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Editor-in-Chief

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IN THIS ISSUE

Early Childhood Psychiatry

Learning Objectives

After reading these articles, you should be able to:

1. Identify appropriate treatment options for dysregulation in autism.
2. Modify assessment and treatment modalities appropriately for young children.
3. Work collaboratively with team members to improve patient care.
4. Summarize some of the findings in the literature regarding psychiatric treatment for children and adolescents.

Dysregulation in Autism: Irritability, Aggression, and "Pathological Demand Avoidance"

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Ms. Aikman has no financial relationships with companies related to this material.

Melanie is a bright, 9-year-old autistic child. Her mother tells you Melanie has "pathological demand avoidance." Melanie's teachers report daily incidents of upset where Melanie is reprimanded for "oppositional behavior." Melanie won't talk about her refusal to comply with instructions, frustrating her mother. The pediatrician has prescribed methylphenidate, guanfacine, and sertraline with no benefit.

Demand avoidance is not included in the diagnostic criteria for autism in the DSM-5; however, this is frequently the chief complaint from caregivers of autistic patients. Caregivers often

Highlights From This Issue

Feature article
We give you a rational path to unpack and address dysregulation in autism that minimizes medication side effects.

Feature Q&A
We help you determine whether a young child has ADHD and what to do about it.

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Learn how to collaborate more effectively with a range of other professionals for better patient outcomes.

Q&A on page 8
Dr. Jeff Rowe offers a comprehensive methodology for formulating complex cases with young children and their families.

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Q&A With the Expert

Treating ADHD in Young Children Natalie Pon, MD

Child and adolescent psychiatrist, Children's Health Council; adjunct clinical faculty, Stanford University, Palo Alto, CA.

Dr. Pon has no financial relationships with companies related to this material.

CCPR: How common is ADHD in young children?

Dr. Pon: About 2%–5.7% of children ages 3–6 meet criteria for ADHD using the DC:0–5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (from birth to 5 years old). But the distribution is 3:1 boys to girls vs 50:50 in adolescence. Girls tend toward the inattentive subtype and are diagnosed later. They may just be less active or partly influenced by cultural pressure to suppress overactivity.

CCPR: Do these diagnostic criteria differ from the DSM-5-TR?

Dr. Pon: The DC:0-5 focuses on inattention during play/activities rather than schoolwork. And while the DSM-5-TR requires "more than one setting," the DC:0-5 phrases it as "more than one relationship." Both consider the context of culture and family. For example, if a child enters their first structured environment, they may seem overactive because they've never needed to sit quietly.

CCPR: Aren't all young children active?

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describe them as prone to "meltdowns" or having a "short fuse."

Dysregulation associated with demand avoidance can result in self-injury, aggression toward others, property damage, disciplinary action, and even legal trouble. Caregivers often feel frustrated, anxious, and helpless dealing with behaviors that seem reactive and controlling.

When dysregulation interferes with functioning, clinicians often feel pressed to medicate. However, medications rarely address the underlying reasons for the upset and can have significant side effects. So, what's the best way to address dysregulation in autism? And what exactly is pathological demand avoidance, or PDA?

Defining dysregulation in autism

Dysregulation is a broad term for a cluster of emotional and behavioral symptoms resulting from difficulty regulating oneself in multiple domains:

- Sensory-motor: Autistic people frequently have hyper-, hypo-, and mixed sensitivity to sensory stimuli (eg, noise, touch) and motor control issues, both of which can result in frustration and upset.
- Communication: Autistic people often have difficulty reading nonverbal signals from other people, comprehending verbal communication, and expressing themselves both verbally and nonverbally. Any of these difficulties can result in misunderstandings and subsequent dysregulation.
- Emotional: Autistic children and teens are often depressed or anxious. Depression leads to a lower threshold for dysregulation in all kids and teens, and more so with autistic youth (Mazefsky CA et al, *J Am Acad Child Adolesc Psychiatry* 2013;52(7):679–688). Irritability is part of the overall picture of dysregulation, but not the full picture. For example, caregivers frequently report that their autistic children exhibit dysregulation when asked to complete minor tasks like brushing their teeth. This can present as repeatedly procrastinating (agreeing to brush their teeth in 10 minutes, then 10 more minutes, etc), and if the caregiver insists the task be completed immediately, this can trigger screaming, crying, and what is perceived as an overall disproportionate response.

(Source: Mazefsky CA et al, *J Autism Dev Disord* 2018;48(11):3736–3746)

Pathological demand avoidance

In the 1980s, child psychiatrist Elizabeth Newson formulated the concept of PDA while working with autistic children. She defined it as a disorder that can co-occur with autism and that presents with labile mood and "socially manipulative" avoidance of "ordinary demands" (Newson E, *Arch Dis Child* 2003;88(7):595–600). Newsom might have described the aforementioned struggle over dental hygiene practices as the child using "social manipulation" to avoid the "ordinary demand" of brushing their teeth. The more modern definition from the PDA Society of the UK describes PDA as a phenomenon in which the patient:

- Exhibits intense or even obsessive resistance to requests or demands
- Engages in avoidant behaviors like distraction or making excuses
- Becomes dysregulated when pressured to comply

(Source: O'Nions E et al, *Adv Neurodev Disord* 2021;5(3):269–281)

Deviations from routine

The need for consistency and sameness are hallmarks of autistic symptomatology and may reflect efforts to manage the stress of living in a world which is often overwhelming. Disruptions to a regulating routine and structure can be distressing. Demands can feel intolerable if they involve deviation from routines or if they interrupt pleasurable ongoing activities with even routine chores. Social communication deficits then make it hard to express distress and problem solve, which leads to the appearance of dysregulation with no clear trigger.

Melanie's teacher reports that Melanie began refusing schoolwork during timed math worksheets. The teacher tried giving Melanie extra free time to reward her for complying with the math task. When this had no effect, she tried taking away recess as a punishment. The problem worsened, after which the pediatrician tried medications.

Compliance vs collaboration

Adult responses to these meltdowns can range from the sharper commands of a frustrated adult to an opposite response in which the defeated adult carefully

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avoids actions that might trigger more outbursts. Either response can exacerbate the problem. Reward-based or punishment-based systems tend to make the child depend more on external direction rather than developing internal self-control, and avoidance of triggers can lead the child to become even more sensitive and exacting in their requirements to stay calm (Kohn A. *Punished by Rewards: The Trouble with Gold Stars, Incentive Plans, A's, Praise, and Other Bribes*. 25th anniversary ed. Boston, MA: Mariner Books; 2018). Kohn adds that treatment teams frequently develop reward-based or punishment-based compliance plans; however, this approach does not help children develop their own problem-solving skills and impedes the larger goal of helping them to grow up into assertive adults who can advocate for themselves.

Assessing dysregulation

While outbursts may appear to "come out of nowhere," it is usually possible to sort out the reasons for upset. Sift through the possibilities with caregivers, teachers, and the autistic person themselves if they can respond. Ask about their thoughts and experiences across all relevant domains. For example questions, see the "Assessing Dysregulation: Tips for Identifying Stressors" table.

Ask caregivers about social determinants that create distress for autistic people, including:

- Physical environment (eg, "Is the classroom too warm or too cold for the child?")
- Cultural issues (eg, "How does the family feel about the child's diagnosis?")
- Financial issues (eg, "Are you able to meet the family's needs?")
- Logistical barriers (eg, "Is the school team available to talk with?")

Melanie presents as a pleasant girl in "Addams Family" themed attire who recites dialog from the TV show. She tells you she wants more friends and then becomes withdrawn when you gently ask about school. Melanie's parents report that she responds best when they wait for a natural pause in whatever she is doing and give her several extra seconds to respond.

Meaningful goals

Once you understand the reasons for dysregulation and address what you can (eg, accommodations for delayed language processing), you need to help the team balance their expectations with increased support for the autistic child or teen. This will involve:

- Educating parents and teachers about the child's individual strengths and challenges
- Facilitating communication between the child, parents, and teachers
- Designing complementary goals in an Individual Educational Plan or accommodations in a 504 plan that support peer friendships in an academic learning context, or support assertiveness and self-advocacy

Include the child or teen to empower them and help parents and teachers understand their perspective. This allows for more precise and effective interventions. For children or teens who have limited capacity to express their concerns, the team can use developmental, relationship-based approaches to strengthen social communication (Sandbank M et al, *Psychol Bull* 2020;146(1):1–29).

The teacher pivots to hands-on math activities among table groups with semi-structured roles that give Melanie time to respond and clearer expectations. Melanie participates happily and tells her parents about her growing friendships with other kids who enjoy horror themes.

The role of medication

Medication treatment should be considered after nonpharmacologic approaches have been tried for specific co-occurring conditions such as depression, anxiety, and ADHD. In severe cases, antipsychotic medication may be used for limited periods (see *CCPR* Oct/Nov/Dec 2023 and our algorithm for autism irritability in Feder J et al. *Child Medication Fact Book for Psychiatric Practice*. 2nd ed. Newburyport, MA: Carlat Publishing; 2023).

CARLAT VERDICT

Traditional approaches using reward, punishment, and medication may aggravate demand avoidance. Assess for underlying problems, then empower the patient to join in designing strategies for collaborative learning and daily function.

Assessing Dysregulation: Tips for Identifying Stressors

Domains to Consider	Description	Example Questions
Communication	• Availability of spoken communication • Comprehension (eg, concrete vs abstract) • Gestural expression • Processing speed for responding to others	• Is this child able to express their distress with words or in other ways (eg, gestures, changes in activity level, etc)? • Do people wait for you to talk? • Do conversations go too fast? • What can your teacher or parents do to make communication easier?
Emotional concerns	• Anger • Anxieties • Frustration • Loneliness • Sadness	• Are you worried or stressed out about anything right now? • Do you feel in control of your own feelings most of the time? • What kids do you like to be with at school? When do you spend time with them?
Sensory-motor	• Internal discomfort • Motion • Motor control • Motor tone • Position • Smell • Sound • Taste • Touch • Visual	• Are you bothered by the feel of your clothes? • Are you bothered by certain foods, or smells, or textures of food? • Are certain times of the school day more stressful because of how loud everything is, or because too many things are going on at once?
Social-environmental	• Academic expectations • Bullying • Family stress • Social expectations	• How do you feel about your school performance? • Has there been any conflict or stress at home between anyone in your family? • Is anyone making you feel that you're different in a bad way?

Expert Interview – Treating ADHD in Young Children

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Dr. Pon: Typical preschoolers are in constant motion, have short attention spans, and lose interest or move rapidly from toy to toy. Parents of preschoolers with ADHD tend to seek care in more extreme circumstances, such as expulsion from day care or preschool due to aggression, dangerous situations, or injuries.

CCPR: What are your thoughts about the characterization of ADHD as neurodiversity, with goals of acceptance and facilitating function, instead of a disorder?

Dr. Pon: I favor neurodiversity. Parents don't want their children hearing the label ADHD. And children with ADHD get so much negative feedback. There are great children's books—*My Whirling Twirling Motor, My Wandering Dreaming Mind, My Brain is a Racecar*—that frame the child's experience in a positive way, highlighting strengths like creativity, adventure, or willingness to take risks. Everybody's brain has different strengths, and some brains must work harder on some things than others. A strengths-based approach is helpful, especially for young kids, because while we want to validate the parents' concerns and challenges, we don't want parents to feel their child is doomed. Kids' brains are developing, and treatment and early intervention can help.

CCPR: How do you assess for ADHD symptoms in preschoolers?

Dr. Pon: Look at the whole picture, including the parents' upbringing, parenting style, and expectations. Assess the child's sleep, diet, physical outlets, and sensory sensitivities, including their response to stooling. Some kids are hyperactive when constipated or withholding stool, and symptoms remit after they defecate. Diet matters too: Malnutrition and high sugar in the diet are associated with ADHD symptoms (Pinto S et al, *Nutrients* 2022;14(20):4332). In utero exposure to drugs, alcohol, or tobacco increases risk of ADHD. Other confounders include anxiety, trauma, and maternal depression. It's hard for families to talk about trauma and easier to report the child is touching everything, hitting, or not listening. We do preschool observations, see parents and children together, see the child alone, and compare these observations. I see the child at least twice plus a preschool observation. I use videotapes or telehealth to see how structured the child's natural environment is.

CCPR: How do autism and related conditions fit into the differential diagnosis of ADHD in young children?

Dr. Pon: Children with ADHD struggle to read the room because they are moving so fast. If they can pause, they can think and utilize social cues. Autistic children may not know what to do with these social cues even when there is a pause. They may also have more trouble with joint attention (eg, they might not look at people to share enjoyment).

CCPR: How do bipolar disorder and anxiety in young children compare with ADHD?

Dr. Pon: Parents may describe their child as "bipolar." However, the rate of early childhood bipolar disorder is so low that, without a significant family history and mood symptoms, that is low on my list. On the other hand, 10%–20% of preschoolers have anxiety disorders and can be hyperactive and/or inattentive due to anxiety (Whalen DJ et al, *Child Adolesc Psychiatr Clin N Am* 2017;26(3):503–522). Also, children with ADHD often develop anxiety because they are constantly corrected, worried about making mistakes, or becoming anxious after getting into dangerous situations. Anxious children may fidget or talk too much. A pediatrician's office or an unstructured preschool is a stressful environment for a 3- or 4-year-old, and as a result the child may show ADHD features, resulting in a referral. This is why it's crucial to evaluate the child across multiple settings and relationships.

CCPR: What is the role of sleep when assessing ADHD in young children?

Dr. Pon: Poor sleep creates ADHD symptoms, and ADHD affects sleep. Sleep symptoms are also common with mood disorders or anxiety. The structure around bedtime can also affect sleep. Other reasons for preschool sleep issues include obstructive sleep apnea, restless legs, and medication side effects (eg, asthma, allergy medications). We help caregivers implement a consistent, structured, and developmentally appropriate bedtime routine for at least two to four weeks before other interventions.

CCPR: Is there a link between nutrition or metabolic problems and ADHD symptoms in preschoolers?

Dr. Pon: Red food dye and lead can exacerbate ADHD symptoms. Thyroid testing may be important if there are other symptoms consistent with thyroid problems. But avoid traumatizing the child with too many blood draws.

CCPR: How do culture or race influence diagnosis of ADHD in young children?

Dr. Pon: Studies are mixed. The Early Childhood Longitudinal Study Birth Cohort tracked US kids through age 5; secondary analysis found that kindergarten teacher–reported classroom behavior had no difference in frequency for ADHD symptoms across ethnic groups, but Black children were 70% less likely to be diagnosed with ADHD than White children (Morgan PL et al, *J Child Psychol Psychitar* 2014;55:905–913). Hispanic children seemed underdiagnosed; however, that difference was nonsignificant after controlling for whether English was the primary language at home. Other studies show that Black children are *more* likely to be diagnosed with ADHD (www.tinyurl.com/5n8j9ctk).

CCPR: What resources can we use to help make the diagnosis?

Dr. Pon: The DC:0–5 can help practitioners clarify symptoms in that age group. The Child Behavioral Checklist 0–5 is a good general assessment for all psychiatric conditions. ADHD-specific scales, like the Vanderbilt, work better in latency-age children. For preschoolers, I usually use the ADHD Rating Scale IV–Preschool Version (www.tinyurl.com/2s3r3rf3). The BRIEF-Preschool and the Conners Early Childhood are typically used by assessment psychologists. For tracking progress, I like the Eyberg Child Behavior, which captures in detail "problematic behaviors" that parents report.

CCPR: Tell us about treatment.

Dr. Pon: Behavior management is the first line for young children. It's easier for 3- to 5-year-olds to learn to work with us than older children. These programs train parents to scaffold their child's regulation, then help their child learn independent self-regulation: Parent Management Training (PMT), Positive Parenting Program, Incredible Years, and

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Expert Interview – Treating ADHD in Young Children

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Parent-Child Interaction Therapy (PCIT). For ages 2–7, I favor PCIT, because sessions include both parent and child, using live coaching to help the parent practice skills to use outside of sessions.

CCPR: How do you explain therapy to the parent?

Dr. Pon: I tell parents these skills will help all their children—understanding age-appropriate behaviors, setting expectations, using positive-labeled behavior praises to get more of the behaviors they want, and delivering developmentally appropriate, consistent, natural consequences. PCIT improves the child's social behavior, fosters parent-child attachment, and teaches parent behavior management skills. Therapy distinguishes behaviors from feelings, so parents can model support and validation rather than consequences for negative emotions.

CCPR: Which professionals do PMT?

Dr. Pon: Some child psychiatrists do PMT, but psychologists, licensed marriage and family therapists, and licensed clinical social workers deliver these treatments. This is different from parent coaching—this isn't "how to be a better parent." These are specialized skills to address ADHD. For example, transitions are often extremely difficult for young children with ADHD. The tendency to hyperfocus, time blindness, difficulty with initiation, and emotional dysregulation impair a child's ability to move from one task to another throughout the day. We train parents to scaffold their child with visual timers, transition prompts, brief effective commands, and positive reinforcement to support transitions. We also help parents organize their day to manage common points of dysregulation (moving from preferred to unpreferred tasks) with movement/activity or rewards. We also train parents on how to give effective commands to their young child with ADHD. These need to be brief, single-step, specific, and immediate; we may recommend the parent pairs the command with physical touch (like a hand on the back), or a visual cue (like a transition card) to optimize listening as children with ADHD often cannot follow auditory directions alone.

"Empower parents to learn skills now that they'll use for 20 years. Help parents understand how constantly correcting a child, telling them 'don't do that,' or getting into trouble affects self-esteem."

Natalie Pon, MD

CCPR: Is it difficult to find therapists who do these therapies?

Dr. Pon: If you self-pay, there are many providers. It is hard to find insurance-based providers who work with 3- to 5-year-olds and have the experience to tailor techniques and developmentally appropriate expectations. Parents should ask: "Do you have a lot of experience with young children?"

CCPR: How is therapy with a young child different from therapy with older children?

Dr. Pon: We nurture relationships through play before any commands or consequences. Young children learn and navigate the world through play, and we support child-directed play where the parent utilizes verbal reflections and behavior descriptions while minimizing commands, questions, and critical statements. Without that positive nurturing, the young child is unlikely to listen despite any consequences. Children with ADHD are told all day what to do and not to do, so the parent directing play can increase the child's anxiety and elicit oppositionality.

CCPR: What's the problem with asking questions?

Dr. Pon: Adults naturally communicate through questions; however, young children experience questions as intrusive and a command to answer. If you observe young children and their parents, you will notice they ignore a lot of questions from the parents (and possibly the provider). We want to help parents utilize child-centered language and decrease unnecessary questions so they don't inadvertently create or reinforce a cycle of "not listening." I see many young children improve behaviorally with just this positive time and these skills with the parent.

CCPR: Are there differences in how you reinforce behavior in young children vs latency-age children?

Dr. Pon: A token economy is a common behavioral intervention that we teach parents. Latency-age children might earn stars and spend them on a screen time privilege. A 3-year-old child cannot wait and save up stars for even a day. They need a developmentally appropriate tighter reinforcement schedule—a third of the day or at most half of the day.

CCPR: What is the role of medication in the treatment of ADHD in young children?

Dr. Pon: Consider methylphenidate if there are safety concerns or severe impairment. The Preschool ADHD Treatment Study (PATS) showed that methylphenidate reduces symptoms of ADHD in preschool children. Up to 30% of young children are likely to experience adverse side effects, including emotional outbursts, irritability, sleep difficulties, decreased appetite, and weight loss. Parents in the PATS discontinued medication more often compared to older children because of adverse side effects. So start low and go slow. For medication-naive patients on the younger side, consider starting at 0.3 mg/kg/dose of methylphenidate as the PATS showed an average of 0.7 +/- 0.4 mg/kg/day. Another study used 0.3 mg/kg/dose and 0.5 mg/kg/dose with BID dosing, though I usually start with once daily to evaluate tolerability. Also consider whether the child still needs naps (Musten LM et al, *J Am Acad Child Adolesc Psychiatry* 1997;36(10):1407–1415). The FDA has also approved short-acting amphetamines for treating ADHD in 3- to 5-year-olds, but they tend to produce even more side effects (Childress AC and Stark JG, *J Child Adolesc Psychopharmacol* 2018;28(9):606–614).

CCPR: Do the side effects have to do with CNS development?

Dr. Pon: Absolutely. Young children lack myelination and development of the prefrontal cortical tracts, and we think that this is the cause of the side effects and reduced efficacy of stimulant medications in this population.

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Expert Interview – Treating ADHD in Young Children
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By 7, 8, or 9, children do beautifully, with the response that we would expect. Counsel parents about this difference so that they modulate their expectations.

CCPR: How do medications fit into the bigger plan?

Dr. Pon: Preschool children may have a hard time at dinner or bedtime, but these are bad times to give stimulants. I talk with parents about behavior therapy, structure, and setting limits (eg, safety rules, limits on electronics, and bedtime) in combination with medications during the day. This scaffolding helps the child develop self-regulation even at times with no medication.

CCPR: Do you use central alpha-agonists like clonidine or guanfacine in the evening?

Dr. Pon: Clonidine and guanfacine are helpful off-label for young children, especially children with comorbid anxiety or sleep issues. Alpha-agonists reduce hyperactive-impulsive symptoms in young children, which at this age often are more problematic than "inattentive" symptoms. There are no randomized controlled trials of alpha-agonists in the preschool population, but about 25% of young children with ADHD are prescribed an alpha-agonist vs 35% who are prescribed stimulants. The efficacy of alpha-agonists for ADHD in young children seems lower than for stimulants but with fewer side effects. Young children can become irritable or have sleep disturbances on alpha-agonists.

CCPR: Is there a role for supplements?

Dr. Pon: Many of my patients take melatonin, but parents need to know to dose it 1.5–2 hours before the target bedtime. I start with 1–3 mg and give it 10–14 days to see if it works (Gleason MM et al, *J Am Acad Child Adolesc Psychiatry* 2007;46(12):1532–1572). Magnesium can help sleep, constipation, and stooling issues. I usually recommend "Calm" gummies with 81 mg, no more than 200 mg for a young child, and monitor their stools.

CCPR: Are there other therapies that you typically recommend for young children with ADHD?

Dr. Pon: We mentioned sleep. Also think about increasing exercise. I refer young children with ADHD to occupational therapists (OTs) and social executive functioning skills groups. Skilled OTs can teach young children body-based regulation strategies, especially when the child is hyperactive, impulsive, sensory-seeking, or avoiding. OT programs such as Zones of Regulation address both emotional and physical self-regulation. Social executive functioning skills groups differ from traditional social skills groups for children with autism, which tend to be more basic. ADHD symptoms affect friendships (eg, when a child dominates play, is too rough or intrusive, makes unfiltered statements that alienate peers, or struggles to maintain friendships). Groups are usually led by a speech therapist with two to four children and focus on scaffolding play, slowing things down, and practicing prosocial interactions. This can improve frustration tolerance, perspective-taking, and flexibility with play.

CCPR: How do you talk with parents about the course of ADHD?

Dr. Pon: ADHD is a lifelong condition, with different challenges at different developmental stages. Inattention often becomes obvious when the child begins formal education, and overactivity may abate in young adulthood. Empower parents to learn skills now that they'll use for 20 years. Help parents understand how constantly correcting a child, telling them "don't do that," or getting into trouble affects self-esteem. Help parents monitor their children for mood and anxiety symptoms over the years even if the child doesn't have those symptoms early on.

CCPR: Thank you for your time, Dr. Pon.

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Practical Advocacy in Child and Adolescent Psychiatry

Abishek Bala, MD, MPH. Director, Psychiatry Clerkship; Assistant Program Director, Child & Adolescent Psychiatry Fellowship; Assistant Professor, Central Michigan University, Saginaw, MI.

Dr. Bala has no financial relationships with companies related to this material.

Topher, a 10-year-old boy with no psychiatric history, is admitted to the inpatient child and adolescent psychiatry unit due to suicidal and homicidal ideation linked to bullying at school. "They were rude and called me names," he tells you. Topher placed people on a "death list," stating he did not plan to kill them but needed to express his anger. The school suspended him, triggering guilt and thoughts of self-harm.

Child psychiatrists' roles extend beyond traditional medical practice. They are guides, educators, advocates, and problem solvers for families as external forces overshadow patient care and treatment planning. Advocacy can be a daunting process, and while we work toward an ideal, we recognize that it is not always achievable. This article will help child and adolescent psychiatrists and related professionals to envision and labor toward that ideal using targeted education and collaboration to improve patient care.

Strategic role of the child and adolescent psychiatrist

Further history reveals Topher's exposure to parental alcoholism, recent relocation to a new town, and COVID-19 disruptions. Still, he wants help and has good family support. Topher complies with unit rules and participates in milieu activities, interacting well with peers without aggression. The evening before discharge, a school shooting in a neighboring state alarms Topher's parents and school. The next morning, his parents request continued hospitalization so that Topher can start on medication to prevent any aggression.

Clinicians must often navigate community circumstances not directly related to the patient. For instance, during the COVID-19 pandemic, clinicians had to work with schools to address family fears, particularly around gun violence, in returning to in-person classes (Sanchez C

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et al, *Am J Emerg Med* 2020;38(10):2169–2178; Schmidt CJ et al, *J Behav Med* 2019;42(4):706–723). In Topher's case, we must respect parental concerns in the context of community strife while ensuring that Topher receives care appropriate to his specific circumstances.

Mobilize an interdisciplinary team

You shift from your usual child psychiatry role into an advocacy role, assembling the inpatient unit interdisciplinary treatment team—nurses, therapists, and social workers—and discussing options for addressing the fears of Topher's parents.

Share the burden of complex clinical cases, whether inpatient or outpatient. Make time to think about the nuances of your patient's situation from multiple perspectives to create a patient-centered treatment plan. In outpatient settings, the team may consist of parents, therapists, school personnel, and a psychiatrist.

- Restate the barrier: *All team members are aware of the community's concern that Topher's recent threats suggest he might harm people if he is released.*
- Summarize the case: *The team highlights Topher's challenges, your interventions, and Topher's progress.*
- Discuss diverse viewpoints: *The team discusses Topher's clinician interactions, engagement in groups, and peer interactions. This gives everyone a nuanced understanding of Topher's readiness for discharge.*
- Review the alternative plan: *The team examines the option of prolonged hospitalization and finds no clinical justification to delay Topher's discharge.*
- Distribute tasks: *Specific team members ensure care continuity, placing supportive phone calls to Topher's family and broader support system, and social workers coordinate with outpatient and aftercare services.*

The patient's support system

Engage with a patient's family to:

- Listen to concerns: *You regularly speak with Topher's parents over the phone, acknowledging their fears and ensuring they feel heard, eg, "I know you are concerned that Topher might hurt someone. Help me understand what you are seeing and hearing from him and how that might indicate that there is some danger."*
- Summarize the treatment course: *The team sets out their professional assessment that Topher does not pose a risk to others and supports their assessment with detailed observations of his interactions with staff and peers: "We thought this through carefully using well-studied guidelines about risk and safety, and here is why we think that Topher is safe to leave and why it would be best for him."*
- Clarify the role of psychiatric treatment: *Inform Topher's parents and school support staff that Topher is demonstrating no symptoms requiring medication at this point. Explain that during his time on the inpatient unit, the focus was on supportive therapy and strategies for coping with stress and anxiety, particularly regarding his school environment.*
- Define treatment objectives: *To make sure all members of Topher's care team are on the same page (including his parents and his school), you suggest a key goal: ensuring Topher feels safe and accepted upon returning to school. This includes building a supportive network of teachers and students around him.*
- Discuss the outpatient plan: *You recommend scheduling regular sessions with a therapist who will coordinate with school counselors to monitor Topher's adjustment, and regular check-ins by your outpatient liaison with the parents to reassess Topher's needs and progress.*
- Acknowledge and address issues stemming from outside factors: *You help Topher's parents learn how distress can arise even when individuals are not physically close to an incident* (Shultz JM et al, *Curr Psychiatry Rep* 2014;16(9):469).

Navigating community challenges

Topher's mother shares that her neighbors are pushing back against the family, saying "anything could happen" with Topher, and the school is debating Topher's return to classes. You decide to add Topher's outpatient therapist and a school representative to the multidisciplinary team.

In cases with greater community implications, clinicians can collaborate with other people in the patient's life to hear their concerns and clarify the roles of all the people involved. This can serve as a useful platform to educate and solidify partnerships between inpatient and outpatient clinicians, and between outpatient providers and schools.

Tips for implementation

- Early work with school personnel: Focus on building a supportive environment and specific accommodations. *You communicate with the school counselor and provide a letter discussing the team's recommendations.*
- Community reintegration: Consider community outreach to foster a supportive neighborhood environment. *The team's outpatient liaison explores case management to help the family navigate community challenges.*
- Continuous evaluation: Keep the plan dynamic with scheduled reviews to ensure that the approach remains responsive to evolving needs. *You recommend Topher and his parents regularly communicate with your outpatient liaison post-discharge.*

Bear in mind that it's not always easy to engage schools, you don't often have community interface personnel, and you might have trouble getting kids back to clinic as soon as you'd like. Sometimes phone calls need to substitute for meetings, warm handoffs, and check-ins. Still, if you consider the approaches set forth here, you can often find avenues for improving communication and care.

The multidisciplinary team, which now includes the vice-principal, advocates for Topher's return while addressing strategies to combat bullying and provide parent support (Hardaway C et al, J Youth Adolesc *2016;45(7):1309–1322). The team recommends:*

- Antibullying strategies: *Teachers and students should receive training on empathy and inclusivity, establishing clear antibullying policies, and a confidential reporting system.*

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Q&A With the Expert

Early Childhood Psychiatric Care

Jeffrey Rowe, MD

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Dr. Rowe has no financial relationships with companies related to this material.

CCPR: Why is it important for clinicians to know about early childhood mental health and early childhood psychiatry?

Dr. Rowe: Early childhood mental health focuses on the development and behavioral health of children 0–5 years of age. Most of us see kids over 5, and yet their problems frequently started in early childhood (Zeanah CH et al, *J Am Acad Child Adolesc Psychiatry* 2002;40(2):214–221). If we don't consider development, we might diagnose "atypical bipolar" in a 10-year-old child who actually has emotional dysregulation, which is a problem with the amount of emotional upset more than the quality of mood. They are explosive and might say, "I'm gonna kill myself. I'm gonna kill other people." But when they come down, those thoughts go away. I look for their quantity of mood, mood stability, slope of increased intensity, and time it takes to return to baseline.

CCPR: What percentage of young kids need clinical attention?

Dr. Rowe: That may depend on the population. Dr. Laurel Leslie and Kristin Gist studied a child welfare population and found that kids under 6 had developmental disabilities 50% of the time while the general population rate was 10%, and 30% had a behavioral health diagnosis while the general population rate was 3% (Leslie L et al, *J Dev Behavior Pediatr* 2005;26(2):140–151).

CCPR: What mental health problems occur in young children?

Dr. Rowe: Young children can have challenges in 1) self-regulation, 2) self-advocacy, 3) executive function, and 4) their sense of well-being. These four core areas are usually solid by age 5. If not, the child carries these problems forward, often complicated by DSM-type mental health problems.

CCPR: Can you describe these four areas?

Dr. Rowe: Sure. **Self-regulation** includes sleeping, eating, mood, attention, social interaction, impulse control, and aggression. **Self-advocacy** reflects a positive sense of self, the sense that their efforts can matter, the ability to use communication, and physical abilities. **Executive function** involves modulating attention, resisting distractions, holding thoughts in mind, figuring out saliency (what's important), planning and predicting what could happen next, and learning from experience. A child's **sense of well-being**, emotionally and physically, includes experiencing belonging, a purpose of life, a sense of morality (right and wrong), and freedom from physical and emotional pain.

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CCPR: Do these give a complete picture of a young child?

Dr. Rowe: There are other areas to consider. A fifth chunk is **internal working models**—basic assumptions of who they are, what they should or should not do, and who is a safe and nurturing support. A sixth area is the **sense of attachment**: Who nurtures or encourages the child? Another consideration is **interrupted development**, particularly before age 5. *(Editor's note: For a list of these areas and factors with examples, see page 1 of our online resource: www.thecarlatreport.com/EarlyChildhoodPsychCareResources.)*

CCPR: What other factors affect neuropsychiatric function in young children?

Dr. Rowe: Genetic anomalies can affect brain structure and function. **In utero events** include exposure to toxins, drugs, strokes, and infections. **Perinatal insults** can occur—infection, trauma, cancer, or surgery. One child I worked with needed bilateral frontal lobe surgery before age 2, had no impulse control or executive function at 5, but by 7 had improved wonderfully. Another factor is **complex PTSD** from prolonged neglect or physical, sexual, or emotional trauma, often before age 2.

CCPR: Any other factors to keep in mind?

Dr. Rowe: **Autism** can result in difficulties with sensory processing, communication difficulties, fixation on routines, and responding to internal scripts. There are also 10 characteristics of temperament that can interfere with everyday function, such as poor adaptability to change and sensory oversensitivity. These impact the child's relationships with parents, teachers, and peers. There are many other kinds of difficulties, including ADHD, anxiety, and depression.

CCPR: What does a child with these difficulties experience?

Dr. Rowe: By age 5, children compare themselves with peers and may feel like a failure: "I'm not fast." "I can't use scissors." "I can't write my name." Demoralization from problems in the four big areas can cause problems with peers and preschool teachers. Parent struggles with stress, mental illness, or substance use can impact attachment, temperamental mismatch, and responsiveness to their children. Children look for connection, including kids on the spectrum, and without it they suffer traumatizing stress. The excessive cortisol triggers neuropsychologic and neuroendocrine consequences that impact the alert and arousal systems (National Scientific Council on the Developing Child. *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain*; 2012:Working Paper 12). *Continued on page 9*

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CCPR: What happens with poor self-regulation?
Dr. Rowe: Dysregulated children are too reactive (with excessive arousal), too underreactive, too quick to escalate, or too slow to recover. The child may feel as though they "might blow up." They lack a sense of self-advocacy or mastery over their behavior. Parent-child interactions also impact self-regulation, eg, when parents pay too much or too little attention to the child. By age 4 you can have difficulties with mood, anxiety, behavior, and self-management, resulting in kids and caregivers who are really suffering.
CCPR: How do you organize your assessment?
Dr. Rowe: I use the following 10 questions: 1) In how many areas does a child have problems, and is the case straightforward or complex? 2) When did the problems start? 3) What is the course of the difficulties? 4) What is the child's chronological age and their developmental age? 5) Are there any heritable conditions present in the family, and do they influence the diagnosis? 6) Did treatments help; if so, which ones, and why were they stopped? 7) Did any stresses make the problems worse? Are there protective factors that are present or that went away? 8) Are recognized complex behavioral health disorders present? 9) What are the needs of the caregiver (concrete, medical, behavioral health)? 10) What are the primary relationships in the home (parent/child, parent/parent, any relationship difficulties)? *(Editor's note: For examples of each, see page 2 of our online resource: www.thecarlatreport.com/EarlyChildhoodPsychCareResources.)*
CCPR: How do social determinants affect assessment of young children?
Dr. Rowe: Dr. Pradeep Gidwani coined the phrase "a culture of one" to reflect how everyone's social determinants are wide-ranging and unique: socioeconomic status, where they were raised, who raised them, what their family was doing. Did they have an immigration or refugee experience? Has skin color or gender impacted their access to services? Do they have food, housing, transportation, education, a safe and supportive community and home environment?
CCPR: How do these aspects affect care?
Dr. Rowe: They impact mental health care attitudes and access: "What does your culture think of child psychiatry? Has anybody in your family had therapy? Is anyone in your family similar to your child?" If they don't have food, shelter, and clothing, or if an abusive or alcoholic person lives in the home, it may be impossible to offer effective help such as psychotherapy.
CCPR: How do you build rapport with families?
Dr. Rowe: With families from minoritized groups I'll ask, "Are you okay with having a White psychiatrist from Milwaukee, Wisconsin? Because we're not all the same either." They laugh and say, "We'll see." This is true for all families. Dr. Gidwani says families want to know: "Does this psychiatrist see us for who we are? Do they care that we have problems? Will they be there when things are difficult?" If not, the therapeutic alliance suffers. You might recommend medication and families don't try it. If they're taking the bus, you need to be flexible about their appointment times. Understand the socioeconomic, racial, cultural, and experiential factors related to getting help from you. That's a culture of one.
CCPR: How do you use medication in young children?
Dr. Rowe: We may need to address excessive arousal so that therapies and school plans can work. This includes sleep-wake cycle, hyperactivity, and flares of temper. I want children to fall asleep, stay asleep, and not be groggy in the morning. A second target is aggression. Look at the frequency, intensity, and duration of the aggression and use medications to cut the frequency down (eg, from 20 times a day to five times a day). If they shift from hitting people with sticks to calling people a bad word, or if the duration drops from 45 minutes of blowups to five minutes, I've made progress.
CCPR: What other areas can you address with medication?
Dr. Rowe: Look at quality of emotion, anxiety, and parent-child interactions. For one complicated 5-year-old girl, we targeted attention, focus, and hyperactivity with methylphenidate. She came back saying, "Dr. Rowe, this medicine is working great."
CCPR: What do you do for sleep?
Dr. Rowe: Most kids I see have behavioral dyscontrol during the day and sleep difficulty, so I work with parents to implement sleep hygiene since young children generally cannot engage in cognitive behavioral therapy for insomnia. If necessary, I start with melatonin, then use central alpha-adrenergic agonists. I start with guanfacine, which has a longer half-life than clonidine and less morning sedation. Also, the duration of effect for clonidine is about four hours, so kids may wake up at night.
CCPR: What do you do for the daytime problems?
Dr. Rowe: I try to avoid using D2-blocking antipsychotic medications if possible due to their serious metabolic and neurologic side effect. However, if the child is severely impulsive, hyperactive, or aggressive and no other nonpharmacologic or medication approaches are working, I'll use low dosages of second-generation antipsychotic D2 blockers for 24-hour arousal reduction. The sedation is usually in the first eight hours, but the benefit lasts longer. I start with 0.5 mg of risperidone or 2.5–5 mg of aripiprazole. Olanzapine works, but about 30% of the kids have weight gain and glucose metabolism problems, so I don't use that first. If the antipsychotic causes weight gain or excessive prolactin excretion with breast growth and galactorrhea, I might use ziprasidone at 10–40 mg or quetiapine at 12.5 mg or 25 mg. I occasionally use the antidepressant mirtazapine if a child has both sleep problems and picky appetite.
CCPR: How do you follow the effects of medication and when do you discontinue it?
Dr. Rowe: I developed a 10-item checklist for families. It is not "normed," but it helps me track symptoms and side effects. I try to stabilize kids, get a good overall plan in place, then gradually discontinue the medication. *(Editor's note: See page 5 of our online resource: www.thecarlatreport.com/EarlyChildhoodPsychCareResources.)*
CCPR: What is the prognosis for young children with mental health difficulties?
Dr. Rowe: You can see rapid improvements within three months of intervention for attachment,

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behavioral management, sleep, and self-regulation. Brain plasticity peaks from 0 to 2 years, it's about 80% at 5, and 20% during adolescence. The prognosis is outstanding with the right services. This relies on comprehensive diagnosis: What are the areas of difficulties? What's the focus of treatment? Should we do child-parent psychotherapy? Should we do speech and language? Should we do OT and PT at the same time? But many localities don't have those specialty services.

CCPR: What's the prognosis for older children who did not get early intervention?

Dr. Rowe: If you don't fix these basic building blocks by age 6, the problems are compounded—lifelong trouble with self-management, teens who cannot sleep or regulate themselves without marijuana or alcohol. Still, intervention at later ages can be helpful. In one study, reading levels of teens in our juvenile hall were at the second-grade level. A judge paid for a reading program, and they rose to eighth grade in four months. The kids were proud that they could read, learn, and remember. This is the kind of developmental thinking that we all need to be doing. *(Editor's note: For a treasure trove of resources related to this article, see: www.thecarlatreport.com/EarlyChildhoodPsychCareResources.)*

CCPR: Thank you for your time, Dr. Rowe.

Research Updates IN PSYCHIATRY

ADHD

Stimulants in Preschool-Age Children

Earth Hasassri, MD. Dr. Hasassri has no financial relationships with companies related to this material.

REVIEW OF: Chiu HJ et al, *Eur Psychiatry* 2023;66(1):e24

STUDY TYPE: Meta-analysis

How young is too young to treat children with medication for ADHD? ADHD medications are FDA approved for children as young as 3. However, for preschool-age children, the first-line strategy is usually behavioral intervention. When therapy is ineffective, we still might hesitate to use stimulants. This report attempts to clarify the role of stimulants in young children with ADHD.

In this meta-analysis, researchers combined data from nine clinical trials, totaling 544 kids under 7 years old (average 5 years; 88% male). The average treatment duration was 4.3 weeks. The authors looked at validated ADHD rating scales given to parents and teachers, improvements on neuropsychologic tests, and adverse events.

Parents reported an effect size of 0.62 and teachers reported 0.65—both medium-to-large effect sizes, like what's seen in adults. Stimulants were better for hyperactivity and impulsivity (medium effect size of 0.45–0.59) than for inattention (small effect size of 0.30–0.33). On neuropsychologic tests for impulsivity and inattention, stimulants did not perform better than placebo. Treatment was more effective in boys, with older age, and for longer treatment duration.

The only significant adverse effect of stimulants was decreased appetite. Stimulants did not cause more irritability, sleep disturbance, tendency to cry, or anxiety, nor were there changes to heart rate or blood pressure compared with placebo.

This study had several limitations. The quality of evidence from the included studies was rated as low to very low, and there was no clinician assessment of ADHD in these trials. The maximum duration of the study was six weeks, preventing conclusions about long-term side effects and efficacy.

CARLAT TAKE

Despite the optimistic tone of this report, the time frames are very short. The Preschool ADHD Treatment Study demonstrated significant reductions in growth and weight gain in preschoolers with ADHD treated with stimulant medications over a three-year period while showing less than optimal impact on ADHD symptoms, and it remains the best gauge we have. If a preschooler struggles with ADHD despite a good trial of behavioral interventions, we suggest you think carefully before trialing stimulants. If you do try these medications, closely monitor symptoms, vital signs, and growth parameters.

How Safe Is Methylphenidate?

Earth Hasassri, MD.

REVIEW OF: Man KKC et al, *Lancet Psychiatry* 2023;10(5):323–333

STUDY TYPE: Naturalistic, prospective, longitudinal, controlled study

Stimulants are safe and effective for childhood ADHD in the short term. Most studies, however, only look at safety up to 12 weeks. We have limited data on the long-term safety of stimulant treatment for kids, particularly regarding growth parameters. For instance, the well-known MTA study only followed children on medication for 14 months. This study offers fresh insight.

The study tracked the growth of 1,410 children and teens across five European countries over two years. Participants were divided into three groups: 1) new methylphenidate users with ADHD, 2) children with ADHD who did not intend to use methylphenidate, and 3) children without ADHD. Notably, none of the subjects received prior stimulant exposure. The average age was 9 years old (range 6–17 years). Subjects were predominantly male (76%) and White (93%). A European Union program provided public funding for this study, ensuring a level of objectivity.

After two years, methylphenidate showed no impact on growth velocity for height; however, there was a temporary reduction in weight velocity over the first six months of the study. Although the study did not account for family history of hypertension, methylphenidate was linked to small but significant increases in systolic and diastolic blood pressure and heart rate. In this study, methylphenidate did not exacerbate psychiatric or neurologic symptoms.

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1. Pathological demand avoidance is listed as a formal diagnosis in the DSM-5 for autism spectrum disorder (LO #1).
   [ ] a. True [ ] b. False

2. According to the Preschool ADHD Treatment Study, what percentage of preschool-age children with ADHD are likely to experience adverse effects from stimulant medication (LO #2)?
   [ ] a. 10% [ ] b. 20% [ ] c. 30% [ ] d. 40%

3. What should a child psychiatrist do first when faced with parental fears regarding a patient's readiness for discharge (LO #3)?
   [ ] a. Emphasize the psychiatrist's authority in making discharge decisions
   [ ] b. Reassure the parents that the patient will continue to receive the same care at home
   [ ] c. Validate the parents' concerns and engage in a collaborative discussion
   [ ] d. Recommend that the patient stay longer to address the parents' anxiety

4. According to a 2023 study, what was the primary finding regarding the effect of methylphenidate on growth velocity in children with ADHD over two years (LO #4)?
   [ ] a. Methylphenidate significantly increased height growth velocity
   [ ] b. Methylphenidate had no impact on height growth velocity but caused a temporary reduction in weight velocity
   [ ] c. Methylphenidate led to significant growth deficits in both height and weight
   [ ] d. Methylphenidate had a long-term negative impact on growth that was not observed in the first six months

5. What is the main drawback of using reward- or punishment-based systems to address demand avoidance in autistic children (LO #1)?
   [ ] a. They help children develop independence [ ] c. They make children more dependent on external direction
   [ ] b. They are effective in teaching self-regulation [ ] d. They reduce the number of meltdowns over time

6. According to Dr. Rowe, what negative impact might demoralization have on children by the age of 5 (LO #2)?
   [ ] a. Problems with peers and preschool teachers [ ] c. Increased academic performance due to overcompensation
   [ ] b. Development of motor deficits such as poor handwriting [ ] d. Enhanced social engagement to seek approval from adults

7. Which of the following strategies is recommended for supporting a child's reintegration into school following psychiatric hospitalization (LO #3)?
   [ ] a. Increasing academic workload to promote a sense of normalcy
   [ ] b. Using antipsychotic medication to manage any remaining symptoms
   [ ] c. Establishing clear antibullying policies and providing empathy training for students
   [ ] d. Limiting communication with the family to avoid overwhelming them

8. According to a 2023 meta-analysis in preschool-age children, stimulant medications have been shown to have significant long-term effects on both symptom improvement and growth (LO #4).
   [ ] a. True [ ] b. False

Research Updates

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CARLAT TAKE

Some patients are on stimulant medications for far longer than two years, and the very-long-term side effects are not clear. Still, this study offers some reassurance about the safety of methylphenidate for ADHD, particularly regarding growth, while supporting regular blood pressure and heart rate monitoring. This seems true even for younger children who may have a longer duration of exposure to side effects from stimulant medications.

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- Mentorship programs: *Social groups centering on shared interests can help build a social network.*
- Family care coordinator following discharge: *Engaging a coordinator can help navigate challenges in the community and school.*

School advocacy might include urging the school to convene a student study team to offer more resources and options for managing bullying, and school-based antibullying programs such as www.tinyurl.com/bdftyzks.

Three months later, Topher's parents contact you to thank you and your team. Topher has teachers who are watching out for him and classmates who include him in activities. Topher feels safe and valued.

Education

Help healthcare professionals in training to learn these principles by including them in advocacy efforts. They can offer perspectives that challenge assumptions

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and remind us to reassess biases that influence decision making. Mentors also add depth, offering valuable frameworks for navigating challenging situations, especially when the team is stuck. Collaborative learning experiences reinforce our sensitivity to the complex ways patients communicate distress and help us practice identifying and addressing barriers to care.

CARLAT VERDICT

Depending on your setting and resources, good advocacy could be good care, or it could be an ideal to strive for. Either way, Topher's case demonstrates several aspects of clinical advocacy. Clinicians in similar circumstances can take steps to mobilize an interdisciplinary team, engage the family, navigate community challenges (eg, the patient's return to school), and leverage mentorship and collective learning. Child psychiatrists have a pivotal role as guardians of evidence-based care in a patient's journey through the labyrinth of challenging circumstances, particularly in the face of complex and intense dynamics involving the child's family and community.

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