1 "What's Happening to My Teenager?"

Emilia, a 44-year-old single parent who worked as a waitress during the day and managed a health care supply business at night, was getting increasingly concerned about her son, Carlos, age 14. For the last 2 weeks Carlos had been "wired" and "snapping at everyone." He would explode into tirades when the Internet went down for even a few minutes, if his sister took too long in the bathroom in the morning, or if the dog wanted his attention when he was busy. Emilia suspected he had been staying up most nights well after she had gone to bed and on at least two occasions had not gone to sleep at all. She felt nervous and fearful about an odd stare he had developed and about his unusual ideas about religion, death, burial, and the afterlife. Carlos said he believed in reincarnation, which was not in itself unusual, but he also believed he could communicate with his former soul via email. He had become more irritable and disrespectful of her since he had turned 13 (for example, by swearing and occasionally shoving her out of his way), but this new behavior was a big change for him. She wondered whether she had been in denial about the milder odd behaviors that she had been seeing in her son for a long time.

Emilia decided she was not spending enough time with her son or her 12-year-old daughter, Yolanda. One Saturday, Carlos awoke at noon as usual after having been up until 4:00 A.M. the night before "doing experiments in instant messaging." Because Yolanda was at a birthday party, Emilia suggested that they see a movie with one of his friends. Although she was initially delighted that he wanted to go, she felt hurt and frustrated when an innocent conversation about which movie to see turned into a shouting match.

After the movie, Carlos said good-bye to his friend and they headed home. Carlos took his soft drink into the car and began sloshing the ice around loudly in his mouth. Suddenly, he angrily turned to her and said, "I want to go to Pizza Hut." She explained calmly that she had defrosted a steak and didn't want it to go to waste and that they had already spent $25 on the movie, popcorn, and other snacks. Carlos started yelling that he was hungry and that she'd better turn the car around and go back to Pizza Hut "or else." Emilia couldn't believe her son was demanding that she now take him out for dinner and said sharply, "You know I never give in to you when you get like this."

Carlos dumped his soft drink in her lap and then picked up a stray auto map binder that had fallen out of her glove compartment and hit his mother on the head with it. She stomped on the brakes and the car swerved. She pulled over, and they began a screaming match during which he scratched her. She felt angry, hurt, and at the same time feared for her physical safety. To escape a situation that had escalated beyond her control, she finally agreed, against her better judgment, to take Carlos to Pizza Hut.

He ordered his food and ate it quickly. They got back in the car. They were silent for the rest of the evening. When she got home, Emilia poured herself a stiff drink and drank it alone in her bedroom. She heard a knock on her door. "Mom, can I come in?," Carlos said in a plaintive voice. She let him in. He sat on the edge of her bed shaking, with the empty stare she had seen earlier that week that had made her shudder. He said, "Mom, what happens when you die? If you kill yourself, does that mean you'll go to hell?"

Emilia was devastated. What had made her son act this way? Was he just going through a strange teenage phase? Was she a bad parent, and should she have seen this coming years ago? Where could she get help? And what would happen to her and her daughter while they were trying to deal with this overwhelming problem? Would they be able to stay together as a family? Emilia desperately wanted answers, but scanning websites and reading brochures didn't give her nearly enough information.

Having a teenager who is developing or has developed bipolar disorder is extremely upsetting, frustrating, even heartbreaking. The ups and downs of adolescent bipolar disorder are difficult to manage, and its rippling effects on the family can exhaust your energies. Whether your teen is having mood problems but hasn't received a diagnosis, has already

been diagnosed but is just starting treatment, or has been in treatment for some time, you'll benefit from knowing as much as possible about the adolescent form of this disorder. Knowing how to recognize episodes of the illness before they build, how to get your teenager the most up-to-date treatments, and how best to respond so that your teen's condition is more likely to stabilize will boost your confidence and energy.

This book is for you if:

- You think your teenager (ages 12–18) or preteen may have bipolar disorder but it has not been diagnosed yet, and you want to gather information to see if the diagnosis is applicable.
- Your teenager has recently been diagnosed and you want to know more about what kind of treatment he or she should be getting.
- You have been dealing with bipolar disorder in your child for several years and want to learn new skills for coping with it now that your child is entering the already challenging phase of adolescence.

Knowing the facts about adolescent bipolar disorder will help you accept and learn to cope with it, and, in turn, help your teen and other family members come to terms with the illness. Each of the following chapters describes the problems you and your teen and family are probably facing, and provides a set of solutions we've found effective in our work with families like yours. If your son or daughter was diagnosed with bipolar disorder as a child, you may already have a pretty firm grasp of the fundamentals and prefer to go straight to the chapters of current interest. But chances are that you'll find some new information on the fundamentals. Everything in this book is based on up-to-date research findings as well as clinical wisdom from our own practices and those of our colleagues.

"What Is Bipolar Disorder?"

If you're not yet familiar with the full list of bipolar symptoms and how the disorder is diagnosed, you'll find complete explanations in Chapters 2 and 3. But essentially bipolar disorder is an illness involving extreme fluctuations in mood, usually from the highest of highs to the lowest of lows, like what Carlos was experiencing. The highs are called *mania* and

the lows *depression,* which is why the disorder once was and sometimes still is called *manic–depression*.

Although bipolar disorder is difficult to deal with at any age, in our experience it is particularly challenging for teenagers and their families. For example, the shifts from high to low or low to high can occur even more quickly in teens than in adults. As Emilia observed in her son, teens can quickly change from elated, happy, and highly energized to angry, irritable, or morose, with suicidal despair. Some teens even experience mania and depression simultaneously. When manic, teens, like children and adults, experience euphoria, intense irritability, an inflated sense of self (grandiosity), increased energy and activity, rapid speech and thinking, distractibility, impulsive and reckless behavior, and a decreased need for sleep. When depressed, they feel intensely sad, lose interest in life, feel fatigued, slowed down, guilty, hopeless, and suicidal; they cannot sleep or they sleep way too much. For kids who are already undergoing huge developmental changes, these symptoms create an enormous burden in their young lives.

It's hard to say how many teens actually have bipolar disorder at any one time because so much depends on accurate diagnosis. Many people are not diagnosed until years after the symptoms appear—or at all. We know that about one in 25 adults (4% of the population) has bipolar disorder and that about half of these develop bipolar disorder in their childhood or teen years. The average age at first onset of bipolar disorder is between 15 and 19. This means that there is a good chance your teen is not the only one in his high school class who is suffering the mood swings of bipolar disorder.

Whoever they may be, teens with bipolar disorder usually have significant difficulties in school, not just at home. People with the disorder—young and old—have trouble managing their work, relationships, and family life. They are often codiagnosed with disorders like attention-deficit/hyperactivity disorder (ADHD; as in Carlos's case). Others have anxiety disorders, substance (drug or alcohol) abuse, or learning disabilities, all of which can complicate the process of getting an accurate diagnosis and appropriate treatment.

Fortunately, though, we're learning more and more about how to help teens with bipolar disorder, both with medication and with coping methods that pick up where medicine leaves off. Sharing them with you is the goal of this book.

In Part I you'll find up-to-date information about the symptoms, causes, and course of bipolar disorder over time. What does the disorder look like, and how is it experienced by the bipolar teen (Chapter 2)? How

is it diagnosed (Chapter 3)? How will you experience it as a parent, and how will it look to other members of your family, like siblings (Chapter 4)? How does the disorder look at different stages of development? What happens to bipolar teens as they enter adulthood?

"Why Is It So Hard for Anyone to Tell Me What's Wrong?"

> Emilia took Carlos back to see the psychiatrist who had evaluated him when he turned 13. That's when he was diagnosed with ADHD, a diagnosis that had also been suggested by an elementary-school teacher. The physician met with Emilia and listened sympathetically, but seemed uninterested in her recounting of the increasingly hostile interactions she had been having with Carlos. He met briefly with Carlos, who said little other than "I just get pissed off sometimes."
>
> Carlos's psychiatrist told Emilia that he still believed Carlos had ADHD. He renewed Carlos's prescription for Adderall, a stimulant medication, and recommended he start taking Zoloft, an antidepressant, for his morose mood.

The parents we work with have usually been told many different things about what is wrong with their teen. Most have been told at one point or another that their teen has ADHD. Often this is true, although not always. Many are told that the teen is just depressed, anxious, or going through the ups and downs of growing up. You may have gone through numerous lengthy evaluations where the same questions were asked again and again, only to be told that your teen was going through "growing pains" or "a phase." The truth is that the distinction between bipolar disorder in teens and other disorders—and even between bipolar disorder and normal teenage development—is very hard to make (see Chapter 4). Professionals are not always reliable in making this distinction.

Securing an accurate and reliable diagnosis is the first step toward obtaining proper treatment for your child. Fortunately, there are things you can do to maximize your chances of getting an accurate diagnosis, but this process is still fraught with the potential for trial and error. Some studies have found that the lag time between the onset of bipolar disorder and getting first treatment for it can average 8–9 years! This typically happens, as it did with Carlos, when the child is repeatedly treated for the wrong conditions because he has never had the benefit of a proper diagnostic evaluation.

If you've had this experience, you, like Emilia, may feel frustrated and angry at the mental health system. But you may be able to resolve your doubts and answer nagging questions by reading Chapter 3, where you'll learn how doctors diagnose bipolar disorder in teens and how they distinguish it from ADHD, oppositional defiant disorder, and a host of other mental health complications. You'll learn how to get a proper referral for a diagnostic evaluation, what questions you should ask of the mental health provider who performs it, and what you can do if you're not satisfied with the results.

You'll become familiar with the term *comorbidity,* which means the codiagnosis of two or more disorders in the same person (for example, bipolar disorder in conjunction with ADHD). Knowing about illness comorbidities will help you select among the various treatment alternatives for your teen because the medications recommended for comorbid illnesses are often quite different. Hopefully, you will feel less isolated by knowing that many other parents have gone through the long and often frustrating process of finding the right diagnosis for their teens.

Still, one of the greatest difficulties associated with bipolar disorder is its effects on family life. You, and most parents coping with the illness, probably feel considerable stress and have had to make great sacrifices financially, practically, or emotionally. Emilia stopped inviting friends over for fear that she would be embarrassed by one of Carlos's "meltdowns." Chapter 4 offers a frank discussion of how bipolar disorder will affect your family. What are the various stages families go through in learning to accept the realities of the disorder? How will it affect your teen's healthy siblings? How can your family work to recognize your teen's strengths despite the disruption caused by the illness? Although your situation may differ from those described, they will give you some ideas (which will be built on later) for dealing with the stress caused by the illness.

"Why Can't I Get a Handle on What This Illness Is and Is Not?"

> *Before I was diagnosed, I felt like my life was a 100-piece jigsaw puzzle. Now it seems like 1,000 pieces and the first 100 don't even seem to belong to the same puzzle.*
>
> —A 17-year-old teen with bipolar disorder

Kids with bipolar disorder do all the things normal teens do: they argue with their parents, take unnecessary risks, experiment with drugs or alcohol, and have mood swings. How do you know when your child is behav-

ing like a normal teenager and when he or she is starting to become manic or depressed? What is the teen experiencing internally, and how might that be different from what healthy teens experience?

Emilia went back and forth between believing there was something wrong with Carlos and believing he was just an annoying teen. Carlos argued this point fervently: "I don't act any different than any of my friends. It's just you who freaks out, unlike their parents."

To make matters even more complicated, once you become acquainted with the disorder, you may find yourself overly concerned that every small change in your teen's behavior heralds a new episode of illness. This is an understandable confusion, and it's easy to err in one direction or another. Even professionals, including us, sometimes mistake a normal reaction to a stressful situation for the beginning of mania—or, worse, mistake a burgeoning manic episode for normal adolescent behavior. Chapter 4 offers the wisdom regarding this tough distinction that we've collected with the help of many bipolar adolescents and their families. When you see your teen start to act angry or defiant, it helps to have some guidelines to fall back on in determining whether it's the normal assertion of independence or the extreme, unfocused irritability that is a key symptom of bipolar disorder.

"Why Is This Happening to My Child?"

In the 2 weeks immediately after Carlos started taking Adderall and Zoloft, he started getting worse. For nearly a week, he stayed up most of the night without any need to catch up on sleep during the day. He said that sleep was a waste of his time. He seemed constantly angry and on the brink of hitting Emilia. He knocked over a lamp and slammed doors. After he verbally threatened Yolanda, Emilia began to fear for her daughter's safety. He talked incessantly about a book he had obtained on occult powers and witchcraft. He started collecting odd fragments of wood and trash and used them to build a prayer altar in his room.

Things came to a head one morning when Emilia insisted Carlos get out of bed in time to get to school. He groaned and cursed at her. Later that morning, after she assumed he had already left, she found him in the bathroom with a razor, scratching "I hate you" in his arm. She called the police, and Carlos was admitted to a hospital.

Once her son was admitted, Emilia met with the inpatient attending psychiatrist, Dr. Roswell, a woman who specialized in mood

disorders among teens. Dr. Roswell took a thorough history of Carlos's development, symptoms, and family history and asked questions that Emilia had never been asked before. Dr. Roswell told her that Carlos's mood and behavioral problems were probably the end result of a family history of mood disorders, although no one in the family had been diagnosed with bipolar disorder. Carlos's father had been intermittently depressed and alcoholic. Emilia herself had had several episodes of depression, one immediately following Carlos's birth and another when her husband left. Carlos's paternal grandfather had been "a ramblin', gamblin' man" (her words) who had never had a fixed address for very long.

After a week-long hospitalization, Carlos was diagnosed with bipolar disorder and started on a regimen of Depakote (a mood stabilizer) and Seroquel (an atypical antipsychotic). Dr. Roswell agreed to see him on an outpatient basis in her practice. Carlos and Emilia began a family educational program along with other families of bipolar teens, which met weekly during the evening at the hospital's outpatient clinic.

The group meetings, while highly informative, left Emilia with a combination of frustration, worry, and intense sadness. For her, the issues surrounded grieving over the loss of who she thought Carlos would be: a bright, artistically talented, and creative young man. She began to think she would spend her life taking him in and out of hospitals. These events were equally hard on Carlos, who, despite his bravado, expressed the worry that he would always be mentally ill and that he would never have a career or his own family. Privately, both Carlos and his mother agonized over the question "Why him?" How could this have happened?

Part of coming to terms with bipolar disorder is accepting that it may have been inherited and that your child is biologically prone to future episodes. Knowing that what's wrong with your teen has a name and a biochemical basis may alleviate some of the guilt and nagging fears that you or your teen's other parent may harbor. You may believe that you somehow caused the symptoms because of your parenting style, a divorce, inadequate nurturing when your child was a baby, or other life circumstances. But it may also raise a series of questions for you: Will the illness last for the rest of his life? Will my other children get the illness? Do I have it and just not know it? Will my teen have to take medications forever, and what will these medications do to him?

These questions and others about treatment are answered in Part II. In Chapter 5 we lay out our biopsychosocial model for treating teens with the illness, which emphasizes the interaction of psychological, environmental, and biological factors in causing episodes of the disorder. For example, stress elicits symptoms in most bipolar children, but teens are also particularly likely to create their own stressful circumstances, especially within the family. This biopsychosocial model is important in understanding why we combine medications with psychotherapy in treating the illness.

The biological basis for the disorder will also help you understand your teen's medical treatment. For example, if you know that your teen is biologically predisposed to manic episodes, you will know to be cautious about the use of antidepressant medications, which can cause depressed teens to become manic if used without accompanying mood stabilizers. Carlos was already developing mania at the time his first doctor encouraged him to take the antidepressant Zoloft. This medication accelerated his mania and eventually led to the recognition of his bipolar disorder.

"What Can Be Done to Treat My Child?"

In our experience, the biggest concern of parents is getting their teen into treatment and making sure the teen stays in treatment. Emilia succeeded in getting Carlos to see a psychiatrist, but getting him to follow through on his medications was another matter entirely. You can feel particularly hurt if your child does not see the need for treatment despite the fact that her mood swings are having a clearly negative impact on you and other members of your family. You may also be frustrated and angry if you and your spouse don't share the same vision about what needs to be done.

Our first goal in Part II is to acquaint you with available treatments for bipolar teenagers. Having all of this in one place will consolidate a lot of the information that you'd ordinarily have to seek from websites, radio and television programs, and the things your doctor tells you. Chapter 6 explains what we know about the different medications used to treat bipolar disorder. Medications for bipolar teens, which usually fall into the mood stabilizer and atypical antipsychotic classes, are often used in combination. The array of available medications is changing constantly, but there are "old standbys" like lithium that still play an important role in stabilizing kids with the disorder.

Many teens with bipolar disorder benefit from individual, family, or

group therapy (Chapter 7) in addition to medication. Many of these treatments have not been tested experimentally in bipolar teens, but we know a lot about them from studies of bipolar adults or teens with depression. Psychotherapy and support groups (as in Carlos's case) can also help you to learn to cope with the illness. They can provide a forum for teens to vent about and develop solutions to problems in their peer relationships. Psychotherapy is an essential adjunct to medication in managing the ups and downs of bipolar disorder, even though the positive results may not be obvious right away.

"How Can I Help My Child Stay in Treatment?"

> When Carlos and Emilia began attending support groups, Emilia felt like her eyes were being opened. Other parents' descriptions of their kids' problems seemed to mirror her own, and for the first time she felt not quite as alone. Carlos, in contrast, hated going to the groups. He described the other kids in the group as "losers" and "whiners" and said he had no intention of going back. He also began to toy with his medications, sometimes leaving tablets around the house or forgetting where he left his pill bottles. He disliked Dr. Roswell and saw her as lacking in understanding, prone to using "big words that don't mean anything," and uninterested in his religious and spiritual beliefs.

As a parent, much of the responsibility for your teen's ongoing stability will fall on you. This means finding ways to keep your teen compliant with his medications. Toward this end, it's important to develop an alliance with your child's treatment providers, even when you find yourself frustrated by our imperfect mental health care system.

Teens are notorious for going off the medications intended to stabilize their moods. Getting Carlos to accept the necessity of Depakote or Seroquel was a long and arduous process that involved several more illness episodes before he finally agreed to take them consistently. Your teen may be going through something similar. Maybe your teen keeps changing her mind about medications. Or maybe she has finally begun to accept the need for them—but has agreed to take only one of two that have been prescribed. At one point Carlos was willing to take a stimulant medication for ADHD because it made him feel hyper and racy, but was not willing to take a mood stabilizer to prevent mania. Your teen may accept medications at first and then stop taking them (like Carlos) or never agree to take them in the first place.

Sometimes teens resist medications because of unpleasant side effects. No one likes to take medications every day, especially ones that can cause acne, weight gain, insomnia, headaches, shakiness, or fatigue—even though some side effects can be ameliorated by the physician. Other issues are more complicated to resolve, such as when medications make a teen feel like a "mental patient." But there are more and less effective ways to get a teenager to commit to a medication regimen. In Chapter 8, we offer some methods for discussing medications with your child, negotiating dosage levels with doctors to minimize side effects, and monitoring whether the medications are helping your teen's mood or causing more problems than they are worth. Getting your child—and sometimes your other family members as well—to buy into his treatments will make your life and your child's life much easier.

"How Can I Keep My Child from Getting Worse?"

Understanding the diagnosis and getting appropriate medication treatments are only two parts of the complex puzzle of keeping bipolar teens well. Bipolar disorder waxes and wanes. It follows a "relapse–remission" course in which teens have episodes followed by periods of better functioning followed by more episodes. Knowing the triggers for your child's symptomatic periods and what the early warning signs look like (and how they are experienced by your child) is essential to preventing illness recurrences. This book will help you recognize when your child is cycling into an episode of mania, depression, or mixed disorder. You'll learn how to develop a relapse prevention plan that involves identifying triggers for mood episodes or suicidality, identifying early symptoms, and introducing preventative or palliative measures (Chapters 10–13).

For most teens, there is a brief but recognizable period when they are becoming ill but are not there yet. Emilia noticed that Carlos began to snap at everybody and developed an odd stare when he was getting manic. Many of the parents we work with say things like "I know he's getting manic when he gets that look in his eyes" or "When she gets depressed, she starts looking like a rag doll, flopping around, like her arms and legs are useless sticks that she has to drag along."

You may have noticed some signs that your child is getting worse, and also felt the frustration of trying to distinguish a true sign of oncoming illness from an ordinary change in mood. If your teen has not yet been diagnosed, or perhaps was just recently diagnosed, his "cycling pattern" (that is, when the onsets and offsets of illness episodes occur and how they de-

velop) may not be clear yet. In Chapter 11, you'll find useful information about how to identify the early warning signs of mania and what to do when you see them. Emilia learned to recognize Carlos's "odd stare" and religious preoccupations as signs that he needed an increase in his atypical antipsychotic medication (Seroquel). As a result, on at least one occasion she was able to keep him out of the hospital. You will feel empowered when you learn to apply similar principles to your unique situation.

A key tool is to know when to communicate with the psychiatrist. You and your family members need to have an agreed-on plan to call the psychiatrist for an emergency medication change. Sometimes these changes can be quick and easy, like increasing the dosage of a mood stabilizing medication. At other times, the interventions are more complicated and may require hospitalization to keep the teen safe and give new medications a chance to take effect.

A separate set of tools can be used when a teen is getting depressed (Chapter 12). Depression can have a sudden onset in adolescents and can be difficult to distinguish from mania (and sometimes even coexists with it). In many ways, we know more about how to manage depression than mania since there is a larger literature on the self-management of depression. In Chapter 12, we'll acquaint you with techniques such as behavioral activation (developing a plan for keeping your child physically active and engaged with her environment) and cognitive restructuring (helping her identify and challenge pessimistic thinking).

In Chapter 13, you'll become familiar with techniques that can be used should your teen express suicidal thoughts. Emilia was understandably worried that Carlos's intellectual preoccupation with death and the afterlife were suicidal thoughts in disguise. In fact, bipolar disorder in teens is associated with a high risk of suicidal behavior, but fortunately there are things you can do to prevent this behavior. Preventing suicide is more than just being sympathetic. It can involve, for example, removing from the house weapons that could cause harm or drugs that could cause overdose.

"How Can I Help My Child Stay Well over the Long Haul?"

After talking with other parents, Emilia began to understand the importance of keeping Carlos on a consistent sleep schedule. When he got home from the hospital, he started staying up most of the night instant-messaging his friends or talking on his cell phone. Later, Emilia discovered that Carlos had called someone in Venezuela and someone else in Newfoundland, but her son had little memory of

these calls. Emilia insisted that Carlos go to bed at 11:00 and be up by 7:00 the next day for school, which he had begun to miss. The lack of predictable family routines, however, made enforcing these rules nearly impossible.

Dr. Roswell encouraged Carlos to take Seroquel in the evening to help him fall asleep. Reluctantly, Carlos began recording his bedtimes, wake times, and mood each day on an online sleep–wake chart Emilia had obtained in the group. Carlos called the chart "lame" and said it made him feel like a mental patient, but he used it, and over the next several weeks his mood began to stabilize.

Much of helping your teen stay well involves acquainting yourself and your teen with *self-management techniques*, such as keeping a regular sleep–wake cycle, avoiding overstimulation at night, keeping a mood and sleep chart, avoiding drugs or alcohol, and learning to keep family stress to a minimum (Chapters 9–10). These habits and skills that can help your son or daughter maintain a stable mood can be viewed as tools in a toolkit that will work with some problems and not others. Not all of them will fit every nail or screw that needs pounding or tightening, but their availability will make you feel empowered to cope with even the most stressful situations. As with medication, however, getting your teen to use these strategies can be a challenge, which is why in Part III we'll offer lots of examples of how to get a teen to follow through. We also provide worksheets for recording your mutual efforts, which you'll find well worth your time. As Emilia said, "Managing this illness really involves changing your whole routine. It's not something you can medicate away."

Even more important than the practicalities of managing the disorder is experiencing a sense of hope and communicating this to your teen. You may feel defeated by the wrong turns that treatment can take or angry at doctors for making promises that haven't been fulfilled. Emilia certainly felt this way. But knowing that you have hope for his future is extremely important to your teen, even if he doesn't know it yet. Throughout this book, we will give you many reasons to remain optimistic and offer many ways to communicate this optimism to your child.

"Can My Teenager Lead a Normal Life at School and with Friends?"

Carlos got out of the hospital on a Saturday afternoon and was back in school on Monday. At 11:00 Tuesday morning Emilia got a call from

the guidance counselor that Carlos was waiting to be picked up. He had cursed at a teacher, overturned a desk, and angrily walked out of class. The counselor raised the possibility that Carlos wasn't ready for high school, that perhaps he was too immature. Emilia tried to explain what she knew about Carlos's bipolar disorder. The counselor did not acknowledge her use of the term *bipolar* but said that she had worked with many kids in the "SED [seriously emotionally disturbed] category." She mentioned something about special education classes or home schooling. Emilia protested that Carlos was not seriously emotionally disturbed, that he was taking medications, that he was ordinarily a fine student, and that he just needed time to stabilize. The counselor asked if there were "problems at home." Emilia eventually hung up, feeling she had no advocate in the school setting.

Around this time, Carlos began withdrawing from his friendships. He had never been a particularly social child, but the friends he had were good ones. Now, however, he seemed uninterested in going to their houses, although he continued to "binge on instant messaging," as Emilia put it. The phone calls he had with his friends sounded short and perfunctory, like "a series of grunts," unlike the lively and humorous conversations he used to enjoy.

Bipolar disorder takes a heavy toll on the functioning of a teenager. Unlike children with ADHD, teens with bipolar disorder can be functioning well and then suddenly "take a dive" in their school performance, from straight A's to F's or from being punctual and conscientious to cutting classes. Often, the deterioration coincides with a significant episode of mania or depression. Unfortunately, schools are often not set up to handle the myriad of mental health diagnoses that are brought to them, including bipolar disorder, Asperger syndrome, or ADHD. Like Emilia, you may have experienced significant conflict with teachers and school guidance counselors and may feel that the people who are supposed to help you are causing more problems than they solve.

Some schools deal with the complexities of psychiatric disturbance by lumping all children into one category, like "seriously emotionally disturbed" or "in need of special education." Yet this solution glosses over the important differences between children who have quite different psychiatric problems. A teen like Carlos, for example, needs a different school program from one with ADHD. Carlos needed classes that started at later times, more frequent breaks during the day, the availability of a school counselor when he had mood swings, and special help with arith-

metic. A teen with ADHD may need behavioral plans that have been developed for this disorder, which may include training in how to maximize attention and minimize distraction, organizational skills, memory or recall strategies, and social skills.

Chapter 14 is devoted to helping your child succeed in school. In our experience, parents of bipolar teens can be quite effective in navigating the school system and are often quite helpful to each other in making this happen. What kinds of educational plans can be made for a bipolar teen, and how are these different from what would be proposed for a teen with ADHD or a learning disability? What are the pros and cons of disclosing your teen's bipolar disorder to teachers or fellow parents? How can you help your teen deal with the stigma of the disorder in the school system or with peers?

In our experience, school counselors and teachers are usually willing to help but are overwhelmed by the number of students in their charge. In all likelihood, your teen will need a "Section 504 plan" or an "individualized educational plan" (IEP). These are written, agreed-on educational protocols whose objective is to maximize your child's learning potential. To develop these plans—and, even more important, to make sure they are actually implemented—you will need to be assertive with your child's school authorities. You will need to walk a fine line between advocating for your child and not alienating teachers or counselors who can react defensively to these demands.

Finally, because of their difficulty regulating emotions, teens with bipolar disorder often have trouble negotiating healthy peer relationships within the school setting. Keeping your child involved with peers is essential to her mood stability. We will talk about treatment strategies for managing social relationships in Chapters 7 and 14.

"How Do I Keep This Illness from Destroying Me and My Family?"

> Emilia had been having difficult interactions with Carlos since he had been a little boy, but they had gotten worse since puberty. The behaviors that counselors had told her reflected her son's "normal developmental quest for independence" seemed more like poisonous verbal brawls that made her feel ineffective and threatened. Carlos was no longer a little boy and towered over her physically. She was beginning to feel afraid of him. To make matters worse, Emilia had to deal with relatives and friends who said "He's just being a teenage

boy" or "He's a brat. Don't let him get so much control over you" or "Take him over your knee" or "Send him to a military academy." Another friend who was schooled in mental health care asked, "Do you think maybe he's been sexually abused by someone and hasn't told you? Could he be taking drugs?" These responses made Emilia feel like her competence as a parent was more and more in question.

Emilia was simultaneously having problems of her own. Her job was very stressful, and the business was not going well. Financially, she was barely making ends meet. She got minimal child support from her ex-husband, who played a marginal role in Carlos's and Yolanda's lives. When he did make an appearance, he usually brought lavish gifts for the kids and took them out with his latest girlfriend. Whenever this happened, Carlos seemed to escalate his anger and hostility toward his mother.

Emilia began drinking to alleviate an increasing anxiety that seemed to pervade her consciousness from almost the moment she woke up. To make matters worse, Yolanda began having problems. In apparent imitation of Carlos, she was beginning to swear and kick household furniture when she didn't get her way.

One time, in a particularly vulnerable moment in her support group, Emilia began crying, saying, "I didn't think my life would turn out this way. I had all these dreams for me and my kids. Maybe I just wasn't meant to be a parent."

It would be an understatement to say that being the parent of a bipolar teenager is a rough road. It can turn your life upside down and have negative, rippling effects on your relationships, your work, and your other kids. Although bipolar disorder is often glibly compared to medical diseases like diabetes, such comparisons gloss over the stigma and shame experienced by parents of the psychiatrically ill. Like Emilia, you may have already experienced a great deal of practical burden from dealing with the illness, such as lost income from work, huge financial costs, and strained relationships. The emotional burden can be equally crippling. You may end up feeling like you need mental health services yourself, as parents of bipolar people often do. Moreover, because this illness is transmitted genetically, some parents are simultaneously dealing with their own mood disorder as well as their kid's, or with mood disorder in a spouse or other members of the family.

Our research has found that a person's family environment during and just after a manic episode has a significant influence over the possi-

bility of a recurrence in the following year. This is not surprising; many psychiatric illnesses are strongly affected by the family environment. Fortunately, there are things you can do to take care of yourself, your spouse, and your other children while still staying on top of the care your teen with bipolar disorder needs.

A major purpose of this book is to give you some tools for managing your own emotional states and reactions to stressful circumstances in your family. Some of these tools are practical skills like learning how to respond when your teen is blowing up at you; how to solve problems collaboratively before they get out of hand; and when and when not to negotiate with your teen (Chapter 9). Other tools involve in-the-moment "mindfulness" techniques such as refocusing, breathing, or distancing yourself from disturbing thoughts. These emotional self-regulation skills will keep you from losing control yourself when you're being provoked.

You may find Chapters 4 and 9 to be the most useful of all. They look at questions such as: How is the family affected by bipolar disorder? How can the family create a positive, protective environment for the teen that also protects the parents' marriage and the well-being of the other children? What is the parent's role, the affected teen's role, and the sibling's role in maintaining this balance?

Throughout these chapters we'll refer frequently to our family therapy techniques. We have found in numerous studies that family education and skills training can prevent recurrences and stabilize mood in those taking medications for bipolar disorder. Other research groups have shown that support groups like the one Emilia took part in can stabilize a child's mood disorder. We'll acquaint you with many of the skills we train families to use, such as effective listening, negotiating strategies, and problem solving.

We offer a number of exercises for practicing illness management techniques with your family members. If you can master these techniques when things are calm, they will be much more effective when things get tense. Parents who get in the habit of using effective communication and problem-solving skills can help their teenager stabilize more completely and help their other children cope with stress caused by the illness.

Emilia and Carlos: Epilogue

Carlos is 18 now, and things have gotten better for him, Emilia, and Yolanda. He obtained a G.E.D. (a high school graduation equivalent cer-

tificate) and eventually enrolled in community college. Central to his stabilization was his eventual willingness to accept that he had bipolar disorder and needed to take medications for it. This came about gradually, not overnight, through a combination of meetings with his psychiatrist, a good individual therapist, and the education and support that Emilia got through her multifamily group. Carlos still has significant mood swings and often complains of an ongoing depression that he can't shake. His rage attacks are fewer and farther between, and he and Emilia have developed a civil, if not exactly close, relationship. Yolanda never developed bipolar disorder. She has had her own problems in high school, and received counseling, but is otherwise a normally functioning teenager.

Emilia has developed close relationships with parents in her support group, which still meets monthly, even years later. They have developed a system by which parents substitute for each other when feeling overly stressed. For example, on one recent Saturday night in which she was fighting with both kids, Emilia's friend Nancy agreed to come over to the house with her husband. Emilia left for a few hours. The kids seemed to welcome this change, and when their mother came back, they had both calmed down.

Emilia still struggles with her urge to drink. She goes to AA groups and obtains support from her sponsor. She is still employed but decided that trying to manage a business at night was too much. She is more philosophical these days about the cards she was dealt in life: "I wouldn't wish this illness on anyone or their family. But I guess it's made me a stronger person than I might have been otherwise." She gets considerable satisfaction from helping other parents whose children have just been diagnosed with bipolar disorder.

A key message of this book is to remain hopeful. Many parents are dealing with the same kinds of problems that you are. Our knowledge of this illness isn't complete, but there are things you can do to make life better for your teen and you.

Emilia and Carlos's story is only one of many we have heard. Many children have much better outcomes, and some have had worse. But we hear a common theme in these stories: when you, as the parent, come to accept the illness and are successful in getting your teen the best treatment available, your teen will eventually come to see the value of your efforts, even if hostile to them early on. Accepting bipolar illness is a lifelong process. We hope the information and strategies we offer here will make your journey more successful and hopeful.