Assessment and Treatment of Mental Health Problems in Early Childhood

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Disclosures

• I have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider of commercial services discussed in this CME activity.
• I will be discussing off label use of medications
Mental Health Disorders in 0-5 year olds?

• Do they exist?
• How do we know?
• What do we look for, and how do we know if we should treat it?
• What are the treatments? Are medications indicated?
• What is typical in this age group?
• What about temperament?
Epidemiologic studies of 2-5 year olds have shown:

(1) DSM-type symptoms scales & diagnoses can be reliably measured in this age group;
(2) Overall rate of impairing psychiatric disorders is about 10% (remarkably similar to that found for older children & adults);
(3) Early childhood disorders are as impairing, persistent & associated with known psychopathology risk factors as disorders at other points in childhood

Persistence over time

- Specific diagnoses with "homotypic continuity"
  - ADHD (PATS 6 y follow up)
  - PTSD
- The more severe the condition, the more likely it will persist as is
- Many will continue to have psychiatric diagnoses, but not the same condition
Typical development

- Tantrums are common (Belden et al., 2007):
  - 70% of 18-24 month olds have tantrums
  - Highest incidence in 3-5 year age range
  - In 18-60 month olds:
    - Occur 1x/day on average
    - Typically 1.5-5 minutes
- When does aggression peak?
- What are typical anxieties of early childhood?
- What is temperament vs disorder?

Development of Aggression

From Tremblay et al. (2005) and Restiolo et al. (1985)

% Frequency of peer to peer aggression seen in preschool
(Male rates ≈ females)
Comparison of Cutoffs in ODD symptoms

- Using the cutoff of the 90th % frequency for older children would grossly overestimate symptom severity in preschoolers

Ex:
- Loses temper >= 2x/week: 30% of preschoolers (2-3x/day)
- Actively defies >= 2x/week: 57.1% of preschoolers (5x/day)
- Blames others > 1x/3 months: 26.7% of preschoolers (1x/week)
- Angry and resentful >=4x/wk: 20.7% of preschoolers (1x/day)

Temperament

- **Negative affectivity**
  - Sadness, fear, anger, frustration, poor adaptability, high emotional intensity
  - Predicts internalizing and externalizing sx

- **Behavioral inhibition**
  - Shyness, fear, withdrawal in novel situations
  - Associated with parental anxiety disorders
  - Risk factor for anxiety and depressive disorders

- **Behavioral disinhibition**
  - High approach, high novelty seeking, low harm avoidance, irritable distress
  - Possible risk factor for ADHD, disruptive behavior disorders, mood disorders, aggression

Egger and Angold, 2006
What Do We See?

At SCH Early childhood Clinic

Common Concerns in SCH ECC

- Tantrums, rages, outbursts
  - When young, we think of these as regulatory disorders
- Kicked out of daycare
- Aggression toward parents, sibs or peers
  - Usually accompanied by non-compliance
- Pattern of high activity, noncompliance, impulsivity, inattention
- Sleep problems, sleep problems, and more sleep problems
  - Nearly always coupled with child daytime behavior problems (anxiety, disruptive behavior) and sometimes with parental psychopathology (or at least serious sleep deprivation)
Common Concerns in SCH ECC (cont.)

- Subtle presentations of autism spectrum disorder
  - Ether were not screened as possible for the Autism Center, or were referred for other problems and discovered to have ASD (this comes in surprisingly often)
- Medical problems where behavior has become an additional issue
  - e.g. pediatric cancer, craniofacial anomalies, vision difficulties, many intensive and painful medical procedures for anomalies
- Separation anxiety, and a variety of other interesting early-onset anxiety disorders
  - Can overlap with the subtle ASD group

Less Common Concerns in SCH ECC

- Unusual genetic conditions, coupled by a behavior problem
- Disturbed behavior, such as threatening to kill themselves, dissociative behavior, attempting to planfully harm caregivers
- Won’t talk outside of the home
- Adjustment to traumatic incidents (a fall, a divorce, a parental death) with behavioral sequelae
- Highly unusual symptoms, e.g.:
  - Situations where a symptom may have a different cultural meaning
  - Hearing voices
Other Mental Health-Related Problems Seen Elsewhere at SCH/UW

- Very low-functioning children from a developmental level
  - Usually go to the Neurodevelopmental Clinic or Autism Center
- Children with prenatal alcohol/drug exposure as the main concern
  - UWFASD Clinic or referred to specific provider
  - (Note that many children seen in the ECC for disruptive behavior have had in utero exposures)
- Eating/feeding disorders
  - Feeding disorders clinic

Information courtesy of Heather Carmichael Olson, PhD

Assessment

Key Principles
Key Principles in Assessment

- Critical: Knowledge of Typical Development
- Critical: Observing Context (multiple contexts)
- Critical: Multiple Informants

Comprehensive Evaluation

- Multiple sessions
- Multiple informants
- Multidisciplinary approach
- Multicultural perspective
- Multiple modes of assessment
  - Interviews
  - Rating scales
  - Observations
  - Consider others, e.g.: ADOS, developmental assessment, cognitive assessment
- Multiaxial diagnostic perspective (Egger, 2009)
Rating Scales (examples)

- **Broadband**
  - Child Behavior Checklist (CBCL) 1 1/2 -5 (aka Achenbach): parent, teacher/childcare provider
  - Early Childhood Inventory-4 (ECI-4), 3-6
  - Infant Toddler Social Emotional Assessment (ITSEA), 12-36 months

- **ADHD Rating Scales**
  - Conners EC Behavior, 2-6: parent, teacher/childcare provider
  - ADHD Rating Scale IV Preschool Version, 3-5
  - FYI, Vanderbils are not normed for children under 6

- **Other disorder-specific scales**
  - Preschool Anxiety Scale, 2-6 (freely available at http://www.scaswebsite.com/1_5_.html)
  - Preschool Feelings Checklist

- **Developmental Assessments, e.g.:**
  - Adaptive Behavior Assessment System (ABAS)
  - Vineland Adaptive Behavior Scales

- **Others, e.g.:**
  - Parenting Stress Index

Diagnostic Classifications

- **DSM**
- **DC:0-3 (Diagnostic Classification: 0-3) R**
  - Limited research, but widely used in some settings
  - Revised multi-axial system
    - Axis I = Clinical disorders
    - Axis II = Relationship classification
    - Axis III = Medical and developmental disorders/conditions
    - Axis IV = Psychosocial stressors
    - Axis V = Emotional and social functioning
  - Not recognized for billing purposes

- **RDC-PA**
Treatment

Targets
Externalizing
Internalizing
Special Populations

Infant mental health: Targets

- Promoting social-emotional development in child
  - Increased ability to handle emotions
  - Increased empathy and self esteem
  - Improved relationships with parents and peers
  - Early detection of developmental problems
  - Enhanced school readiness
- Healthy caregiver-child relationships
  - Enhance attachment
  - Prevent child abuse/neglect
- Increased parenting skills
  - Increased knowledge of development
  - Increased ability to identify child's needs/cues
    - Increased ability to know if they are responding appropriately
  - Effective, developmentally - appropriate emotion and behavior management
Treatment of Externalizing disorders

- Increasing positive, supportive and sensitive parenting
  - Grounded in attachment theory
  - Forms a necessary foundation
- Increasing parental consistency through proactive, appropriate discipline strategies
- Increasing parental monitoring through use of consequence-based strategies

Externalizing disorders in Preschoolers: Specific Strategies

- Child directed interaction/Child directed play
- Positive reinforcement
- Active ignoring
- Giving clear instructions
- Having clear and consistent limits
- Distraction
- Natural and/or logical consequences
- Time out
- Problem solving
- Emotion Coaching
  - Validating emotions: recognizing and responding to emotions in an accepting, supportive way
  - Setting limits on behavior
  - Teaching healthy ways to cope
Externalizing disorders in Preschoolers: Examples of evidence based approaches

- Incredible Years - Parent Training (Webster-Stratton & colleagues)
- Parent Management Training (Patterson & colleagues; Kazdin & colleagues)
- Helping the Noncompliant Child (Forehand & McMahon)
- Parent-Child Interaction Therapy (PCIT) (Eyberg; pcit.org, pcit.phhp.ufl.edu)
- Triple P (series of programs) (Sanders & colleagues)
  - Levels 2-4
  - 8 module online parenting course at http://www.triplep-parenting.net/glo-en/home/
- Parents as Teachers
  - One example of a program focused on both parenting & school readiness

Internalizing disorders in Preschoolers: Common features of treatment

- Based on EBTs for older children
  - But less evidence
- More parent involvement, e.g.:
  - Psychoeducation without child
  - Involvement in sessions with or without child
  - Coaching child in skill use in session and out
  - Target characteristic parenting patterns of parents of anxious children
    - Unwittingly reinforcing and exacerbating anxiety
    - Modeling fear and avoidance behaviors
    - Reinforcing anxious coping styles
    - Failing to facilitate child’s autonomy by being highly protective and controlling

Luby, 2013
Internalizing disorders in Preschoolers:
Specific treatments for anxiety

- Short term group CBT-based therapy for parents of preschoolers at high risk for anxiety (Rapee et al)
  - 6 ninety minute parent-only sessions
  - Psychoeducation and parenting techniques
- Age-adjusted CBT for anxiety disorders in preschool aged children, e.g.:
  - “Being Brave: A Program for Coping with Anxiety for Young Children and their Parents” (Hirshfeld-Becker; adapted from Coping Cat by Kendall et al)
  - CBT for preschoolers with PTSD, such as CBT-SAP, PPT
  - PCIT + BDI (Bravery Directed Interaction) (Pincus et al)
  - “Family” CBT for OCD

Internalizing disorders in Preschoolers:
Specific treatments for Depression

- PCIT-ED
  - Includes Emotion Development module (Stalets et al)
    - Help child accurately identify and understand emotions
    - Learn to effectively regulate intense emotions
    - Enhance capacity to experience positive affects
- Treating parent’s depression
  - May be helpful, but may not be enough
Internalizing disorders in Preschoolers: Specific treatments for Depression

• What else?!
  • CBT adapted for a younger child and parents?
  • Acceptance and Commitment Therapy (ACT) adapted for a younger child and parents?
  • Psychodynamic treatment of child?

Examples of Interventions for Target Populations

• Positive parenting for children with special needs:
  • Triple P Stepping Stones Program
  • Families Moving Forward Program

• Treatments for children in foster care:
  • ABC intervention: Attachment & Biobehavioral Catch-Up (Dozier & colleagues).
  • Multidimensional Treatment Foster Care for Preschoolers (Fisher & colleagues).
Examples of Interventions for Target Populations (cont.)

- Treatments for children living with mothers in substance abuse treatment:
  - The Mothers & Toddlers Program: (Mayes & colleagues).
  - Locally, there are programs designed for this, offering therapeutic childcare.
- Prevention for families at high psychosocial risk:
  - Family Check-Up Model

Sleep Disorders: Finding the right level of intervention

May need to intervene at different “levels,” depending on the needs of the family:

**Level 1:** Medical consultation, sleep hygiene, sleep interview & sleep log to identify triggers & work to reduce those

**Level 2:** Psychoeducation, behavior modification
Sleep Disorders:
Finding the right level of intervention (cont.)

**Level 3:** Examine what is getting in the way of behavioral protocols, think about a variety of clinical approaches, both child & parent must be in the appropriate state in order to learn & be effective

- CBT
- Attachment-based
- Family systems
- Referrals for other therapies (e.g., marital therapy, PCIT, parent anxiety therapy)

Slide courtesy of Heather Carmichael Olson, PhD

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Psychopharmacology

Always second option to therapy
Psychopharmacology

- Use evidence based psychotherapeutic interventions before medications
- Use only when there is *reasonable expectation* that medications may help
- Use evidence when possible, but think of every child as a clinical case “n of 1” trial
- Start *even lower* and go even slower
- Remember that we don’t fully understand what effect psychotropic medications may have over time

FDA Approved Medications (<6yo)

- Haloperidol
- Chlorpromazine
- D-amphetamine
- Risperidone

- Thus, most prescribing is “off label”
Anxiety

- Most common psychiatric disorder in preschoolers
- Psychotherapy first line
- Consider medications (in combo with therapy) if not adequately responding and severe
  - Case reports in preschools, more data in older children
    - Fluoxetine first line for most types of anxiety (off label)
    - Fluoxetine or sertraline for OCD (off label)
    - Meds not recommended for PTSD

Fanton and Gleason 2009

ADHD Symptoms in Preschoolers

- Some degree of inattention and hyperactivity is developmentally normal for preschool children
  - At least 1/3rd of preschoolers had significant inattention or hyperactivity in one parent survey
- No ADHD-specific rating scales validated under 3 years of age
- Increase your skepticism with lower age

Smidts DP and Oosterlaan J 2007; JAACAP practice parameter 2007
ADHD

• Behavioral/environmental interventions first
• Evidence of disorder in multiple settings
• Be aware that medication with most evidence is not the medication that is FDA approved

PATS

• Complicated design due to safety concerns with young children
• 303 enrolled, age 3-5 ½
• 10 weeks Parent Management Training before medication trial
• 147 completed crossover titration with placebo
PATS: Results

- **Higher rates of side effects** than with older kids
- Methylphenidate (off label) works, but **not as well** as in older kids
- Significant reductions in ADHD symptoms with 2.5-, 5-, and 7.5 mg doses t.i.d.
- Mean optimal dose was 14.2±8.1 mg/day (0.7±8.1 mg/kg/d)

Non-stimulants

- Atomoxetine (off label)
  - Small, open label study of 12 kids aged 3-5 (5.0±0.72)
    - 75% response
    - 67% had side effects, mostly GI
  - RTC of 101 5 and 6 year olds
    - Some children with “robust” response, others not
    - “Generally tolerated and reduced core ADHD symptoms…did not necessarily translate to overall clinical and functional improvement…”
Disruptive Behavior Disorders

- Evidence for therapy FAR OUTWEIGHS evidence for medications
- Consider medication when not improving with behavioral treatment and problems are severe
  - Treat ADHD if present
  - Consider evidence base and risk of adverse effects
    - While risperidone (off label) has the most data of non stimulants, side effects can be very significant and long term effects not known
      - Caused 5.5 kg weight gain in one case series of aggressive preschoolers

Mood Disorders

- Depression
  - Psychotherapy first!
  - Meds (if severe impairment despite adequate therapy)
    - Fluoxetine (based on data for older kids) first line
      - Off label in this age group
- Bipolar disorder
  - Extremely controversial
  - Refer to professional with early childhood expertise
Mood Disorders

- Depression
  - Psychotherapy first!
  - Meds (if severe impairment despite adequate therapy)
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Autism

- Non pharmacological treatments first!
  - Educational, behavior therapy, OT, speech/language, etc..
- FDA approved for autism-related irritability:
  - Abilify, 6 and up
  - Risperidone, 5 and up
- Safety and Efficacy RTC in 24 children ages 2.5-6 (Luby et al 2006)
  - Both placebo and risperidone groups improved over 6 months: "only minimally greater improvement in target symptoms was evident in the risperidone group, possibly due to the differences between groups at baseline or due to the small sample size"
  - Generally well tolerated, mean 2.96 kg weight gain (0.61 kg in placebo)
Safety

• Medline search of “guanfacine” and “preschool” (May 2015)
  • 2 out of the 5 first results are about unintentional exposure (resulting in respiratory and CNS depression, bradycardia and hypotension)

• Use only when necessary

• Use only in combination with non-pharmacological interventions

• Have specialist involved when possible

• Avoid polypharmacy as much as possible

• Advise against extra doses or increasing doses without prescriber authorization

References


• Cam redirection: Heather, personal communication.


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