

Clinicians' Treatment Manual
**for Family-Focused Therapy for Early-Onset Youth and Young Adults (FFT-
EOY)**

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I. INTRODUCTION

An Introduction to Working with Early-Onset Youth

The purpose of this manual is to explain an early intervention treatment for adolescents and young adults who may already have, or may be at risk for developing bipolar disorder (BD) or psychosis (hereafter referred to as Early-Onset Youth, or EOY). Family Focused Treatment for EOY and their families (FFT-EOY) consists of 8 weekly and 4 biweekly sessions (12 sessions over 4 months).

The relevant populations for FFT-EOY are age 13-25, with a recent onset of bipolar I or II disorder (mania, depression, mixed, or hypomanic episodes); a recent-onset of psychosis (including first- or second-episode schizophrenia or schizophreniform disorder); and the relevant “prodromal” forms of these disorders (bipolar disorder, not otherwise specified; psychosis NOS; attenuated psychosis syndromes). They must have family members who are willing to come in regularly- parents, grandparents, or extended relatives who are in a caregiving role.

For a thorough understanding of FFT, we recommend that you become acquainted with the Miklowitz (2010) Bipolar Disorder: A Family-Focused Treatment Approach manual (2nd Ed) before applying the treatment with your patients. In addition, The Bipolar Teen: What You Can Do to Help You and Your Family (Miklowitz and George, 2008) or The Bipolar Disorder Survival Guide (Miklowitz, 2011) describes many of the strategies discussed in this manual and are resources that can be made available to families.

The overriding goal of the FFT-EOY is to educate families about the symptomatic presentation of the illness and offer tools to prevent its onset and worsening. There are six subsidiary goals:

To assist patients and families to:

- (1) integrate the experiences associated with episodes of bipolar disorder or psychosis,**
- (2) assist the patient and relatives in accepting the patient’s vulnerability to future episodes,**
- (3) accept the current or future role of psychopharmacology to manage symptom states,**

(4) enhance social and academic functioning,

(5) recognize and learn to cope with stressful life events that trigger recurrences of bipolar disorder or psychosis,

(6) assist the family in reestablishing functional family relationships after an episode.

In this manual, you will learn how to proceed with administering FFT-EOY. The three modules of FFT will be covered in a modified form. Case vignettes and typical therapy interchanges are included. All names and identifying information of clients and family members have been altered and disguised so that these persons cannot be identified, consistent with guidelines for preserving the confidentiality of patients.

Note: In the sections that follow, “IP” refers to the “index patient” who is the focus of your treatment (the 13-25 year old who has symptoms of BD, psychosis, or prodromal symptoms). The IP is also called the youth, the young adult, the teen, or the “early-onset youth” (EOY). We wanted to mix up the terms so you wouldn’t get bored! Keep in mind the differences that age can make when planning these interventions.

Parents of Early-Onset Youth

The parents of early-onset individuals are resourceful and proactive enough to have found treatment, and so from the very first encounter we want to communicate that we value them, that their partnership with us is essential, and that we think that the efforts they are directing toward helping their son/daughter matter. In fact, we think that their son/daughter is very fortunate to have a parent in his/her life that is willing to put effort into helping him or her.

While invariably parents entering such programs have tremendous strengths, at the same time, parents first arriving tend to be feeling pretty overwhelmed. Often they are just beginning to come to terms with the fact that their son/daughter could develop a serious mental illness. Because some of individuals you will see have not yet met diagnostic criteria for a bipolar or psychotic illness yet are exhibiting some characteristic early warning signs, parents may feel confused and immobilized by this diagnostic ambiguity.

If their son or daughter is exhibiting a lot of trouble with motivation and social withdrawal, parents have a hard time knowing whether this is “typical teenage behavior” or something more, such as negative symptoms or depression. Parents may be feeling frustrated and fatigued by their son/daughter’s “refusal” or inability to step up and function more independently. It is not uncommon for parents of early-onset youth to spend a lot of time in the morning getting their son/daughter out of bed, urging him or her to shower and groom, and then driving him/her to school. At the same time, the parent may feel conflicted about subjecting him/her to academic and peer struggles that seem

more intense for their son/daughter than for other individuals their age, and with which their son/daughter may seem less well equipped to cope. If the IP has been spending an inordinate amount of time alone in his/her room, and is no longer calling or initiating fun activities with family and friends, parents are understandably concerned that their son/daughter may be lonely, disconnected, and at risk for self-harm. It may be painful for these parents to watch their son/daughter struggle, and they are often confused about what more they can do to help. At the same time, they often wonder if they are doing too much for their son/daughter. In short, they are trying to figure out how best to keep their son/daughter “on track” without over- or under- parenting.

These parents may feel isolated from other parents in the community who are having a very different parenting experience. Advice that works for parents of “normal teens” (e.g., “tell him he’s grounded if he won’t go to bed”) may not seem relevant to these parents. Most likely, these parents would like to be able to step back a bit at this stage of life, and let their son/daughter take greater control of their own life as is recommended in many parenting guidebooks. However, the price for backing off may be to watch their son/daughter flounder and fail. If parents find this price exorbitant and remain quite involved, they run the risk of getting branded “over-involved.” It is important that mental health professionals do not form opinions too quickly about a parent’s level of involvement in his/her young person’s life.

Because of ongoing hypomania/mixed symptoms, depression, negative symptoms and social skills deficits, many early-onset youth have attracted few friends and adult mentors into their life to share the task of providing growth-promoting experiences, so the burden of raising them falls more heavily on the shoulders of their parents. Parents realize that other teens or young adults are spending time with friends, perhaps dating, and engaging in a wide variety of extra-curricular activities. They realize that their son/daughter is missing out on the skill development that is a by-product of these activities. They see their son/daughter slipping further and further behind and are often searching for ways to decrease the gap that is being created between their son/daughter and his/her peers.

While other parents may be enjoying the fruits of years of labor as they watch their son/daughter succeed in a variety of arenas, parents of early-onset youth may be internalizing the message that they must have done something very wrong for their son/daughter to be so “off track.” These parents may be exceptionally skilled with their offspring, yet their parenting efforts may not be appreciated by extended family members, friends or neighbors who only see the adolescent’s school failure or social isolation. It may be easier for others to simply view school failure and social isolation as a reflection of failed parenting than to understand the patience and skill it takes to cope with and support an adolescent who is experiencing psychiatric symptoms. Of course, it can be quite tiring for parents to feel misunderstood.

If their son/daughter is experiencing mania or positive psychotic symptoms, such as grandiose delusions, paranoia and unusual perceptual experiences, parents may be confused and frightened by the symptoms and their implications. While some empirical studies suggest that prodromal youth may benefit from the early introduction of anti-psychotic medications (McGlashan et al., 2006; McGorry et al., 2005), additional study is still required. Therefore, parents are asked to tolerate more ambiguity as they collaborate with psychiatrists and begin the process of figuring out whether medications make sense for their son/daughter.

In summary, parents often arrive at our doors in need of support and information. Hopefully we can help them to feel like they have found a resource that will join with them in their efforts to help their son/daughter.

Youth with or at High-Risk for Bipolar Disorder or Psychosis

We see a variety of young people in our programs. Some of them have bipolar disorder or schizophrenia already. Others have early “prodromal” symptoms that don’t yet meet the full DSM-IV criteria, like mood swings, brief and recurrent hypomanic periods, or mild psychotic symptoms. Most are in some distress and that is what has prompted their visit. Typically their grades are dropping or they are having trouble at work, they are becoming increasingly isolated, and they are starting to wonder about their own future. Our main goal with them initially is to connect. Often IPs express a sense of relief when they are able to talk frankly with a knowledgeable professional about the symptoms that they have been experiencing. They may be “testing the waters” with us before they are willing to fully disclose. They are often relieved to hear that we have worked with many individuals that have symptoms similar to what they are describing, and that we have some ideas about a variety of coping strategies that may be useful.

The youth or young adult may also feel demoralized and confused. We want to help these individuals reconnect with their strengths and interests, and learn how to cope with the symptoms they are experiencing so that they can achieve their goals in spite of the symptoms.

For patients under age 18, it is important that we are clear with them from the start regarding the limits of confidentiality/what we share with their parents. Although it is quite common for therapists who work with adolescents to keep information confidential from parents, often a more collaborative approach works well for the patients at our clinic and their families. We typically encourage the patient to share information about the symptoms he/she is experiencing with his/her parents so that parents can be as useful to the patient as possible. Parents are crucial in setting up (and paying for) appointments with psychiatrists, therapists, school interventions, etc. If parents know what is going on with their son/daughter, they have the opportunity to be empathic and supportive and to set appropriate limits to keep their son/daughter safe. When patients have been quite secretive regarding their symptoms and inform us that their parents are largely in the dark, we encourage greater openness.

In general, our initial goal is to get to know the patient as an individual. We are interested in hearing about symptoms and struggles, but also in hearing about strengths, hopes, and goals for the future. With a solid understanding of where our patients are developmentally, we can start to formulate a collaborative plan with them regarding how they can move on with their lives and make progress toward reaching their goals.

Objectives of FFT-EOY

FFT-EOY consists of three modules: psychoeducation sessions (4 sessions), communication enhancement training (4 sessions), and problem solving skills training (4 sessions). In total, participants will complete 12 sessions over a 4-month period (8 weekly, 4 biweekly).

Pacing and Flexibility of Sessions

FFT can be tailored to the particular family you are working with. While it is ideal to have each family complete all 12 sessions, it might not fit the pace of the family you are working with. For instance, a family might require two sessions to cover one session's worth of material. In this case it is acceptable to stretch the session out to two sessions. In order to accommodate that change, you can skip a problem solving session. On the other hand, if a family is able to address two session's worth of material in one session, it is fine to do so. Furthermore, you might notice that some of the material may not be applicable to a particular family and it is fine to skip that session (for example, their communication is clear so the "communication clarity" handout is not needed). You will find that the educational module has a structured outline at the beginning of each session indicating what you should cover during a particular session. This is meant to be a guide rather than a rule. If you happen to spend more time working on some objectives and you don't get to all of the objectives because it doesn't seem appropriate for a particular family, that is okay.

Clinical Tip

The most important aspect of the educational material is that it is communicated to the family in a way that the family is able to understand and finds meaningful and useful. All of the handouts are simply tools to help convey information. If a particular handout does not support your efforts to provide information to a particular population or to facilitate constructive communication among family members, please feel free to drop or modify the handout.

The manual can be thought of as a toolbox of techniques that the therapist can use with family members at ANY point in the therapy that those techniques seem relevant. For example, during the course of conducting a problem solving session, it may become clear that a discussion of pleasant events scheduling or relaxation techniques may help a family to get beyond an impasse in the problem solving process. This may be the ideal time to teach a skill that didn't seem relevant earlier in the treatment.

Emotional Tone of the Therapy

It is fairly common and understandable that a parent or other family member may become tearful when talking about the impact the patient's symptoms have had on him or her. Parents may experience a lot of grief over their son or daughter's sudden change in functioning and if symptoms are quite severe and precipitous parents may need to "mourn" the change. Alternatively, family members may express anger over how difficult it has become for them to work given the patient's difficulties going to school, or to invite friends over since the onset of the patient's symptoms of depression, reclusiveness, suspiciousness, and/or odd behavior.

It is very important to keep the sessions tolerable and low-key for the patient. Therapists should step in fairly quickly to redirect family interaction when emotions escalate during a session. In some instances it may make sense to spend time gathering information and developing a better understanding of the family members' emotions and what tends to provoke them. You always have the option of asking the family member who is expressing a lot of emotion to schedule a time to meet individually. During an individual meeting the therapist can discuss the family members' emotions further and provide some additional psychoeducation and/or recommendations for individual therapy as appropriate. Alternatively, it may make sense to work on some communication skills with the family earlier in the treatment so that psychoeducation can

proceed more productively once family communication has improved. It may be useful to conduct problem-solving on ways in which family support could be optimized so that family members understand the importance of creating a low-key family environment.

Clinical Tip

With some families, you may find that the sessions have a stilted, overly didactic quality, that participants seem to be blithely going along with the tasks, looking blankly at the handouts, etc., but don't really seem to be aboard with your treatment goals. If so, take a step back. Think with them about their own treatment goals, and explain how the various tasks you've assigned them will help them meet these goals. If you feel like you are missing out on discussing important issues because of the treatment structure, depart from the manual to discuss what's on everyone's mind and then try to bring them back on task. Once you've brought them back on task, try to adjust the psychoeducational tasks to be more consistent with their goals.

Pretreatment Sessions that Support Informed Consent

Sometimes family members express reluctance about participating in family therapy. They may have misconceptions about what family therapy entails. For example, one father reported somewhat in jest that he envisioned using little foam boppers to hit family members over the head when discussing frustrating issues. He had never participated in family therapy before and was relying on an episode from a sitcom to help him form expectations of therapy. While many people may not be as forthcoming as this father, they often have concerns about what they may be getting themselves in to if they agree to family treatment. For those families that express some hesitation, it may be useful to use the first session to lead the family in a discussion of their concerns and get greater clarification regarding the content and process of this approach to family therapy, and make an informed choice about whether they want to enter the study.

During the session it is important that you listen to family members' concerns and normalize them. Often parents are worried that they will be blamed by the therapist or by their youth for causing the youth's symptoms. Let them know that these concerns are quite common, nobody likes to be blamed, and that assigning blame isn't part of this therapy.

It is often helpful to give the family a sample of what the sessions will be like by presenting some information that is relevant to a question they have raised. For example, often parents ask about what types of expectations they should be setting for their child. They may report that if the doctor says they should back off they will but they don't want to just "let their child off the hook too easily" or "set different expectations for this child than they do for other children in the family." This is an excellent question, and there really isn't one standard set of expectations that applies to each and every youth that is experiencing symptoms. Symptoms differ across people and even within the same person over time. You can address the family member's question by saying something like the following.

"When there is a high level of stress in an individual's life and/or he or she is experiencing intense symptoms, one way to consider relieving that stress is to lower expectations temporarily. When symptoms remit or stress is reduced

and/or coping strategies are supported, it may become possible to gradually raise expectations.”

You should then ask the family members what they think about this approach to setting expectations. Does this make sense given their experiences with symptoms so far? Do they think this type of approach might help guide their efforts?

Throughout the therapy we will be presenting information and introducing skills and then talking with them about their reactions to this information. If they find the skills useful we will think together about ways they can integrate the skills into their daily life.

Some young adults have expressed reluctance to participate with their parents in therapy for fear that the therapist will disclose more information than the young adults are ready to share. If this is the case, let the youth know that his/her concerns are common and understandable, and that you will be providing information to the family about symptoms in general, and then inviting the IP and family members to share their experiences with symptoms to the extent that they feel comfortable. However, you will respect the youth’s boundaries, provided that the symptoms are not presenting a danger to him/her self or others. Youths are often relieved to hear that they will be given some control over the pace and content of disclosure about symptoms. Alternatively, you may want to meet with the youth individually to make sure s/he knows what is off-limits, e.g., confusion about sexual orientation, before starting the family therapy.

IPs may worry that once they start talking with their parents in therapy about their symptoms they will be peppered with questions throughout the week and they will feel over-exposed and overwhelmed. In these instances it may be useful to facilitate some negotiations between the parents and the youth regarding what amount of follow-up discussion would be tolerable between therapy sessions. Once boundaries have been established, the youth may feel more comfortable proceeding.

Some young adults have expressed confusion about why they should participate in family therapy when their parents are pushing them so hard to become more independent. Why should their parents be interested in their business on the one hand, but want them to function more independently on the other? This is seen by some youths as contradictory.

Consider the following treatment vignette involving a 22-year old:

Son: My dad is pushing me to finish school, pushing me to get a job, and pushing me to move out of the house. He keeps lecturing me about how I need to be more independent. Then he tells me he wants me to do this family therapy with him. Why would I do therapy together with my dad when he clearly just wants me to do things on my own?

Therapist: Sounds like you are feeling like you are being pushed a lot by your Dad. Dad, what do you think about what Brad just said?

Father: I have been pushing Brad a lot. He is my third child and I pushed the older two when they were his age and they thanked me for it later because they are now all functioning independently. If I change the rules for Brad now, his younger brother will expect the same type of leniency, and that could really mess

up our household. I know that Brad may be going through something different than the others, but I'm not sure what that means and I really don't know how to parent any differently. I definitely need some more information.

Therapist: Dad, is there anything in addition to information that you are hoping to get out of the family therapy? Why do you want to do this with Brad?

Father: I am hoping that Brad will tell me more about what is going on with him so that I can have a better understanding and figure out how I can be more helpful to him. He and I used to be pretty close. We would go bicycling and hiking together. Now he and I barely talk and when we do talk it seems like all we do is argue.

Therapist: Sounds like you want to understand what Brad is going through and have a closer relationship with him?

Father: Yes.

Brad: He can't have it both ways. He is constantly pushing me out and then he wants me to talk to him about my business.

Therapist: Brad, what do you want for yourself? Are you interested in finishing high school or finding a job?

Brad: Yes, but it isn't that easy.

Therapist: No, it certainly isn't easy. In fact these types of transitions out of high school and into the work world are really hard for a lot of people and they can put a lot of stress on family relationships.

One thing that we would be interested in doing in the family therapy would be to get a better understanding of your goals so that we could think together about the best ways that everyone could support you in reaching those. How does that sound to you?

Brad: OK

Therapist: Brad, it sounds like you have felt pushed by your Dad lately and that has sort of disrupted your relationship with him or left you feeling confused about how to relate to him. Did I hear that right?

Brad: Yes.

Dad: I feel really badly about that. I think we are both confused at this point. I would like to have a close relationship with Brad throughout his life. I'm just not sure what approach I am supposed to be taking right now to help him.

Therapist: It may sound contradictory, but a close relationship, one in which people feel like they understand each other and can support each other, can actually help people to function more effectively and independently throughout their lives. Does that make sense?

Another thing we could work on in the family therapy would be opening up channels of communication so that you might be able to talk more directly and constructively about how to improve your relationship with each other. Is that something that you would be interested in?

In other words, you can tell the family that the therapy is fairly structured, with informational handouts provided at most sessions, but that the information will be tailored to try to best meet the needs of a particular family.

Questions about who to involve in the treatment

Family members wonder about who should participate in the therapy. We explain that when one person in the family is experiencing symptoms, all members of the family are typically affected, and in turn family members' reactions to those symptoms affect the person who is experiencing symptoms. Because of this, it is often useful to have everyone who is living in the family home participate in at least some portions of the therapy. If the youth/young adult objects to having certain people participate (i.e. siblings, step-parents, etc.) it may be useful to allow him/her to begin the therapy with primary caregivers and then introduce additional members as he/she becomes more comfortable.

For example, some youths report that they will not discuss symptoms frankly with their parents if their younger siblings are in the room, explaining that it is embarrassing to them to discuss their "weaknesses" in front of their younger siblings. It makes sense to honor this boundary, and then after the educational sessions, to ask the question of whether the IP might be comfortable inviting the siblings to participate in some of the communication and problem solving sessions. Other youths, however, have welcomed the opportunity to have their siblings participate from the start. These contrasting examples highlight the importance of giving thoughtful consideration to whom to include in the various phases of therapy. This should be discussed and decided collaboratively with the IP and his/her primary caregiver(s) during the first session.

Remember that if additional family members join the therapy process after the beginning of the treatment, you will need to schedule some time with them to sign informed consent documents. Also, you may find that adding a sibling, particularly a younger one, to sessions may be a hindrance more than a help. Consider the age of the sibling, his or her health status, and the nature of the relationship between the IP and the sibling before committing to including the younger sibling in each session.

Questions/Concerns about being in a study

In order to participate in the study family members must be willing to accept that the treatment is 12 sessions long, and 4 months. Although family members may express some concerns initially about having their sessions audiotaped, we have had very few families refuse to participate for this reason. Once they hear that the psychologists watching the tapes are focusing mainly on the therapist to evaluate whether he or she is compliant with the treatment approach and is helping the family as effectively as possible, they are reassured. Make sure they understand that the audiotapes will only be listened to by the clinician and the supervising research personnel at UCLA.

Administration of Research Measures Before the First Therapy Session

The UCLA study staff will be completing diagnostic interviews before you start treatment. They will tell you if they have not completed all interview and questionnaire measures before the start of the first therapy session. Siblings or other family members who have not been consented into the study should not complete these questionnaires.

II: EDUCATIONAL SESSIONS (Sessions 1-4)

Session1: Goal Setting, Overview of Treatment

Before the session: Make copies of handouts you will be using.

1. Joining
2. Find out family members' goals for treatment
3. Acquaint family with goals, format and expectations of treatment.
Use Handout 1 – Family focused treatment: What we are going to do and what to expect
4. Build a bridge between family members' goals and the skills they will master in FFT
5. Discuss the research program – re-assessment at 4 months
6. Provide information about clinic procedures
7. Assign Homework: Setting up a weekly family meeting. Identify a day/time for the meeting.
8. Check-in with family members about their reactions to the session
9. Closing

In the first session you have several objectives, the most important of which is to begin the process of joining with the family and starting to establish a therapeutic alliance. The second objective is to develop a treatment plan with the family. Essentially you will be discussing each family member's goals for treatment, then presenting the goals, format, and expectations of the FFT program, and then building a bridge between what each family member wants from treatment and what we plan to provide. Finally, it is important to explain research and clinic procedures, help them to establish the routine of doing some homework between sessions, plan for the next session, and gather their reactions to the first session.

Joining

The best way to build rapport at the beginning of treatment is through a process called "joining." Start the session by asking each family member to tell you something about him or herself, unrelated to symptoms (e.g. favorite movies, things to do, hobbies, etc). You can introduce this process by saying something like the following:

"I would like to start our work together by getting to know you better as people. Of course there is much more to each of you than the current problems affecting you. It is important that I know about your interests and strengths so that I can

try to make the therapy as relevant as possible to each of you and so that we can draw upon your strengths throughout the treatment.”

Clinicians can model this by briefly introducing themselves (their role in the clinic, personal and professional interests, pets, hobbies, favorite foods, etc.). The goal is for the clinician to be friendly and personable while maintaining professional boundaries. Remember that the IP may have been struggling lately, and so avoid presenting a long list of achievements and successes. Talk about ordinary everyday interests and activities. Here is an example:

“I will start us off by telling you a bit about myself. As you know my name is _____ . I have been a therapist here at our clinic for the past two years. I went to college in Boston and did my graduate work at the University of Southern California. I really enjoy working with young people and families and I am excited about doing prevention work.

Now, why don't you each say a bit about yourselves?

Once each family member has had a chance to talk about his/her interests and talk a bit about who they are, you can move the conversation to the goals of treatment.

Joining is an ongoing process that you will continue to work on throughout the treatment. Maintaining an air of friendliness and introducing some levity into the work whenever possible can be very helpful. Also, be sure to chat with the family a bit about fun activities they may have participated in over the weekends, sports teams they follow, or upcoming plans they may have for the following weekend or other light topics at the beginning and end of every session. Once you know their interests, you can follow-up on those with brief questions to open or close later sessions.

Know Your Patient Before the First Session

If this is a new patient, it is important to read the clinical assessment report before sitting down to meet with the family. Talk to the UCLA Research Assistant who will have completed the initial evaluation). You may learn things that will help you focus the initial sessions. For example, you may learn that the youth has had significant social withdrawal and is unlikely to have had many outside interests. If so, you want to avoid coming across as “perky,” expressing your interests in a lot of different activities while the youth is sitting there with very little to say. Tune in to the family members' affective range and pace of communication early in the session so that you aren't completely out of sync with the family. A family that is somewhat depressed may experience a very cheerful presentation as superficial. Establish a tone that is calm, low-key and mature.

Some therapists may feel that they are better able to connect with family members by asking the family members to introduce themselves first so that the therapist can get a feel for each person's interests and add comments about him/herself that are relevant to family members' interests. Either approach is fine. The goal is to make the family comfortable with you, and allay their fears that you will psychoanalyze them, make them feel like bad parents, or expose uncomfortable secrets.

Family Members' Goals for Treatment

Once you feel you have begun to connect with each family member, let the family know that you are interested in hearing about what they hope to get out of the treatment. You want to convey to them that you are knowledgeable about their situation and that you have some ideas about what might be helpful to them, but what is most important first is to hear about what they are interested in getting out of therapy. You could say:

“I know that you have spent a lot of time explaining your situation and describing the challenges you are dealing with in the first interviews. I have a lot of ideas about what I think might be helpful to you in terms of treatment, but before we get into that I would like to hear a bit more about what each of you wants to get out of our work together. In what ways would your lives look different if the treatment were successful?”

In many cases it is useful to start with the IP when asking about treatment goals so that he/she has the first opportunity to express what he/she wants to change in his/her life. Youths are typically most interested in and motivated to achieve goals that they select themselves. Even if the parents express the very same goals, youths are likely to be less enthusiastic about the parents' stated goals because they are experienced as imposed upon them.

If the youth is new to therapy and is having a hard time understanding what you mean by goals, you could structure the process a bit more by posting a list (like the one below) of the various domains in life that one could think about setting goals. What is going well within each of these domains and what could be going better?

- Feelings about oneself (mood, self-esteem, hobbies and interests)
- Managing Symptoms
- Relationships:
 - with family members
 - Mom
 - Dad
 - Siblings
 - with friends
 - with classmates and teachers
- Functioning at school/work
 - ability to get up in the morning independently and get there on time
 - ability to get required work done
 - satisfaction with tasks
- Skills of independent living (grocery shopping, cooking, doing laundry, cleaning, managing finances)

Parents may be similarly confused about what types of goals you would like them to articulate: goals for themselves or for the youth? Since the focus of the therapy is on the IP, it would be helpful to hear the parents' thoughts about goals that relate to the youth. For example, are there particular symptoms that the IP is experiencing that the parents are concerned about or certain aspects of the youths' functioning at school, at work, with friends, or at home that they think merit further thought? In addition, parents might have goals involving their relationship with their son or daughter such as improved communication or reduced conflict. Perhaps parents would like to learn how to be more supportive of the IP. Alternatively, they may list goals that have nothing to do with the

IP, but which you may be able to help them with anyway (e.g., “I get very nervous about job interviews. I’d like to know how to do better in them”).

Most families members will appreciate being asked about their goals and having an opportunity to share their ideas. Some patients (or siblings) may tell you that they don’t want to be here and that they were dragged to treatment by their parents. They have just been “real” with you and have given you an opportunity to connect with them. You could say something like:

“Thanks for being so honest with me. I appreciate that you are here tonight despite your reservations about treatment. Hopefully over time you and I can figure out how to make this work worth your time and effort. Is there anything that you would like to have going a little better in your life? What about with school/work? What about with friends? What about with your family?”

Some IP’s may offer an unconventional treatment goal like “I want to get a car.” Although this goal may seem irrelevant, note that it indicates that they have some drive and motivation. The depression or negative symptoms must not be that bad for this IP. You could ask them a few questions about the type of car they are interested in, and then say something like:

“I can see why you would want a car like that. Has this been an ongoing discussion in your family? I’m interested in hearing some more about the kinds of conversations you’ve had with your parents about this.”

It would be interesting to learn more about the context of this particular goal since it might fit into a larger goal pertaining to autonomy/independence.

Another example might be an IP’s goal of, “I want to get my parents off my back.” A strategy similar to the one used above of validating the IP’s experience and contextualizing it a bit could be useful here. Something like:

“Yeah, a lot of teenagers/young adults raise the same goal in here. You are in good company. And I imagine that your parents might actually enjoy getting off your back as well? (Look at parents and see if they are agreeing with you). Do you think your parents know you feel this way? Tell me some about the kinds of things you think you could do without your parents’ reminders?”

You can get back to this comment later in the session when you are “building bridges.” As you are outlining the FFT therapy, you can weave in the point that better communication and problem solving often helps both IP’s and parents to find ways to work more comfortably and effectively together so that there is less nagging and less provoking.

In general, express a flexible attitude, knowing that the IP and/or parents’ goals may not fit your therapeutic agenda.

This process of goal setting is very important and should not be rushed. These goals are essential to making the treatment relevant to the family members so that they feel that we are responding to their needs and not just imposing some pre-fabricated treatment upon them. You should write down each family member’s treatment goal(s) because you

will want to refer back to these goals frequently as you introduce new skills, making a connection whenever possible between the skill you are asking the family to develop and their treatment goals.

While some family members might bring up several clear goals, keep in mind that others might be unsure of what they want to get out of the treatment. They may be content to hear what you have to offer and that may stimulate some ideas for them regarding what they are most interested in learning. That is fine. It is important to provide each family member with the opportunity to express his/her thoughts. Goal setting typically works best when it is a collaborative process.

The Goals of FFT-PY

Once you have spent some time getting to know the family members and their goals, acquaint the family with the format, and expectations of the FFT-PY treatment. **Handout 1, “Family Focused Treatment: What we’re going to do and what to expect,”** accompanies this first session. Go through each item on the list and let family members know what they can expect from the therapist and what in turn is expected of them. You may want to say something like the following:

“This is a fairly structured treatment. We have a lot of information that we would like to share with you, and a lot of skills that we would like to introduce to you over the next 4 months. We have 12 sessions planned. For the first 2 months we will be meeting every week, and then we will meet every other week for an additional two months. Does that sound manageable for all of you?”

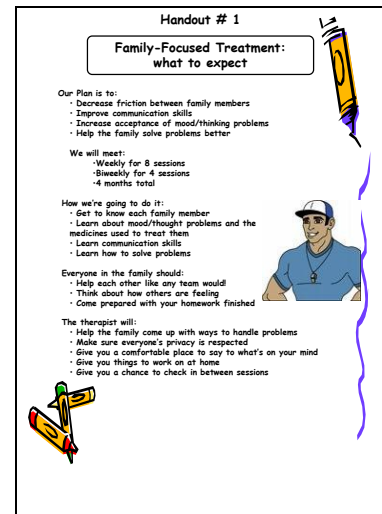
Next week we would like to talk about (mood, thought disturbance, early onset) symptoms, what they are and how you might be able to reduce them. Then over the next few sessions we would like to focus on how to decrease stress, prevention strategies, and how to cope at school, with friends, and at home.

In later sessions we plan to work on strengthening communication skills, and practicing a specific approach to solving problems. We know that people’s symptoms tend to stabilize when families take a calm, constructive, and structured approach to solving problems and we would like to teach everyone techniques that will help you to work together in this way. Can you imagine how this might be helpful?

Toward the end of our work together we will be integrating a lot of the skills that we have developed. How does this sound?”

Check in with the family while you are presenting this information. Avoid “talking at them” and pay particular attention to anyone who seems confused, bored, or annoyed. If so, ask them: “you seem like you’re having a reaction to this. Anything you’d like to talk about?”

Continuing on:



“Now let’s talk about what you can expect of me during this therapy. I will start sessions on time and make sure that we end in about 1 hr. Therapy can be hard work so my job is to make sure to keep our work manageable. If you need to talk to me between sessions, you can reach me at this number (hand family card), and I will do my best to get back to you within 24 hours.

My role is basically that of a teacher or coach. My job is to teach you some skills and then to practice those with you so that by the end of treatment you can use the skills in your day-to-day life, and you no longer need my assistance. I’ll ask you to practice the skills at home in-between sessions.

Sometimes I will ask you to practice some of the skills we are learning at home or at school/work during the week. **We recommend that families schedule a family meeting to go over the therapy homework.** Just like with any skill, the more you practice, the easier the skill becomes. So, we will make better progress if you follow through with these assignments. Do you think this would be manageable? What questions/concerns do you have at this point?”

“Can you think of a time when you’re all together when you could meet?”

When introducing educational sessions explain that “we’re interested not only in giving you information but also in exploring your reactions to it and seeing how it fits your circumstances.”

Building Bridges

Now that you have listened to what each family member has identified as his/her treatment goals and outlined the FFT approach, you can make some clear connections between their goals and how the skills learned in FFT may help them to reach those goals. Pick out a few of the goals that each family member has stated and make some connection to the various skills that you will be working on and talk briefly about how those skills or those sessions will support each person in reaching his or her goals. For example, you could say something like,

“OK, now let’s make sure we are on the same page here. Joe, you mentioned that you wanted to understand more about these changes that have been going on with you. We will start with that in our next session. How does that sound? You also mentioned wanting to manage these changes better so that you feel a bit more in control at school and at home. That is something that we will get to fairly soon as well. We will spend sessions 3-4 talking about strategies for coping with various symptoms.

Mr. X you mentioned wanting to figure out how to get Joe to wake up and get ready in the morning more independently and to have him go to school more regularly, right? I think that first we need to develop a common understanding of the symptoms he is experiencing and how they play out at school and at home. We will be doing that over the next few sessions. Then we will be in a better position to think about strategies he can use to cope with the school environment and perhaps accommodations that could be made at school to help support him there.

Your desire to have Joe get up and out more independently in the morning is one of the most common requests we hear from parents at our clinic. That is something we will definitely take on during the problem solving sessions. How does that plan sound to you?

Mrs. X you mentioned that there has been a lot of arguing in your house lately and that you would like your son to know that you are on the same team and that you are really just trying to help him. Joe you also mentioned wanting to get your parents off your back. These are issues we deal with a lot here. Symptoms often make communication more difficult for families and they can put a lot of stress on relationships. At about session 5 we are going to work on some communication skills so that you have the best shot at working through some of the issues that have been coming up in a calm, constructive manner. Hopefully as we work on these communication skills all of you can feel a bit more like you are on the same team again. How does this sound to you?"

Make sure to check in with the youth and his/her parents every so often to assess whether they understand what you are saying. Are they reacting negatively to what is being discussed (e.g., rolling eyes, or looking angry or distressed)? If you notice these reactions, stop and ask about them. You could say something like:

Therapist: "Tim, I think you may have been rolling your eyes when I mentioned the part about communication training? Did I get that right?"

Youth: "Yeah."

Therapist: "Can you tell me more about your reaction?"

Youth: "Well, when I went to summer camp one year the counselors forced us to do some communication training. Every day we had to say something that we liked about each camper. It was ridiculous. We were inventing stuff that was completely insincere about kids that we actually hated. It just seemed really pointless."

Therapist: That does sound like a bad experience with communication training. I can understand why you might feel reluctant to put yourself in that type of situation again. Have you had any other experiences with communication training?

Youth: Not really.

Therapist: Well, hopefully the types of communication exercises that I have planned will be more helpful to you and your family and less contrived than the ones at summer camp. But, I will be very interested in your experiences of the training as we are going through it and I hope that you will continue to be honest with me about your reactions.

Avoid listing goals that cannot be achieved in this context

If family members have mentioned goals that really aren't appropriate for FFT it is important to be clear that you will not be working on those particular issues and to

provide your rationale. For example, if one family member talks about early abuse that he/she experienced as a child and his/her desire to explore that because he/she thinks that is contributing to current problems, you could say something like:

“That certainly does sound like an important issue and I am glad that you brought it up. It is helpful for me to know that you have had some very difficult experiences in your life. What we have found is that the timing of discussing those types of issues is very important. While young people are experiencing significant symptoms like the ones you (the IP) have described (feeling on top of the world/depressed; feeling suspicious and uncomfortable around others) it is important to do some work that will support your ability to cope with those symptoms and to reduce anxiety. Talking about and revisiting those early abuse experiences can be make people very anxious, and we don’t want to get into that type of work until (the IP’s) symptoms have lessened and you are back functioning well at school and with friends. Once you are feeling better, then you can decide whether you would like to take on those early issues in a different therapy. Trying to do everything at once can be pretty overwhelming, so we think it is important to break therapy into different phases. Does that make sense?”

A similar type of response would be important to use with parents who may have marital issues that they want to focus on. You could let the family know that some of the communication and problem solving skills that we will be learning together may be helpful with those other issues, but that the main focus of the treatment will be on helping the IP to feel and to function better. If families try to change too much at once it becomes overwhelming.

Avoid starting problem solving during the first session

Use this initial session as an opportunity for getting acquainted and information gathering. If the family starts arguing or insisting on talking about difficulties in school, etc., you can redirect them by saying something like,

“I know there are lots of pressing concerns that you have, and we will want to get to those as soon as possible. But, first we need to develop a plan for how we are going to work together. Tonight we are just taking the first step that lays the groundwork for all of our future work together. We will definitely get to the school issues, and many of the other concerns you have.”

Make sure to take note of potential communication pitfalls and ways in which the family may exacerbate problems or escalate conflict, although avoid mentioning them at this point. Also, take note of family strengths that you can highlight and build upon in future sessions.

Explain the research program

Remind the patient and his/her family that there will be research assessment interviews at the end of treatment and then every 4 months (up to one year), to check on the patient’s symptom and functional status. The research assessments are central to the treatment, because this is how we know whether we are being helpful or not, given that our goal is to reduce distressing symptoms and improve functioning. The research is what allows us to offer family treatment at no cost.

Explain the clinic procedures

If this is a new patient to you, you should inform the family how (s)he can be reached between sessions, if needed, and whether or not there is 24 hour coverage by the clinician or the clinic. If there is a psychiatrist or another treatment provider involved in the IP's care, you should clarify whom the family is to contact first in the case of an emergency (typically this would be the psychiatrist). If you/the clinic do not provide 24 hour coverage and there are no other treatment providers involved who do, give the family a list of phone numbers and locations of local emergency rooms. Encourage the family to call you 24 hours prior to a session if they need to cancel/reschedule.

Assign Homework

Toward the end of the session, or even earlier if possible, give the family their first homework assignment, which is to schedule a family meeting during which time they should discuss any questions/concerns that they have about what was discussed in the first therapy session. During the second session you will be discussing symptoms, so they could begin to think together in a low-key way about how various symptoms impact the family.

Help the family schedule a regular between-session meeting.

Ask the family to identify a day and time for the family meeting. The first family meeting may be brief, perhaps only 10-20 minutes. This first meeting will help the family to establish a routine that you would like them to continue throughout the family treatment. The homework that you will assign will vary each week, but typically part of that homework will be completed during the family meeting.

Choice Point

At this point in session 1, you may be almost out of time and may feel like you've covered enough material for one day. If so, close out the session and summarize what you've said, and prep them for the next session (below). Alternatively, you may be only 35 minutes into the 50-minute session and may feel like they (and you) could do more! If so, move to "Facilitate a Family Discussion of the IP's symptoms" (usually covered in session 2). Go through one of the handouts, such as the handout on depression or mania. The instructions on conducting this exercise are below, for session 2.

Plan for the Next Session

If you have decided they've had enough for session 1, set up a date/time for the next meeting, and remind the family that you will be starting with some educational materials at the next session. Give the family an opportunity to ask any questions. They may have been asking questions along the way, and if they have no further questions that is fine. You could say something like:

“We have covered a lot of ground today. Questions may come up for you over the course of the week, and I would like to start our next session by addressing those questions.”

Summarize and Reflect

If there is time, provide a brief summary of the session and then check-in with family members about their reactions to the session. You could say something like:

“Today was sort of an introductory session. We started to get to know each other a little bit. What was that like for you?”

“Then we talked about some goals. I plan to type out those goals and to distribute them to you next week so that we all have a clear reminder of what we want to address in our work together. If you think of additional goals during the week we will add them to our list next week. Anything else you want to put on our agenda?”

“I like the goals that you spelled out and it leaves me feeling hopeful and excited about our work. I think that there is a lot that we can accomplish together over the next several weeks.”

What Does “High Risk” Mean?

A common question that tends to come up in the first or second session is what is meant by the IP having “early onset” or being “at high risk” for bipolar disorder or psychosis. Consider including the following information (box) in your response, pitched to the educational level and language of the family.

“A “high-risk” state is one in which individuals are experiencing a group of symptoms and changes in social and school/occupational functioning. It is the clustering of these symptoms rather than any one symptom in particular, as well as the frequency and intensity of the symptoms and the distress and disruption they create that suggests a high-risk syndrome.

Common high-risk symptoms can include experiences like feeling very moody (up or down, irritable), social withdrawal, a drop in grades, difficulty sleeping, uncharacteristic peculiar behavior, increasing difficulty with concentration, heightened sensitivity to signs, sounds, smells, touch, loss of motivation, exaggerated beliefs about personal powers or influences, and suspiciousness of others. We will be talking a lot more about these kinds of symptoms during our session next week.

A fever is said to be an early warning sign of measles. This means that a fever may be an indication that the measles are on their way. However, as you know, not everyone who has a fever goes on to develop the measles. Similarly, these early warning signs that I just described may or may not be the earliest phase of a mood or psychotic illness. When an illness does develop, there is typically a “build-up” phase of more mild symptoms that precede the most severe symptoms.

The available research suggests that less than 40% of people who meet criteria for a “high risk syndrome” will go on to develop a full bipolar or psychotic disorder within 2-5

years. This is good news indicating that less than half of the folks we have identified through our assessment procedures as having a high risk syndrome or as being in an at-risk state will go on to develop more severe problems. We would like to bring that rate down even further and for that reason are providing family treatment at a very early “high risk” stage. It is our hope that through our work together we will decrease your risk and create a more protective environment for you.”

Related to this issue is the question of what to call bipolar or psychosis symptoms. If the IP has well-established bipolar disorder, she may prefer the terms mania and depression. Some youth or young adults may prefer to talk about mood swings, highs and lows, or other proxies for mania and depression. Ask the youth what terms he or she prefers.

Likewise, the IP may object to the term psychosis. S/he may do better with a less charged term like “thought disorder” or even “thinking problems.” Once again, ask him how he would like you to refer to his symptoms.

Joining/Closing

With this discussion we are emphasizing the importance of reflecting on our experiences in therapy. As sensitive as we try to be, we cannot read the family members’ minds and so it is important that we ask them regularly about their reactions to what is discussed in therapy. Hearing their honest feedback will enable us to try to pace and organize the therapy so that it is tolerable and meaningful for them. If the session has gone well and you are feeling hopeful and enthusiastic, it may be encouraging to the family to express that sentiment and to try to create an atmosphere of optimism.

Spend a few minutes chatting with the family about something light, perhaps fun plans they may have for the weekend, or current events that are relevant to your common interests with the family. It is probably most important to direct efforts toward connecting with the youth as you begin and end the first few therapy sessions. This is especially the case if you sense some reluctance in the youth to participate in the treatment. The more you can join with the youth, the better. If the parents don’t have to drag the youth to treatment, the family will be more likely to attend regularly. Teens are particularly skilled at quickly detecting when an adult is trying too hard, so keep efforts low-key.

Have some fun with each of the family members. Some playful banter will remind them that you actually enjoy them despite some of the difficult conversations that may have just taken place. They may trust you more as they realize that you are going to help them to move along a bit emotionally before they leave your office.

Ideally, this therapy should involve a fair amount of shared low-key laughter. Often parents come in with high levels of distress. This is understandable in light of their circumstances. Of course you won’t be trivializing their concerns or the seriousness of their situation, but you can try to balance all of that with some light-hearted moments. This may prevent you and them from getting “burned out.” An underlying goal of the therapy is to help patients and families to get on with their lives despite symptoms. They can still work, have friends, and connect with each other in fun ways despite symptoms. It may be reassuring to them to be reminded of that implicitly or experientially by sharing some light moments together in therapy.

Session 2: Discussion of Symptoms and the Vulnerability-Stress Model

Goals for session 2:

1. Ask whether the IP or family had any reactions to the first session. Follow-up on the homework assignment – Did the family have a meeting? What questions do they have for you that came up in the meeting? What additional goals do they have for treatment?
2. Review the treatment goals that you discussed last week. Try to make a connection between some of their goals and the discussion of symptoms that is about to take place.
3. Facilitate family discussion of the IP's symptoms . Invite the IP to share his experiences, ask family members how they tend to respond, and ask the IP what reactions he/she finds most helpful.
4. Ask the IP to get started on a mood chart.
5. (If time permits) Introduce the vulnerability/stress model.
5. If time allows, go over the handout: How do people get mood or thinking symptoms?
6. Plan for next session and assign homework – Family meeting to discuss material and generate questions
7. Joining/Closing
8. After this second session and before the 3rd session, spend time on case conceptualization. Map out a game plan for the remaining sessions.

There are two main learning objectives during this session. The first is to facilitate an interactive exchange during which the IP and family members share their experiences of mood and psychosis symptoms and you provide additional information about those symptoms as needed. The second goal is to introduce the Vulnerability-Stress model to the family to provide the theoretical basis for much of the treatment that follows and to highlight the role that stress can play in exacerbating symptoms and functioning.

Follow-up on the assigned homework

Ask them if they were able to have a family meeting and find out if they have any questions/concerns that might have come up during that meeting. If they didn't organize a family meeting last week, let them know that it will be helpful to the progress of the therapy if they get into the routine of meeting weekly between sessions to review some of the educational material that will be presented each week and to practice some of the communication and problem solving skills. Ask them to identify the best time for all of them to talk together as a family. Since this may be a change in their family routine, how will they remember to meet during the specified time? Will they write the meeting time on the family calendar, or will someone take responsibility for gathering everyone together at the designated hour?

Review Treatment Goals

If there is a way to make a connection between one of their goals and the discussion of symptoms that is about to take place, do so.

For example, “Dad, you expressed an interest last week in developing a better understanding of X’s symptoms, and X you wanted to help your parents to understand what it is like for you to experience some of your symptoms. Those are the goals that we are going to focus on today.”

Facilitate a Family Discussion of the IP’s Symptoms

Whether the IP has bipolar disorder, psychosis, or an early-onset “high-risk” type of each, it is important for you to review the medical records before sitting down to meet with the family for this second session. A thorough knowledge of the IP’s symptoms will guide decisions regarding the order in which symptoms should be discussed. For example, imagine you are working with a youth who has some striking mania symptoms (for example, grandiose delusions) or positive psychotic symptoms (hearing voices, thinking that he can control other’s thoughts at times). His parents, however, may be aggravated with his “laziness” and difficulty getting to school. In this case, it might be most productive to talk about the manic or psychotic symptoms first. Once the parents have a better understanding of some of the unusual symptoms that the youth is experiencing, they may be more receptive to thinking about “laziness” as a possible example of depression or a negative symptom.

Also, a clear understanding of the youth’s symptoms will help you to select handouts that are relevant to the family. For example, if the youth is experiencing co-morbid anxiety, then the optional handout regarding those symptoms may be included in the discussion. Think about how best to pace the session, allocating most time to discussion of the symptoms that are most problematic, distressing, and/or disruptive to the youth and/or family. The goal is not to make sure every symptom gets discussed; it is for everyone on the family to be on the same page about the symptoms and the disorder the IP has.

Before the session, you may want to consider how open the channels of communication are within the family regarding the youth’s symptoms. The patient’s psychiatrist or the UCLA research assessment person may have some idea about this. Some IP’s are reluctant to share details about their symptoms with their parents and so questions aimed to draw them out a bit will need to be asked with care. Other IP’s seem quite oblivious to their symptoms or maintain an “everything is fine stance” while the parents have provided striking examples (drop in school grades, staying up all night working on unrealistic projects, inexplicable shouting in their room in a way that suggests they may be answering back to voices, drop in attention to hygiene, etc.) These IP’s may become angry and/or withdrawn when the parent attempts to describe these symptoms to you. Ideally, this session will allow for family members to develop a greater understanding of each other’s experience of the IP’s symptoms. However, when there is a lot of sensitivity in the family about “putting the issues on the table,” you can present the symptom information in more of a didactic format. Given that this is only the second session, we don’t want to stress everyone out by trying to force openness. We want

everyone to be “up to speed” on the various symptoms that we will be focusing on during our work together.

That said, the most common situation is that parents and youths are willing to speak frankly about their experiences of symptoms when invited to do so. The IP is often more forthcoming when he or she is asked to speak first about his/her own experiences and then family members can add to this description or provide their own perspective. Remember, the IP is the “expert” on his or her own illness.

Clinical Tip:

Exploring the IP’s symptoms should not feel like a repeat of the clinical assessment with the family serving as an audience.

Instead, the goal is to facilitate a deeper understanding on the part of family members of what it is like for the youth to experience these symptoms, and perhaps a deeper understanding by the youth of how his symptoms impact family members and family life. So, if you are feeling that you’re just asking about symptoms and the IP is saying yes or no, then step back and encourage a discussion with open questions: What was that like for you, when your thoughts started racing (patient)? When did you first notice it? Mrs. X, what do you notice when Jim gets this way? Jim, what helps you to feel better? How do you know something is feeling different?

When this session is going well, you shouldn’t have to do much; just ask the youth to describe his experiences of, for example, depression, mania, suspiciousness or apathy, and the family members should chime in with their own perceptions of his behavior. Intervene if differing perceptions lead to arguments: say, for example, “it’s not unusual for people in families to disagree about these symptoms or how they affect others, but at this stage let’s just get everyone’s input on the table.”

Avoid asking about symptoms in a yes/no format, i.e., “have you ever had unusual ideas, or is that not something you’ve experienced? “Has it always been that way, or has it been only recently?” All of these questions can be asked openly, e.g., “Have you ever had unusual ideas? When did they start/worsen/get better? What was that like for you?”

Finally, if the IP has had full blown manic or depressive episodes, it is useful to find out what symptoms came first. That is, what was the first sign that a manic episode was developing- decreased need for sleep, racing thoughts, irritability? For depression, was it fatigue, negative thinking? Later, you will be able to use this information to construct the Prevention Action Plan, which requires thinking of illness episodes as a sequence of events.

Clarifying Manic or Hypomanic Symptoms in Bipolar Youth

If the IP has bipolar I or II disorder, or is on the bipolar spectrum (bipolar NOS), you will want to start by discussing manic (or hypomanic) and depressive symptoms. Give the family **Handouts 2 a and b** entitled “**Symptoms of Mania**” and “**Symptoms of Depression**.” These lists are presented with pictures and simplified language to help adolescents and parents understand how symptoms present within mood states. This

section of the education highlights the fact that a mood disorder has a developmental progression, and that it is often comorbid with other disorders. It is important for family members to be familiar with the presentation of bipolar disorder so they can talk with the clinician about the IP's variable mood states. Be open and inclusive of what youth and family members consider symptoms of mood, behavioral and/or attention difficulties, even though you may suspect that some of these behaviors (e.g., manipulateness, argumentativeness, lack of follow-through) are developmentally normative or even represent personality traits. If a child also has a diagnosis of Attention Deficit Disorder or another comorbid disorder, you may want to discuss these symptoms as well and talk about how they differ from manic symptoms.

Handout # 2a

Symptoms of Mania

ELATED/EXPANSIVE MOOD

DECREASED NEED FOR SLEEP

INCREASED ENERGY AND ACTIVITY

INCREASED SEXUAL THOUGHTS

TALKING FAST


LOSS OF SELF-CONTROL

IRRITABILITY!

BEING OVERCONFIDENT OR UNREALISTIC

EASILY DISTRACTED, RACING THOUGHTS, LOTS OF IDEAS


Handout # 2b



Low self-esteem



Low mood or sadness




Tearfulness


Symptoms of Depression

Some people also:


- feel really tired or low in energy
- wish they weren't alive
- feel worthless or guilty
- talk or move slowly
- lack of thoughts




Trouble concentrating



Sleeping too much or too little



Increase or Decrease in Appetite
Crave Sweets or Carbohydrates



Loss of interest in activities/boredom

Adolescents with bipolar disorder often do not have the same symptoms as DSM-IV adult bipolar disorder patients. For example, they may be characterized by episodic short attention span, anhedonia, low tolerance for frustration, sudden outbursts of anger followed by guilt, lengthy states of arousal in response to minor events, and disruptive behavior. Thus, it is important to not get locked into a “discrete episode” model of bipolar symptoms in which the parents and the adolescent are asked to think in terms of identifiable build-up phases, active phases, and residual phases. Instead, ask the family and adolescent to use their own terminology to describe the adolescent’s mood swings, changes in activity, and behavior problems. Several of our adolescent clients have not been able to identify symptoms of depression if they are asked “what happens when you get sad?” They are much more likely to respond to questions regarding times when they felt “bored,” or “wanted to get away from everybody and everything.”

Most parents will want to talk about “raging,” which is a hallmark trait of early-onset bipolar disorder. For a parent to begin to understand the IP’s oppositional and rageful behavior, they will need information about what is happening in the child’s brain. Possibly due to disturbances in neurotransmitter production and output, the IP may have little if any, control over these rages. We have drawn parallels for families between the onset of these rage states and “a train leaving the station. Once it has taken off it follows its own tracks and at some point no one can jump off, not even the conductor. The trick is to try to keep the train from leaving the station in the first place.”

When the patient begins raging, the best laid plans for behavior management will usually be ineffective. The IP will not be moved by threats, explanations, or rewards. The consequences which the parent and IP have agreed upon can only be effective when the IP is in a state of mind to appreciate their meaning (Greene, 1998). Given this, there must be a plan for how to proceed when the teen is symptomatic versus euthymic, which makes this topic of education all the more essential. Later in FFT, you can guide

families, through communication and problem-solving, to develop behavior management plans to implement when the adolescent is beginning to escalate.


Inset: Reactions to the Diagnosis (Jessica, age 15)

Jessica was a 15 year-old female diagnosed with Bipolar I Disorder. She was chronically irritable during her manic or hypomanic stages with infrequent periods of depression. Jessica showed her resistance to the education phase by getting “revved up” during the sessions. When revved, she would become hypervocal, interrupt the clinician or her parents, and change the subject to unrelated topics. On many occasions it was difficult to keep her on task. Her mother would comment that she did not present this way just before the appointment. When asked, Jessica initially denied the observation. We pointed out to her how obvious the difference was and she agreed but was unable to identify the cause. She did share that she was uncomfortable with sharing her own feelings. She also said that she (like many teens) was afraid if she admitted to her problems caused by the illness that her parents would hold it against her and limit her privileges like driving or outings with friends. Finally, she said that she really struggled with seeing herself as different from others and maybe if she did not talk or think about these differences then they would not be true. Admitting this discomfort opened the door for her to discuss her feelings about the diagnosis itself, within the context of the education sessions.

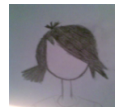
Clarifying Psychosis (or Prodromal Psychosis) Symptoms in Youth

Alternatively, you can start by giving the handouts on **Negative Symptoms** or **Positive Symptoms** (also labeled 2a and 2b) depending on which set of symptoms you believe best characterizes the IP and will lead to the most productive initial discussion. You can use these handouts flexibly to discuss symptoms in whatever order makes the most sense for a particular family.


Handout # 2c



Lack of Motivation




Flat Affect




Disinterest in being social

Negative Symptoms




Trouble with academic/occupational functioning




Disinterest in personal hygiene


Handout # 2d



Grandiosity




Confusion about what is real




Mind Reading


Positive Symptoms




Suspiciousness




Ideas of Reference



Disorganized communication



Perceptual Disturbances



Odd Beliefs

Some family members are confused by the term “negative symptoms” and instead provide examples of their son or daughter’s “negative” or “oppositional” behavior. Likewise, some family members are confused by the term “positive” symptoms and they think that refers to pro-social behavior or signs of improvement. We explain that the term refers to cognitive or behavioral excesses. You may need to clarify that negative symptoms are really “deficit” symptoms, or instances where there is a lack of motivation or disinterest. For example, they may have noticed a change in their son or daughter’s interest in picking up the phone and calling friends and initiating social activities. The IP may be less interested in socializing, school or work activities.

If the IP has schizophrenia or another form of early-onset psychosis, family members may have difficulty telling negative symptoms from depression. We typically acknowledge this problem and use it as an opportunity to reinforce the importance of tracking symptoms over time. We may say something like:

“Yes, you are right. These could be symptoms of depression. There is a lot of overlap between symptoms of depression and the symptoms that accompany psychosis. That is why we would like to track these symptoms carefully over time to get a better handle on what is going on. Depression typically comes and goes, while negative symptoms are more chronic and occur even when someone isn’t feeling particularly sad.”

As family members offer examples, you can ask questions about the symptoms to draw out relevant information. For example, you may ask the youth to elaborate about what it is like for him/her to experience a particular symptom or may ask family members what it is like for them to see their son/daughter or brother/sister experiencing a particular symptom.

When describing unusual thinking, say something like:

“An example of confusion about what is real and what is imaginary might be when you wonder about whether something actually happened or was just a dream. Have you ever had that experience?”

After they respond you can say something like:

“Many people have this experience once or twice and it is brief and only momentarily confusing. When these types of experiences persist for long periods of time, occur frequently and are distressing, they are considered symptoms of unusual thinking.”

Below is an example of how to describe suspiciousness:

“Suspiciousness refers to the thought that people are not trustworthy and/or that someone is trying to harm you. Many of the young people that we see have this experience. Jane (patient), have you ever had this kind of symptom? What was it like?”

At times it can interfere with being able to go to school or with making friends. Did you ever feel suspicious and not want to go to school because of worries that others at school would harm you in some way?

Mr. or Mrs. Hill (parent), are you aware that Jane is experiencing these symptoms of suspiciousness? How do you know when she is experiencing these symptoms? What is it like for you when she is experiencing these symptoms? What do you typically do when she is experiencing these symptoms? Jane, when your mom does X does that tend to help? (If Jane says no, then ask Jane what would be a more helpful reaction. Does Mom think she can respond in the way Jane proposed?)

Sometimes it is a good idea to also ask the other family members whether they have experienced any of the symptoms you are describing. This may help the IP feel less stigmatized and in the spotlight. It could also make the IP feel less alone in his/her experience of dealing with mood or psychosis symptoms. So, for example, ask the father if he has ever felt depressed or unusually suspicious of others, perhaps at work; ask the mother whether she has ever had the experience of things feeling like she was in a dream state.

When discussing symptoms of unusual thinking such as preoccupation with the supernatural, some IP's report that all of their friends must have psychosis because all of them are interested in Wicca and Witchcraft. We may say something like:

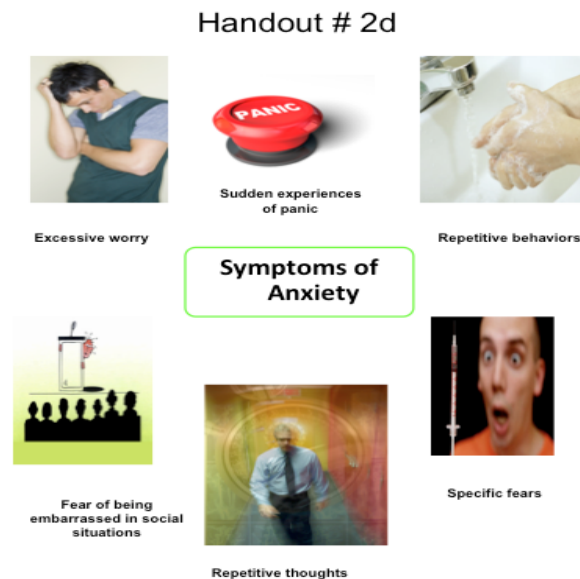
“Fair enough. Teenagers (or young adults) tend to be curious and open-minded and willing to consider a broad variety of ideas. This only becomes a cause for concern when a person becomes preoccupied with these thoughts (such as spotting UFOs) and those preoccupations become disruptive to their functioning at home, school, or work. Do you think any of these ideas have caused problems for you?”

It is important for family members to be familiar with these symptoms so they can better observe and understand what may be going on with the IP and talk with you about what they are observing. Since a goal of treatment is to prevent the onset of a manic/depressive episode or an episode of psychosis, it is important for family members to be able to tell clinicians if they feel that their son or daughter's symptoms are worsening. Create an open and low-key atmosphere so that the full range of symptoms can be discussed.

Guide each family through the handouts at a pace that is comfortable for them. At the end of the discussion of symptoms, ask each person to identify the symptoms they find most distressing, and which ones they would like help with first.

Exploring Anxiety Symptoms

If the youth is experiencing symptoms of anxiety, those symptoms should be discussed as well. **Handout 2d, "Symptoms of Anxiety,"** may be useful when describing these symptoms.



Help the family understand that anxiety can be a symptom of BD or psychosis, but can also be a separate "comorbid" disorder. Generally, severe anxiety symptoms may require adjunctive treatments such as exposure and response prevention, panic control treatment, or other forms of CBT. SSRIs also have a significant role to play in managing anxiety symptoms. You may decide to supplement your treatment with adjunctive CBT techniques for anxiety, such as relaxation or mindfulness exercises. The difference in FFT is that you should involve the whole family in these exercises. A relaxation tape, for example, can be listened to conjointly.

all the IP that “you are the expert in your own
mptoms. We’re going to depend on you to educate us
out what this disorder is really all about. You’re the
ie who’s been through it, and you have a perspective

If Tensions Arise During the Discussion of Symptoms:

Sometimes during the discussion of symptoms, the IP becomes angry when he/she hears other family members describing his/her symptoms. Family members’ descriptions may not hit the mark for the IP and may make him or her feel misunderstood or intruded upon, as if others are trying to tell him or her how he/she feels. If you notice this, explore these feelings and reactions with the family.

It may be useful to validate the IP’s concerns and to remind everyone that the IP is the expert on what these symptoms are like for him/her. Everyone else can comment on their own experiences with similar types of symptoms, but they can only guess or imagine what the symptoms might be like for another person. The tone and language that family members use to share their experiences of the patient’s symptoms can make a big difference in terms of how tolerable this information is for the IP to hear.



Typically when talking about someone else’s internal experience, an inquisitive and tentative approach provokes less reactivity than a more authoritarian statement. Words like “I imagine it might be X to experience Y” tend to work better than “You feel X when you experience Y.” For example, a statement like “I imagine it might be scary (X) to think that others at school are trying to harm you (Y)” tends to be better received than “You get scared when you think others are trying to harm you at school.” When tensions arise the therapist may consider encouraging family members to ask questions so they can better understand the IP’s experiences, or to start with “I imagine” or “I am guessing it might be...” to make any statement about the patient’s experience.

At the same time, family members do have first hand experiences with the IP’s symptoms and the effects of these symptoms on family members. Understandably, family members may be perceiving the IP very differently from how he or she is experiencing him or herself because the family members may be most aware of the “externalizing” aspects of the syndrome, such as irritability, argumentativeness, or school truancy or missing work. The IP may be most aware of internalized experiences such as depression, feeling revved up, or distracting and perhaps anxiety provoking internal experiences (hearing voices, difficulty concentrating, etc.)

In summary, when one family member is experiencing symptoms, it is common for each family member to have a somewhat different experience of that complex event, and each person’s perspective is helpful in understanding the impact of these symptoms on the individual and the family.

Creating an Individualized Self-Rated Mood and Behavior Chart

From the first or second session, try to get the IP into the habit of tracking his/her moods or other significant behaviors or thoughts. In this section, we focus on mood charting as applied to patients with bipolar spectrum disorders. Consider how you might adapt this assignment to a patient whose main problem is paranoia/suspiciousness or auditory hallucinations.

Mood charts are quite valuable in tracking a patient's progress, identifying the emergent signs of worsening symptoms, identifying diurnal variations, recognizing the effect of stressors, and clarifying the role of sleep/wake cycle irregularities. They also make the IP more self-aware and observant of her mood states and behavior. Self-awareness is particularly important in managing a mood disorder. FFT is a good place for the patient and family to learn the value of self-monitoring.

Week of _____

Handout 3: HOW I FEEL

Put an X on the line next to the term that describes how you felt that day. You can use an X and a Y if you want to make a separate rating for morning and night. Feel free to use different terms than the ones provided.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Super-Hyper or _____	[Red bar]						
Energized or _____	[Orange bar]						
Balanced _____	[Blue bar]						
Down _____	[Green bar]						
Angry _____	[Purple bar]						
I woke up at:	___	___	___	___	___	___	___
I went to bed at:	___	___	___	___	___	___	___

Begin by asking the IP to describe her mood states and what descriptors go along with each. If you have a flip chart or a dry erase board, stand by it and draw a horizontal line in the middle (or give the IP **Handout 3**, the **How I Feel** chart). Ask the IP first (or parents if the IP is hesitant) to give a label that describes the absence of symptoms (i.e., mellow, calm, normal, typical). Then, draw a line right above and below the middle line and ask the IP what words she would use for mild ups and downs (e.g. “pretty good” versus “a bit sad” or “frustrated”). Explain that these fluctuations are

representative of the normal moods that someone might experience if she felt like things were going well or not going well. Then, draw a line one step higher and one step lower than the lines you've just drawn. Ask the IP to label each of these lines. For example, the top line might be labeled "excellent mood" or "really happy," whereas the bottom line might be labeled "really bored" or "bummed out." Then, use a separate line for anger and ask the IP to place it on the graph where it most clearly fits for her. (Is it part of an up, active mood? Is it part of the down, depressive cluster? Or both?). You may want to have lines for anger in the up and down sections of the chart. Then ask the IP if there are any other states that should be tracked (i.e., anxiety, suicidality, urges to use substances). Ask the IP to determine where each of these lines should be placed on the chart.

Once the lines are in place and labeled, then each label is placed at the bottom of the page as a heading. The IP begins listing symptoms that go along with each of the states (for example, 'excellent' may include giggling, talking loudly, or feeling more energetic; 'angry' may include cursing, kicking doors, or pushing or hitting). Of course, some youth may not have had experiences of activated or angry states. Be sure to accept the IP and family's input regarding presentation of symptoms. Encourage the parents to join in this process but take cues from the youth. Try to keep an air of curiosity and levity in the room, recognizing that it can be difficult for the IP to focus on her abnormal moods and behavior.

Once this chart has been created, the IP can use it on an ongoing basis. Ask her to complete a mood rating at least twice a day (e.g., best versus worst; morning versus evening) and even more frequently if she is willing. More specifically, ask her to put an X on the line that she felt characterized her mood at various points in the day. Finally, include two vertical spaces at the bottom of each day to record when she went to bed and when she woke up each day. She can also record stressors for that week on the chart to start to recognize how stressors can affect mood.

Give the IP a template that can be dated and copied for each day of the week. It's easiest if a single sheet can be used to characterize the whole week. This exercise is often empowering for the youth in a move towards self-care skills and independence. If the youth is resistant to monitoring mood and/or sleep you can point out that "this is one of the few things you can do- other than just take medications – that puts you in charge of your moods."

Likewise, ask one parent to make a similar rating of the IP's mood each day, or at various times of the day. This is helpful for three reasons: to keep the parent attuned to diurnal shifts in the IP's mood states, to quickly identify a worsening of mood, and to make clear to the youth that he or she is not the only one being given homework. Parents usually appreciate the chance to record the youth's ongoing mood states. You can ask them to rate the same mood chart developed for the IP. Some parents want to keep more detailed notes of the IP's moods, rage outbursts, medications, and/or stressors. Rating the chart may also help the parents confront the misperception that the IP can control his mood swings and may generate more compassion toward him. The chart can be customized to each family's needs. Some families like to take this exercise and create their own chart. As long as all of the information is recorded, individualizing the chart further for the family or patient is encouraged. The more the youth and family feels the chart fits for them the more likely they will be to complete it.

For some patients, you may want to suggest keeping the chart in an obvious place, such as in her backpack or on top of the dresser. Alternatively, the IP may decide to keep her chart with evening medications (if taken) and rate moods then.

If the IP has many mood switches during the day and evening, then he can place any number of Xs on any of the lines corresponding to the times of the day listed. Try not to make the task too complicated, however. Use your clinical judgment in deciding what level of complexity will work best for the youth and ensure his compliance with the task. Obviously, if the IP is an older adolescent or young adult, the more responsibility should be ascribed to him.

Additional chart ratings can be made for other behavioral difficulties or symptoms the patient and family reports. For example, you could ask a child with mild psychosis to keep track of his suspiciousness toward others, her level of apathy or depression, or her feelings of overstimulation.

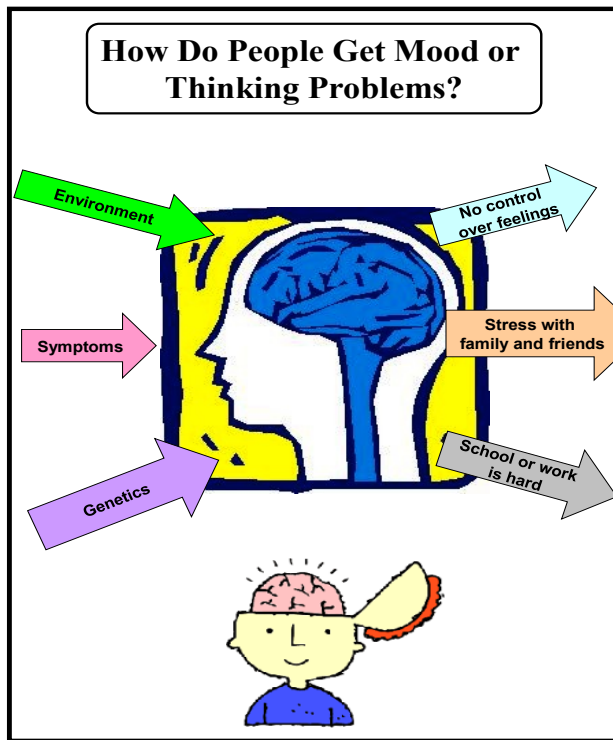
Reflect

Pause for a moment and check-in with the family about the discussion you just had with them. Ask the youth what it was like for him to speak about his/her symptoms, and ask family members what it was like to hear what the youth said and to share some of their own experiences. If it feels genuine to you, compliment the family on the fact that they seem to have taken some risks and made some efforts to help each other understand what is going on for each of them. This process can help to open up channels of communication and is an important step in adapting to life with symptoms and eventually managing symptoms more effectively.

How much time do you have left in the session? Is the family worn out? If you have twenty minutes and the family looks to be comfortable, transition to the next section on vulnerability and stress. If it took you a long time to get through the symptoms, and the family members look maxed out, then transition to planning for the next session and assigning homework and start with vulnerability and stress model at the next session.

If you have time and the family still looks fresh and engaged, ask them if they have the stamina to go through one more hand-out today or whether they would prefer to end now and save it for next week. Make sure that you aren't over-saturating the family with information, and that you are keeping sessions to approximately 50 minutes in length.

Handout # 4



Vulnerability and Stress (How do People Get Mood or Thinking Problems?)

The “vulnerability-stress” theory states that mood or psychosis symptoms come about through an interaction of genetic, biological, and stress factors. This is a simple idea on the surface, but few of your family members will have thought much beyond “it’s both genes and environment.” The objective is to help the IP and family understand what is meant by predisposition and stress, without going into long and complicated explanations of gene and environment interactions.

The overriding goal is for the IP and family to recognize that mood swings (or psychosis symptoms) are not necessarily controllable by the IP, but s/he may be able to maximize use of “protective factors” to prevent the current symptoms from becoming more severe and chronic. With reference to the **Handout no. 4, “How do People Get Mood or Thinking Problems”**, you can say:

“We know that vulnerability (predisposition) to mood disorders and psychosis runs in families (“genetics”). We can’t change the genetic vulnerability that each of has, but we can change the amount of stress in our life (to a certain extent) AND the way we cope with stress to try to keep ourselves healthy. Does this make sense?”

“I am going to explain to you what each of these words mean in the rectangles and in the arrows. Environmental stressors are a part of daily life. One might decide when to change schools or move but there is always some stress in a person’s life. In addition, our biological vulnerabilities or genetic “predispositions” are things that we are born with that we are unable to change. For example,

some people are genetically predisposed to having cavities, meaning that having cavities runs in their family. As a result, that person may brush her teeth just as often and eat the same amount of candy as her friend but she may have cavities and her friend may not. As you can see in the handout, we believe that events or situations that we experience as difficult or stressful can interact with our biological predispositions. This means that some people are more likely to have mood swings even if they have only minor stress, because of their genes or the chemistry of their brain.

We know that mood swings run in families. However, just because your brain chemistry makes it more likely that you will have mood swings (or thinking problems) doesn't mean you will necessarily have them. We also think that stress and other "risk factors" - things that make an illness worse - play a role. But if a person learns to cope with the stress or other difficulties in her life then she will have much less trouble with mood swings. Things we do on a daily basis to manage difficulties so that we feel better - like getting regular sleep - are called "protective factors". Does this make sense?"

"Family members can be very useful with both of these tasks. They can help to create a low stress environment for a vulnerable person and they can help the person to cope effectively with the stress that does occur in daily life."

Follow this up with some probes: "You've talked about how ____ may be genetically vulnerable because mood disorders run in your family. Can you say more about that?"

"What has caused you (the patient) stress in the past? Have you ever felt not in control of your feelings?"

You may need to explain further what is meant by "stress" and "cope". Many adolescents have experienced stress (for example, bullying, being sexually harassed by other teens) but may use other words to describe this experience (e.g., "lots of drama lately"). Other family members may point out things that the teen has found stressful. Ask each member of the family to give you examples of major life stressors that precipitated an episode of physical or mood problems (e.g., the ulcer came on after a large project at work was due, headaches developed after a period of interpersonal stress involving other family members, depression followed a geographical move).

Some family members react to the discussion of genetic vulnerability with guilt or shame. If you notice this, explore these feelings with the family. Remind the parents that, "none of us have control over the genes we inherit or pass on to others." You should also add that, "genes are only a part of the pathway by which a person develops a mood or thought disorders."

Clinical Tip

It is often useful after explaining these handouts to ask one of the family members to repeat back in his or her own words what he or she has heard you say. Asking them to put the material in their own words allows them to reach a deeper level of mastery of the material, and allows us to fill in any gaps in their understanding.

We don't want to put them on the spot or to communicate that we don't think they are bright enough to understand complex concepts. Phrasing it in the following way may avoid those miscommunications.

"I have been talking for a long time, and I don't always say things as clearly as I might like, so I just want to stop and make sure that my message has gotten through. Would one of you please explain to me what your understanding is of how people get bipolar (psychosis, etc) symptoms so that I can be sure that I got my message across effectively?"

Handout # 5

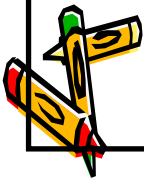
Risk and Protective Factors

Risk Factors

- Drug / alcohol abuse
- Poor sleeping habits
- Not following daily routines
- Stressful life events
- Family conflict or distress

Protective Factors

- Taking appropriate medicine
- Social / family / community supports
- Communication & problem-solving skills
- Using treatment resources like talking to your doctor or counselor



Clinical Tip

One way to help patients understand factors that affect their course of illness is to talk about Risk and Protective Factors. Use **Handout #5**.

Risk factors = anything that can make an illness more likely to occur, or get worse. Examples are drug and alcohol use, excessive amounts of stress, family conflicts, and poor sleep habits, negative self-talk.

Protective factors = anything that makes the person less likely to become ill if they are vulnerable to becoming ill. Protective factors are not just the inverse of risk factors- they are the activities, supports, or treatment resources that make people better when they are biologically predisposed to illness.

Examples: consistent daily routines and sleep/wake cycles, taking medicines, becoming educated about one's illness and learn to identify early warning signs of recurrence, supportive family relationships, therapy or support groups.

So, if your family is having trouble with terms like "coping strategies," try asking, "what protects you from getting ill?" If they equate "stress" with "negative thinking," then explain that negative thinking is a risk factor, but it is a reaction to stress.

Try to help people distinguish environmental stress from "when I get stressed out." The latter usually means worrying excessively or getting irritable. The important issue is, what stressors are most likely to get you stressed out? Relationship problems, work problems, schoolwork, traffic? Having to wait in lines?

Addressing Marijuana use

Drug and alcohol abuse are classic examples of risk factors in mood and psychotic disorders. You will have multiple opportunities to address drug abuse throughout FFT, but none will be particularly effective with youth who have decided to keep using no matter what. In these cases, you may find it more effective to refer the youth for chemical dependency treatment or 12-Step programs.

If relevant to the youth you're seeing, say:

We are going to talk a lot more about stress next time, but I'd like to touch on the marijuana thing a bit more. Invariably young people wonder why we keep telling them not to smoke pot because they see other young people casually experimenting with using it and not having a lot of symptoms. Marijuana is a stressor to our biological system. Some folks with low genetic risk may be able to get away with smoking pot without experiencing symptoms, but once a person is experiencing symptoms, marijuana can make them a lot worse. The same amount of pot can have a much more problematic impact."

Answer Questions

Give the family an opportunity to ask any questions. Say something like, "We have covered a lot of material today. What questions come to mind, or what reactions do you have to the material that we discussed? Pause and allow them to think for a moment. Make sure that you look interested in hearing what is on their mind.

Plan for Next Session and Assign Homework

Remind them of the headlines for the next sessions. You could say something like:

“Next session we are going to try to figure out what is causing the greatest amount of stress in your lives, We will begin to evaluate how you are coping with the stress in your lives and whether additional coping strategies might be useful to you.”

If there is a tie in to family members’ goals, you should mention it by saying something like:

“Manuel, I remember that you were particularly interested in hearing about some additional ways to cope with symptoms and with stress, so next week we will start getting in to that important material. How does that sound?”

Remind the IP to keep his mood or thinking chart.

Ask the family to schedule a family meeting between sessions to review the material you’ve presented and to talk about any questions they may have or any reactions they have to the material. Ask them to share some of those questions or reactions with you at the beginning of next week’s session. Also, ask them to notice sources of stress in their lives, as this will be the focus of next week’s session.

Set up the next meeting time.

Between Sessions 2 and 3: Case Conceptualization

After the second session, spend some time developing a case conceptualization. Case conceptualization will guide skillful implementation of the manual. Some people learning FFT impose the material from the manual on each family in a mechanistic, cookie-cutter, one-size-fits-all kind of way, which is usually ineffective. The material in the manual should be tailored to meet the unique needs of each family, such that each session in the manual is delivered a little bit differently to each family. We want family members to feel like we are speaking to them and addressing their needs, and not like we are reading to them from a manual. Remember that this is therapy, not a class!

By the end of the second session, you have had a chance to hear about the youth's symptoms and family members' reactions to those symptoms, to hear about family members' interests and goals, and you may have a good feel for family members' conversational styles and problem solving abilities. These observations should help you to think selectively about which materials in the manual will be most useful to the family, how to sequence those materials, and how to present them during treatment.

Also, you have had an opportunity to experience what it feels like to be in the room with the family and to observe the ways that you get "pulled into" the family system. In other words, you may find yourself serving specific functions in the family, such as trying to get everyone to stay calm, or trying to defend the youth from the parents' criticism, or structuring and organizing the conversations, or helping the family to slow down and listen to each other before they defend their own point of view. Reflecting on the functions that you find yourself serving can help with the identification of skills that this family may need to strengthen. You can think about how best to teach the family members these skills so that they can meet these needs themselves.

When developing your case conceptualization, ask yourself the following:

What is the "emotional temperature" of this family? Hot, cold, indifferent, angry, silly, depressed, bored, intellectualized?

Who seems closest to whom, and who seems disengaged from whom? Are there any repetitive patterns of interaction? Does one person always seem to contradict the others?

How is the family processing the news of the youth's diagnosis? Do they seem to believe it? Are they "overidentified" with it (e.g., the parents attribute everything the youth does to a biological illness?). In contrast, are they "underidentified" with it (deny that there is anything wrong at the biological or genetic level, attribute laziness, think that annoying behaviors of the youth are purposeful). Alternatively, are some members of the family overidentified with the illness and others underidentified? This often comes up in mother/father pairs: the mother sees the IP's oppositional or aggressive or withdrawn behavior as fueled by an illness, whereas the father sees the need for more strict discipline.

How do you think they developed their style of interacting or patterns of alliance? Did they used to get along and now they don't because of the youth's problems? Are any of their problems as a family long-standing?

Any “secrets” (abuse, parental affairs, financial ruin, etc)?

Below please find an example of a case conceptualization.

A mother and her 21 year-old son.

This mother and son are very good-natured. They are cooperative and candid when responding to the therapist’s questions, calm and low-key during the sessions, and are generally supportive and appreciative of each other. They did report one previous experience in family therapy during which the son started to feel like he was simply an observer while the mother was talking about her own issues. They didn’t think that experience was meeting the son’s needs and so they discontinued treatment.

Youth’s Primary Symptoms: He came in to the clinic because he has been having some difficulties in college. While he was a good student in high school, he found the transition to college quite difficult and his grades have suffered. Recently he has been having a hard time focusing in classes and has had trouble motivating himself. At times he feels like other people in class are reading his mind, which makes him anxious and disrupts his ability to concentrate on the professors’ lectures. Sometimes he believes that he can control other people’s behaviors, although most of the time he realizes that isn’t possible. For example, he might think that a person will soon itch their head and then that person actually does itch their head and he feels like his thought caused the other person’s behavior. Recently he has been less interested in going out with friends and finds it more stressful to socialize with others.

Mother’s Reactions: This youth’s mother reports that she is concerned about some of her son’s beliefs and would like to know how she could help him to decrease the anxiety that is generated by his unusual thoughts. When he is having these thoughts, she tends to say something like “you know it isn’t possible to control other people’s scratching, right? Maybe they just have dandruff, or maybe you noticed that they were about to move their hand toward their head and that is why you thought they would scratch, so their behavior influenced your thoughts and not the other way around.” The son reports that he experiences this type of conversation with his mother to be helpful and reassuring.

Youth’s treatment goals: the son would like to learn more strategies for dealing with his anxiety and some of his troubling thoughts; he would like to develop a more optimistic and confident outlook on life; he would like to learn how to express his opinion even when it is contrary to someone else’s opinion, to find himself as a person, and to express himself more clearly.

Mother’s treatment goals for her son: She would like for him to develop some skills in reducing his anxiety, and in becoming more independent. She would like him to talk more about his feelings so that he can better understand his experiences and know better how to cope with them. Also, it would help her to be more helpful to him if he could tell her more about what is going on with him.

Therapist’s impressions from interactions during therapy sessions: The mother is a very skilled talker. She typically initiates the conversations and can easily discuss her own thoughts and feelings about a complex, multi-faceted experience. The son is very good-natured and he tends to listen to his mother patiently, throwing in a clever joke or comment during pauses to lighten the conversation. When he is asked to express his own thoughts or feelings, he can do so when he speaks briefly about a straightforward situation, but has much greater difficulty when talking about complex experiences, sometimes jumping off topic and becoming very difficult to understand. During the problem-solving task and therapy sessions the mother does most of the talking while the son waits patiently and looks a little bit bored.

The therapist’s experience of herself in the therapy room with this family: I find myself jumping in and trying to organize what the patient is saying by pulling together bits and pieces of information that he has shared to try to create a cohesive meaningful statement. I also notice that I try to explain to the mother what I think the son is trying to say to her, rather than simply allowing the son to express his own ideas himself. I notice that the mother does similar types of things when the youth is speaking to me. I also notice feeling a bit concerned by the amount of time the mother spends expressing her ideas and I try to gently rein the mother in so that I can create more opportunities for the son to talk.

Treatment plan/

Therapy Process:

I will let the family know that in light of their previous experience with therapy - during which the son felt a bit lost and overshadowed - and in line with the son's treatment goals of learning how to express himself more clearly and finding himself as a person, it will be important to give the son plenty of time to talk during this therapy. I'll let them know that mom is a very effective talker, and that is a wonderful strength, and that the son is a very patient and skilled listener with a great sense of humor, and those are wonderful strengths. In order to reach some of the treatment goals, however, the patient will have to push himself to do a bit more talking, and it will be very helpful if the mom and I can do some active listening and ask a lot of follow-up questions so that the son has lots of practice expressing himself and in so doing he may become better able to understand himself and express himself.

I will have to be careful not to jump in and talk for the son and instead to figure out ways to support his abilities to express himself more effectively. This approach fits well with mom's treatment goals because she has expressed interest in hearing her son talk more about his feelings and experiences so that she can better understand how to support him effectively. Also, as he becomes more skilled at expressing himself and gets to know himself better, it will move him toward greater independence.

Sequencing of materials in the manual:

There is no obvious reason to change the general sequence of materials in the manual. In fact, it makes sense to start with psycho-education, then progress to communication skills enhancement, and then to finish with problem solving. The communication skills, especially the active listening skills, may help mom to become more comfortable with reflective listening and asking follow-up questions, skills she needs to play a supportive role while allowing the son to take the lead during the problem solving discussions. I will need to restructure the mom when she starts to pepper her listening with suggestions or interpretations about how he "really feels."

Psycho-educational material:

Much of the psycho-educational material will be useful to this family. After hearing about the son's primary stressors and ways that he tends to cope with those, I'll ask mom to share her ideas about additional coping strategies that might be useful for him to consider. If they are open to the idea, I may introduce some relaxation techniques that he can use unobtrusively during class to cope with stress. It may be useful for him to experiment with changing seats during class, sometimes positioning himself in the front of the room and sometimes in the back or the side to see if there is a spot that helps him to feel less distracted by other people and better able to focus on the lectures. I can help him to become more aware of his self talk and think about becoming more constructive and optimistic, in line with his goals for himself.

Communication Training:

It will be important for both family members to practice as speakers and listeners during all of the communication skills exercises. The son seems to be listening effectively because his jokes are on target, but I will have to evaluate those skills more during the communication unit.

I anticipate that he will continue to have difficulty expressing himself, and it might be useful to create a low-key spirit of experimentation where we try various strategies and see if they help him with self-expression. For example does it help for him to have a notepad so that he can jot down key points to use as a guide?

Problem Solving:

I would like to see the son take more of the lead during the problem solving discussions, or at least to make more contributions. Perhaps he can serve as "secretary" during some of the early discussions (i.e., taking charge of filling out the problem-solving worksheet for the family), and then he can start leading the discussions by directing everyone through the various steps. It will be important for him to be asked to clarify the focus of the problem solving discussion and to generate at least 3 or 4 of the possible solutions to the problems raised.

Of course the case conceptualization can be modified over the course of treatment. In fact, it should evolve as the therapist gets to know the family better.

Session 3: Identifying Stress and Coping Strategies

In the psychoeducational sessions that follow, you'll find specific strategies for managing symptoms among teens and young adults with bipolar or psychosis symptoms. The overarching goal of this portion of psychoeducation is to develop a *Prevention Action Plan*, which identifies:

- early warning signs of symptom intensification
- stressors that may be provoking symptom intensification
- coping skills the youth can use to manage the symptoms,
- ways that family members can help the youth to reduce stress, and
- strategies to overcome obstacles that can be undertaken by the youth and his or her relatives at key points in the symptom escalation.

The family will develop this plan over sessions 3-4. The specific sessions cover the following:

Stress

- Identification of relevant stressors that may be eliciting symptoms
 - identification of typical reactions to stress
 - development of the “stress thermometer” that will help family members evaluate and communicate about their experiences of stress
- Coping: Building a Tool Box
 - Identification of coping skills the youth can use to manage symptoms, which may include sleep/wake cycle regulation, behavioral activation plans (e.g., pleasant events scheduling), relaxation training or mindfulness meditation, and maintaining consistency with a medication regimen.
 - Prevention Action Plan

Pulling all of the strategies together into an action plan. The plan will be most successful if it is developed when the youth is less symptomatic, so that he or she has maximum ability to practice skills that will be needed should symptoms intensify.

Steps of Session 3

Before the session: prepare handout 6, “Sources of Stress,” 7a, “Recent Life Events,” 8, “Coping Strategies,” 8b “Medications,” and 9 (“Good Sleep Habits”). You can also include handout 7b (Stress Thermometer example) if you think a completed stress thermometer will help the family understand the concepts.

1. Joining
2. Review homework and answer questions
3. Facilitate a discussion of the main stressors the IP and other family members are dealing with in their lives. Use the handouts to the extent that they are useful for a particular family in supporting this goal.
4. Help family members to identify how they experience and express stress. Do family members differ in their expressions of stress? Do they know when they are starting to experience stress at a low level so they can catch it and cope with it early?
5. Discuss coping strategies, including staying consistent with medications (handout 8b) and keeping consistent sleep habits (handout 9).
6. Answer Questions and Assign Homework – ask family members to identify sources of stress during their daily lives. Ask them to discuss these stresses during the family meeting, and to start to talk about how they ordinarily cope.
7. Plan for next session
8. Joining/Closing

Goals of session 3

The first goal of this session is to help the IP and each family member to identify a variety of stressors from different domains of their lives, such as stress generated by the family, the school and the work contexts. Family members may be able to identify their own typical reactions when they are feeling “stressed out” (e.g. “I get angry, withdrawn, I reach for a cigarette, I get high”). The second goal is to develop a list of coping strategies that will become an important component of the prevention plan.

Review homework

Check in with the IP: has s/he filled out and brought in the mood chart? If so, what has s/he learned from it so far? What are some of the connections between mood and sleep? How variable has her mood (or thinking patterns/paranoia) been?

Hopefully, she has brought it in and you can examine it with her: “sounds like you had some ups and downs last week. Why do you think you were so down on Thursday?” Or, “Have you noticed how much your sleep times change throughout the week? Do you think that affects your mood (or your thinking processes)? If the IP is complaining

Clinical tips on addressing homework noncompliance

If your patients and family members will come in without having completed any of the homework assignments you recommended. You will be less frustrated by this if you expect it to happen. For example, assume that, even if you've explained the mood chart to the IP, the IP will not have filled it out, and the family members may have no memory of it. ~~about paranoia: "Do you feel more/less suspiciousness when you've had a change in your sleep hours?"~~

A low key approach to noncompletion. Say, "how about we try filling one out now. How was your mood today? How high/low? Have you had any of the suspiciousness you mentioned last week?" If they did have a family meeting, how did it go? Did they talk about any of the content of the sessions? Did they start to think about the various sources of stress in their lives?

Explain again why I think this will be useful. A mood chart will help you see if you have lots of ups and downs during the week, and whether these changes are related to your sleep. Later, we may be able to figure out how stress affects you, and for how long. Does this seem like it would be useful? Would it be good if your (mom, dad, etc.) reminded you?"

Also, if the family did not have a family meeting, normalize it (e.g., "lots of families struggle to find a time when everyone can sit down for 15 minutes and have a discussion. It can be like herding cats. But is there a natural time when you're all together, like at dinner?"). Explain again how a family meeting will help them get more from the sessions. It will allow them to generate questions for you, practice skills, and learn to manage stress more effectively in the IP's problems.

If they did not have a family meeting, ask them why: was it a scheduling problem? Were they unclear why they were meeting? Briefly problem-solve with them regarding how they can make it happen in the upcoming week because we would like them to establish this while they are in FFT.

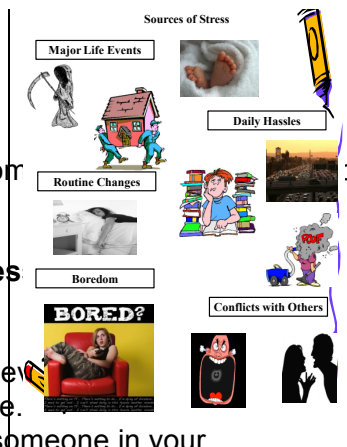
Do not rush through the review of the homework assignment. If we don't convey the importance of it in what they have done together, they will view the homework as unimportant. If they have engaged in the homework, praise them and ask them to show you the chart and talk about what they observed/learned.

Stress Identification

"As we talked about last week, stressful experiences can lead to symptom intensification. A first step in containing stress is to identify the various sources of stress in our lives. When stress remains "invisible" and unidentified, it can wreak the most

havoc. Once we know where stress is coming from, we can deal with it more effectively.”

Distribute **Handout #6, “Sources of Stress”** to each family member.



about how to deal with

“This handout shows the types of events that typically generate stress for people. **major life events** such as when someone in your family dies or you move to a different house.

Even positive events like the birth of a new brother or sister can also cause stress. Why do you think these positive events are considered stressful?” (They are emotional events and often require change in routines)

If you have a **sudden change in routines**, like when the school year starts or you start a new job, that can feel pretty stressful. Having a predictable routine helps to keep stress low.”

“**Daily hassles** such as driving in traffic or forgetting homework assignments can be stressful too. These are the small stressors that are often “invisible” In that we don’t stop and deal with them like we do something big. Some people think that these kinds of things are the most draining because they are so sneaky. We may not realize the toll they are actually taking because they pile up little by little. Have any of these experiences happened to any of you?”

“Conflicts with others, especially family members, but also friends or teachers can be very stressful. Isn’t it interesting that not enough activity, “boredom,” can generate stress as well? Humans seem to need a balance between too much and not enough activity to minimize stress.

Some may be surprised to hear that boredom or not having enough to do can generate stress, partly due to too much time left for rumination or worry. Sitting on the couch and watching TV for hours can seem like a “low stress” thing to do, but can generate stress when an individual starts to feel uncomfortable about not making more progress in their schoolwork or social life. Also, a lot of sedentary activity may throw off sleep wake cycles, such that it is hard to sleep at night and feel rested the next day.

The Stress Thermometer

Ask each family member to talk a bit about what his/her experience of being “stressed out” tends to be like. Do family members know they are stressed out because they feel irritable and they snap at others, or do they have a lot of negative or critical thoughts whirling in their heads, or do their bodies feel tense and their shoulders hunch way up, or do they find themselves declining social invitations and shutting down?

It will be useful for the IP and family members to become aware of when they are getting stressed out so they can catch it early, at a time when they can cope most effectively.

Also, it is helpful if each family member can become more skillful at identifying other family members' signs of distress. Every person reacts to stress differently. While one person may get quiet when overwhelmed by stress another person may become very chatty and another argumentative. Once family members understand each other's signs of feeling stressed, they are more likely to be able to help each other more effectively by providing space or reducing expectations, or providing support during times of stress.

Distribute Handout #7a, "Recent Life Events," to the IP and each family member. The purpose of this handout is to:

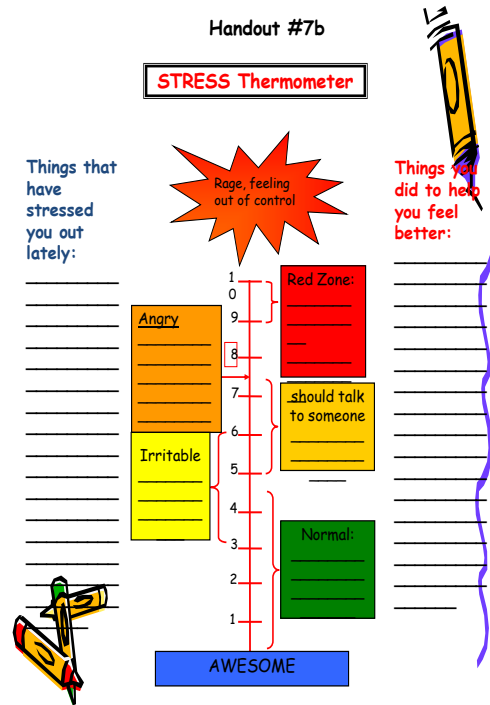
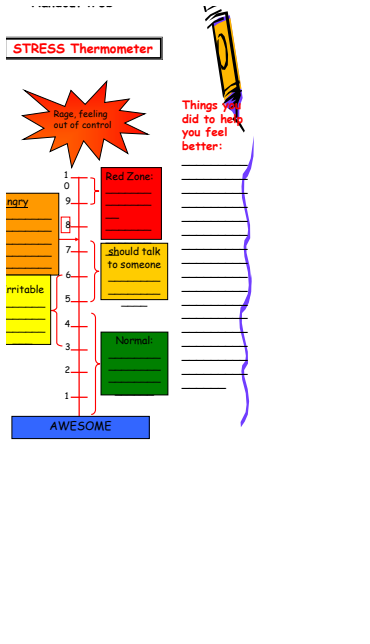
1. **Identify Stressors:** Explore recent events, even minor ones that have led to mood swings, rage reactions, or periods of depression. Ask the IP to describe any events that have stressed him our lately.
2. **Identify Early Warning Signs of Recurrences:** To describe the feeling states (or bodily sensations) associated with stress and mood changes. Help them to identify words that capture low, moderate, and high levels of emotion for them, and have them write those words in the blanks. Although two of the wide-ranging emotions of bipolar disorder are depicted - the transition from euphoria to anger or irritability - you may want to substitute going from normal mood to depression or anxiety (for example, going from feeling "a little tense" to feeling panic). If your patient has psychosis symptoms, consider replacing anger with "overstimulation" or "paranoia". This will help you to make a list of early warning signs of mood or psychosis episodes.
3. **Identify Coping Strategies.** To make an initial list of things the IP can do to make himself feel better, preferably activities that involve other family members or at least other persons who can introduce some balance into the situation.

You can explain the following:

"In the next two sessions, we're going to be developing a prevention plan to help you get better control over your mood swings (thought problems). First, we're going to figure out what causes stress for you. Then we can develop a plan to help you manage stress. Sometimes just having a plan can provide some immediate relief."

Start by asking the IP to imagine recent events that have been associated with feeling upset, angry, or enraged. So, being told to stop playing a video game might make a teen feel annoyed but not angry (mid-scale), whereas being grounded for a week might provoke a rage reaction. You can also identify stressors or events, even positive ones, associated with "happy" or "very happy" (i.e., hypomanic or manic) moods (e.g., getting accepted for a date). When discussing a stressful event, ask the IP, "where would you put that on a scale from 1-10?"

If all of this is too vague or abstract for the IP or family members, show them **Handout #7b, "Stress Thermometer Example,"** that has an example of how another patient completed the stress thermometer based on his experience of stress.



Family members may want to chime in about specific events that caused stress for the IP, or for themselves (i.e., “when I got a call from her teacher”). The main purpose of this task, though, is to begin to develop the Prevention Action Plan – try not to get in to problem-solving at this point. Right now, we are only asking them to identify what is feels like in their body or how they behave and express themselves when they are under varying levels of stress.

Over time they will better understand what types of events are most stressful for the IP and other family members. Perhaps social situations provoke the strongest stress reactions for one family member while school tests and homework assignments provoke the strongest reactions for another. The stress thermometer may be a useful tool for individuals as they experience stress, implement coping strategies, and then reevaluate the stress level to see if their coping efforts have been effective.

Mobilizing Coping Efforts

The next step is to start to list efforts the IP and family can take to cope with stress and changes in mood.

The following strategies will likely be useful for the IP in resulting symptomatic changes (see Handout 8, below)

- Talking to others, especially supportive interact friends
- Positive self-talk
- Pleasant life events scheduling
- Staying on a regular medication regimen
- Using relaxation or meditation exercises

Examples of Coping Strategies

1. Exercise
2. Keeping regular sleep habits
3. Talking to your doctor/therapist
4. Getting your medications changed
5. Enjoying art and music
6. Talking openly with people you're close with
7. Relaxation or meditation
8. Spirituality
9. Helping someone else with their problems
10. Positive self-talk
11. Do something new and different

In the sections that follow, we will consider several of these coping options. There are other possibilities as well, as described in the Appendix.

Coping with stress

Distribute Handout # 8, “Examples of Coping Strategies”.

Explain that a coping strategy is really just a way of dealing with stress. Some strategies may help you to feel better or less upset about the problem, while other strategies may help to actually solve the problem directly. Ask the IP and other family members which of these strategies they’ve used at times of stress. Have they worked well? Do they feel could benefit from new strategies? What additional strategies do they think might be useful?

This discussion will allow family members to learn about the types of coping strategies that each person tends to use now, and often leads to additional suggestions for coping.

For example, consider a 19-year old with early-onset psychosis who says that he is having a hard time in math class because he is sitting in the front of the room and it feels like everyone is staring at him and it becomes “really distracting and uncomfortable.” The way the youth copes with those feelings during class is to imagine that he is somewhere else. While this helps with managing the feelings of self-consciousness, not surprisingly his math grade has been dropping. Family members may suggest talking to the teacher and asking for a change in seat assignment. In fact, one of his parents might be willing to help with this. You might suggest some relaxation or mindfulness exercises before he goes into class.

Developing a Toolbox of Coping Strategies

At this point in the treatment, you are likely to have a much clearer sense of the stressors that are present in the individual, family, and school/work contexts for the IP and of the strategies that s/he is currently using to cope with those stressors. During session 3, you have the opportunity to introduce the importance of **scheduling pleasant life events, medication adherence and sleep regulation** (often issues for young bipolar and psychosis patients) or one of the other coping strategies discussed in the Appendix (school accommodations, relaxation training, mindfulness, social skills training). For example, you can let them know about relaxation techniques or

mindfulness exercises that might be useful with reducing anxiety or helping to get to sleep at night; the pleasant event scheduling if they are feeling down because there isn't enough going on in their lives; the social skills unit if it seems like identifying potential friends and initiating contact are stressful. If there is another topic that you think would be more relevant, this session provides you with the time to teach that skill.

You can also pull in any one of these topics later in the treatment. For example, school accommodations may need to be addressed in session two if the youth is not attending school and this has created a crisis for the family. If the family raises medication non-adherence early on, you may want to address it in the context of symptoms and the vulnerability/stress model. Alternatively, you may decide to wait until the problem-solving section if the issues have to do with forgetting to take medications, and the youth may benefit from generating a list of reminders. Sleep-wake cycle regularity is a good thing to suggest for most patients, although the way this coping strategy is used may vary; one patient may benefit from an earlier bedtime, and another from not "sleep-bingeing" during the weekends.

Similarly, pleasant event scheduling, relaxation training, or social skills training may be useful to pull in during a particular problem solving session. Basically, as opportunities arise throughout the therapy, you are helping the family to develop a "toolbox" of coping strategies that they may use as needed.

Optional Topic 1: Pleasant Events Scheduling

Often the IP's we see do not have enough enjoyable activities in their lives. They are isolated from peer and school/work satisfactions, and spend inordinate amounts of time with technology (computers, televisions, etc.) or sleeping. This may be due to depression, negative or positive psychosis symptoms, social anxiety, and/or medication side effects. Sometimes by talking about the patient's reasons for avoiding activities, the therapist and family can figure out strategies that may help the patient to re-engage. We typically ask family members about activities they enjoyed in the past, but that they aren't currently involved in, or anything they would like to do but haven't been able to get started for whatever reason. We may brainstorm regarding how they could get those activities back in their lives. Alternatively, consultation with the treating psychiatrist may lead to medication changes that alleviate the problem for the youth.

In other cases, however, the reason for the inertia is not clear, and youths may seem pretty stuck in very restricted lives. Enticing them back into engaging more actively with their community, family, and peers and helping them to find greater satisfaction are important steps on the road toward higher functioning. Explain to the family that it is difficult to cope with the many stressors one encounters in life if there isn't a "stock pile" of pleasant experiences to balance the situation. It would be great if the youth could start enjoying him/herself more.

Sometimes it is the case that families have become immobilized by the symptoms and have stopped enjoying pleasant activities together. It is difficult to communicate well if family members are not sharing some fun times together. So, the pleasant event list may support individuals and families in creating more pleasurable and collaborative experiences in their lives.

1	asking someone to help (something?)	44	what really gets about you
2	driving, shopping, and parking	45	making a list of things you would like to do during
3	having a night	46	your free time (what are you used to do?)
4	going to the beach	47	being a fan
5	driving along the coast	48	going to a party with a friend
6	calling someone from a restaurant	49	having an interesting discussion with a friend
7	reading a book, magazine, or newspaper	50	trying around the house
8	going to the library and reading the newspaper in	51	going to a party
9	another language	52	making a list of all the things you like about
10	looking at a picture of a friend in the library or a	53	yourself
11	bookstore	54	going to a party
12	looking at a picture of a friend in the library or a	55	looking over parents for making their
13	bookstore	56	bedroom
14	looking for a new place to live	57	going to a party with a friend
15	looking for a new place to live	58	going to a party with a friend
16	looking for a new place to live	59	going to a party with a friend
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55	looking for a new place to live	98	going to a party with a friend
56	looking for a new place to live	99	going to a party with a friend
57	looking for a new place to live	100	going to a party with a friend

We share with them the list we have generated “Pleasant Activities for Families” (see Har which is a modification of the Adult Pleasant Schedule found in the Skills Training Manual for Borderline Personality Disorder by Marsha Linehan (1993). The goal in using this list is to get them to broaden their thinking about possible events they can schedule into their lives.

Have family members take turns reading items from the list aloud, and ask each of them to circle the events that pique their interest. After the family has reviewed the list, you can invite them to add some ideas of their own to the list. Then you can ask that they spend a few minutes picking out a few of the activities they have circled that they would be willing to try over the next few weeks.

After they have each identified several activities they would be willing to try, spend some time developing an action plan with each of them regarding when and how they can make sure to follow-through with these activities. Help them schedule the events as clearly and specifically as possible.

This activities list is particularly useful when the parents have tried repeatedly to suggest activities, or require activities of the youth and this process of trying to get the youth to become more active has turned into a tension filled power struggle within the family and perhaps within the therapy room during a particular session. In these cases, one goal of introducing this “pleasant activities for families” list is to decrease the tension in the family and to change the dynamic in the room from one of the parents pushing and youth resisting to a process in which we invite and entice the youth to try something new. When the family members read through the list we want them to linger on items that may spark memories of particularly good times that they have shared together, and to talk about those experiences. By reflecting on these pleasant events, we may create a different mood and atmosphere in which the youth feels a little more flexible and receptive. We would like to rekindle interest in some activities that he/she used to enjoy but has forgotten about or entice the youth to try something completely novel that he/she hasn’t thought about before.

Also, we would like to support the family in having some enjoyable experiences together. Usually warmth and connection grease the wheels for all of the communication and problem solving work to follow. Sometimes using the pleasant activities for families list changes the family dynamic because now the youth is saying that items on the list are stupid, rather than the ideas that the parent has suggested are stupid. This seems to create less defensiveness and tension and more laughter in the family, which sometimes helps them through an impasse.

For example, while reading through the list of pleasant family activities, one youth commented that the item about reading the newspaper in another language was totally ridiculous and should be on a list of homework assignments rather than of pleasant events. After everyone laughed, his mother reminded him that she routinely reads the newspaper in Spanish, and that in fact most of the family’s favorite recipes have come from that newspaper. The son asked her why they haven’t had paella in a while, and

she reminded him that he is the best paella maker in the house. They decided to go shopping for ingredients together that weekend and to cook some other favorite dishes as well.

Another youth read the item about “drinking an ice cold glass of water” and laughed out loud mockingly. He thought that was a ridiculous pleasant event and couldn’t believe that we would have something that “stupid” on the list. We asked him if he ever had the experience of drinking water after a long walk, and he agreed that it could actually be quite pleasant. That led to a discussion of all kinds of simple pleasant experiences that often get overlooked because we are too preoccupied to really pay attention to them. The family talked about how humans seem to be wired to focus on negative things that happen or problems that are unresolved rather than ruminating about all of the hundreds of pleasant little moments that occur every day. The family thought that was unfortunate and decided to try to shift their focus for a week to appreciating small pleasant moments and reported that was a major improvement in family life for them.

Another youth and mother that were at an angry impasse during a session because the youth was refusing to do anything active read through the list and it stimulated a discussion of how they used to take their dog out for a walk together just about every evening. The mom started recounting stories about how the dog had stolen a gentleman’s hat one time and led them on a merry chase, and the son remembered how the dog constantly chased rabbits and squirrels, but never actually managed to catch one. They wondered about why they were able to enjoy walks together when the dog was alive, but had such difficulty now, and the son suggested that it was because they had the dog to entertain them and they didn’t have to talk. Now when they walk the mom constantly asks the son questions about how he is doing and he finds that very irritating. They agreed to try taking a few walks during the week provided that the mother would save up entertaining stories to tell and would not ask the son any questions about his health.

Optional Topic 2: Enhancing Medication Adherence

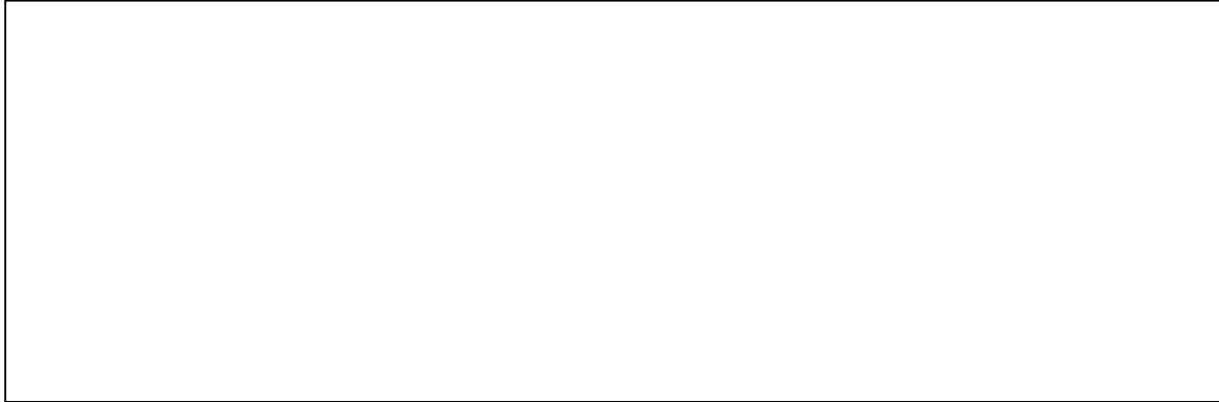
(Address this issue if you have reason to believe the IP has been inconsistent with medications – whether these are mood stabilizers such as lithium, Depakote or Lamictal or atypical antipsychotics like Risperdal, Seroquel, Latuda, or Abilify).

Often, during the education component of FFT, the issue of medication nonadherence emerges. This is an important issue for individuals with psychiatric disorders in general, and is even more pertinent to adolescents and young adults. At one time or another, many of our adolescents or young adults have either forgotten doses of medication, “played with” the doses and times to take the medication, or ceased taking their medication altogether. In most cases the parents were unaware until they began noticing emergent/intensified symptoms in the adolescent or young adult.

FFT assumes that people are more likely to commit to a regimen of psychotropic medications if:

- (1) they receive information from mental health professionals about their symptoms and how the medications may help;

- Do you ever try to cope on your own without the medication?
- Many people miss taking their medications from time to time; how has it been for you?
- In your opinion, will medications help you to attain your personal goals?
 - (2) they are approached with compassion and with acknowledgment that taking medications doesn't change one's identity;
 - (3) it is their own decision and not one foisted on them by others; and
 - (4) dosages can be adjusted or other medications substituted to control side effects.



stabilize mood and which work on psychotic thinking or hallucinations (atypical or typical antipsychotics) and which are antidepressants, anxiolytics or sleep medicines. Try not to get into a prolonged discussion with the IP or family about side effects, however. If they have concerns about side effects (e.g., weight gain on antipsychotics; trembling hands on lithium), refer them to their psychiatrist or GP for a discussion about changing agents or altering dosages.

Handout # 8b

Medications Commonly Used In Outpatient Settings

<i>Generic Name</i>	<i>Brand Name</i>	<i>Generic Name</i>	<i>Brand Name</i>
Mood-Stabilizers: To regulate ups and downs Lithium Carbonate Eskalith/Lithonate Carbamazepine Tegretol Divalproex Sodium Depakote Lamotrigine Lamictal Oxcarbazepine Trileptal Topiramate Topamax		Antipsychotics: To control agitation, hallucinations or distorted thinking; to help with sleep Olanzapine Zyprexa Risperidone Risperdal Quetiapine Seroquel Ziprasidone Geodon, Zeldox Aripiprazole Abilify Lurasidone Latuda Paliperidone Invega	
Antidepressants: To improve mood Serotonin-Reuptake Inhibitors: Fluoxetine Prozac Sertraline Zoloft Paroxetine Paxil Fluvoxamine Luvox Citalopram Celexa Escitalopram Lexapro Monoamine Oxidase Inhibitors: Phenelzine Nardil Tranylcypromine Parnate Stimulants: Methylphenidate Ritalin, Concerta Dextroamphetamine Adderall Vyvanse Focalin Guanfacine Tenex		Benzodiazepines: To control anxiety, improve sleep and induce calm Lorazepam Ativan Clonazepam Klonopin Diazepam Valium Alprazolam Xanax Medications to improve attention and concentration Methylphenidate Ritalin, Concerta Dextroamphetamine Adderall Vyvanse Focalin Guanfacine Tenex	

Case Example: Alicia, age 17

For example, one family called between sessions to talk about their concern about their 17 year-old daughter Alicia. They said that Alicia had become more defiant, impatient, silly, and had been sleeping less; she had also become irritable, was withdrawing more, and received failing grades on two tests over the past week. They were unsure as to what they should attribute her change in behavior. After several days of this change in behavior she told her parents that she had not been taking her medications for the last seven days. Her parents called to make sure that we would spend time on this issue in the next session. This event provided an opportunity to educate the IP and family about medication nonadherence and to talk about prevention.

Therapist: So, it sounds like over the last couple of weeks that there was a period of time where you stopped taking your Depakote.

Alicia: Yeah.

Therapist: What made you decide to stop taking it? The last time we met you said that it was really helpful to you.

Dad: She quit taking her medicine because she wanted to drink on her birthday and the doctor told her that she couldn't drink and take her medicine too.

Alicia: That's not true. You always think the worst.

Mom: Well, why did you quit taking your medicine?

Alicia: I was just feeling a lot better and I wanted to see if I still needed it. Obviously I do (stated dejectedly).

Therapist: It seems that there are a number of issues here. First, it may be helpful for us to talk a bit about the importance of medication to treat your particular symptoms. Second, Alicia, you have some feelings about having to take medication to make yourself feel better and I would like to hear more about those. I'd also like to hear more about this increase in your symptoms and see how your family responded (*summarizes issues within a prevention framework*)

Dad: Well, this time things certainly seemed to go a little better. We got into the same kind of conflicts we have gotten in before which led to Alicia moving out. This time we just asked her what was going on and that she seemed like she was having more symptoms and that generated some discussion, diffused the situation, and for the first time in a long time, Alicia didn't just walk out.

Alicia: I almost did.

Therapist: (to Dad) So it sounds like you noticed that she was experiencing more symptoms, and this time you were able to talk about it instead of getting into a fight. (*reinforces family for coping efforts*)

Dad: Yes, it seemed to make a difference. But it has still been very hard.

Therapist: I'm sure it has. It is often very difficult for family members when they see that their kid is doing so well and then they go off of their medication and

things get really difficult again. Let's talk about why kids, and adults also, for that matter, quit taking their medication.

First, often the medication has side effects that the person taking the medication doesn't like. A person may quit taking the medicine or reduce it to decrease side effects. Second, when people start to feel better, as you did Alicia, they think that they don't need the medicine anymore. They kind of think of it like aspirin, "I take it when I have a headache and then quit taking it when the headache goes away." Finally, some people just forget to take their medication. It is often difficult with a busy life to get into the habit of taking and carrying your medicine with you. Do any of these fit for you, Alicia? (*summarizes reasons why people become inconsistent*)

Alicia: The feeling better one. I didn't think I needed it or ever really needed it in the first place.

Therapist: I can understand that, but it's important for you to know, Alicia, that taking your medicine is one of the most protective things you can do against having more symptoms, even when you are feeling fine. The medicine you take is similar to the medicine people take for diabetes or high blood pressure. The medicine keeps the symptoms from intensifying. One of the reasons that you are feeling better now is probably because you are taking the medicine, not because you don't need the medicine. Do you understand how this could be so?

Alicia: It's a drag that I have to take medicine for the rest of my life. I hate it.

Therapist: That's understandable. In fact, that's the other issue I wanted to talk about today. Feeling frustrated with having to take medication is pretty normal. But if you're not able to find a way to manage that frustration it could make you want to stop taking it.

Alicia: What's the big deal about going off the medication anyway? I can just take it again if my symptoms get worse.

Therapist: Well, it's actually a bit more complicated than that. There are studies that have shown that for some people who discontinue their medications all of a sudden, they can get worse.

Mom: You mean it could stop working?

Therapist: Yes, for some people that is the case.

Alicia: I actually do care when I don't get along with my parents, and the medicine really isn't that bad, but I just don't like being different.

Therapist: Well, that's understandable, but you'd be surprised to find out how many of the kids at school have to take some medicine to manage their health. People don't necessarily talk about it.

Alicia: Yeah, there are a lot of kids at my school who have to take drugs for something. My friend Stacy has to take this medicine for her eyes all the time.

In this section, the clinician has done several things: clarified Alicia's reasons for believing she doesn't need medication; normalizing those reasons; making analogies between the medical treatment of psychiatric disorder and the treatment of other medical disorders; and educating Alicia and her family about the hazards of nonadherence.

Key Themes in Medication Nonadherence

In our experience, medication adherence among adolescents and young adults can be facilitated by the following:

- Helping the adolescent develop cues for pill storage and use (for example, pill boxes, watch alarms, post-it notes, telephone reminders from family members)
- Examining the role of medications in the patient's family or marital relationships;
- Examine subtle or overt pressures from family members to discontinue medications
- Clarify the "symbolic significance" of taking medications (e.g., loss of creativity, fears about giving up one's experiences of emotions, relationships, music, or other pleasures)

In some cases, the issue is "grieving over the lost healthy self," when adolescents or young adults fear that taking medication means giving up aspirations, goals, or their view of themselves as a person with a future. These and related issues are discussed in more depth in *Bipolar Disorder: A Family-Focused Treatment Approach, 2nd ed.* (Miklowitz, 2010).

Who Should be in Charge of the Adolescent's Medications?

While there are no hard and fast rules about this, use the following guidelines when helping a family decide to what extent to hand control over to the young person. These guidelines will be less relevant to young adults.

- If the youth is to take responsibility, he or she must buy into the clinical concerns and treatment plan
- The youth must be cognitively able to handle the dosing requirements
- Issue of boundaries: is the youth more or less likely to take medications if the parents play an active role?
- Older adolescents/young adults are more likely to be able to take responsibility than early adolescents
- Make sure that medications do not become the battleground in which autonomy battles are fought.

Optional Topic #3: Addressing Sleep Problems

(Address this issue with most adolescents and young adults – once again, you are in the section on coping strategies for stress, and getting regular sleep and keeping regular routines is a major way to fend off the effects of stress on mood and thinking).

Sleep problems are often a central complaint among IPs with psychiatric disorders and their family members. Fortunately, you can acquaint the parents and IP about the options available to them when they have insomnia or restless sleep. For

example, you can encourage the adolescent to structure the bedtime routine with very predictable times for turning off the television, brushing teeth, reading, and finally, turning out the lights. Many families, however, do not have a “bedtime ritual” or even an agreed-upon bedtime for their adolescents. This is not because they haven’t thought of doing this. Rather, the adolescent has been quite resistant to following through.

We stress that having the same bedtime and awakening time for the adolescent or young adult may help with this problem. The list below offers many possible alternatives when coping with sleep problems. Specify whether the problem seems more biochemical (i.e., the IP lies in bed and feels too “revved” to fall asleep) or more behavioral (i.e., there are no consequences for the IP for failing to follow an agreed-upon bedtime routine). The solutions may also be quite different for younger and older adolescents or young adults.

One family brought in the bedtime routine as a topic for problem solving. The parents described how difficult it was to get their two adolescent boys (ages 12 and 13) in bed and have them keep the lights out and go to sleep. Once the kids were in bed with the lights out, they were able to fall asleep, but getting them to bed was a major hassle. As a family, they engaged in problem solving and came up with a solution generated by the boys. They all agreed that if the boys got in bed at the agreed upon time with lights out that they received points toward the purchase of DVDs (each point was worth \$.50). If they did not follow the agreed upon bedtime plan, their consequence was that they would not have TV the next day. The family implemented the plan that night and all went well. This is an example of how sometimes sleep difficulties can be changed behaviorally.

For older adolescents and young adults, the reinforcers for maintaining a good sleep/wake cycle tend to have to do with access to peers, job demands, and academics. So, for example, a 19-year old contracted with his parents to be in bed by 12 each night, and up by 8, in exchange for use of the car on weekends.

Try to determine why sleep problems are occurring: are they related to antecedent-behavior-consequence chains or are they highly correlated with other symptoms? Implement an intervention appropriate to the nature of the problem. There are cases where the sleep difficulties are related to unresolved symptoms and may require additional medications. Be sure to involve the treating psychiatrist in designing sleep plans with the family. Avoid recommending certain sleeping pills (including melatonin) unless you are either the treating psychiatrist or you have discussed this with him/her.

Pass out Handout 9, “Good Sleep Habits”:

Handout 9: Good Sleep Habits

- Establish a regular bedtime and wake time, even on weekends
- Avoid caffeine, alcohol, illicit drugs, and other stimulants, especially at night
- Exercise early in the day, not right before bed
- Avoid emailing or texting in the bedroom
- Have an hour-long "wind-down" time before bed
- Avoid highly stimulating activities right before bedtime
- Anticipate events that could de-stabilize daily routines



Spend some time discussing each bullet point with the IP: does s/he have a regular bedtime? What does she do right before trying to sleep? How much do her sleep habits vary from the week to the weekends? If she has been keeping a mood chart and writing down sleep/wake times, you can refer back to these to develop some solutions to the problem of sleep disturbance.

Ending Session 3

Reflect

Summarize for the family what you've covered today, but do it in a "Socratic" format:

What kinds of stress affects you most?

What are the symptoms you experience when you're under stress?

What are some of the things you can do when you're under stress?

How can your family help you?

Answer Questions and Assign Homework

Design an assignment that encourages them to think ahead to the next session and practice new skills you have taught them. There are several assignments you can give them:

- To parents and IP: keep having a family meeting, only this time everyone should make a list of stressors that have affected them this week, and how they coped with them.

- b. To IP: Keep your mood and thinking chart only this time make sure to track your sleep patterns and note anything that you think threw them off.

Try to determine what the IP and family can handle this week. If the session has gone smoothly, err on the side of expecting them to do more. Once you have given them an assignment, you may want to ask them to repeat it back to you. If they have not been consistent with homework so far, ask them: what could get in the way of getting this done?

Session 4: Optimizing Family Support and Drafting the Prevention Plan

Before the session: copy handouts 10, “How the Family can Help” and 11, “The Prevention Action Plan.”

1. Joining
2. Review homework assignment related to coping
3. Introduce the role of the family environment
4. Talk with family about what family members do that is experienced as helpful by the IP, and what others do that makes stress worse for him/her. If time allows, ask other family members talk about what is helpful and difficult for them regarding what others do when they are stressed out.
6. Go over handout “How the family can help”.
7. Develop a draft of the Prevention Plan, building on coping strategies you discussed in session 3.
8. Joining/Closing

The main learning objectives during this fourth of four psychoeducation sessions are to (a) explain that the family environment can play a key role in improving the patient’s symptoms by reducing the patient’s experience of stress and supporting his/her efforts to cope with stress, and (b) help the IP and family develop a prevention action plan.

Answer Questions and Review Homework Assignment related to coping

Ask the family whether they met and discussed stress and coping, and if they made a list, to show it to you. Review the IP’s mood/thinking chart, and ask him if he had any thoughts about the content from last time. Did he/she have any insights into the role of stress in his or her disorder?

Introduce the Role of the Family Environment

Introduce this topic:

“Today we are going to build off of what we have been working on in the past couple of sessions. Last week we talked about stressors and strategies that we can use to cope. Today we are going to focus on what family members can do to help each of us to cope with our stress, and in turn what each of us can do to make it easier for family members to help us.

Start by asking someone other than the IP to say what others in the family have done when s/he is under stress. Ideally, we’d like a husband to say “my wife gives me a back rub” or for the mom to say, “Curt (son) asks me what’s wrong and listens.” Try to

redirect the discussion if the family's first impulse is to blame the IP for making the world stressful for them. We want to know what others do that helps.

Next, ask the IP how each family member responds when he is under stress or has mood symptoms or psychosis symptoms. How do those reactions impact the IP? What do family members do that is helpful? Ask the family to think about what would be most helpful to the IP when s/he is symptomatic. And how could the IP express his needs so that he has a better chance of getting support from family members?

If there is time, go through some of the other family members' stressors as well (or mood problems) and ask them what others could do to be helpful to them in those situations. What do others do that tends to be helpful? What do others do that tends to make matters worse?

Try to work through a couple of examples during the session. At times, parents may have trouble responding to their son/daughter's symptoms or problems with day-to-day functioning.

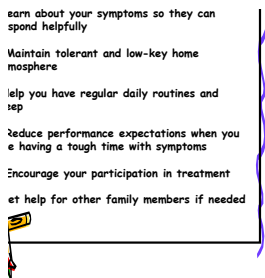
For instance, consider a patient that had listed "trouble with focus and attention related to increased sensitivity to sounds," as one of her areas of concern. Due to the IP's trouble with attention, she has not been getting her homework done. The patient is so far behind in her classes that she is at risk of failing. The IP, wanting to do well but unable to focus enough to get her work done, is experiencing a high level of stress. The IP explained that her parents reacted to her poor academic performance by closely monitoring her time spent studying, but she noted that this has made her feel more stressed out and led to increased conflict.

The clinician should (1) ask the IP how she has experienced her family's reaction to this problem, (2) ask the family members if they believe their responses to the IP are working effectively. If not, facilitate a discussion of alternative responses. For instance, in reference to the above example, the patient identified that an alternative helpful response would be to study on her own and then show her parents her homework when she is done with it.

Make sure to encourage alternative responses, as appropriate. For the example being discussed, you might suggest that the parents talk with their daughter's teachers about allowing her to have more time to complete assignments in light of her recent troubles. In addition, you could suggest that the parents decrease their expectations during times of worsening symptoms. If there are two parents, emphasize the importance of "being on the same page" regarding how to address problems that involve their son/daughter. Keep in mind that such discussions are likely to continue throughout the course of treatment and that alternative responses will improve with practice.

No matter how well the discussion has gone, praise them for their openness to talking about what is helpful and not helpful with each other. Allow for them to reflect on the experience a little bit.

Let them know that their ability to listen and their willingness to change strategies and experiment with various ways of helping each other is a real strength and often leads to more satisfying and effective solutions to problems. Remind them that you will be helping them with these issues more directly when you get to communication training.



How Can the Family Help?

Much of the material in Handout 10 (“How Can the Family Help”) has been discussed already, but your families will find it helpful to have it all in one place. Also, this material will be important in the prevention plan. You may need to explain some of these items. For example, when discussing “maintain a tolerant and calm home atmosphere,” possibilities include: be willing to walk away from arguments; institute the “three volley rule” where family members agree to terminate or derail discussions that have reached three negative “back and forth” interactions; or use “time outs” as a way of helping family members calm down in intense situations. When you get to the last bullet point, “use good communication skills,” lead the family in a discussion of what communication is like at home and ask whether the family uses specific skills like active listening or praise or acknowledgement. The family can supplement these discussions by reading Chapter 9, “Family Management and Coping” in The Bipolar Teen (Miklowitz and George, 2008).

Concerns about a teenager’s school performance or behavior are often at the forefront of parents’ minds. If there are school problems, find out how much the parents know about getting help or accommodations from the school to increase the chances of their teen being successful.

When explaining “structure and consistency,” point out that irregular bed times in teens can often be traced to irregularities in the family’s overall routines. For example, if no one in the house eats dinner together, the IP’s dinnertime is likely to vary from night to night. If there is no “bedtime ritual” (for example, the internet is unavailable after 11; the TV goes off at 10; quiet is expected after a certain hour) then the youth is unlikely to get to bed on time. Although older teens and young adults may no longer be tied to the parents’ or younger siblings’ routines, it is not unreasonable to ask the parents to set time expectations such as the above to help the young person regulate his hours.

Additional Information to Consider if Tensions Arise During the Discussion of Family Support

Sometimes parents struggle with what they perceive to be a contradictory message. We tell them that they did not cause the symptoms, yet we also tell them that there are things they can do to decrease symptom severity. Some people think that if they have some control over symptoms, then they are essentially blameworthy for causing the symptoms to begin with. If parents start to look uncomfortable, or you suspect that the parents are starting to feel blamed, you can introduce the following material that does help them to see that although they aren’t responsible for causing the symptoms, they still can be helpful with reducing them.

Christopher Amenson, Ph.D of the Pacific Clinics explains that:

“If you are a family that likes to rearrange your house a lot and move the furniture around from room to room every few months to create a new experience of the house, this is not a problem. In fact, it may help keep things fresh and interesting

and there is nothing problematic at all about having a child that gets an illness and you have to redecorate your room. Your redecoration habit is not the problem. The problem is that the situation with your child has changed and you have to refrain from moving the furniture because your child is sensitive to loud noises. Your family will need to adapt to this situation and find ways to have fun as a family.”

Handout #11 Prevention Action Plan			
Stressors or Triggers	Early Warning Signs	Coping Skills	Overcoming Obstacles
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

However, if you suddenly become blind, you would need to rethink your redecoration habit. You would need to adapt and refrain from moving the furniture because your child is sensitive to loud noises. You would need to find some other ways to have fun as a family.”

After this general explanation, get back to concretizing it for the particular the family, e.g., “In other words, just because Robert is extra-sensitive to loud voices, that doesn’t mean that talking to him loudly made him become that way. But it may suggest that he’ll adapt easier in an environment where people keep their voices down.”

Introduce the Prevention Action Plan

At this point you have the opportunity to integrate a lot of the material that has been covered into the development of a plan to help prevent symptoms from getting worse. In particular, you can draw from the discussion about symptoms, sources of stress, coping skills, and family support to develop an intervention strategy that the family can use if symptoms worsen.

The action plan consists of four steps:

- (1) identify relevant stressors that may be affecting the IP or the family as a whole,
- (2) identify early warning signs that moods or mental health functioning is deteriorating,
- (3) mobilize efforts to cope with stressors and early warning signs, and
- (4) plan ways to overcome obstacles.

In introducing the plan, you can explain that developing a prevention plan is indicated since research has shown that early interventions are much more effective than waiting until symptoms are at a more severe level. Explain to the youth that “this is a way to maintain control over your life even when your thinking/mood/energy start to change.”

Provide the family with the “**Prevention Action Plan,**” **Handout # 11.** Ask them to discuss what should go in each column. Ideally, the IP will be in charge of filling out the form as you go, although you may also want to appoint a parent or sibling if the IP is resistant.

The first column is “Stressors-Triggers.” Invite the family members to pull from the prior discussions on identifying stress, or invite the IP to report on recent stressors from her mood chart. Remind them that stressors can change from week to week. You can also put “triggers” here, such as “my irregular sleep patterns,” “missing several days of medications,” or “fighting with my parents about my room.”

The next column, “Early Warning Signs,” should be familiar to everyone at this point. Remember that EWSs are different than symptoms – these are the first signs that a person is going into an episode of depression, mania, or psychosis, and that functioning is becoming harder. Examples of “Early Warning Signs,” might include, “I have more

trouble concentrating,” “I seem to need more (or less) sleep;” “my mood gets more irritable,” “it’s harder for me to get my responsibilities done,” or “I am feeling more suspicious of other people and haven’t wanted to go out with friends, “ or “It’s harder to get up in the morning.” Family members can draw from the items that they listed in the first column. For instance, for an IP who put that things are going well for him/her when he/she wants to spend more time with friends, an early warning sign could be, “avoiding seeing friends.”

Sometimes, EWSs are specific to the person. One parent said that her son “gets this wild look in his eyes.” Another parent said that his daughter “starts hiding food under her bed.” Another said that her daughter “gets these big movements, talks with her hands more – it’s like Broadway versus the small screen.” Once a number of EWSs have been listed, encourage the IP to record them on the Plan sheet.

Third, and most importantly, they should list coping/prevention skills. These can be pulled from the prior discussions, which may include some of the items on the “Protective Factors” list:

- Taking medications more regularly
- Sleeping more regularly
- Talking with others about difficult feelings
- Monitoring one’s mood more regularly
- Staying away from alcohol and drugs
- Keeping the household low-key
- Reducing conflicts (e.g., the three-volley rule)
- Engaging in pleasurable activities (e.g., hobbies)
- Exercise

The next column is “Overcoming Obstacles.” The clinician explains that sometimes when things aren’t going as well, it can be more difficult to utilize some of our coping skills. The goal with these columns is to proactively look ahead at obstacles to implementing coping skills that may come up when symptoms arise. These barriers can be overcome more easily if anticipated with an action plan already in place. For instance, when we are feeling healthy and happy, it may be easy to draw on our coping skills such as engaging in hobbies or spending time with friends. However, when we aren’t feeling as well, there can be obstacles to using these much-needed coping skills. A bipolar patient who is currently well and says, “when I’m getting manic and elated, my parents should tell me and bring me back to earth” is unlikely to be this insightful when actually getting manic and elated.

For example, Jonathan, age 23, relied on spending time with friends as a coping skill, but his tendency to withdraw when depressed was an obstacle to using this coping skill. An action plan that was set up ahead of time involved a discussion with his girlfriend when he was doing well. Jonathan informed his girlfriend that his early signs of depression included withdrawing and self-isolating, which inhibited him from reaching out to her or to friends. Together they decided that when Jonathan started to pull away, his girlfriend would take the initiative to draw him out more and become more active in making plans to see each other.

Ramon, age 25, enjoyed the euphoric feelings that came with getting hypomanic or manic. As a result, he did not want to take medications at those times, although he was usually very compliant. He said that “my parents should tell me I’m getting high, and remind me to take them. I won’t like it at the time, but they should do it anyway.”

Melissa, age 19, listed spending quiet time alone in her room as a coping skill. However, one of her early warning signs included a tendency to shut down and not communicate. Family members became concerned by Melissa’s withdrawal and thought they were being helpful by constantly checking in and offering suggestions or inviting her to spend time together. This led Melissa to have difficulty communicating her need for alone time. The family developed a “signal” to relieve Melissa from having to explain her need for some space and time alone. In this case, the family decided to have Melissa put a note on her door stating, “Alone time ‘til 6pm.” This met both Melissa’s need for her quiet time along with her parents’ need to know that she was okay and that they could check in with her at a specific time.

Answer Questions and Assign Homework

At the end of the session, review the patient’s prevention plan worksheet and allow time to answer questions. **Be sure to give all participants praise for their efforts.** Remind the family to have a family meeting between sessions and review the materials that were introduced during this session. Encourage the IP to continue filling out his mood chart but also to think about what else could be added to the prevention action plan.

Plan for/schedule next session

Let them know that you will be transitioning out of the psycho-educational segment of your work together and into communication enhancement training as a primary focus. You will revisit the prevention plan throughout treatment but the next focus will be on improving the emotional “climate” of the family.

III. COMMUNICATION ENHANCEMENT TRAINING (Sessions 5-8)

Sessions 5 and 6: Provide Overview of Communication Skills; Teach the Family about Expressing Positive Feelings and Active Listening

Handouts needed:

12 (The Five Basic Communication Skills)

13 (Expressing Positive Feelings)

14 (Catch a Person Pleasing You)

15 (Active Listening)

16 (Communication Skills Assignment).

- 1. Joining**
- 2. Review the Prevention Action Plan Homework**
- 3. Facilitate a Discussion of the Family Members' Current Communication Styles**
- 4. Preview Skills of Communication Enhancement Training**
- 5. Teach Skill #1: Expressing Positive Feelings; start Active Listening**
- 6. Assign Homework, Answer Questions, and Plan for the Next Session**

Prior to introducing the second module, review the prevention plan homework and answer any questions that might have come up between sessions. Review the IP's mood chart.

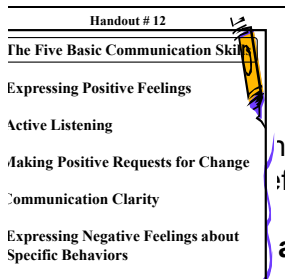
Background Information Regarding the Communication Enhancement Training

The second module of FFT, communication enhancement training (CET), runs for approximately 4 sessions (sessions 5-8). These sessions are not as tightly structured as the prior sessions. Families learn at different paces, and there may be significant material from sessions 1-4 that needs further review. For this reason, we present the lesson plan for sessions 5-6 in this section, and 7-8 in the next.

CET is guided by two assumptions. First, aversive family communication reflects distress within the family due to family members' attempts to deal with the patient's symptoms and trouble with functioning. Second, aversive communication patterns can be improved through skill training and practice. CET uses a role-playing format to teach patients and their relatives five communication skills: *offering positive feedback, active listening, communication clarity, and making positive requests for change in others' behavior.*

The purpose of communication enhancement training is to create a home atmosphere that is protective against increased symptoms. These skills – if practiced earnestly - foster a feeling of collaboration between members of a family. However, it may take some time for family members to get used to the role-play format.

For each skill, the clinician gives the participants a handout listing its components (e.g., for active listening: making good eye contact, paraphrasing), and models the skill for the family. Then, the participants practice the skills with each other, with coaching and



ing by the clinician. A homework assignment, in which the participants keep a log of efforts to use the skills, facilitates generalization to the home setting.

ate Current Communication Style

ommunication module begins with a discussion regarding the importance of using communication skills to create a family environment that is calm, clear, and supportive. Also, good communication skills are typically in each person's best interest because they are more likely to get what they want when they are able to listen to and address the other person's concerns.

Ask the family: what currently goes well in your family's communication; what doesn't go so well? Is it any different when _____ has symptoms? How about when (mother or father) are under stress at work?

If someone in the family describes their tendency to get worked up or to yell when something is upsetting, normalize this: "most families do this to some degree, and it can be especially difficult to listen to someone else's perspective when you feel like you've been wronged."

Introducing the Communication Skills

Give the family Handout 12, "Communication Enhancement Skills". **Then, preview the skills that you intend to teach the family.** The key task in CET is role-playing with each other inside and outside of the session. It is important for the family to understand the role-playing process. Describe it by saying:

"You are going to learn four or five communication skills: expressing positive feelings, active listening, communication clarity, making positive requests for change, and if needed, expressing negative feelings about specific behaviors. We'll have you do something in here that we call 'role-playing.' This means that we will be asking you to turn your chairs to each other and practice new ways of talking among yourselves. It may be a little awkward at first but you'll be surprised at how quickly you get used to it when everyone else is doing it too. In fact, it can be fun for the family to try out these new ways of talking to each other."

Briefly make connections between some of the ways they have said they would like to improve and some of the skills listed on this handout. Then continue with the introduction:


"Good communication and problem solving leads to less family tension and fewer mood symptoms (psychosis symptoms). Having the skills makes it much easier to solve problems that may have been there for a long time."

Make sure that everyone in the family understands what you mean by good communication. For younger adolescents, "communication" can seem like an adult word

and it may be necessary to say to them “it r understand each other.”

Expressing Positive Feelings

- Look at the person
- Say exactly what s/he did that pleased you
- Tell him/her how you felt when s/he did that



and another person

Introducing Skill #1: Expressing Positive

After introducing the concept of communication, present the skill of expressing positive feelings. This skill is taught first because it is an easy skill to learn and usually leads to a sense of connection and good feeling between family members. To begin, briefly summarize the nature and purpose of the skill: it is a direct way to make other members of the family feel valued and appreciated, and makes them want to reciprocate those good feelings in the future. Also, it helps to create a balanced approach to family life. It can be very easy to identify ways that other people irritate us, and we can easily take for granted the many things that others are doing each day to help us out. The most satisfied families tend to praise each other a lot more often than they ask for changes.

Then explain the components using **Handout 13, “Expressing Positive Feelings”**.

It is sometimes hard for individuals to come up with “feeling words.” For example, a family member might say, “It made me feel like you cared,” which is really not a disclosure of his or her own feeling state. Help family members to find the right feeling that goes along with that experience, such as “happy”, “appreciated”, or “touched”. Explain to the participants that expressing positive feelings typically goes better if the praise is offered for a relatively specific behavior instead of a generic attribute such as being a “terrific person”. Finally, model the skill for them. For rapport-building, direct your modeling to the patient as the receiver. For example, say,

“Keith, I really appreciate that you’ve been willing to talk about your school problems so openly. It makes me feel good that our time has been well spent.”

Or,

“Mr. Williams, I really appreciate how you have come to every session and tried to participate even though it has been hard for you some days. Your involvement makes me feel encouraged that I may be helpful to you and your family.”

If your attempt to model the compliment falls flat, try not to become defensive. Try to bring humor to the situation (e.g., “boy, that one went over like a lead balloon”). Your willingness to be vulnerable and persevere in the face of rejection may make family members and the IP feel less defensive themselves and more open to the process of positive communication.

Once it is clear that family members know the features of positive communication, have them think of something specific and pleasing that someone else in the family did in the last week. Once a family member is ready to give feedback and has chosen a recipient, instruct the members of the dyad to turn their chairs toward each other, and talk directly to each other with the one giving the feedback designated the “speaker” and the one

Handout # 14

Catch a Person Pleasing You

Day	Person Who Pleased You	Exactly What Did They Do That Pleased You?	What Did You Say to Him or Her?
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Directions: Record a compliment you give to someone else each day. Record the person's name, what they did that pleased you, and what you said to them.

Compliments: Making a suggestion, Giving a compliment, Offering to help, Asking for help, Making fun.

Being considerate: Caring for someone, Sharing resources, Being courteous, Attending someone, Making phone call.

Compliments: Being Good!

receiving the feedback the “listener”. Your role is to provide direction. Make sure that the person receives feedback on how to do the skill correctly.

practicing the skill, based on the feedback supported but also

Consider the following example. A father agreed to his 19-year old son on his attempts to stay out of trouble with the police.

his 19-year old son on his son,

“I am really glad that you didn’t get into any trouble this week.”

The clinician praised the father’s efforts at coming up with a compliment for his son, and pointed out to him that another way to state his compliment was to say what his son did that he appreciated, as opposed to what he did not do.

The father tried again and stated,

“Son, your behavior was really exceptional this week and it made me really happy to see you behave so well.”

At this point the clinician gave a lot of praise to the father for being flexible and performing the skill in the way it was intended. However, she still encouraged the father to try again, giving examples of what he meant by “really exceptional behavior.”

Sometimes, there will be resistance to replaying the exchange (and in so doing, practicing the skill) in accordance with the therapist’s feedback. If this occurs, you can share with the speaker that the skills are like trying on a new pair of shoes. If they do not fit, the speaker is welcome to take them off. However, he or she will only know whether they fit if they are “walked in awhile to see if you can break them in. It’s the same way with these skills – you’ve got to mold them to your particular style before they’ll feel natural.”

Next, ask each member of the family to practice the skill while you praise and provide direction. Ideally, each member of the family will have practiced giving a compliment to someone else, and will have been the recipient of one as well. If one person is being left out (i.e., no one said that mom did anything well), encourage the family to do so (e.g., “No one has said anything about what Beth did this week. I imagine she must have done something nice for someone in here.”).

Assign Homework

Once you are fairly certain that each of the family members – including the IP – is using the positive feedback skill in the correct manner, assign the homework sheet, “**Catch a Person Pleasing You Task**” (Handout 14). This assignment (to be completed between sessions) can be treated as a game. Each member of the family is given one sheet. The goal is for each family member to try to do something every day that he or she perceives as pleasing to another member of the family (which can vary day by day). All family members record on their sheets when something pleasant was done for them by another member of the family. They also record how they expressed positive feelings about what was done. This can lead to a discussion of what family members “catch” and what they “miss”.

For example, in one family, the father brought a box of chocolates to the mother. He was very surprised when his gesture was not “caught” by her. She explained to him that she was actually offended because she was trying to decrease her sugar intake and recalled that he had commented earlier in the week that she had been gaining weight. She did express positive feelings about some other things he had done, however (i.e., rubbing her back, playing with the kids when he came home). He was surprised that these behaviors meant so much to her. Family members may realize that the efforts they expend to please each other are ineffective because they are not always in sync with the other person’s desires. What better way to demonstrate the importance of direct communication!

Troubleshooting the Expressing Positive Feelings skill

Most of the time family members will be receptive to this approach and perhaps even enjoy the exercise. However, if family members persist in expressing strong negative reactions, discuss their feelings and consider modifications. For example, one single-parent father and his son laughed out loud during this exercise and stated:

Dad: Doctor, guys just don’t talk like that. I don’t mean any disrespect, and I can imagine how you might say things in this way, but in my world it just won’t happen. I just want to be honest with you.”

Therapist: I appreciate your honesty. Tell me some more about what feels weird to you about this approach.

Dad: My son and I do nice things for each other, and I like to let him know that I appreciate what he does, but I would give him a high five and just say “thanks,” or I might say “good job with the laundry, pound it (father puts up his fist).”

Therapist: So you are noticing what your son is doing and you are praising him for it in your own way. You have a briefer style that doesn’t involve talking about how it makes you feel and so on.

Dad: Yeah. Those words just wouldn’t be mine. It would feel really stilted.

Therapist: Ben, how do you tell your Dad when he has done something that you like?

Son: I just say “thanks for picking me up from school Dad, or thanks for cooking chicken tonight, that’s my favorite.”

Therapist: You know, I like the way that you communicated there and I’m glad that you brought this up because the whole point of this exercise is really just to remind us to focus on and comment on the good things that we are doing for each other. Sounds like you guys have your own way of doing that and it works for you.

Son and Dad: Yeah.



Therapist: Do you think that there is room for you to be a little bit more aware of what you are doing for each other day-to-day and to comment on it a bit more so that each of you might feel a bit more appreciated and would know more about what each other likes?

Dad: Yes, there is definitely room for that. I can see what you are saying about the need to keep a balance so that I'm not just always telling him to pick up his room and do his homework.

Therapist: What about you Ben? Do you think that your Dad knows what you like about what he does for you?

Son: I think so, but I'm not sure.

Therapist: Would you be open to going through the role plays again only this time using whatever way feels comfortable for you to express positive feelings?

Dad: Sure.

Alternatively, the clinician here might have accepted the family's way of expressing positive feelings, but assigned the Catch a Person Pleasing You task so that they could keep track of how often these exchanges occurred.

Introducing skill #2: Active Listening

An essential building block for good communication is the ability to listen. Because it is in many ways the basis for other communication skills, active listening can be introduced before expressing positive feelings. However, active listening is a more difficult skill to learn and can be anxiety producing for family members, so expressing positive feelings can be an opportunity to begin communication training with a concrete skill that has a positive tone.

If a week has passed since you introduced Expressing Positive Feelings, check in on the "Catch a person pleasing you" homework. Ask them how it felt for them to give each other more positive feedback during the week. What was it like for them to hear others noticing and commenting on some of the efforts they made to be helpful or supportive during the week? If they haven't done the assignment, ask them each to come up with one positive thing another member of the family has done in the intervening week, and to express it now in a rehearsal within the session. Remember to coach them to be specific about the feeling they enjoyed (pleased, relieved, happy, touched) and also about the behavior the other person performed.

Next, give **Handout 15** and describe **Active Listening** to the family by saying:

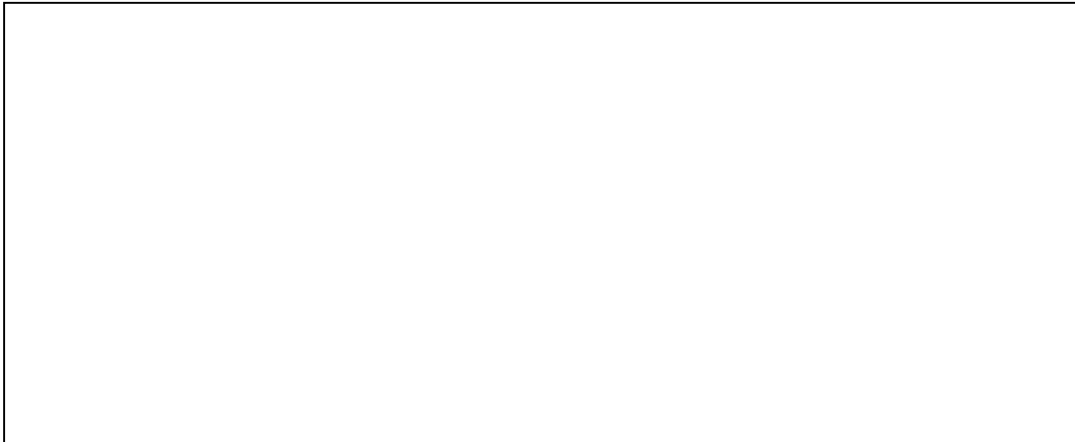
"This is a skill you are probably all familiar with, known as active listening. It's a skill that is useful anytime, but it is really helpful when there is an argument or disagreement. It helps to slow things down because each person has to let the other person know that they heard what was said. That way, the other person feels like you're listening. It's

When teaching Active Listening, it can be tempting to coach the speaker and the listener simultaneously. For example, some clinicians try to get a parent to practice “Making a Positive Request” while the son or daughter listens actively. In our experience, this doesn’t work well. The speaker may bring up a topic that is hard for the listener to summarize, or that may make the listener feel defensive. Typically, coach the person who is learning the new skill only. The exception to this is when another family member, assigned the role of speaker, sees it as an opportunity to criticize the listener. There are a couple of parts to it. If you want to let a person know you are listening to them, look at them, nod your head, and ask some questions to make sure you understand, like ‘When did that happen?’ It’s also a good idea to try to tell the person what you heard them say, what we call “checking out what you heard.” Mrs. X, when someone listens to you and asks you questions, how does it feel?”

After introducing the skill, model the skill for the family. That is, be the listener and ask a member of the family to talk to you. You may want to ask for a volunteer. Once you have modeled the listening skill, solicit input from family members as to their experience of the demonstration (e.g., “What did you see me doing just now? How did you know I was listening?”). Next, ask for volunteers to try practicing the skill (a speaker and a listener).

It is important to start with low conflict topics for active listening, given that it is difficult to learn a skill in the face of anxiety and/or criticism. Also, practicing the skill should not provide an opportunity for a parent to give the patient a lecture.


As with the other skills, continue to model, and give positive reinforcement for the family member’s efforts, even if these efforts are only modest. There is often more direction involved in the active listening skill than the others because of its difficulty and complexity.



If there are more than two family members participating in the therapy, assign a speaker and a listener and give the other family members the job of observing to see if the listener is following all of the steps. Sometimes it is easier for people to learn the skills when they are not in the “hot seat.” After the role-play, ask the observers what they noticed. What did the listener do well? Did the listener follow all of the steps?

Communication Skills Assignment

Person You Talked To	What You Talked About	What Positive Feedback Did You Give?	What Active Listening Skills Did You Use?	What Communication Clarity Skills Did You Use?	What Positive Requests Did You Make?
Mon					
Tue					
Wed					
Thu					
Fri					
Sat					
Sun					



It is very common for family members that individual who is speaking by defending th of view on a particular topic. Let them kno not what we mean by active listening. Hel said or to ask follow-up questions to clarify know that they will have a chance to share practicing listening skills. When everybody be a breakdown in family communication a

answer back to the ing their own point ected response, it is the other person ctive. Let them : for now we are stening, there will

If the IP is experiencing problems with memory or concentration/attention, he/she could consider jotting down notes while the other person is talking. That way, s/he will have an easier time reflecting back what was said and asking relevant follow-up questions.

Some youths will say: “it is obvious that I’m listening because I am sitting here and he/she doesn’t want me to just repeat back what he/she said.” Encourage them to consider that if they are able to summarize the other person’s point, that person will “feel heard” and won’t have to keep trying to get a point across. This is a big shift for many youths who tend to have little experience with active listening. Parents may be more familiar with the concept, but may still find it difficult to actually put into action.

Case Example

Ben, a 13-year-old with both bipolar disorder and ADHD began to experience frustration during the communication module. When the family was asked what they would like to improve in their communication, Ben’s father, Richard, said that he would like for he and Ben to share more with each other. Ben asked him what he meant. His father said that he would like to know what Ben wanted out of life, what made him happy, and where he saw himself in the future. Ben, becoming increasingly frustrated, told his father that he still did not understand. The clinician tried to help Richard focus his request a little more but he had a very difficult time defining what he meant. Finally, Ben said, “Dad, I’ll tell you about my day today, OK?” and proceeded to give his father a very detailed account of all he did at school and after school. The clinician assigned Richard the task of listening and reflecting. This role seemed to please Richard very much who thanked Ben by saying, “that helps me know what makes you happy and what is happening in your life”. Luckily, Ben was able to intercept what was becoming an uncomfortable impasse by making a guess about what his father wanted. The clinician can help parents avoid abstract dialogue and focus on the concrete, specific communication to which the child will respond more positively.

Go over Homework Assignment

Continue the process of integrating communication skills into the family’s daily life by assigning homework. If you’ve already explained the “*Catch a Person Pleasing You*” assignment, you will have an easy time explaining the **Communication Skills Assignment (Handout 16)**. Explain that only the first two skills should be practiced (Expressing Positive Feelings and Active Listening) - they should not fill out the information regarding “communication clarity” or “positive requests” until you review those skills. Instruct

the family to practice active listening with various people in their daily lives, and to describe each instance on the homework sheet.

Troubleshooting the Active Listening Skill

Because of the importance and difficulty of mastering active listening techniques, it may take more than one session to practice this skill. You may want to make modifications to the active listening training based on the comprehension of a particular youth or family member. Feedback from the family and careful observation of the interactions are essential processes for ensuring that the teaching hits the mark.

For example, one 15 year-old boy had a very difficult time listening to his mother talk. His mother became aggravated with him during the role-play exercises because he would stop making eye contact with her, which she felt was disrespectful and a sign that he wasn't listening. He explained that it was hard for him to deal with people's facial expressions, that he found them confusing and overwhelming, and that he could listen better when he could look away from their face, or could do something with his hands (e.g., play "Angry Birds" on his cell phone). He said that, far from distracting him, using his hands to play the game helped to ease his anxiety and helped him focus on another person's message. The mother was surprised to hear this and became more understanding of his difficulty with eye contact. She proceeded to talk with him while he was looking at his cell phone, and he was consistently able to summarize what she had said. In fact, she discovered that he actually listened better when he was able to busy himself with his hands, especially when they were talking about emotionally charged topics.

This example serves to highlight that the goal of the listening exercise is to facilitate effective communication in a family. A therapist may need to modify the listening tasks to accommodate the needs of particular individuals with unique sensitivities and characteristics.

If you'd like more examples, consult pages 221-228 of *Bipolar Disorder: A Family-Focused Treatment Approach*.

Ending Sessions 5-6

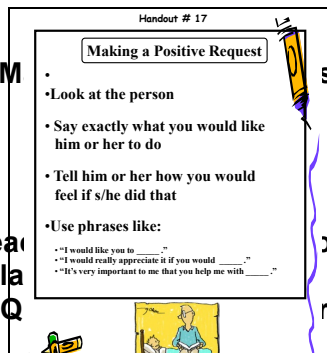
When wrapping up these sessions, summarize the skills the family has learned and why they're important. Ask them to repeat back to you what they're supposed to do with the "**Catch a Person Pleasing You**" and the **Communication Skills Handout** assignments. Offer praise for their attempts to master the skills, even if very modest.

Mostly, encourage them to practice these skills at home, and with others. The skills will feel increasingly comfortable as they generalize to other settings.

Remind the family that, at session 9, you'll be switching to every other week. That is, the first 8 sessions are weekly, and then we switch to biweekly. This will not be a big issue for many families, but give them some time to prepare. Pair this statement with, "Because we'll be meeting less frequently, it will be extra important for you to have a family meeting and practice these skills between sessions. Are you still having a family meeting?"

Sessions 7-8: Communication Skills: Making Positive Requests for Change and Communication Clarity

1. Joining
2. Review the Homework
3. Provide Rationale for and teach Making Positive Requests for Change and Communication Clarity
4. Assign Homework, Answer Questions



Steps for Change and

Positive Requests for

for the Next Session

Needed: Handouts 17 (Making a Positive Request), 18 (Communication Clarity), and 16 (Communication Skills Assignment)

Review Homework

If you haven't done so in session 6, start out session 7 by reviewing the "Catch a person pleasing you" homework from the previous week. Ask them how it felt for them to give each other more positive feedback during the week. What was it like for them to hear others noticing and commenting on some of the efforts that they made to be helpful or supportive during the week?

Next, ask them if they had any experience with active listening. If they have completed the Communication Skills assignment, ask to see it. Ask family members to describe their attempts at practicing active listening and what they observed about the impact on their conversations. Ask them to talk about the kinds of situations when they may want to use active listening in the future, and the kinds of situations when this wouldn't be feasible (e.g., when they are in a hurry and don't have time to open up a conversation). Often people are able to report that the listening skills deepened their conversations and that they felt more satisfied with the outcome of their discussions.

The next two communication skills, making positive requests for change and expressing negative feelings, address a family member's desire for change in another family member's behavior. "**Making Positive Requests**" (e.g., "I would appreciate it if you would take out the trash") is the first step in requesting behavior changes (see *Handout 17*). "**Expressing Negative Feelings About Specific Behaviors**" (e.g., "When you ignore me, it hurts my feelings; what can we do about this?") can be tried when positive requests have not achieved their desired effects (see *Handout 19*).

There are two caveats to keep in mind when teaching positive requests. **First, the request should be for another person to do something, rather than stop doing something. Second, the person receiving the request is not under obligation to do what is being asked of him or her.** The request may best be conceptualized as one of a number of solutions to a family problem that can be taken up further through the problem-solving venue (see Problem solving section). Consider the contrast between these three ways of presenting feedback about tone of voice:

"I hate it when you use that negative tone of voice." (criticism)

“I would appreciate it if you’d use a more respectful tone of voice when we talk.” (positive request for change)

“I’ve asked you to speak to me in a respectful tone several times, but you haven’t followed through. What are we going to do about this? (expressing negative feelings about a specific behavior)

To proceed with ‘positive requests,’ pass out the **“Making a Positive Request”** handout, and introduce the skill:

“The next skill is called making a positive request. This is a good skill to use when you want someone to do something differently. As you can see in the handout there are a few parts to this skill – look at the person, say what you would like him or her to do, and say how it would make you feel.”

After presenting the components of the skill, model the skill, either by asking for a volunteer or including someone in the family who has been “hanging back” during the treatment. If you feel you have a good relationship with the family, you can use this as an opportunity to address an issue that’s been bothering you as a clinician. For example, “Alan, I’d appreciate it if you’d let me know if you need to cancel by calling me the day before. I understand there are things that can get in the way of attending, but I’d feel better because I could plan around it.”

Once you have modeled the skill, ask all family members to make a request of another family member (or of you) and then role-play the skill in pairs. As with the other skills, praise all members of the family for their efforts, and provide feedback to each family member to make sure the skill is being performed correctly.

Once the family has practiced this skill for a while, you can introduce some variety into this work. You could ask the family to think about phrases that they hear a lot around the house. How could each of these statements be rephrased so that they are expressed as positive requests for change?

For example,

Between siblings: “Stop being such a pain;” “Don’t touch my stuff.”

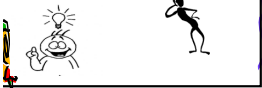
From parents to youth: “How can you live in that room of yours, it is so gross?” “Why are you watching TV when you have homework to do?” “What are your dishes still doing in the living room?”

From youth to parents: “Get off my case;” “I took out the garbage yesterday, it’s Sophia’s (sister) turn today” “I’ll walk the dog later.....why are you always nagging me?”

Then you could ask them to practice turning those into positive requests for change and role-play the new approaches to communication. Remember to coach the family member through these exercises. Examples of how we’d like them to express the above might include:

“I’d really appreciate it if you’d ask me first if you want to borrow my clothes. It would make me want to share them with you more often.”

- Figure out what you want to say
- Use short sentences to highlight the main points
- Be specific rather than abstract
- Bring up one topic at a time
- Stop and make sure other person understood you



...I appreciate your getting your homework done before you watch another TV program. I'd say, I wouldn't have to worry about whether it's getting done."

...Sometimes I'm in the middle of something when you ask me to do a chore. I'd appreciate our working out a time interval when these things are supposed to get done. I'd say I'd feel like I have some control over my free time."

Teach Skill #3: Communication Clarity

Throughout treatment the clinician may have encouraged family members to use concrete and brief statements instead of abstract and lengthy statements (see the example of Ben and his father, above). You can now offer family members the opportunity to practice these skills. The goal of 'Communication Clarity' is to help the IP or family members stay on track and direct sentences towards a goal.

Provide the family with **Handout #18, "Communication Clarity."** Go through and explain the purpose of each item:

Figure out what you want to say: Getting to the main point quickly will result in fewer misunderstandings. Organize your thinking so that you communicate the most important points. Oftentimes we can get caught up in providing too much detail and our point can get lost.

Use short sentences to highlight the main points: Short statements are easier to understand and respond to than lengthier statements.

Be specific rather than abstract: Using language that is specific is less confusing than abstract and/or general statements. For instance, making the statement, "I noticed you have been spending more time alone lately, is there something wrong?" is a clearer statement than "What's wrong with you? You seem to be in the clouds lately."

Bring up one topic at a time: Attempting to discuss many topics at once can be confusing and overwhelming. For instance, making the statements "You have been sleeping constantly, I don't think you've been taking your meds, and you haven't been spending time with your friends," could be overwhelming. Instead, it would be more effective to prioritize and convey one point at a time, such as, "I've noticed that you have not taken your medications for the past 2 days and I want to talk with you about it." Leave the other issues for another time.

Once you have reviewed the handout; it's time to practice. Ask family members to think of one problem that they would like to discuss. Ask them to take turns in the speaker and listener roles with any additional family members serving as observers who will coach the speaker. Ask the speaker to try to follow the guidelines and to discuss the one problem he/she has selected briefly, getting to the main points and then stopping.

Ask the observers to comment on whether the speaker followed the guidelines on the handout, and ask the family members to change roles and continue practicing.

Below is a case example of a possible scenario in which the clinician could intervene and educate the family regarding the importance of using more focused communication,

Case Example

During sessions the clinician noticed that Anthony, a 15 year-old, was having difficulty getting his point across and appeared confused. During today's session Maria, Anthony's mother, tried to help Anthony by explaining what had been covered so far in the session, "Anthony, we are talking about how to get better at communicating and (Ms. Alvarez, the clinician) wants to know what we are doing now. I think it would be better if you shared more." Anthony asked her what she meant. Mark, Anthony's father, stated, "It's not that difficult, we just want to hear from you more." The clinician intervened and suggested that Maria and Mark provide more specific, concrete, requests for what they mean by "sharing more" or "hearing from you more ." Anthony's parents tried again and stated, "We want you to talk with us if you are having a bad day and tell us how we can help." Anthony, responded, "Oh, well sometimes it's hard to talk about things, but I can try." Anthony was able to follow the content being discussed once it was presented in a brief and specific manner.

Ending sessions 7-8

Assign Homework, Answer Questions, and Plan for Next Session

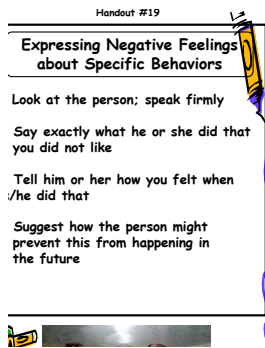
Ask the family to practice communication clarity over the next week and to once again track of their efforts on the "**Communication Skills Assignment**" (**Handout 16**) chart. Spend some time summarizing and reflecting upon the communication skills.

If time permits, you may want to ask the family to role-play each skill one final time. After the skills have been practiced, ask each member of the family to discuss the usefulness of each skill. Some skills are more useful to one family member than another. Ask the family if there are other communication skills that they think would be useful to them. Ask them to continue practicing with each other between sessions, whether or not they actually write down all their attempts.

For example, some family members have mentioned that they would like to try to keep the atmosphere at home a bit lighter and not take everything so seriously. They would like to add more humor to their discussion of problems. Spend some time thinking with them about ways they might be able to practice a particular skill they are interested in.

There is one more skill to learn - *expressing negative feelings about specific behaviors*- which can be difficult for people because it involves negative content. However, this skill sets you up to transition into the problem-solving module.

Remind the family that session 9 will be in two weeks, not one.



Sessions 9-12: Expressing Negative Feelings and Problem Solving

1. Joining
2. Review the homework
3. Provide Rationale for and teach “Expressing negative feelings” skill
4. Begin problem-solving module
5. Assign Homework, answer questions, and plan for the next session

Needed: Handout 19 (Expressing Negative Feelings About Specific Behaviors), and 20 (Expressing Negative Feelings About Specific Behaviors Assignment). Session 9

Start out the session by reviewing the homework on making positive requests for change. Was it hard for people to make clear specific positive requests during the week? This is a skill that takes some thought and some practice. How did it go? Did the requestor get more cooperation when making the effort to phrase things this way?

How did the communication clarity assignment go? Did they do it? Are they starting to get a feeling for what is clear and unclear communication?

This is also a good time to check in with the family about the IP’s prevention action plan. Has there been any opportunity to use it? Have any early warning signs emerged? Do they want to add anything to it? Make sure they are aware that they have a plan in case the IP’s symptoms get worse, and that they now have some communication skills they can use to lessen stress as well.

Introduce Communication Skill #5: Expressing Negative Feelings

In many ways, expressing negative feelings is the most difficult skill to learn because it involves delivering an unpleasant message. Specifically, it is a way to give another family member **constructive criticism** about his or her behavior. Family members need to express their frustration with each other from time to time and may not have a productive forum for sharing this type of feedback. This skill offers family members a useful alternative when positive requests have been ineffective. Highlight that expressing negative feelings is a recommended step taken only as a last resort if other attempts (i.e., positive requests) have failed. But criticism in any form is difficult to accept. Given that it can stir up disagreement, the expressing negative feedback skill is a segue into problem solving.

To proceed with negative requests pass out **Handout 18, “Expressing Negative Feelings about Specific Behaviors,”** and introduce the skill:

“What do you do if you’ve made a positive request for change and you don’t feel that anything has been accomplished? The final communication skill we want to teach you to is ‘expressing negative feelings about specific behaviors.’ It is useful when someone is doing something that bugs you, and you want that person to stop or to do it differently. Our handout shows you one way to do this. When someone is doing something that bothers you, look at the person, say exactly what he or she did that upset you, how it

Handout #20

Expressing Negative Feelings about Specific Behaviors Assignment			
	Person Who Displeased You	What Exactly Did He or She Do That Displeased You?	How Did You Feel (angry, sad, etc.)? What Did You Ask Him or Her to Do in the Future?
Mon			
Tue			
Wed			
Thu			
Fri			
Sat			
Sun			

made you feel, & it from happenin

r she could prevent

As with the other skills, facilitate a role-play with concern that he or she will be the primary target of the role-play so that family members practice as if *of the family*. This is probably more important than with adults, since they may have often felt disapproval from parents. The example of Kevin (inset), a 16-year old with bipolar I disorder, illustrates the initial role-play of this skill.

to alleviate the IP's issues, structure the first role-play with *someone outside the family* as the initial target of

CLINICIAN: Kevin, tell me about something that someone you know, other than your family, does that really bothers you.
 KEVIN: A friend of mine lately has been asking to copy off of my school work and it makes me really pissed off.
 CLINICIAN: So, what do you think you could you say to your friend?
 KEVIN: Nothing, I don't want him to stop wanting to hang out with me.
 CLINICIAN: Well, how do you think he would respond if you said, "(Name of friend), you've been asking to copy some of my work. I know you've been having a hard time with some of the assignments, but I'm working hard to do well and I don't want to get in trouble if we get caught with you copying me. It makes me uncomfortable to say this 'cause you're my friend." What do you think he would say? (*Clinician models skill*);
 KEVIN: It was pretty long, and I think he might get upset, but I don't know. It might work.
 CLINICIAN: Well, you know, those were just my words. Maybe there are better ways to say it. Why don't you pretend I'm your friend and say it the way you'd do it?
 KEVIN (thinking): Um (Name of friend), I am not down with you copying off of me anymore. You're my friend and I want to help you out but I so don't want to get in trouble again. How about we hang out and I can show you how to do some of the stuff for class or something.
 CLINICIAN: That's a really good effort, Kevin. Richard (father), how did you like the way Ben just said that? What else do you think he could say?


Once you feel that family members understand the skill, have them practice with each other once or twice. It is good to make family members aware of this skill but don't spend too much time on it. You want to avoid "throwing gasoline on a fire and igniting old flames" that you have worked hard to extinguish in the previous sessions.

Once each member has had a chance to practice the skill, **provide the family with Handout 20, "Expressing Negative Feelings About Specific Behaviors" Assignment**, Again, ask family members to practice it in the upcoming week (if relevant in their day-to-day lives) and record their efforts on the form.

CONTINUE SESSION 9: PROE
Introduce the module problem s
Identify specific problems for pr
Complete problem solving steps

Solving Problems

- Identify and agree on the problem
- Suggest many possible solutions
- Discuss pros and cons
- Agree on best solutions
- Plan and carry out best solution(s)
- Praise efforts; check out if it worked!



RAINING

Problem solving is one of the most effective methods for working with families (for a review, see Clarkin & Miklowitz, 1997). When problem solving is conducted with adults the focus is on collaboration. However, teens (and sometimes, young adults) do not necessarily have equal say in the decisions that get made in a family. It may be more appropriate for the parent to come up with two or three choices for the patient, and then allow the patient to help decide which choice seems to be the most appropriate. This may be a particularly important adjustment for younger people who sometimes believe that they are the parents' equals if not their parents' superiors. When parents try to assert their authority over their sons/daughters, the kid may feel an intense need to resist because he or she perceives that the parent is trying to dominate him or her.

It may be necessary to build in a reward and/or consequence system to ensure follow-through once a solution has been chosen, but only if it is developmentally appropriate. The rewards for a younger adolescent (e.g., access to a cell phone, computer time) will not be the same as for a later adolescent (use of the car, money, curfew times). Young adults may not be responsive to physical rewards from their parents at all.

The purpose of the problem-solving module is to reduce the family distress and tension that develops in response to life events, including the ups and downs of living with a son/daughter with functional impairment and distressing symptoms. Other objectives are to (1) open up a dialogue in the family about difficult problem topics, (2) allow a forum for expressing reactions to the issues raised and (3) offer patients and family members a framework for solving problems.

The first step is to offer the family a rationale for problem solving.

“Up until now we have been talking about how you communicate or talk with each other. Now we would like to look at some of the things you think are problems and work together to solve them. We are going to teach you a model for working as a team.”

You can provide the family with **Handout 21** entitled **Solving Problems**. The description below is an overview of problem solving.

“We think of problem solving as having several steps. These steps are a little like what we do in our heads automatically, but there are some tricks to doing it as a family that make it go better. First, you need to define the problem, where you try to identify what the problem really is and all agree on it. In this step you’ll use a lot of active listening because different people often have different ideas about what the problem is. The more specific you can be about defining the

problem, the better. Next, you give as many different solutions as you can think of – what we call ‘brainstorming’. Then together you decide what the advantages (or pluses) and disadvantages (or minuses) are. Then you pick one or more solutions that you think will work and decide when and how you will put them into practice.”

Once you have explained the steps in problem solving to the family, help them identify a practice problem. Summarize some of the goals the family stated at the beginning of treatment. Do they feel that each goal has been met or should it be on the agenda for problem solving? Invite the IP and family members to list any additional issues that may be more pressing. For example, the youth may not have thought about school at the beginning of FFT, but may be planning to go back for the next semester and may need help in planning her schedule.

As with communication training, problem solving works best when simple, relatively nonconflictual problems are chosen as illustrations first, saving the more difficult problems for when the parents and IP’s have some mastery over the skill. Initially, you should guide the family to start with more simple problems since even the simplest problem may be the “tip of the iceberg.” A more central, global conflict may be underneath the surface. Of course, use your clinical skills in choosing problems and guiding the family through the problem solving process.

As was true in communication training, your role in problem solving is that of an active facilitator or coach. Guide the family through the problem solving steps, keeping them on task and consistently praising them for their efforts, no matter how small. It is helpful to point out to families the importance of using the communication skills when defining problems or evaluating advantages and disadvantages (e.g., practicing positive requests while generating solutions).

It may be that in the midst of brainstorming it becomes apparent that everyone has not agreed on the definition of the problem. You may need to stop the problem solving briefly to have the family return to active listening so that a clearer understanding of the problem can be achieved. This speaks to the importance of taking the time to clearly and specifically define and agree on the problem. Often individual family members may have different perspectives on how to define it. Thus, defining the problem is a critical first step. You can facilitate the transition back to problem definitions by “owning the mistake.” “Looks like I jumped ahead too quickly in encouraging you to throw out solutions before I fully understood what the problem was. Let’s go back to defining it.”

In every session, draw from the family’s strengths and teach skills that can help to improve symptoms and functioning. Recommend that families try the problem-solving format on their own at home as an exercise between sessions.

The Format of Problem Solving

Working through a specific problem is aided by the introduction of the “**Problem Solving Worksheet**” (**Handout 22a and 22b, two pages**). Whether using the worksheet or easel, help the family go through the problem definition, proposed solutions, advantages and disadvantages, and implementation strategies while recording each step on paper.

Step 1: Define "What is the problem?" Talk. Listen. Ask questions. Get everybody's opinion.

Step 2: List all possible solutions: "Brainstorm." List all ideas, even "bad" ones. Have everyone come up with at least one possible solution. DO NOT EVALUATE ANY SOLUTION AT THIS POINT.

- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____
- (6) _____

Step 3: Discuss and list the advantages and disadvantages of each possible solution.

Advantages (Pros)	Disadvantages (Cons)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Step 5: Plan how to carry out the chosen solutions AND set a date to carry it out. Date: _____

A. Specifically decide who will do what. List.

B. Decide what resources will be needed; list and get them.

C. Think about what can go wrong when you try it, and figure out how to overcome the problems.

D. Practice carrying out the solution.

E. DO IT! (ON TIME)

Step 6: Review the solution and give positive feedback to all family members about their participation.

Step 7: If the plan didn't work, go back to Step 1 and try again. Do not become discouraged.

If you have a problem ready to submit to this method, choose one member of the family as the "secretary." That is, one person writes down what everyone else has said and tries to keep them on task. Usually, this is done by the patient (who may relish his/her role as the one who organizes the family's work on this task). But you can also encourage a parent who hasn't said much, or a quiet sibling, to be the secretary.

As the family becomes familiar with the problem-solving format, encourage them to begin to use this skill at home. Once they have solved a couple of problems in the sessions, ask them to take another small, specific problem and work on it outside of the session. If it seems like the process is not fully within their grasp, ask them to take a specific part of the problem solving process (e.g., brainstorming and evaluating solutions) to work on at home after defining the problem in the session. Encourage the family to implement one problem solving session on their own between sessions, using the Problem Solving Worksheet to record their efforts.

Transitioning from one Problem-Solving Session to the Next

Start off every session by asking how the problem-solving went (or whether they had an opportunity to practice new skills, such as expressing negative feelings). Ask to see any completed communication or problem-solving skill forms.

Recall that you are now meeting biweekly. When switching to biweekly sessions it is important to explain to the family that this is to help them independently implement the skills that have been reviewed during the sessions. What you might find is that many events have occurred between sessions but there has been little effort to utilize the problem-solving skills. Keep stressing to the family that most of the work needs to be done outside of the session during these final phases. The sessions should be seen as "booster sessions" or "tune-ups" regarding using the problem solving skills (and where relevant, the communication enhancement skills) and a chance to help the family get out of intractable conflicts that the members have felt incapable of solving. Try to get through one full problem-solving task, from problem definition to solution implementation, in each of the final sessions. Nonetheless, continue to integrate education, communication skills, and problem solving depending on what the family brings into each session.

Typically the therapist is most central in structuring and directing the problem solving process when introducing it to the family, but it is important to take a less active role over time and to ask family members to lead the family through the various steps of problem-solving, and to make sure they have a well articulated and feasible action plan by the end of the session.

It is not uncommon for a family member to complain that he or she is practicing the skills and trying to implement them into daily life, but others don't seem to be doing so. In sessions 10-12 (if not sooner), check in with family members about how they are doing with implementing stress management, communication, and problem solving skills in their daily lives. If they are struggling with these, it may be helpful to have a problem solving discussion on that topic. How can family members implement the skills they have learned in therapy into their daily lives?

Occasionally there might be a need or request to conduct a problem solving session without the IP present. This is not typical and certainly, most problem solving should be conducted with the whole family present. An example of a problem that might be worked on without the patient could be a discussion of financial problems. In this protocol, you may conduct 1-2 sessions without the IP present, but the IP should agree to this arrangement. The overarching goal of the problem-solving phase of treatment is to teach problem-solving skills that the whole family can utilize. If sessions do not include the IP, it will be difficult for him/her to benefit from the skills practiced in session. Nonetheless, there may be situations in which it makes sense to meet with the parents alone, just as there may be cases in which you will want to meet with the patient alone.

Sessions 11-12: Termination

Review skills learned

Ask family members to reflect on therapy

During the termination sessions, discuss the family's reactions to the therapy. During this session, ask questions of the form, What did you like/not like about the treatment? How was it helpful? How could it have been more helpful? What was your reaction to the education? The communication training? The problem solving? If we were to do the program with you all over again, what would you want to do differently?

You can also communicate your own reaction to working with the family in these final sessions. Underline the progress the IP and family have made (if this is the case) and express optimism about the future. Encourage each member of the family to express their feelings, positive or negative, about treatment ending. Keep in mind that if the patient or one or more family members is "happy we're done," this may be a good thing and indicative of growth.

Discuss the family's transition out of FFT and about their ongoing participation with the research program. In particular, the IP will be interviewed at the end of treatment (i.e., right now), and again at 8 and 12 months to determine his or her symptomatic and social-occupational functioning. Talk with them about treatment options either at your clinic or in the community should they want to continue with some form of therapy.

Explain to the family that they can call you over the next 8 months (if that is the case) and that you can arrange emergency follow-up appointments if needed. Each clinic has

a different structure for follow-up care, so use the structure that works best in your facility.

Good luck in your implementation of FFT!

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Optional Topic 1: School Accommodations

If the youth has a history of academic difficulties or learning disability. Or, the striking social and emotional or psychotic symptoms that are exacerbated by school. The importance of making changes in the school context. There are many services the youth can obtain through the school. Many changes that can be made within each classroom to help the youth functioning.

Handout #4c

How Can the School Help?

What can be expected from the school:

- Under the Individuals with Disabilities Act (IDEA: 1975), schools are responsible for identifying and evaluating students with disabilities who require special education and services and following through and providing them with an Individualized Education Program (IEP).
- These services are to be provided in the least restrictive environment appropriate to the child's needs and that children should be integrated with other children with and without disabilities, and still receive special services (inclusion).

Ways in which the school is helping thus far:

-
-
-

Ways in which the school could be more helpful:

-
-
-

Whether he has a learning disability or perhaps nearly any other point to the fact that you do not know that the current school system, and the youth's

The optional handout entitled “How the School Can Help”

is very useful in educating families about what they can expect from the schools in general terms (for example, the right to learn within the least restrictive environment; the notion that school accommodations can serve to create a less stressful environment for the youth). This form is a useful tool for helping the therapist to focus family discussion on what is working well in the school environment and what may not be working well and require intervention.

Ask all members of the family to participate in the discussion with the eventual goal of generating a list of issues and a plan for addressing those issues with the school. Ideally, the family should be supported in taking responsibility for setting up meetings with teachers, and/or the school counselor and/or the school psychologist. It is important that the family has control over the amount of information they feel comfortable sharing with the school. They may want to talk about the best way to phrase requests and about how much information is necessary to share within the school context to get the services that they need. Also, communicating with school officials is an ideal time for the parents to practice their communication skills!

Optional Topic 2: Relaxation Training

The goal in this lesson is to teach the IP and his/her family a behavioral technique that they can use to reduce anxiety in a variety of situations. We tend to use an abbreviated form of the “relaxation via tension-relaxation” technique described in Goldfried, M. R. and Davison, G. C. (1976) in their book entitled *Clinical Behavior Therapy* on pages 88 – 89. Family members are told that after some practice, this is a technique that they can use inconspicuously in class, at work, or when out with friends. Usually we introduce the technique and help them to tense and relax several muscle groups, but do not go through all of the muscle groups described in the text.

For example, we instruct family members to sit back and relax and to close their eyes if they feel comfortable doing so. We then read the following from the Goldfried and Davison text:

“Direct your attention to your left hand. I’d like you to make a fist with your left hand and to squeeze that fist tightly. Study the tension in your left hand and arm (5 second pause). Now relax the left hand and let it rest. Notice the difference between the tension and the relaxation (5 second pause). Now squeeze your left hand into a fist again, tightly, and notice the tensions in your hand and arm. Study those tensions (5

second pause), and now let go. Let your fingers spread out and relax. Notice the difference between tension and relaxation.

Now let's do the same thing with the right hand. Repeat the steps above with the right hand. Then invite the family to take note of the difference once again between the tension and the relaxation and enjoy the contrast.

Now clench both your hands into fists and bring them towards your shoulders. Feel the tension in your arm and shoulder muscles (pause 5 seconds). Now relax. Let your arms drop down to your sides, and notice the difference between the tension that was in your arms and the relative relaxation that you feel now (5 second pause). Let's do that once again now. Clench both hands and bring them up toward your shoulders, trying to touch your shoulders with your fists. Study that tension. Hold it. Study it. And now relax. Once again, let the arms drop and study the feelings of relaxation, the contrast between tension and relaxation. Just keep letting go of those muscles further and further (5 second pause).

Now we can direct our attention to the shoulder area. Shrug your shoulders, bringing both shoulders up toward your ears, as if you wanted to touch your ears with your shoulders. And note the tension in your shoulders and up in your neck. Study that tension. Hold it. And now relax. Let both shoulders return to a resting position. Just keep letting go further and further. Once again, note the contrast between the tension and the relaxation that's now spreading into your shoulder areas (5 second pause). Do that once again. Bring both shoulders up as if to touch the ears. Feel the tension in the shoulders, in the upper back, in the neck. Study the tension in these muscles. And now relax. Loosen those muscles. Let your shoulders come down to a resting position, and study the contrast once again between the tension and the relaxation (5 seconds)."

After this introduction, the IP may be better able to "tune in" to his/her body and describe what muscles they tend to clench when stressed. Then, those particular muscle groups can be targeted in further work. For example, if one adolescent says that he/she tends to furrow his/her brow, the family can practice wrinkling up their foreheads, creating tension in their foreheads, and then relaxing their foreheads. The therapist should continue tailoring the relaxation exercise to the habits/tendencies of the participants.

If some family members have difficulty falling asleep at night, they could try this muscle tension/relaxation technique, starting with the top of their head and working their way down to their toes, briefly tensing and relaxing all of the various muscle groups in their face, neck, shoulders, arms, stomach, back, legs, and feet. This type of focused relaxation may help them to calm their bodies and minds down enough to fall asleep.

Relaxation techniques may be particularly useful for people who experience distressing positive symptoms, such as perceptual abnormalities or paranoia. Relaxation techniques may help them to refocus their attention.

Optional Topic 3: Social Skills Enhancement

It is useful to start out this section by checking in with the youth and asking about his/her level of social functioning. You can say something like the following:

Clinician: “Sara, I know in the first session you mentioned that you have not been spending much time with friends because you ‘haven’t felt like it.’ What’s it like for you when you are around your peers at school?”

Sara: “I don’t know. I guess I’ve noticed that this whole school year I’ve just felt kind of awkward around people, like I don’t know what to say. I get nervous and worry that people are going to make fun of me. I usually just spend time by myself when I’m at school.”

Clinician: “I’ve talked with many young adults) in our program who have said the same thing; they don’t know what to say to people and they feel nervous in social situations. Oftentimes this can be a stressful experience since so much of our day-to-day lives take place in social situations. Sara, if you are interested, I think it could be useful to talk some more about this.”

Sara: “Okay, that’s fine with me.”

Typically, it is difficult to figure out whether the patients we see in our program are experiencing social functioning impairments because they lack social skills, suffer from depression or negative symptoms, have some mild paranoia, have social anxiety and related social avoidance, or have co-morbid Asperger’s or Pervasive Developmental Disorder NOS. Despite the difficulty discerning what factors are influencing the youth’s social impairment, it is a good idea to introduce the potential relationship between symptoms and social functioning. For instance, you can explain that positive symptoms, such as suspiciousness and/or odd beliefs, can cause the patient to be ostracized or feel worried about taking social risks (e.g. meeting new people, initiating social contact, entering into a conversation, etc.). Ideally, it is best to tailor this discussion to the family you are working with. You can highlight the particular symptoms that you believe could be impacting the youth’s functioning. Below is an example of how you might initiate this conversation,

Clinician: “Many of the people we see in our program talk about having a hard time socially. Sometimes symptoms such as anxiety, depression, or feeling suspicious can make it difficult to be in social situations. Jonathan, have you noticed a change in your level of interest in being social?”

Jonathan: Well I don’t like to be around lots of people. It makes me nervous.

Clinician: Do you know what it is about being around people that makes you nervous?

Jonathan: I guess I think that people are talking about me. I know that sounds stupid since they probably aren’t, but I still worry about it.

Clinician: I don’t think that sounds stupid. It is actually really common for many of the young people we see in our program to have suspicious thoughts and to feel nervous around people. If you could learn

strategies to make yourself feel more comfortable in social situation, do you think you would be more interested in being around people?

Jonathan: Yes, but it's hard to imagine not feeling nervous.

Clinician: Well perhaps we can spend some time talking about what kinds of goals you have in regards to being social. For instance, do you want to learn strategies to identify people that might be kind and supportive friends? Or would you like to brush up on some conversation starting skills? I bet your parents might have some ideas too.

Identifying Goals for Enhancing Social Skills

At this point in the session many concerns about social functioning might have already been brought up. You should draw from some of those concerns and facilitate a discussion aimed at defining the specific goals you plan to work on during the session. Examples could include,

1. I want to meet some new people.
2. I want to learn how to start a conversation with a new person.
3. I want to feel more comfortable in social situations.

You should write down some of the goals on a piece of paper with 2 columns (1 for goals and the other for social skills strategies). If the IP is having trouble generating ideas for particular goals you can offer up some of the above examples as common goals that individuals like to work on.

Develop and Practice Social Skills

Once you have listed about 3-4 goals you can work with the family to generate ideas to help develop social skills and coping strategies. It is a good idea to work through each goal one at a time.

Here is an example of working on the goal of learning how to initiate a conversation with a new person: Turn to the parent and ask,

“_____ (mother's name), how do you typically start a conversation with someone new?”

Write down some of her ideas. You can ask for more ideas from other family members. Be sure to create an idea-friendly atmosphere by not being too quick to criticize the suggestions. You can also add some ideas of your own once the family members have listed a number of suggestions.

Once you have listed a few strategies, it is a good idea to role-play some of them. It is normal for individuals to feel awkward and/or feel resistant to role-playing at first. Try turning to the IP and ask if he/she would be willing to practice some of the strategies with you. If he/she seems uncomfortable you can have one of the parents role-play the strategy with you first. Once a strategy has been practiced, you can encourage the patient to try it out with the person of their choice in the room.

If a goal is not conducive to role-playing that is fine. An example of a goal that might not warrant a role-play, at least initially, is if the IP stated that she wants to meet new people but she does not know how to go about finding someone to talk to. A good strategy for tackling this goal is to encourage the IP to identify her interests (music, videogames, skateboarding, etc). Next you can ask for ideas about where to find someone who shares those interests (e.g. music store, school club, skate park, etc). Once you have generated some ideas about where to find potential friends, you can ask the IP if he/she knows how to initiate a conversation with someone new. If he/she is uncertain about how to do that, then you can move on to a role play exercise.