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EARLY ONSET BIPOLAR SPECTRUM DISORDER: PSYCHOPHARMACOLOGICAL, PSYCHOLOGICAL, AND EDUCATIONAL MANAGEMENT

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Although published research continues to advocate medication as the first line of treatment for early onset bipolar spectrum disorder (EOBSD; N. Lofthouse & M.A. Fristad, 2004), preliminary research demonstrating the utility of cognitive, cognitive-behavioral, and psychoeducational therapies is promising. It appears as if future treatment of EOBSD will most likely include a combination of psychosocial treatments and medications; however, additional research needs to be conducted to support this assumption. This article provides a brief overview of published research related to EOBSD, the most common medications used to treat EOBSD, and preliminary research on the effectiveness of psychological treatments with children and adolescents classified with EOBSD. Finally, due to the lack of published behavioral and educational management strategies, this article provides practical suggestions for helping children and adolescents with EOBSD within the home and school settings. © 2006 Wiley Periodicals, Inc.

A primary objective of this article is to provide an overview of the medication and psychological treatments used with children and adolescents classified with early onset bipolar disorder (EOBSD; Lofthouse & Fristad, 2004) for school psychologists, school counselors, teachers, and parents. Another objective is to assist teachers and parents in developing behavioral and educational management strategies; therefore, suggestions for helping children and adolescents within the home and school settings who are displaying inflated self-esteem, sleep problems, erratic academic performance, or excessive involvement in reckless activities are provided. We begin by providing a brief overview of published research on the differential diagnosis of EOBSD.

Overview of EOBSD

A review of the literature found that mania and depression were first recognized with pre- and postpubertal children between the mid-19th and early 20th centuries (Faedda et al., 1995). For example, Kraepelin (1921) documented the onset of mania before age 10 in 4 of 903 manic-depressive patients. He also noted an increasing likelihood of mania after puberty. From the 1930s through the 1960s, mania and depression in children were often not considered when making a diagnosis; instead, these symptoms were often associated with schizophrenia or other mood disorders, resulting in many children with EOBSD being misdiagnosed (Faedda et al., 1995). During the 1970s, there was an increase in published research focused on better understanding the diagnostic features of mania with children and adolescents (Faedda et al., 1995; McClellan & Werry, 1997). Studies during the 1970s and 1980s revealed nearly one fifth of adults with bipolar disorder (BPD) presented manic episodes before age 19 and challenged the preconception that mania did not occur in children and adolescents (Carlson, Davenport, & Jamison, 1977; Joyce, 1984; Loranger & Levine, 1978).

Within the past 10 years, there has been a growing body of published research focused on identifying the characteristics of EOBSD to assist clinicians in making a differential diagnosis (Faedda et al., 1995; Faraone, Glatt, & Tsuang, 2003; Geller & Luby, 1997; E.B. Weller, Weller, & Fristad, 1995; Wozniak et al., 2003). Although these studies have increased understanding of EOBSD, there is still need for research that would enhance diagnostic accuracy and help in better

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understanding the overlap of symptoms with other childhood and adolescent disorders (Biederman, 1998; Carlson, 1990; Klein, Pine, & Klein, 1998). Until there is agreement on the diagnostic criteria and how children and adolescents display manic and depressive symptoms, it will be difficult to study and develop effective treatments for EOBSD (Bowring & Kovacs, 1992; Kafantaris, 1995; E.B. Weller et al., 1995; Wozniak et al., 2003). To date, minimal EOBSD treatment research has been published (James & Javaloyes, 2001; McClellan & Werry, 1997). Interestingly, the consensus is that EOBSD continues to be underdiagnosed (Cassano, McElry, Brady, Nolen, & Placidi, 2000; Robertson et al., 1994; R.A. Weller, Weller, Tucker, & Fristad, 1986; E.B. Weller et al., 1995; Wozniak et al., 1995), although there is still debate regarding the diagnostic features of EOBSD.

Prevalence estimates of EOBSD are difficult due to the absence of any national (or international) epidemiological study to determine the disorder's prevalence in the pediatric population (Costello, 1989; Geller, 1997; Lewinsohn, Klein, & Seeley, 1995; E.B. Weller et al., 1995). For adults, the lifetime prevalence is estimated to be 0.8% (American Psychiatric Association, 1994). Compare this to a survey of over 1,700 adolescents (14–18 years of age) by Lewinsohn et al. (1995), who found a lifetime prevalence of BPD of approximately 1% (0.90–1.41%). Kashani et al. (1987), utilizing the *Diagnostic and Statistical Manual of Mental Disorders*, third edition–revised (DSM-III-R; American Psychiatric Association, 1987) criteria, reported that 0.7% of a community sample of 150 nonreferred adolescents met the diagnostic criteria for mania. Carlson and Kashani's (1988) survey of 14- to 16-year-olds found that the prevalence of mania was 0.6% when severity and duration criteria were applied to the 13% displaying manic symptoms.

Loranger and Levine (1978) interviewed adults classified with BPD to determine the onset of their symptoms. Age of onset was found to be between 5 and 9 years for 0.5% of the patients and between 10 and 14 years for 7.5%. Over a $4\frac{1}{2}$-year period, E.B. Weller et al. (1995) found that 6 of the 36 preschool children admitted to an inpatient unit met DSM-III-R diagnostic criteria for mania or hypomania. Of particular interest was the finding that children presented similar symptoms of EOBSD as did older children. There is some evidence that the prevalence of EOBSD among children and adolescents is similar to adult BPD (Geller & Luby, 1997).

Developmental influences, atypical presentation, comorbidity, symptomatic overlap with other disorders, and occasional clinician reluctance to diagnose result in misdiagnosis and underdiagnosis of EOBSD in children (Biederman, 1998; Bowring & Kovacs, 1992; Carlson, Bromet, & Sievers, 2000; Emslie, Kennard, & Kowatch, 1995; Faraone et al., 2003; Steele & Fisman, 1997). Unlike adults with BPD, children with mania typically do not manifest euphoria, but severe irritability (Carlson, 1984; Davis, 1979; Emslie et al., 1995). In a study of 6- to 12-year-old prepubertal children diagnosed with mania using DSM-III-R criteria, E.B. Weller et al. (1995) reported that 50% described a primarily irritable mood. Carlson's (1983) literature review revealed that children younger than 9 years reported emotional lability, crying, and irritability while those 9 years and older more commonly described grandiose delusions and euphoria. Without the typical manic presentation, clinicians may erroneously attribute a child's emotional outbursts (Davis, 1979) and belligerence to psychosocial factors or conduct disorder (Wozniak et al., 1995). Not only must clinicians differentiate EOBSD from more common childhood disorders but they also need to consider whether behaviors (e.g., playing, activity levels, rate of speech) are consistent with those displayed by normal children and adolescents (McClellan & Werry, 1997).

Identification of the disorder is further complicated by the course it follows in children. Instead of being episodic or acute in course, as is the case with most adults, EOBSD tends to be chronic and continuous, which makes identifying discrete episodes very difficult (E.B. Weller et al., 1995); however, this does not mean that on occasion children will not demonstrate similar syndromal characteristics observed in adults with BPD (Cassano et al., 2000).

Diagnostic confusion also exists because of the similarity between BPD and attention deficit hyperactivity disorder (ADHD). Symptoms such as impulsivity, hyperactivity, irritability, and distractibility are shared by both disorders (Emslie et al., 1995; James & Javaloyes, 2001). The ease of misdiagnosis is highlighted by the findings of Biederman et al. (1996), where 96% of children who meet the criteria for EOBSD also meet the criteria for ADHD; however, only 16% of ADHD patients met the criteria of mania/hypomania (Biederman et al., 1996). Similarly, Geller and Luby (1997) reported that of children presenting bipolar symptoms, approximately 90% of prepubertal and 30% of adolescent subjects were classified with ADHD. This significant comorbidity makes prognosis and treatment all the more difficult for children with EOBSD (Kovacs & Pollock, 1995; McClellan & Werry, 1997). However, differentiation is not impossible. James and Javaloyes (2001) suggested that the two disorders can be distinguished by examining the history of the child to determine the persistence and earlier onset of ADHD versus the lack of euphoria or depressed mood of EOBSD. Children with EOBSD also may be more irritable compared to children classified with ADHD. One measure, the Adult Mania Rating Scale, was used by Fristad, Weller, and Weller (1992) with a group of prepubertal children and was found useful in delineating between children with mania from those with hyperactivity.

The differential diagnosis between BPD and conduct disorder also can be difficult due to the overlap in symptomology. Outbursts of anger, antisocial behavior, substance abuse, hypersexuality, and adolescent turmoil are often associated with BPD and misdiagnosed as conduct disorder (Cassano et al., 2000; Emslie et al., 1995; Kovacs & Pollock, 1995), although there are instances of comorbidity as well (Carlson, 1990). Bowring and Kovacs (1992) contended that a mental-status examination and a detailed patient history enable differentiation between the two disorders. The diagnostic history may reveal a sudden onset of severe behavioral disturbances with BPD whereas with conduct disorder the duration of disturbances may have been evident over several years (James & Javaloyes, 2001). A further possibility for delineation lies in determining the nature of the troubling behaviors. Mischievousness and not vindictiveness distinguishes a manic-child's behavior from one who has conduct disorder, whose behavior is typically more hurtful of others (E.B. Weller et al., 1995). E.B. Weller et al. (1995) also noted that children with conduct disorder do not have psychotic symptoms, pressured speech, or flight of ideas as do children with mania.

Dunner and Clayton (1987) indicated that the biggest deterrent to treating EOBSD is recognizing it in the first place. Although more recent research has enhanced the ability of clinicians to make better diagnostic decisions, their view continues to be accurate. Continued research is necessary to better understand the prevalence of pediatric-onset BPD so that clinicians may avoid over- and underdiagnosing it. Accurately differentiating BPD from other disorders will reduce misdiagnosis and the application of ineffective treatments.

Treatment

Pharmacotherapy

As with adult BPD, psychopharmacological treatment is considered by many as the first line treatment for EOBSD (Walsh, 1998; Weckerly, 2002); however, the efficacy of medications used to treat EOBSD has yet to be established. This is primarily due to the lack of studies using children and the poor quality of these studies (Bowden & Rhodes, 1996). It also is important to consider that several medications (e.g., lithium, carbamazepine, valporate) used to treat children and adolescents with EOBSD have not been approved by the Food and Drug Administration, although these medications are often used as mood stabilizers with children (Giedd, 2000); however, lithium has been approved by the Food and Drug Administration for children 12 years and older.

Although lithium has been found to be 40 to 60% effective in treating children and adolescents (Emslie et al., 1995; Kafantaris, 1995; Strober, Morrell, Lampert, & Burroughs, 1990; E.B. Weller, Weller, & Fristad, 1986) in the past, physicians are beginning to use recently approved medications (e.g., Risperdal, Seroquel) to treat EOBSD. Specifically, combination pharmacotherapy appears to be an increasing trend, especially when different combinations of mood stabilizers, stimulants, and antipsychotics have been shown effective (Davanzo et al., 2003; Kafantaris, Coletti, Dicker, Padula, & Kane, 2001; Kowatch, Sethuraman, Hume, Kromelis, & Weinberg, 2003). For example, during manic episodes, it is not uncommon for both antipsychotics and mood stabilizing medications to be prescribed (Emslie et al., 1995).

Due to many physicians' hesitancy in prescribing lithium because of decreased tolerability (Bowden & Rhodes, 1996), risk of lithium toxicity, and difficulty in maintaining a therapeutic dosage among children and adolescents, they are beginning to explore the use of newer manufactured medications. Lithium also is not typically used with children under 8 years of age. Therefore, physicians must consider other medications when treating EOBSD.

Carbamazepine and valproate are anticonvulsants; however, they are commonly used to treat BPD and other affective disorders. Walsh (1998) noted that these medications have the same level of effectiveness in reducing the frequency of manic cycles as does lithium; other studies have suggested carbamazepine is inferior to lithium (Bowden, 1996; Janicak, Davis, Preskorn, & Ayd, 1993). Preliminary research has suggested that valproate may be more effective in addressing rapid cycling compared to carbamazepine (Keck & McElroy, 1996; Walsh, 1998). With carbamazepine, there is increased risk of agitation and aggression (Popper, 1995). For both carbamazepine and valproate, the side effects are well known because of their extensive use as anticonvulsants with children. However, Davanzo and McCracken (2000) noted that no controlled studies have been published regarding children or adolescents demonstrating the efficacy of carbamazepine in treating manic and depressive episodes.

Lamotrigine, gabapentin, topiramate, and tiagabine are recently approved anticonvulsant medications that have been considered as potential mood stabilizers for children with EOBSD (Davanzo & McCracken, 2000); however, Davanzo and McCracken (2000) do not recommend their use as mood stabilizers with children and adolescents until controlled studies demonstrating their efficacy and exploring their safety have been published.

In summary, in the past, lithium and anticonvulsants (e.g., carbamazepine and valproate) were the primary medications used to treat EOBSD; however, there appears to be an increasing use of combination pharmacotherapy (Wilens, Spencer, Biederman, Wozniak, & Connor, 1995) using lithium and anticonvulsants along with various combinations of newly developed medications. Only a limited number of studies have been published exploring the efficacy of combination pharmacotherapy. Although these have been promising, additional research is needed to substantiate their results with children and adolescents.

Psychological Interventions

Published research demonstrating the value of psychological interventions in treating the depressive, manic, and hypomanic features of EOBSD is lacking. Although there has been a large amount of research published supporting cognitive and behavioral interventions when treating unipolar depression with children and adolescents (e.g., Dujovne, Barnard, & Rapoff, 1995; Reynolds & Coats, 1986), few studies have been published regarding their effectiveness with EOBSD. Lofthouse and Fristad (2004) did delineate the critical features needed when developing effective psychosocial interventions for children and adolescents with EOBSD, but stipulated the need for additional research demonstrating the efficacy of evidence-based interventions. Therefore, to

determine the potential efficacy of psychological interventions with children and adolescents with EOBSD, it seems prudent to review research on adults with BPD.

Vieta and Colom (2004) conducted a systematic review of the literature to assess the effectiveness of psychological interventions for BPD. They determined that cognitive, cognitive-behavioral, and schema-focused therapies were the most effective psychosocial interventions to address the depressive features of adult BPD. They also concluded that there was little efficacious research, if any, to support the use of these therapies in addressing the manic and hypomanic symptoms of adult BPD. Instead, pharmacological treatments appear most efficacious in addressing these symptoms (Vieta & Colom, 2004). The same may be true when treating children and adolescents with EOBSD; however, research is needed before making similar assumptions.

Otto, Reilly-Harrington, Kogan, Henin, and Knauz (1999) developed a treatment manual for BPD that might be adapted for children and adolescents. They initially focused on cognitive restructuring and activity-management strategies. As treatment progressed, they focused on enhancing an individual's emotional and social problem-solving skills (Otto, Reilly-Harrington, & Sachs, 2002). Otto (2000) also recommended the use of vivid metaphors and stories to assist clients in recognizing the specific aspects of BPD and when teaching emotional regulation. Similar treatment programs are being studied such as the multisite Systematic Treatment Enhancement Program for Bipolar Disorder funded by the National Institute of Mental Health, which is studying the efficacy of various psychotherapy approaches (Otto et al., 2002). This type of large-scale research is encouraging and may lead to similar research with children and adolescents. Nonetheless, when developing treatment programs for children and adolescents, Vieta and Colom (2004) suggested the inclusion of psychotherapy (e.g., cognitive, cognitive-behavioral) to augment medication. It also is important to consider that children and adolescents who have not been stabilized by medication may respond poorly to psychotherapies regardless of the approach used.

Psychoeducational Treatment

Several researchers have advocated for the use of psychoeducational techniques with parents and teachers as essential in the treatment of children and adolescents with EOBSD (Emslie et al., 1995; Pavuluri et al., 2004). Pavuluri et al. (2004) incorporated education as a primary element of their Child- and Family-Focused Cognitive-Behavioral Therapy (CFF-CBT) program. For example, the use of psychoeducation can help parents and teachers better understand the biological basis of mood swings often displayed among children with EOBSD. By recognizing that mood swings and difficulties with regulation of affect may have a biological basis, parents and teachers may be more likely to respond empathically and recognize the unintentional aspects of EOBSD. Another goal of psychoeducation is to help parents and teachers be in a better position to problem solve and immediately focus on affect regulation. For example, teaching parents therapeutic exercises or anger-management skills they can implement with their children might be helpful in affect regulation. In addition, teaching parents and teachers how to monitor (e.g., recognize behavioral antecedents that trigger some mood swings) a child's mood can help address rapid cycling (Pavuluri et al., 2004).

Management of Symptoms within the Home and School Settings

Although to our knowledge no research has been published demonstrating the effectiveness of the following recommendations and suggestions, they warrant consideration when developing accommodations within the home and school environments. The importance of consulting with a physician or psychiatrist to determine whether medication is warranted also cannot be overemphasized prior to implementing behavioral and educational interventions. Specifically, children with EOBSD can find it difficult to learn or follow a home discipline program if not stabilized by

medications. Finally, the following suggestions should not be considered comprehensive, but should help parents and teachers begin to formulate management strategies. The specific recommendations and suggestions are as follows:

1. Children and adolescents with EOBSD may benefit from consistent and structured routines within the home and school settings. Routine daily activities should be followed as consistently as possible. For example, bedtime and naps should be at the same time each day. Structure provided during dinners, when taking a bath, or getting ready for bed may help children maintain their composure and help with transitions. Weekend routines should not deviate too much from those followed during the week. A consistent and structured discipline program should be used within the home setting. Babysitters should be taught to follow the "house rules" and the home discipline program. When selecting daycare, parents should consider the number of children per room, the number of staff changes, and the daycare's approach to discipline. At school, teachers should develop and follow a classroom discipline program. Selecting highly structured teachers who can recognize the need for flexibility when teaching children who may react with frustration and display poor affective regulation should be considered. For middle-school and high-school students, schedules should be highly individualized to meet their educational and emotional needs. Developing assignment-completion checklists (Emslie et al., 1995) and using organizers may increase structure for middle-school and high-school students. Students should be told in advance of any changes in the classroom or daily school schedule.
2. Erratic academic performance (Emslie et al., 1995) can be expected at times and may stem from poorly modulated affect. The erratic academic performance may be characterized as periods where assignments are on time, fully completed, and completed with enthusiasm, but also with periods where assignments are late, partially completed (or not completed at all), and completed with low motivation. Teachers should be flexible and may need to shorten assignments, request work that has a high likelihood of being completed, and send less work home to be completed. At home, parents can break homework into manageable units to help assure completion. Recognize when a break is needed to avoid levels of frustration that can lead to angry outbursts. Schedule homework that best accommodates the emotional needs of a specific child. For example, some children and adolescents need to decompress from the stress of attending school and prefer to complete homework later in the evening while others would prefer to complete homework as soon as they are home so they can have their evenings free. At home and school, there may be times when the priority should be on meeting the emotional needs of children and adolescents instead of focusing on completion of academic work. Putting work aside and helping children and adolescents learn effective methods for controlling their anger and mood are just as important as academic performance.
3. During manic episodes, children and adolescents often display inflated self-esteem or grandiosity. Parents and teachers need to be taught to recognize these episodes and how to effectively address them. Middle-school and high-school students may overly commit to projects and extracurricular activities or pursue projects that have little chance of being completed. Teachers and parents can help redirect students during periods of inflated self-esteem so that the students avoid being embarrassed later when they realize they have over committed. It also will help reduce later stress or avoid becoming depressed from trying to complete an overwhelming project. Younger children may make unusual claims or tell eccentric stories during periods of inflated self-esteem. Patience while gently confronting the reality of these claims and stories is needed. Such claims can result in teasing by peers; therefore, teachers and parents should be prepared to address teasing and find effective ways to address the emotional impact it has on the child with EOBSD.
4. A decreased need for sleep is a common symptom of both children and adolescents with EOBSD. Weckerly (2002) indicated that children with EOBSD may have extreme difficultly falling asleep, frequently wake up during the night, and engage in activity during the night. Beginning the transition to bed over a period of 30 to 60 min instead of abruptly letting children know that it is time for bed may prove helpful. Implementing a quiet time, where the television is turned off, lights are turned down, and play is limited

to nonphysical activities, 30 to 60 min before bed also may assist in helping children transition to bed. Providing background noise (e.g., fan running), a cool sleeping environment, and not allowing children to watch television in bed may prove helpful. Teaching children and adolescents muscle-relaxation exercises they can use while falling asleep also should be considered. It is important to understand that children and adolescents with EOBSD who have difficulty falling asleep are not to blame for this behavior. In fact, many children become very frustrated and upset that they are unable to fall and stay asleep. At night, if children wake up and have difficulty falling back to sleep, it is important to avoid scolding or being demeaning; most children cannot help it. Allowing children and adolescents to read in bed, complete puzzles, or play quietly is a better alternative than letting them watch television, play video games, or listen to music. If leaving the bedroom or the house is a concern, inexpensive alarms can be purchased and used to help monitor the children's activities in the home. In the morning, children and adolescents with EOBSD can be very difficult to wake. At school, they may be tired, irritable, and fall asleep in class. It is important for teachers not to assume that because children and adolescents fall asleep in class that the parents are to blame or the students are being oppositional. If students with EOBSD are consistently tired during the school day, a shortened school day may need to be considered. For high-school students, correspondence and Internet courses may be useful because they can complete the work outside the school setting.

5. One of the more challenging features to address with children and adolescents with EOBSD is the excessive involvement in reckless activities (Weckerly, 2002). Specifically, these behaviors can be very dangerous and can be very difficult to address. With children, these behaviors may include climbing trees, jumping off roofs, climbing fences, getting in cars, playing with the stove, playing with knives, or self-stimulating behaviors in public. With adolescents, these behaviors may include using drugs and alcohol, speeding, gambling, visiting pornography sites on the Internet, promiscuous sex, or having sex without protection. Prevention is likely the most effective approach to addressing these behaviors with young children. Modifying the home by putting locks on gates and windows, locking up materials (e.g., ladders) that can be used for climbing, trimming lower branches on trees, and locking knives and cigarette lighters in drawers when they are not being used are examples of preventive measures. Similar preventive measures can be implemented within the school setting. Very young children may need to be shadowed by an adult in classroom, playground, or daycare settings.
6. Hypersexuality and inappropriate public displays are not uncommon with children and adolescents with EOBSD. This is the area that many professionals and parents find difficult to address. With children and adolescents, the goal should be to set limits on developmentally appropriate sexual behaviors while still accepting their emerging sexual development (T.A. Kruczek, personal communication, October 5, 2005). Therefore, it is important for parents and teachers to become familiar with what is considered normal sexual behavior for different ages and stages; then they can determine if the behavior is atypical for the child's developmental level. When the child engages in a behavior that is out of bounds developmentally or socially, parents and teachers can address it in that context. A practical way to do this is to acknowledge the impulse to perform the sexual act in a nonjudgmental way, but set a limit on the behavior in the inappropriate setting or context (T.A. Kruczek, personal communication, October 5, 2005). For example, self-stimulating behaviors (e.g., masturbation) is commonly seen in the school setting. Acknowledge that the stimulation feels good, but indicate this is a behavior that is not appropriate in public. It also is important for teachers to avoid overreacting to public displays of sexual behaviors. With adolescents who are exploring their emerging sexuality, this is a little more complicated and needs to be done within the context of the family's value system (T.A. Kruczek, personal communication, October 5, 2005). Parents can take a preventative approach with adolescents by having open and clear dialogues about sexuality and sexual choices. Included in these conversations should be discussions about contraception with both males and females. Females may need to consider using birth control pills/patches/shots to prevent unwanted pregnancy, but males need to use condoms to also prevent sexually transmitted diseases. Adolescents with EOBSD are at high

risk for sexual activity; therefore, parents need to accept this risk, and professionals need to help parents understand it. It is not enough simply to tell these adolescents to "abstain," and it is unrealistic given the symptom profile and their poor capacity for impulse control around sexuality and other risk/thrill-seeking behaviors. Internal mechanisms of control are not sufficient. Medication to help regulate impulses in conjunction with external limits and close monitoring by adult caregivers can be helpful (T.A. Kruczek, personal communication, October 5, 2005).

7. For adolescents who have considerable difficulty controlling public displays of affection during school, it might be helpful to limit the amount of free time between classes, before and after school, and lunch to decrease opportunities to participate in these behaviors. For example, the student could work with the school counselor in the morning and during lunch. At home, set realistic curfews, have the adolescent check in every hour, and become very familiar with the adolescent's friends. Finally, if the excessive involvement in reckless activities escalates or is determined to be dangerous, immediate inpatient placement should be considered.
8. Children with EOBSD can display dramatic changes in appetite. At times they may feel the need to overeat while at other times they may hardly eat anything. With both children and adults, it is not uncommon to overeat or totally lose their appetite. Consultation with a physician is recommended, especially if children or adolescents are taking medication. For both children and adolescents, provide nutritious snacks and drinks that they can keep in their desks and backpacks so they can eat when hungry. Schools should be highly tolerant and allow them to eat during class if needed. Several smaller meals may be better instead of three large meals during the day. Children and adolescents wake during the night hungry, so having nutritious food available at this time is suggested.

Summary

While there has been a plethora of studies published exploring the diagnostic symptamology of EOBSD, clinicians continue to struggle when diagnosing EOBSD. The difficulty stems from overlapping symptomology with other mood and behavioral disorders, hesitancy to diagnosis young children with EOBSD, and lack of agreement among researchers on the presentation of mania in children. Medication is considered the first line of treatment for EOBSD. In the past, lithium, carbamazepine, and valproate were the most commonly used medications to treat EOBSD. Combination pharmacotherapy using lithium, carbamazepine, and valproate with newly approved medications has shown promising results; however, there still is a lack of controlled studies with children demonstrating the efficacy and exploring the safety of combination pharmacotherapy. Preliminary research demonstrating the utility of cognitive, cognitive-behavior, and psychoeducational therapies has been encouraging, but research studying the effectiveness of psychological, behavioral, and academic management strategies with children and adolescents classified with EOBSD is warranted. In the future, it appears the treatment of EOBSD will most likely include a combination of psychosocial treatments and medications.

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