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Pediatric bipolar disorder: Efficacy and core elements of adjunctive psychotherapy

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INTRODUCTION

Although pharmacotherapy is the primary treatment for children and adolescents with bipolar disorder, adjunctive psychotherapy is nearly always essential [1]. This approach is consistent with treatment guidelines [2], including those from the National Institute for Health and Care Excellence [3], Royal Australian and New Zealand College of Psychiatrists [4], and International Society for Bipolar Disorders Task Force [5].

Psychotherapy can provide support for patients and families, and address disruption of developmental processes (eg, family, social, and academic functioning), comorbidities (eg, substance use disorders) and preexisting behavioral problems, medication adherence, and relapse prevention. A relatively simple form of psychotherapy is psychoeducation, which appears to be efficacious and is a core element of more elaborate and intensive psychotherapies (eg, family therapy).

This topic reviews the efficacy and core elements of different adjunctive psychotherapies for children and adolescents with bipolar disorder. Choosing a specific psychotherapy is discussed separately in the context of an overview of choosing treatment for mania, comorbid disorders, and maintenance treatment. Other aspects of pediatric bipolar disorder are also discussed separately, including choosing treatment for bipolar major depression; the efficacy, administration, and side effects of second-generation antipsychotics for pediatric mania; the

general principles of using pharmacotherapy; assessment and diagnosis; and the epidemiology, clinical features, and course of illness:

- (See "Pediatric bipolar disorder: Overview of choosing treatment".)
- (See "Pediatric bipolar major depression: Choosing treatment".)
- (See "Pediatric mania and second-generation antipsychotics: Efficacy, administration, and side effects".)
- (See "Pediatric bipolar disorder and pharmacotherapy: General principles".)
- (See "Pediatric bipolar disorder: Assessment and diagnosis".)
- (See "Pediatric bipolar disorder: Clinical manifestations and course of illness".)

GENERAL PRINCIPLES

As with all psychotherapies, patients must have the necessary motivation, interest, and cognitive capacity to participate in treatment and complete assigned tasks. In addition, it is often necessary to defer adjunctive psychotherapy until severe symptoms (eg, psychotic features) are stabilized. It may be possible to improve motivation with motivational interviewing. (See "Overview of psychotherapies", section on 'Motivational interviewing'.)

SPECIFIC THERAPIES

Specific psychotherapies that can be added onto pharmacotherapy for pediatric bipolar patients include:

- Cognitive-behavior therapy
- Dialectical behavior therapy
- Family therapy
- Interpersonal and social rhythm therapy
- Motivational interviewing
- Psychoeducation

Choosing a specific psychotherapy is discussed separately. (See "Pediatric bipolar disorder: Overview of choosing treatment", section on 'Adjunctive psychotherapy'.)

Cognitive-behavioral therapy — One type of psychotherapy for pediatric bipolar disorder has integrated cognitive-behavioral therapy (CBT) with family therapy, and a randomized trial found that this model was efficacious [6]. (See 'Family therapy' below.)

In addition, an observational study of youth with bipolar disorder (n = 8) who received pharmacotherapy suggests that add-on CBT may potentially help improve symptoms and functioning [7]. The intervention is administered over 12 weekly sessions and emphasizes psychoeducation, medication adherence, mood monitoring, cognitive restructuring, sleep hygiene, and family communication. Homework assignments in between sessions reinforce the skills that are taught.

The core elements of CBT are discussed separately. (See "Overview of psychotherapies", section on 'Cognitive and behavioral therapies'.)

Dialectical behavior therapy — Evidence supporting this approach includes a small, one-year randomized trial that compared adjunctive dialectal behavior therapy with psychotherapy as usual (psychoeducation, supportive, cognitive behavioral therapy, or family therapy) in 20 adolescents with bipolar disorder who were treated with pharmacotherapy [8]. Dialectal behavior therapy included 36 sessions devoted to individual skills training (which target problematic behaviors such as nonadherence to medications) and family therapy (psychoeducation, tolerating distress, emotion regulation, and interpersonal effectiveness). In addition, patients monitor mood, sleep, suicidal ideation and behavior, and medication adherence on a daily basis, and can call therapists in between appointments [9]. The mean number of therapy sessions attended was greater with dialectal behavior therapy than the control treatment (30 versus 9), perhaps reflecting greater engagement [8]. In addition, depression was less severe in patients who received dialectal behavior therapy than the controls, and the estimated mean number of euthymic weeks was two times greater with active treatment. Patients treated with dialectical behavior therapy were three times more likely to show improvement in rating scale scores of suicidal ideation.

Additional information about dialectal behavior therapy is discussed separately. (See "Overview of psychotherapies", section on 'Dialectical behavior therapy'.)

Family therapy — Evidence for the efficacy of family therapy for pediatric bipolar disorder includes randomized trials:

- One type of family therapy integrated the therapy with CBT, and a trial compared this family therapy model with psychotherapy as usual (control) in 69 acutely symptomatic children receiving pharmacotherapy [6]. Both treatment groups received 12 weekly sessions followed by 6 monthly maintenance sessions. Family therapy included psychoeducation, communication training, family problem-solving skills, developing routines, affect regulation, mindfulness techniques, and improving self-esteem. The control therapy was selected by the therapist and largely avoided the elements of family

therapy. Reduction of manic and depressive symptoms, as well as improvement of psychosocial functioning, was greater with family therapy.

- A second trial compared family therapy with psychoeducation in 58 adolescents with bipolar disorder who were treated with pharmacotherapy and followed for up to two years after study entry [10]. Family therapy consisted of 21 sessions focused upon psychoeducation, communication, and problem solving. Psychoeducation consisted of three weekly sessions administered to the patient and family. The mean time to recovery from depressive symptoms was faster with family therapy than psychoeducation (10 versus 14 weeks). Time to recovery from mania also favored family therapy (8 versus 14 weeks), but the difference was not statistically significant. Time to recurrence of a mood episode was comparable for the two treatments.

- A third trial compared family therapy with an education control condition in 40 youth with acute symptoms of hypomania and/or depression [11]. Diagnoses at study entry consisted of other specified bipolar and related disorder, cyclothymic disorder, or unipolar depression; patients with bipolar I disorder or bipolar II disorder were not enrolled. Nearly half of the patients were not taking medication at study entry. Family therapy consisted of 12 sessions focused upon psychoeducation, communication, and problem solving; the control consisted of one to two family sessions devoted to reviewing the patient's diagnosis, daily mood monitoring by the family, and managing symptoms. Both groups were followed for up to one year after study entry. The mean time to recovery from symptoms was faster in the family therapy group than the control group (13 versus 21 weeks), and total time in remission was greater with family therapy (27 versus 20 weeks).

A common element of different family therapy models is enhancing communication among family members. Therapists work with the family on active listening, which includes looking at the speaker, concentrating on what is said, and clarifying any uncertainties [10,12,13]. In addition, the family is encouraged to offer each other positive feedback and to criticize specific behaviors or request changes in behavior in a constructive and positive manner (eg, "Would you please play the music more softly?"). The family is also encouraged to reduce "expressed emotion," which is defined as critical and hostile comments about the patient, as well as emotional over-involvement with the patient [14,15]. Some of the work aimed at improving communication can involve role playing.

Problem solving is another aspect that is generally addressed in family therapy. Therapists work with the family to identify and define their problems, and for each problem, consider the barriers to its resolution, set an achievable goal, list and evaluate the advantages and

disadvantages for all available solutions (brainstorming), choose one option, develop an action plan and implement it, and evaluate the outcome.

Family therapy can also help the family [13]:

- Support the use of pharmacotherapy
- Minimize conflict and volatility in the home
- Maintain reasonable expectations for each other
- Maintain routines (eg, meals together)
- Acquire social services

Interpersonal and social rhythm therapy — An observational study of adolescents with bipolar disorder (n = 12) who were treated with medications suggests that adjunctive interpersonal and social rhythm therapy may perhaps help improve symptoms and functioning [16]. The therapy consists of 16 to 18 sessions (over 20 weeks) that address a relevant interpersonal problem (unresolved grief, interpersonal disputes, role transition, or interpersonal deficits), and also focuses upon psychoeducation, daily routines, and sleep/wake cycles.

Additional information about interpersonal psychotherapy is discussed separately, in the context of unipolar depression. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Specific interventions and techniques".)

Motivational interviewing — Motivational interviewing may possibly improve medication adherence in pediatric bipolar disorder. A small, six-month, open-label randomized trial compared pharmacotherapy alone with pharmacotherapy plus motivational interviewing in adolescents with bipolar disorder (n = 43) [17]. Motivational interviewing consisted of three sessions, each lasting 30 minutes, administered over the first three months. The intervention addressed adherence by educating patients about bipolar disorder and medications, eliciting thoughts and feelings about pharmacotherapy, assessing to what extent patients are ready to change their behavior regarding adherence, collaborating with patients to create an action plan for improving adherence, and evaluating the utility of the plan and need for modifications. The average medication adherence in the two groups was comparable, but the average improved in the group that received motivational interviewing and decreased in the control group.

General information about motivational interviewing is discussed separately. (See "Overview of psychotherapies", section on 'Motivational interviewing'.)

Psychoeducation — Psychoeducation can be administered to an individual patient and family, or to a group of patients and families. Evidence supporting the psychoeducation for pediatric

bipolar disorder includes multiple randomized trials [18,19]:

- One trial compared psychoeducation (eight weekly sessions administered within a multifamily group setting) plus treatment as usual (eg, pharmacotherapy and/or other psychotherapy) with treatment as usual alone in 165 children aged 8 to 12 years [20]. Bipolar disorder was the primary diagnosis in approximately 70 percent of the children, and unipolar depression in the remaining children. One year after study entry, improvement of mood symptoms was greater in the group who received psychoeducation than the control group.

- A second trial compared psychoeducation with family psychotherapy in adolescents with bipolar disorder who were treated with pharmacotherapy and followed for up to two years after study entry (n = 145) [12]. Psychoeducation consisted of three sessions administered weekly to the patient and family, and focused upon the phenomenology of bipolar disorder, monitoring the patient's mood symptoms, and relapse prevention. Family psychotherapy consisted of 21 sessions, administered over nine months, focused upon psychoeducation, communication, and problem solving. Time to recovery from either depressive symptoms or manic/hypomanic symptoms was comparable for adjunctive psychoeducation and family therapy. In addition, time to recurrence of either depression or mania/hypomania was comparable for the two groups. The results suggest that psychoeducation may be preferable because it is the less intense intervention [21]. However, the lack of a placebo (nonactive) control makes it difficult to interpret the results; one possibility is that neither treatment was effective.

- A small, 12-week trial compared individual family psychoeducational psychotherapy (two sessions/week) with active monitoring in a study that randomly assigned youth with either bipolar disorder not otherwise specified or cyclothymic disorder (n = 23) to one of four treatments: psychoeducation plus omega-3 fatty acids, psychoeducation plus placebo, active monitoring plus omega-3 fatty acids, or active monitoring plus placebo [22]. In the analysis that compared the two groups receiving psychoeducation with the two groups receiving active monitoring, the clinical benefit of psychoeducation for improving depressive symptoms was moderate to large. However, the benefit of psychoeducation and active monitoring for improving manic symptoms was comparable.

The topics covered in psychoeducation often include [11,12,20,23-25]:

- Symptoms of mania (table 1), hypomania (table 2), and major depression (table 3), as well as mood episodes with mixed features or psychotic features (see "Pediatric bipolar disorder: Assessment and diagnosis")

- Course of illness (see "Pediatric bipolar disorder: Clinical manifestations and course of illness", section on 'Course of illness')

- Pharmacotherapy

  - Medication names, doses, efficacy, side effects, administration, and monitoring

  - Patient and parental attitudes about and expectations for medications

  - Adherence with pharmacotherapy (see "Pediatric bipolar disorder and pharmacotherapy: General principles", section on 'Adherence' and "Bipolar disorder in adults: Managing poor adherence to maintenance pharmacotherapy", section on 'Management')

- Managing symptoms

  - Using pleasant and relaxing activities to counteract negative emotions
  - Maintaining sleep hygiene
  - Recognizing and exiting volatile situations
  - Working with clinicians to change medications

- Recognizing prodromal symptoms and preventing relapse

Additional information about the efficacy and content of psychoeducation is discussed separately in the context of adult bipolar disorder. (See "Bipolar disorder in adults: Psychoeducation and other adjunctive maintenance psychotherapies", section on 'Content'.)

Information for patients and families — UpToDate offers two types of patient education materials, “The Basics” and “Beyond the Basics.” The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topics (see "Patient education: Bipolar disorder (The Basics)" and "Patient education: Coping with high drug prices (The Basics)")

- Beyond the Basics topics (see "Patient education: Bipolar disorder (Beyond the Basics)" and "Patient education: Coping with high prescription drug prices in the United States (Beyond the Basics)")

These educational materials can be used as part of psychoeducational psychotherapy.

The National Institute of Mental Health also has educational material explaining the symptoms, course of illness, and treatment of pediatric bipolar disorder in a booklet entitled " Bipolar Disorder in Children and Teens," which is freely available for downloading and printing.

The Depression and Bipolar Support Alliance (800-826-3632) is a national organization that educates members about bipolar disorder and how to cope with it. Other functions include increasing public awareness of the illness and advocating for more research and services. The organization is administered and maintained by patients and family members and has local chapters.

The National Alliance on Mental Illness (800-950-6264) is a similarly structured organization devoted to education, support, and advocacy for patients with any mental illness. Bipolar disorder is one of their priorities.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Bipolar disorder".)

SUMMARY

- **Psychotherapy's role in treatment** – Although pharmacotherapy is the cornerstone of treatment for pediatric bipolar disorder, clinicians nearly always choose to include a specific adjunctive psychotherapy as part of the treatment regimen. (See 'Introduction' above and "Pediatric bipolar disorder: Overview of choosing treatment", section on 'Adjunctive psychotherapy'.)

- **General principles** – Patients must have the necessary motivation, interest, and cognitive capacity to participate in psychotherapy and complete assigned tasks. (See 'General principles' above.)

- **Psychoeducation** – Multiple randomized trials indicate that psychoeducation is efficacious for pediatric bipolar disorder.

  Psychoeducation can be administered to an individual patient and family, or to a group of patients and families. The treatment addresses symptoms of mania (table 1), hypomania (table 2), and major depression (table 3); course of illness; medication names, doses, efficacy, side effects, administration, and monitoring; patient and parental attitudes about medications; adherence with pharmacotherapy; managing symptoms; and recognizing prodromal symptoms and preventing relapse. (See 'Psychoeducation' above.)

- **Family therapy** – Randomized trials have found that family therapy is efficacious for pediatric bipolar disorder.

  Common elements of different family therapy models include problem solving and enhancing communication among family members. Family therapy can also help the family support the use of pharmacotherapy, minimize conflict and volatility in the home, maintain reasonable expectations for each other, maintain routines (eg, meals together), and acquire social services. (See 'Family therapy' above.)

- **Other psychotherapies** – Other psychotherapies that can be added onto pharmacotherapy for pediatric bipolar patients include dialectical behavior therapy, cognitive-behavior therapy, interpersonal and social rhythm therapy, and motivational interviewing. (See 'Dialectical behavior therapy' above and 'Cognitive-behavioral therapy' above and 'Interpersonal and social rhythm therapy' above and 'Motivational interviewing' above.)

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