Starting Early:
Promoting emotional and behavioral well-being in early childhood

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Partnership Access Line
Disclosures

• No conflicts of interest
Background
Prevalence

- 25% lifetime prevalence of mental or behavioral disorders worldwide (WHO 2001)
- ~1 in 5 children under the age of 18 in the US have a diagnosable mental illness (Report of the Surgeon General 1999)
  - Only ~25% receive treatment
- Up to 10% of children 2-5 demonstrate mental health impairment (Egger HL and Angold A JCPP 2006)
Accessing Evidence-based Treatments

- Poor dissemination
- Complicated health-care systems
- Workforce shortages
  - Rates utilization unknown
  - As of 2012, 8300 child psychiatrists serving 15 million children (AACAP 2013)
  - <1000 developmental pediatricians, avg wait >6mos.
    (Jimenez J Dev Behav Pediatr 2017)
Ages 0-5: A unique opportunity

- A period of rapid brain changes
- Radical cognitive, linguistic, motor and socioemotional development
- Frequent encounters with health professionals
Evidence-based treatments do exist

• Ages 0-3
  • Family-centered parent-child (dyadic) treatment
  • **NO** studies of safety/efficacy of psychopharm treatments for infants and toddlers

• Ages 4-5
  • Family-centered parent-child (dyadic) treatment
  • Medications*
Prenatal Maternal Mental Health

• >50% postnatal depression begins prior to birth

• MH problems associated with poor fetal outcomes (Wisner KL et al JAMA Psych 2013) (Stein A et al. Lancet 2014)
  • Pregnancy complications
  • Non-live birth
  • Low birthweight
  • Preterm Birth
  • Increased risk of child mental health concerns.
Prenatal Maternal Mental Health: Specific Conditions

- Depression
- Severe Anxiety
- Bipolar Disorder
- Schizophrenia
- Eating Disorders
- Substance Use Disorders
Prenatal Maternal Depression and Anxiety

• Cognitive Deficits
• Mood
• Anxiety
• Behavioral difficulties in childhood, adolescence, adulthood (Stein A et al. Lancet 2014)

• Paternal psychological distress associated with behavioral and emotional difficulties in offspring at 36 mos (Kvalevaag AL et al. Pediatrics 2013)
Prenatal Environmental Factors

- **Alcohol exposure**
  - Growth retardation, characteristic facies, developmental delays, both externalizing and externalizing symptoms (Behnke et al. Pediatrics 2013)

- **Illicit Substances**
  - Behavioral problems, developmental delay (Behnke et al. Pediatrics 2013)

- **Smoking**
  - ADHD, Conduct Problems (Joelsson P et al. BMC Psych 2016)
Prenatal Environmental Factors

• Maternal Stress
  • Dysregulation of the HPA axis in offspring incl. altered infant cortisol and higher resting cortisol in adolescents (Lewis AJ et al. BMC Medicine 2014)

• Diet
  • High intake of highly processed foods during pregnancy predicts externalizing problems at age 5 (Jacka FN et al. JAACAP 2013)
Year 1

• Infant – caregiver dyad becomes primary focus
• Infant development of internal models of relationships
Postnatal Period

• Assess for psychosocial adversity
  • Food Insecurity
  • Community Violence
  • Home environment

• AAP recommends universal screening for maternal depression
  • Patient Health Questionnaire-2
  • Edinburgh Postnatal Depression Screen
Postpartum Depression

• “Baby Blues” common
  • Present in first month
  • Typically resolve without formal treatment

• Severe/prolonged symptoms may reflect postpartum depression
  • Up to 10% of mothers during first 3 months (Earls MF Pediatrics 2013)
  • Can present initially as anxiety
  • Reassurance, referral (OB, PCP, Psychiatrist)
  • Delusions, paranoia, hallucinations, mania?
    – MEDICAL EMERGENCY
Year 1: Social-emotional Milestones

- 3 months: social smile
- 7-9 months: focused attachment behaviors
  - Selective comfort seeking from primary caregiver
    - Physical Exam
    - Immunizations
  - Separation distress
  - Stranger anxiety
“EBCD”

• Explore the environment
• Build relationships
• Cultivate development
• Develop parent confidence
Year 1: An opportunity to intervene

- Use the well child visit to reinforce nurturing caregiving through positive feedback
- Concerned about parent-child relationship?
  - Referral to adult mental health provider
  - Referral to infant-parent mental health provider
Evidence based treatments

**Nurse Family Partnership**
- 28 wks gestation – 24 mos.
- Home nursing visits beginning in pregnancy
- Improved well-being, academics, health, decreased risk-taking behaviors

**Parents as Teachers**
- 0- 5 yrs
- Home visiting program by parents for parents
- Improved cognitive development, school readiness, 3rd grade achievement

**Video Interaction Project**
- 0-36 mos
- Videotaped review of 5 min parent-child interaction as part of well-child visit
- Improved interaction quality, cognitive develop, decreased stress

**Video Interaction for Positive Parenting**
- 12-36 mos
- 5 session in-home intervention with video review, coaching
- Increased maternal sensitivity, secure attachment rates
Evidence based treatments, cont’d

**Attachment Biobehavioral Catchup**
- 0-48 mos
- Foster parent intervention
- Increased secure attachment rates, normalization of diurnal cortisol release patterns.

**Infant Parent Psychotherapy**
- 12-36 mos
- Dyadic treatment for families who have experienced trauma
- Increased rates secure attachment. Decreased trauma sxs, behavioral problems.

Olds D 2010
Mendelsohn AL et al. J Dev Behav Pedia. 2007
Toddlerhood
Toddlerhood

• Expanded opportunities to promote well-being and identify children at risk
• Observe how the child organizes their feelings when stressed
  • “Attachment Behaviors”
Circle of Security®
Parent Attending To The Child’s Needs

I need you to...
- Watch over me
- Delight in me
- Help me
- Enjoy with me

Support My Exploration

I need you to...
- Protect me
- Comfort me
- Delight in me
- Organize my feelings

Welcome My Coming To You

ALWAYS BE: BIGGER, STRONGER, WISER & KIND.
WHENEVER POSSIBLE: FOLLOW MY CHILD’S NEED.
WHENEVER NECESSARY: TAKE CHARGE.

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www.circleofsecurity.net
Attachment Theory

• John Bowlby (1907-1990)
• Mary Ainsworth (1913-1999)
  • The Strange Situation Procedure (SSP) (Ainsworth MD Child Dev 1970)
**The Strange Situation**

<table>
<thead>
<tr>
<th>Episode</th>
<th>Duration (min)</th>
<th>Action</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>Clinician observes parent-child free play</td>
<td>Note especially familiarity, comfort, and warmth in child as the child interacts with attachment figure</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Clinician talks with, then approaches, then attempts to engage child in play</td>
<td>Most young children show some reticence, especially initially, about engaging with an unfamiliar adult</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Clinician picks up child and shows child a picture on the wall or looks out window with child</td>
<td>This increases the stress for the child. Again, note the child’s comfort and familiarity with this stranger</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>Caregiver picks up child and shows child a picture on the wall or looks out window with child</td>
<td>In contrast with stranger pick-up, child should feel obviously more comfortable during this activity</td>
</tr>
<tr>
<td>4a</td>
<td>1</td>
<td>Child is placed between caregiver and stranger and remote control novel (eg, scary/exciting) toy is introduced</td>
<td>Child should seek comfort preferentially from parent. If interested rather than frightened, child should share positive affect with parent</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>Clinician leaves the room</td>
<td>This separation should not elicit much of a reaction in the child, because the clinician is a stranger</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>Clinician returns</td>
<td>Similarly, the child should not be much affected by the stranger’s return</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>Caregiver leaves the room</td>
<td>Child should take notice of caregiver’s departure, although not necessarily show obvious distress. If the child is distressed, the clinician should be of little comfort to the child</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>Caregiver returns</td>
<td>Child’s reunion behavior with caregiver should be congruent with separation behavior. That is, distressed children should seek comfort, and nondistressed children should reengage positively with caregiver, by introducing caregiver to the toy or activity or talking with caregiver about what occurred during the separation</td>
</tr>
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The Strange Situation

https://www.youtube.com/watch?v=QTsewNrHUHU
Attachment Styles

- Secure (~60%) (Ainsworth MD Child Dev 1970)
- Insecure (~40%) (Ainsworth MD Child Dev 1970)
  - Insecure-ambivalent
  - Insecure-avoidant
- Disorganized
- Research classification, NOT DISORDER
Attachment Disorders

• Reactive Attachment Disorder
  – Inhibited, withdrawn toward caregivers
  – Persistent social and emotional disturbance
  – CONTEXT: Extremes of insufficient care
    • Rare: 10% of those with severe early neglect

• Disinhibited Social Engagement Disorder
  – Inappropriately interacts with unfamiliar adults
  – Tends to be clinically stable over time
    • Rare: 20% of those with severe early neglect

Why is this important?

• Children with insecure/disorganized attachment can have problems regulating emotions and understanding mental states of others later in life

• Associated with circumstances in which parent cannot adequately attend to child’s needs
  • Postpartum depression, substance abuse, mental illness, trauma/loss, institutionalization
Tips for well-child visit

• Impractical and unsafe to attempt SSP in the office
• Observe for warning signs, refer if overt
• Ensure that all possible measures being taken to support consistent, loving caregiving.
• Refer parent for mental health treatment if indicated
• “Catch the child being good.”
• Suggest pleasant one on one activities
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<td>Mothers Toddlers Program</td>
<td>12-36 mos</td>
<td>Dyadic treatment for substance-involved mothers and child. Improved mentalization capacity, attachment-based caregiving.</td>
</tr>
<tr>
<td>Circle of Security</td>
<td>13-88 mos</td>
<td>Combines group process approach with video review. Increased rates secure attachment, changes in externalizing/internalizing behaviors, caregiver mentalization.</td>
</tr>
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Autism Spectrum Disorder

• Signs emerge in the second year of life
  • Delay in language
  • Delay in social reciprocity

• DSM-5 Diagnosis
  – Social communication impairments
  – Restrictive, repetitive patterns of behavior

• ~1 in 68 children in the US (Developmental Disabilities Monitoring Network Surveillance Year. 2014)
ASD: What to do if you suspect

• Slam dunk? Make the diagnosis!
• Unclear? Refer for formal evaluation (ADOS)
  • Long waits
• Encourage parent to apply for DDA services
  • Age 0-3: Developmental Delay
  • Age 4+: Dx, onset prior to 3, Adaptive fxn <69, FSIQ<84
• Applied Behavior Analysis
• Speech Therapy
• Occupational Therapy
Behavioral Problems

• Developmentally appropriate
  • “Terrible 2s” (and 3s)

• Parent Psychoeducation

• Encourage “positive parenting practices”
Positive Parenting

• Positive reinforcement for positive behaviors
  • Specific praise
  • Smiling/high-fiving
  • Describing what the child did that was pleasing
  • “Time in”

• Avoidance of positive attention for negative behaviors
  • Active ignoring (as long as behaviors not unsafe)

• Consequences
  • Immediate, and consistent!
  • Delivered in neutral tone
  • Time out
    – Quiet, non-distracting, non-entertaining space
    – 1 min per year of life
Evidence based treatments

- **New Forest**
  - 30-77 mos
  - Children with ADHD

- **Incredible Years**
  - 3-8 yrs
  - Children with CD, ODD, ADHD

- **Triple P**
  - 36-48 mos
  - Children at high risk with parental concerns about behavioral difficulties
  - Online version (2-9y)

- **Parent Child Interaction Therapy (PCIT)**
  - 2-7 yrs
  - Children with clinical level disruptive behavior symptoms

- **Helping the Noncompliant Child**
  - 3-8 yrs
  - Children with noncompliant behaviors
Other things to watch for in toddlers

• Anxiety
• Severe Inhibition
• Symptoms associated with trauma exposure

• Helpful Screeners:
  • Ages and Stages: Social Emotional (2-60mos)
  • Brief Early Childhood Screening Assessment (18-60mos)
  • Baby-Pediatric Symptom Checklist (0-18 mos)
Preschool
Preschool: social-emotional milestones

• Seeks to please friends
• Engages in fantasy play
• More likely to agree to rules
• Enjoys singing/dancing/acting
• More independent
Preschool : 3-5yrs

- Emotional and behavioral impairments emerge with slightly greater fidelity
  - Autism Spectrum Disorder
  - Oppositional Defiant Disorder
  - Attention-Deficit/Hyperactivity Disorder
  - Posttraumatic Stress Disorder
  - Major Depressive Disorder
  - Anxiety Disorders
  - Sleep Disorders

Preschool ADHD Treatment Study (PATS)

- NIMH funded multi-center randomized crossover efficacy trial
- 3-5.5 yo with severe ADHD unresponsive to 10 week parent training intervention
- 37/279 patient parents said behavioral treatment resulted in satisfactory improvement.

Greenhill et al JAACAP 2006.
Stimulants generally effective

- N = 147
- Effect size = 0.4-0.8
- Optimal dose ranges 2.5mg PO BID – 7.5mg TID

Lower doses provided better balance of benefits and side effects

Lower response rates compared to older children

- ES in MTA (7-9 y/o) = 0.5-1.3

Higher rates of side effects

- 30% incidence; 8% dropped out due to SEs, vs 4% in MTA.

PATS at 6 years

- ADHD diagnosis is stable over time - 89.9% still meeting diagnostic criteria
- Patients with comorbid ODD or conduct disorder had higher rates of ADHD.
- Girls experienced a steeper symptom decline (but girls’ baseline symptoms more severe).
- Some indication of long-term benefit based on parent ratings

Atomoxetine

- 5-6 y/o
- 8 week double blind placebo-controlled RCT, N = 101
- ADHD-IV ratings improved, ES = 0.6-0.8.
- No significant difference on CGI measures
- 25-33% experienced significant side effects.

Kratochvil CJ et al 2011
No other large studies of safety or efficacy of psychopharmacological treatments for children under 6.

Risperidone has FDA approval down to 5 for irritability and aggression in autism.

Adderall and Dexedrine have FDA approval down to age 3, but tend to be less well tolerated than methylphenidates.

In 2014, over 100,000 atypical antipsychotic and antidepressant rx written for children under 3 y/o in the US.
Summary

• Parental mental illness and psychosocial adversity are early risk factors
• Early assessment of parent-child relationship is important
• Early intervention should focus on improving the parent-child relationship
• Data supporting the use of psychiatric medications in children under 6 is limited.
Questions?

PARTNERSHIP ACCESS LINE
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