Family Focused Therapy in Managing Bipolar Disorder

250427208

University of Western Ontario

**Introduction**

 Bipolar disorder (BD) describes a spectrum of disorders involving a combination of both depressive and manic episodes (Davison, Blankstein, Flett, & Neale, 2008). Depressive episodes are defined as a period of at least two weeks with a depressed mood or loss of interest and pleasure, along with at least four of the following symptoms: change in weight or appetite, insomnia or hypersomnia, change in activity level (lethargy or agitation), fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, reduced cognitive abilities (thinking, concentrating, indecisiveness), and recurrent thoughts of death or suicide (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association [APA], 2000). Manic episodes are defined as a period of at least one week with an abnormal and continuing expansive, elated, or irritable mood, along with at least three of the following symptoms: exaggerated grandiosity or self-esteem, decreased need for sleep, urgent speech, rapid thoughts, distractibility, an increase in goal-directed activities, and unrestrained involvement in pleasurable activities with potential for negative consequences (APA, 2000); Manic episodes can also include delusional thought patterns. An episode is considered mixed when episodes of both depression and mania occur every day for one week, while a hypomanic episode is differentiated from a manic episode by a lack of significant social impairment (APA, 2000).

Bipolar I Disorder (BD-I) presents in individuals as at least one depressive episode and at least one manic or mixed episode (APA, 2000). Bipolar II disorder on the other hand, is characterized by the presence of at least one depressive episode and at least one hypomanic episode with no history of full mania (APA, 2000). In either case, BD typically represents a recurring, life-long disorder (Davison et al., 2008). For the purposes of this article, when discussing BD, it is in reference to both BD-I and BD-II.

 According to the World Health Organization (2004) approximately 29.5 million people have been diagnosed with BD, making BD the seventh leading cause of non-fatal burden worldwide (Ayuso-Mateos, 2000). In Canada alone BD has been reported to have a one-year prevalence of approximately 1.0% and a lifetime-prevalence of approximately 2.4% (Government of Canada, 2006). Results of the United States’ National Comorbidity Survey Replication (Kessler, Chiu, Demler, & Walters, 2005) showed that among those diagnosed with BD, 82.9% were classified as having serious impairment, the highest proportion among mood disorders. Research has also demonstrated that those with BD are at a significantly higher risk of death by suicide than the general population (Ösby, Brandt, Correia, Ekbom, & Sparén, 2001). Taking all this into account, it is clear the BD represents a serious disorder that most mental health practitioners are likely to encounter.

Due to the relatively high prevalence of BD it is important that counsellors have some knowledge of the empirically supported interventions available to treat BD. The bulk of BD treatments are pharmacotherapy interventions such as mood stabilizers, antidepressants, and antipsychotics (Miklowitz, 2011), with the use of lithium salts being the most widespread pharmacological treatment (Muller-Oerlinghausen, Berghofer, & Bauer, 2002). Psychotherapy is also commonplace in treating BD; typically occuring adjunctive to pharmacological treatment (Miklowtiz, 2011). Division 12 of the American Psychological Association (2009) maintains a web report on empirically validated psychotherapies, as defined by Chambless et al. (1998). The following review explores the one such empirically supported treatment for BD, family focused therapy (FFT)

**Family Focused Therapy**

 Dr. David Miklowitz and his colleagues pioneered the use of FFT in the treatment of people with BD (Miklowitz, 2008). FFT for BD was originally built upon the use of FFT as a psychoeducational program for people and families with schizophrenia, as a treatment aimed at preventing a relapse of schizophrenia (American Psychological Association, 2009; Miklowitz, 2008). Since then, Miklowitz and others have tailored FFT to meet the specific considerations of working with BD, and taken great steps in supporting its efficacy through a series of randomized control trials.

**Basic Philosophy of FFT in treating BD**

 Miklowitz (2008) describes the FFT perspective as a multisystemic approach to treating BD. While acknowledging the significant support in the literature for a biological basis of BD (Badner & Gershon, 2002), FFT also takes into account the impact of psychological stressors and interpersonal relations on the development and maintenance of the disorder (Miklowitz, 2008). Taking the notion of BD as a biological disorder, FFT encourages a treatment protocol consisting of pharmacological treatment with a concurrent systemic psychotherapy component.. The focus of FFT is on integrating patients and their family members into a comprehensive unit tasked with managing the recurring and lifelong symptoms of BD, in hopes of reducing the probability of future BD episodes.

 **BD as a family problem.** Although BD is known to be a biological disorder (Badner & Gershon, 2002; Miklowitz, 2011), FFT conceptualizes its development and consequences as a “family problem” (Miklowitz, 2008, p. 5). Research has demonstrated that there are significant differences in the manner families with and without BD interact, such that families with BD show less commitment, helping and support, and less direct expression of feelings to one another (Romero, DelBello, Soutullo, Stanford, & Stakowski, 2005). This combined with findings that home environments characterized by critical, hostile, negative, and conflict-laden interactions directed at the person with BD were more predictive of BD remission then low-conflict family environments (Miklowitz, Goldstein, Nuechterlein, Snyder, & Mintz, 1988) suggest that the family environment influences and is influenced by the course of BD. Perlick and colleagues (2004) demonstrated that the commonly observed high levels of burden in families of those with BD disorder indirectly and negatively impact on the patient’s adherence to pharmacological treatment, leading to a higher rate of relapse. This evidence supports FFTs conception of BD not being an issue of the individual, but a problem that touches the whole family.

 **Six objectives of FFT.** In his manual on FFT Miklowitz (2008) outlines the six key objectives in a family focused approach to treating BD. First, FFT must help both the family (including the individual with BD) process or integrate their experiences of living with BD, including achieving a deeper understanding of the characteristic features of the disorder. Research has shown that the experience of caring for someone with BD can be an extremely stressful experience, directly leading to higher levels of mental and physical health troubles (Perlick, Hohenstein, Clarkin, Kaczynski, & Rosenheck, 2005), thus processing these experiences is especially pertinent. The second objective involves helping patients and their families to accept the chronic and recurrent nature of BD. As Miklowitz (2008; 2011) explains, following an initial episode with BD it is typical for both the patient and their family to expect that their trouble has come to an end, as the individual with BD may no longer be exhibiting symptoms; this is not the case. The next objective is tied with this chronic nature of BD; FFT must support families in understanding that long-term adherence to pharmacological treatment is a necessary component in managing BD. In a study of over 44 000 patients receiving pharmaceutical treatment for BD, it was found that almost half of all patients were not taking their medication as directed, with over one in five being completely non-adherent (Sajatovic, Valenstein, Blow, Ganoczy, & Ignacio, 2007). With research demonstrating the importance of the family in ensuring treatment adherence (Perlick et al., 2004), family psychoeducation on the importance of medication adherence in treating BD is very beneficial (Miklowitz, 2011). The fourth objective involves supporting the family as they distinguish their family member’s personality from their BD. As Miklowitz (2008) explains, very often both family members and the patient over identify with the BD diagnosis such that everything the patient does is seen in light of the diagnosis. It is important that all parties involved understand just because someone has BD does not mean they *are* BD. The fifth objective of FFT treatment is to help families recognize and cope with stressful events that may trigger episodes of BD. The sixth, and final, goal of FFT is to help families rebuild relationships and establish better methods of communication in light of the stress of BD. This is in keeping with previously mentioned findings that more adaptive communication styles in families are correlated with better outcomes in BD (Miklowitz et al., 1988).

 Miklowitz (2008) captured the purpose of FFT, and the six main objectives described above, in three brief assumptions underlying FFT. One, BD is, in essence, a disaster for the family system. Two, as is the case with other types of disaster, each BD episode creates disorganization in the family system. Finally, the overarching focus of FFT is in helping patients and their families regain stability following a BD episode. In order to achieve these objectives and establish stability in the family FFT advocates a three-phase approach to treatment (Miklowitz, 2008).

**The Process of Family Focused Therapy**

 The three treatment phases of FFT are modeled after Falloon, Boyd, and McGill’s (1984) family focused approach to treating schizophrenia (Miklowitz, 2008). The stages include: psychoeducation, communication enhancement training, and problem-solving training, and are delivered across 12 weekly sessions, six biweekly sessions, and three monthly sessions (Miklowitz, 2008).

 **Psychoeducation.** Psychoeducation comprises the bulk of the initial stages of FFT treatment. In general this stage is centered on helping the patient and their family gain a deeper understanding of the facts of BD, while also having an opportunity to discuss their experiences, thoughts and emotions surrounding the diagnosis (Miklowitz, 2008). Some of the topics to be discussed with patient families during this time include: BD symptoms, progression, causes, and available intervention strategies (Miklowitz, 2008). It is important that all family members (including the patient) are encouraged to actively discuss and learn about these topics in a general sense (i.e. typical symptoms of BD) as well as in a manner more specific to their relative (i.e. the symptoms their relative manifests, their experience of the relatives most recent episode of BD, etc.). This is also an excellent opportunity to review the importance of family involvement, and the positive outcomes of a supportive, non-stressful home environment in preventing BD relapse (Perlick et al., 2004; Romero et al., 2005). Family members’ understanding that BD can be a chronic, recurring, and debilitating mental health problem may go a long way in assuaging resistances to treatment or inaccurate expectations of BD (Miklowitz, 2008).

 FFT advocates that therapists discuss BD from the perspective of a “vulnerability-stress model” (Miklowtiz, 2008, p. 49). Developed from practice with schizophrenia (Zubin & Spring, 1977), the vulnerability-stress model is analogous to the diathesis-stress model of psychopathology; an individual’s genetics confer a level of predisposition or resilience to a disorder, which then interacts with the individual’s environment and experiences to determine the manifestation of the disorder. Educating family members and patients with BD from this perspective consolidates understanding of the important impact that family interactions and environment can have on future BD episodes. Coinciding with family understanding of BD as a biologically determined illness, is psychoeducation regarding the role of the family in supporting medication adherence (Miklowitz, 2008).

 In essence the main goals of the psychoeducational phase of treatment are having patients and their families gain a deeper understanding of the realities of BD, treatment options, and their role in recognizing episodes of BD as well as having a chance to process their experiences of the patient’s BD.

 **Communication enhancement training.** At this point in FFT, patients have become sufficiently stabilized through medication to actively participate in treatment. The family system still is still in a state of disorder, tension and adjustment due to the preceding BD episode and learning about BD during the psychoeducation phase (Miklowitz, 2008). The communication enhancement training (CET) portion of FFT is centered on the development of more functional communication patterns and dynamics within the family system (Miklowitz, 2002).

 CET is framed in light of the vulnerability stress model, such that maladaptive communication patterns surrounding stressful events in the family leads to poor problem solving strategies which in turn leads to a higher probability of relapse; family environments with good communication patterns and problem solving strategies are less stressful leading to lower probabilities of relapse (Miklowitz, 2002). Building on Falloon and colleagues’ (1984) FFT for schizophrenia, four communication skills are taught: expressing positive feelings, active listening, making a positive request for change in the behaviour of another family member, and expressing negative feelings (Miklowitz, 2002; 2008). Through therapist modelling, role play, homework assignments, and practice outside of session the implementation of these skills is thought to improve communication within the family system, increasing a sense of collaboration in the family unit and decreasing feelings of tension (Miklowitz, 2002). While the use of skills learned during CET is encouraged in day-to-day life, it becomes especially pertinent in times of high stress and conflict. It is important that family members learn to communicate with one another to help prevent stress-induced episode of BD.

 **Problem solving.** The final phase of FFT focuses on the family and patient analyzing pertinent problems, learning problem solving strategies to help alleviate the stress of these problems, and implementing said strategies (Miklowitz, 2002; 2008). These sessions are modeled on Falloon and colleagues’ (1984) problem solving approach in FFT for schizophrenia. This approach is comprised of identifying specific problems as a family, proposing possible solutions to these problems, evaluating the costs and benefits of proposed solutions, implementing a selected solution, and reviewing the outcome (Miklowitz, 2002).

The therapist provides positive reinforcement in the form of praise and encouragement as the family works together to solve problems common to the period following an episode of BD (Miklowitz, 2008). These problems include: the issue of medication adherence, the patient’s return to their normal social roles (i.e. work, school, etc.), “life trashing”, and relationship conflicts (Miklowitz, 2002; 2008). Medication adherence is a self-explanatory issue, which as previously discussed, is a major barrier in the treatment of BD (Sajatovic et al., 2007). Life trashing refers to the damage that patients inflicted on their lives (financial, social, relational, health, etc.) during a BD episode (Miklowitz, 2002). Relationship conflicts, especially within the family system, commonly arise in the stress following an episode of BD (Miklowitz, 2002; 2008). No matter the actual problem, it is important that the family works together in an effort to solve these pressing problems. Initial efforts take place within the context of a therapy session, and as the family becomes more proficient they are encouraged to practice the problem-solving strategy beyond the therapeutic setting (Miklowitz, 2002). In this way, problem-solving behaviour generalizes to a multitude of situations.

**The therapeutic relationship in FFT.** As FFT involves treatment of an entire family system, rather then just an individual diagnosed with BD, it is important that a therapeutic alliance is built with each individual as well as the family as a system (Miklowitz, 2008). The FFT therapist is expected to communicate to the family that they are genuinely interested in the family’s well being and not solely in the BD diagnosis. Miklowitz (2008) advocates that the therapist avoid merely presenting material to the client family, and instead ensure that the sessions include active involvement of both the therapist and the family. Perhaps most essential in FFT, the therapist is expected to maintain an optimistic attitude regarding the family’s future, without patronizing (Miklowitz, 2002; 2008). It is important to communicate that, despite a diagnosis of BD, by following the FFT program, providing family support, and adhering to medication, the family and the patient can live a satisfying and meaningful life (Miklowitz, 2008).

**Empirical Support**

As previously mentioned, FFT is considered to have strong research, or meet Chambless and colleagues’ (1998) criteria for a well-established treatment (American Psychological Association, 2009). Further support of FFT is seen in the abundance of randomized control trials (RCT) investigating the efficacy of FFT.

**Caregivers.** Perlick and colleagues (2010) investigated the effect of FFT on caregivers without treatment of the BD patient. The researchers randomly assigned 46 caregivers to participate in FFT or a videotape psychoeducation course. Following treatment, caregivers showed significant and robust reduction in depressive symptoms and risky health behaviours; furthermore, the diagnosed relatives of those in the FFT group demonstrated significantly lower depressive and manic symptomology following FFT. Merely treating family members indirectly effected improvement in the BD patients. It is unclear whether the effects of FFT in this study were a result of the treatment itself or the inequality in treatment length and access to a therapist. It may be that increased frequency of sessions and access to a therapist caused the improvement. As well, no data was collected on the treatment regimens of the BD patients themselves; there may have been a systematic difference between the two conditions in the treatment the family members with BD were receiving.

 **Patients.** A number of RCT have reported on the efficacy of FFT in managing BD (Miklowitz, George, Richards, Simoneau, & Suddath, 2003; Miklowitz et al., 2000; Rae et al., 2003). In general, these studies have compared the efficacy of FFT and a treatment as usual community management (CM) intervention. The repeated finding is that FFT results in lower rates of relapse (Miklowitz et al., 2003; Miklowitz et al., 2000; Rae et al., 2003), a greater time interval between relapses (Miklowitz et al., 2003; Miklowitz et al., 2000), and a greater reduction in symptoms of mania and depression (Miklowitz et al., 2003; Miklowitz et al., 2000). Rae et al. (2003) also found reduced rates of hospitalization in family members with BD in the FFT condition. These studies are limited by therapists working simultaneously with both treatment conditions (lack of blinding), and uneven treatment implementations. Having the same therapists involved in both treatment conditions likely leads to an observer-expectancy bias. Treatment outcome can also be ascribed to differential intensities of the treatment conditions. FFT may have appeared more effective due to more frequent and longer clinical contact with patients and families.

 In another RCT comparing FFT and CM in BD patients and their families (Simoneau, Milowitz, Richards, Saleem, & George, 1999), researchers found a significant difference in post-treatment communication styles. Those families in the FFT condition exhibited greater improvement in non-verbal communication, especially positive communication. This is in keeping with FFT’s use of CET (Miklowitz, 2008). In addition, Simoneau et al. (1999) found a direct relationship between improved non-verbal communication and improvement in the symptoms of patients. It seems as though the CET module of FFT does improve the well being of BD patients. Simoneau and colleagues (1999) study’s main limitations included: unequal treatments (as described in the previous paragraph), and the non-naturalistic setting (laboratory) used to observe familial interactions.

**Limitations & Conclusion**

 There are limitations to the use of FFT in managing BD. The central philosophy of FFT rests on the involvement of family members in psychotherapy. Given the stress of caring for someone with BD, and the stigma attached to BD, it is likely that a great deal of family members would be unwilling to participate in FFT. FFT would likely not be a viable option for these people. The same is true for individuals living independently; with an emphasis placed on family involvement outside of session, it is unlikely that families living separately from the patient would be able to sufficiently follow FFT. The relatively long-term (approximately 9 months) of FFT may also prove to be a barrier to some.

 Overall, available RCT research supports the efficacy of FFT in managing BD; however, more studies need to be done to address the previously discussed limitations in methodology. In addition, studies independent of Dr. Miklowitz, the originator of FFT for BD are advised as he has collected much of the existing evidence. Dr. Miklowitz’s vested interest in FFT for BD raises questions about the bias of the research.

 Aside from these issues, FFT represents a well-established and empirically supported psychotherapeutic intervention for managing BD (American Psychological Association, 2009), one that should be considered by any counsellor treating patients with BD.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th revised ed.). Washington, D.C.: Author.

American Psychological Association. (2009, January 19). A guide to beneficial psychotherapy. Retrieved from http://www.apa.org/divisions/div12/cppi.html

Ayuos-Mateos, J. L. (2000). *Global burden of bipolar disorder in the year 2000*. Geneva, CH: The World Health Organization.

Badner, J. A., & Gershon, E. S. (2002). Meta-analysis of whole-genome linkage scans of bipolar disorder and schizophrenia. *Molecular Psychiatry, 7*,405-411.

Davison, G. C., Blankstein, K. R., Flett, G. L., & Neale, J. M. (2008). *Abnormal psychology* (3rd Canadian ed.). Mississauga, ON: John Wiley & Sons Canada.

Falloon, I. R. H., Boyd, J. L., & McGill, C. W. (1984). *Family care of schizophrenia: A problem-solving approach to the treatment of mental illness.* New York, NY: The Guilford Press.

Government of Canada. (2006). *The human face of mental health and mental illness in Canada 2006* (Cat. No. HP5-19/2006E). Ottawa, ON: Government of Canada Publications.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617-627.

Miklowitz, D. J. (2002). Family-focused treatment for bipolar disorder. In S. G. Hoffman, & M. C. Thompson (Eds.), *Treating chronic and severe mental disorders: A handbook of empirically supported interventions* (pp. 159-174). New York, NY: The Guilford Press.

Miklowitz, D. J. (2008). *Bipolar disorder: A family-focused treatment approach* (2nd ed.). New York, NY: The Guilford Press.

Miklowitz, D. J. (2011). *Bipolar disorder survival guide: What you and your family need to know.* New York, NY: The Guilford Press.

Miklowitz, D. J., George, E. L., Richards, J. A., Simoneau, T. L., & Suddath, R. L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry, 60*, 904-912.

Miklowitz, D. J., Goldstein, M. J., Nuechterlein, K. H., Snyder, K. S., & Mintz, J. (1988). Family factors and the course of bipolar affective disorder. *Archives of General Psychiatry, 45*(3), 225-231.

Miklowitz, D. J., Simoneau, T. L., George, E. L., Richards, J. A., Kalbag, A., Sachs-Ericsson, N., & Suddath, R. (2000). Family-focused treatment of bipolar disorder: 1-year effects of a psychoeducational program in conjunction with pharmacotherapy. *Society of Biological Psychiatry, 48*, 582-592.

Muller-Oerlinghausen, B., Berghofer, B., & Bauer, M. (2002). Bipolar disorder. *The Lancet, 359*, 241-247.

Ösby, U., Brandt, L., Correia, N., Ekbom, A., & Sparén, P. (2001). Excess mortality in bipolar and unipolar disorder in Sweden. *Archives of General Psychiatry, 58*(9), 844-850.

Perlick, D. A., Hohenstein, J. M., Clarkin, J. F., Kaczynski, R., & Rosenheck, R. A. (2005). Use of mental health and primary care services by caregivers of patients with bipolar disorder: A preliminary study. *Bipolar Disorders, 7*, 126-135.

Perlick, D. A., Miklowitz, D. J., Lopez, N., Chou, J., Kalvin, C., Adzhiasvili, V., & Aronson, A. (2010). Family-focused treatment for caregivers of patients with bipolar disorder. *Bipolar Disorders, 12*(6), 627-637.

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Maciejewski, P. K., Sirey, J., Struening, E., & Link, B. (2004). Impact of family burden and affective response on clinical outcome among patients with bipolar disorder. *Psychiatric Services, 55*(9), 1029-1035.

Rae, M. M., Tompson, M. C., Miklowitz, D. J., Goldstein, M. J., Hwang, S., & Mintz, J. (2003). Family-focused treatment vs individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 71*, 482-492.

Romero, S., DelBello, M. P., Soutullo, C. A., Stanford, K., & Strakowski, S. M. (2005). Family environment in families with versus families without parental bipolar disorder: A preliminary comparison study. *Bipolar Disorders, 7*, 617-622.

Sajatovic, M., Valenstein, M., Blow, F., Ganoczy, D., & Ignacio, R. (2007). Treatment adherence with lithium and anticonvulsant medications among patients with bipolar disorder. *Psychiatric Services, 58*(6), 855-863.

Simoneau, T. L., Miklowitz, D. J., Richards, J. A., Saleem, R., & George, E. L. (1999). Bipolar disorder and family communication: Effects of a psychoeducational treatment program. *Journal of Abnormal Psychology, 108*(4), 588-597.

The World Health Organization. (2004). *The global burden of disease: 2004 update.* Geneva, CH: Author.

Zubin, J., & Spring, B. (1977). Vulnerability – A new view of schizophrenia. *Journal of Abnormal Psychology, 86*(2), 103-126.