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Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: An Overview of DC:0-5™

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Introducing DC:0-5™

Get updates at www.zerotothree.org or see description https://www.zerotothree.org/resources/services/dc-0-5-manual-and-training

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Development of Diagnostic Classification in Infancy and Young Children

1987–2003	Original Task Force convened by ZERO TO THREE: National Center for Infants, Toddlers, and Families
1990–2003	Task Force expanded
1994	DC:0–3 published
1997	DC:0–3 Casebook published
2003–2005	DC:0–3R Task Force convened
2005	DC:0–3R released
2013–2016	Diagnostic Classification Revision Task Force convened
2016	DC:0–5 released

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Why Revise DC:0-3R?

- Capture new empirical data and studies relevant to diagnoses in young children (11 years since DC:0-3R was published)
- DSM-5 published in 2013
- Address lingering concerns about DC:0-3 and DC:0-3R

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Process

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ZERO TO THREE Diagnostic Classification Task Force

- Alice Carter -- University of Massachusetts, Boston
- Julie Cohen -- ZERO TO THREE
- Helen Egger – New York University
- Mary Margaret Gleason -- Tulane University
- Miri Keren -- Tel Aviv University
- Kathleen Mulrooney -- ZERO TO THREE
- Alicia Lieberman -- University of California San Francisco
- Cindy Oser -- ZERO TO THREE
- Charles H. Zeanah -- Tulane University

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Soliciting Feedback

- Task Force conducted a web-based survey of 20,000 users of *DC:0-3R* worldwide.
- E-mail invitations with links to the survey instrument were sent to all users for whom we had access,
  - participants in *DC:0-3R* training sessions
  - all members WAIMH and affiliates
  - U.S. state infant mental health associations and contacts
  - AACAP Infant and Preschool Committee
  - Irving Harris Foundation Professional Development Network
  - purchasers of the *DC:0-3R* and related materials
  - *Zero To Three Journal* subscribers
  - ZERO TO THREE Board, staff and Academy Fellows

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Initial Decisions

- Each disorder evaluated in terms of evidence base and their clinical usefulness
  - no automatic commitment to DC:0-3R disorders
  - did not preclude including new disorders
- Attempted to be comprehensive and not rely on other nosologies (e.g., DSM-5)
  - Includes an impairment criterion for every disorder.

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Impairment for Every Disorder

Symptoms of the disorder, or caregiver accommodations in response to the symptoms, significantly impact the young infant's/young child's and/or family's functioning in one or more of the following ways:

1. Cause distress to the infant/young child;
2. Interfere with the infant's/young child's relationships;
3. Limit the infant's/young child's participation in developmentally expected activities or routines;
4. Limit the family's participation in everyday activities or routines; or
5. Limit the infant's/young child's ability to learn and develop new skills, or interfere with developmental progress.

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Framework for Creating the Diagnostic Classification: DC:0–5

- Empirically derived
  - weight given to those disorders with more research
- Clinically meaningful
  - value practitioner input

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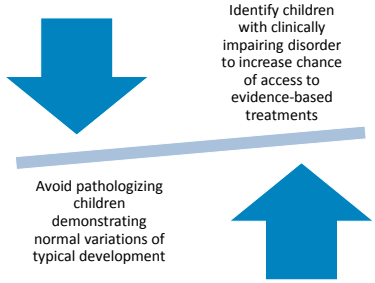
The Balancing Act



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Content

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Key Changes in Revision of DC:0-3R

- The new edition (DC:0-5) includes disorders occurring in children from birth through 5 years old.
- DC:0-5™
  - Continues a multiaxial classification system
  - Is comprehensive and does not rely on other nosologies
  - Includes a number of disorders not previously included in DC:0–3R
  - Defines and specifies symptoms in children less than 1 year old whenever possible
  - Includes impairment criteria for each disorder for infant, young child or infant/young child as applicable

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Multiaxial System

DC: 0-3R

- Axis I: Clinical Disorders
- Axis II: Relationship Classification
- Axis III: Medical & Developmental Disorders and Conditions
- Axis IV: Psychosocial Stressors
- Axis V: Emotional & Social Functioning

DC: 0 - 5

- Axis 1: Disorders
- Axis II: Relational Context
- Axis III: Physical Health Conditions and Considerations
- Axis IV: Psychosocial Stressors
- Axis V: Developmental Competence

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Revised Axes

Axis I (Clinical Disorders): Expanded from 30 to 42 disorders and more closely aligned with DSM-5 (APA, 2013).

Axis II (Relational Context): Includes rating both the child-primary caregiving relationship adaptation and the caregiving environment.

Axis III (Physical Health Conditions and Consideration): expanded list of examples of physical, medical and developmental conditions.

Axis IV (Psychosocial Stressors): expanded list and reorganization of stressors for young children and their families.

Axis V (Developmental Competence): expanded to capture a broad range of developmental competencies through the first five years.

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Red Flag Emotional or Behavioral Patterns

Patterns that:

- are unusual for the infant/young child
- cause parents and others to see the infant/young child as "difficult"
- make satisfying interactions difficult
- are seen in multiple settings by a number of people
- persist
- cause distress or impairment to the infant/young child and family
- are outside of the wide range of age-appropriate or cultural norms

Parlakian and Seibel (2002)

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Why Diagnose in Infancy and Early Childhood?

- To use shared language among professionals and families
- To guide treatment
- To provide service for families
- To determine the need for additional services
- To be able to link the infant's/young child's presentation to research that has focused on diagnoses to describe course and treatment approaches
- To seek authorization/reimbursement

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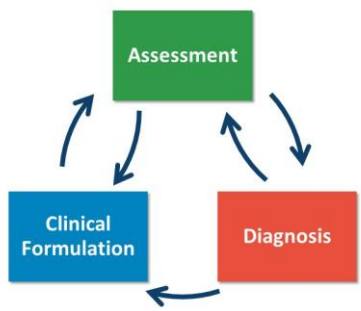
The Diagnostic Process



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Diagnosis

We diagnose disorders not children…

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Multiaxial Framework

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Axis I Disorders

Axis I – Disorder Categories:

- Neurodevelopmental Disorders
- Sensory Processing Disorders
- Anxiety Disorders
- Mood Disorders
- Obsessive Compulsive and Related Disorders
- Sleep, Eating and Crying Disorders
- Trauma, Stress and Deprivation Disorders
- Relationship-Specific Disorder

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Neurodevelopmental Disorders

- Attention Deficit Hyperactivity Disorder
- Overactivity Disorder of Toddlerhood
- Autism Spectrum Disorder
- Early Atypical Autism Spectrum Disorder
- Global Developmental Delay
- Developmental Language Disorder
- Developmental Coordination Disorder
- Other Neurodevelopmental Disorder

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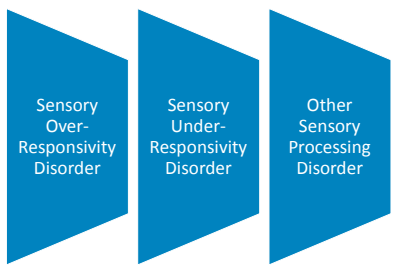
Sensory Processing Disorders



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Anxiety Disorders

- Generalized Anxiety Disorder
- Separation Anxiety Disorder
- Social Anxiety Disorder (Social Phobia)
- Selective Mutism
- Inhibition to Novelty
- Other Anxiety Disorder

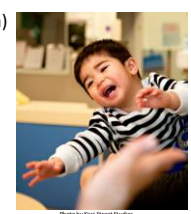

Photo by Kiwi Street Studios

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Mood Disorders

- Depressive Disorder of Early Childhood
- Disorder of Dysregulated Anger and Aggression of Early Childhood
- Other Mood Disorder

Photo by Kiwi Street Studios

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Obsessive Compulsive and Related Disorders

- Obsessive Compulsive Disorder
- Tourette's Disorder
- Vocal or Motor Tic Disorder
- Trichotillomania
- Skin Picking Disorder
- Other Obsessive Compulsive and Related Disorders

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Sleep, Eating and Crying Disorders

Sleep Disorders
- Sleep Onset Disorder
- Night Waking Disorder
- Partial-Arousal Sleep Disorder
- Nightmare Disorder of Early Childhood

Eating Disorders of Infancy
- Overeating Disorder
- Undereating Disorder
- Atypical Eating Disorder

Excessive Crying Disorder

Other Disorder of Sleep, Eating or Crying

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Trauma, Stress and Deprivation Disorders

- Posttraumatic Stress Disorder
- Adjustment Disorder
- Complicated Grief Disorder of Early Childhood
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Other Trauma, Stress and Deprivation Related Disorder

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New Relationship Disorder

Relationship Specific Disorder of Early Childhood

- Disorder is evidenced between the child and a specific primary caregiver rather than within-the-child and expressed in most settings.
- Children construct different kinds of relationships with different caregivers based on their lived experiences with each caregiver.
- Relationship disorder diagnosis
  - calls attention to what may be the most useful target of intervention
  - Not intended to blame a parent or caregiver for shortcomings.

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Axis II: Relational Context Overview

- Used to characterize the caregiving context
- Encourages systematic characterization of relationships and caregiving environment
- Part A: Caregiver–Infant/Young Child Relationship Adaptation
  - Table 1: Dimensions of Caregiving
  - Table 2: Infant's/Young Child's Contributions to the Relationship
  - Levels of Adaptive Functioning—Caregiving Dimension
- Part B: Caregiving Environment and Infant/Young Child Adaptation
  - Table 3: Dimensions of the Caregiving Environment
  - Levels of Adaptive Functioning—Caregiving Environment

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Axis III-Physical Health Conditions and Considerations

- Full diagnostic assessment of a young child includes attention to physical health in addition to emotional, relational, developmental, and environmental well being
- All aspects of infants' and young children's health and wellness are interrelated

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Physical Health Conditions and Considerations

1. Acute medical conditions
2. Conditions requiring medical or dental procedures
3. Recurrent or chronic pain (from any cause)
4. Physical injuries or exposures reflective of caregiving environment
5. Growth trajectory problems
6. Medication effects
7. Intellectual and developmental conditions
8. Markers of health status

ZERO TO THREE, 2016, p. 151

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Axis IV - Psychosocial and Environmental Stressors

- May influence the presentation, course, treatment, and prevention of mental health symptoms and disorders
- Stressors often co-occur
- Comprehensive consideration of stressors impacting the child is an important part of understanding a child in context

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Axis IV Stressors - Categories

- Challenges Within the Child's Family/Primary Support Group
- Challenges in the Social Environment
- Educational/Child Care Challenges
- Housing Challenges
- Economic and Occupational Challenges
- Child Health
- Legal/Criminal Justice Challenges (Child Protective Services involvement, child victim of crime, custody dispute, undocumented immigration status, parental deportation)
- Other (disease epidemic, disaster, war, terrorism)

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Axis V: Developmental Competence

- Axis V is designed to capture the young child's developmental competencies
  - in relation to expectable patterns of development
  - in and independent of interactions with important caregivers
- The clinician rates the child's functioning in key developmental domains understanding that development is integrative.
- Mental health must be evaluated and understood in the context of developmental capacities

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Competency Domain Rating Summary Table

Competency Domain Rating	Emotional	Social-Relational	Language- Social Communication	Cognitive	Movement & Physical
Exceeds developmental expectations					
Functions at age-appropriate level					
Competencies are inconsistently present or emerging					
Not meeting developmental expectations (delay or deviance)					

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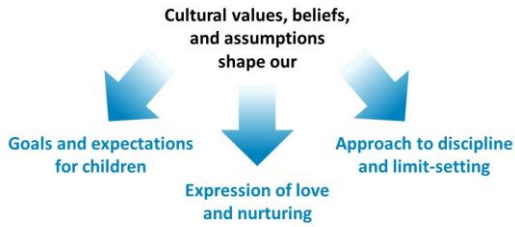
Our Culture Is Our Context



Parlakian & Day, 2004

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Cultural Formulation for Use With Infants and Toddlers

- Cultural Identity of the Individual
  - Cultural Identity of Child and Caregivers
- Cultural Conceptualizations of Distress
  - Cultural Explanations of the Child's Presenting Problem
- Psychosocial Stressors and Cultural Features of Vulnerability and Resilience
  - Cultural Factors Related to the Child's Psychosocial and Caregiving Environment
    - Infant's Life Space and Environment
    - Infant's Caregiving Network
    - Parent's/Caregiver's Beliefs About Parenting and Child Development
- Cultural Features of the Relationship Between the Individual and Clinician
  - Cultural Elements of the Relationship Between the Parents/Caregivers and the Clinician
- Overall Cultural Assessment
  - Overall Cultural Assessment for Child's Diagnosis and Care

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DC:0-5 Crosswalks and Training Offerings

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DC:0-5™ Crosswalk

- The "crosswalk" links:
  - DC:0-5 disorders
  - Diagnostic and Statistical Manual (DSM5) disorders
  - ICD-10 codes

- Available at:

https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-dsm-5-and-icd-10

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Examples from ZERO TO THREE DC:0-5™ Crosswalk

Crosswalk from DC:0-5™ to DSM-5 and ICD-10

DC:0-5™	DSM-5	ICD-10	
Disorder Name	Disorder Name	Disorder Name	Code
Neurodevelopmental Disorders			
Early Atypical ASD	Other Specified Neurodevelopmental Disorder	Pervasive Developmental Disorder, Unspecified	F84.9
Overactivity Disorder of Toddlerhood	ADHD, predominantly hyperactive-impulsive presentation	Disturbance of Activity and Attention	F90.1
Anxiety Disorders			
Social Anxiety Disorder (Social Phobia)	Social Anxiety Disorder (Social Phobia)	Social Anxiety Disorder of Childhood	F93.2
Trauma, Stress, and Deprivation Disorders			
Complicated Grief Disorder	Other Specified Trauma- and Stressor-Related Disorder (Persistent Complex Bereavement Disorder)	Other Reactions to Severe Stress	F43.8

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DC:0-5 Training Offerings

DC:0-5™ Training
- Official two-day training for advanced infant and early childhood mental health professionals

DC:0-5 Seminars
- Online or onsite overview trainings customized for a variety of disciplines and experience levels

DC:0-5 Faculty Teaching Resource
- Resource for higher education course instruction to include information on DC:0-5

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Questions or Reflections?

Case Vignette - Turner

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Turner – 18 months

Parental death, 2 foster placements, intense distress and compromised relationships with foster parents

Vignette adapted from Alicia Lieberman (1997*) DC:0-3 Casebook.* A. Lieberman, S. Wieder and E. Fenichel (eds). Washington DC: ZERO TO THREE. pp 69-80.

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- Turner, an 18 month old boy, was referred to program by his child welfare worker. Turner, the only son of a single parent mother was placed in foster care after the death of his mother when he was 12 months old due to drug overdose. Since mother had no family willing to care for him and father who had been estranged was not able to be located, this was an emergency placement in a temporary foster home for 4 weeks. He then was placed with a set of foster parents who were interested in longer placement and possible foster/adoption arrangements. Turner's new foster parents agreed to take Turner after observing him together with his first foster parents for 45 minutes at the child welfare visiting playroom and being told about the death of his mother. By report they felt an immediate chemistry with him and felt they could provide him with a loving/caring home. Turner went to live with the foster family 1 week after this meeting. There was no other transitional process for the new placement.

- Reasons for referral were Turner's incessant crying, poor appetite and little interest in his surroundings. When not crying, he often stared silently. He often cried for "mama" and would go to window or door looking out longingly. He seldom smiled and had very little speech for expressing himself. He showed little joy or interest in photos placed in a life book of he with his mother.
- The worker reported that this child's foster parents had been considering adoption when Turner was placed with them, but were expressing reservations as a result of Turner's emotional and behavioral patterns. Foster mother was especially concerned that Turner might be developmentally delayed or otherwise "damaged." They requested a thorough diagnostic assessment to rule out chronic disabilities which would preclude their adoption of Turner.

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- Turner had been exposed to cocaine prenatally and as a newborn had some tremors, he was difficult to console.
- By 3 mos. old, he had become a quieter baby who smiled often and liked to be held. Turner's developmental milestones had been met on schedule. All descriptions of Turner's early life provided by physician records and extended family report indicated that Turner was developing along expectable lines even when placed in first foster home. There were signs of grief that were expressed when first placed including calling for "mama" and difficulty sleeping. However, the intense and prolonged behaviors began to emerge after the removal/transition to second foster family.

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Home observations:

- Turner's behavior at foster home was quite different from his demeanor during the administration of the Bayley Scales. At home he seemed like a younger baby, prone to wailing at the slightest frustration. When foster mother picked him up to sooth him, he held himself stiffly in her arms, arching away from her and avoiding eye contact. Cried inconsolably. Nothing seemed to help him (singing, rocking, patting, etc). He had trouble falling asleep at night and bedtime rituals were vehemently protested by him. Foster father appeared to have more patience and more success in calming Turner after bouts of crying or protest.
- Frustrated and angry, his foster mother eventually resorted to leaving him alone in his crib to cry it out. Foster mother and child were quite detached from one another. Foster father had two grown children from previous marriage, but foster mother married later (late 30's) and had deeply wanted children. She sought spiritual meaning in the situation of foster/adoption and saw it as a duty to give love and economic resources to a child who did not have a home.

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- Unfortunately Turner had not reciprocated their eagerness to form an attachment. From the beginning Turner's foster mother felt disappointed that Turner was not the cuddly responsive baby she had hoped for. She found herself irritated by his lack of joy and failure to respond to her positively. She often found herself suppressing the wish to shake him to make him stop crying.
- Turner's foster father was affectionate and supportive and felt that Turner just needed time to get used to them and begin to love them. Turner's foster father was patient with him and able to use his sense of humor and empathic response to calm his crying. This made foster mother feel patronized and angry with foster father. She felt guilty about not being more patient with both Turner and her husband.

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Case Vignette - Turner

- Axis I: Complicated Grief Disorder of Infancy/Early Childhood
  Relationship Specific Disorder of Infancy/Early Childhood (foster mother-inconsolability, protest[stiffening, arching, gaze aversion], detachment)
- Axis II: Foster mother-child: Level III Compromised to disturbed relationships, Foster father-child: Level II strained to concerning relationships; Caregiving Environment: Level III Compromised to disturbed relationships risk to child's safety, persistent distress and risk for subsequent problems and future placement.
- Axis III: Prenatal conditions including cocaine exposure, opioid withdrawal., some expressive speech delay
- Axis IV: death of parent, placement in foster care (2 placements), parental substance abuse, unstable family constellation, risk of another placement vs adoption, intense changes/losses experienced in toddlerhood
- Axis V: Child demonstrates normative cognitive, motor and physical functioning, receptive language but shows delay/regression in expressive speech and social communication and has restricted range of emotions and compromised social-relational capacities.

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For more information…

- For updates, visit https://www.zerotothree.org/resources/services/dc-0-5-manual-and-training
- For specific questions regarding DC:0-5™ email us at DC05@zerotothree.org
- Please direct training requests to Kathy Mulrooney
  kmulrooney@zerotothree.org

Thank you for your participation in today's presentation and interest in understanding diagnosis and classification in infancy and early childhood.

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