

Preschoolers and



AD/HD

Can the disorder be diagnosed and treated before children enter elementary school?

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by Mark L. Wolraich, M.D.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

(AD/HD) is a condition that is due to genetic factors in the majority of cases. Some mothers even report noticing their child's increased activity level before the child is born. As recognition that AD/HD is likely present from birth, the diagnostic criteria include the requirement that a child exhibit some of the symptoms prior to seven years of age. Brain-imaging studies have found that certain parts of the brain in individuals with AD/HD are, on average, smaller and less active than in those without AD/HD. Despite brain differences that are probably there from birth or an early age, most children are not diagnosed with AD/HD until they enter elementary school, and until recently, it has been unusual to diagnose any child prior to that age.

AD/HD is now being recognized at an earlier age in some children for several reasons. Parents and clinicians are more knowledgeable about the condition, so they are detecting the problems earlier. Most children attend preschool programs, and thus they begin school readiness activities at an earlier age. Additionally, most parents realize that success at school has become even more important to success in our society.

Can AD/HD be reliably diagnosed in preschool-aged children? If so, how can it be treated? Helen Egger, M.D., and colleagues reviewed all the studies about diagnosing preschool-aged children. They concluded that the behaviors of preschool-aged children were sufficiently similar to those of older children so that a clinician can use the same criteria to determine the presence of AD/HD in a preschooler. They also found that many of the children who meet the criteria have not been evaluated, diagnosed or treated. Therefore, they concluded, if parents and preschool teachers are noticing behaviors characteristic of children with AD/HD, it is appropriate for the parents to seek further evaluation and treatment.

Treatment with medication

Of the two types of stimulant medications used to treat individuals with AD/HD, those with methylphenidate (Ritalin, Metadate, Concerta, Focalin, and Daytrana) are not recommended by the Food and Drug Administration (FDA) for children under six years of age, while those with amphetamines (Adderall, Dexedrine and the just-approved Vyvanse) are recommended down to age three.

The difference in the FDA recommendations, however, has to do more with the regulations that were in place when the FDA approved the medications than they do with how much evidence there is about how well they work or how safe they are in preschool-aged children. All the studies specifically examining the safety and efficacy of these medications in preschool-aged children have focused on methylphenidate and not amphetamine. Until

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recently, all ten studies entailed a small number of children; six showed methylphenidate to work better than a placebo (pill with no medication in it), two did not, and two indicated more side effects than had been seen in older children.

To clarify the issue, the National Institute of Mental Health (NIMH) funded a study at six different locations with a total of 165 children (Greenhill et al., 2006). The study found that methylphenidate worked better than placebos and did not have worse side effects than are seen in older children, but it had a weaker effect in preschoolers than it has in older children. Although methylphenidate can be used safely with children under age six, most clinicians remain appropriately cautious in using it with this age group because the brains of these children are at an earlier stage of development and all the long-term effects may not yet be known.

Parent training

The design of the NIMH study required parents of children enrolled in the study first to participate in a ten-week parent training program. The children of 15 percent of those parents who participated in the training clearly improved on the behavioral treatment alone, and another 13 percent of the parents chose not to try their children on medication.

Preferring to be conservative, most clinicians recommend trying parent training before trying medication. Programs that focus on improving parental consistency, using both rewards and punishments, have been shown to be effective in treating many children with problematic behaviors, including those characteristic of AD/HD.

Parent training is provided in group programs, such as the CHADD-sponsored Parent to Parent program, or individually for more intense training, such as Parent Child Interaction Training. PCIT is a short-term, special-

ized behavior management program designed for young children experiencing behavioral and/or emotional difficulties and their families. PCIT works with the child and caregiver together to improve overall behavior and to reduce parenting stress. The interventions also do not require a child to be diagnosed with a specific condition, so parents learn the enhanced parenting skills even if it is not clear their child has the diagnosis of AD/HD. Visit <http://devbehavpeds.ouhsc.edu/pcit.asp> or www.pcit.org for more information.

Addressing the problem

Based on what is known about treatment, parents concerned about a child's behavior can start by finding an appropriate behavior-modification parent training program. To benefit from this intervention, the child does not have to have a diagnosis of AD/HD. The parent will learn skills that can help them become better parents, and they can also help their child's preschool program to implement similar techniques.

If this intervention does not sufficiently address the problems, parents should find a clinician who can assess their child. Many parents start with their primary-care physician, first determining whether the doctor is knowledgeable about AD/HD and its manifestations in young children. If the physician is not comfortable in providing the needed assessment, he or she may refer the family to a child psychiatrist or psychologist or a developmental-behavioral pediatrician. Based on the evaluation, parents can consider a more intense behavior modification program and/or treatment with stimulant medication. Once the diagnosis is clarified, if stimulant medications are considered, the primary-care physician often can provide medication management, or can take over management after the most effective medication and dose has been determined.

Parents of preschoolers might also want to consider other treatment choices and strate-

FOR MORE INFO:

For a list of references and additional reading, visit www.chadd.org/ attention/references.

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gies. Dietary manipulations (restricting, balancing, or supplementing) might make more sense for a preschooler than for older children. Speech therapy could help the child be more verbal and less motoric, if there is a speech delay. Although not proven to help AD/HD, sleep hygiene or substituting outdoor activity for television time would probably benefit any child. A concern often expressed about the less well-documented alternative treatments is that they might delay proven treatment. But in the case of preschoolers, delaying stimulant treat-

ment might be a good thing.

Preschool children with AD/HD can be accurately diagnosed. It is best to treat them conservatively, first trying behavioral interventions, but stimulant medications can be effective, providing benefits similar to those the stimulant medications provide to older children. It is appropriate for both parents and clinicians to want to intervene early, in order to help children with AD/HD before they experience years of failure and receive the message that they are bad children. ■
