



Acute Mania with Psychotic Features in an Adolescent Female: A Case Report

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Abstract: The current report examines a 19-year-old female university student who developed acute manic symptoms following hospitalization for gastritis. The patient, previously without psychiatric history, presented with complete sleep cessation, pressured speech, grandiose delusions, and inappropriate social behavior. Her most prominent symptoms included fixed false beliefs about career achievements, inflated self-importance, uncontrollable speech patterns, and preoccupation with marriage themes. Prior to her January 2025 medical admission, she had functioned normally with no mental health concerns. Psychiatric symptoms emerged abruptly five days post-discharge and intensified over four consecutive days. Clinical evaluation revealed elaborate delusional thinking, flight of ideas, emotional lability, and complete absence of insight. This case highlights the challenges in recognizing and managing first-episode mania in young adults and demonstrates the potential temporal relationship between medical hospitalization and psychiatric symptom onset in vulnerable individuals.

Keywords: *Manic Episode, Young Adults, Bipolar Disorder, Case Report, Psychiatric Emergency*

1. Introduction

Bipolar disorder is a chronic psychiatric condition characterized by alternating episodes of mania or hypomania and depression, affecting approximately 1-2% of the global population

(Grande et al., 2016). The disorder typically manifests during late adolescence or early adulthood, with the average age of onset being 18-22 years, making early recognition crucial for optimal outcomes (Leboyer et al., 2005). First-episode mania presents unique diagnostic and therapeutic challenges, particularly when it occurs without a preceding depressive episode, as timely intervention can significantly impact the long-term trajectory of the disorder (Birmaher et al., 2007).

The diagnostic criteria for a manic episode, as outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), require a distinct period of abnormally elevated, expansive, or irritable mood and increased goal-directed activity lasting at least one week (American Psychiatric Association, 2022). During this period, at least three symptoms from a specific cluster must be present, including decreased need for sleep, more talkative than usual, flight of ideas, distractibility, increased goal-directed activity, and excessive involvement in risky behaviors. The symptoms must represent a noticeable change from usual behavior and be severe enough to cause marked impairment in functioning or necessitate hospitalization.

Grandiose delusions, a hallmark feature of manic episodes, involve inflated self-esteem and unrealistic beliefs about one's abilities, importance, or identity (Knowles et al., 2011). These delusions can range from mild overconfidence to elaborate belief systems involving special powers, relationships with famous individuals, or professional achievements that are clearly inconsistent with reality. The presence of such delusions often correlates with greater severity of the manic episode and may indicate a need for immediate psychiatric intervention (Carlson et al., 2000).

First-episode mania in young adults presents particular diagnostic challenges, as the presentation may be confused with other psychiatric conditions, substance use, developmental factors, or stress-related responses (Youngstrom et al., 2008). The differential diagnosis must consider various conditions including substance-induced mood disorders, medical conditions affecting mood, attention-deficit/hyperactivity disorder, and personality disorders. Early recognition is crucial, as longer duration of untreated illness is associated with more severe subsequent episodes, greater functional impairment, and increased risk of suicide (Altamura et al., 2010).

Cultural and familial factors significantly influence the presentation and recognition of bipolar disorder, particularly in collectivistic societies where family involvement in treatment decisions and support systems can substantially impact treatment adherence and outcomes (Chandra et al., 2019). Additionally, family history of psychiatric disorders, particularly mood

disorders and psychotic conditions, represents a significant risk factor for bipolar disorder development, with genetic factors contributing substantially to disease susceptibility (Lichtenstein et al., 2009).

The current report examines the experience of a 19-year-old female university student who developed her first manic episode following medical hospitalization for gastritis. Her symptoms included classic manic features such as decreased sleep, grandiose delusions involving professional achievement as an IPS officer, hypersexuality, and behavioral disinhibition requiring psychiatric hospitalization. The case illustrates the typical presentation of first-episode mania in a young adult and highlights the importance of comprehensive psychiatric evaluation and early intervention.

The goals are as follows:

1. To provide a detailed clinical presentation of first-episode mania in a young adult, contributing to the understanding of early-onset bipolar disorder presentation and diagnostic considerations.
2. To explore the potential role of medical illness and hospitalization as precipitating factors in vulnerable individuals, examining the complex interplay between physical and mental health.
3. To discuss the diagnostic challenges and differential considerations in first-episode mania, highlighting the importance of comprehensive psychiatric assessment in young adults presenting with acute behavioral changes.

This case aims to raise awareness among healthcare professionals about the complexity of first-episode mania presentation, emphasizing the need for early detection and intervention, especially in young adults with no prior psychiatric history. This report contributes to the literature on early intervention strategies and their impact on long-term outcomes in bipolar spectrum disorders.

2. Research Evidence

Birmaher et al. (2007) conducted a comprehensive longitudinal study examining the clinical course of children and adolescents with bipolar spectrum disorders. Their research demonstrated that early-onset bipolar disorder follows a more chronic and severe course compared to adult-onset variants, with participants experiencing more frequent mood episodes and greater functional impairment over time. The study highlighted the critical importance of early recognition and intervention, as participants who received timely treatment showed better long-term outcomes in terms of episode frequency, severity, and psychosocial functioning. The

researchers identified specific risk factors for poor prognosis, including family history of mood disorders, early age of onset, and presence of psychotic features during initial episodes.

Grande et al. (2016) provided a comprehensive review of bipolar disorder, examining the complex neurobiological, genetic, and environmental factors that contribute to its development and course. Their analysis revealed that the pathophysiology of bipolar disorder involves dysregulation of multiple neurotransmitter systems, including dopamine, serotonin, and GABA, along with alterations in neuroplasticity and cellular resilience. The review emphasized that first-episode mania often represents the clinical manifestation of underlying neurobiological vulnerabilities that may have been present sub clinically for years. The authors highlighted the importance of understanding bipolar disorder as a multisystem condition affecting not only mood regulation but also cognitive function, circadian rhythms, and stress response systems.

Altamura et al. (2010) investigated the relationship between duration of untreated illness and suicide risk in bipolar disorder through a naturalistic study design. Their findings revealed a significant correlation between delayed treatment initiation and increased suicidal behavior, with patients experiencing longer periods of untreated illness showing higher rates of suicide attempts and completed suicide. The study identified first-episode mania as a critical intervention window, demonstrating that early treatment not only improves symptom control but also substantially reduces mortality risk. The researchers emphasized that the first manic episode often provides the clearest opportunity for diagnosis and treatment initiation, making prompt recognition and intervention essential for optimal outcomes.

Youngstrom et al. (2008) examined the validity and diagnostic challenges associated with pediatric bipolar disorder, providing crucial insights applicable to young adult presentations. Their research highlighted the complexity of differentiating bipolar disorder from other psychiatric conditions in younger populations, identifying key diagnostic features that improve diagnostic accuracy. The study revealed that grandiose delusions, decreased need for sleep, and episodic nature of symptoms were among the most reliable indicators of bipolar disorder in young patients. The authors emphasized the importance of comprehensive assessment approaches that consider developmental factors, family history, and longitudinal symptom patterns rather than relying solely on cross-sectional presentations.

3. Case Presentation

Patient Information and Demographics

The patient was a 19-year-old female, a first-year student pursuing a degree in special education at a university in Delhi. She resided with her extended joint family comprising approximately 22 members. Primary information for this assessment was provided by her paternal aunt and uncle, who served as her caregivers. The patient's own statements were considered only partially reliable due to her mental state. The family expressed significant concern regarding abrupt behavioral changes, including complete sleep deprivation, incessant speech, and fixed false beliefs relating to personal achievements.

Presenting Complaints

- Complete absence of sleep for four consecutive nights, accompanied by a lack of perceived need for rest
- Persistent and rapid speech that could not be interrupted
- Exaggerated and unrealistic claims regarding personal accomplishments and future goals
- Fixed false beliefs about attaining a prestigious government post
- Inappropriate sexual comments and flirtatious behavior toward male family members
- Public speaking incidents involving unrealistic claims about personal success

History of Present Illness

The patient was functioning well academically and socially until January 2025, when she experienced severe abdominal pain and was hospitalized from January 11th to 14th for treatment of gastritis. During her hospital stay, she was observed by medical staff and family members to be unusually talkative, a change initially attributed to anxiety related to hospitalization.

Following her discharge on January 14th, her behavior escalated markedly over the next four days. She ceased sleeping entirely, while asserting that she felt energized and did not require rest. She began expressing delusions, including claims that her deceased grandmother had appeared in her dreams to inform her of having become an Indian Police Service (IPS) officer through a special achievement initiative.

On January 16th, the patient attended a community education conference where she approached the stage uninvited and began delivering a speech proclaiming her professional accomplishments. She refused to yield the stage even when redirected by organizers and interpreted standard conference materials as personalized awards of recognition.

She also began making inappropriate and flirtatious comments toward male relatives and insisted on holding family gatherings in which she delivered lengthy, boastful monologues. These included imagined wedding plans and exaggerated accounts of success.

On January 18th, following four days of complete sleep deprivation and persistently disruptive behavior, her father and uncle facilitated her admission due to safety concerns and the impact of her symptoms on the family environment.

Past Psychiatric History

There was no reported history of prior psychiatric illness, treatment, or medication use. This presentation was identified as her first psychiatric episode, with no previous indications of mood disturbances, psychosis, or psychological difficulties.

Medical History

- January 2025: Hospitalization for severe gastritis, associated with weight loss due to dietary restrictions and medication
- Late 2021: Typhoid fever during grade 10 examinations, treated with hospitalization and antibiotics
- 2021: Leg injury requiring surgical management and brief hospital stay

Personal and Social History

The patient had a history of strong academic performance and aspired to a career in education. She resided within a traditional joint family and was generally well-liked by family members. She maintained a particularly close bond with her father and had been emotionally attached to her late grandmother, who passed away in 2021.

Premorbid Personality

Described by family as optimistic, confident, and ambitious, the patient had a tendency to seek attention and recognition for her achievements. She was known to be socially outgoing, nurturing in friendships, and generous—often prioritizing others' needs over her own. She occasionally exhibited overconfidence and enjoyed being in the spotlight.

4. Mental Status Examination

- **General Appearance and Behavior:** The patient appeared underweight and presented with messy hair, though otherwise clean and appropriately dressed. She was cooperative during the interview but displayed restlessness, frequently pacing and avoiding direct eye contact.
- **Speech and Language:** Speech was rapid, pressured, and difficult to interrupt. Though the volume remained normal, her responses were tangential and often lacked coherence.
- **Mood and Affect:** She reported feeling “normal,” but her affect was labile, fluctuating rapidly between sadness, laughter, and irritation. Clear mood-affect incongruence was noted.

- **Thought and Perception:** Thought process was characterized by flight of ideas and tangentiality. The patient held fixed, grandiose beliefs about being a law enforcement officer and referenced guidance from her deceased grandmother, though she denied hallucinations.
- **Cognition:** The patient was oriented to person, place, and time. Attention was partially sustained, and her memory appeared intact. Intellectual functioning was judged to be average.
- **Judgment and Insight:** Social judgment was severely impaired. Insight was absent, as evidenced by her belief that her hospitalization was part of a surprise celebration planned by family members.

5. Diagnostic Assessment

Based on the clinical history, symptom presentation, and mental status examination, the patient fulfilled the diagnostic criteria for a Manic Episode with Psychotic Symptoms as per the ICD-10 classification (F30.2).

The diagnosis was supported by elevated, expansive, and irritable mood lasting more than four days; complete absence of sleep over multiple nights without signs of fatigue; pressured, rapid speech and flight of ideas; fixed grandiose delusions related to occupational identity (believing herself to be an IPS officer); disinhibited and socially inappropriate behavior; and complete denial of illness and impaired insight.

Differential diagnoses such as Acute and Transient Psychotic Disorder (F23) and Schizoaffective Disorder (F25) were considered. However, the mood-congruent nature of psychotic symptoms and the clear presence of manic features supported the current diagnosis. Organic or substance-induced causes were ruled out based on medical history and absence of relevant findings.

To support clinical impressions and assess symptom severity, the following standardized tools were administered under supervision:

Young Mania Rating Scale (YMRS): Administered to quantify the severity of manic symptoms. The patient scored in the moderate to severe range, indicating elevated mood, increased motor activity, decreased need for sleep, and pressured speech.

Brief Psychiatric Rating Scale (BPRS): Utilized to evaluate a broad range of psychiatric symptoms. Elevated scores were observed in items related to grandiosity, conceptual disorganization, and unusual thought content.

Positive and Negative Syndrome Scale (PANSS): Conducted to assess the presence and severity of psychotic symptoms. Elevated scores on the positive symptom subscale were consistent with prominent grandiose delusions and suspiciousness.

Mini Mental State Examination (MMSE): Administered to screen for cognitive deficits. The patient was fully oriented to time, place, and person, with scores indicating no significant cognitive impairment.

These assessments supported the clinical impression of a manic episode with psychotic features and helped guide treatment planning.

6. Treatment Plan

Immediate Stabilization Phase

The primary treatment objectives focused on ensuring patient safety, managing acute symptoms, and establishing therapeutic rapport. Given the severity of symptoms and complete absence of insight, involuntary hospitalization was deemed necessary. The treatment team prioritized rapid symptom control while minimizing adverse effects and establishing a foundation for long-term management.

Pharmacological Interventions

Mood Stabilization: A mood stabilizer was initiated with gradual titration based on serum levels and clinical response. Regular monitoring of therapeutic levels, renal function, and thyroid function was established to ensure safety and efficacy.

Antipsychotic Medication: An atypical antipsychotic was prescribed to address psychotic symptoms and provide additional mood stabilization. The medication selection was based on its favorable side effect profile in young adults and established efficacy in managing grandiose delusions and behavioral disinhibition.

Sleep Restoration: A short-acting benzodiazepine was prescribed to address severe insomnia and provide anxiolytic effects. The medication was intended for short-term use during the acute phase, with plans for gradual discontinuation as sleep patterns normalized.

Monitoring and Adjustment: Daily assessment of symptom severity using standardized rating scales was implemented to guide medication adjustments. Regular monitoring included vital signs, metabolic parameters, and neurological examination to detect potential adverse effects.

Psychosocial Interventions

Family Psychoeducation: Comprehensive education sessions were conducted with family members to enhance understanding of bipolar disorder, treatment expectations, and

relapse prevention strategies. The sessions addressed stigma reduction, medication adherence support, and recognition of early warning signs of mood episodes.

Individual Supportive Therapy: Brief, supportive psychotherapy sessions were initiated to establish therapeutic alliance and provide reality orientation. The approach focused on building insight gradually while maintaining patient dignity and self-esteem.

Behavioral Management: Structured daily routines were implemented to promote sleep hygiene, regular meal patterns, and gradual activity scheduling. Environmental modifications included reducing excessive stimulation and providing a calm, predictable setting conducive to recovery.

Milieu Therapy

The patient was placed in a structured inpatient unit with experienced nursing staff trained in managing acute mania. Due to the severity of disinhibited behavior and psychotic symptoms, group activities were not conducted during the acute phase of treatment. Occupational therapy assessment was planned to evaluate functional capacity and develop rehabilitation goals once symptoms stabilized.

7. Discussion

The patient's presentation demonstrated classic features of acute mania, including the triad of elevated mood, increased energy, and decreased need for sleep, accompanied by psychotic features that were mood-congruent in nature.

Temporal Relationship with Medical Illness

The temporal proximity between the patient's medical hospitalization for gastritis and the subsequent emergence of psychiatric symptoms raises important questions about potential precipitating factors. Medical illness and hospitalization represent significant stressors that may trigger psychiatric episodes in vulnerable individuals (Kessler et al., 2010). The inflammatory processes associated with gastritis, combined with the psychological stress of hospitalization, may have contributed to the activation of underlying neurobiological vulnerabilities predisposing to bipolar disorder.

Research suggests that inflammatory cytokines can influence mood regulation and may precipitate manic episodes in susceptible individuals (Rosenblat & McIntyre, 2017). The patient's weight loss and physical debilitation from gastritis may have further compromised her stress resilience, creating conditions conducive to psychiatric decompensation. This case underscores the importance of monitoring psychological well-being during medical hospitalizations, particularly in young adults with no prior psychiatric history.

Diagnostic Considerations

The differential diagnosis of first-episode mania requires careful consideration of multiple factors, including symptom presentation, course of illness, and response to treatment. In this case, the absence of substance use, medical conditions affecting the central nervous system, and clear temporal relationship between symptoms and functional impairment supported the diagnosis of bipolar disorder with psychotic features.

The presence of grandiose delusions, while concerning, was consistent with the severity of the manic episode and did not necessarily indicate a primary psychotic disorder. The mood-congruent nature of the delusions, involving inflated self-esteem and unrealistic career achievements, aligned with typical presentations of mania rather than schizophrenia or delusional disorder (Carlson et al., 2000).

Cultural and Family Factors

The patient's presentation within a collectivistic cultural context influenced both symptom expression and treatment planning. The large joint family structure provided both protective factors, including social support and early recognition of behavioral changes, and potential stressors related to reduced privacy and increased social expectations. The family's prompt recognition of the severity of symptoms and willingness to seek professional help likely contributed to earlier intervention than might occur in other contexts.

The patient's grandiose delusions involving prestigious career achievements may reflect cultural values emphasizing academic and professional success. Understanding these cultural factors is essential for developing culturally sensitive treatment approaches and engaging family members as therapeutic allies (Chandra et al., 2019).

Treatment Response and Prognosis

The patient's response to pharmacological intervention was consistent with typical patterns observed in first-episode mania. The combination of mood stabilization and antipsychotic medication provided effective symptom control while minimizing adverse effects. The restoration of sleep patterns was particularly important, as sleep deprivation can perpetuate manic symptoms and delay recovery.

Early intervention in first-episode mania is associated with better long-term outcomes, including reduced episode frequency, improved functional recovery, and enhanced quality of life (Altamura et al., 2010). The patient's young age, absence of comorbid conditions, and strong family support system represent positive prognostic factors that may contribute to favorable long-term outcomes.

Clinical Implications

This case highlights several important clinical implications for healthcare providers. Recognition of first-episode mania requires high clinical suspicion, particularly in young adults presenting with sudden behavioral changes following medical illness or other stressors. The absence of prior psychiatric history should not delay consideration of bipolar disorder when clinical features are consistent with mania.

The importance of comprehensive assessment using standardized rating scales cannot be overstated, as these tools provide objective measures of symptom severity and treatment response. Regular monitoring of both therapeutic effects and potential adverse effects is essential, particularly in young patients who may be more sensitive to medication side effects.

Family involvement in treatment planning and ongoing care is crucial, especially in collectivistic cultures where family dynamics significantly influence treatment adherence and outcomes. Psychoeducation for family members should address both the biological nature of bipolar disorder and practical strategies for supporting recovery and preventing relapse.

Limitations

Several limitations should be acknowledged in this case report. The relatively short follow-up period limits conclusions about long-term outcomes and treatment response. Additionally, the absence of detailed family psychiatric history may have overlooked important genetic risk factors that could inform prognosis and treatment planning.

The reliance on family-reported information for historical details introduces potential recall bias, though this is unavoidable given the patient's impaired insight during the acute episode. Future research might benefit from longer-term longitudinal follow-up to examine recovery patterns and functional outcomes in first-episode mania.

8. Conclusion

The report demonstrates the complexity and clinical significance of first-episode mania in young adults, highlighting the importance of early recognition, comprehensive assessment, and prompt intervention. The patient's presentation following medical hospitalization underscores the potential role of physical stressors in precipitating psychiatric episodes in vulnerable individuals.

Key clinical insights from this case include the importance of maintaining high clinical suspicion for bipolar disorder in young adults presenting with acute behavioral changes, even in the absence of prior psychiatric history. The temporal relationship between medical illness and psychiatric symptom onset suggests that healthcare providers should monitor

psychological well-being during medical hospitalizations, particularly in adolescents and young adults.

The successful management of this case demonstrates the effectiveness of early intervention strategies combining pharmacological treatment, psychosocial support, and family involvement. The patient's positive response to treatment and gradual restoration of insight suggest favorable short-term outcomes, though long-term follow-up will be essential to monitor for recurrence and functional recovery.

This case contributes to the growing literature on early intervention in bipolar disorder and emphasizes the critical importance of recognizing and treating first-episode mania promptly. Healthcare providers across all settings should be equipped to identify early signs of mania and facilitate rapid access to specialized psychiatric care.

The cultural context of this case also highlights the importance of culturally sensitive treatment approaches that engage family members as therapeutic allies while respecting individual autonomy and privacy. Future research should continue to examine the effectiveness of early intervention strategies and their impact on long-term outcomes in bipolar spectrum disorders.

Lastly, this case underscores the need for integrated care approaches that address both physical and mental health concerns, particularly during vulnerable periods such as medical hospitalizations. The development of systematic screening protocols for psychiatric symptoms during medical admissions may help identify at-risk individuals and facilitate earlier intervention.

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