chapter 1

Bipolar Disorder

Why Family Treatment?

Stewart was admitted to a city hospital for an acute episode of mania. He was extremely irritable and euphoric, pressured in his speech, and preoccupied with his "campaign" for the U.S. presidential election, for which he claimed to be a write-in candidate. The admitting physician immediately put him on a combination of lithium and antipsychotic medications, but his hospitalization lasted only 8 days. For his wife, Susan, this hospitalization seemed too short, given how ill he had been when he was admitted. In fact, in the weeks after his discharge his symptoms were still quite evident: He still slept only 4 hours per night, continued to talk of how he could "wire the presidential election," became angered easily, had trouble concentrating on conversations, and behaved in an embarrassing manner in public (talking and laughing too loudly, yelling inappropriately at waiters in restaurants). His intention to return to his computer programming job seemed to Susan like a pipe dream.

Susan tried to arrange for outpatient care with the same physician who had treated Stewart on an inpatient basis. However, Stewart refused to see this doctor, arguing heatedly, "That was the same guy who locked me up in those restraints." He finally agreed to a session at a local mental health center with a staff psychiatrist. He did not like this doctor either, describing him as "an idiot in a lab coat." Becoming desperate, Susan tried to get an appointment with a social worker at the center, only to be told there was a 3-week waiting list for such an appointment. She read everything she could get her hands on to educate herself about bipolar disorder, but everything pointed to the importance of taking medication

and being under the regular care of a psychiatrist. She became quite angry with Stewart: Much of his behavior—particularly his unwillingness to consult a psychiatrist—seemed purposeful and intent upon hurting her. Stewart reacted to her criticisms by "upping the ante" and threatening to leave her.

Meanwhile, Stewart's symptoms did not abate, and the prescription given to him at the time of his discharge was starting to run out. He turned his anger upon his wife, arguing that what she was calling his symptoms of mania were really his personality and that he didn't need the medication at all. One night, after a heated argument, he revealed that he had discontinued his medications 3 days earlier to prove to her that he was healthy. "See?" he yelled triumphantly. "You said I'd have a breakdown, but here I am!"

Two days later, Stewart's behavior became increasingly disorganized. His condition resembled that which had led him into the hospital in the first place. That night, he disappeared. Early in the morning, Susan was telephoned by a police officer, who said that Stewart had been arrested while trying to break into the downtown Republican election headquarters. He was again admitted to the hospital with a recurrence of mania.

One could describe the events that occurred in this case from several different vantage points. A *biological psychiatrist* would argue (1) that Stewart's brain has genetically determined imbalances in catecholamines or other neurotransmitter or hormone systems, (2) that these must be corrected with medication, and (3) that his unwillingness to take medications has made his illness worse. In contrast, a traditional *family systems-oriented* practitioner, although perhaps not denying the presence of a biological predisposition, would argue that Stewart's disturbed behavior cannot be separated from his distressed marital relationship, which is both a cause and an effect of his symptoms and drug noncompliance. Moreover, a *community mental health-minded* professional would view Stewart and Susan's experiences as reflecting inadequacies in the delivery of mental health services to those who are most needy, and speaking to the need for better continuity of care between inpatient and outpatient services, and between different mental health subdisciplines.

Which of these views is correct? Aren't they all correct? What model might pull these different arguments together? From my perspective as a *family psychoeducational* clinician, I would agree that this patient is indeed dealing with a biologically based disorder that is likely to recur if not treated with medication. However, I would also argue that the course of his illness is influenced by the stress in his marital relationship, even if this relationship did not play a causal role in the original onset of the dis-

order. Likewise, Stewart's wife is suffering, rather severely, from the burden of taking care of her ill husband and from the frustration of trying to find answers. Finally, I would argue that this patient has not accepted the fact that he has a severe, recurrent psychiatric illness, a precondition for agreeing to a medication regimen. Thus, this couple needs to be educated about Stewart's illness—bipolar disorder—and taught to communicate about and solve problems related to the stress it causes for both of them. They also need coaching in how to obtain proper pharmacological care and make the mental health system work for them.

This is a book about bipolar disorder and families. In it, I recount the problems experienced by patients and their family members who are trying to adapt to this lifelong condition. I also describe how, based on both my and others' research and clinical experience, they can benefit from a psychoeducational, family-focused treatment (FFT).

How Is Bipolar Disorder a Family Problem?

Bipolar disorder is a relapsing and remitting illness. Even patients receiving optimal medication are likely to have multiple recurrences and to have trouble holding jobs, maintaining relationships, and getting along with their significant others (Perlis et al., 2006; Gitlin, Swendsen, Heller, & Hammen, 1995; Coryell et al., 1993).

The behavioral and emotional experiences of the person with bipolar disorder affect everyone—the patient's parents, spouse, siblings, and children. In fact, as hospitalizations have become shorter and shorter, and as patients are discharged in quite unstable clinical states, the burden on the family has become considerable (Perlick, Hohenstein, Clarkin, Kaczynski, & Rosenheck, 2005). In this milieu, family members need support, education, and advice in coping with the ups and downs of their relative's condition.

A second reason to view bipolar disorder as a family problem stems from the effects of the family environment on the course of this disorder. Several years ago, we examined in our research a cohort of hospitalized bipolar, manic patients whom we followed over a 9-month outpatient period (Miklowitz et al., 1988). We found something quite interesting, as well as clinically useful: A patient who returns from the hospital to a stressful family environment is at greater risk for subsequent recurrences of the disorder. When recently manic patients returned from the hospital to high-expressed-emotion (EE) homes (those in which relatives held attitudes such as criticism, hostility, or emotional overinvolvement toward the patient) or to homes characterized by negative, conflictual interactional patterns (negative *affective style* [AS]), their chances of relapsing

were much higher than if they returned to low-conflict, relatively benign home situations. Further, patients from stressful environments did not function as well over time in the social–interpersonal domain as those in less stressful environments.

Interestingly, the frequent follow-ups with patients and relatives required by this study had the side effect of bringing us in close contact with the impact of a bipolar patient's disorder on his or her family, and vice versa. It became obvious to us that episodes of bipolar disorder were major life events not only for the patient, but for all who cared about him or her. Patients and relatives frequently turned to us for advice, even when our only role in the case was to conduct follow-up interviews. It appeared that no one else was available to assist them with their many problems related to dealing with the disorder.

Why FFT?

Our observations in our research and clinical work suggested we take the next step by developing a family-focused intervention program. This program, we believed, could be analogous to the psychoeducational programs that had been developed and found successful in delaying relapses for patients with schizophrenia (for a review, see Pitschel-Walz, Leucht, Bäuml, Kissling, & Engel, 2001) and should include the core components of these approaches: psychoeducation, communication skills training, and problem-solving skills training. However, we felt this program would need to address some of the unique issues relevant to bipolar patients in family contexts (described below).

This book describes our model for the family treatment of bipolar disorder. *It is not a treatment that should stand alone, but, rather, is an important component of the combined pharmacological and psychosocial treatment of the disorder.* When the model and procedures proposed here are implemented properly, they provide an organizing framework within which the goals of the pharmacological treatment can be more readily achieved. A close working relationship between the bipolar patient and his or her close family members can not only address the multiple psychological problems that emerge in the context of this disorder, but can also facilitate the patient's willingness to follow a prescribed medication regimen.

The FFT described in this book has grown out of our experience over the last 25 years in treating and conducting research with more than 300 bipolar patients—both youths and adults. These treatments have been carried out in the context of controlled clinical trials that I and my close colleagues have directed. In general, these trials have addressed the postepisode phases of a patient's bipolar disorder.

The Six Objectives of FFT

How might the symptomatic course of bipolar disorder be improved by adding a family intervention to medication maintenance? A family program has to address six important objectives if it is to have a significant impact on the stressful family relationships accompanying episodes of the disorder.

Goal 1. Assist the Patient and Relatives in Integrating the Experiences Associated with Episodes of Bipolar Disorder

Stewart and Susan began the FFT program shortly after his second hospitalization. They both were quite shaken and confused by what had occurred. Susan appeared to be experiencing a posttraumatic stress reaction, with intense, free-floating anxiety and fears that Stewart would relapse any minute. She raised the question of whether he really had bipolar disorder or some other condition—she had spoken by phone to one clinician who told her Stewart might have multiple personality disorder. Stewart, who continued to show symptoms, denied that he had even had a manic episode, arguing that he had simply been "talking too much and drinking too much coffee." He related difficult, humiliating experiences in the hospital and railed against the incompetence of the mental health system.

My colleagues and I frequently observe that patients and families have difficulty (1) recognizing the essential features of this disorder, (2) understanding the nature of the inner experience of a person who undergoes a manic or depressive episode, and (3) accepting the seriousness of the illness. Thus, a family-focused intervention must provide a theoretical structure within which patients and their relatives can gain a greater understanding of the disorder and assimilate, in a meaningful way, what has transpired in their lives. This is particularly significant for the bipolar patient who struggles to deny the seriousness of his or her disorder. But we also frequently find in the patient's relatives a struggle to accept the existence of a major psychiatric disorder in a loved one.

Goal 2. Assist the Patient and Relatives in Accepting the Notion of a Vulnerability to Future Episodes

Although there is wide variation in the clinical status of patients in the period following an acute episode of bipolar disorder, in general their most flamboyant symptoms are muted and sometimes barely evident. It

is easy at this juncture to assume that the episode was a discrete event that had a beginning and is now at an end. In the absence of the most dramatic symptoms, both patients and relatives attempt to convince themselves that this was a one-time event with few implications for the future. "It won't happen again" is a frequent refrain from patients and their relatives.

The evidence I discuss in Chapter 2 strongly suggests otherwise. Thus, a major goal of FFT is to help the patient and close relatives accept that bipolar disorder is real, and that it is a chronic condition requiring long-term management. With successful management, a more benign life course can be achieved, but without it, a downward course is very likely. Of course, acceptance of an underlying vulnerability in the face of apparent recovery is a difficult challenge. For the patient, it involves a painful restructuring of his or her self-concept, and for the relatives, substantially revising their view of the loved one.

Goal 3. Assist the Patient and Relatives in Accepting a Dependency on Mood-Stabilizing Medication for Symptom Control

Stewart had already had one instance of medication nonadherence, precipitating his second manic episode. After being discharged from the hospital the second time, he agreed to a trial of lithium, Prozac, and Navane (an antipsychotic) for "3 months max." He denied having an illness and noted with an irritated tone that he was taking medication "because I have to," and "because other people say I'm better if I do, even if I feel a lot worse." Susan, in turn, argued with dismay, "You should be just taking it for yourself!" She was understandably worried that he would discontinue his medications again. When she pushed him to stay on his medications, he would mock her by sucking his thumb and saying, in a lisp, "Honey, would you get me my Prothac?"

As I discuss in Chapter 2, the evidence for the prophylactic value of mood-regulating medications is very compelling. Clinicians recognize this evidence, but it is not always easy for bipolar patients, and sometimes their relatives, to do so. Often, patients or relatives recognize the necessity of medication during the period immediately after an acute manic or depressive episode, but over time their feelings change. Why take pills, which can have some unwanted side effects, when you or your relative is doing well? This is a reasonable question to ask and is often at the root of what clinicians term *noncompliance* or *nonadherence.* About 40% of people with bipolar disorder are partially or fully nonadherent with their medications over a 2-year period, and as many as two-thirds become nonadherent over their lifetimes (Colom et al., 2005).

In my experience, problems with adherence to a recommended medication management program are often the basis of very intense conflicts between bipolar patients and their close family members. Thus, this issue must be addressed intensively and repeatedly in a family-focused program. Family psychoeducation has to address this issue at two levels: at a cognitive level, by providing important information about the risks of stopping maintenance medication; and at an affective level, by addressing significant feelings of patients and their relatives about this dependence. The FFT treatment model is designed to assist the patient and his or her close relatives in working through the emotional resistances to pharmacotherapy.

Obviously, there is a significant linkage between the second goal and this one. When the patient and close relatives can accept, despite clinical improvement following the most recent episode, that there is an underlying vulnerability to future episodes, acceptance of the need for a prophylactic medication regimen is more readily achieved.

Goal 4. Assist the Patient and Close Relatives in Distinguishing between the Patient's Personality and His or Her Bipolar Disorder

Stewart continually maintained that the behaviors other people were calling "mania" were really just exaggerations of his personality and temperament. In contrast, for Susan, everything Stewart did had become a sign of his bipolar disorder. She began labeling his reactions to even mundane daily events as signs of an impending relapse. Her hypervigilance led to great hostility on Stewart's part, who said, "You can't just hand me a tablet of lithium every time I laugh at a movie." His hostile reactions convinced Susan even further that he was relapsing again.

FFT is oriented toward assisting members of a family to accept the existence of bipolar disorder in one of them. But there can be hazards in this approach. For example, the family may come to this acceptance fairly readily and begin to see everything the patient feels or does as a sign of his or her disorder. These perhaps overgeneralized attributions cause great resentment in the patient, who may begin to lose the ability to distinguish his or her normal emotions or desires from pathological ones. Like the proverbial centipede who, when asked how he moved all 100 legs with such beautiful coordination, could not do it anymore once he thought about it, the person with bipolar disorder can be similarly paralyzed by an excessive vigilance for signs of his or her disorder.

Many patients who stop taking mood-stabilizing medication do so to distinguish their normal personality from the effects of the drugs they are

taking. As one patient expressed it, "I don't know what's me and what is due to the lithium. I need to know what I'm like without it."

We have observed another, quite different side effect of education about bipolar disorder, namely, overidentification with the diagnosis by the person with the disorder. Once such patients accept the diagnosis, it explains everything. They cannot be successful in their careers because they have bipolar disorder, or relationships go sour because they have bipolar disorder, and so on. The net result is that these patients, and ironically, sometimes their relatives, no longer accept responsibility for improving their lives.

Given these hazards, it is vital that a family-focused program assist patients and their family members in finding a way to recognize the enduring qualities that define the personality of the individual with bipolar disorder (particularly those qualities that reflect positive attributes) and to distinguish them from the early warning signs of the return of the disorder. When the patient and family begin to acknowledge these continuities in the self and to challenge their assumptions that being bipolar means giving up a happy or productive life, an important impasse has been broken in their struggles to accept the disorder.

Goal 5. Assist the Patient and Family in Recognizing and Learning to Cope with Stressful Life Events That Trigger Recurrences of Bipolar Disorder

Approximately 1 month before his first manic episode, Stewart had been functioning well on a regular 9-to-5 shift at his computer programming job. However, as a result of corporate downsizing, his firm decided to redefine his job requirements and give him expanded duties and an increased salary. He was at first quite pleased with this, but the new duties required that he work well into the evening and on weekends. He tried to adapt to this new schedule by drinking excessive amounts of coffee, but found he was too "wired" and overstimulated to go to sleep at his usual time. He began to experience racing thoughts concerning new and more efficient computer programs, most of which sounded unrealistic to others.

He began to feel more agitated at work and started having run-ins with his boss and coworkers. Stewart's boss suggested he take a leave of absence and "get a handle on his nerves." Stewart reluctantly agreed, and tried to get back on a normal sleep–wake cycle. However, he continued arguing with Susan and began avoiding her by spending more and more time away from home. He found it increasingly difficult to sleep at night, and his mania escalated until he stopped sleeping altogether. When he was eventually hospitalized, he hadn't slept in several days and had

developed paranoid delusions regarding plots against him initiated by his wife, boss, and coworkers.

The family-focused program described in this book is based on a vulnerability–stress model. This model emphasizes the interaction of genetic and biological factors that define the vulnerability to the disorder, and environmental stress factors that activate the underlying vulnerabilities. Our model is founded on the notion that patients and their relatives are best served when they comprehend how these two classes of factors interact with one another.

I have frequently observed that bipolar patients and their close family members do not recognize an association between life events inside or outside the family and the onset of an illness episode. As discussed in subsequent chapters, life events (such as Stewart's change in job duties) often interact with biological vulnerabilities (e.g., a central nervous system that is highly reactive to changes in the sleep–wake cycle) in producing symptoms of mania. Thus, one of the major objectives of FFT is to heighten awareness of the significance of stressful events in the life of the patient and of the family unit.

With this awareness, patients and their close relatives are more willing to examine their previous coping patterns, which may not have been effective in managing significant life events. In particular, discussions of life events open the door for patients and close relatives to examine their communication and problem-solving styles, as a prelude to developing more effective ways of dealing with stressors both inside and outside the family.

Goal 6. Assist the Family in Reestablishing Functional Relationships after the Episode

As the case of Stewart exemplifies, family relationships become quite dysfunctional in the prodromal, active, and postepisode phases of bipolar disorder. When the patient has been manic, the conflicts tend to center on his or her residual hostility, grandiosity, and denial of the disorder, as well as his or her need to reestablish independence and the often-associated rejection of a medication regimen. Family members in turn may react with criticism or overprotectiveness. In contrast, when the patient becomes depressed, family members at first try hard to help, but eventually become angry and rejecting when no amount of support seems to be enough (e.g., Coyne, Downey, & Boergers, 1992). These family conflicts cause a great deal of stress and anxiety and put a substantial burden on caretaking relatives. In turn, their negative reactions may be associated with poorer outcomes of the patient's disorder.

A major focus of FFT is to encourage the patient and family members to develop skills for open family communication and problem solving. However, unlike family psychoeducational programs for schizophrenia (e.g., Falloon et al., 1984, 1985), our focus is less on skill acquisition and more on the effects of new communication techniques on the family system. Specifically, when persons in a family are able to listen to each other and offer positive and negative feedback in constructive ways, role relationships change, power imbalances become more egalitarian, and healthier alliances develop. The result is that families who were previously critical or overprotective instead become protective influences in the course of the patient's disorder and aid his or her adaptation to a medication regimen.

The Core Assumptions and Structure of FFT

In addition to the six basic objectives outlined above, there are three core, interrelated assumptions about episodes of bipolar disorder and the need for a family-focused psychoeducational program (Table 1.1). On the basis of our clinical and research work, we have concluded that an episode of bipolar disorder is a very stressful life event for a patient and his or her family, an event that significantly disrupts the family's equilibrium. This event must be understood and accepted, but also requires the development of new coping strategies to deal with its aftermath and its likely recurrence in the future. To address these issues, we have developed three relatively distinct treatment phases or modules (after Falloon et al., 1984): *a psychoeducational phase, a communication enhancement training phase* (CET), and *a problem-solving training phase.* These treatment modules are normally delivered in 12 weekly, 6 biweekly, and 3 monthly sessions (21 total) spread over a 9-month outpatient period following a manic or depressive episode. Clinicians can also offer booster sessions after the 9-month period is over, depending on their availability and the family's needs.

The first phase—psychoeducation—involves assisting the patient and close relatives in comprehending the nature of the disorder and

TABLE 1.1. Significant Assumptions Underlying FFT

- An episode of bipolar disorder represents a disaster for the whole family system.
- Like other disasters, each episode of the disorder produces a state of disorganization in the family system.
- The overall goal of a family-focused program is to assist the family to achieve a new state of equilibrium.

its often disastrous consequences. This includes providing them with a model for understanding the origins and course of the disorder and a rationale for various components of the treatment program. Providing this information reduces guilt and mutual recrimination among family members and creates a readiness for change in family relationships.

The second phase—CET—involves assisting patients and family members to establish or reestablish effective communication patterns with one another. Many psychiatric disorders produce a deterioration in the capacity of family members and patients to communicate. This is particularly acute with a severe condition like bipolar disorder, where the symptoms of the active phase of the disorder have blocked normal communication and the residue of the episode leaves everyone unsure of how to talk to each other or reluctant to do so. Thus, an effective family-focused program needs to provide a context in which clear and effective communication can occur.

The third phase—problem solving—involves training in bringing about effective conflict resolutions. Any disaster interferes with the ability of members of a family to solve problems of daily living. Thus, a psychoeducational program needs to provide a structure in which effective problem solving can occur and to stimulate activities in which problem-solving techniques can be spontaneously implemented.

In addition to these core treatment modules, we have found that recurrent crises are expectable in the course of recovery from an episode of bipolar disorder. Most patients nowadays leave hospitals with residual symptoms—such as ongoing depression and intermittent suicidal feelings or impulses—that are difficult for them or their relatives to handle. Major or minor exacerbations of the disorder are very likely during this phase, and rarely does the course of the disorder run smoothly. Moreover, many patients develop or show a continuation of substance abuse problems that interfere with their recovery and responses to medication. Thus, a significant component of FFT is crisis intervention, provided by a clinician who knows the family well and is readily available. In our experience, this type of access to care can be extremely important in dealing with the early signs of the recurrence of the disorder and preventing full-blown relapses.

Is FFT Helpful?

There is an increasing emphasis within the research and clinical communities on empirically demonstrating the efficacy of new psychosocial treatments, usually through randomized clinical trials (RCTs) involving experimental treatment groups and comparison or control groups. As

indicated above, FFT is a fairly well-operationalized treatment with a clear outline and thus lends itself to experimental evaluation.

We have evaluated the efficacy of FFT with bipolar patients in three RCTs, one at the University of Colorado at Boulder, one at the University of California, Los Angeles (UCLA), and one in a multicenter effectiveness study called the Systematic Treatment Enhancement Program for Bipolar Disorder. Much of the clinical material presented in this book is drawn from these trials. Clearly, FFT benefits patients and families coping with bipolar disorder.

Initial Pilot Work

We began with a pilot study at UCLA in 1987–1988. We treated nine patients who had been admitted to the hospital with a manic episode and offered them and their family members (parents or spouses) the 9-month, 21-session FFT protocol (psychoeducation, CET, and problem-solving training). All patients were treated with standard medications for bipolar disorder (either lithium carbonate, carbamazepine, or both, with adjunctive antipsychotic or antidepressant medications). We compared them with 23 patients consecutively admitted into a 9-month longitudinal program consisting of similar, aggressively delivered medications and active case management by our team, but no FFT (Miklowitz & Goldstein, 1990). The two groups were comparable in age, gender, and illness characteristics.

We examined proportions of manic and depressive relapses in each group over 9-month periods of follow-up. The rate of relapse was only 11% (1 of 9) in the FFT group, whereas it was 61% (14 of 23) in the comparison, no-FFT group. This finding of reduced relapse rates among patients in FFT encouraged us to evaluate the efficacy of the treatment in RCTs.

The Colorado RCT

The first RCT was conducted at the University of Colorado (Miklowitz, George, Richards, Simoneau, & Suddath, 2003; Miklowitz et al., 2000). Patients (N = 101) were recruited in a manic, depressive, or mixed affective episode and, after individual and family assessments, were randomly assigned to FFT or to a comparison treatment condition called crisis management (CM). The CM consisted of two sessions of family education and crisis intervention sessions offered as needed over the next 9 months, At minimum, patients in CM received one telephone call per month from a crisis manager. Patients in both treatment conditions received modern pharmacological treatment using mood-stabilizing medications (for details, see Miklowitz et al., 2003).

As indicated in Figure 1.1, patients who participated in FFT with their parents or spouses, and who also received medications, were much less likely to relapse during the 2-year study than patients who received CM and medications. In fact, patients in FFT were three times more likely to finish the study without relapsing and had longer periods of stability without relapse (73.5 weeks vs. 53.2 weeks). FFT was also associated with lower depression and mania severity scores over 2 years. Furthermore, patients in FFT were more likely to maintain adherence to their recommended mood-stabilizing medications than patients in CM. This enhanced level of adherence contributed to their lower mania scores over the 2-year study (Miklowitz et al., 2003).

In further analyses of this Colorado study, Simoneau, Miklowitz, Richards, Saleem, and George (1999) found that intrafamilial communication improved among patients and family members in FFT. As compared with patients in the CM condition, participants in FFT (both patients and key relatives) showed dramatic increases from pre- to posttreatment in the frequency of positive communication, as assessed in laboratory-based family problem-solving interactions. They showed increases in communication behaviors such as self-disclosures of feelings, statements of support to other members of the family, paraphrasing of each other's ideas, and statements intended to help define and solve problems. There were increases in the frequencies of positive nonverbal behaviors (e.g., smiling, helpful gesturing) as well, particularly among patients. Patients and family members in the comparison condition actually showed decreases over

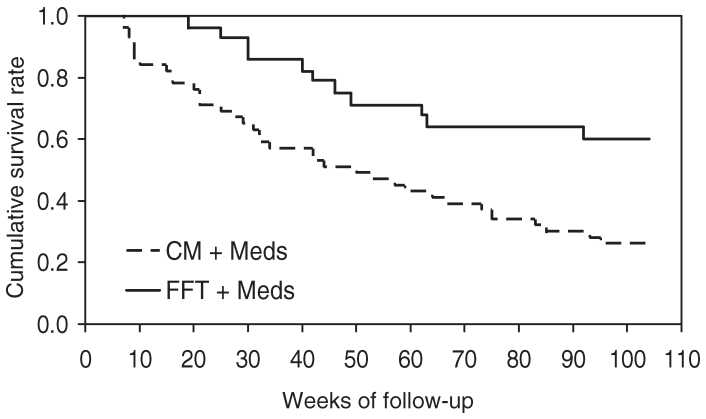

FIGURE 1.1. FFT + medication delays relapse more than crisis management and medication. $N = 101$; $p = .003$; FFT, mean survival = 73.5 weeks; CM, 53.2 weeks. From Miklowitz et al. (2003). Copyright 2003 by the American Medical Association. Reprinted by permission.

time in the frequencies of these kinds of verbal and nonverbal behaviors. When patients showed improvements in their interactions with relatives from pre- to posttreatment, they also showed greater improvements in their illness over 1 year.

The UCLA Study

The UCLA study was carried out in tandem with the Colorado study (Rea et al., 2003). In the UCLA study, patients who had been hospitalized for mania—and who returned following the hospitalization to their parents' homes—were randomly assigned as outpatients to FFT and medications or to individual therapy and medications. The individual therapy had many of the same ingredients as the FFT—psychoeducation, relapse prevention planning, and encouragement of medication adherence—but families were not involved. Like those in FFT, patients in individual therapy received 21 weekly, biweekly, and then monthly therapy sessions over 9 months, as well as the same types of medications.

The results are pictured in Figure 1.2. Patients in FFT and those in individual therapy had similar rates of relapse and rehospitalization during the first year of the study, during which they were getting the study-based psychotherapies. Once this year was over, however, patients in individual therapy relapsed (60%) and were rehospitalized (60%) at a much higher rate than patients in FFT (28% and 12%, respectively). In addition, when patients in FFT did relapse, they were less likely to require hospitalization than the patients in individual therapy who relapsed. In all likelihood, parents became skilled in identifying when their son or daughter was getting manic and called the psychiatrist for a change in medications when these prodromal signs were present. We concluded that FFT was not effective just because it was longer than other

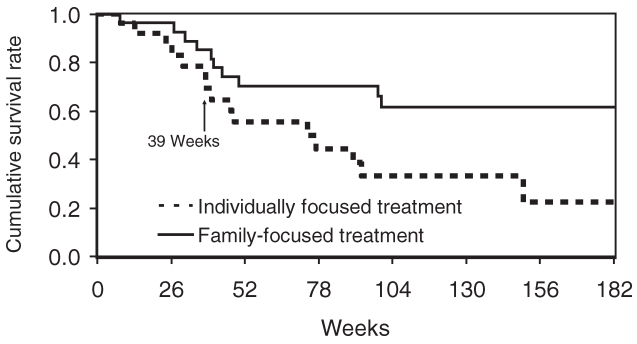

FIGURE 1.2. Greater persistence of effects of family versus individual therapy: Time to rehospitalization. UCLA FFT study. $N = 53$; $\chi^2(1) = 3.87$; $p < .05$.

comparison therapies. Instead, engaging the family, educating its members (including the patient) about the illness, and forming an alliance with them as treatment partners over the long-term course of the illness was more beneficial to the patient than psychoeducation in an individual format.

The Systematic Treatment Enhancement Program

The studies discussed above were conducted at the sites in which FFT was developed (Colorado and UCLA). How did FFT fare when tested at other sites around the country where clinicians may have had different theoretical orientations? Modern views on empirically supported treatments recommend that a treatment be tested in sites different from its origination site, as a way of minimizing the effects of theoretical allegiances to a particular program (Chambless & Hollon, 1998).

In the 15-site, NIMH-funded Systematic Treatment Enhancement Program for Bipolar Disorder, or STEP-BD (Miklowitz et al., 2007a, 2007b; Sachs et al., 2003), 293 patients with bipolar depression took part in a medication study and were randomly assigned to intensive psychotherapy (30 sessions over 9 months) or to brief psychoeducational therapy (3 sessions over 6 weeks). The intensive therapies offered varied by the site of the study and included FFT, interpersonal and social rhythm therapy (Frank, 2005), or cognitive-behavioral therapy (Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2002. The brief therapy was called collaborative care (CC).

Over 1 year, we found that being in *any* of the three intensive psychotherapies led to higher recovery rates from bipolar depression (64.4%) than being in CC (51.5%) (p = .01) (Miklowitz et al., 2007b). Patients in intensive treatment were also 1.6 times more likely to remain well during any given month of the 1-year study than patients in the CC group. Year-end rates of recovery for the specific modalities were as follows: FFT, 77% (20/26), interpersonal therapy, 65% (40/62), and cognitive-behavior therapy, 60% (45/75). Patients in intensive therapy also had better relationship functioning and higher life satisfaction at 1-year follow-up (Miklowitz et al., 2007a)

This study, while showing that FFT was effective when given in multiple sites around the country, also revealed one of its limitations: Many adult patients with bipolar disorder—about 46%—do not have families who are willing or able to come in for treatment. In STEP-BD we defined the family broadly, to include parents, spouses, siblings, romantic partners, and in a few cases, close friends. In cases where family members are unavailable or unwilling to take part in treatment, you can investigate these individual forms of therapy using the clinicians' manuals cited above.

Conclusion

FFT is a valuable and useful way to clinically engage patients and family members coping with bipolar disorder, and leads to better outcomes over 1- to 2-year periods than control treatments in symptomatic recovery or recurrence. Participants benefit in terms of their communication with each other and their abilities to solve family problems. Patients are also more likely to adhere to their medication regimens.

The Organization of This Book

This book is designed to orient clinicians to be capable of implementing FFT. It is organized to permit clinicians with different levels of familiarity with bipolar disorder to enter the book at different points. The first step in learning FFT is to be able to recognize the signs and symptoms of bipolar disorder, to understand its course and necessary drug treatments, and to gain an understanding of the impact of these illness factors on the family. Chapters 2 and 3 offer this background. Chapter 2 reviews the diagnostic criteria for the disorder, evidence regarding course and outcome, and the impact of medication regimens on the course of the illness. This chapter examines in detail the ways in which different symptom constellations of bipolar disorder and different patterns of the illness course affect family functioning. In turn, Chapter 3 discusses the roles of family relationships and stressful life events in influencing the course of the disorder.

Those familiar with this background material may wish to go directly to Part II (Chapters 4–13), which is devoted to the actual methods of treatment delivery. I describe our methods for connecting with and engaging families in treatment (Chapter 4), conducting initial family assessments (Chapter 5) and providing psychoeducation (Chapters 6–8), CET (Chapters 9 and 10), and problem-solving skills training (Chapter 11). Chapter 12 addresses managing clinical crises: how one deals within this treatment model with bipolar relapses, suicidality, and the crises associated with substance or alcohol abuse disorders. Finally, Chapter 13 discusses issues involved in the termination of the treatment.

In these chapters you will see some of the complexities that arise in delivering this model of treatment to the families of persons with bipolar disorder. We follow the guidelines presented in this book in providing a structure for families, but it is important to note that this structure can be useful only when delivered with a "psychotherapeutic attitude." I mean by this a sensitivity to emotional issues and resistances to change and a

reliance on family and individual assessments to guide the content and focus of the sessions. Thus, these chapters outline the actual therapeutic techniques as well as our specific methods for dealing with resistances, crises, and complex emotional reactions among patients and families coping with this disorder.

Throughout the book, I give suggestions as to how to adapt the approach to the different settings in which clinicians are likely to work. For example, abbreviated versions of the treatment modules can be given in settings in which the practitioner is limited to a six-session contract. In these circumstances, one must decide which of the treatment modules is most applicable to a family under consideration: Some families may benefit most from the psychoeducation module, whereas others (particularly couples) may be better helped through the communication enhancement module.

For Whom Is This Book Intended?

FFT can be conducted with adult or adolescent patients with bipolar disorder, and examples of each are given throughout the book. This book does not target specific mental health subdisciplines. FFT can be delivered by clinicians in a variety of settings, including community mental health centers, health maintenance organizations (HMOs), hospital settings, forensic settings, and private practice. We have trained psychologists, psychology graduate students, social workers, marriage and family therapists, and psychiatric nurses to administer the treatment. We have also trained child and adult psychiatrists who desire a family-psychoeducational approach to medication management. The book is also applicable to researchers interested in treatment–outcome investigations or studies of the basic psychosocial processes associated with adult- or childhood-onset bipolar disorder. Finally, we believe that much useful information is provided for patients or family members who are coping with this disorder, who may begin to see in a different context the symptoms, life disruption, and family distress they experience.

Although I do not take a stand as to who should do this treatment, I believe that there are certain experiences that make it easier to learn the approach. They include some background and comfort in working with severely ill patients with mood disorders, training in psychotherapy, and experience in working therapeutically with groups, particularly families. These are not essential, but they are helpful. Further, some degree of familiarity with the medication management of bipolar disorder is useful, although the clinician can expect to learn some of the basics of this material in this book.

A Word about Terminology

In the forthcoming chapters, I use certain terms that require explanations. Particularly, when I refer to "family," I am including any of the various constellations the clinician is likely to encounter nowadays: (1) families with either one or two parents and an adult or underage offspring who is the patient, (2) couples in whom one member is bipolar (whether these be same- or opposite-sex pairings), (3) sibling pairs, (4) adoptive or foster families, and (5) other family constellations (e.g., grandparents raising ill grandchildren).

When I describe how the family clinician speaks with the family, I often use sentences that start with "we" rather than "I." This is because there are advantages to working in cotherapy teams, as discussed in Chapter 4. However, FFT can easily be conducted by a single therapist. I also refer to the reader as "you" rather than "the clinician," because of the unnecessary level of formality introduced by the latter term. Finally I use certain technical terms such as "vulnerability," "predispositions," "biochemical imbalances," and "psychosocial treatment." In conducting FFT, you should adapt your terminology to the educational level of the family, as well as your own style. Some clinicians prefer to use these medically based terms, and others prefer simpler language.

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com