



Addressing Early Childhood Emotional and Behavioral Problems

COUNCIL ON EARLY CHILDHOOD, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

Emotional, behavioral, and relationship problems can develop in very young children, especially those living in high-risk families or communities. These early problems interfere with the normative activities of young children and their families and predict long-lasting problems across multiple domains. A growing evidence base demonstrates the efficacy of specific family-focused therapies in reducing the symptoms of emotional, behavioral, and relationship symptoms, with effects lasting years after the therapy has ended. Pediatricians are usually the primary health care providers for children with emotional or behavioral difficulties, and awareness of emerging research about evidence-based treatments will enhance this care. In most communities, access to these interventions is insufficient. Pediatricians can improve the care of young children with emotional, behavioral, and relationship problems by calling for the following: increased access to care; increased research identifying alternative approaches, including primary care delivery of treatments; adequate payment for pediatric providers who serve these young children; and improved education for pediatric providers about the principles of evidence-based interventions.

abstract

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INTRODUCTION

Emotional, relationship, and behavioral problems affect nearly as many preschoolers as older children, with prevalence rates of 7% to 10%.¹⁻³ Emotional, behavioral, and relationship problems, including disorders of attachment, disruptive behavior disorders, attention-deficit/hyperactivity disorder (ADHD), anxiety and mood disorders, and disorders of self-regulation of sleep and feeding in children younger than 6 years, interfere with development across multiple domains, including social interactions, parent-child relationships, physical safety, ability to participate in child care, and school readiness.⁴⁻⁶ Importantly, if untreated, these problems can persist and have long-lasting effects, including measurable abnormalities in brain functioning and persistent emotional and behavioral problems.⁷⁻¹⁰ In short, early emotional,

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behavioral, and relationship problems in preschool-aged children interfere with their current well-being, jeopardize the foundations of emotional and behavioral health, and have the potential for long-term consequences.¹¹

Pediatricians and other child health care providers can reduce the risk of childhood emotional and behavioral problems by reducing exposure to toxic stress, promoting protective factors, and systematically screening for risk factors for emerging clinical problems.^{12,13} Existing policy statements address universal approaches, early identification, and strategies for children at risk. The present policy statement focuses on clinical interventions for children with clinical disorders that warrant targeted treatment. Treatment planning is guided by a comprehensive assessment of the clinical presentation with attention to the child, the parent-child relationships, and community stressors. Beyond assessment, effective treatment of clinical disorders requires the following: (1) access to evidence-based treatments; and (2) primary care providers' sufficient familiarity with evidence-based treatments to implement first-line approaches, make informed and effective referrals, and collaborate with specialty providers who have expertise in early childhood emotional and behavioral well-being.¹⁴ Currently, most young children with an emotional, relationship, or behavioral problem receive no interventions for their disorder. This policy statement provides a summary of empirically supported approaches, describes readily identifiable barriers to accessing quality evidence-based interventions, and proposes recommendations to enhance the care of young children. This statement has been endorsed by Zero to Three and the American Academy of Child and Adolescent Psychiatry.

EVIDENCE-BASED TREATMENTS

Awareness of the relative levels of evidence supporting pharmacologic and nonpharmacologic therapies for emotional, behavioral, and relationship problems can guide clinical decisions in the primary care setting. The evidence base related to psychopharmacologic agents in children younger than 6 years is limited and has only addressed ADHD.¹⁵ Only 2 rigorous trials have examined the safety and efficacy of medications in this age group. Both the trial of methylphenidate and the study of atomoxetine for moderate to severe ADHD demonstrated that the trial medication was more effective than placebo but was less effective for younger children than for older children and produced higher rates of adverse effects in younger children.^{16,17} Other medications have been less rigorously evaluated in preschool-aged children, although the rates of prescriptions for atypical antipsychotic agents, with their potential for substantial metabolic morbidity, have increased steadily in this age group.¹⁸⁻²⁰

Nonpharmacologic treatments have more durable effects than medications, with documented effects lasting for years.²¹⁻²³ A first step in reducing the barriers to evidence-based treatments is to ensure that primary care pediatricians are familiar with these approaches, which should be available to young children with emotional, behavioral, or relationship problems.²⁴

For infants and toddlers with clinical-level emotional, behavioral, or relationship concerns, dyadic interventions promote attachment security and child emotional regulation and can promote regulation of stress hormones. Examples of these interventions include infant-parent psychotherapy, video feedback to promote positive parenting, and attachment biobehavioral catch-up. These interventions often use real-time

infant-parent interactions to support positive interactions, enhance parents' capacity to reflect on their parenting patterns, and promote sensitivity and an understanding of the infant's needs.²⁵

For preschool-aged children, parent management training models, including parent-child interaction therapy (PCIT), the Incredible Years series, the New Forest Program, Triple P (Positive Parenting Program), and Helping the Noncompliant Child,²⁶ are effective in decreasing symptoms of ADHD and disruptive behavior disorders. Parents are actively involved in all of these interventions, sometimes without the child and sometimes in parent-child interactions. All share similar behavioral principles, most consistently engaging parents as partners to: (1) reinforce positive behaviors; (2) ignore low-level provocative behaviors; and (3) provide clear, consistent, safe responses to unacceptable behaviors. Table 1 presents some of the characteristics of the best-supported programs for disruptive behavior disorders and ADHD.^{25,27}

Posttraumatic stress disorder can be treated effectively with cognitive behavioral therapy and child-parent psychotherapy in very young children. In cognitive behavioral therapy for posttraumatic stress disorder, preschool-aged children learn relaxation techniques and are gradually exposed to their frightening memories while using these techniques. Child-parent psychotherapy focuses on supporting parents to create a safe, consistent relationship with the child through helping them understand the child's emotional experiences and needs.³³ Cognitive behavioral therapy is also effective for other common anxiety disorders, and recent promising studies report effectiveness of modified PCIT for selective mutism and depression.³⁴⁻³⁶ Adaptations for use in primary care, including

TABLE 1 Characteristics of the Best-Supported Programs for Disruptive Behavior Disorders and ADHD

Program	Ages	Formal Psychoeducation for Parents?	Real-Time Observed Parent–Child Interactions?	Special Characteristics	Duration	Evidence Suggesting Effective for ADHD? (Effect Size)	Evidence Suggesting Effective for Disruptive Behavior Disorders? (Effect Size)
New Forest ²⁸	30–77 mo	Yes	Yes	Parent–child tasks are specifically intended to require attention Occurs in the home Explicit attention to parental depression	5 weekly sessions	Yes (very large, 1.9)	Yes (moderate, 0.7)
Incredible Years Parent Training and Child Training ^{29,30} (incredibleyearsseries.org)	24 mo–8 y	Yes	No	Separate parent and child groups Parental training uses video vignettes for discussion Child training includes circle time learning and coached free play	20 weekly 2-h sessions	Yes	Yes
Triple P ³¹ (triplep.org)	Birth–12 y	Yes (primary)	Yes	Multiple levels of intervention Primarily training parents with some opportunities to observe parent–child interactions Handouts and homework supplement the treatment	Primary care, four 15-min sessions Standard treatment is 10 sessions	No	Yes
PCIT ³² (pcit.org)	24 mo–7 y	Yes, minimal	Yes	Through a 1-way mirror, therapist coaches parent during in vivo interactions with child Homework requires parent child interactions Progress through therapy determined by parents' skill development	Duration depends on parental skill development	Modest	Yes
Helping the Noncompliant Child ²⁶	3–8 y	Yes	Yes	Involves 2 phases: (1) differential attention; (2) compliance training using demonstration, role plays, and in-office and at home practice	8–10 average (depends on demonstrated progress)	Yes (1.24 parent report; .23 [NS] teacher report)	Yes

Triple P, the Incredible Years series, and PCIT, similarly show positive outcomes, although further research is warranted.^{37–39}

Ensuring that parents have access to appropriate support or clinical care is often an important component of clinical intervention for children.

Effective parental treatment (eg, for depression) may reduce child symptoms substantially.⁴⁰

SYSTEMIC BARRIERS

Despite the strong empirical support for these interventions, most young children with emotional, behavioral,

and relationship problems do not receive nonpharmacologic treatments.⁴¹ Physical separation, challenges coordinating across systems, stigma, parental beliefs, and provider beliefs about mental health services may interfere with identification of concerns and success of referrals. New models

such as co-located care, in which mental health professionals work together with medical care providers in the same space, improve care coordination and referral success, decrease stigma, and reduce symptoms compared with traditional referrals.⁴²⁻⁴⁴ There are insufficient numbers of skilled providers to meet the emotional, behavioral, and relationship needs of children (and young children in particular) who require developmentally specialized interventions.^{45,46} Therefore, when a primary care pediatrician identifies an emotional, relationship, or behavioral problem in a young child, it is often difficult to identify a professional (eg, social worker, psychologist, child and adolescent psychiatrist, developmental-behavioral pediatrician) with expertise in early childhood to accept the referral and provide evidence-based treatments.

Mental health coverage systems may also reduce access to care.⁴⁷ Although mental health parity regulations took effect in 2014, there are still “carved out” mental health programs that prohibit payment to primary care pediatricians for care of a child with an emotional, relationship, or behavioral health diagnosis and may limit access to trained specialists.⁴⁸ Even when a trained provider of an evidence-based treatment is identified, communication, coordination of care with primary care pediatricians, and adequate payment can be challenges.^{14,49} Many health care systems do not pay for, or underpay for, necessary components of early childhood care such as care conferences, school observations, discussions with additional caregivers, same-day services, care coordination, and appointments that do not include face-to-face treatment of the child.

RECOMMENDATIONS

1. In the context of the focus of the American Academy of

Pediatrics on early child and brain development, pediatricians have the opportunity to advocate for legislative and research approaches that will increase access to evidence-based treatments for very young children with emotional, behavioral, and relationship problems.

1a. At the legislative level, pediatricians should advocate for: (1) funding programs that increase dissemination and implementation of evidence-based treatments, especially in areas with limited resources; (2) addressing the early childhood mental health workforce shortage by providing incentives for training in these professions; (3) decreasing third-party payer barriers to accessing mental health services to very young children; and (4) promoting accountable care organization regulations that protect early childhood mental health services.

1b. In collaboration with other child-focused organizations, pediatricians should advocate for prioritization of research that will enhance the evidence base for treatment of very young children with emotional, behavioral, and relationship problems. Comparative effectiveness studies between psychopharmacologic and psychotherapeutic interventions and comparison of mental health service delivery approaches (eg, co-located models, community-based consultation, targeted referrals to specialists) are needed to guide management and policy decisions. In addition, studies that examine moderators of treatment effects, including family, social, and biological factors, are warranted. Studies of interventions adapted to treat young children with mild

symptoms in the primary care setting could decrease barriers to care.

2. At the community and organizational levels, pediatricians should collaborate with local governmental and private agencies to identify local and national clinical services that can serve young children and explore opportunities for innovative service delivery models such as consultation or co-location.
3. Primary care pediatricians and developmental-behavioral pediatricians, together with early childhood mental health providers, including child and adolescent psychiatrists, and developmental specialists, can create educational materials for trainees and providers to enhance the care young children receive.
4. Without adequate payment for screening and assessment by primary care providers and management by specialty providers with expertise in early childhood mental health, treatment of very young children with emotional and behavioral problems will likely remain inaccessible for many children. Given existing knowledge regarding the importance of early childhood brain development on lifelong health, adequate payment for early childhood preventive services will benefit not only the patients but society as well and should be supported. Mental health carve-outs should be eliminated because they provide a significant barrier to access to mental health care for children. Additional steps toward equal access to mental health and physical health care include efficient prior authorization processes; adequate panels of early childhood mental health providers; payment to all providers, including primary care providers, for mental health

diagnoses; sustainable payment for co-located mental health providers and care coordination; payment for evidence-based approaches focused on parents; and payment for the necessary collection of information from children's many caregivers and for same-day services. Advocacy for true mental health parity must continue.

5. To ensure that all providers caring for children are knowledgeable participants and partners in the care of young children with emotional, behavioral, and relationship problems, graduate medical education and continuing medical education should include opportunities for training that ensure that pediatric providers: (1) are competent to identify young children with emotional, behavioral, and relationship problems as well as risk and protective factors; (2) are aware that common early childhood emotional, behavioral, and relationship problems can be treated with evidence-based treatments; (3) recognize the limitations in the data supporting use of medications in very young children, even for ADHD; (4) are prepared to identify and address parental factors that influence early child development; and (5) can collaborate and refer across disciplines and specialties, including developmental-behavioral pediatrics, child and adolescent psychiatry, psychology, and other mental health services.

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ABBREVIATIONS

ADHD: attention-deficit/hyperactivity disorder
PCIT: parent-child interaction therapy

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