Mental Health Guide

For Primary Care Clinicians

Bipolar

OPAL-K

Oregon Psychiatric Access Line about Kids

DOERNBECHER CHILDREN'S HOSPITAL
OHSU
Oregon Health & Science University

E: OPAL-K Psychosis Care Guide

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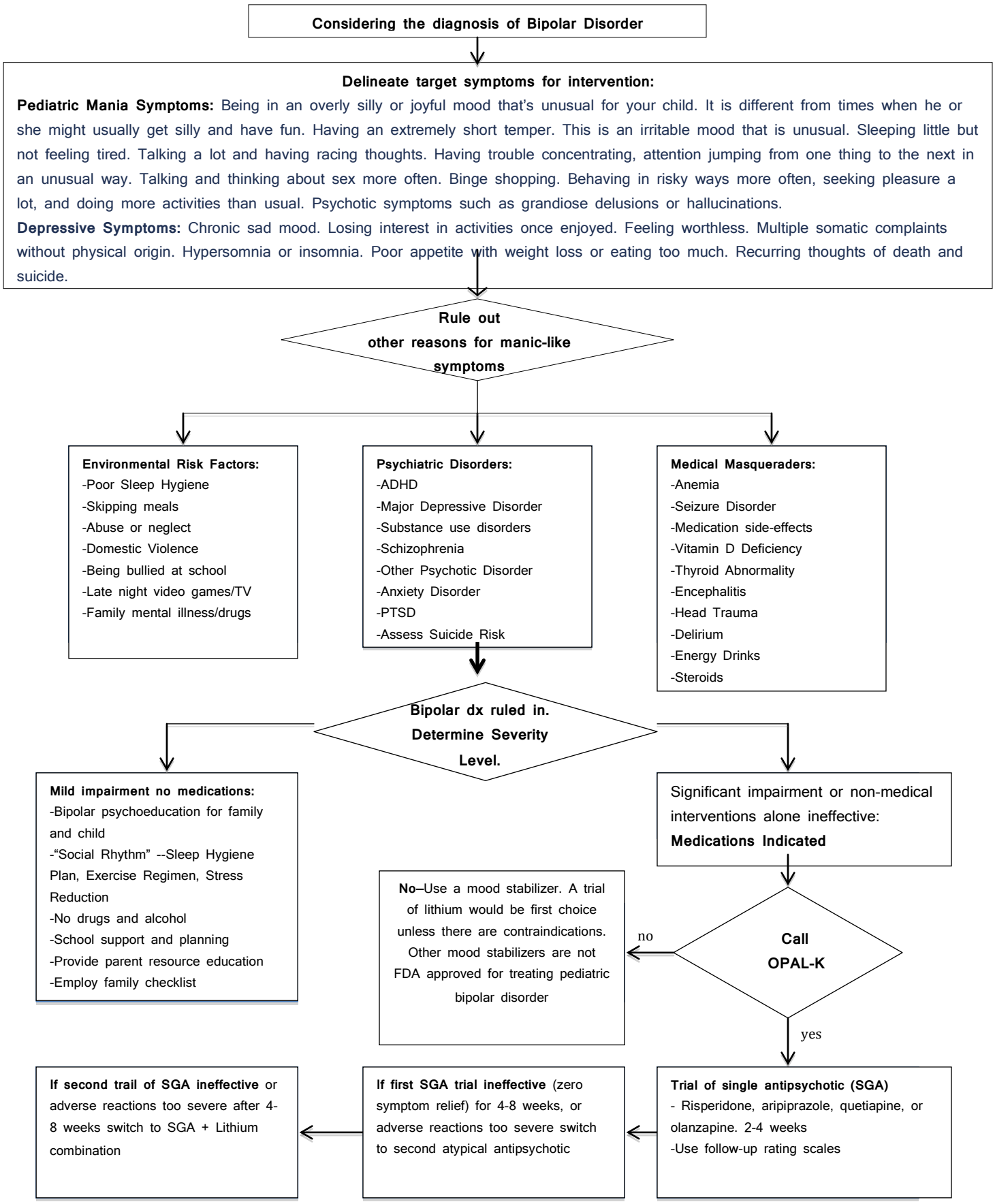
E1: OPAL-K BIPOLAR ASSESSMENT & TREATMENT FLOW CHART



E-2: OPAL-K Bipolar Assessment Guidelines

- The child or adolescent interview should include open-ended questions and discussion of unrelated topics in order to assess thought processes

- Always inquire about psychotic symptoms

- Always inquire about suicidality which is a risk during both depressed and manic stages due to impaired judgment

- For older children and adolescents part of the interview should occur without parental presence in order to assess risk-taking behavior, such as substance abuse, sexuality, and legal transgressions

- Family members' behavioral observations provide corollary information regarding the patient's range of difficulties and comorbidity

- Physical examination, review of systems, and laboratory testing are included to rule out suspected medical etiologies including neurological, systemic, and substance-induced disorders

- The clinical interview of the youth is the cornerstone of assessment for BD. Although many young patients lack insight regarding their manic symptoms, they can often describe their internal states

- A longitudinal perspective with a timeline of symptom evolution is needed to demonstrate cyclicity and understand the youth's illness

- No clear role for rating scales at this time – Young mania rating scale can help families monitor for mania symptoms, but is not diagnostic alone.

- School performance and interpersonal relationships should be assessed to determine the youth's functional impairment and educational needs

- Assess for Disruptive Mood Dysregulation Disorder (DMDD)

- Assess suicide risk

E3-E4: OPAL-K YOUNG MANIA RATING SCALE (YMRS)

GUIDE FOR SCORING ITEMS

The purpose of each item is to rate the severity of that abnormality in the patient. When several keys are given for a particular grade of severity, the presence of only one is required to qualify for that rating.

The keys provided are guides. One can ignore the keys if that is necessary to indicate severity, although this should be the exception rather than the rule.

Scoring between the points given (whole or half points) is possible and encouraged after experience with the scale is acquired. This is particularly useful when severity of a particular item in a patient does not follow the progression indicated by the keys.

Specify **one** of the reasons listed below by putting the appropriate number in adjacent box.

1. ELEVATED MOOD

☐

0 - Absent
1 - Mildly or possibly increased on questioning
2 - Definite subjective elevation; optimistic, self-confident; cheerful; appropriate to content
3 - Elevated, inappropriate to content; humorous
4 - Euphoric; inappropriate laughter; singing

2. INCREASED MOTOR ACTIVITY ENERGY

☐

0 - Absent
1 - Subjectively increased
2 - Animated; gestures increased
3 - Excessive energy; hyperactive at times; restless (can be calmed)
4 - Motor excitement; continuous hyperactivity (cannot be calmed)

3. SEXUAL INTEREST

☐

0 - Normal; not increased
1 - Mildly or possibly increased
2 - Definite subjective increase on questioning
3 - Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report
4 - Overt sexual acts (toward patients, staff, or interviewer)

4. SLEEP

☐

0 - Reports no decrease in sleep
1 - Sleeping less than normal amount by up to one hour
2 - Sleeping less than normal by more than one hour
3 - Reports decreased need for sleep
4 - Denies need for sleep

5. IRRITABILITY

☐

0 - Absent
2 - Subjectively increased
4 - Irritable at times during interview; recent episodes of anger or annoyance on ward
6 - Frequently irritable during interview; short, curt throughout
8 - Hostile, uncooperative; interview impossible

6. SPEECH (Rate and Amount)

☐

0 - No increase
2 - Feels talkative
4 - Increased rate or amount at times, verbose at times
6 - Push; consistently increased rate and amount; difficult to interrupt
8 - Pressured; uninterruptible, continuous speech

7. LANGUAGE - THOUGHT DISORDER

☐

0 - Absent
1 - Circumstantial; mild distractibility; quick thoughts
2 - Distractible; loses goal of thought; change topics frequently; racing thoughts
3 - Flight of ideas; tangentiality; difficult to follow; rhyming, echolalia
4 - Incoherent; communication impossible

8. CONTENT

☐

0 – Normal
2 - Questionable plans, new interests
4 - Special project(s); hyperreligious
6 - Grandiose or paranoid ideas; ideas of reference
8 - Delusions; hallucinations

9. DISRUPTIVE - AGGRESSIVE BEHAVIOR

☐

0 - Absent, cooperative
2 - Sarcastic; loud at times, guarded
4 - Demanding; threats on ward
6 - Threatens interviewer; shouting; interview difficult
8 - Assaultive; destructive; interview impossible

10. APPEARANCE

☐

0 - Appropriate dress and grooming
1 - Minimally unkempt
2 - Poorly groomed; moderately dishevelled; overdressed
3 - Dishevelled; partly clothed; garish make-up
4 - Completely unkempt; decorated; bizarre garb

11. INSIGHT

☐

0 - Present; admits illness; agrees with need for treatment
1 - Possibly ill
2 - Admits behavior change, but denies illness
3 - Admits possible change in behavior, but denies illness
4 - Denies any behavior change

E-5: OPAL-K The Mood Disorder Questionnaire (MDQ) - Overview

The Mood Disorder Questionnaire (MDQ) was developed by a team of psychiatrists, researchers and consumer advocates to address the need for timely and accurate evaluation of bipolar disorder.

Clinical Utility

The MDQ is a brief self-report instrument that takes about 5 minutes to complete. This instrument is designed for screening purposes only and is not to be used as a diagnostic tool. A positive screen should be followed by a comprehensive evaluation.

Scoring

In order to screen positive for possible bipolar disorder, all three parts of the following criteria must be met: “YES” to 7 or more of the 13 items in Question 1 AND “Yes” to Question number 2 AND

“Moderate Problem” or “Serious Problem” to Question 3

Psychometric Properties

The MDQ is best at screening for bipolar I (depression and mania) disorder and is not as sensitive to bipolar II (depression and hypomania) or bipolar not otherwise specified (NOS) disorder.

Out-patient clinic serving primarily a mood disorder population1

37 Bipolar Disorder patients 36 Unipolar Depression patients3

Sensitivity 0.73 Specificity 0.90

Overall Sensitivity 0.58 (BDI 0.58-BDII/NOS 0.30) Overall Specificity 0.67

General Population2 Sensitivity 0.28 Specificity 0.97

Primary care patients receiving Sensitivity 0.58 treatment for depression4 Specificity 0.93

E6-E7:

CMRS PARENT VERSION

Child's name _____ Date of Birth (mm/dd/yy) ____ ____ ____ Case # / ID # _____

INSTRUCTIONS

The following questions concern your child's mood and behavior in the **past month**. Please place a check mark or an 'x' in a box for each item. Please consider it a problem if it is **causing trouble** and is beyond what is normal for your child's age. Otherwise, check 'rare or never' if the behavior is not causing trouble.

Does your child . . .	NEVER/ RARELY	SOMETIMES	OFTEN	VERY OFTEN	
1. Have periods of feeling super happy for hours or days at a time, extremely wound up and excited, such as feeling "on top of the world"	0	1	2	3	_____
2. Feel irritable, cranky, or mad for hours or days at a time	0	1	2	3	_____
3. Think that he or she can be anything or do anything (e.g., leader, best basket ball player, rap singer, millionaire, princess) beyond what is usual for that age	0	1	2	3	_____
4. Believe that he or she has unrealistic abilities or powers that are unusual, and may try to act upon them, which causes trouble	0	1	2	3	_____
5. Need less sleep than usual; yet does not feel tired the next day	0	1	2	3	_____
6. Have periods of too much energy	0	1	2	3	_____
7. Have periods when she or he talks too much or too loud or talks a mile-a-minute	0	1	2	3	_____
8. Have periods of racing thoughts that his or her mind cannot slow down , and it seems that your child's mouth cannot keep up with his or her mind	0	1	2	3	_____
9. Talk so fast that he or she jumps from topic to topic	0	1	2	3	_____
10. Rush around doing things nonstop	0	1	2	3	_____
11. Have trouble staying on track and is easily drawn to what is happening around him or her	0	1	2	3	_____
12. Do many more things than usual, or is unusually productive or highly creative	0	1	2	3	_____
13. Behave in a sexually inappropriate way (e.g., talks dirty, exposing, playing with private parts, masturbating, making sex phone calls, humping on dogs, playing sex games, touches others sexually)	0	1	2	3	_____
14. Go and talk to strangers inappropriately, is more socially outgoing than usual	0	1	2	3	_____

Does your child . . .

	NEVER	SOMETIMES	OFTEN	VERY OFTEN	
15. Do things that are unusual for him or her that are foolish or risky (e.g., jumping off heights, ordering CDs with your credit cards, giving things away)	0	1	2	3	_____
16. Have rage attacks, intense and prolonged temper tantrums	0	1	2	3	_____
17. Crack jokes or pun more than usual, laugh loud, or act silly in a way that is out of the ordinary	0	1	2	3	_____
18. Experience rapid mood swings	0	1	2	3	_____
19. Have any suspicious or strange thoughts	0	1	2	3	_____
20. Hear voices that nobody else can hear	0	1	2	3	_____
21. See things that nobody else can see	0	1	2	3	_____

TOTAL SCORE _____

Please send comments to:
Mpavuluri@psych.uic.edu

E8: OPAL-K Bipolar Treatment Guidelines

- Second Generation Antipsychotics (SGA) are the cornerstone for treatment of Bipolar Disorder (BD).

- Adjunctive antipsychotic medication can be used during acute mania to rapidly stabilize the youth, assure safety, and provide sleep. Chronic use may be needed.

- If using antipsychotic medications, establish baseline labs and then monitor for "hypermetabolic syndrome" due to hyperphagia and weight gain. Establish dietary plan and exercise regimen at the start of pharmacotherapy.

- Baseline labs should include CBC, complete metabolic panel, TSH, fasting lipid, and fasting glucose.

- Antidepressants should be avoided; but if the youth becomes depressed and is not responsive to other pharmacotherapy, cautious use of antidepressants may be necessary. Carefully monitor for manic "activation" or "switch."

- Stimulants may be used to treat comorbid ADHD once the patient has been stabilized on a mood stabilizer.

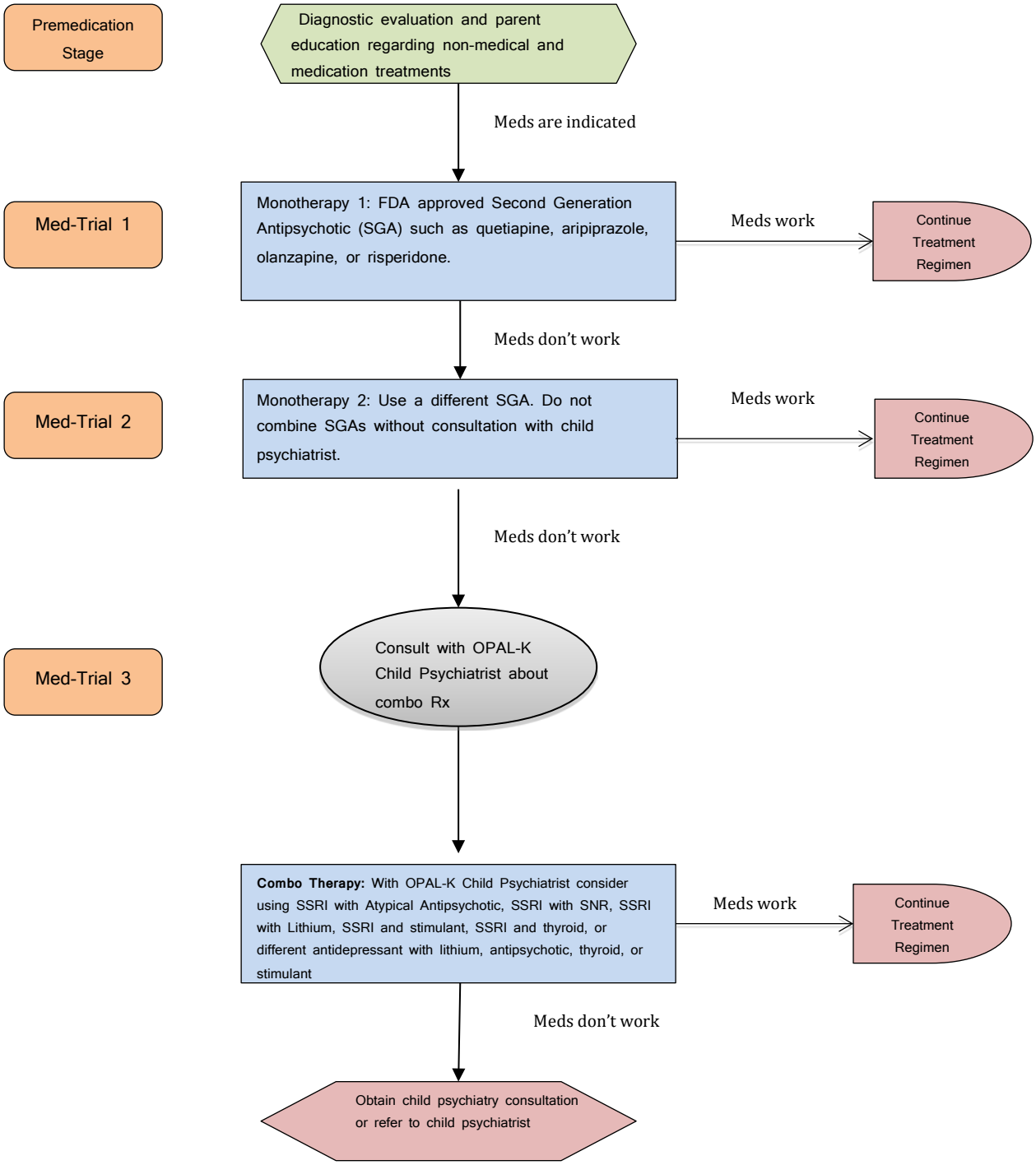
- Adjunctive psychosocial treatments (e.g., psychoeducation, family therapy, individual therapy) are always indicated in the treatment of early onset BD. At a minimum, treatment should include psychoeducation about BD, its risks, treatment, prognosis, and complications associated with medication non-compliance.

- Constant vigilance about suicide potential during any phase of BD is indicated.

- Ongoing collaboration with the school should focus on education about BD, development of an appropriate Individualized Education Plan, and assistance with behavioral management planning.

- Longterm management will need community mental health support.

E9: OPAL-K BIPOLAR MANIA/HYPOMANIA MEDICATION TREATMENT ALGORITHM (v.052212)



E10-E11: OPAL-K Bipolar Medication Table (07.29.14)

(Medication information based on www.epocrates.com)

Drug/Category	Dosing	FDA Approval	Monitoring	Comments/Precautions	Cost
Risperidone (Risperdal) Forms Available: tablets, oral disintegration tabs, liquid and depot injection Atypical Antipsychotic	Initial Dosing Children 0.25 mg/day Adolescents 0.5m g/day Maximum Dosing Children 3mg/day Adolescents 6 mg/day	Approved for treatment of youth with: 1) schizophrenia 13 yrs and older 2) bipolar 10 yrs and older 3) autism 5-16 yrs	1) CBC as indicated by guidelines approved by the FDA in the product labeling. 2) Pregnancy Test and clinically indicated 3) Weight and BMI monitoring - at initiation of treatment, monthly for 6 months then quarterly when the antipsychotic dose is stable. 4) Fasting plasma glucose level or hemoglobin A1c - before initiating a new antipsychotic, then yearly. If a patient has significant risk factors for diabetes and for those that are gaining weight 4 months after starting an antipsychotic, and then yearly.		Generic 0.25 mg -- $$$$ 0.5 mg -- $$$$ 1 mg -- $$$$ 2 mg -- $$$$ 3 mg -- $$$$$ 4 mg -- $$$$$ Risperdal Tabs 0.25 mg -- $$$$ 0.5 mg -- $$$$ 1 mg -- $$$$ 2 mg -- $$$$ 3 mg -- $$$$ 4 mg -- $$$$ Risperdal Solution 1 mg/ml $$$$ Oral Disintegrating Tabs 0.5 mg -- $$$$ 1 mg -- $$$$ 4 mg -- $$$$$
Aripiprazole (Abilify) Forms Available: tablets and liquid Atypical Antipsychotic	Initial Dosing Children 2 mg/day Adolescents 5 mg/day Maximum Dosing Children 15 mg/day Adolescents 30 mg/day	Approved for treatment of youth with: 1) schizophrenia 13 yrs and older, 2) bipolar 10 yrs and older, 3) autism 6 yrs and older	5) Lipid Screening-Every 2 years or more often if lipid levels are in the normal range, every 6 months. 6) Sexual Function ROS - Ask about any problems with galactorrhea, menstrual problems, gynecomastia, libido disturbance, erectile dysfunction. 7) Before and after initiation of treatment extra pyramidal symptoms (EPS) evaluation each visit weekly till dose titration is complete.		Abilify 2 mg -- $$$$$ 5 mg -- $$$$$ 10 mg -- $$$$$ 15 mg -- $$$$$ 20 mg -- $$$$$ 30 mg -- $$$$$ Dissolvable Tablet 10 mg -- $$$$$

			8) Tardive Dyskinesia Eval - Abnormal Involuntary Movement Scale (AIMS) every 6-12 months. 9) Check prolactin level if gynecomastia or galactorrhea develops.		
Quetiapine (Seroquel) Forms Available: tablets and liquid	Initial Dosing Children 12.5mg/day Adolescents 25mg/day Maximum Dosing Children 300mg/day Adolescents 600mg/day	Approved for treatment of youth with: 1) schizophrenia 13 yrs and older, 2) bipolar 10 yrs and older		Monitor for QT prolongation Ocular Evaluations every 6-12 months for cataracts	Seroquel 25 mg -- $$ 50 mg -- $$ 100 mg -- $$ 200 mg -- $$$$ 300 mg -- $$$$$ 400 mg -- $$$$$ Seroquel XR 50 mg -- $$$$ 150 mg -- $$$$ 200 mg -- $$$$ 300 mg -- $$$$$ 400 mg -- $$$$$
Olanzapine (Zyprexa) Forms Available: tablets, oral disintegrating	Initial dosing Children 2.5 mg/day Adolescents 2.5-5mg/day Maximum dosing Children 12.5mg/day Adolescents 30 mg/day	Approved for treatment of youth with: 1) schizophrenia 13 yrs and older, 2) bipolar 13 yrs and older			Zyprexa 2.5 mg -- $$$$ 5 mg -- $$$$ 7.5 -- $$$$ 10 mg -- $$$$$ 15 mg -- $$$$$ 20 mg -- $$$$$ Zyprexa Zydis 5 mg -- $$$$ 10 mg -- $$$$$

Mood Stabilizers

Drug/Category	Dosing	FDA Approval	Comments/Monitoring	Warning/Precautions	
Lithium Generic Eskalith Eskalith CR	Children: Start 15-20 mg/kg/day in 2-3 divided doses	Approved for the treatment of bipolar disorder in youth 12 years and older	Get Baseline, Chemistry Panel, CBC with platelets, Serum creatinine, initially Pregnancy Test, ECG,	Toxicity about therapeutic levels, particularly in renal, cardiovascular disease, and dehydration. Do	Generic tablets 300 mg -- $$ Generic Capsules 150 mg -- $$

Lithobid	Adolescents: Start 300 mg po bid to tid Titrate dose to levels between 0.6 and 1.2 mEq/L		thyroid panel. Monitor thyroid function 6-12 months during maintenance phase. Initial lithium level after 7 days of initiated. Weekly levels till therapeutic dose. Then 3-6 months after.	not use with NSAIDS. Watch for polyuria, tremor, diarrhea, nausea, hypothyroidism. Teratogenic, FDA rated category D for pregnancy.	300 mg -- $$ 600 mg -- $$ <u>Extended Release</u> 300 mg -- $$ 450 mg -- $$
Divalproex Depakote tabs Depakene Liquid caps Depakote Sprinkles Depacon IV	<u>Children Start:</u> 250mg/day target dose range 500mg-2000mg divided doses bid to tid <u>Maximum dosing</u> Based on level titrate to level 50-100mcg/ml	FDA approved for epilepsy for youth age 10 years and older.	Initial chemistry panel CBC with platelet count LFTS Pregnancy Test	<u>Black Box Warning for:</u> Liver Failure Pancreatitis Teratogenicity, FDA rated category D for pregnancy.	<u>Depakote</u> 125mg -- $$ 250mg -- $$$ 500mg -- $$$ <u>Depakote Sprinkles</u> 125mg -- $$$ <u>Depakene</u> 250mg -- $$$$
Lamotrigine Lamictal	Adolescents Start: 25mg qd increase by 25 mg/d every 1-2 weeks till reaching a max dose of 200-300 mg/day usually in divided doses bid	Safety and effectiveness not established. Not FDA approved for use in minors for bipolar disease.	Serious rashes including Steven's Johnson syndrome and asceptic meningitis	Dermatological reactions Potential Stevens Johnson rash, Acute multi organ failure, withdrawal seizures, blood dysrasias, hypersensitivity, suicidal ideation	<u>Lamictal</u> 25mg -- $$$$ 100mg -- $$$$$ 150mg -- $$$$$ 200mg -- $$$$ Lamotrigine 25mg -- $$$ 100mg -- $$$$ 150mg -- $$$ 200mg -- $$$

Cost Code:

$ -- $10 or less $$ -- $11 to $49 $$$ -- $50 to $99 $$$$ -- $100 to $499 $$$$$ -- $500 or more

E12: OPAL-K Psychosis Intervention Checklist for Families and their Bipolar Child

Living with a child who has bipolar disorder is confusing, frustrating and at times scary. The following checklist can help families become more effective in managing the behavior issues associated with bipolar children and adolescents.

Checklist for parents:

- ☐ Secure and lock all weapons or other items that can be used for self-injury or suicide since bipolar youth have an increased risk for suicide.
- ☐ Keep expressed emotions at a low level. Eliminate emotionally charged responses or scolding (try to stay positive).
- ☐ Help your child set up a written schedule for home, school, & activities in the community.
- ☐ Watch for signs of drinking or use of other drugs. Use of substances aggravate bipolar symptoms or increase risk of relapse.
- ☐ Monitor medications. Do not stop without consulting your prescribing clinician. The risk of relapse increases greatly when medications are stopped without physician supervision.

Checklist for siblings:

- ☐ Make sure you understand what mania/hypomania/depression is and what to expect for your sibling with bipolar disorder.
- ☐ Don't feel responsible for your sibling's behavior.
- ☐ Don't hesitate to communicate worries to your parents about your siblings bizarre thoughts or behaviors.
- ☐ Don't hesitate to ask your parents for attention when you need it.
- ☐ Do be patient if they are unable to meet your needs immediately.
- ☐ Have a plan of how to handle bizarre or unsafe behaviors from your bipolar sibling.
- ☐ Agree with parents on a safe place to go if needed.

Checklist for schools:

- ☐ Assist parents in getting leave of absence for student how is acutely ill.
- ☐ Help parents in getting home schooling or transfer to special education classes or day treatment if student to fragile to go to regular school.
- ☐ Check in with student about workload and adjust and adjust as needed (late arrival or early dismissal, decreased number of classes and assignment requirements).
- ☐ Be aware of multiple truancies or absences and communicate this to parents.
- ☐ Report excessive bizarre behaviors or difficulties functioning to parents.
- ☐ Assist in evaluation for IEP or 504 accommodations when indicated.

Checklist for child:

- ☐ First and foremost have regular sleep schedule. Staying up late is highly likely to aggravate or cause a relapse of bipolar symptoms.
- ☐ Take your medications regularly every day. They have less of a chance of working or keeping you well if taken irregularly.
- ☐ Stay away from caffeine, alcohol and other foods that can sleep problems.
- ☐ Make sure to tell your doctor if your medicine is bothering you.
- ☐ Develop a routine and stick with it everyday. Tell your parents if your mood swings are becoming overwhelming.
- ☐ Agree with your parents on ways to keep yourself safe.

E13: OPAL-K SUGGESTED RESOURCES FOR FAMILIES

Books

"The Bipolar Disorder Survival Guide: What You and Your Family Need to Know, by Miklowitz DJ (2002)
(For families living with an individual with Bipolar Disorder, geared to the adult, but the principles apply at all ages. The author is an investigator of family process contributing to mental illness)

Additionally, patients and families can benefit from information and connection with support groups some of which can be found on the following websites:

Websites

National Association for the Mentally Ill: www.nami.org

The Depression and Bipolar Support Alliance (DBSA): www.dbsalliance.org

The Balanced Mind Parent Network (a program of DBSA): http://www.thebalancedmind.org/

National Alliance on Mental Illness (NAMI): http://www.nami.org/Template.cfm?Section=Child_and_Adolescent_Action_Center&Template=/ContentManagement/ContentDisplay.cfm&ContentID=163696

Bipolar Disorder Resource Center, American Academy of Child & Adolescent Psychiatry: http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Bipolar_Disorder_Resource_Center/Home.aspx

PsychGuides.com: http://www.psychguides.com/guides/living-with-bipolar-disorder/

National Institute of Mental Health (NIH): http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens-easy-to-read/index.shtml

Parent Version of the Young Mania Rating Scale (P-YMRS) http://www.thebalancedmind.org/learn/library/parent-version-of-the-young-mania-rating-scale-p-ymrs

E14: OPAL-K Bipolar Clinician Resources

AACAP Bipolar Disorder Resource Center
http://www.aacap.org/cs/BipolarDisorder.ResourceCenter

Medscape Bipolar Learning Center (Get CME from bipolar learning modules)
http://www.medscape.org/resource/bipolardisorder/cme

An irritable, inattentive, and disruptive child: Is it ADHD or bipolar disorder?
http://www.currentpsychiatry.com/articles/evidence-based-reviews/article/an-irritable-inattentive-and-disruptive-child-is-it-adhd-or-bipolar-disorder/d16f8a9a80bf98ec962f55543850fca6.html

The child bipolar questionnaire: A dimensional approach to screening for pediatric bipolar disorder http://www.sciencedirect.com/science/article/pii/S0165032706001741

Bipolar Disorder Parents' Medication Guide for Bipolar Disorder in Children and Adolescents
http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CDkQFjAC&url=http%3A%2F%2Fwww.psychiatry.org%2FFile%2520Library%2FMental%2520Illness%2FBipolar-parentes-med-guide.pdf&ei=_-EQVIWQE6a7igKe8IGwAw&usg=AFQjCNGvz8vhFZgA8UuircOHyFzoT_V9xA&bvm=bv.74894050,d.cGE

Cognitive function across manic or hypomanic, depressed, and euthymic states in bipolar disorder http://www.ncbi.nlm.nih.gov/pubmed/14754775

Validity of the Parent Young Mania Rating Scale in a Community Mental Health Setting
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004712/

Child Mania Rating Scale: Development, Reliability, and Validity
http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCwQFjAB&url=http%3A%2F%2Fwww.researchgate.net%2Fpublication%2F7179182_Child_mania_rating_scale_development_reliability_and_validity%2Flinks%2F0912f506c5db22a98b000000&ei=BiESVL_JJIjIiwLujoGICA&usg=AFQjCNHZPnIqGgS_OUAq57FY71rhevRjKg&bvm=bv.75097201,d.cGE

LAMICTAL prescribing information
https://www.gsksource.com/gskprm/htdocs/documents/LAMICTAL-PI-MG.PDF

E15-20: OPAL-K Bipolar Care Guide BIBLIOGRAPHY

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 1994

Alloy LB, Abramson LY, Urosevic S, Walshaw P, Nusslock R, Neeren AM. The psychosocial context of bipolar disorder: Environmental, cognitive, and developmental risk factors. *Clin Psychol Rev.* 2005;25:1043-1075.

Althoff RR, Faraone SV, Rettew DC, Morley CP, Hudziak JJ. Family, twin, adoption, and molecular genetic studies of juvenile bipolar disorder. *Bipolar Disord*. 2005;7:598-609.

American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents with bipolar disorder. *J Am Acad Child Adolesc Psychiatry.* 2007;46:107-125.

Birmaher B, Axelson D, Goldstein B, et al. Four-year longitudinal course of children and adolescents with bipolar spectrum disorders: The Course

and Outcome of Bipolar Youth (COBY) study. *Am J Psychiatry*. 2009:166:795-804.

Birmaher B, Axelson D, Strober M, et al. Clinical course of children and adolescents with bipolar spectrum disorders. *Arch Gen Psychiatry*. 2006;63:175-183.

Blumberg HP, Fredericks C, Wang F, et al. Preliminary evidence for persistent abnormalities in amygdala volumes in adolescents and young adults with bipolar disorder. *Bipolar Disord.* 2005;7:570-576.

Chang K, Karchemskiy A, Barnea-Goraly N, Garrett A, Simeonova DI, Reiss A. Reduced amygdalar gray matter volume in familial pediatric bipolar disorder. *J Am Acad Child Adolesc Psychiatry.* 2005;44:565-573.

Consoli A, Deniau E, Huynh C, Purper D, Cohen D. Treatment in child and adolescent bipolar disorders. *Eur Child Adolesc Psychiatry.* 2007;16:187-198.

Danielson CK, Youngstrom EA, Findling RL, Calabrese JR. Discriminative validity of the General Behavior Inventory using youth report. *J Abnorm Child Psychol* 2003;31:29-39.

DelBello MP, Hanseman D, Adler CM, Fleck DE, Strakowski SM. Twelve-month outcome of adolescents with bipolar disorder following first hospitalization for a manic or mixed episode. *Am J Psychiatry*. 2007;164:582-590.

DelBello MP, Schwiers ML, Rosenberg HL, Strakowski SM. A double-blind, randomized, placebo-controlled study of quetiapine as adjunctive treatment for adolescent mania. *J Am Acad Child Adolesc Psychiatry.* 2002;41:1216-1223.

DelBello MP, Simmerman ME, Mills NP, Getz GE et al. Magnetic resonance imaging analysis of amygdala and other subcortical brain regions in adolescents with bipolar disorder. *Bipolar Disord.* 2003;6:43-52.

Feeny NC, Danielson CK, Schwartz L, et al. Cognitive Behavioral Therapy for bipolar disorder in adolescents: A pilot study. *Bipolar Disord*. 2006;8:508-515.

Findling RL, McNamara NK, Youngstrom EA, et al. Double-blind 18 month trial of lithium versus divalproex maintenance treatment in pediatric bipolar disorder. *J Am Acad Child Adolesc Psychiatry*. 2005;44(5):409-417.

Frazier JA, Ahn MS, DeJong S, et al. Magnetic resonance imaging studies in early-onset bipolar disorder: a critical review. *Harv Rev Psychiatry.* 2005;13(suppl):125-140.

Fristad MA, Verducci JS, Walters K, Young ME. Impact of multifamily psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders. *Arch Gen Psychiatry*. 2009; 66:1013-1020.

Geller B, Cooper TB, Sun K. Double-blind, placebo-controlled study of lithium for adolescent bipolar disorders with secondary substance dependency. *J Am Acad Child Adolesc Psychiatry.* 1998;37:171-178.

Geller B, Tillman R, Bolhofner K, Zimerman B. Child bipolar I disorder: prospective continuity with adult bipolar I disorder, characteristics of second and third episodes, predictors of 8-year outcome. *Arch Gen Psychiatry*. 2008;65:1125-1133.

Goldstein TR, Axelson DA, Birmaher B, Brent DA. Dialectical behavior therapy for adolescents with bipolar disorder: a 1-year open trial. *J Am Acad Child Adolesc Psychiatry*. 2007;46:820-830.

Goodwin FK, Jamison KR. *Manic-Depressive Illness Bipolar Disorders and Recurrent Depression.* New York: Oxford University Press; 2007.

Gracious BL, Youngstrom EA, Findling RL, Calabrese JR. Discriminative validity of a parent version of the Young Mania Rating Scale. *J Am Acad Child Adolesc Psychiatry.* 2002;41:1350-1359.

Hlastala SA. Stress, social rhythms, and behavioral activation: psychosocial factors and the bipolar illness course*. Curr Psychiatry Rep.* 2003;5:477-483.

Hlastala SA, Frank E. Adapting Interpersonal and Social Rhythm Therapy to the developmental needs of adolescents with bipolar disorder. *Dev Psychopathol*. 2006;18:1267-1288.

Kim EY, Miklowitz DJ, Biuckians A, Mullen K. Life stress and the course of early-onset bipolar disorder. *J Affect Disord.* 2007;99:37-44.

Kafantaris V, Coletti DJ, Dicker R, et al. Lithium treatment of acute mania in adolescents: a placebo-controlled discontinuation study. Lithium treatment of acute mania in adolescents: a placebo-controlled discontinuation study. *J Am Acad Child Adolesc Psychiatry*. 2004;43:984-993.

Kowatch RA, Fristad M, Birmaher B, Wagner KD, Findling RL, Hellander M. Child Psychiatric Workgroup on Bipolar Disorder. Treatment guidelines for children and adolescents with bipolar disorder. *J Am Acad Child Adolesc Psychiatry*. 2005; 44: 213-235.

Leibenluft E, Charney DS, Towbin KE, et al. Defining clinical phenotypes of juvenile mania. *Am J Psychiatry.* 2003;160:430-437.

Lewinsohn PM, Klein D, Seeley JR. Bipolar disorders in a community sample of older adolescents: prevalence, phenomenology, comorbidity, and course. *J Am Acad Child Adolesc Psychiatry.* 1995;34:454-463.

Malkoff-Schwartz S, Frank E, Anderson BP, et al. Social rhythm disruption and stressful life events in the onset of bipolar and unipolar episodes. *Psychol Med.* 2000;30:1005-1016.

Merikangas KR, Akiskal HS, Angst J, et al. Lifetime and 12-month prevalence of bipolar spectrum disorder in the National Comorbidity Survey replication. *Arch Gen Psychiatry*. 2007;64:543-552.

Miklowitz DJ, Axelson DA, Birmaher B, et al. Family-Focused Treatment for adolescents with bipolar disorder: Results of a 2-year randomized trial. *Arch Gen Psychiatry* 2008;65:1053-1061.

Pavuluri MN, Graczyk PA, Henry DB, et al. Child and family-focused cognitive behavioral therapy for pediatric bipolar disorder: Development and preliminary results. *J Am Acad Child Adolesc Psychiatry*. 2004;43:528-537.

Pavuluri MN, Henry DB, Carbray JA, Sampson G, Naylor MW, Janicak PG. Open-label prospective trial of risperidone in combination with lithium or divalproex sodium in pediatric mania. *J Affect Disord*. 2004;82:103-111.

Pavuluri MN, Henry DB, Devineni B, Carbray JA, Birmaher B. Child Mania Rating Scale: Development, Reliability, and Validity. *J Am Acad Child Adolesc Psychiatry.* 2006;45:550-560.

Pavuluri MN, Henry DB, Moss M, Mohammed T, Carbray JA, Sweeney JA. Effectiveness of lamotrigine in maintaining symptom control in pediatric bipolar disorder. *J Child Adolesc Psychopharmacol*. 2009;19:75-82.

Perlis RH, Miyahara S, Marangell LB, et al. STEP-BD Investigators. Long-term implications of early onset in bipolar disorder: data from the first 1000 participants in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *Biol Psychiatry*. 2004;55:875-881.

Rich BA, Vinton DT, Roberson-Nay R, et al. Limbic hyperactivation during processing of neutral facial expressions in children with bipolar disorder. *Proc Natl Acad Sci USA.* 2006;103:8900-8905.

Sachs GS, Nierenberg AA, Calabrese JR, et al., Effectiveness of adjunctive antidepressant treatment for bipolar depression. *NEJM*. 2007; 356:1711-1722.

Scheffer RE, Kowatch RA, Carmody T, et al. Randomized, placebo-controlled trial of mixed amphetamine salts for symptoms of comorbid ADHD in

pediatric bipolar disorder after mood stabilization with divalproex sodium. *Am J Psychiatry.* 2005;162:58-64.

Stahl SM. *Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications,* 3rd Ed. New York: Cambridge University Press; 2008.

Strober M, Schmidt-Lackner S, Freeman R, Bower S et al. Recovery and relapse in adolescents with bipolar affective illness: a five-year naturalistic, prospective follow-up. *J Am Acad Child Adolesc Psychiatry.* 1995;34:724-731.

Taylor E. Managing bipolar disorders in children and adolescents. *Nat Rev Neurol*. 2009; 10:1038/nrneurol.2009.117

Tillman R, Geller B. Definitions of rapid, ultrarapid, and ultradian cycling and of episode duration in pediatric and adult bipolar disorders: A proposal to distinguish episodes from cycles. *J Child Adolesc Psychopharmacol.* 2003;13:267-271.

Tohen M, Baker RW, Altshuler LL, et al. Olanzapine versus divalproex in the treatment of acute mania. *Am J Psychiatry.* 2002;159:1011-1017.

Tohen M**,** Kryzhanovskaya L, Carlson G, et al. Olanzapine versus placebo in the treatment of adolescents with bipolar mania. *Am J Psychiatry.* 2007;164:1547-1556.

Wagner KD, Kowatch RA, Emslie GJ, et al. A double-blind, randomized, placebo-controlled trial of oxcarbazepine in the treatment of bipolar disorder in children and adolescents*. Am J Psychiatry*. 2006**;**163(7):1179-1186.

Wehr T A, Sack DA, Rosenthal NE. Sleep reduction as a final common pathway in the

genesis of mania. *Am J Psychiatry.* 1987; 144: 201-204.

Young RC, Biggs JT, Ziegler VE, Meyer DA. A rating scale for mania: reliability, validity, and sensitivity. *Br J Psychiatry* 1978;133:429-435.

Youngstrom EA, Findling RL, Danielson CK, Calabrese JR. Discriminative validity of parent report of hypomanic and depressive symptoms on the General Behavior Inventory. *Psychol Assess.* 2001;13:267-276.