

## Juvenile-onset Bipolar Disorder: A Purpose for a Psychoeducational Program

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Because the nature of the bipolar disorder (BD) and because its direct impact on reasoning, pharmacologic treatment is necessary but not enough for the optimal symptom improvement. In recent years and from a biopsychosocial approach, evidence has been collected about the effectiveness of complementary non-pharmacological treatments, comprising individual, in-group or familiar interventions. Different kinds of psychological treatments for BD –psycho education (PE), cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), psychoanalytical therapy (PAT)- were reviewed by Jones (2004) who concluded that all of these benefit patients but CBT achieved the greatest social function improvement and the largest reduction both in symptoms and in risk of relapse. However, the analyzed studies had small methodological validity, there were not controlled groups to compare, and most of the measures used were not standardized. In the same way, Vieta & Colom (2004) found only four works fulfilling necessary methodological standards, and considered that PE and CBT were the unique prophylactic approaches with extensive demonstrated efficacy for patients with BD. The efficacy of PE in a variety of mental disorders, like schizophrenia, obsessive-compulsive disorder, borderline personality disorder or major depression, in addition to BD, has been supported by about thirty randomized controlled trials (Murray-Swank & Dixon, 2004). Vieta (2005) and Colom & Vieta (2004) reported that PE aids patients to understand and to minimize the symptom impact, to reduce the number of altered mood episodes and hospitalizations, to increase the duration of euthymic states, and to improve adherence to pharmacological treatment.

Now, in the last decade, we know something else about the childhood onset BD. Nevertheless, the therapeutic strategies tried are almost totally pharmacological. There are no powered trials that answer for the effect of complementary psychosocial interventions. Few pilot designs and outcomes were presented by Fristad, Garazzi & Mackinaw-Koons (2003) about PE programs over unifamiliar and multifamiliar groups. Adolescence is one of the most important stages in personal evolution, and in which psychosocial stressors may produce a larger imprint. The combination of pharmaceuticals and PE interventions provided to patients and their relatives must be the top priority. It is essential that the youngster can understand the magnitude of the disorder and not underestimate the importance of the maintenance of pharmacological treatment. Few studies analyzed PE programs in adolescents with BD. Miklowitz *et al* (2004, 2003) carried out a randomized controlled trial which showed the positive effect of a 9-month family-focused treatment, adapted from an adult PE program, in 20 teenagers for one year post intervention.

As far as we know, to date no trials have been published that estimate the efficacy of a PE program in a juvenile European population with BD. Now, in our hospital, a 6-month PE workshop addressed to boys and girls under eighteen with BD and their relatives has been initiated. We describe the program, sessions and topics and offer baseline data.