dZ vš Œ (}Œ }µv• o]vP
W}o] ÇU v Z • Œ Z
}µv• o]vPX}ŒPl‰Œ Ÿ z Œ](• n
American Counseling Association Practice Briefs

December 2016

Counseling Youth Who Have Bipolar Disorders

Victoria E. Kress, Walden University and Youngstown State University
Stephane Sedall, Youngstown State University
Matthew Paylo, Youngstown State University

DESCRIPTION OF BIPOLAR DISORDERS

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

The bipolar disorders are characterized by dramatic shifts in mood, activity, and energy levels which affect day-to-day activities (NIMH, 2015). Bipolar I is characterized by one or more manic episodes: intense, severe shifts in energy and activity levels that require immediate care. Depressive episodes may also be present with a bipolar I diagnosis and these must have persisted for at least 2 weeks. Bipolar II is characterized by a pattern of depressive and hypomanic episodes, where less severe shifts of mood and activity levels are present especially with regard to hypomanic f Cyclothymia is characterized by patterns of hypomanic and depressive symptoms, but the individu

Resources:

American Psychiatric Association. (2013). *D* (5th ed.). Washington, DC: Author.

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

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

The National Institute of Mental Health (NIMH). (2009). *B : N* . Retrieved from: http://www.nimh.nih.gov/research-priorities/scienti c-meetings/2009/bipolar-disorder-in-children-and-adolescents-new-data-to-inform-classi cation/index.shtml

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

IDENTIFICATION/ASSESSMENT STRATEGIES

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

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

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

Youth Mania Rating Scale

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

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

The CMRS-P will assess the child's mood and behavior symptoms over the past month, as reported by the parent or teacher. Each response is given a point value ranging from 0-3 (i.e., never/rarely-sometimes often-often-very often). It is appropriate for children between the ages of 8-18

}µv• o]vP z}µšZ tZ} , À]‰}o Œ]•}Œ Œ n ð

}µv• o]vP z}µšZ tZ} , À]‰}o Œ]•}Œ Œ n ñ

Resources:

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

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

Family-Focused Treatment

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

Resources:

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

REFERENCES

American Psychiatric Association. (2013). *D* (5th ed.). Washington, DC: Author.
Bernstein, B. E. (2015). *P & : P* . Retrieved from: http://emedicine.medscape.com/article/913464-treatment#d8
Frank, E., Swartz, H. A., & Kupfer, E. (2000). Interpersonal and social rhythm therapy: Managing the chaos of bipolar disorder. *B P , 48,* 593-604. doi:10.1016/S0006-3223(00)00969-0
Fristad, M. A., Verducci, J. S., Walters, K., & Young, M. E. (2009). Impact of multifamily psychoeducational psycho-

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