

DIFFERENTIATING ADHD FROM JBPD

SIMILARITIES: Talkative, distractible, and overly active.

KEY DIFFERENCES ASSOCIATED WITH JBPD: Daily transitions in mood and diurnal cycling that is ultra-rapid; grandiosity; elated mood (co-occurs with irritable mood 87% of the time); hyper-sexuality; flight of ideas or racing thoughts; decreased need for sleep; “mission mode” in which there is a relentless pursuit of needs; and family history of Mood Disorders (including Bipolar) and alcoholism.

ADHD	JBPD
Inadvertently engage in risky behaviors.	Intentionally seek out hedonistic and/or dare-devil activities; hypersexuality is in this category.
Possible difficulty falling asleep. Typically, no difficulty with morning arousal and hyperactivity predictably occurs upon awakening.	Decreased need for sleep rather than insomnia; and difficulty staying asleep, typically due to night terrors. Sleep inertia (difficulty with morning arousal) with bursts of energy from late afternoon to very early morning. With decreased need for sleep, typically engage in goal directed activities during typical hours of sleep.
OCCASIONAL IRRITABILITY OR AGGRESSION. Usually triggered by sensory or affective over-stimulation; do not cause severe regressions; recovery occurs within 20-30 minutes. Occasional unintentional destruction of things; stumbles into fights.	SEVERE, UNCONTROLLABLE AGGRESSION. Often triggered by limit-setting, and may last several hours. Intentional destruction of things (destructive rage); instigates fights.
Interview tolerant: pleasant upon first meeting.	Interview intolerant: may be dysphoric and rejecting.
Natural course is chronic and continuous, with trend toward improvement.	More severe or dramatic symptoms over the lifespan during symptomatic periods, especially without medical treatment.
Similar behavioral difficulties at home and school.	Behavioral difficulties likely to be worse at home than school or during difficult time of day for the student (due to irregular circadian rhythms).
No loss of reality testing expected.	Psychosis (loss of reality testing) with Bipolar-One and Bipolar-Two. More likely to occur for adolescents than children.
20% meet criteria for JBPD.	93% meet criteria for ADHD.
Onset is at birth, although symptoms typically appear by age 2, and diagnosis is usually by age 4.	Onset “rarely” occurs before age 6.

Time Magazine August 19, 2002: *Young and Bipolar. Inside the Bipolar Brain* (chart describing areas of brain injury associated with JBDP); and *Mood Spectrum Table* in Handout 3
 Handout 2: Diana Browning Wright

INSIDE THE BIPOLAR BRAIN

Scientists can't point to one lobe that makes a person bipolar, but they have identified several areas that are involved in ways they are just beginning to understand

VENTRAL STRIATUM

WHAT IT DOES: Helps the brain process rewards

WHAT HAS GONE WRONG: Studies show overactivity and a 30% loss in gray matter in this region, causing people to lose judgment about how certain behaviors, such as overspending or being sexually indiscriminate, will affect their lives

PREFRONTAL CORTEX

WHAT IT DOES: Parts of the prefrontal cortex regulate emotion and are instrumental in processing rewards and motivation

WHAT HAS GONE WRONG: Studies show a 20% to 40% reduction in gray matter—the result of a loss of the branches that connect neurons

AMYGDALA

WHAT IT DOES: One of the brain's emotional centers; helps in the recognition of facial expressions and tones of voice. Neural transmissions increase in response to emotional stimuli. Normally, repeated exposure to the same experiences or images leads to habituation, or reduced response

WHAT HAS GONE WRONG: Habituates slowly to some stimuli, remaining reactive beyond the usual response time

HIPPOCAMPUS

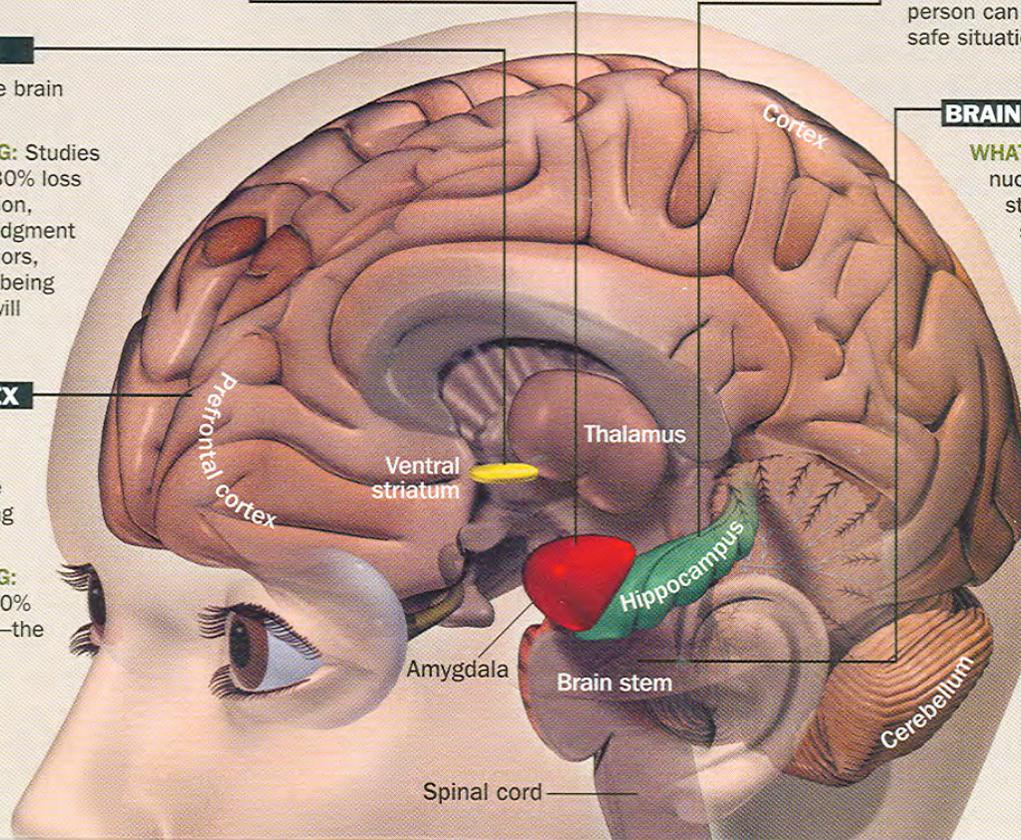
WHAT IT DOES: One of the brain's memory centers. One layer of the hippocampus, the subiculum, helps recognize contexts that represent danger or reward

WHAT HAS GONE WRONG: Loss of branches that connect neurons may lead to a constant state of anxiety because the person can no longer identify safe situations

BRAIN STEM

WHAT IT DOES: The raphe nucleus in the brain stem is home to serotonin cell bodies, which create and disperse the neurotransmitter to different parts of the brain

WHAT HAS GONE WRONG: Bipolar patients have a 40% loss of the serotonin 1a receptor in the raphe, which may contribute to atrophy of neurons and depression



SOURCE: Wayne Drevets, M.D., National Institute of Mental Health

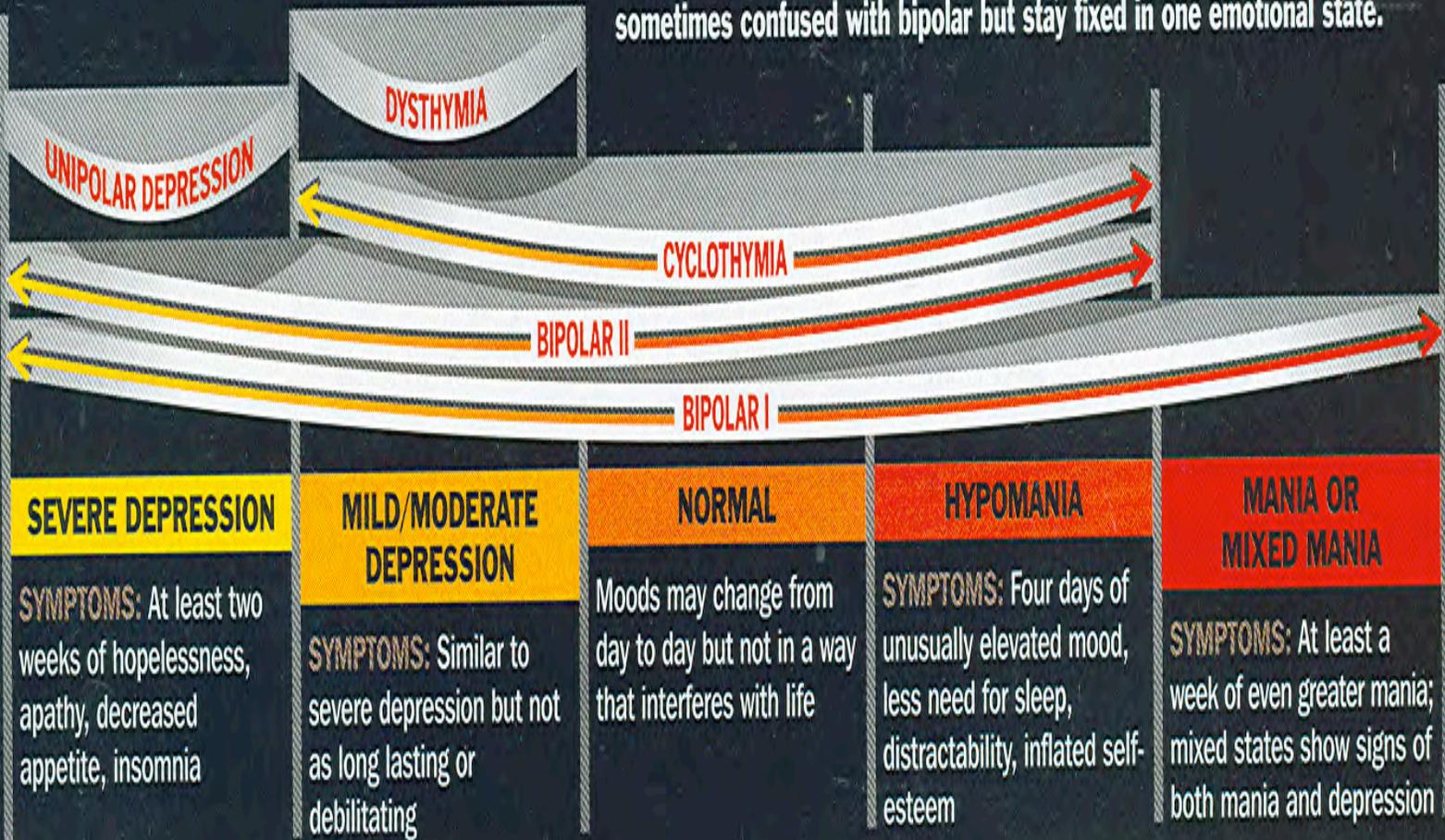
Text by Sora Song
 TIME Diagram by Joe Lertola

THE MOOD SPECTRUM

Not all bipolar states are alike. The three major forms of the disorder—bipolar I, bipolar II and cyclothymia—cover different parts of the mood arc. Other conditions, such as dysthymia or depression, are sometimes confused with bipolar but stay fixed in one emotional state.

Types of disorders

Mood states



Summary of A CONTROVERSIAL DIAGNOSIS : Juvenile Bipolar Disorder

Because of the following issues, many have questioned the validity of a Juvenile diagnosis of Bipolar Disorder:

- DSM-4 criteria for Mania were developed for persons 18 and older (although no youngest age was identified).
- Mania & Depression are addressed as separate, distinct phenomena in DSM4, but are often combined in children as chronic irritability, which is considered by many to be a non-specific feature.
- Irritability is an acceptable alternative to mania according to DSM4 criteria for mania.
- It was not until relatively recently that chronic irritability was recognized as a possible alternative to the hallmark criteria of euphoric mood and grandiosity for children.
- In addition to a debate over presence or absence of episodes, the type of rapid cycling seen in children is far more rapid than the type that meets the Rapid Cycling criteria in DSM4.
- In addition to a debate over presence or absence of episodes that define JBPD, there are variations of the cycling that define it:
 - *Complex Cycling* - short cycles embedded within a more prolonged cycle or episode.
 - *Ultrarapid*: 5 to 364 cycles per year.
 - ***Ultradian*: 365+ cycles per year (or, at least 1/day) with mania duration of 4+ hours per day.**
- **According to DSM4, an ultradian cycle is not considered an episode or a cycle of mania, hypomania or depression; thus, no criteria corresponding to this type of cycling seen in children.**
- **Some have suggested that children have ultra-ultra-rapid cycling.**
- **Symptoms of mania are not yet in the behavioral repertoire of young children. (e.g., *disinhibition* manifested by *immodest attire* or *excessive spending* are precluded by parental control.)**
- **Labile moods are common in young children.**
- **Labile moods (shifts from elevated to depressed states) are common in young children.**
- **DSM4 describes Mania and Depression Episodes separately, while the majority of children with JBPD present *chronic irritability* or**

“affective storms” instead of distinct episodes of mania and depression.

- **Mania experienced differently by children: adults enjoy mania (at least hypomania) while many children experience it as negative and agitating.**
- **Some of the symptoms of mania are not yet in the behavioral repertoire of young children and are colored by developmental stage of the child (e.g., disinhibition manifested by immodest attire or excessive spending would be precluded by parent control over dress and money management.**
- **Symptoms often do not meet 4 to 7 days duration criterion; therefore, diagnosis of BPD-NOS is commonly given.**
- **Symptoms of JBPD significantly overlap those of other childhood disorders, including ADHD, Autism Spectrum Disorders, Anxiety Disorders, OCD, and Disruptive Behavior Disorders.**
- **There have been no objective measures to substantiate clinical impressions, which may be influenced by idiosyncratic experiences of the clinician, with cases in which certain symptoms are pronounced.**
- **Some researchers emphasize centrality of *irritability*, even in absence of elation, grandiosity, and episodicity.**
- **Others consider irritability a core symptom only if it co-occurs with elated mood or grandiosity.**
- **Grandiosity alone is not adequate for a diagnosis.**
- **At the outset, I mentioned JBPD may be a controversial diagnosis because clinicians are diagnosing children with criteria that were established primarily for adults and adolescents.**
- **It is also possible that Bipolar Disorder simply looks different in children, i.e., there are no distinct “polar” episodes of mania, then depression, then mania.....and so on; rather, mania and depression are fused, causing severe mood and behavioral dysregulation.**
- **We will review the features of a “core phenotype,” or diagnostic model, at the end of the training, as a review.**
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Conclusion: Despite controversy, the consensus of NIMH Roundtable group is that there is a spectrum of JBPD phenotypes, ranging from “Narrow” (meets extant DSM4 criteria) to “Broad” (includes features established since publication of DSM4 in 1996.) New diagnostic guidelines are being developed by several research bodies and the next DSM manual will likely provide further clarification.

ACCOMMODATIONS FOR JBPD

THEME: BLEND CONSISTENCY AND FLEXIBILITY

- *Assist family and school in providing flexible, low-stress home environments.*
- *Modify or eliminate homework if it is creating extreme stress*
- *Consider home instruction when symptoms preclude attending.*
- *Consider a later start time when sleep is disordered.*
- *Provide access to water and restroom (dehydration and frequent urination are side effects of mood stabilizers).*
- *Provide streamlined access to nurse (when appropriate) for medication and to deal with medication side effects.*
- *Supervise and support organization strategies for remembering assignments, such as agenda and second set of books for home;*
- *Use cues and prompts to assist concentration, retrieval, memory*
- *Provide a visual checklist of required steps for problem solving.*
- *Consistent schedule; prior notice of changes or transitions.*
- *Flexible grading, expectations, and possibly assignment reduction when energy levels fluctuate.*
- *Assure a safe haven when emotions are overwhelming; e.g., access to counselor.*
- *Give extra time or individual assistance when concentration and organization are reduced or unreliable.*
- *Modify demands that elicit anxiety.*
- *Alter P.E. instruction or excuse absence when energy level takes downturn. Most students will NOT require APE; so alter this in an accommodation plan portion of the IEP*
- *Remember the sleep disorder aspect of JBPD: Carefully schedule tasks and courses so they occur during periods in the diurnal cycle when student is typically most alert and compliant.*
- *Consider accommodations for sensory differences (reduce or eliminate irritating input; provide sensory diet of soothing input).*

Supporting Positive Behavior, and Managing Challenging Behavior

A function based behavior support plan is recommended for students whose strong “rejection” behaviors require careful staff attention. See: www.pent.ca.gov/forms for forms that embody the key concepts in behavior analysis, and www.pent.ca.gov for the BSP Desk Reference on developing a high quality behavior plan.

Effective PREVENTATIVE Strategies

Provide teacher and staff interactions that easily convey to the student unconditional positive regard and obvious affection. This is the primary preventative component!

Be proactive with environmental supports that reduce the likelihood of defiance and other problem behaviors (see BSP Desk Reference at: www.pent.ca.gov)

Provide ample praise, contingent access to desired activities and other reinforcers for compliance. Remember to “shape” behavior, reinforce closer and closer approximations to the desired behavior

Use task pacing aids (e.g., when 4 items are checked off on your list, then you earn a break! Come on, we can get this done together!)

Provide adult supports to “reality check” if hostile intention is attributed to neutral stimuli

Allow and even prompt a “Time Away”--a brief break from tasks self-initiated by the student, different from “Time Out” (see: BSP Desk Reference, chapter 13 at: www.pent.ca.gov)

Teach peers to check the student’s attribution to their actions

Teach adults to understand the source of problem behavior

Teach the student disability Awareness and Self-Advocacy Training that includes a relapse prevention plan.

Effective REACTIVE Strategies

1. Prompt to an agreed upon alternate strategy or redirect

- In handling defiance, recognize it is often rooted in manic grandiosity, which can be delusional.
- Redirect to an activity known to be soothing.

2. Manage the Problem Safely

- Use non-violent crisis prevention programs with *verbal de-escalation* techniques (NCPI: PROACT).
- Avoid struggles for control, especially when it is evident refusals or opposition is due to grandiosity.
- Fear of harm to self or other is a feature of aggression associated with JBPD that causes dangerous behaviors. Maintain relationship, use calm voice, with decreasing volume, spaces between words to bring the situation under control.

3. Debrief following episode

Student is likely to be fearful of his/her rage. Be reassuring and perform a “social autopsy” on how WE can handle a frustration TOGETHER in the future.

4. Consequence if necessary

- RAGE IS A CARDINAL FEATURE that requires interventions or accommodations; and threat assessment when threats are made to determine whether the student is on a path toward violence. Characteristics of the rage have included:
 - Stab or hit others, often a family member (esp. mother).
 - Parents become fearful of them; younger siblings at risk of harm.

Final Comments JBPD: Accommodations, Behavior Plans & Related Services

What if the family of the student with Bipolar Disorder asks for accommodations, related services or a behavior intervention plan and school personnel do not believe is appropriate?

- **Do not respond with:**
 - ***“We can’t provide those in this setting”*** (FACT: Accommodations and BIPs are necessary in any setting prior to consideration of a more restrictive placement change; related services can be provided on site, through transportation elsewhere, or through funding other options on site. All students, with & without IEPs need individualization of supports to meet state standards)
 - ***“We can’t afford that”*** (FACT: students with IEPs receive an education without regard or consideration of affordability.)
 - ***“That wouldn’t be fair to the other students “*** (FACT: Fair is not everyone getting the same thing, fair is everyone getting what they need---a free appropriate public education in the least restrictive environment, with all necessary supplementary aids to support the LRE, and all related services to benefit from the special education)
- **Respond with:**
 - ***First, think carefully before you respond. Be sure the request is not appropriate, be open to the complex support needs of these students. Ask questions and build bridges***
 - ***If you believe the requested intervention is not appropriate: “Let me show you the facts and data that support our conclusion that the intervention you request would not be appropriate for your son or daughter.” And, “Let me explain our training, expertise and background in serving students with Juvenile Bipolar Disorder that is at the basis of our conclusion. Let us describe interventions that are supported by research.”*** Reach consensus. If not, remember parent rights for mediating differences if the student has an IEP.

Eligibility Issues

- Not all students with a Juvenile Bipolar Disorder diagnosis will be eligible for special education services. Report of a JBPD dx should trigger a “child find” for possible eligibility. JBPD is a mental health disorder.
- Those that are eligible, likely qualify as emotionally disturbed, but consider all other possibilities as well, including other health impaired.
 - They will require specialized instruction due to the unique nature of that disability, and
 - supports to maintain least restrictive environment, and
 - commonly, related services to benefit from their special education.
- Some students with Juvenile Bipolar Disorder have other diagnoses that qualified them for special education. They may require multiple supports for both the other diagnoses and for bipolar disorder.

EVIDENCED-BASED PSYCHOTHERAPY/COUNSELING SERVICES

Cognitive Behavioral Therapy (CBT): Focuses on cognitive distortions that affect mood and challenges them. Manualized programs of CBT are more standardized and have stronger evidence of benefit.

- *University of Maryland operates a web site that publishes an inventory of evidence-based psychotherapy approaches according to disorder (depression, anxiety, substance abuse, disruptive behaviors, etc.) and whose effectiveness was established for school-based mental services. U. Maryland Center for School MH: Empirically-Supported Interventions in School Mental Health:*
http://csmh.umaryland.edu/resources.html/resource_packets/download_files/empirically_supported_2002.pdf

Affective Education: Also known as Patient Education (Medical/Psychiatric Model); includes disability awareness, especially implications for social interactions and the types of explicit social skills training (explicit instruction in how to handle social interactions) that are appropriate. One effective approach, especially with younger students, is the use of social stories to teach them the features of the disorder, how to advocate for their exceptional needs, and how to more effectively handle interpersonal problems.

- A resource for social stories: www.bpinfo.net/children.htm (books available include *Storm in My Brain*, *Anger Mountain*, *My Bipolar Rollercoaster*, and *Brandon and the Bipolar Bear*).
- *My School Day with and without Accommodations (Help)* is available at www.bpkids.org.

Adult Guided Practice to Help Internalize Affective Education.

Interpersonal and Social Rhythm Therapy: Strategies to regularize daily routines and sleep schedules, which can stabilize mood; and strategies to stabilize interpersonal relationships, such as relationship maintenance/repair. Based on the work of Frank (2005), who found **two factors** that impact the course of Bipolar Illness:

- ✓ *Supports for maintaining consistent daily routines, especially sleep-wake cycles.**
Sleep is critical for the production of neurotransmitters that help regulate mood.
- ✓ *Supports for maintaining social relationships.*

***Compromised Circadian Rhythm Integrity, especially alterations of the sleep/wake cycle, has negative impact. Loss of deeper stages of sleep can trigger mania. One intervention for this is the reduction caffeine intake to less than 250 mg, as it impairs quality of sleep, especially stages 3 and 4 (deep sleep when neurotransmitters are produced by the brain), and thereby can trigger mania.**

Family Therapy: Emphasis on training the family in relapse prevention (e.g., systems for monitoring child for early warning signs; establishing a relapse response drill/scripts). Also emphasizes reducing the tremendous level of stress caused by the illness; and grieving or mourning the loss of the healthy child (more common in families who have experience with the disorder). Note that:

- Behaviors at home are often more intense and problematic than at school, because affect and associated behaviors are more intense in close interpersonal relationships.

- Parents are likely to have Bipolar Disorder, given strong inheritability; while “inside knowledge” of this disorder may be helpful, it also increases awareness of disabling implications, and this can result in earlier and more intense grieving.
- Recovery more likely in an intact nuclear family; additional factors of parental warmth, low tension between parent and child, and flexibility also affect outcome.

CAUTION: Forcing a child into therapy will negatively impact outcome future receptivity to treatment.

WEB-BASED RESOURCES

BIPOLAR AND JBPD:

- www.bpkids.org (Local Resources Categorized by State; Social Story for Disability Awareness & Self-Advocacy Training).
- www.bipolarchild.com .
- www.bpchildren.com .
- www.jbrf.org (click LIBRARY; first document is Final Diagnostic Manual that includes *Child Bipolar Questionnaire*).
- www.bpinfo.net (several social stories books).
- www.nimh.nih.gov/publicat/index.cfm (*informal rating scale for hypomania*).

MENTAL HEALTH IN SCHOOLS:

- www.dmh.ca.gov/mhsa California Department of Mental Health School Mental Health Project
- U. Maryland Center for School MH: Empirically–Supported Interventions in School Mental Health:
http://csmh.umaryland.edu/resources.html/resource_packets/download_files/empirically_supported_2002.pdf

PENT WEBSITE FOR downloading powerpoints, and other materials: www.pent.ca.gov

What Educators Need to Know About Medications for JBPD Why do Physicians Medicate?

Empirically Validated Information: BIPOLAR MEDICATIONS REDUCE BRAIN INJURY

HYPERCORTISOLEMIA

With Major Depression and Bipolar, increased levels of Cortisol (**Hyper-cortisolemia**) cause damage to various areas of the brain. For example, it causes structural damage to the hippocampus, which results in poor regulation of emotions as well as learning disabilities. Some medications reduce Cortisol toxicity by turning on a naturally occurring protective protein, Brain-derived Neurotrophic Factor (BDNF), which helps repair nerve cells. BDNF latches onto Cortisol molecules, rendering them less toxic. The gene that turns on BDNF naturally becomes disabled when an individual has Bipolar or Major Depression. Lithium and antidepressants are able to turn on BDNF, reducing the likelihood of brain injury caused by Cortisol.

UNREGULATED APOPTOSIS

Lithium also prevents **unregulated Apoptosis** (neural pruning). This is a naturally occurring type of “neural pruning” is turned on genetically at specific stages of development to optimize neural functioning. Bipolar affects the gene that switches it off, resulting in unregulated pruning or loss of neural cells.

MEDICATIONS FOR BIPOLAR DISORDER YOUR STUDENT MAY TAKE

Many medications prescribed for children with Bipolar Disorder are used “off label,” i.e., for purposes or populations other than those in drug studies of efficacy and safety. For example, Risperdal has been in use with children for at least several years, but was only recently approved by the FDA for treating children; *and the evidence pertains only to children with Autism.*

Prescribing medication is more complex for children. This is due in part to the fact that students may require more medications:

- Twenty percent of children with Bipolar respond to monotherapy (a single medication).
- Eighty percent require four medications, whereas most adults require three.

Obtaining accurate reports about therapeutic effects and side effects is also more difficult, as the information is obtained second hand through parents (mostly). The algorithm involves targeting a symptom, treating it with a medication; monitoring the effects and altering dose or adding a medication; and proceeding in this fashion, one medication at a time, trying to maximize the dose before discontinuing a drug of little apparent benefit. Conclusion: SCHOOL COMMUNICATION TO AUGMENT PARENT REPORTS IS CRITICAL

Mood Stabilizers

Lithium Depakote (Divalproex) Lamictal (Lamotrogine) Tegretol (Carbamazepine) Trileptal (Oxcarbazepine) Topamax (Topiramate)

[Most are also Anti-Epilepsy or Seizure Medications. By definition, mood stabilizers prevent depression and mania, but Lithium is the only one that does both. For example, Depakote appears to have more anti-mania effects, while Lamictal has more anti-depressant effects.]

Second Generation Antipsychotics (SGAs)

Risperdal (Risperidone), Geodon (Ziprasidone) Zyprexa (Olanzapine), Seroquel (Quetiapine Fumarate), Abilify (Aripiprazole)

Antidepressants

SSRIs (Serotonin Re-uptake Inhibitors), MAOIs (Monoamine Oxidase Inhibitors), TCAs (Tricyclic Antidepressants)

The Evolution of Bipolar Diagnosis and Treatment

400 B.C. -Mania and melancholia described as separate illnesses by Hippocratic physicians.

150 AD . First written account of bipolar disorder in adolescence

1817 - Lithium discovered in a Swedish iron mine.

Late 1800- British physician Sir Alfred Garrod describes lithium as therapeutic for mood disorders.

1913 -Kraepelin establishes modern concept of manic-depressive illness as separate from schizophrenia.

1930s - Freud states that a classical depressive syndrome could not occur in children before puberty.

1949 - Australian researcher John Cade reports the benefits of lithium to treat 10 patients with mania.

1952 - The American Psychiatric Association publishes the first Diagnostic and Statistical Manual (DSM), includes the diagnosis "manic-depressive reaction." J.D. Campbell reports 18 cases of pediatric onset of psychotic mania with strong family history of affective disorders in Journal of Nervous and Mental Disorders.

1969 - Swedish psychiatrist Dr. Anna-Lise Linell successfully treated manic-depression in children as young as 6 using lithium.

1960s - A handful of articles in the medical literature observe that many adult bipolar patients have been ill since adolescence. Leading psychiatrists insist that to diagnose manic-depression in children, they must meet adult criteria.

1970 - Lithium is approved by the FDA to treat mania; doctors in U.S. and Sweden begin using lithium to treat children as young as age 5 with good results ..

1973 - First use of anticonvulsants in treatment of bipolar disorder.

1980 -Bipolar disorder replaces manic-depressive disorder as a diagnostic term in the DSM-111.

1980s - Researchers establish differences between adult and early-onset bipolar disorder, but most psychiatrists continue to maintain that pre-pubertal children cannot have the disorder.

1986- National Depressive and Manic-Depressive Association (National DMDA) founded.

1995 -Baldessarini, M.D., *et al*/publish "Clinical and Public Health Problem," in Harvard Review of Psychiatry, Vol 3, No.4, 171-195.

1997 - The Journal of the American Academy of Child & Adolescent Psychiatry publishes "Child and Adolescent Bipolar Disorder: A Review of the Past 10 Years" by Barbara Geller, M.D. and Joan Luby, M.D., and "Practice Parameters for the Assessment and Treatment of Children and Adolescents With Bipolar Disorder" by Jon McClellan, MD., and John Werry, M.D.

1999 - Parents of children with JBPD swell support groups on the Internet and flood the telephone lines of national mental health organizations; they established The Child & Adolescent Bipolar Foundation.

1999 - Bipolar Disorders medical journal founded; International Society for Bipolar Disorders begun.

Late 1990s - Multi-site treatment studies and longitudinal studies following early-onset children are funded by the National Institute of Mental Health and the Stanley Foundation. More psychiatrists begin to diagnose and treat the disorder successfully in children.

2000 -***The Bipolar Child*** by Demitri Papolos M.D. and Janice Papolos is published; ABC News airs a segment of *20/20* on early-onset bipolar disorder; and The Child & Adolescent Bipolar Foundation interactive web site (www.bpkids.org) is launched.

2005 - **Treatment Guidelines for Children and Adolescents with Bipolar Disorder** published (written by a consensus conference of experts convened by CABF)

The Ups and Downs of Bipolar Disorder: REFERENCES

- Adler C, DelBello M, Strakowski S(2006). Brain Network Dysfunction in Bipolar Disorder. [CME course by CNS Spectrums/International Journal of Neuropsychiatric Medicine: <http://www.cnsspecturms.com/asp/article/pf.aspx?articleid=363> .
- Dickstein D, Treland J, Snow J, McClure E, Mehta M, Towbin K, Pine D, & Leibenluft E (2004). Neuropsychological performance in pediatric bipolar disorder. *Biological Psychiatry* 2004; 55; 32-29.
- Frank, E (2005). *Treating Bipolar Disorder: A Clinician's Guide to Interpersonal and Social Rhythm Therapy*. New York: Guilford Press.
- Geller B, Zimmerman B, Williams M, DelBello M, Frazier J, & Beringer L (2002). Phenomenology of prepubertal and early adolescent bipolar disorder: examples of elated mood, grandiose behaviors, decreased need for sleep, racing thoughts and hypersexuality. *Journal of Child and Adolescent Psychopharmacology* 2002: 12:1, 3-9.
- Geller B, Delbello M (Eds), (2003), *Bipolar Disorder in Childhood and Early Adolescence*. New York: Guilford Press.
- Goldstein T, Birmaher B, Axelson D, Ryan N, et al: History of suicide attempts in pediatric bipolar disorder: factors associated with increased risk. *Bipolar Disorders* 2005: 7 (December): 525-535
- Kaufman, Bimaher, Brent, Rao & Ryan (1996), *Schedule for Affective Disorders and Schizophrenia for School Aged Children (6-18 Years)*.
- Liebenluft E, Charney DS, Towbin KE, Bhangoo RK, Pine DS (2003), Defining clinical phenotypes of juvenile mania. *American Journal Psychiatry* 160; 430-437.
- Neel R, Cessna K, Borock J, Bechard S (2003). Quality program indicators for children with emotional and behavioral disorders. *Beyond Behavior*, Spring 2003.
- Papolos D, and Papolos J (1999), *The Bipolar Child*. New York: Broadway Books.
- Papolos D (2007), *Core Diagnostic Criteria* for JBPD. Published on the web site for Juvenile Bipolar Research Foundation (www.jbrf.org; library link).
- Patel N, Delbello M, Strakowski, M: Ethnic differences in symptom presentation of youth with bipolar disorder. *Bipolar Disorders* 2006: 8: 95-99.
- Pavuluri M, Birmaher B, Naylor M (2005). Pediatric bipolar disorder: a review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry* 2005: 44:9, 846-871.
- Preston, John (2007). *Childhood Bipolar Disorder*, presentation at the California Association of School Psychologists Convention, Los Angeles.
- Sovner, R (1986). Limiting factors in the use of DSM-III criteria with mentally ill/mentally retarded persons. *Psychopharmacology Bulletin*, 22(4), 1055-1059.
- Weckerly J (2002). Pediatric Bipolar Mood Disorder. *Developmental and Behavioral Pediatrics* 2002: 22:1, 42-55.