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- Dr. Cox is supported by NMSS Fellowship grant FG-1376-A-1. Address correspondence to Darcy Cox, Psy.D., 449 Octavia St., Suite 102, San Francisco, CA 94102; e-mail: darcyc@itsa.ucsf.edu.

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Psychosocial Treatment of Bipolar Disorders In Adolescents: A Proposed Cognitive-Behavioral Intervention

Carla Kmctt Danielson, *Case Western Reserve University*

Norah C. Feeny and Robert L. Findling, *Case Western Reserve University and University Hospitals of Cleveland*

Eric A. Youngstrom, *Case Western Reserve University*

Despite the severity of bipolar disorder (BP) and the amount of attention the psychosocial treatment of BP among adults has been given (e.g., Basco & Rush, 1996; Miklowitz, Frank, & George, 1996), no published outcome study or psychosocial treatment manual to date exists for children with this disorder. Based upon what is known about the phenomenology of BP in adolescents and what has been published with regard to existing treatments and their efficacy for adults with BP and adolescents with unipolar depression, the purpose of this article is to describe a model for an empirically driven cognitive behavioral treatment for BP in adolescents. The manualized intervention described herein includes the following intervention components: psychoeducation, medication compliance, mood monitoring, anticipating stressors and problem solving, identifying and modifying unhelpful thinking, sleep regulation and relaxation, and family communication. In addition, optional modules devoted to substance abuse, social skills, anger management, and contingency management are offered. The treatment includes a 12-session acute phase of treatment, followed by a maintenance phase and biyearly "booster" sessions. The rationale for and format of each session is presented. Currently, a pilot study is under way to evaluate the preliminary efficacy of this treatment for adolescents with BP. To illustrate the treatment, we present a case study including outcome data for a 13-year-old boy with bipolar I.

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BIPOLAR DISORDERS (BP) are chronic, debilitating psychiatric disorders that appear to affect 1% to 2% of adolescents (Lewinsohn, Klein, & Seeley, 1995). Initial evidence indicates that pharmacological agents can be

beneficial in the treatment of BP in adolescents (Geller et al., 1998). However, research in this area is quite limited, and experts seem to agree that the best treatment approach should include both pharmacological and psychosocial interventions (American Psychiatric Association, 1994). Despite the call for psychosocial interventions in adolescents, the severity of BP, and the amount of attention psychosocial treatment for adults with BP has received (e.g., Basco & Rush, 1996; Miklowitz, Simoneau, Sachs-Ericsson, Warner, & Suddath, 1996), to date no published outcome study or psychosocial treatment manual exists for adolescents. Thus, the goal of this article is to describe a testable, empirically driven cognitive behavioral intervention, intended to be used in conjunction with pharmacological treatment, that we have developed for adolescents with BP. We will describe for *whom* the treatment was developed, present a brief explanation of *how* the treatment was developed, and provide a session-by-session overview of the treatment. Finally, a case study illustrates how the intervention was used to treat a 13-year-old male with bipolar I disorder (BPI).¹

Clinical Population

This intervention was developed for adolescents (ages 11 to 18) diagnosed with any type of BP, including BPI, BPII, BP Not Otherwise Specified (NOS), or cyclothymia. Medication is considered a frontline treatment for BP (American Psychiatric Association, 1995), and lithium, in particular, has been demonstrated to be beneficial to adolescents with BP with secondary substance dependency (Geller et al., 1998). Thus, the treatment we developed was designed to be used in conjunction with appropriate pharmacotherapy. Efficacy of the treatment, which is being evaluated in an ongoing clinical trial with adolescents with BP, is promising (Feeny, Danielson, Youngstrom, & Findling, 2002); results will be published when the trial is complete.

Treatment Development

The first author performed a comprehensive literature review using PsychLit and MEDLINE to gather current empirical literature related to the identification, assessment, etiology, course, prognosis, and treatment of BP in adults and youths. Problems/difficulties common to this population were identified and developed into intervention components. These components include: (a) psychoeducation (e.g., Peet & Harvey, 1991; Van Gent & Zwart, 1991); (b) medication compliance (e.g., Brondolo

& Mas, 2001); (c) mood monitoring; (d) identifying and modifying unhelpful thinking; (e) stressor/trigger identification (e.g., Gitlin, Swendsen, Heller, & Hammen, 1995); (f) sleep maintenance (e.g., Wehr, Wirz-Justice, & Goodwin, 1982); and (g) family communication (e.g., Miklowitz, Frank, & George, 1996). In addition, optional modules devoted to other problems common among adolescents with BP (i.e., substance abuse, social skills, anger management, and contingency management) are offered.

We focused on therapy techniques that have been shown to be useful in treating adults with BP, as well as psychoeducation strategies, given that psychoeducation is the only promising psychosocial intervention for youths with BP published thus far (Fristad, Gavazzi, & Soldano, 1998; Fristad, Goldberg-Arnold, & Gavazzi, 1999). In addition, because depressive episodes are typically part of BP, treatments that have been found to be efficacious in treating adolescents with depression (e.g., Coping With Depression Course; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Lewinsohn, Clarke, Hops, & Andrews, 1990; Lewinsohn, Clarke, Rhode, Hops, & Seeley, 1996) were included. Integrated into the authors' clinical experiences with CBT techniques and treatment of adolescent mood disorders, this information produced an outline of the skills and topics that would be potentially beneficial to this population.

Various CBT treatment manuals served as models for the manual we developed, with particular emphasis on the manual in use in the ongoing NIMH-funded "Treatment for Adolescents With Depression Study" (TADS; Curry et al., 2000; Wells & Curry, 2000).² Further, consistent with other cognitive-behavioral approaches, homework assignments were formulated to accompany each session in order to encourage regular practice of the skills taught. Modeled closely on the TADS treatment manual and Kathleen Carroll's (1998) work with substance abuse, each session in the current treatment follows the same structure: (a) review symptoms; (b) review homework; (c) set the agenda (i.e., what does the teen want to work on?); (d) teach new skill(s); (e) address agenda items; and (f) assign new homework.

The weekly treatment is delivered individually but includes some parent involvement, as family involvement has been shown to be particularly useful to families coping with BP (e.g., Miklowitz & Alloy, 1999; Miklowitz & Goldstein, 1997; Miklowitz, Wendel, & Simoneau, 1998). Thus, 2 sessions are conjoint sessions with the adolescent and parents, and 1 session midway through treatment is with parents only. Further, optional 15-minute parent check-ins are offered at the end of every session for families with

¹ According to the *DSM-IV* (APA, 1994) bipolar I is characterized by the occurrence of one or more manic or mixed episodes, usually accompanied by major depressive episodes.

² Permission for use of material from the TADS manual was given by John Curry, Ph.D., a principle investigator of the TADS project and first author on the TADS CBT manual.

whom it seems appropriate. We developed a 12-session acute phase treatment that incorporated all the modules/skills identified above. In addition, based on research (Clarke et al., 1999) and expert recommendations (Birmaher, Brent, & Benson, 1998), a 12-week maintenance phase was developed, with further recommendations for

regular 6-month booster sessions. In the following section, the sessions are described in greater detail. Specifically, we present the rationale (i.e., the empirical basis upon which the session topic/skill is based) and format (i.e., suggested way to introduce session material) for each session. Table 1 provides a summary of the format

Table 1
Suggested Format for Session Topics

Week	Session	Length of Session	With Whom	Topic
1	1	60 minutes	Child and Parent	Psychoeducation about BP (symptoms, causes, etc.) and medication, provide overview of sessions, answer questions, set goals with parents and child, provide reading and handouts to parents HW: Parents: read materials
1	2	30 minutes	Child	Review psychoeducation material, answer questions, further develop treatment goals HW: take one step toward a goal
2	3	60 minutes	Child	Medication compliance and mood monitoring HW: complete medication log and mood monitoring
3	4	60 minutes	Child	Anticipating stressors and problem solving HW: mood monitoring, medication log
4	5	60 minutes	Parent	Catch up/review, teach problem solving; vulnerability to mood swings HW: Document 3 situations where you used the new problem-solving techniques you learned—include the situation, strategy used, and outcome; mood monitoring, medication log
5	6	60 minutes	Child	Identifying and countering negative thinking HW: mood monitoring with “challenge to the thought” and “new feeling” columns added; medication log
6	7	60 minutes	Child	Sleep regulation, relaxation HW: Maintain a regular sleeping schedule for the week; identify obstacles to maintaining a schedule and falling asleep, mood monitoring, medication log
7	8	60 minutes	Child	Communication, assertiveness HW: Document an example of positive communication and negative communication over the week with a family member or close friend (How could the negative communication have been handled differently?); mood monitoring, medication log
8	9	60 minutes	Child and Parent	Family communication; role-playing HW: Plan a 1-hour family activity; mood monitoring, medication log
9	10	60 minutes	Child	Optional modules: substance abuse or anger management HW for substance abuse: Complete log of substance use, initiate positive activity with a friend who does not use drugs HW for anger: Document situation involving anger where assertiveness skills were applied
10	11	60 minutes	Child or *Child and parent	Optional modules: social skills or *contingency management HW for social skills: Assign social task in an area the adolescent has difficulty (e.g., social initiating, group activity, etc.) HW for contingency management: Maintain a chart documenting frequency of target behaviors (as well as rewards and consequences)
11	12	60 minutes	Child, Parent in the last 15 min.	Wrap-up, review, what worked and what did not, what still needs to be addressed, plans for maintenance phase HW: Anticipate upcoming stressors

Note. This acute phase of treatment is followed by a 6–10 session maintenance phase of biweekly meetings. Biannual follow-up booster sessions are recommended after the maintenance phase. The sessions will build on skills already taught and will be focused on the individual needs for each child. Optional 15-minute check-in at the end of each session with parent.
HW = homework.

for treatment, including weekly session topics and homework assignments.

Session 1: Psychoeducation

Rationale. Psychoeducation is a basic component of most psychosocial treatments. It is generally accepted that when a patient understands the nature of the disorder from which he or she suffers, as well as his or her role in the disorder's treatment, the patient is more likely to be an active participant in the treatment (Basco & Rush, 1996). In fact, studies have demonstrated that providing psychoeducation to adults with BP can be useful in improving attitudes and increasing medication compliance (Seltzer, Roncari, & Garfinkel, 1980). Because parents are key participants in an adolescent's everyday life, we recommend that the initial educational sessions for treatment of adolescents with BP include both the adolescent and the parents. Importantly, parents are typically the ones who have sought treatment for their teen, and they are responsible for ensuring session attendance.

Education that involves family members and/or significant others of a client with BP also has been demonstrated to be useful in maintaining medication compliance (e.g., Van Gent & Zwart, 1991). Specific to youths, psychoeducation has been shown to be advantageous for parents of hospitalized children with mood disorders (Fristad, Arnett, & Gavazzi, 1998; Fristad, Gavazzi, et al., 1998).

Format. As is typical at the beginning of therapy with any client, confidentiality and its limitations should be addressed with the adolescent and the parents in the first session. Although the content of what the adolescent shares in therapy will not be disclosed to the parents, in the first session parents will be informed of the specific skills their child will learn; furthermore, parents directly participate in specific sessions (i.e., sessions 1, 5, and 9). Optional 15-minute check-ins after each session are offered in instances where the parent or adolescent seems particularly concerned about family-related issues or when doing so may ensure attendance to or compliance with therapy.

Given the data that indicate adolescents with BP are at an increased risk for completed suicide (Brent, Perper, Goldstein, & Kolko, 1988; Brent, Perper, Moritz, & Allman, 1993; Strober et al., 1995), the completion of a no-suicide contract occurs during the first session. The contract entails identifying what precipitated past suicidal ideation and/or behavior, identifying what has helped improve the teen's mood in the past, developing a plan in the event of future suicidal ideation/intent, and contracting not to commit suicide. The parent's assurance that the adolescent does not have access to lethal weapons is also part of this contract, based on evidence that having firearms in the home increases the risk for adolescent suicide (Brent & Perper, 1995).

The adolescent receives a workbook that contains all treatment handouts and homework assignments (divided by session). The parents also receive handouts of the first session's information, comprised of five primary elements. First, the structure of the treatment is introduced in a table (see Table 1) that lists the session number, estimated length of time, who is participating, and skills/topics addressed. Second, the teen and his or her parents are oriented to cognitive behavioral therapy (CBT) in a discussion that includes an overview of the treatment as active, time limited, skills oriented, and symptom focused. Further, a model is provided that illustrates the connection between thoughts, feelings, and behaviors. The use and importance of homework in CBT (and this treatment in particular) should be explained as well. Third, education on BP symptoms, possible etiologies, course, and treatment (e.g., importance of medication compliance) is provided. This is an opportunity to determine how much education the adolescent has received about BP and what his or her concerns are about having the disorder. The following is an example from the manual for how this can be introduced:

"I'm going to review a couple things that I think are important about bipolar disorder (or mania), and then I'd like to hear what you already know about it and its causes. I already know about the things that are causing you the most problems (e.g., sleep disruption) and later I'd like to hear more about what parts of your life bipolar disorder has affected most. The thing about bipolar disorder that some people don't realize is that it is a 'disorder,' not just mood 'ups' and 'downs,' and it is not something that you can just 'snap out of.' BP is different from just feeling restless, sad, or irritable, because it is much worse or more intense, and lasts much longer. What sort of moodiness have you seen in your son/daughter (or noticed in yourself)? This moodiness is not intentional, or under the teen's control, it is part of BP."

Fourth, the therapist suggests strategies for how parents can assist the adolescent throughout the treatment, including being supportive, recognizing the adolescent's strengths, attending the parent sessions of the treatment, helping the adolescent work on skills at home, and making sure the adolescent gets to each treatment session. Fifth, if time permits, we set initial treatment goals with both the child and the parents and provide parents with reading materials, including additional information on BP. Goal setting with the adolescent will continue in Session 2, described below.

Session 2: Psychoeducation Continued

Rationale. Session 2 immediately follows Session 1 (i.e., on the same day) so that the therapist has an opportunity

to meet with the adolescent individually. This can be helpful in establishing rapport and trust. In addition, this one-on-one time provides the adolescent an opportunity to ask questions and make comments that he or she may not feel comfortable asking in front of a parent. The rationale and topics for psychoeducation in Session 2 is the same as in Session 1.

Format. The beginning of Session 2 introduces the adolescent to the structure of subsequent sessions, which may be stated by the therapist as follows:

“At the beginning of each session I will ask you what you would like to work on. I call this ‘setting the agenda.’ You may want to address something that has occurred since we saw each other last or it may be something in the future you are nervously anticipating or unsure about. We will always try to get to all those things you would like to cover, although sometimes we may need to prioritize and break down the issues into smaller chunks so that we’re able to cover the things that are most important to you.”

The therapist explains that after the adolescent introduces the agenda item, a new skill is taught, and then the agenda item is revisited. The hope is that the newly learned skills can be applied to the adolescent’s agenda item. Within the session, which should last for approximately 30 to 45 minutes, the psychoeducational material can be reviewed, additional questions can be answered, and treatment goals can be further established (or started if there was not enough time in Session 1). As in other CBT protocols for youths, the therapist introduces the metaphor of a toolbox (or backpack), likening the skills taught in treatment to tools (i.e., to “fix,” work on, or improve problems), with certain tools working better for certain problems than others. At the end of Session 2, individualized homework that involves taking a step toward an identified goal is assigned. It is important that the goal be motivating and realistic so as to increase chances of success.

Session 3: Medication Compliance and Mood Monitoring

Medication compliance. Kay Redfield Jamison, a professor of psychiatry whose 1995 book documents her own struggle with BP, wrote, “My manias, at least in their early and mild forms, were absolutely intoxicating states that gave rise to great personal pleasure, an incomparable flow of thoughts, and a ceaseless energy that allowed the translation of new ideas into papers and projects” (pp. 5–6). This “seductiveness” of the manic episodes she describes contributes to the poor medication compliance among BP clients.

Rationale. Medication is usually considered an essential

frontline treatment for BP in children and adolescents (McClellan & Werry, 1997). As indicated overwhelmingly in the adult and the emerging adolescent treatment literature, consistent medication use is essential to the alleviation of BP symptoms (see Kafantaris, 1995; Prien & Potter, 1990) and, in some cases, in the prevention of future episodes (Strober, Morrell, Lampert, & Burroughs, 1990). The literature also indicates that even when an episode is in remission, it may be better for an individual to continue the medication rather than going off and on as needed (e.g., Sharma, Yatham, & Haslam, 1997). Thus, in the context of a psychosocial treatment, it is important that BP symptoms are stabilized pharmacologically so that the adolescent is able to more fully comprehend and participate in the psychosocial component of the treatment.

In one review of lithium compliance trends, it was reported that, in general, 45% of individuals did not adhere fully to medication recommendations within the first year, and that compliance worsened over longer periods of time (Shaw, 1986). Moreover, many individuals with BP drop out of treatment altogether (Priem, Caffey, & Klett, 1973; Priem et al., 1984; Stallone, Shelley, Mendlewicz, & Fieve, 1973).

Format. At the beginning of Session 3, the therapist asks the adolescent to rate his or her medication compliance on a scale of 1 to 10. Then, the therapist helps the adolescent identify the following: (a) benefits of taking the medication (e.g., feeling more able to handle stressors; feeling more in control; getting along better with family members); (b) obstacles that may tempt the adolescent to stop taking the medication (e.g., side effects, enjoyment of highs of mania, overwhelmed by daily regimen); and (c) consequences of noncompliance (e.g., becoming more irritable, getting in trouble, having problems sleeping). To improve medication compliance outside of the session, the therapist also teaches the adolescent how to complete a daily medication log, which from this session forward becomes a weekly homework assignment. The therapist should become familiar with the specific pharmacological agent(s) the adolescent is taking. A recently published review of the current pharmacological treatments for individuals with BP may be useful for this purpose (Rivas-Vazquez, Johnson, Rey, Blais, & Rivas-Vazquez, 2002).

Mood monitoring. Psychosocial interventions such as Lewinsohn et al.’s (1990) Adolescents Coping With Depression (CWD) course focus on teaching a basic skill early on in treatment, from which more complex skills can later be taught. The present treatment follows that model in attempting to alleviate affective symptoms of BP. Specifically, mood monitoring is taught to the adolescent in the early sessions of treatment (Session 3). Then, after several weeks of practicing this skill via homework assignments, the adolescent learns more complex skills

of identifying negative thoughts and generating realistic counterthoughts. Mood monitoring is discussed in more detail below; identifying and challenging unhelpful thoughts will be discussed later in the section.

Rationale. CBT with adults who have BP involves educating the patient and family members about the disorder and teaching mood monitoring and how to cope with obstacles and problems (Rothbaum & Astin, 2000). CBT has been shown to be effective in adults with BP in individual (Cochran, 1984; Lam et al., 2000) and group therapy formats (e.g., Patelis-Siotis et al., 2001) and in adolescents with unipolar depression (e.g., Clarke et al., 1999; Lewinsohn et al., 1990; Reynolds & Coats, 1986).

Several excellent, recent reviews have been published describing the studies that have investigated the efficacy of CBT, as well as other treatment modalities, in youths with unipolar depression (Asarnow, Jaycox, & Tompson, 2001; Birmaher, Ryan, Williamson, Brent, & Kaufman, 1996; Curry, 2001; Reinecke, Ryan, & Dubois, 1998). The majority of research in this area has found CBT to be efficacious in adolescents with unipolar depression. For example, in his review on specific psychotherapies for depressed youth, Curry (2001) reported that seven out of nine controlled or comparative studies for adolescent depression found CBT to be efficacious at the end of acute treatment.

Format. In Session 3, adolescents with BP are taught how to recognize and pay attention to these moods at the most basic level: What are feelings and how do I recognize them? The therapist helps the adolescent point out the physical cues (e.g., I have no energy, I feel tense) and emotional cues (e.g., I feel overwhelming sadness, I'm incredibly irritable) associated with the mood states. An emotions thermometer is used to help the adolescent gauge situations in which he or she experiences different "degrees" of sadness, irritability, elation, happiness, and so on. The therapist and the adolescent discuss the concept of affect (e.g., How does it feel to be manic?), symptoms associated with the mood states (e.g., I start to feel really good about myself, I talk faster than normal), and changes in affective states (e.g., What happens first when I start to move from really "good" feelings to really "bad" feelings). Specifically, adolescents are taught to monitor their mood on a daily basis using a three-column (i.e., situation, thought, feeling) log.

Session 4: Anticipating Stressors and Problem Solving

Rationale. The role of life events has not been investigated in BP as thoroughly as it has with regard to other psychiatric illnesses (Hlastala, Frank, Kowalski, Sherrill, & Tu, 2000); however, research has indicated that stressful life events do indeed affect onset and recovery from manic and depressive episodes (Hammen, Ellicott, & Gitlin, 1992; Hunt, Bruce-Jones, & Silverstone, 1992; Johnson

& Miller, 1997; Johnson & Roberts, 1995; Kennedy, Thompson, Stancer, Roy, & Persad, 1983; Reilly-Harrington, Alloy, Fresco, & Whitehouse, 1999). For example, high levels of stress are common triggers for episodes. In a 2-year follow-up of BP outpatients, individuals with high levels of life stress were more than four times as likely to experience a mood disorder relapse than individuals with low levels of life stress (Ellicott, Hammen, Gitlin, Brown, & Jamison, 1990). Other examples of stressors identified in the literature that can serve as triggers for manic and depressive episodes include life events that disrupt the individual's daily social and circadian rhythms (Malkoff-Schwartz et al., 1998) and life events that involve striving for goal attainment (Johnson et al., 2000). Given these findings, a component of treatment addressing the anticipation of stressors has been incorporated into psychosocial interventions for adults with BP (e.g., Rothbaum & Astin, 2000). Helping adolescents identify what global and specific stressors or life events serve as triggers to certain mood states and/or episodes, while also instructing the adolescent on ways to alter negative cognitions, may provide a foundation from which the client can attempt to circumvent future episodes.

Format. In an attempt to provide the adolescent with a structured opportunity to identify and explore those factors that may act as "triggers" for affective symptoms, this treatment includes a module for anticipating stressors. To help reduce the risk of future relapse, the therapist also teaches the adolescent strategies to lower daily stress levels (Ellicott et al., 1990). Within this component of the treatment, the therapist addresses typical stressors—factors that affect all clients, such as striving to achieve life goals (Johnson et al., 2000; Lozano & Johnson, 2001)—by demonstrating how to make goal setting and attainment less stressful and more manageable (e.g., by breaking goals down into manageable chunks). In addition, individual stressors or particular maladaptive responses to such stressors are addressed. Clearly, stressors other than those mentioned exist, which may affect the treatment and functioning of an adolescent with BP. Opportunities to work on such additional stressors are addressed in the Optional Modules section.

In conjunction with anticipating stressors, it is important to teach the adolescent specific problem-solving skills. These skills can be useful to adolescents when they are faced with a specific trigger or when other conflicts are presented. Instead of becoming overwhelmed when faced with a problem, specific problem-solving tools help the adolescent break down conflicts into smaller, more manageable steps and slow down impulsive decision making that can lead to poor choices. When applying problem-solving skills, the therapist teaches the adolescent how to evaluate his or her choices and consequences, which serves as a future guide to handling problems and stressors.

As part of teaching problem solving, the therapist presents hypothetical vignettes of various minor and major problems for the adolescent to practice. An example of a vignette is as follows:

“This upcoming Saturday night is the big homecoming dance at our school. I am really excited because I am going to the dance with the person I really like. I don’t know what to do because my date and all of my friends are allowed to stay out until 1:30 A.M. and my parents said that I have to be home by my normal curfew, which is midnight. My parents hate me—they want me to be unpopular! I am going to miss out on the big party after the dance because I have to be home! Everyone is going to think I am so lame. I am thinking about just staying out and making up an excuse when I get home late. What do you think I should do?”

After being presented such a vignette, the adolescent is asked to identify the problem, brainstorm possible solutions, evaluate consequences to each, choose a solution, and evaluate the decision outcome.

Session 5: Parent Session

Rationale. Session 5 is conducted with parents only and includes a review of the material covered in Sessions 2 through 4. The therapist reviews with parents what topics and skills have been taught in treatment thus far and how parents can reinforce these skills at home. Conducting a session with parents only at this stage in the treatment may help keep the parents engaged (and thus help to keep the adolescent in treatment) and can address questions and concerns that have arisen.

Format. Session 5 starts with a check-in that includes a review of progress made thus far and setting a session agenda. In the second part of the session, the therapist reviews all skills covered in Sessions 3 and 4: medication compliance, mood monitoring/pleasant activities, identification of stressors, and problem solving. In addition, the toolbox metaphor is reintroduced. Following this review, the therapist checks in with the parents in the following manner:

“As you see, we have covered a lot of material in a relatively short time. However, these concepts like mood monitoring and problem solving are important skills for your son/daughter to learn. Let me ask you a few questions: (1) Have you seen your child begin to use any of these skills at home? Which ones? (2) How can you help your child learn these skills at home?”

If the parent has difficulty answering these questions, suggestions are made for how to optimally reinforce these skills at home. The session ends by addressing the

parents’ agenda item and by reviewing the schedule of treatment for the remainder of the sessions.

Session 6: Learning to Identify and Counteract Negative Thinking

Rationale. Patterns of unhelpful thinking (e.g., automatic maladaptive thoughts) negatively influence emotions and behaviors in individuals with depressive disorders (Beck, 1995). In cognitive behavioral therapies, a primary focus of intervention is teaching clients to identify and challenge these cognitive errors/distortions. Distorted cognitions that may impede treatment progress or lead to relapse include misconceptions about the disorder, catastrophic beliefs about the poor prognosis of treatment, and overgeneralizations about the presence of specific symptoms (Brondolo & Mas, 2001). Thus, it is essential to teach the youth how to counteract negative and/or irrational thinking that can lead to experiences of depression, irritability, and mania.

Format. Session 6 is comprised of three separate but intertwined skills: mood monitoring, examining the role of thoughts in mood disturbance (identifying negative thoughts), and replacing distorted or overly negative thoughts with more realistic thoughts. By Session 6, the adolescent will have completed 3 weeks of the three-column mood log (in which the adolescent identified an event, a thought, and a feeling). In this session, adolescents are taught how thoughts affect behavior and mood, common thinking errors, how to identify negative or unrealistic thinking, and how to challenge these cognitions. Ultimately, adolescents learn how challenging negative and distorted thinking patterns can alter their mood. Session 6 is a good opportunity to challenge thoughts and beliefs with regard to control over mood states and related behaviors, such as, “I can’t stop myself from screaming and slamming doors, because that’s what happens during my BP episodes.” The therapist demonstrates how replacing negative thoughts with positive ones helps the adolescent gain some control of his or her mood state and behaviors. After Session 6, the three-column mood monitoring log is replaced with a five-column mood monitoring log, which asks the adolescent to identify a thought countering the negative cognition and the subsequent change in feeling. After practice in session, the adolescent uses this log to begin to identify triggers and distorted cognitions that preceded the mood, and attempts to challenge the negative thinking.

Session 7: Sleep Maintenance

Rationale. Over the past 30 years, several specific factors have been identified as contributing to the onset of manic episodes, including disruptions in routine, such as job change (Ambelas, 1979; Lieberman & Strauss, 1984); biological changes, such as during the postpartum period

(Reich & Winokur, 1970); and stressful interpersonal problems and other negative life events (Parkes, 1964).

One mechanism by which many of these factors may act as triggers of BP symptoms is sleep disruption (Wehr, Sack, & Rosenthal, 1987). Sleep disruption in adolescents has been linked to a range of deficits in functioning, including mood disturbance and suicidal ideation (Roberts, Roberts, & Chen, 2001). In fact, several community-based studies have found that sleep problems are robust risk factors for depressive episodes (see Ford & Cooper-Patrick, 2001). Specific to BP, research indicates a close relationship between sleep loss and the onset of mania (Leibenluft, Albert, Rosenthal, & Wehr, 1996; Wu & Bunney, 1990). Investigations in this area have demonstrated that partial or total sleep deprivation for one night can induce "switching" into manic or hypomanic episodes in BP adults (Barbini, Bertelli, Colombo, & Smeraldi, 1996; Post, Kopin, & Goodwin, 1976; Stoddard, Post, & Bunney 1977; Wehr, 1992; Wehr et al., 1982). Wehr (1989) described a "vicious" cycle that can be established, in which mania disrupts sleep and sleep disruption alternatively provokes manic symptoms, causing the episode to become increasingly worse. Such findings provide the basis for the rationale for including a session on sleep regulation in the context of a psychosocial treatment of BP.

Another rationale for addressing sleep with adolescents with BP is based on investigations of Interpersonal and Social Rhythm Therapy (IPSRT; see Frank et al., 1994), which have indicated the value of maintaining regular circadian rhythms. IPSRT is an approach to individual therapy developed by Frank and colleagues that focuses on the BP patient and his or her interactions with the social environment. IPSRT is based on a belief that stressful life events can influence the prognosis of BP by disturbing the stability of sleep-wake habits, daily activity routines, and social stimulation patterns (i.e., social rhythms; Rothbaum & Astin, 2000). Thus, therapy targets the regulation of these social rhythms and strengthening coping styles when life stressors are present.

Format. To begin this session, the therapist discusses with the adolescent the importance of sleep and provides education about the research (noted above) findings that sleep deprivation can lead to the onset of manic symptoms (and, in turn, can be an indicator of a manic episode). It is particularly important that adolescents, who may maintain irregular sleeping habits as a result of spending time with friends at sleep-overs, doing schoolwork, talking on the phone, or playing video games late at night, be educated on the importance of regular sleep routines.

The therapist then works with the adolescent to determine his or her specific obstacles to getting a good night's rest. The therapist teaches two skills after the obstacles have been identified: relaxation techniques and developing and maintaining a regular sleep/wake schedule. De-

pending on the need of the adolescent and his or her ability to learn the relaxation techniques, the therapist may decide to make an audiotape of relaxation exercises within the session, with exercises such as progressive muscle relaxation and guided imagery. An example of a homework assignment following this session is keeping a "sleep block book," in which the adolescent documents habits or events that disrupt or block sleep and, alternatively, formulates strategies for following a regular sleeping schedule. Other practical interventions in this module include removing the TV from the child's bedroom, setting consistent sleep and wake times and pre-bed routines, and/or negotiating with parents to limit access to TV or video games after a certain time in the evening.

Sessions 8 and 9: Assertiveness and Family Communication

Rationale. A major psychosocial factor that appears to affect the course of BP is interactions within the family of the BP patient (Miklowitz, Goldstein, Nuechterlein, Snyder, & Mintz, 1988). Specifically, certain styles of family communication and expression of emotion have been associated with relapse of BP (Miklowitz et al., 1998). High "expressed emotion" (EE) is the term applied to expressed negative feelings and interactions that exist in a family environment. High EE includes relatives' attributions about illness in the patient; these attributions often involve criticism, hostility, rejection, and/or emotional overinvolvement (Rothbaum & Astin, 2000).

Research on EE originally focused on patients with schizophrenia and found that the emotional quality of the family environment to which a patient returned upon being discharged from a hospitalization was one of the best predictors of the patient's subsequent course of illness (Miklowitz et al., 1988). These results seem to apply to many families with a BP member as well. Negative non-verbal behaviors (e.g., hostile glares), attack-counterattacks, and family discord are also observed in patients with BP (Simoneau, Miklowitz, Richards, Saleem, & George, 1999). These interactions, which have been shown to predict the course of BP in adults (see Miklowitz et al., 1996; Miklowitz et al., 1988; O'Connell, Mayo, Flatow, Cuthbertson, & O'Brien, 1991; Priebe, Wildgrube, & Muller-Orelinghausen, 1989), have been the focus of certain family psychoeducational treatment models. These family models, which typically target post-episode treatment, assume that the family environment in which the client exists plays an important role in preventing relapse. Further, these models of treatment include an understanding of how family members of BP patients often experience a significant emotional and financial burden attributable to the illness (which contributes to the high levels of EE observed in such families).

Including family members in the treatment of a BP

adolescent is important for several reasons. First, it is generally the parent who gets the youth involved with treatment and transports the youth to and from treatment. Second, adolescents may be more likely to engage in treatment (e.g., by completing homework assignments between sessions) if parents are supportive of the treatment. Third, as discussed above, the communication style and attitude of family members can directly affect the course of treatment for patients with BP. Thus, training the family in communication skills, including reducing the hostile attitudes and interactions and increasing positive communication, could be an important part of treatment in preventing future relapse. This part of the treatment also teaches parents to help their adolescents continue to develop the skills and strategies taught in the sessions, such as problem solving and affect regulation. Further, some researchers have argued that high EE and critical and/or hostile attitudes partly result from relatives' beliefs that an individual with a psychiatric disorder actually has the ability to control the symptoms and behaviors of the disorder if only the individual put forth more effort (e.g., Hooley, 1987). Thus, treatment that incorporates information that challenges the belief or attitude that the patient with BP is to blame for the disorder may indirectly improve the communication style of the family, creating a more beneficial family environment (i.e., lower in EE) for the adolescent with BP.

Format. Given the importance of the role of assertiveness in family communication (e.g., teaching the adolescent how to express feelings and needs in an effective manner without being too passive or aggressive), assertiveness skills are taught as a precursor to the module on family communication, which occurs over the course of two sessions: Session 8 and Session 9. In Session 8, the therapist meets with the adolescent alone as an opportunity to build the foundation for learning how to appropriately share feelings and how to problem solve during family disputes. The adolescent learns the importance of engaging in active listening and developing positive communication behaviors (and alternatively decreasing negative communication behaviors). Practicing the family communication skills first with the adolescent alone allows time to prepare for possible disputes and problems that may arise when parents join the session the following week in Session 9. For example, when identifying negative communication behaviors, an adolescent might say, "My mom always calls me names like 'lazy,' but she will never admit it." Session 8 is an opportunity to then ask the adolescent, "What recent examples can we use of her calling you names? How can we frame this so she does not become overly defensive?" as well as, "Can you think of times that *you* have called your mother names?" This latter question is an example of how to encourage the adolescent to start to think about his or her own role in fam-

ily disputes and communication. Session 9, then, is a joint session with the adolescent and the parent, where the family members identify current problems in communication styles, the parent learns the positive communication skills (e.g., active listening), and the adolescent and the parent together can practice the skills in role-playing exercises. The participants also are given situations to role-play at home using the newly learned communication skills as homework.

Sessions 10 and 11: Optional Modules

Our treatment model includes four optional modules in order to meet the individual needs of the adolescents and to help them cope with additional stressors: substance abuse, anger management, social skills training, and contingency management. Each of these modules are briefly discussed in more detail below.

Substance abuse. It is well documented that those with BP are more likely than the general population, or patients with other psychiatric disorders, to have substance use problems (Dunner, Hensel, & Fieve, 1979; Reiger, Farmer, & Rae, 1990; Winokur, Coryell, & Akiskal, 1995). Thus, the first optional module focuses on co-occurring substance use problems. Substance abuse may be a treatment issue particularly for adolescents, who are experiencing a developmental period characterized by substance use experimentation. Substance abuse can affect an individual's motivation for treatment. In addition, mood-altering substances can be used as "self-medication" by individuals suffering from psychological problems and, thus, can affect the course of BP. As a result, the inclusion of a module that would educate adolescents with BP regarding the risks of substance use would be justified in a comprehensive psychosocial treatment. The substance abuse module that is part of this treatment includes identifying high-risk or "trigger" situations and people for substance abuse; revisiting skills learned earlier in the treatment that could serve as strategies to avoid or reduce substance use, including problem solving and assertiveness; and educating the adolescent about how substances affect mood and coping abilities.

Anger management. The second optional module, anger management, is related to the common presence of irritability in adolescents with BP. Depending on the individual, this increased irritability can lead to anger, aggression, and even violence (Basco & Rush, 1996). In fact, conduct disorder has been identified as a common condition comorbid with BP (Bowring & Kovacs, 1992). As such, we suggest teaching anger management to adolescents who have exhibited extreme histories of "losing their tempers" and are experiencing consequences because of such reactions. This module includes helping the adolescent identify specific situations in which they have had difficulty managing feelings of anger and revisiting skills

that may help them cope with such situations more appropriately. These skills include relaxation training, problem solving, and examining and challenging unhelpful thinking.

Social support. The third module is related to the empirically demonstrated influence of social support on the course of BP (Johnson, Winnet, Meyer, Greenhouse, & Miller, 1999). Johnson and colleagues followed 59 individuals with BP and found that those with low social support took longer to recover from depressive episodes and had more depressive symptoms over time than those with higher levels of support. Receiving social support of self-esteem (i.e., both positive appraisal of self by others and positive self-comparison to others) also seems to play an important role in BP depression (Johnson, Meyer, Winnett, & Small, 2000). In addition, a recent prospective investigation of the course of BPII symptoms found that poor previous social functioning predicted greater chronicity of BP symptoms (Judd et al., 2003). Thus, addressing behaviors that involve social interaction and support, such as social activity planning and fostering interpersonal problem solving, could be useful components of treatment for adolescents with BP. This module is offered to help adolescents learn basic social skills, including how to initiate and maintain conversations, how to use body language to convey interest, how to greet peers, and how to utilize problem-solving skills, which can be necessary in building and maintaining friendships.

Contingency management. The fourth optional module, contingency management, is for families in which the adolescent with BP also displays defiant and oppositional behavior. This module may be most useful for young adolescents with BP, particularly those with co-occurring attention-deficit/hyperactivity disorder, which is commonly diagnosed concurrently with BP (Biederman, 1995). The format of this module includes the therapist specifically targeting the parent's strategies to elicit cooperation from the adolescent. The therapist then assists the family in setting up a contingency management system, where the adolescent is rewarded for good behavior and receives consequences for defiant behavior. The target behaviors are defined in operational terms (e.g., improving school social behavior is defined as no reports of physical altercations with peers at school) and both the parent and the adolescent assist in determining the rewards and consequences.

Session 12: Wrap-up and Relapse Prevention

The majority of the final session of the acute phase of treatment is conducted with the adolescent alone, with the parents joining the session for the last 15 to 20 minutes. The format of this session is slightly different because the emphasis is on reviewing skills taught in therapy as opposed to learning new ones. After reviewing homework,

the therapist and adolescent examine progress toward the goals set at the beginning of therapy. All of the skills taught in therapy are then summarized and the therapist helps the adolescent identify which techniques have been most helpful. The "helpful" skills can be considered the "tools" in the youth's toolbox. Based on a discussion of anticipated future challenges, a relapse prevention plan is developed. Parents join the session to review progress of goals and develop their role in the relapse prevention plan. This role can include helping the adolescent practice skills learned in therapy, modeling and engaging in positive family communication, and supporting the youth during stressful situations. At the end of the session, the therapist also can introduce the upcoming maintenance phase, which will follow the same format of the acute phase sessions, but will be less frequent.

Maintenance Phase

Identified in the literature as useful, and often recommended by experts in the field (Birmaher et al., 1998; Clarke et al., 1999; Kroll, Harrington, Jayson, Fraser, & Gowers, 1996), a maintenance phase in which weekly sessions are replaced eventually with less frequent meetings can reinforce previously taught skills and can give an adolescent more independence in self-maintenance without breaking off the therapeutic relationship immediately following acute treatment. Tapering also gives the therapist an opportunity to observe if symptoms will reappear in the face of less intensive treatment. The maintenance phase in our treatment model includes 12 weeks of monthly sessions (i.e., three sessions). The sessions provide an opportunity to address those areas in which the adolescent needs additional work in order to assist with relapse prevention.

Given that BP is a chronic and long-term problem, a maintenance phase that extends beyond 4 months is optimal. Regular, biannual follow-up sessions (i.e., one session every 6 months), regardless of the child's current status, serve as booster sessions to review materials learned earlier in the acute phases of treatment. In addition, these sessions provide an opportunity to address any new or current stressors in the adolescent's life and possibly identify early symptoms of a mood episode onset. In other medical fields, such as dentistry, it is standard to schedule regular check-up sessions every 6 months so as to prevent the occurrence of more severe problems, which are often more difficult and more expensive to treat. Adolescents with BP are good candidates for such a model. Thus, instead of waiting for a suicide attempt or a trip to the Emergency Room because of an extreme manic episode to re-start psychosocial treatment, earlier intervention may be more desirable (e.g., more beneficial and cost-efficient). Of course, given the realities of clinicians' busy schedules, clients' motivation to come in,

managed care/billing issues, and possibly hectic family environments, the reality is that implementing such a check-up may be a slow and difficult process.

Case Example

John, a 13-year-old Caucasian male, was recruited to participate in a study evaluating the efficacy of the intervention outlined in this article. Twelve sessions were conducted from April 2002 to July 2002 in the Division of Child and Adolescent Psychiatry at a large midwestern hospital. The therapist was a master's-level clinical psychology doctoral student (C.K.D.) supervised by a Ph.D.-level clinical psychologist (N.C.F) who specializes in CBT. One year prior, John participated in a psychopharmacology study in the same division comparing two mood stabilizers for the treatment of BP in youths. As part of his participation in the psychopharmacology study, he was diagnosed with BPI, Most Recent Episode Depressed, via the Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children—Present and Lifetime version (K-SADS-PL; Kaufman et al., 1997), administered by a trained research assistant and confirmed by a child and adolescent psychiatrist. Immediately prior to the CBT study, his symptoms were reevaluated and were consistent with a BP diagnosis, the most recent episode depressive. John was considered by his psychiatrist to be stable on a mood-stabilizing medication (no dose changes had been made in 3 months); however, his mother was still concerned about his sad mood, loss of interest, extreme irritability, academic difficulties, and poor medication compliance (i.e., he would only take the morning dose of his medication and would forget his evening dose). His parents reported that John had seen a therapist once in the previous year; however, John refused to attend after the first session.

Prior to Session 1, John and his mother completed clinician-administered versions of the Inventory of Depressive Symptoms (IDS; Rush, Gullion, Basco, Jarrett, & Trivedi, 1996) and the Young Mania Rating Scale (YMRS; Young, Biggs, Ziegler, & Meyer, 1978) and completed the self-report General Behavior Inventory (GBI; Depue, 1987) to assess his baseline functioning (see Table 2 for scores). During Session 1, which John and his mother attended together, John was initially quiet. As he was encouraged to participate in the session, he was sarcastic and irritable. His mother responded well to the psychoeducational material related to bipolar disorder and asked a lot of questions with regard to behaviors she had observed in John. As described above, in Session 1, both parent and teens are asked to set goals for treatment; John set three broad goals: (1) to be a better brother; (2) to do better in school; and (3) to be grounded less. His mother's goals were: (1) to help John do better in school; (2) to observe John in a pleasant mood more frequently;

and (3) to improve family relationships (less fighting). Session 2 immediately followed Session 1, during which the therapist met with John alone. John appeared more comfortable and was more forthcoming in his responses. He was able to state in his own words some of the information he had learned about BP and CBT. He also helped devise his homework assignment, which involved taking a step toward one of his goals: John decided that he would play his 5-year-old brother's favorite sports game with him before the next session.

Session 3 focused on John's difficulties with medication compliance. John was able to describe his prescribed medications and when he was supposed to take them. He was aware that he had the most trouble with the evening dose. In attempting to identify factors that contributed to John's noncompliance with his evening dose of medication, he stated that he would simply "forget" to take the medication. The first attempt at improving compliance was to put the pill on the dinner plate before sitting at the table nightly. Although in the first week this improved compliance slightly (he complied 2 out of 7 nights), he was still forgetting to take the pill out to put on his plate. Interestingly, John was lactose intolerant and would remember to take his lactose medication immediately prior to dinner every night to prevent from getting ill from the food. Thus, we tried keeping the mood stabilizer with his lactose pills, which were stored in a separate drawer in the kitchen. With this simple intervention, John's compliance improved substantially to remembering on average 5 out of 7 doses a week. Session 4 was focused on learning the relationship between thoughts, feelings, and behaviors, and John had difficulty initially identifying his own thoughts and reactions in situations. By reading sample letters from teens, which included a problem, as well as the hypothetical teen's thoughts and feelings with regard to the problem, John was able to begin to learn how to identify underlying thoughts more easily. In Session 5, a parent-only session, the therapist met John's father for the first time. The therapist administered psychoeducation related to BP and depression for the father, who was struggling with John's "poor attitude" and "lack of motivation" to do well in school and "laziness" around the home. The therapist explained how these behaviors could be a result of John's mood disorder, and that lack of interest, lack of energy, and problems with concentration and self-esteem were common symptoms of depression. Though they were still concerned about him, John's parents reported significant improvement in his mood and behaviors by this fifth session. During this session the therapist also worked with his parents on how to be supportive of John's CBT homework without it becoming a source of conflict.

In Session 6, John adapted well to learning how to counter negative thinking by coming up with a list of

"realistic counterthoughts," such as, "I may not be good at math, but I do well in science" and, "Even if I didn't play well this game, I usually have several hits (during a baseball game)." The therapist and John also reviewed facts and myths about BP in Session 6 to help John learn to counter his thought that "when I get out of control with my anger, it is my BP disorder acting up; it's not my fault" with an alternative thought: "It may be more challenging for me in annoying situations, but I can do some things to help keep myself out of trouble (like going in my room to relax before responding to my dad)." During the session on sleep (Session 7), John identified that arguing with parents in the day and listening to the radio in his room were factors that increased difficulty in falling asleep after going to bed. He agreed to refrain from listening to the radio in his room for the hour before bed and relaxation was taught as a tool to help him settle down for bed. After completing a sleep diary, he reported that relaxation techniques were most useful to him in helping him get to sleep. Because John tended to be more irritable and sarcastic with his parents, the therapist used Session 8 to prepare him for the upcoming family communication session (Session 9). This included teaching him specific problem-solving and assertiveness skills. In session, role-plays were used to practice common conflicts at home, such as what to do when a note is sent home from the school reporting that John did not complete his homework. The family communication session also was useful in problem solving around the parents taking away pleasant activities (e.g., baseball) as a consequence of negative behavior and educating the parents on the importance of the pleasant activities (i.e., for reasons of behavioral activation and social support). With coaching, the parents were able to generate other negative consequences, such as loss of TV time. Of the four optional modules, John, his mother, and the therapist selected the social skills and anger management modules for Sessions 10 and 11 to help reinforce the skills with which John needed the most practice.

The last session of the active phase of treatment (Session 12) was aimed at reviewing progress and developing a relapse prevention plan. During this session, John identified several skills that he thought were important for the goal of relapse prevention. These skills included relaxation techniques, countering negative thinking, continuing with medication compliance, and problem-solving skills. He and his mother were also able to identify "red flags" that might signal a relapse. During this session, both John and his mother reported some improvement on all goals set at the beginning of the treatment, with the most observable changes related to John's mood, disciplinary status (being grounded less), and family relationships. As seen in Table 2, John's symptoms diminished across all measures, with the ex-

Table 2
Pre-, Post-, and 8-Week Follow-up Treatment Scores for
Case Study of Adolescent Boy With BPI

Measure	Pre-treatment	Post-treatment	8-Week Follow-up
P-GBI-Depression	30	2	14
P-GBI-Hypomanic-Biphasic	8	1	9
C-GBI-Depression	12	0	0
C-GBI-Hypomanic-Biphasic	3	0	0
IDS	17	3	—
YMRS	0	0	—
CGI	4	1	—

Note. P-GBI-Depression = General Behavior Inventory Depression Subscale, Parent report form; P-GBI-Hypomanic-Biphasic = General Behavior Inventory Hypomanic-Biphasic Subscale, Parent report form; C-GBI-Depression = General Behavior Inventory Depression Subscale, Child report form; C-GBI-Hypomanic-Biphasic = General Behavior Inventory Hypomanic-Biphasic Subscale, Child report form; IDS = Inventory of Depressive Symptoms; YMRS = Young Mania Rating Scale; CGI = Clinical Global Inventory.

ception of the YMRS, on which he remained at zero symptoms.

Although John's family over the course of treatment was generally very consistent with attendance, scheduling conflicts resulted in the acute phase of therapy lasting approximately 16 weeks, at which point the therapist was moving out of state. Thus, no maintenance phase sessions were delivered. The therapist did telephone check-in 2 weeks after the last session, and John and his mother reported improvements had been maintained. He and his mother then returned for an 8-week follow-up to complete the symptom measures. Although John did not report a return of symptoms, his mother reported a return of some depression and many hypomanic symptoms. This may speak to the importance of the maintenance phase in helping to prevent relapse and facilitate maintenance of gains achieved during the active treatment phase. In sum, John and his family seemed to benefit from this brief adjunctive cognitive-behavioral intervention, although maintenance sessions would likely have been quite useful in sustaining therapeutic gains and reducing the risk for relapse. See Table 2 for scores on measures of depression, mania, and global functioning at pretreatment, posttreatment, and at an 8-week follow-up.

Conclusion

The purpose of this article was to describe a newly developed cognitive-behavioral intervention for adolescents with BP, based on the current state of the science of BP treatment in adolescents. The proposed treatment, intended to be used in conjunction with pharmacological intervention, is based on empirical demonstrations of what we know about the course of BP in general, what has

been shown to be effective in adults with BP, and what has been shown to work in the psychosocial treatment of unipolar depression in adolescents and in the psychoeducation of parents of mood-disordered children. With regard to the proposed treatment, it is our hope that the addition of an empirically derived psychosocial intervention for the treatment of adolescents with BP will not only reduce symptoms and the risk of future episodes, but also will lead to improvements in overall quality of life for the adolescents.

It is extremely important that psychosocial treatments for adolescents with BP be developed and empirically tested. Initial investigations should compare the outcomes of adolescents with BP who have received a psychosocial treatment in conjunction with a pharmacological intervention with the outcomes of adolescents with BP who have received a pharmacological intervention alone. The authors are in the process of conducting such a clinical trial using the manualized treatment outlined in this article.

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Address correspondence to Norah C. Feeny, Ph.D., 11100 Euclid Ave., Hanna Pavilion, Cleveland, OH 44106; e-mail: ncf2@po.cwru.edu.

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