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Psychosocial Intervention for Pediatric Bipolar Disorder (PBD): Current and Future Directions

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Summary

Pediatric bipolar disorder (PBD) affects approximately two percent of the population and disrupts mood regulation, psychosocial functioning, and quality of life among affected youth and families. Given the significant psychosocial impairment and poor long-term prognosis associated with PBD, psychosocial intervention is considered to be an essential component of a multi-modal treatment approach. This relatively young field of research has witnessed significant growth in the evidence base for psychosocial treatments targeting youth in the past decade, particularly family-based interventions grounded in a biopsychosocial framework. This article reviews existing empirically-supported interventions for children and adolescents with PBD. Common elements of successful interventions are identified, and future research directions to address current limitations in the field and advance understanding of treatment for PBD are discussed.

Keywords

pediatric bipolar disorder; mood disorders; psychosocial intervention; cognitive-behavioral therapy; family-based treatment

Introduction

Pediatric bipolar disorder (PBD) is a chronic and debilitating illness that affects one to two percent of the population [1,2]. PBD is characterized by periods of episodic mood disturbance (e.g., fluctuating extreme irritability/rage or elevated/expansive mood, and depression) and accompanying symptoms including decreased need for sleep, grandiosity, hypersexual behavior, increased goal directed behavior, poor judgment, impulsivity, pressured speech, and racing thoughts. These symptoms are associated with pronounced impairments across the domains of social, academic, and family functioning [3,4] and devastating long-term consequences for affected youth, including high rates of repeated hospitalizations and suicide attempts [5].

The unique symptoms of PBD are associated with significant psychosocial impairment in several domains across development. Academically, children and adolescents with PBD demonstrate neurocognitive deficits and academic underperformance [6,7], as well as

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disruptive school behavior [8]. Social functioning is marked by limited peer networks, peer victimization, and poor social skills [9-11]. In addition, families of PBD youth experience frequent sibling and parental conflict [11,12], lower levels of warmth, family adaptability and cohesion [13-15], and chronic stress in the context of family life [16]. Difficulties also extend to the intrapersonal sphere, as youth with PBD exhibit low self-esteem, hopelessness, external locus of control, and maladaptive coping strategies [17,15].

The multitude of psychosocial impairments and morbid consequences associated with PBD has led to consensus that high-quality, evidence-based psychosocial treatment is essential to improve the prognosis and course of the disorder [18]. Indeed, although pharmacotherapy is considered the front-line treatment for PBD, findings indicating negative side effect profiles and high rates of non-response to medication [19-21] underscore the need for adjunctive psychosocial treatment. Moreover, pharmacotherapy primarily targets symptom improvement but often does not address the associated social, academic, and family difficulties that compromise quality of life and long-term outcomes. Thus, adjunctive psychosocial treatment has been indicated as a critical component of optimally effective treatment for PBD [18].

This article provides an overview of evidence-based psychosocial interventions designed for adjunctive use with pharmacotherapy to target PBD. Whereas research in the area has made significant advances in the past decade, randomized controlled trials of psychosocial interventions for the pediatric population are still quite limited. We provide a review of the state of the field at this time, focusing specifically on psychosocial treatment models that have been developed for children and adolescents with bipolar spectrum disorders and have evidence from randomized clinical trials or open trials to support their efficacy. Following guidelines provided by the Task Force on the Promotion and Dissemination of Psychological Procedures [22-25], we present the treatments by level of current evidence, including those with support in randomized clinical trials (RCTs) as well as interventions with non-RCT support. In addition, a summary of the specific treatment methods, targets, and evidence supporting each intervention is provided in Table 1.

Interventions with Support in Randomized Clinical Trials

Family-Focused Treatment for Adolescents (FFT-A)

Originally developed for adults with bipolar disorder, Family-Focused Treatment (FFT) has been adapted for adolescents with bipolar disorder and evaluated in several studies by Miklowitz and colleagues [26-28]. FFT-A is designed for youth ages 12 to 17 with bipolar disorder and involves 21 sessions of varying frequency delivered to youth, siblings, and parents over a 9-month period (12 weekly sessions, 6 bi-weekly sessions, and 3 monthly sessions). Recognizing the central role of the family in managing a youth's bipolar disorder, as well as the criticism, expressed emotion, and conflict that characterize families affected by PBD, the goals of this family-based treatment are to improve illness course and outcomes by enhancing the family's understanding of ways to cope with the disorder while also improving family functioning [26]. This is accomplished through three main components: (1) Psychoeducation, which focuses on improving understanding of PBD symptoms, self-

management, medication adherence, triggers of mood episodes, and relapse prevention; (2) Communication Enhancement Training; and (3) Problem-solving Skills Training.

The efficacy of FFT-A as an adjunct to pharmacotherapy has been established in a two-site randomized controlled trial with 58 adolescents (12-17) with bipolar spectrum disorders and their families [28]. All participants received pharmacotherapy and were randomized to receive either FFT-A or “Enhanced Care” (3 weekly family sessions focused on psychoeducation and relapse prevention). Results indicated that those who participated in FFT-A had improved speed and quality of recovery, including shorter time to recovery from depression, less time in depressive episodes, and lower depression severity scores over the two year study period as compared to those in the control condition. Interestingly, youth in families with higher expressed emotion (i.e., characterized by high criticism, hostility, or overinvolvement) showed more favorable responses as compared to families with lower expressed emotion, suggesting FFT-A is particularly suited for high-conflict families [29].

Recently, FFT-A was adapted for children and adolescents at high risk for developing bipolar disorder (FFT-HR), defined as having a lifetime diagnosis of Major Depressive Disorder, Bipolar Disorder, Not Otherwise Specified (NOS), or cyclothymic disorder; current affective symptoms (mania or depression); and a first degree relative with bipolar disorder type I or II [30,31]. FFT-HR is a 12-session modified version of FFT delivered over 4 months to youth ages 9-17 and their families, with goals to help the family identify and intervene early on symptoms of mood episodes as well as improve family communication and problem-solving. In addition to modifications for at-risk youth, the content of FFT-HR was adapted for school-aged children. A randomized trial of FFT-HR in combination with pharmacotherapy (N=40 youth) as compared to an education control (1-2 family psychoeducation sessions) showed more rapid recovery from initial mood symptoms, more weeks in symptom remission, and greater improvement in hypomania symptoms across the one-year study period among those in FFT-HR [31]. Findings thus support the use of FFT-HR as promising early intervention for youth at risk for PBD.

Multi-/Individual-Family Psychoeducational Psychotherapy (MF/IF-PEP)

Fristad and colleagues have developed and evaluated group- and individual-formats of a manualized, psychoeducation-based psychotherapy intervention (PEP) for school-aged children [32-37]. In contrast to FFT, this approach is designed for children with bipolar or depression spectrum disorders and their families as an adjunct to other psychosocial treatment in addition to pharmacotherapy. Youth with all mood spectrum disorders are included to enhance early detection and intervention of pediatric bipolar disorder, given the evidence that a substantial portion of youth with pre-adolescent onset depression will eventually develop bipolar disorder [34]. PEP combines psychoeducation, family systems, and cognitive behavioral techniques to target mood symptoms and associated psychosocial impairment, centered on the following goals: educating parents and children about mood disorders and their treatment, including how to advocate for mental health care and school services for their child; enhancing family support through interactions with other families in the group as well as service providers; and building skills in mood symptoms management, affect regulation, problem-solving, and communication. The treatment was originally

developed as an 8-session multi-family psychoeducation psychotherapy group (MF-PEP) for children and parents, and has subsequently been adapted as a 24-session individual family format (IF-PEP) to enhance accessibility and attractiveness to families [34]. Sessions are primarily conducted separately with parents and children in both the individual and group formats of PEP, with joint family portions also included in MF-PEP.

Two randomized clinical trials have examined the efficacy of MF-PEP. An initial randomized clinical trial with 35 children aged 8-11 with depression and bipolar spectrum disorders and their families examined the efficacy of a 6-session MF-PEP plus treatment as usual (n=18) compared to a wait-list control condition plus treatment as usual (n=17) [32]. At the six-month follow-up, families receiving MF-PEP demonstrated improvements in knowledge about mood symptoms, family functioning, perceptions of parental and peer support, and greater utilization of services as compared to those in the wait-list control. However, changes in child mood symptom severity post-treatment were not significant. A larger randomized clinical trial with 165 children aged 8-12 with depression and bipolar spectrum disorders and their families examined MF-PEP plus treatment as usual (n=78) compared to a wait-list control condition plus treatment as usual (n=87) [33]. MF-PEP demonstrated efficacy in reducing mood symptoms as compared with the wait-list control over a one-year follow-up. In addition, MF-PEP resulted in improved quality of services utilized, mediated by parents' beliefs about treatment. Quality of services was also found to mediate treatment effects, suggesting that MF-PEP helps parents access higher quality services for their children, which in turn may improve symptoms. However, parental psychopathology was associated with worse response to MF-PEP, indicating that parent characteristics may adversely affect treatment outcomes [36]. The individual format (IF-PEP) has also been examined in a small randomized controlled trial with 20 children aged 8-11 and their families [36]. Results indicated significant improvement in mood symptoms and family climate in IF-PEP as compared to the wait-list control condition at post-treatment, with mood effects maintained at a one-year follow-up.

Recently, a small open trial examined the dissemination of MF-PEP beyond the academic medical center to real-world settings [37]. This trial provided preliminary descriptive implementation outcomes, indicating that MF-PEP was acceptable, feasible, sustainable, and had manageable costs in these setting; moreover, findings indicated significant improvement in parental knowledge of mood disorders post-treatment. Such promising results suggest that specialized psychosocial interventions for PBD may be transportable and effective in real-world settings.

Child- and Family-Focused Cognitive-Behavioral Treatment: The RAINBOW Program

Child- and Family-Focused Cognitive Behavioral Treatment (CFF-CBT) is a family-based adjunctive psychosocial intervention developed by our research group for children ages 7-13 with bipolar spectrum disorders and their families [38-41]. CFF-CBT integrates psychoeducation and cognitive-behavioral therapy (CBT) with complementary techniques from mindfulness-based intervention, positive psychology, and interpersonal therapy to augment the traditional CBT framework and address the range of therapeutic needs of families affected by PBD. The CFF-CBT treatment model is grounded in the neuroscience and

psychosocial literatures, specifically: (1) research documenting dysfunction in the neural systems responsible for processing and modulating emotions in PBD, including poor problem-solving during affective stimulation driven by overactivity in the limbic system in concert with underactivity in dorsolateral prefrontal cortex [42]; (2) developmentally-specific symptoms of PBD in school-age children (e.g. rapid cycling, mixed mood states, comorbid disorders); and (3) the impact of PBD on psychosocial functioning (e.g. poor social functioning, family stress). As such, the treatment components aim to address these impairments in affective circuitry and interpersonal functioning through techniques employed with the child and family along with intensive individual work with parents.

The CFF-CBT format is a 12-session protocol-driven treatment program, alternating between child, parent, and family-focused sessions. CFF-CBT has also been adapted to a 12-week group format that consists of weekly 60-minute parallel parent and child groups and a 15-minute multi-family child/parent combined component. In both formats, treatment is structured around seven core components that comprise the acronym “RAINBOW:”

Routine: establishing predictable and simplified routines; *Affect Regulation:* psychoeducation about affective circuitry dysfunction; monitoring moods and developing cognitive and behavioral coping skills to manage triggers of mood episodes; and learning behavioral management techniques specific to PBD; *I Can Do It:* enhancing self-esteem and self-efficacy in the child and family; *No Negative Thoughts and Live in the Now:* learning cognitive restructuring and mindfulness techniques to decrease negative and distorted cognitions; *Be a Good Friend and Balanced Lifestyle for Parents:* promoting child social skills and enhancing balance and self-care in parents; and *Ways to Get Support:* accessing support in the family, school, and community [41].

Findings from a preliminary open trial of CFF-CBT [38], conducted with 34 youth and families (mean age = 11.33 years, SD=3.06), demonstrated feasibility, consumer satisfaction, and promising outcomes. Youth experienced significant reductions in symptoms of attention problems, aggression, mania, psychosis, depression, and sleep disturbance, and increased global functioning after the intervention. Subsequently, a maintenance model of CFF-CBT, comprised of psychosocial booster sessions and pharmacotherapy, was examined with the 34 patients from the initial trial [39]. Results indicated that the initial positive effects of treatment were maintained over a three-year follow-up period with continued booster treatment. These findings suggest that maintenance models may facilitate long-term symptoms management and potentially reduce the high relapse rates associated with PBD. The adaptation of CFF-CBT to a parent/child group format was also examined in an open trial with 26 families (mean age=9.45, SD=1.93). Results indicated that the group adaptation was feasible to deliver and resulted in significant improvement in mania symptoms, child coping skills, parenting stress, and parent knowledge and self-efficacy in coping with PBD across treatment [40].

A randomized controlled clinical trial of CFF-CBT is currently underway to examine the efficacy of CFF-CBT in the individual/family format compared to psychosocial treatment as usual (TAU) in children 7-13 with bipolar spectrum disorders (N=60). Treatment is delivered across a 9-month period, with the core RAINBOW sessions delivered weekly for 12 weeks followed by 6 monthly booster sessions; families in the TAU control condition

receive an identical treatment dose. Preliminary results suggest that CFF-CBT results in significantly greater improvements in symptoms of mania and depression as compared to the control TAU [43].

Interventions with Support in Non-Randomized Trials

Dialectical Behavior Therapy (DBT) for Adolescents

Goldstein and colleagues [44] developed an intervention specific to adolescents with bipolar disorder based on an adaptation of Dialectical Behavior Therapy (DBT) for adolescents. DBT [45] is an evidenced-based intervention with demonstrated efficacy for adults with borderline personality disorder [46], and has been adapted for adolescents with suicidality [47]. A primary focus of DBT is emotional dysregulation and, given the extreme emotional dysregulation experienced by youth with PBD [48,49], DBT has been applied to the treatment of adolescents with PBD to improve this feature of the disorder. The intervention protocol is based on the manual for suicidal adolescents [50] with illness-specific adaptations designed for the unique needs of the bipolar population. Treatment involves 36 total sessions delivered over the course of one year, and is comprised of two modalities: (1) family skills training, delivered to the entire family, which focuses on psychoeducation and development of skills of mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness; and (2) individual psychotherapy for the youth, which focuses on the application of skills to manage target problem behaviors and mood states in their daily lives. Across the year, youth are also provided access to their clinician by pager for in vivo skills coaching. Thus, although sharing a strong family-based component, DBT for adolescents with bipolar disorder differs from FFT-A in the specific focus on mood regulation and suicidality through mindfulness and distress tolerance skill-building.

A small, preliminary open trial of DBT for bipolar adolescents has been conducted with 10 youth aged 14 to 18. Findings demonstrated significant decreases in suicidality, non-suicidal self-injurious behavior, emotional dysregulation, and depression symptoms after the one-year intervention. Albeit promising, future studies aim to establish treatment efficacy in a larger controlled trial [44].

Interpersonal and Social Rhythm Therapy for Adolescents (IPSRT-A)

Grounded in biopsychosocial theory, Interpersonal and Social Rhythm Therapy (IPSRT) is an empirically-supported adjunctive psychotherapy for adults with bipolar disorder [51,52] that has been adapted for adolescents with bipolar disorder (IPSRT-A) [53]. In contrast to other adolescent-focused interventions for PBD, IPSRT specifically targets a biological diathesis for bipolar disorder – instability in circadian rhythms and neurotransmitter systems involved in regulation – as well as the social routines that affect circadian systems [51].

IPSRT-A is a 16 to 18 session individual-based treatment that incorporates brief family psychotherapy. Intervention components focus on stabilizing social and sleep routines, and also address psychosocial stressors that may precipitate or exacerbate routine disruption and mood dysregulation through an interpersonal-based approach. This may include interpersonal conflict, role transitions, and interpersonal functioning deficits [53]. IPSRT-A has been examined in a small open trial with 12 adolescents aged 12 to 18 with bipolar

spectrum disorders across a 20-week period. Results revealed significant improvement in mania, depression, and general psychiatric symptoms as well as global psychosocial functioning, with medium to large effect sizes, from pre- to post-treatment. Promising findings warrant replication in a larger controlled study to establish treatment efficacy; to this end, a randomized controlled trial is underway although findings have not yet been published [54].

Cognitive Behavioral Therapy (CBT) for Bipolar Disorders in Adolescents

A manualized, adjunctive cognitive-behavioral treatment has also been developed for adolescents with bipolar disorder [55,56]. This intervention employs a traditional CBT framework, incorporating principles from the CBT literature for adolescents with depression [i.e., 57] but targeted for difficulties specific to adolescents with bipolar disorder.

Intervention modules focus on psychoeducation, medication compliance, mood monitoring, modifying negative thinking, sleep regulation, and family communication, with optional modules offered for problems commonly observed in this population (substance abuse, social skills, anger management, and contingency management). The treatment is delivered across 12 sessions primarily targeting individual work with the adolescent, with the entire family unit included in two sessions and one session devoted to parents.

A pilot study examined CBT as an adjunct to pharmacotherapy for adolescents aged 10-17 with bipolar spectrum disorders (n=8) as compared to eight matched historical controls (youth who had received pharmacotherapy only) [56]. Results demonstrated feasibility and significant improvement in parent-report of manic and depressive symptoms in the CBT condition; however, data on matched controls were not available for comparison. Youth in CBT did not differ from controls on interviewer-assessed symptoms of depression and mania, although the authors note that findings revealed moderate to large effect sizes with statistical significance likely limited by the small sample sizes.

Expert Commentary

Despite the recognized importance of psychosocial intervention for PBD, relatively limited work has evaluated the efficacy of interventions in randomized controlled studies. However, the field is growing; a comparison of the current state of the field – two interventions with established efficacy in controlled trials [28, 31, 33], and four interventions with preliminary efficacy, many of which have controlled trials currently underway [43,44,54, 56] (see Table 1) – versus five years ago (e.g., [58]) shows remarkable advances in the evidence base for interventions that improve symptom and functional outcomes in PBD. Although each model described has a unique focus and theoretical approach, be it on family functioning [27], skill development [34, 55], mood instability [44], biological rhythms [53], or combination of these factors [41], perhaps more striking are the common elements that emerge across successful interventions. In particular, existing treatments are similar in their adjunctive approach; the incorporation of psychoeducation about the nature and symptoms of PBD; the intensive involvement of the family; and a focus on developing cognitive, behavioral, and/or mindfulness skills for coping with mood dysregulation and interpersonal functioning. In addition, each treatment is grounded in a comprehensive theoretical model that emphasizes

the influences of biological and psychosocial vulnerability factors in the onset and maintenance of the illness.

Such similarity across approaches begs the question of how practitioners may select among relevant evidence-based treatments for a particular child or adolescent with PBD. Currently, research suggests that treatments may not be equally efficacious for all consumers; rather, findings point to the presence of child and family factors that predict or moderate treatment outcomes and thus may be factored into treatment selection (i.e., [29, 36]). How the identification of such factors at treatment entry may guide intervention selection is a promising question to be explored in future research.

Five-year View

The next five years will likely yield the emergence of more rigorous and nuanced evaluation of psychosocial intervention for PBD to meet the diverse needs of this complex population. First and foremost, the completion of ongoing clinical trials examining DBT, CFF-CBT, and IPSRT-A will add to the evidence base for empirically-supported treatments for PBD. Yet beyond simply examining treatment outcomes, the National Institute of Mental Health (NIMH) [59] has called for a shift in the focus of clinical studies to the development of personalized therapeutic approaches that will dictate research priorities; i.e., determining what treatment is ideally suited for a particular patient given a set of characteristics at treatment entry. To this end, the next generation of RCTs will explore how various individual and contextual characteristics (e.g., symptom severity, family functioning, neurocognitive functioning) may influence treatment outcome to address questions of what works, for whom, and under what conditions. Personalized treatment approaches are particularly relevant in PBD: as noted, parent and family characteristics have been shown to influence treatment outcome in PBD [36,29]; moreover, nearly every trial of psychosocial treatment for pediatric bipolar disorder (PBD) has observed variability in patient outcomes, particularly in residual symptoms of mania, depression, and irritability [3]. As the field evolves, future research will aim to identify symptom, psychosocial, and neurocognitive moderators and predictors of intervention response to inform the development of personalized approaches to meet the individual needs of youth and families presenting for treatment. Such data is critical for guiding the selection of optimal evidence-based treatment for a particular patient as well as for improving treatment outcomes in the population.

In addition, advanced understanding of the neural substrates of PBD symptoms (e.g., [42,60,61]) has propelled the integration of imaging methods (e.g., fMRI) and intervention research to explore how treatment outcomes may be mediated by changes at the brain-level. Beyond the examination of symptom and behavioral change, such research is needed to elucidate the neurobiological outcomes of treatment; that is, how do interventions influence the brain networks involved in the core deficits in affect dysregulation and executive function in PBD? Such questions are being addressed within the realm of pharmacologic intervention [61,62] and the examination of neural response to psychosocial interventions (e.g., CFF-CBT) is forthcoming. Ultimately, findings hold enormous promise for refining and tailoring interventions to specifically target the neurobiological dysfunction inherent in PBD, thus fundamentally altering the course of illness.

Last, the next five years will see the expansion of research into the areas of prevention of bipolar disorder and related outcomes. Research progress in our knowledge of phenotypes and biomarkers indicating risk for the onset of bipolar disorder [19] has paved the way for the development of preventive interventions in PBD. For example, Miklowitz and colleagues [30,31] recently adapted FFT-A to target the prevention of bipolar disorder in youth with high-risk phenotypes for PBD. As our understanding of early indicators of illness risk continues to develop, further research in the area of prevention and early intervention approaches can be expected. Prevention research focused on suicide is also a critical area of need in the field. Suicidality in PBD is an extreme, yet largely unaddressed, problem: PBD has the highest risk for, and mortality from, suicide of all childhood disorders, with rates of ideation and attempts ranging from 20% to 55% [63]. Such rates, coupled with mixed evidence on the effectiveness of medication for managing suicidality [64], underscores the need for psychosocial research focused on suicidality in PBD. Yet the literature on psychosocial interventions for suicidality in PBD is extremely limited. Increasingly, attention has focused on psychosocial interventions that target suicidality among adolescents with bipolar disorder, with promising preliminary findings (e.g., [44]). The development of prevention interventions for pre-adolescent youth, who evidence similarly high rates of suicidal ideation to adolescents despite their young age [43], is needed to address suicidality early on in the continuum of morbidity – before youth progress to more significant suicidal behavior. Together, research in these emerging areas of treatment moderators and outcomes, prevention, and suicide-focused interventions will significantly advance the field towards improving the lives and outcomes of children and families affected by bipolar disorder.

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Key Issues

- Pediatric bipolar disorder (PBD) is characterized by periods of episodic mood disturbance (e.g., fluctuating extreme irritability/rage or elevated/expansive mood, and depression) and devastating long-term consequences including high rates of repeated hospitalizations, poor quality of life, and suicide attempts.
- The multitude of psychosocial impairments and morbid consequences associated with PBD, along with limited efficacy of medication to address broad domains of functioning, has led to consensus that psychosocial treatment is an essential component of treatment for PBD.
- Several promising adjunctive psychosocial interventions have been developed for children and adolescents with PBD and demonstrate efficacy in open trials: Child- and Family-Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy for Adolescents, Interpersonal and Social Rhythm Therapy for Adolescents, and Cognitive Behavioral Therapy for Bipolar Disorders in Adolescents.
- Two interventions for PBD have demonstrated efficacy in controlled studies: Multi-Family Psychoeducation Group Psychotherapy and Family-Focused Treatment for Adolescents.
- Effective interventions share common elements including an adjunctive approach; the incorporation of psychoeducation about the nature and symptoms of PBD; the intensive involvement of the family; and a focus on developing skills for coping with mood dysregulation and interpersonal functioning.
- Future research is needed to examine moderators of treatment response, early intervention approaches for youth at-risk for PBD, and suicide prevention interventions in PBD to meet the diverse needs of this complex population.

Table 1
Empirically Supported Psychosocial Interventions for Pediatric Bipolar Disorder

<u>Intervention</u>	<u>Target</u>	<u>Format</u>	<u>Treatment Length</u>	<u>Core Elements</u>	<u>Empirical Support</u>	<u>Key References</u>
FFT-A, FFT-HR	Adolescent, Family; High-risk youth	Individual	21 sessions; 12 sessions (HR)	Psychoeducation, Communication, Problem-Solving	2-site RCT (FFT-A); small RCT (FFT-HR)	26-31
MF-PEP, IF-PEP	Child, Parents, Family (MF-PEP)	Group or Individual	Group: 8 sessions; Individual: 24 sessions	Psychoeducation with CBT-based skill-building	2 RCTs (MF-PEP); small RCT (IF-PEP)	32-37
CFF-CBT	Child, Parents, Family	Individual or Group	12 sessions + 6 booster	CBT with psychoeducation, mindfulness, social skill development, family communication and problem-solving	3 open trials; RCT with preliminary findings	38-41, 43
DBT-A	Adolescent, Family	Individual	36 sessions	Mindfulness, distress tolerance, interpersonal effectiveness, problem-solving	Small open trial	44
IPSRT-A	Adolescent, Briefly Family Portion	Individual	16-18 sessions	Social and sleep routines, Interpersonal therapy	Small open trial; RCT underway	53-54
CBT	Adolescent, Brief Parent/Family Portion	Individual	12 sessions	CBT with psychoeducation, optional modules for specific problem areas	Small pilot trial with matched controls	55-56

Note. CFF-CBT=Child-and Family-Focused Cognitive Behavioral Therapy; MF/IF-PEP=Multi-/Individual Family Psychoeducation Psychotherapy; FFT-A/HR=Family-Focused Treatment for Adolescents-/High Risk version; DBT-A= Dialectical Behavior Therapy for Adolescents; IPSRT-A= Interpersonal and Social Rhythm Therapy for Adolescents; CBT = Cognitive Behavioral Therapy for Bipolar Disorders in Adolescents; RCT=randomized controlled trial. For Treatment Targets, Child=Child-focused individual sessions; Parents=Parent-focused individual sessions; Family=sessions targeting the family unit (youth and parents together, with or without siblings).