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Counseling Youth Who Have Bipolar Disorders

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DESCRIPTION OF BIPOLAR DISORDERS

The prevalence of bipolar disorder among youth ranges from approximately 0.5-3% depending upon the assessment strategy and the type of bipolar disorder assessed (APA, 2013; NIMH, n.d; NIMH, 2009; Singh, 2008). The bipolar disorders include bipolar I, bipolar II, and cyclothymia. Those who do not meet the criteria for these more traditional bipolar disorder diagnoses may be diagnosed as having other specified and unspecified related disorders (NIMH, 2015).

The bipolar disorders are characterized by dramatic shifts in mood, activity, and energy levels which affect day-to-day activities (NIMH, 2015). Bipolar I is characterized by one or more manic episodes: intense, severe shifts in energy and activity levels that require immediate care. Depressive episodes may also be present with a bipolar I diagnosis and these must have persisted for at least 2 weeks. Bipolar II is characterized by a pattern of depressive and hypomanic episodes, where less severe shifts of mood and activity levels are present especially with regard to hypomanic symptoms. Cyclothymia is characterized by patterns of hypomanic and depressive symptoms, but the individual does not meet the criteria for having full episodes of hypomania/mania or depression. According to the Diagnostic and Statistical Manual for Mental Disorders-5 (DSM-5), children must display a full year of hypomanic and depressive symptoms in order to meet the criteria for cyclothymic disorder (APA, 2013). A new specifier, "with mixed features," has been added to the DSM-5 and can be applied to describe episodes that include both mania/hypomania and depressive episodes (APA, 2013).

Children diagnosed with a bipolar disorder experience unusual shifts in mood, activity and/or energy levels–that are atypical from a normal state–and include either manic or hypomanic episodes or depressive episodes. Manic or hypomanic episodes (hypomanic episodes do not meet the full criteria for mania) are described as abnormally elevated "ups," while depressive episodes are described as "lows" which may include low energy and irritableness (APA, 2013). Children who have these disorders may also display mixed episodes in which they demonstrate characteristics of both mania and depression.

Bipolar disorders are among the most difficult disorders to accurately diagnose. Many youth are not being accurately assessed, identified, and diagnosed until later in life. Diagnosis can be difficult due to challenges associated with identifying mood episodes (i.e., manic or depressive) in children. The delay in accurate identification may be due to parents and physicians attributing moodiness to the ups and downs of adolescence rather than the emergence of bipolar disorder (Singh, 2008).

Resources:

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Singh, T. (2008). Pediatric bipolar disorder: Diagnostic challenges in identifying symptoms and course of illness. *Psychiatry, 5,* 34-42. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/journals/901/#psych

The National Institute of Mental Health. (n.d). *Bipolar disorder among children*. Retrieved from: http://www.nimh.nih.gov/health/statistics/prevalence/bipolar-disorder-among-children.shtml

The National Institute of Mental Health (NIMH). (2009). *Bipolar disorder in children and adolescents: New data to inform classification*. Retrieved from: http://www.nimh.nih.gov/research-priorities/scientific-meetings/2009/bipolar-disorder-in-children-and-adolescents-new-data-to-inform-classification/index.shtml

The National Institute of Mental Health (NIMH). (2015). *Bipolar disorder in children and teens*. Retrieved from: http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens-qf-15-6380/index.shtml

IDENTIFICATION/ASSESSMENT STRATEGIES

Many disorders are comorbid with a bipolar disorder diagnosis. A number of symptoms can overlap with other childhood disorders such as attention-deficit/hyperactivity disorder (ADHD), major depressive disorder, substance/medication induced bipolar disorder, and generalized anxiety disorder.

Disruptive mood dysregulation disorder (DMDD), a new diagnosis in the DSM-5 (APA, 2013) was developed and included, in part, to address the misdiagnosis and over diagnosis of bipolar disorder in children. DMDD applies to children who have chronically unstable moods, heightened irritability, and intense and disruptive behaviors which persist three or more times in a given week over a 12-month period (APA, 2013).

The following assessment tools may help in the identification of bipolar disorders.

Youth Mania Rating Scale

The Youth Mania Rating Scale (YMRS; Young, Biggs, Ziegler, & Myer, 1978) is an 11-item, client-rated measure used to assess the severity of manic symptoms over the last 48 hours. It is one of the most frequently used scales to assess manic symptoms in youth. The measure assesses the severity of disruptions in sleep, irritability/thought content, speech/language, sexual thoughts, increased activity/energy, elevated mood, appearance, insight, and aggressive behaviors. Irritability, speech, thought content, and aggressive behavior is assessed on a scale ranging from 0-8 while the remaining items are assessed on a range from 0-4.

The YMRS is designed to be administered by counselors and is appropriate for children between the ages of 5-17 years old. Administration and completion typically takes approximately 15-30 minutes. A pdf of the YMRS scale is available at: http://dcf.psychiatry.ufl.edu/files/2011/05/Young-Mania-Rating-Scale-Measure-with-background.pdf

Child Mania Rating Scale-Parent Version

The Child Mania Rating Scale-Parent Version (CMRS-P; West, Celio, Henry, & Pavuluri, 2011) is a 21-item, parent-rated measure assessing mania symptoms over the past month. The CMRS-P assesses all of the DSM-5 criteria for mania symptoms and can be reported by the parent or teacher.

The CMRS-P will assess the child's mood and behavior symptoms over the past month, as reported by the parent or teacher. Each response is given a point value ranging from 0-3 (i.e., never/rarely-sometimes often-often-very often). It is appropriate for children between the ages of 8-18 years old. Administration takes about 15 minutes. A pdf of the CMRS-P is available at: http://www.midss.org/content/child-mania-rating-scale-parent-version-cmrs-p

Child Bipolar Questionnaire

The Child Bipolar Questionnaire (CBQ; Papolos, 2002) is a 65-item behavioral assessment tool. It may be administered by the child's primary caretaker or by the counselor. It is a self-administered test that collects data on the DSM-5 criteria of bipolar disorder that the child meets as well as other disorders that are considered to be comorbid with bipolar disorder (i.e., major depressive disorder, generalized anxiety disorder, attention-deficit/hyperactivity disorder). The assessment reports on the degree of severity and frequency of the symptoms rather than "absent" or "present" symptoms. The CBQ may be requested through this website: http://www.bpchildresearch.org/publicsurveys/signup.cfm?request=CBQ

Resource:

Papolos, D. F. (2002). *The child bipolar questionnaire.* Retrieved from: http://www.jbrf.org/the-child-bipolar-questionnaire-for-families-use/

INTERVENTION/TREATMENT STRATEGIES

Pharmacotherapy

Because bipolar disorder is biologically based, medications and medication management play a critically important role in treating those who have this disorder, with most people requiring medications throughout their lives (Gaudiano, Weinstock, & Miller, 2008). In recent years, many new medications have emerged for the treatment of youth who have bipolar disorder. However, many of these medications involve short and long term side effects (i.e., weight gain, increased appetite), and may impede medication adherence.

Mood stabilizers, such as lithium, valproic acid (e.g., Depakote), and carbamazepine, are the most commonly used medications to treat bipolar disorders with a success rate of 60-70% (Bernstein, 2015). Because of the unique ways children metabolize lithium and the risk of toxicity, routine blood work is required to ensure proper physical functioning (Bernstein, 2015).

Other forms of medications such as atypical antipsychotics (i.e., risperidone, aripiprazole) are considered first line alternatives to lithium, valproic acid, or carbamazepine. Anticonvulsants (i.e., lamotrigine [e.g., Lamictal], valproic acid, or divalproex sodium) are also used to treat bipolar disorder (Mckeage, 2014). Selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (i.e., SNRIs; e.g., Effexor, Wellbutrin) should be administered with caution as they may lead to worsened rapid cycling and can stimulate hypomanic/manic episodes in those who have bipolar disorders (Mckeage, 2014). These medications are generally used only when the youth is also taking a mood stabilizing medication.

Medication compliance is very important and counselors play an important role with young people and family members in helping them to adhere to their medication management plan.

Resources:

For more information on pharmacotherapy and youth visit:

http://albertsfoundation.org/sites/default/files/treatment_guidelines_0.pdf

http://www.bphope.com/kids-children-teens/creating-healthy-lifestyles-for-children-with-bipolar/

http://www.bphope.com/kids-children-teens/kids-bipolar-getting-comfortable-with-therapy/

Interpersonal and Social Rhythm Therapy

Interpersonal and social rhythm therapy (IPSRT; Hlastala, Kotler, McClellan, & McCauley, 2010) is an evidence-based treatment approach and a helpful psychosocial approach when working with those who have bipolar disorder. Halastala et al. (2010) described the IPSRT-Adolescent model which is an adaption to IPSRT, but is specific to adolescents with bipolar disorder.

Interpersonal and social rhythm therapy is designed to help individuals understand their biological and social rhythms (i.e., everyday actions: sleeping, eating, socializing, and exercise patterns) and how rhythms can be altered to avoid an escalation of symptoms. The desired outcome is to improve symptoms by highlighting a connection between daily routine/ rhythm disruptions and mood destabilizations. IPSRT techniques are used to help improve medication adherence, manage stressful life events, create strategies for social support and relationships, and reduce disruptions in social rhythms. For example, counselors may chart a young clients' normal 24-hour day, and identify areas where positive changes can be implemented. This can help youth and their families better structure their days to avoid relapse and escalation of symptoms. Counselors using IPSRT need to help the client/family keep track of the client's routines. To do so, counselors may utilize a charting system such as the Social Rhythm Metric (SRM; Monk, Flaherty, Frank, Hoskinson, & Kupfer, 1990), which allows the youth and family to track their daily routines (i.e., bed time, eating schedule).

Researchers using this approach have found decreases in manic, depressive, anxious, and general psychiatric symptoms associated with bipolar disorder (Halastala et al., 2010; Frank, Swartz, & Kupfer, 2000). Some researchers also suggested that youth experienced an increase in psychosocial functioning secondary to treatment (Halastala et al., 2010).

Resource:

Social Rhythmic Metric pdf: http://www1.appstate.edu/~hillrw/Bipolar%20CBT%20Tx/documents/SRM.pdf

Child and Family Focused-Cognitive Behavior Therapy

Child and family focused-cognitive behavioral therapy (CFF-CBT) is an intervention developed for use with children aged 8-12 and their families. CFF-CBT is a unique family-based model as it integrates psychoeducation, cognitive behavioral therapy, and interpersonal thera-

py techniques to address the impact of bipolar disorder (West et al., 2009). It is a 12-session treatment program implemented over the course of three months. The goal of this treatment approach is to improve symptoms and to enhance psychosocial and family functioning. Parental support is greatly encouraged as it gives the opportunity for the child and family to practice interpersonal, problem solving, emotion regulation, and relationship skills with the goal of helping them to understand and manage the symptoms of bipolar disorder. CFF-CBT is nicknamed "RAINBOW" as there are seven main "ingredients." The model uses the colors of the rainbow to represent different moods ranging from sad (violet), to moderate (green), to more manic moods or rages (red; West et al., 2009). The details of the "ingredients" are shown here in this table: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2732730/table/t1-ccap18_3p0239/

Researchers have found strong theoretical and conceptual support for this approach as it has been shown to effectively address the symptoms and functional impairment of bipolar disorder (West et al., 2009; 2014). CFF-CBT is shown to be effective in reducing mood symptoms, parent-child stress, and psychosocial functioning in children who have bipolar disorders (West et al., 2009; 2014). CFF-CBT and pharmacotherapy work together to help attain remission of symptoms (West et al., 2009; 2014).

Resources:

For more information on CBT relating to youth visit:

- http://www.bphope.com/kids-children-teens/bipolar-treatment-options-for-troubled-teens-and-their-families/
- http://www.bphope.com/successful-cognitive-behavioral-therapy-in-youth-leads-to-decreased-thinking-about-suicide/

Multifamily-Psychoeducational Psychotherapy

Multifamily-psychoeducation psychotherapy (MF-PEP) is an evidence-based treatment approach specifically for families and youth ranging from ages 8-12. MF-PEP is a program designed to provide information to youth and parents about bipolar disorders, treatment options, and symptom-control skills (Fristad, Verducci, Walters, & Young, 2009). It is designed to be an adjunct with medication(s) and includes psychoeducation with elements of family systems and cognitive behavioral psychotherapy. The psychoeducational component provides youth and families with an understanding of the disorders and symptoms, how they are diagnosed, and how they are treated in combination with medication. The psychotherapy component of the program then provides support and symptom management skills (i.e., coping skills, problem solving, emotion regulation, and communication skills; Fristad et al., 2009). MF-PEP usually consists of (8) 90-minute sessions held weekly. Counselors usually meet with both the youth and the parents together at the beginning and end of the session, and counselors meet separately with the youth during the middle of the session. Studies have shown an increase in parental knowledge about the symptoms and disorders, improved child-parent interactions, and child-parent support. Follow-up research after one year has shown a decrease in mania and depression, and changes in anxiety levels following treatment (Fristad et al., 2009).

Resources:

To view the MF-PEP website for additional information visit: http://www.moodychildtherapy.com/

The treatment manual on MF-PEP can be ordered at: http://www.guilford.com/p/fristad2

Family-Focused Treatment

Family-focused treatment (FFT) is a nine-month, 21 session counseling approach that is used with youth who have bipolar disorders and their families. FFT involves psychoeducation for the family, communication training, problem solving skills training, teaching, identifying, and using relapse-prevention skills, and support for adherence to pharmacotherapy (Miklowitz et al., 2008). Session duration is 50 minutes in which there are 12 weekly, 6 biweekly, and 3 monthly sessions for nine months. These sessions include the youth, the parent(s), and sibling(s). Psychoeducation is the main goal during the first sessions in which it is important for families to understand the symptoms, etiology, course of the illness, and precipitants for reoccurrence (e.g., family conflict; Miklowitz et al., 2008). It is also important for families to be educated on the importance of adherence to pharmacotherapy and conduct a plan for the case of relapse. Next, communication skills are addressed and families learn to recognize patterns of appropriate communication, problem solving, and solution building, which are all achieved through the implementation of various activities (e.g., role play; Miklowitz et al., 2008).

Resources:

Miklowitz, D. J., Axelson, D. A., Birmaher, B., George, E. L., Taylor, D. O., Schneck, C. D., … Brent, D. A. (2008). Family-focused treatment for adolescents with bipolar disorder: Results of a 2-year randomized trial. *Archives of General Psychiatry, 65*(9), 1053-1061. doi:10.1001/archpsyc.65.9.1053

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Fristad, M. A., Verducci, J. S., Walters, K., & Young, M. E. (2009). Impact of multifamily psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders. *Archives of General Psychiatry, 68*, 1013-1021. doi:10.1001/archgenpsychiatry.2009.112

Gaudiano, B. A., Weinstock, L. M., & Miller, I. W. (2008). Improving treatment adherence in bipolar disorder: A review of current psychosocial treatment efficacy and recommendations for future treatment development. *Behavior Modification, 32,* 267-301. doi:10.1177/0145445507309023

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McKeage, K. (2014). Aripiprazole: A review of its use in the treatment of manic episodes' in adolescents with bipolar I disorder. *CNS drugs, 28*(2), 171-183. doi:10.1007/s40263-013-0134-2

Monk, T. H., Flaherty, J. F., Frank, E., Hoskinson, K., & Kupfer, D. J. (1990). The social rhythm metric. An instrument to quantify the daily rhythms of life. *The Journal of Nervous Mental Disease, 178,* 120-126. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/2299336#

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The National Institute of Mental Health (NIMH). (2015). *Bipolar disorder in children and teens*. Retrieved from: http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens-qf-15-6380/index.shtml

West, A. E., Jacobs, R. H.,Westerholm, R., Lee, A., Carbray, J., Heidenreich, J.,…Pavuluri, M. N. (2009). Child and family-focused cognitive-behavioral therapy for pediatric bipolar disorder: Pilot study of group treatment format. *Journal of Canadian Academy of Child and Adolescent Psychiatry, 18*, 239-246. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/19718425

West, A. E., Celio, C. I., Henry, D., & Pavuluri, M. N. (2011). Child mania rating scale-parent version: A valid measure of symptom changes due to pharmacotherapy. *Journal of Affective Disorders, 128,* 112-119. doi:10.1016/j.jad.2010.06.013

West, A. E., Weinstein, S. M., Peters, A. T., Katz, A., Henry, D., Cruz, R.,…Pavuluri, M. N. (2014). Child- and family-focused cognitive-behavioral therapy for pediatric bipolar disorder: A randomized clinical trial. *Journal of Canadian Academy of Child and Adolescent Psychiatry, 53,* 1168-1178. doi:10.1016/j.jaac.2014.08.013

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