a homework sheet to record their attempts to use the skill at home between sessions.

#### *Problem Solving (Sessions 15–21)*

Families are taught a problem-solving model that takes them through a series of steps: defining the problem, brainstorming possible solutions, weighing the pros and cons of each possible solution, choosing one or more solutions, and reevaluating the solution after implementation. The family records the results of each step.

Toward the end of FFT, sessions are tapered to trimonthly. Maintenance sessions revisit the objectives of FFT: Has the family gained an understanding of the cyclic nature of the disorder? Is consistency of medication treatment in place? Has the family developed and implemented a relapse prevention plan? Are escalating verbal conflicts being managed? These sessions usually involve reviewing problem-solving and communication skills. (For further details about FFT, see Miklowitz, 2008, *Bipolar Disorder: A Family-Focused Treatment Approach*; and Miklowitz & George, 2008, *The Bipolar Teen: What You Can Do to Help Your Child and Your Family*.)

### Empirical Support for FFT

A number of open and randomized controlled trials of FFT have been conducted (for review, see Miklowitz, 2008). Probands have included adults and adolescents. Control groups have typically received a brief course of psychoeducation with crisis management as needed. FFT was shown in one adult trial ( $N=101$ ) to be more effective in stabilizing bipolar mood symptoms (particularly depressive symptoms) and delaying recurrences of mood episodes and hospitalizations than a shorter family psychoeducational treatment (Miklowitz et al., 2003). Likewise, adolescents who received FFT and pharmacotherapy had shorter times to recovery from depression, more time in remission from depression, and a less severe trajectory of depressive symptoms than adolescents who received brief family psychoeducation and pharmaco-

therapy (Miklowitz et al., 2008). In one trial involving adult manic patients ( $N=52$ ), FFT was compared to an equally intensive individual therapy (Rea et al., 2003) and patients were followed over 2 to 3 years. The advantages of FFT over individual therapy were apparent after the first posttreatment year. FFT showed lower rates of rehospitalization (12% vs. 60%) and symptomatic relapse (28% vs. 60%) than individual therapy. The multisite STEP-BD program ( $N=293$ ) found that FFT was at least as effective as cognitive behavioral therapy and interpersonal therapy, and more effective than brief psychoeducation in hastening time to recovery from bipolar depressive episodes, enhancing psychosocial functioning, and increasing the likelihood of remaining well over a 1-year follow-up (Miklowitz, Otto, Frank, Reilly-Harrington, Kogan et al., 2007; Miklowitz, Otto, Frank, Reilly-Harrington, Wisniewski, et al., 2007). Thus, FFT has a strong record of empirical support in randomized trials.

### Difficult Case Illustration<sup>1</sup>

#### Pretreatment Assessment

Isaiah, a 15-year-old white male, was referred for FFT after a month-long major depressive episode. The family consulted their pediatrician (Dr. Lang) who tested Isaiah for a host of illnesses, including mononucleosis. Dr. Lang was unable to find an explanation for Isaiah's extreme fatigue, anhedonia, and hypersomnia. He referred Isaiah to our research program for assessment. Prior to this, Isaiah had never been in psychiatric treatment. In accordance with our protocol, both Isaiah and his parents were administered the Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (K-SADS-PL; Chambers, et al., 1985; Kaufman et al., 1997), a structured clinical diagnostic interview. The results of the K-SADS yielded the diagnosis of bipolar II disorder. Isaiah had a history of experimentation with alcohol and marijuana, so the Substance Abuse KSADS Supplement was administered. His responses to that supplement suggested a possible past diagnosis of alcohol abuse as a result of binge drinking the previous summer.

In addition to the K-SADS, we administer a number of questionnaires at intake and follow-up to assess the adolescent's symptoms: Beck Depression Inventory-II (BDI-II; Beck et al., 1988); Self-Report for Childhood Anxiety Related Disorders (SCARED; Birmaher et al., 1997); and Drug Use Screening Inventory (DUSI; Tarter, 1990). We also assess parents' symptoms (BDI-II; Symptom Checklist-90; Lipman et al., 1968) at intake and follow-up. At intake, Isaiah described himself as severely depressed and anxious. He reported that he had not had any alcohol since the previous summer (5 months prior) and that he "didn't do drugs." Mother

reported no current mood symptoms while father reported that he had experienced bouts of moderate depression.

#### Early Psychoeducation Sessions

Isaiah came to treatment with his mother, Susan (35), his father, Bruce (40), and his two siblings, Ada (a 13-year-old girl) and Henry (a 9-year-old boy). At the time Isaiah and his family began family therapy, he was taking lithium (a mood stabilizing medication) and quetiapine (Seroquel, an atypical antipsychotic) prescribed by the FFT-A program psychiatrist. Since beginning medication, just prior to entering treatment, Isaiah's depression had remitted and, though he was irritable and anhedonic at times, he did not appear to have any acute hypomanic or depressive symptomatology.

Treatment began by asking the family to describe their individual goals for therapy. Isaiah wanted to do better in school and be more independent. Both parents were unable to come up with personal goals for themselves. They were focused on Isaiah getting well, although they seemed to have different beliefs about what was required to accomplish that goal. Ada wanted the family to spend more time together. Henry just wanted to spend more time with his brother. During the initial psychoeducation portion of FFT, the therapist encouraged family members to discuss their experiences with mood swings and to develop individualized mood charts. Isaiah described periods in the past of being happy (feeling more confident, having more energy), angry (being more defiant, fighting with peers, experiencing distorted thinking), and sad (feeling bored and tired, not liking himself, feeling helpless and hopeless). In creating Susan's mood chart we learned that she had experienced a major depressive episode in the past but was currently in remission. She had taken an antidepressant medication at that time. Though her depression wasn't problematic, she stated that she was currently quite anxious about Isaiah's health. She reported that if she didn't know where Isaiah was at all times she would feel sick to her stomach. She did not see anxiety as being problematic in her day-to-day life. Isaiah's father, Bruce, had bipolar mood symptoms that had been treated well with medication alone. Bruce believed that his moods were infrequent and mild, and did not involve accompanying symptoms. Ada did not come into the study with a formal diagnosis but, in preparing her mood chart, she described a major depressive episode in the past and was continuing to struggle with symptoms of depression and anxiety. Her parents wondered if she should be evaluated for medication. Henry did not report any symptoms.

#### Initial Resistances to Treatment

Susan brought Isaiah to every session and made calls between the sessions with concerns about his symptoms, but Bruce, Ada, and Henry attended inconsistently during the first 5 sessions of the psychoeducation. Susan explained that

<sup>1</sup> Details about the case have been modified to protect the identity of the client.

she didn't bring the younger kids because she wanted to focus on Isaiah, and that the others created a distraction. It is not unusual for family therapists to have difficulty scheduling sessions such that all family members can attend. In addition, therapists often can strategize with parents about which sessions might be most useful for younger family members to attend, and sometimes plan sessions for family dyads, triads, or other subsets that might particularly benefit from focused communication or problem-solving exercises. In this case, however, the inconsistent session attendance seemed related to Susan and Bruce's discordant beliefs about what would help Isaiah.

Bruce started missing more and more due to "work obligations." By Session 6, Bruce relayed that he thought Isaiah's medication was working well and he didn't see the point of family therapy. The therapist became aware that a problem was developing, as the family dynamics seemed to be shifting toward a detached father and an "enmeshed" or overinvolved mother, with the parents' alliance and executive role seemingly at risk of strain. Isaiah became more distant during the psychoeducation sessions. Susan became consumed by worry about Isaiah's moods. A typical interchange went like this:

SUSAN: Isaiah, you seem depressed to me. You hardly talk anymore.

ISAIAH: Mom, I am doing fine. Dad is right, the medication is working and I don't need you worrying about me. I want to start going out with my friends again and being treated like a normal kid.

SUSAN: I am still concerned that you are having symptoms and are at risk for having an episode. We've learned in these sessions how dangerous it is for you to have mood episodes and that the medication isn't the only answer to managing this illness.

ISAIAH: This is useless. I may as well not talk to you anymore since you don't trust me to know when I am doing okay or not.

CLINICIAN: Isaiah, because relapse can happen with bipolar disorder, it makes sense that your mother would be concerned. However, Susan, Isaiah does seem to be doing well right now. We'll be talking about relapse prevention soon and that should help you with deciding when Isaiah is at greater risk. Hopefully, the two of you can compromise about when to be concerned and when to let Isaiah have a bit more independence.

SUSAN: I am open to discussing a compromise in the future but I think that supervising Isaiah more closely is working well right now.

### Subsequent Sessions of Psychoeducation

Over the next several weeks, Isaiah became more irritable and less communicative. The therapist felt like she was losing him but was confused about what was driving his withdrawal. Bruce was inconsistently attending sessions and seemed irritable in the sessions he attended. Susan had become more involved with Isaiah, whom she wouldn't leave home alone or allow to go out with friends.

At Session 8, Susan requested an individual meeting with the therapist. She felt like her family was splintering and was unsure about what to do. She and Bruce frequently disagreed about how to be supportive to Isaiah. She was also concerned that no matter how hard she tried to connect with Isaiah, he was completely unresponsive and uncommunicative. Because the family had largely completed the psychoeducation module, the therapist decided to move on to the next module of FFT (communication skills training) to reengage the family and facilitate Susan's expression of her concerns.

### Communication Skills Training

Isaiah, Bruce, and Susan came to the next session together and the therapist introduced the "active listening" skill. This skill often opens up blocked lines of communication because its components (attending to the speaker, asking questions, and paraphrasing what the speaker is saying) foster a sense of collaboration. Susan expressed concerns about Isaiah's distance and unresponsiveness, and Isaiah was able to reflect back his mother's words. Isaiah became angry and said that he felt like his mother was putting all of her energy into him instead of dealing with her own life. He complained that he felt stifled and wanted to be treated like a typical teenager. Susan replied that she couldn't quit worrying about him because, now that she knew he had bipolar disorder, she was afraid he would have a relapse and possibly die.

ISAIAH: Mom, I am still not having any problems, you don't need to be so worried about me all the time!

SUSAN: We don't know what may happen if you start going out with friends, staying up late, and possibly getting into trouble. You could get sick again and have another episode.

CLINICIAN: Isaiah, would you mind using active listening so your mom knows what you think you heard?

ISAIAH: I hear that you are still worried about me and that is why you won't let me go out with my friends. But, I am taking my medication, coming to these

appointments, and being very careful. I'm not stupid—I don't want to have another episode—then you'll worry even more about me.

BRUCE: Susan, the boy is right, you have to give him his freedom and see how he will do. If we don't let him be more independent we will never know if he can succeed in taking care of himself or not.

SUSAN: So what I hear is that you both think that Isaiah is not in danger of having an episode and that I should back off.

The therapist made a point of praising the family's efforts to practice the skill. With the therapist's help, Susan agreed to experiment with letting Isaiah go out with friends on weekends and spending some time home alone during the week.

### **Problem-Solving Skills Training**

During the next session, Susan stated that she had let Isaiah go out with some friends on Saturday during the day and that he had been responsible in letting her know where he was and when he would be back. Encouraged by Susan's report, the therapist introduced the problem-solving handout and helped Susan, Isaiah, and Bruce generate additional options for giving Isaiah more independence. Susan agreed that Isaiah could go out with friends on weekends as long as he kept to his curfew. She also agreed to leave him at home alone when she had appointments or errands to run, as long as she knew that he was taking his medication regularly and his mood chart did not reflect any escalating mood symptoms. Isaiah agreed to keep his mood chart, come home by his curfew, and tell his mother when he was taking his medication each day.

For the next several sessions the whole family attended therapy together. The therapist was able to move through the rest of the communication skills and complete another problem-solving exercise. Susan and Bruce seemed to be getting along better, the family was spending more time together, and there was less tension during the sessions. Isaiah was still distant and irritable, however. When asked by his parents whether something was wrong, he insisted that he was fine but that he still felt that they were overly controlling. His parents agreed that because his mood chart was asymptomatic and he had been sticking to curfew and taking his medication, he could stay out 30 minutes later on the weekends and spend time with friends if all of his homework was completed during the week. Susan had doubts about giving Isaiah more freedom, but Bruce and the therapist supported Isaiah's request for more autonomy.

### **Suicide Attempt**

Within 2 weeks, Susan called to tell the therapist that Isaiah had made a serious suicide attempt (an overdose of his prescription medications) and was in the hospital. The inpatient toxicology screen found cannabis and cocaine. She faulted the therapist for pushing her to give Isaiah more freedom and terminated the treatment sessions, stating that she did not want to be contacted further. She said that she would be finding another provider who would support her parenting style and her necessary involvement in her son's life. Unfortunately, despite attempts to reconnect with Susan, Bruce, and Isaiah, this was the last contact that the therapist had with the family.

### **Factors That Might Account for the Unsuccessful Outcome**

When a treatment approach fails in a specific case, it may be that characteristics of that particular patient/family are the logical place to begin looking for an explanation. In clinical trials, this problem is usually addressed by examining if some subjects benefit more or less from the treatment than others. This is an argument for using a broad range of variables in the study's assessment battery. It may become apparent that the standard approach is unlikely to be successful with families with certain definable problems or dynamics, or adolescents with certain comorbidities (e.g., substance abuse). Alternately, the treatment protocol may be adequate for addressing the patient's and family's difficulties, but treatment delivery variables may interfere with obtaining a successful outcome. Many of these factors were at work in this case.

An issue inherent in doing family therapy, and one that has challenged us in FFT, is the problem of developing and maintaining an alliance with parents and adolescent simultaneously. Maintaining a good alliance with all members of a family can be challenging for a number of reasons. In some families of bipolar adolescents, the child comes across as disrespectful, irresponsible, and at times even verbally or physically abusive to the parents. It can be difficult for the clinician to join with the child, as one's sympathies go to the plight of the beleaguered parents. In other families, the parents are clearly behaving inappropriately (e.g., abusing substances, terrifying family members with their rage attacks, being unnecessarily punitive or physically abusive), and allying with the parent (s) becomes the challenge. Even in situations that are not so extreme, the parents and the teen often see their own interests in conflict with the others'. Subtle support of one party may feel like a betrayal to the other. In these polarized families, the therapist's best efforts to maintain neutrality can go awry.

In the case presented, the therapist felt that she had a good connection with Isaiah. Due to Isaiah's age and

apparent mood stability, the therapist perceived Susan as being unnecessarily anxious and overprotective, and her sympathies went toward the adolescent. Additionally, the therapist was able to create a sufficient enough alliance with Susan to suggest that she was too involved in managing her son's life and encourage her to back off a bit. Susan was not convinced, but was willing to follow the therapist's advice. When Isaiah attempted suicide, the tenuousness of the alliance with Susan became apparent. She was angry at the therapist for encouraging her to relax her supervision of her son and blamed the therapist for putting her son in harm's way. A second difficulty in this case has to do with the delicate nature of intervening with parental EOI, typically defined as overconcern, overprotectiveness, and an inordinate level of self-sacrifice. When researchers have separately examined the three components of EE (criticism, hostility, and overinvolvement), findings on the relationship between patient outcome and EOI have varied across studies. One complicating factor is the diverse composition of families in these studies; caregivers have been parents, grandparents, spouses, and siblings. Relatives' EOI has been associated with worse patient outcome in schizophrenia (Miklowitz, Goldstein, & Falloon, 1983; Vaughn et al., 1984), anxiety disorders (Chambless & Steketee, 1999), and eating disorders (Szmukler, Eisler, Russell, & Dare, 1985), but has predicted better outcomes among patients with borderline personality disorder (Hooley & Hoffman, 1999) and adolescents at risk for psychosis (O'Brien et al., 2006). Several authors (Fredman, Chambless, & Steketee, 2004; King, 2000; Wearden et al., 2000; Wiedemann et al., 2002) have commented that EOI, at least as judged from the Camberwell Family Interview (Vaughn & Leff, 1976), is quite heterogeneous and reveals little about what familial behaviors might influence relapse in specific disorders. In defense of the EOI parent, there is no conclusive evidence that this stance is always unhealthy.

Bipolar adolescents, like many healthy adolescents, frequently complain about their parents being too nosey, intrusive and controlling. But when an adolescent has a severe psychiatric disorder, parents usually make the case that they *have* to step in and manage the child's life. In teaching families communication and problem-solving skills, clinicians hope to strengthen boundaries between individuals and subsystems within a family, encourage the adolescent's healthy functioning and autonomy, and reduce the parents' distress levels. But encouraging parents of unstable adolescents to give their child more responsibility and freedom can backfire (as in this case), and there may be a price to pay in terms of alliance with the parent and, more importantly, risk to the child's safety. In some cases, parents have told the therapist that gaining some emotional distance from their offspring's

disorder was a key gain from treatment. At the end of FFT, one mother said, "It was helpful to learn that she can't always control herself because of her brain biology. . . . It's helped me to back off and take better care of myself." In other families, the "backing off" had a hostile edge (for example, a mother said to the therapist, "You deal with him, then"), but nevertheless, seemed to contribute to improved outcome, probably by reducing the level of conflict in the family. Some parents report a great sense of relief at being given "permission" to distance themselves from the patient's problems, especially if they simultaneously learn to take care of their own health. Fleshing out helpful and unhelpful aspects of parental overinvolvement may be the most helpful approach.

The third, and most obvious, factor that contributed to this treatment failure was Isaiah's hidden substance abuse. The comorbidity of BD and substance use disorders (SUD; i.e., abuse or dependence of alcohol or drugs) has been well documented in the adult BD literature, and is associated with markedly increased illness severity across a broad spectrum of parameters (Cassidy, Ahearn, & Carroll, 2001). Both clinical and epidemiologic data indicate that the lifetime prevalence of SUD among child- and adolescent-onset subjects is significantly greater than among adult-onset subjects (Goldstein & Levitt, 2006; Perlis et al., 2004). Indeed, SUDs (most commonly alcohol and cannabis disorders) are prevalent among approximately 20% of adolescents with BD in large-scale clinical studies (Biederman et al., 2005; Goldstein et al., 2008). Epidemiologic data from the United States (Lewinsohn et al., 1995) and Germany (Wittchen et al., 2007) indicate that BD is associated with elevated prevalence and incidence of SUD compared to adolescents with and without other psychiatric diagnoses.

Adolescents with BD and comorbid SUD incur significant risks. Recent findings from a first-hospitalization sample of adolescents with BD indicate that alcohol use was a significant predictor of mood episode recurrence during 12 months of follow-up, and that this effect persisted after controlling for the poorer medication adherence of this group (DelBello et al., 2007). Youth with comorbid BD and SUD demonstrate high rates of academic difficulties (Geller et al., 1998), problems with police, and higher prevalence of pregnancy. Finally, there is a nearly three-fold increased prevalence of suicide attempts among bipolar youth with comorbid SUD as compared to bipolar youth without SUD (Goldstein et al., 2005).

Though our initial assessment of substance abuse disorders (based on the K-SADS) indicated that Isaiah did not have a SUD at the time of study intake, this case clearly illustrates that substance use status can change at any time without parents or therapist being aware of the change.

When a family member is secretly abusing substances, treatment effectiveness will likely be undermined.

### Implications for Modifications of FFT

There are lessons to be learned from systematically identifying and examining the factors that create problems in FFT. Understanding these elements allows changes to be made in the treatment that may promote more consistent positive outcomes. In addition, these insights may lead to new directions in research to inform the treatment process.

Because their goals frequently appeared to be at odds, one of the challenges in Isaiah's treatment was to simultaneously create and maintain an alliance with both Isaiah and his mother. A number of research measures have been developed to operationalize therapeutic alliance (see Fenton et al., 2001, for a comparison of the predictive validity of several different instruments) and studies have looked at the relationship between alliance and outcome (e.g., Barber, et al., 1999; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). A meta-analysis (Horvath & Symonds) found a moderate but reliable association between good working alliance and positive therapy outcome. Clients' assessments of working alliance were more predictive of outcome than therapists'. The picture becomes more complicated in the context of family therapy when a number of individual alliances must be maintained simultaneously.

One study (Smerud & Rosenfarb, 2008) examining family education in the treatment of schizophrenia found that patients whose families developed a good alliance with the therapist had significantly better outcomes than patients whose families had a poor therapeutic alliance. In addition, when parents developed a positive therapeutic alliance with the therapist early in treatment, patients were less likely to show prodromal symptoms of relapse or be rehospitalized over a 2-year follow-up period. Moreover, when patients developed a positive therapeutic alliance with a therapist, relatives tended to be less rejecting of patients and tended to be less likely to feel burdened in caring for the patients. Future research might examine the complex combinations of therapeutic alliance that often appear in family therapy settings. The more difficult clinical questions occur when the alliance is unbalanced and some family members feel allied with the clinician and some do not. Cases in which therapists become "caught in the middle" may have the most difficult course of treatment.

The second issue that proved problematic in this treatment was Susan's emotional overinvolvement. Fredman et al. (2004) developed and validated an observational coding system for EOI that provided separate ratings for intrusiveness, excessive self-sacrifice, and exaggerated emotional responses in an anxiety sample.

This coding system was extended to differentiate between appropriate and inappropriate displays of involvement (Fredman et al., 2008). Results indicated that it was possible to differentiate among the three aspects of overinvolvement in a bipolar sample and that it was feasible to distinguish between appropriate and inappropriate displays of these behaviors.

Differentiating between appropriate and inappropriate involvement is a key clinical issue in working with families of severe psychiatric patients. Attempting to intervene with the inappropriately involved caregiver can be challenging and carries the risk of causing a breach in the alliance. Often, the clinician's judgment of whether a parent's behaviors are appropriate or inappropriate can seem very subjective to the parent; a case of "your way versus my way." More clearly defined, empirically derived, objective guidelines for what constitutes appropriate versus inappropriate parental involvement for different ages and functioning levels, and which may vary with the severity of the patient's disorder, would be immensely helpful for clinicians to present as a guide for parents.

Adolescents with bipolar disorder will need more familial support when they are symptomatic and less help when they are doing well. The therapist must promote healthy involvement (i.e., responding to the adolescent's specific requests for support; turning specific responsibilities over to the patient as he or she improves) and provide a functional model of when and how to step back. When possible, clinicians should provide specific, concrete guidance to parents as opposed to just try to get them to "back off." Perhaps Susan would have responded better to the development of specific parenting goals that fit with Isaiah's age and functioning level (ideally, goals based on research findings on appropriate parental involvement in this disorder, a currently underdeveloped area).

A modification to the treatment in emotionally overinvolved families might involve adding a parenting session without the adolescent where the clinician provides examples to the parents of appropriate and inappropriate levels of involvement, self-sacrifice, and emotional response, and facilitates a discussion of where the parents see themselves in this regard. This session could focus on parental emotions that may lead to maladaptive parenting behaviors. For example, parental anxiety may lead to intrusiveness, overconcern, and extreme self-sacrifice. Parents who feel guilty about their child's illness may overindulge the child and not hold him or her accountable for his or her behavior. Parents can be taught that the most adaptive model is acceptance of the illness, leading to compassion and more positive interactions with the child, less family tension, and encouragement of independence (and corresponding responsibility) on the part of the adolescent.

The third issue that presented difficulties in the treatment was Isaiah's exacerbation of mood symptoms and substance abuse. Examination of Isaiah's BDI-II and SCARED anxiety scores over 9 months of follow-up reveals an interesting pattern. Scores on both of these questionnaires were quite high at intake, dropped markedly at the 1.5-month follow-up, and then gradually crept up over the following 9 months, culminating in his suicide attempt and hospitalization. The family discontinued treatment after the suicide attempt, but continued with follow-up and psychiatric visits through the 2-year study period. Isaiah's BDI-II and SCARED scores shot up and remained elevated (close to intake level) through the 18th month of follow-up and then dropped to milder levels by 24 months. We do not systematically use an adolescent's research follow-up data to inform his or her treatment, but by not doing so, we may be losing valuable information. Perhaps addressing his increasing depression and anxiety scores would have preempted his suicide attempt.

Our clinical protocol calls for excluding adolescents who currently meet criteria for substance abuse or dependence disorder from entrance into the study. Nonetheless, many adolescents develop new substance abuse during treatment or have relapses of preexisting problems. Isaiah revealed his prior binge drinking at intake, but reported no drug or alcohol use on the questionnaire. Clinicians may want to consider adding a regular substance abuse assessment (or, in some cases, urinary drug screens) for youth who may be at risk. Because substance abuse is so prevalent in the bipolar population, a modified version of FFT has been developed to address adolescent substance abuse (Goldstein, Goldstein, et al., 2008).

### **FFT for Bipolar Adolescents With Substance Abuse**

The goals of the adapted version of FFT for substance abusing bipolar teens focus on: (a) reducing the frequency and amount of the adolescent's substance use; (b) preventing and/or minimizing negative outcomes that are related to substance use, including medication nonadherence, legal difficulties, injuries/accidents, suicide attempts, and negative sexual outcomes (unwanted pregnancy, STDs, sexual assaults); and (c) promoting "substance-free" homes, and facilitating the process of minimizing substance use in the family members of adolescents with BP.

FFT takes an empirical approach to substance use. The speed with which substance use among adolescents with BD can spiral from experimental to problematic underscores the importance of various methods of screening in order to identify substance use at the earliest point possible. The main strategy for motivating the adolescent and family to change substance-related behavior is longitudinal gathering of data—particularly on the mood

diary, but any observations are valuable—regarding the role substances play in affecting mood, sleep, family functioning, and risky behaviors. Although clearly a delicate topic, parents are encouraged to discuss their own alcohol and drug use—particularly current use—as it relates to these factors.

It is critical that parents are on the same page when it comes to their stance on substance use. Particularly early in therapy, many parents and adolescents will not feel comfortable discussing substance use candidly. For this reason, FFT sessions focusing on substance use can be divided so that the adolescent and parents each have their own time with the therapist. The adolescent may discuss more candidly substance use or risk behaviors that he feels too uncomfortable discussing in the presence of the parents. In this case, the therapist works toward helping the adolescent problem-solve how to integrate this information into family sessions, and by fostering the appropriate use of communication skills during family sessions in which these emotionally charged topics are discussed. In turn, the therapist works with the parents in order to help guide them toward a consensus regarding substance use, both their own and that of the adolescent.

Therapists can dedicate a problem-solving session to identifying ways in which household contingencies, rewards, and consequences can be directed toward the adolescent's substance use. In one example, the parents of a 16-year-old, who had been concerned about him driving while intoxicated, agreed to take him to get his learner's permit immediately after the next negative urine drug screen. In another family, the parents and adolescent collaboratively agreed on a reward system in which the "currency" was the number of curfews met each week, which could be cashed in for such rewards as deciding where the family went for dinner or getting permission for independent activities such as going on a trip with friends. Several other strategies that have been used successfully for adolescents with SUD can be integrated easily into FFT. For example, psychoeducation sessions should include detailed information regarding the specific risks of substance use for adolescents with BD (as described above). Communication enhancement sessions can be applied to practicing substance refusal skills. Problem-solving sessions can help to identify strategies for avoiding predictable triggers (people, places, activities) for substance use, and to identify ways to cope with cravings or urges to use substances. These sessions can also focus on ways to enhance social supports and increase pleasant activities, both of which are reviewed during psychoeducation sessions as strongly protective against substance use.

Addressing substance use directly with Isaiah and his parents and connecting this use with an increase in mood symptoms and additional negative consequences might



have improved the outcome of this treatment. For example, the clinicians could have met with Isaiah individually when it was clear that he had become withdrawn and distant (in spite of the family's overall improvement), and ask if there were any events, aversive feeling, habits, or risk behaviors that they were missing. Since it is not uncommon for adolescents to falsely deny substance use when asked directly, relying on additional sources of information such as self-report questionnaires can be helpful in bringing this issue to light—and to the foreground of treatment. Surprisingly, some teens will deny substance use when confronted face to face, but admit it on self-report questionnaires (often inquiring into the confidentiality of their responses before doing so). In this situation, the therapist may ask for an individual session with the adolescent, and ask the teen's permission to raise the issue with his parents present.

### Conclusion

The use of FFT to treat adolescent bipolar disorder was described. An FFT case with poor outcome was examined in an attempt to understand what went wrong. Several factors contributed to the poor outcome: difficulty allying with different family members who had seemingly conflicting goals, the pitfalls of intervening with an overinvolved parent, and the adolescent's secret substance abuse. Examination of these factors led to suggested modifications to FFT which could improve the outcome of patients with these risk factors.

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Address correspondence to Elizabeth L. George, Ph.D., Department of Psychology, University of Colorado, Boulder, CO 80309-0345; e-mail: [elizabeth.george@colorado.edu](mailto:elizabeth.george@colorado.edu).

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