DC:0–5™ Clinical Training

ZERO TO THREE | LEARN DC:0-5

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood

Welcome

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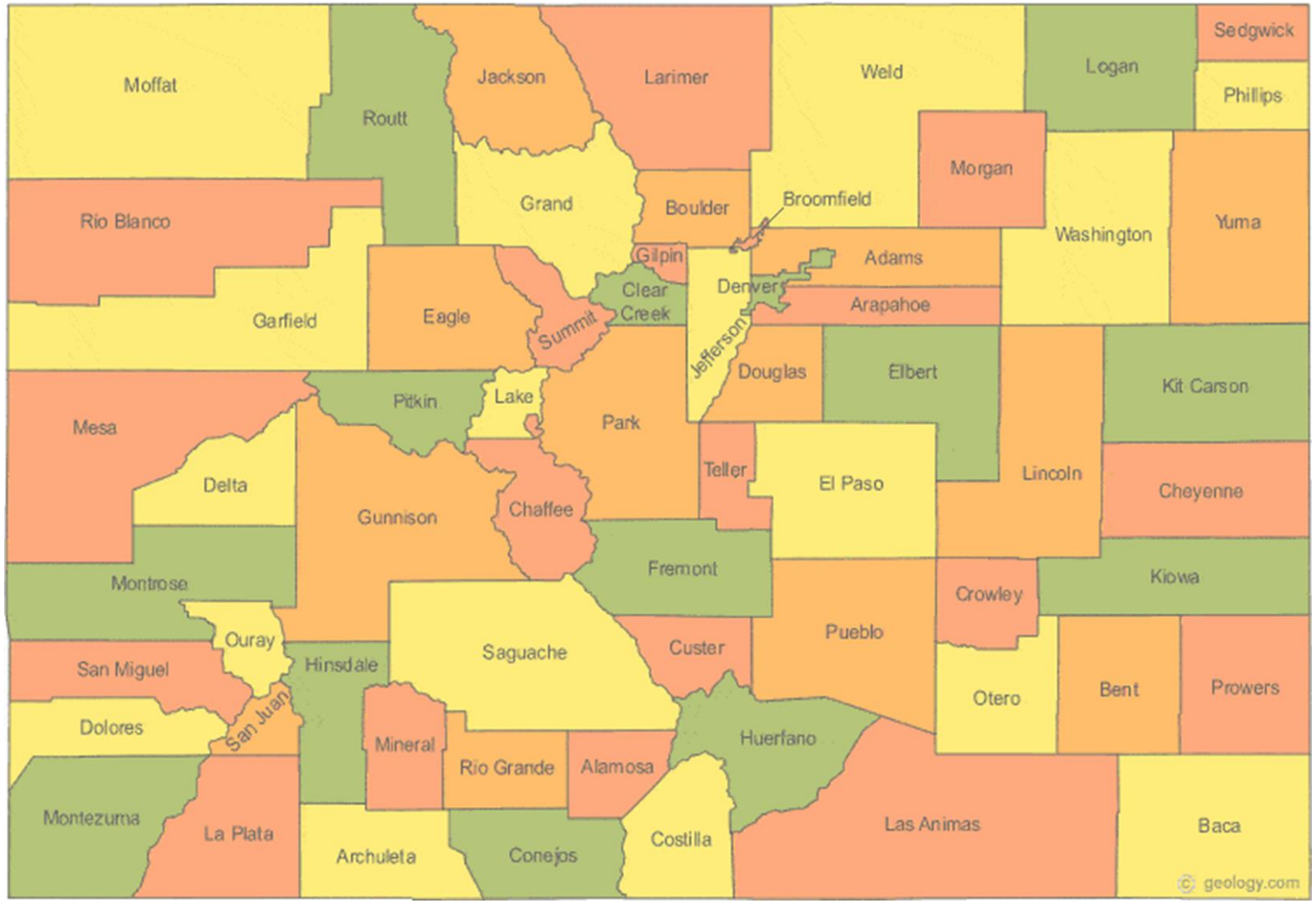
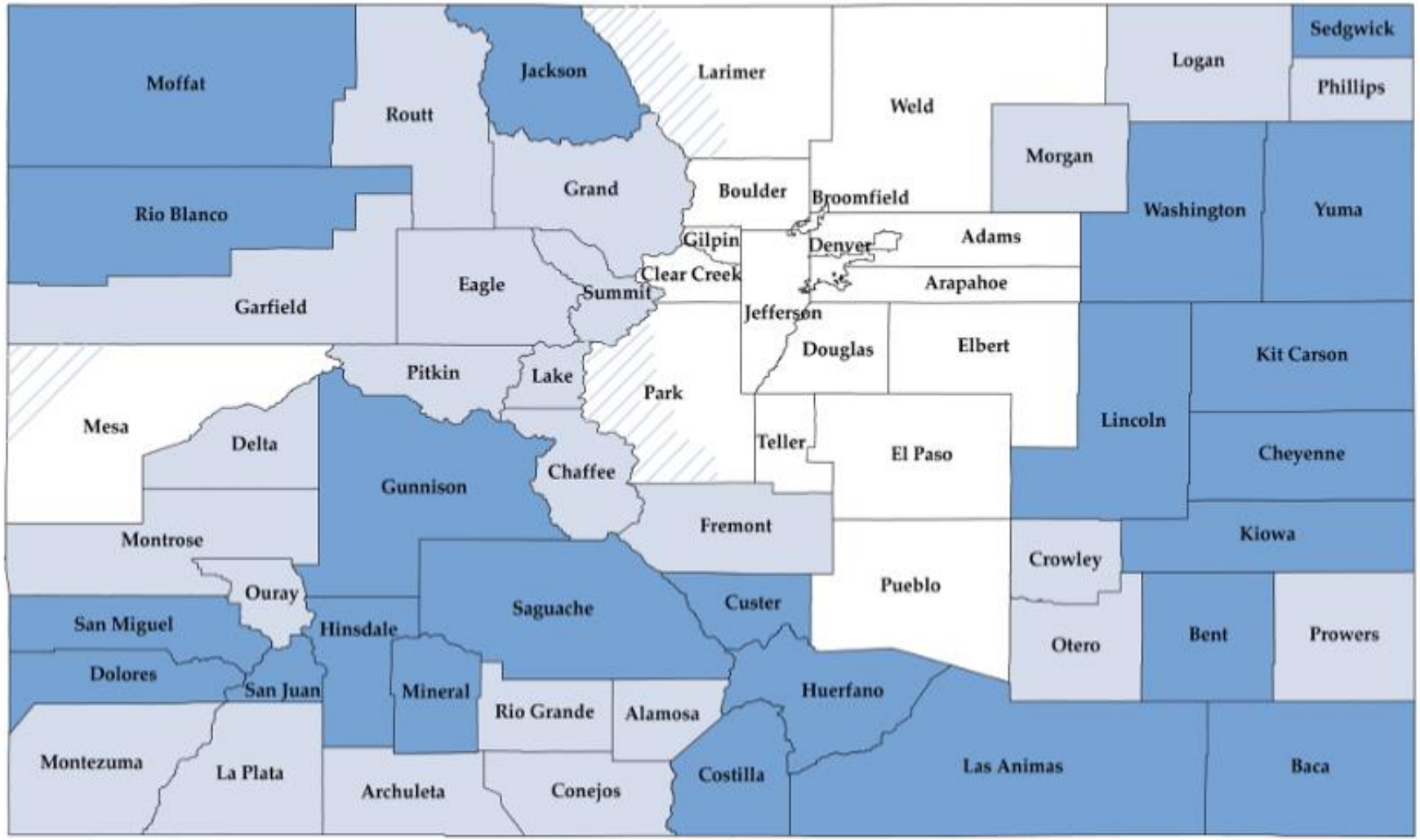
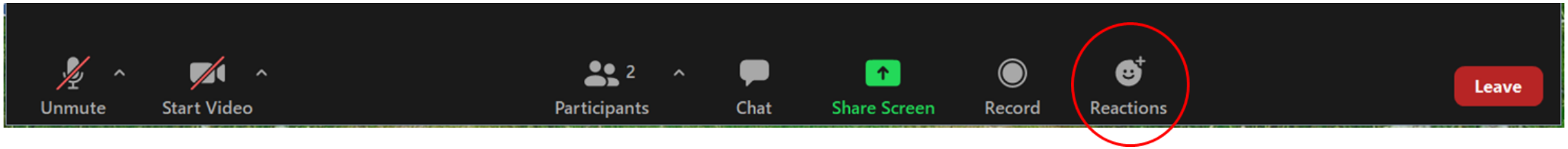
A Moment of Acknowledgement

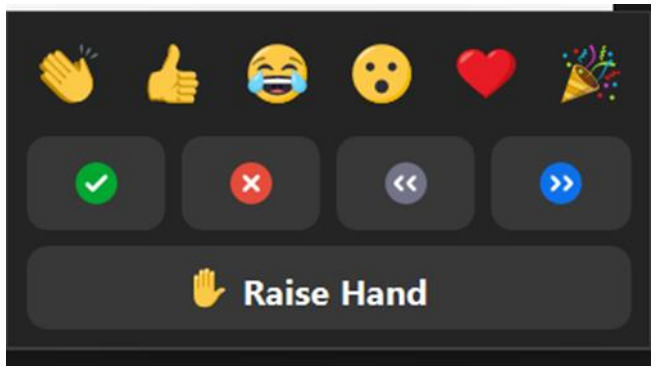


A Moment of Acknowledgement



How to Raise Hand in Zoom





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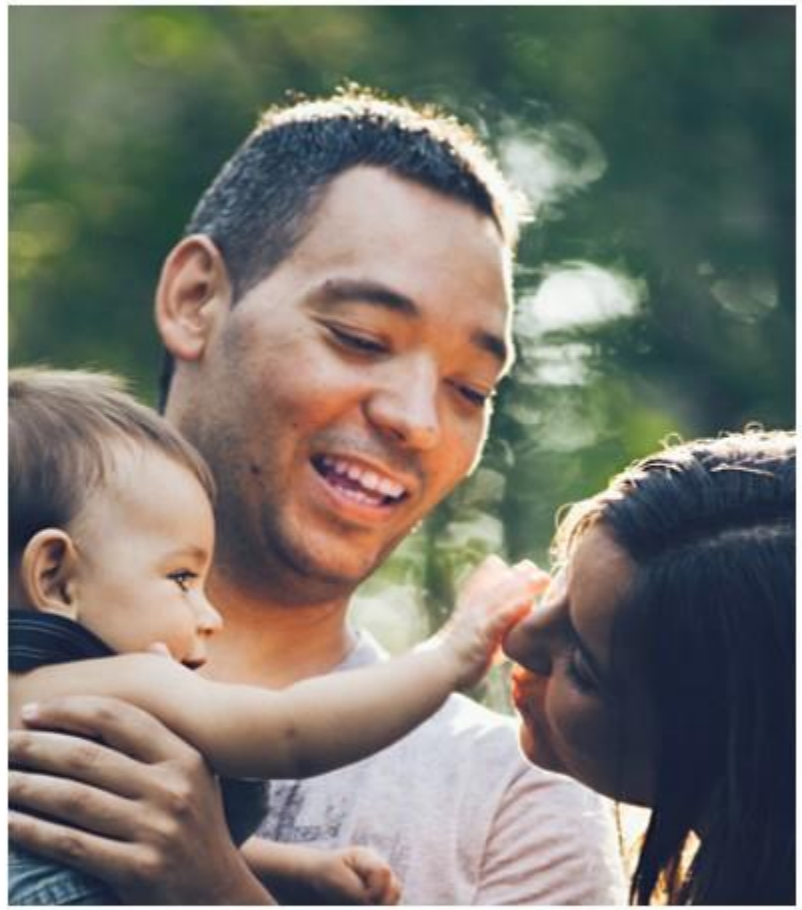

ZERO TO THREE is a national nonprofit organization whose mission is to ensure that ALL babies and toddlers have a strong start in life.

ZERO TO THREE:

- trains professionals and builds networks of leaders,
- influences policies and practices, and
- raises public understanding of early childhood issues.

Our Commitment

ZERO TO THREE continues its work to further elevate and center the cultural considerations essential to understanding each infant/child's environmental and relational context, the influence of historical and generational trauma, systemic racism, as well as resilience in its DC:0–5 professional development offerings

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Session 1 – Introduction

Learning Objectives

- Summarize the history of ZERO TO THREE's efforts to develop a diagnostic classification system for infancy/early childhood
- Define infant/early childhood mental health
- Describe the purpose for using the DC:0-5 to diagnosis infants/young children
- Explain the recommended approach for diagnosing disorders in infancy/early childhood
- Identify DC:0-5 Axes I - V

Agenda

Session 1

- Take Inventory
- Introduction of DC0-5
- Approach to Diagnosis in Infancy and Early Childhood
- Cultural Context
- Axis III, Axis IV

Session 2

- Axis V
- Axis II
- Axis I

Session 3

- Axis 1, cont.
- DC:0–5 in Relation to DSM-5 and ICD-10
- Clinical Case Application

Welcome Activity

Take Inventory: Using the DC:0–5 to Fidelity

- Licensed/ Licensure Eligible in Clinical MH or Related Field
- Understand My Own Scope of Work
- Cultural Considerations
  - Humility, Responsiveness, Diversity, Equity, Inclusion
- Infant and Child Development
- Foundations of IECMH
- Multiaxial Mental Health Nosology
- IECMH Assessment Skills
- Trauma-Informed Care/Healing Centered
- Relationship-Focused Practice

What do I already know?

What do I need to know?

Take a Moment to …

Take Inventory: Why am I here?

Notice Emotions: How do I feel about diagnosing infants and young children?

Actively Engage: What is my learning style? How will I participate?

Link: How will this content inform or benefit my work?

Integrate: How will I integrate this information into my own scope of work?

*Coined by Jeree Pawl and adapted by Carmen Rosa Noroña

Introduction to DC:0–5™

Module 1 | Version 4.0

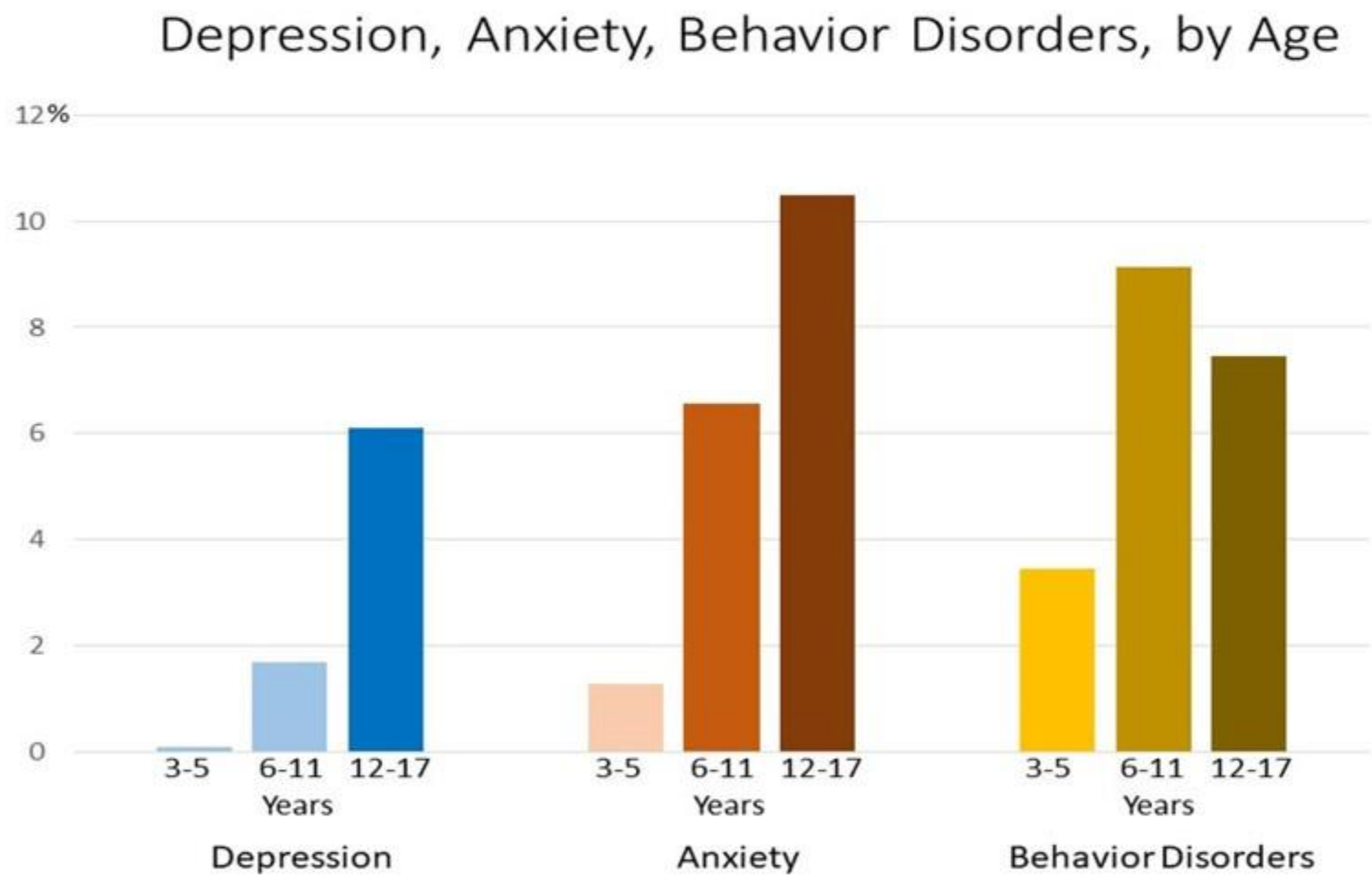
What Does Mental Health Have To Do With Babies?

Infant and Early Childhood Mental Health (IECMH)

Infant and early childhood mental health (IECMH) is the developing capacity of the child from birth to 5 years old to:

1. form close and secure adult and peer relationships;
2. experience, manage, and express a full range of emotions; and
3. explore the environment and learn,
    - all in the context of family, community, and culture.

IECMH Disorders



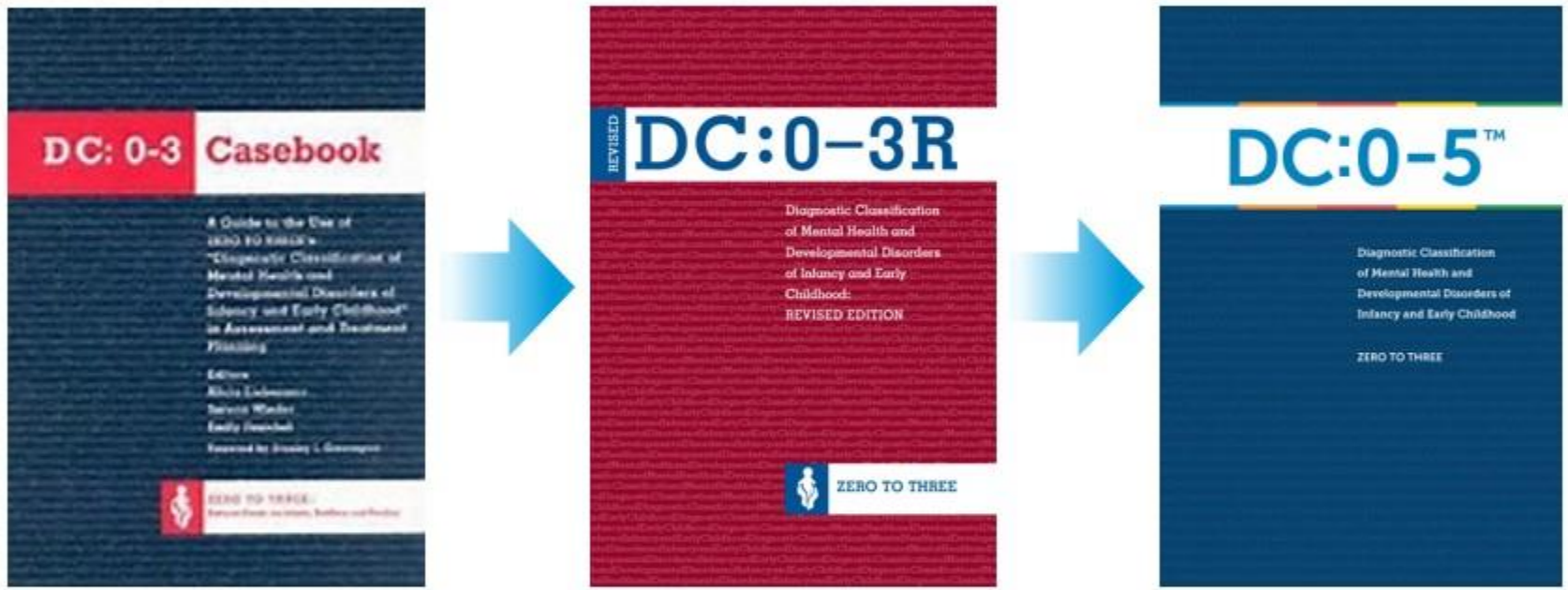
Source: https://www.cdc.gov/childrensmentalhealth/data.html

Positive Mental Health Indicators

Parents of children ages 3-5 years report that their child mostly or always showed:

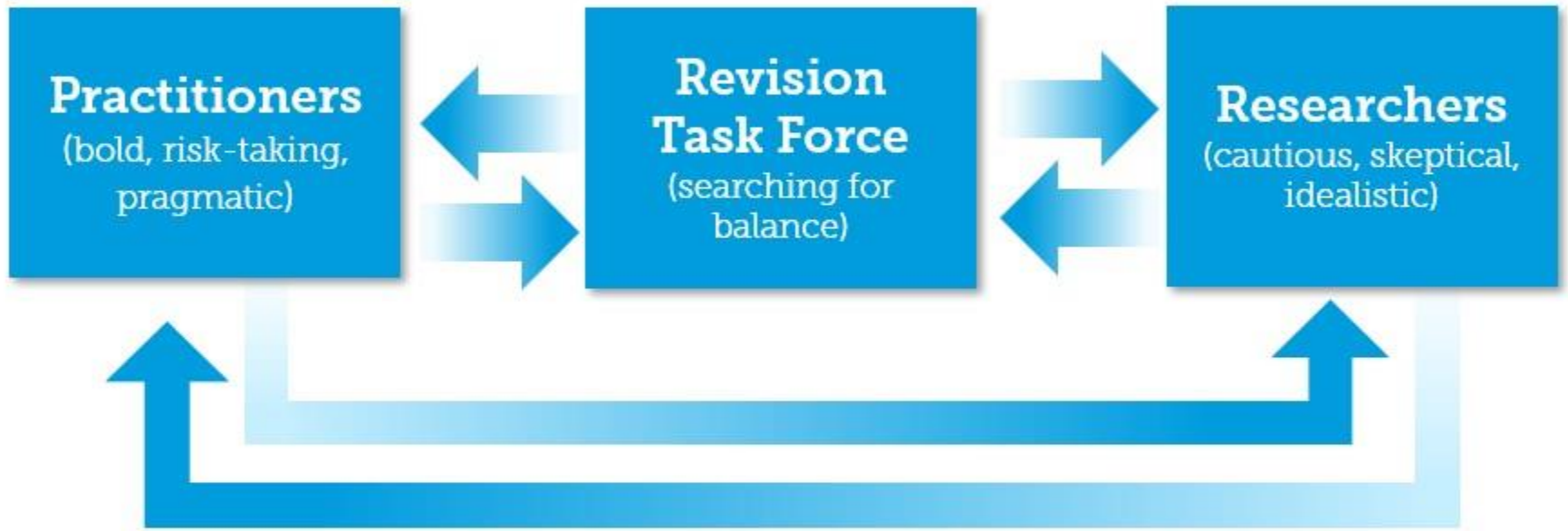
- affection (97.0%)
- resilience (87.9%)
- positivity (98.7%)
- curiosity (93.9%)

History of Diagnostic Classification



1994 2005 2016

Framework for Creating DC:0–5



- Empirically derived
- Clinically meaningful

Scope and Reach of DC:0–5 V.2

Manuals 2016–2023 Purchased

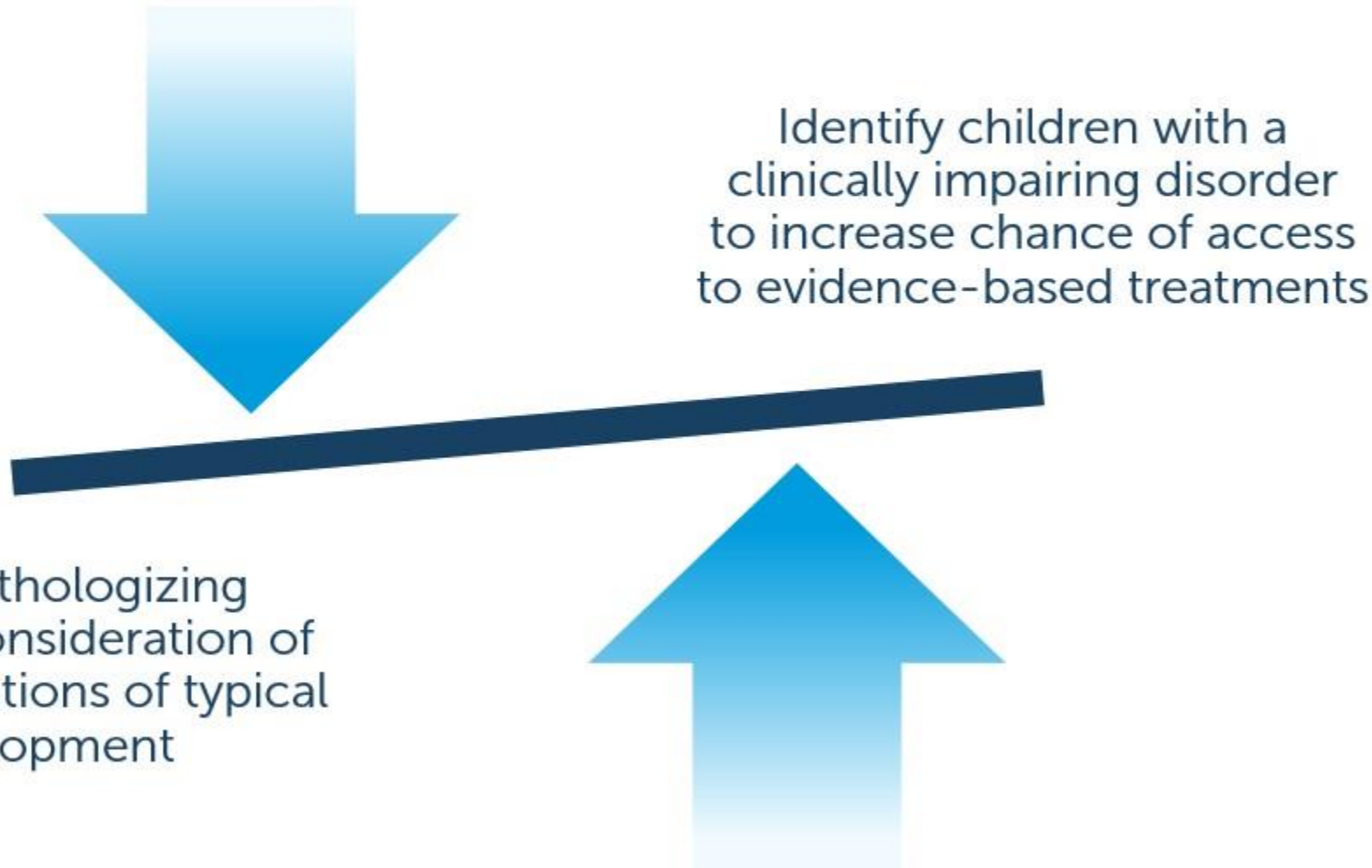
Print and Digital: 23,700

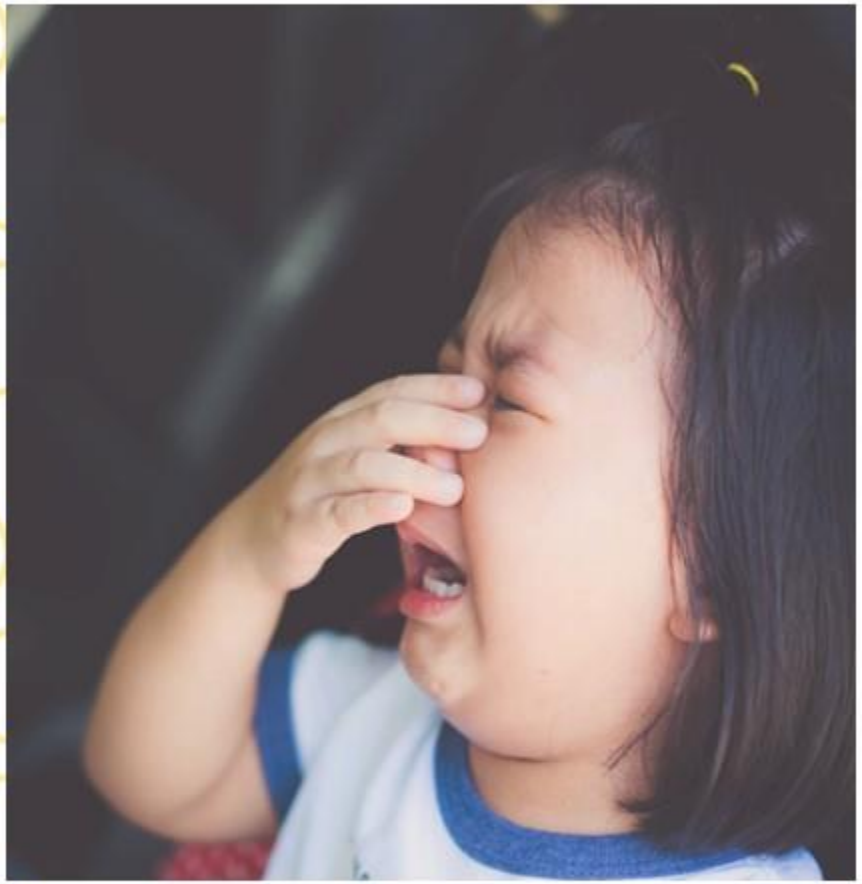
Translations:
(Completed) Chinese, Dutch, French, German, Hebrew, Hungarian, Italian, Portuguese, Russian Spanish, and Turkish. (In-process) Hungarian, Japanese, Polish, and South Korean

Participants from the following countries:
Algiers, Australia, Austria, Belgium, Brazil, Canada, China (Shanghai), Denmark, Estonia, France, Germany, Hungary, Israel, Italy, Japan, Netherlands, Norway, Paraguay, Poland, Portugal, Russia, Slovenia, South Africa, South Korea, Sweden, Switzerland, Turkey, United States

DC:0–5 and Research

The Balancing Act





Impairment Necessary For Every Disorder

Symptoms:

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

DC:0–5 Multiaxial System

Axis I (Clinical Disorders)	Forty-two disorders; closely aligned with DSM-5 (APA, 2013).
Axis II (Relational Context)	Includes ratings: 1) the child–primary caregiving relationship adaptation and 2) the caregiving environment.
Axis III (Physical Health Conditions and Considerations)	List of examples of physical, medical, and developmental conditions.
Axis IV (Psychosocial Stressors)	Organized list of stressors for young children and their families.
Axis V (Developmental Competence)	Captures a broad range of developmental competencies through the first 5 years.

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Approach to Diagnosis in Infancy and Early Childhood

Module 2 | Version 4.0

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 more than one person
- persist
- cause distress or impairment to the infant/young child and family
- are outside of the wide range of age-appropriate or cultural norms

The Diagnostic Process

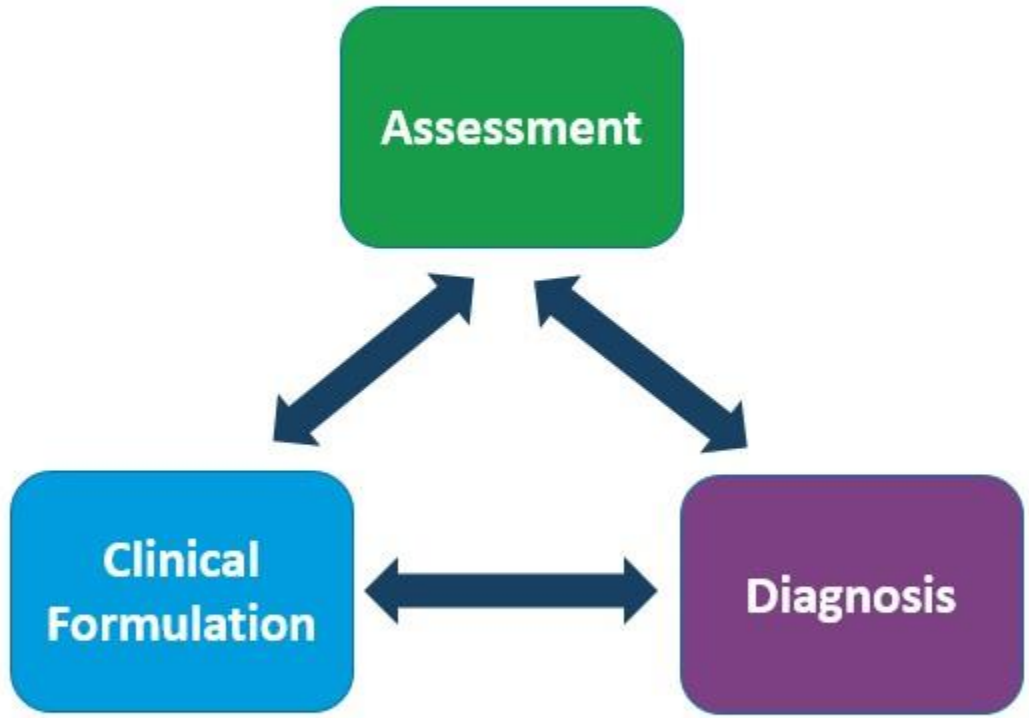
Assessment
Gathering data from record reviews, observations, and perceptions from caregivers

Diagnosis
Identification and classification of disorders

Formulation
The way in which the infant's/young child's clinical presentation is understood in the context of biology, relationships, social network, and culture

Principles of the Diagnostic Process

- A comprehensive process
- Relational and family-focused
- Contextually grounded
- Culturally informed
- Developmentally specific
- Strength-based



Disorder vs. Identity

We diagnose disorders not children...

Diagnosis as part of identity...

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Calm and Connected

Case 1
Introduction

Cultural Context Axes III-V

Module 3 | Version 4.0

Cultural Context & the Cultural Formulation for Use With Infants and Toddlers Table

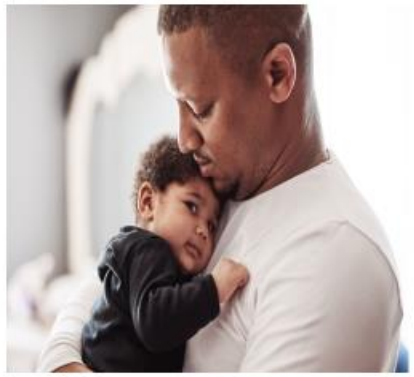
Cultural Context

Factors influencing cultural values, beliefs, and assumptions include:

- socioeconomic conditions
- national origin and history
- immigration status
- ethnic and racial identity
- sexual orientation
- religious and spiritual beliefs
- family traditions
- other sources of diversity

Culture Influences Development

Culture is mediated through the parenting relationship and influences infant/young child development.



Cultural Values and Practices

- Shape infant/young child from moment born
- Often unconscious
- Carry enormous influence on sense of right and wrong in raising an infant/young child

Clinical Culture Considerations

- Families are increasingly multicultural
- Individuals hold several identities simultaneously
- Active exploration of parents' perceptions and explanations of the situation
- Mainstream clinical attitudes and practices may not be shared by the family

Cultural Formulation for Use With Infants and Toddlers

Table 1

Cultural Identity of the Individual

Cultural Identity of Child and Caregivers

- ✓ Race, ethnicity, national origin, acculturation, gender, gender identity, sexual orientation, religion, socioeconomic status
- ✓ How do caregivers intend to raise the child with respect to these ethnic or cultural reference groups? Will there be potential issues of multiculturality for the child?
- ✓ What degree of involvement is there between the culture of origin and the host culture? Do they anticipate generational issues?
- ✓ Language abilities/use/preference—What do they intend to teach the child?

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Cultural Formulation for Use With Infants and Toddlers

Table 2

Cultural Conceptualizations of Distress

Cultural Explanations of the Child's Presenting Problem

- ✓ Who first noticed the problem?
- ✓ Extent to which the caregivers see a problem?
- ✓ Is there a conflict between the parent's/extended family's awareness?
- ✓ What do caregivers observe as signals of distress? The meaning and severity of distress as it relates to their expectations for behavior and development?
- ✓ Are there local illness categories that describe the presenting problem?
- ✓ What is/are the caregiver's:
  - __ perceptions about the cause of the presenting problem?
  - __ belief about treatment of the presenting problem?
  - __ belief about who should be involved in the treatment?

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Cultural Formulation for Use With Infants and Toddlers

Table 3

Psychosocial Stressors and Cultural Features of Vulnerability/Resilience

Cultural Factors Related to the Child's Psychosocial and Caregiving Environment

- ✓ Infant's life space and environment
  - Community
  - Home factors
  - Infant's sleeping arrangements
  - Parents culturally relevant interpretations of social supports and stressors
- ✓ Infant's caregiving network
  - Role and extent of involvement of primary and secondary caregivers
  - Continuities and disruptions in the child's caregiving network
- ✓ Parents beliefs about parenting and child development
  - Ceremonial practices, beliefs about gender roles, disciplinary practices, goals and aspirations for child, support systems, beliefs about caregiver's role

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Cultural Formulation for Use With Infants and Toddlers

Table 4

Cultural Features of the Relationships Between the Caregivers and Clinician

Cultural Elements of the Relationships Between Parental Caregivers and Clinician

- ✓ Are there differences in culture? Social status? What difficulties may be anticipated?
- ✓ Differences in understanding the child's distress, language difficulties, communication styles, involvement of others in the diagnosis and treatment process
- ✓ Parents level of comfort with seeking help
- ✓ Parents' past experiences with clinicians or treatment/service systems
- ✓ Reflect on the Irving Harris Foundation's *Diversity-Informed Tenets for Work With Infants, Children and Families* https://diversityinformedtenets.org

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Cultural Formulation for Use With Infants and Toddlers

Table 5

Overall Cultural Assessment

Overall Cultural Assessment for Child's Diagnosis and Care

- ✓ Summarize the implications of these components to the care of the child and support of the parent/caregiver-child relationship
- ✓ How will this inform ongoing assessment, diagnosis, and treatment?

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Case 1
Cultural Context

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Axes III–V

Module 4 | Version 4

Axis III:
Physical Health Conditions and Considerations

Why the Attention on Physical Health?

Because all aspects of infants'/young children's lives are interrelated, physical conditions may influence mental health:

- directly
- indirectly
- through the "caregiver" environment

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Assessing Physical Conditions

- Note the health domains listed in the DC:0–5 manual
- Listen to parents' description of medical illnesses
- Communicate with health providers involved with the infant/young child and family

Physical Health Conditions and Considerations

- Prenatal conditions and exposures
- Chronic and acute medical conditions
- History of procedures
- Recurrent or chronic pain
- Physical injuries or exposures reflective of caregiving environment
- Medication effects
- Growth trajectory problems
- Markers of health status
- Developmental conditions

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Chronic Medical Conditions

- Allergies
- Colic
- Congenital anomalies
- Cancers and tumors
- Endocrine (e.g., thyroid, diabetes, hormone deficiencies)
- Gastrointestinal
- Genetic syndromes (e.g., Trisomy 21, Fragile X)
- Hematologic/blood disease
- Immunization status
- Neurological conditions (e.g., seizures, hydrocephalus)
- Metabolic conditions (e.g., storage diseases, urea cycle disorder)
- Immunologic (e.g., autoimmune disorders, PANDAS)
- Infectious disease (e.g., HIV/AIDS, polio, measles)
- Respiratory
- Sensory problems

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Direct Influences of Physical Illnesses

- Physiologic effects of exposure to toxins/medications
- Central nervous system, congenital malformations, insults or injuries, or effects
  of genetic syndromes
- Influence of physical symptoms on emotional expression, sleep, and feeding patterns
- Pregnancy and perinatal complications

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Indirect Influences of Physical Illnesses

Child

- Experience of potentially traumatic medical events
- Limitations on normative activities and interactions
- Separations and multiple caregivers
- Developmental delays because of limitations
- Functioning of caregivers

Parent

- Perception of:
  - child's vulnerability or resilience
  - congenital malformations or chronic medical issues
  - attribution of responsibility for medical conditions

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Comments on Axis III

Case 1
Axis III: Physical Health Conditions

Axis IV: Psychosocial Stressors

Why the Attention on Psychosocial Stressors?

Psychosocial and environmental stressors:

- May influence the presentation, course, treatment, and prevention of mental health symptoms and disorders
- Often co-occur

Axis IV Stressors

Categories:

- Challenges within the infant's/young child's family/primary support group
- Challenges in the social environment
- Educational/childcare challenges
- Housing challenges
- Economic and employment challenges
- Infant/young child health
- Legal/criminal justice challenges
- Other

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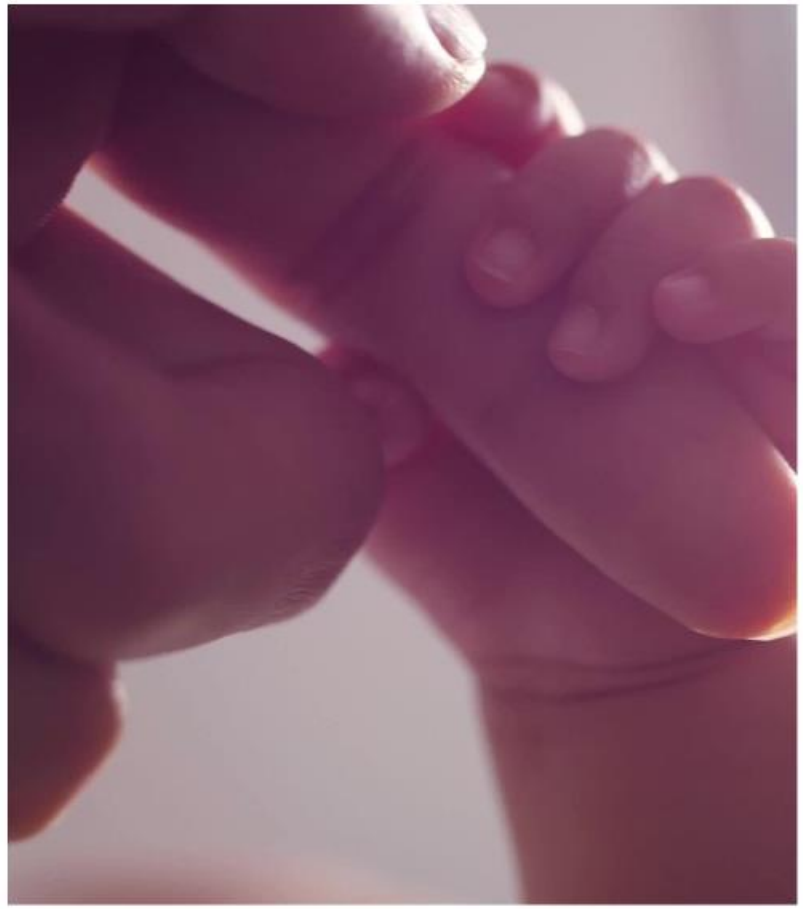


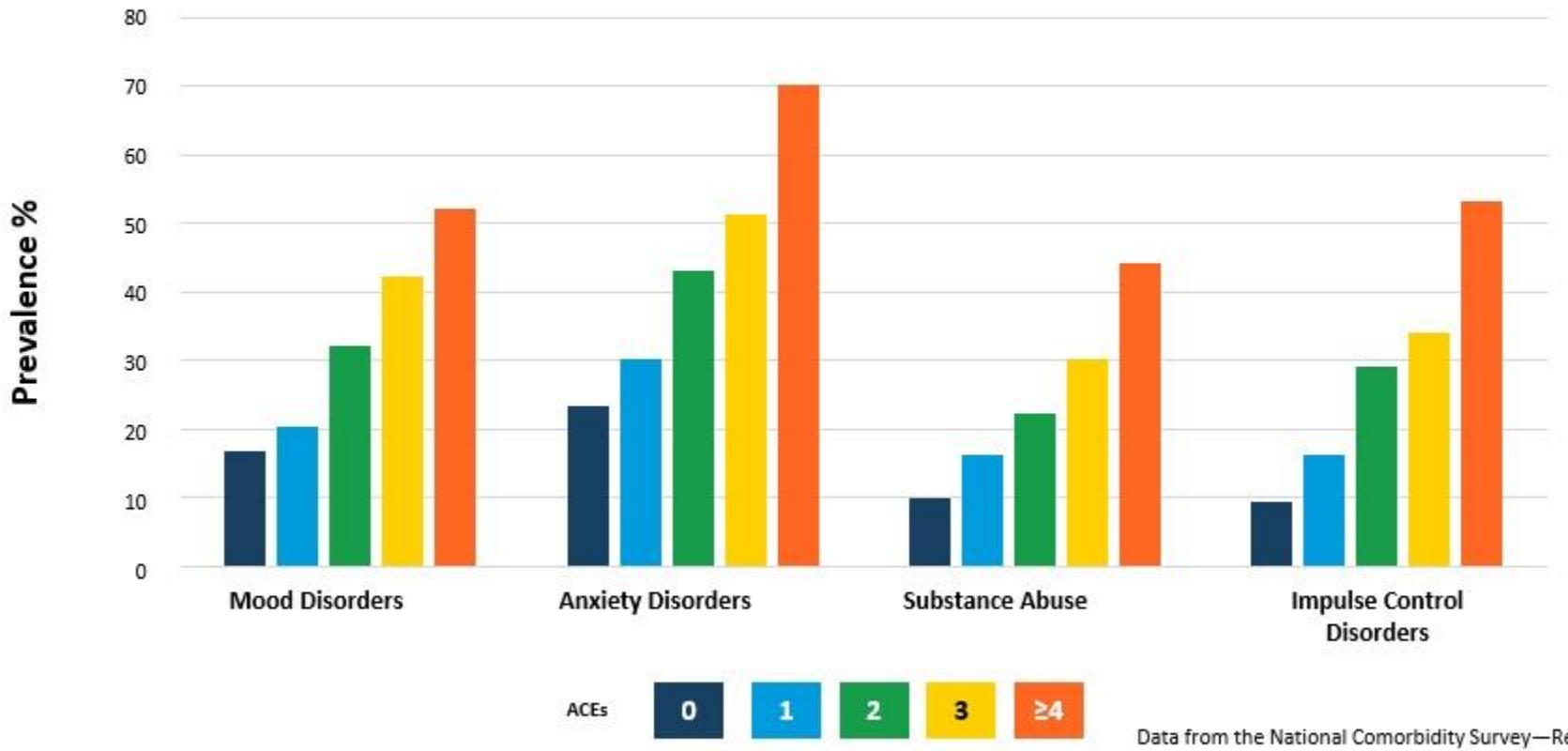
Impact of Stressors

- Severity of the stressor
  - intensity, duration, spacing, timing, and predictability
- Developmental level of the child
- Availability and capacity of adults to:
  - serve as protective buffers
  - help the child understand and cope with the stressor

Adverse Childhood Experiences (ACEs)

- Economic hardship (persistent)
- Parental divorce/separation
- Parental/caregiver substance abuse
- Parental/caregiver mental health problem
- Victim of violence in the community
- Violence in the home
- Parental incarceration
- Parental death

Cumulative ACEs and Mental Health



Data from the National Comorbidity Survey—Replication (NCS–R) sample

Putnam, Harris, and Putnam (2013)

Case 1
Axis IV—Psychosocial Stressors

In Summary – Session 1

- Taken inventory
- Reflected on scope of work
- Defined infant/early childhood mental health
- Discussed the history and reach of the DC:0–5
- Examined the approach to diagnosis in infancy/early childhood
- Explored cultural context
- Applied Axes III and IV to Case 1

Session 1 Wrap-Up

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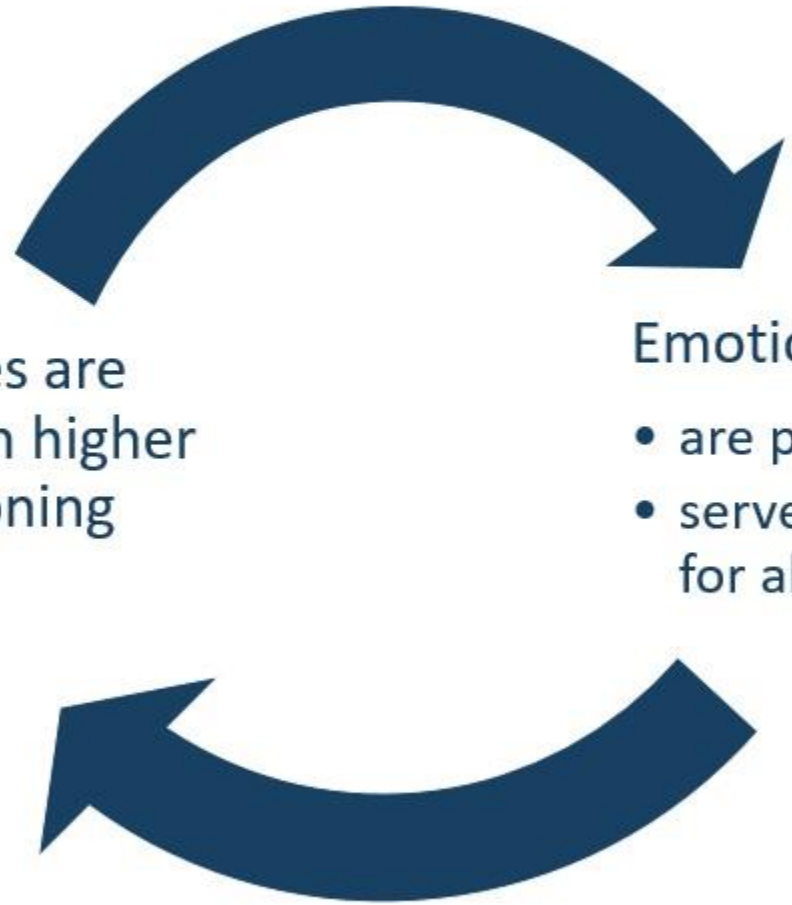
Session 2 – Axis V, II and I

Axis V: Developmental Competence

Developmental Concepts



Earlier capacities are needed to reach higher levels of functioning

Emotional/social capacities:

- are present at birth
- serve as the foundation for all development

Developmental Milestones and Competency Ratings on "By 6 Months Old" Table

Competency Domain	Milestone	Milestone Rating	Comments	CDR*
Emotional	Responds to affection with smiling, cooing, or settling.	2		2.5
	Demonstrates a range of emotions that includes happiness, excitement, sadness, fear, distress, disgust, anger, joy, interest, and surprise.	3	Flat affect	
	Expresses anger, frustration, or protest with distinct cries and facial expressions.	3		
	Recovers from distress when comforted by caregiver.	2	Never really shows significant distress	
Social-Relational	Imitates some movements and facial expressions, (e.g., smiling or frowning).			
	Engages in socially reciprocal interactions (e.g., playing simple back-and-forth games).			
	Seeks social engagement with vocalizations, emotional expressions, or physical contact.			
	Watches faces closely.			

1 = Fully present

2 = Inconsistently present or emerging

3 = Absent

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Developmental Milestones and Competency 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	2.5 or X				
Not meeting developmental expectations (delay or deviance)					

Gather data in 5 developmental domains

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Developmental Milestones and Competency

What do you notice about Chase's development ? Emotional? Social Relational? Language and Social Communication? Cognitive? Movement and Physical?

https://www.zerotothree.org/dc05resources

Case 1
Axis V–Developmental Competence

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Axis II:
Relational Context

*"There is no such thing as **a baby**...*

*there is **a baby** and **someone**."*

—Winnicott, 1948

Impairment and Diagnostic Formulation

Axis II: Relational Context

Within the primary caregiving relationships, the infant/child develops a sense of trust and expectation of safety in the world.

The child needs this to develop optimally.

Relationship Specificity

Relationship quality between Primary Caregiver #1 and child	Relationship quality between Primary Caregiver #2 and child	Relationship quality between Primary Caregiver #3 and child

Each relationship is unique

Axis II: Relational Context Overview

Part A: Caregiver & Infant/Young Child Relationship Adaptation

- **Table 1:** Dimensions of Caregiving
- **Table 2:** Infant's/Young Child's Contributions to the Relationship: Child Characteristics
- **Levels of Adaptive Functioning:** Caregiving Dimension

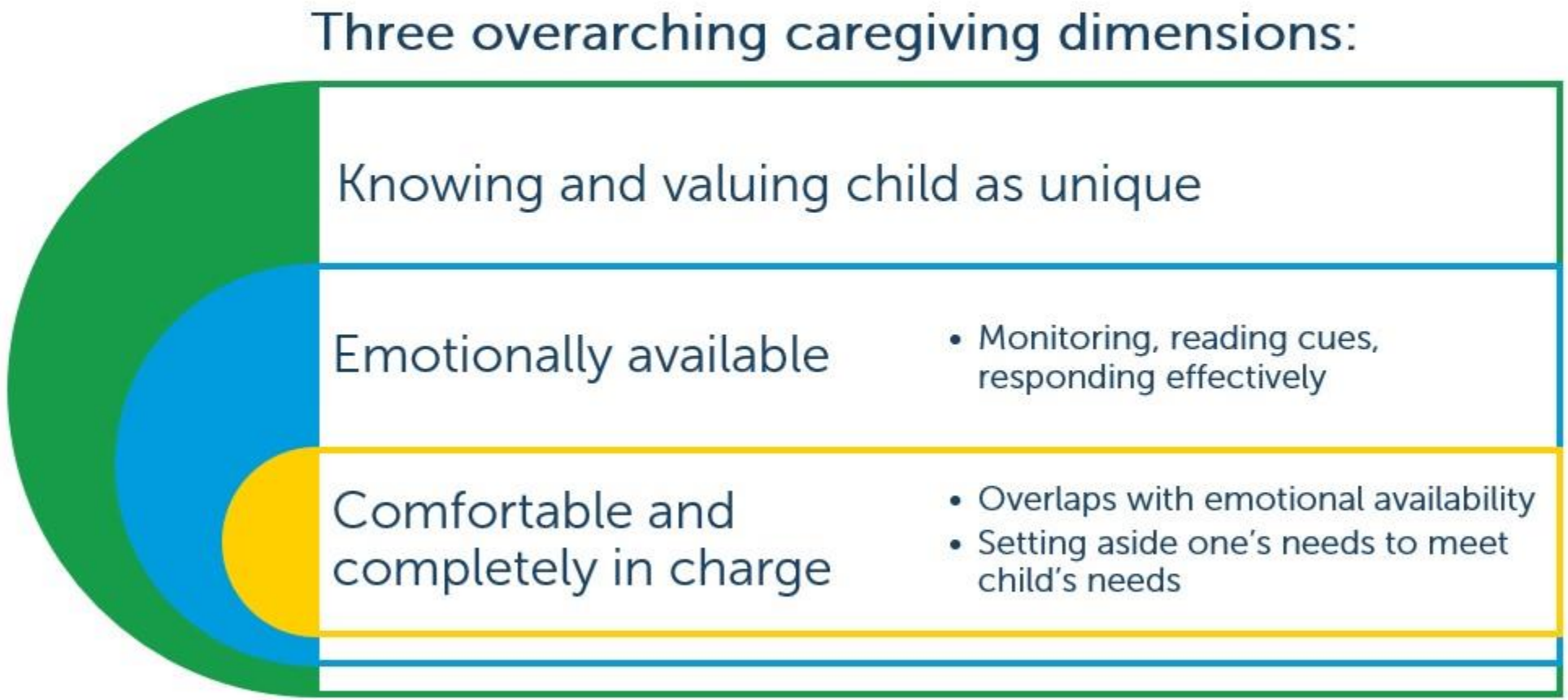
Part B: Caregiving Environment and Infant/Young Child Adaptation

- **Table 3:** Dimensions of the Caregiving Environment
- **Levels of Adaptive Functioning:** Caregiving Environment

Axis II: Relational Context

Part A: Assessing the Relationship

Table 1—Dimensions of Caregiving



Axis II: Relational Context

Part A: Assessing the Relationship

Table 1. Dimensions of Caregiving

Caregiving Dimensions	Contribution to Relationship Quality		
	Strength	Not a Concern	Concern
Ensuring Physical Safety			
Providing for basic needs			
Conveying psychological commitment to and emotional investment in the infant/young child			
Establishing structure and routines			
Recognizing and responding to the infant/young child's emotional needs/signals			
Providing comfort for distress			
Teaching and social stimulation			
Socializing			
Disciplining			
Engaging in play and enjoyable activities			
Showing interest in the infant's/young child's individual experiences			
Demonstrating reflective capacity regarding the infant's/young child's developmental trajectory			
Incorporating the infant's/young child's point of view in developmentally appropriate ways			
Tolerating ambivalent feelings in the caregiver–infant/young child relationship			

Ensuring Physical Safety

Providing comfort for distress

Engaging in play and enjoyable activities

Tolerating ambivalent feelings in the caregiver-infant and young child relationships

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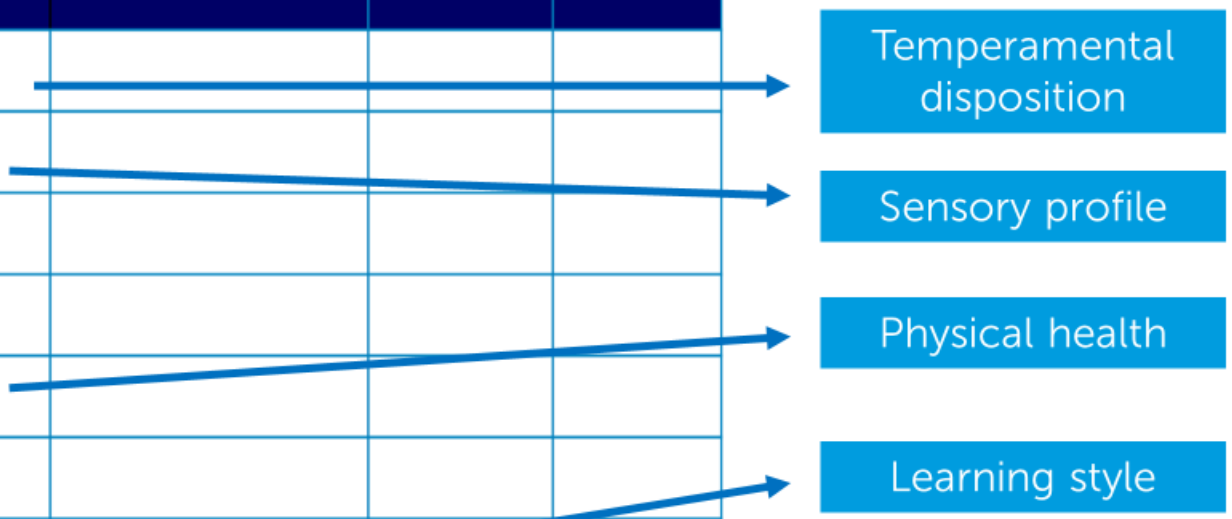
Axis II: Relational Context

Part A: Assessing the Relationship

Table 2. Infant's/Young Child's Contributions

Child Characteristics	Contribution to Relationships Quality		
	Strength	Not a Concern	Concern
Temperamental disposition			
Sensory profile			
Physical appearance			
Establishing structure and routines			
Physical health (Axis III)			
Developmental status (Axis I and V)			
Mental health			
Learning style			



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Axis II: Assessing the Relationship

Part A: Caregiving Dimension Levels of Adaptive Function

Level 1. Well-Adapted to Good Enough Relationships

- No clinical concern

Level 2. Strained to Concerning Relationships

- Careful monitoring is indicated; intervention may be required

Level 3. Compromised to Disturbed Relationships

- Clearly in the clinical range, and intervention is indicated

Level 4. Disordered to Dangerous Relationships

- Intervention is not only required but urgently needed because of the severity of the relationship impairment

ZERO TO THREE, 2021, pp. 140–145

Axis II: Assessing the Relationship

Part A: Caregiving Dimension Levels of Adaptive Function

Level 1: Well-Adapted to Good-Enough Relationships

- No clinical concern
- Consistently protected from danger
- Caregiver WILL be available
- Relationship promotes infant's/young child's needs for emotion regulation
  - comfort and closeness
  - exploration
- Conflicts not characteristic

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Ratings Axis II: Assessing the Relationship

Part A: Caregiving Dimension Levels of Adaptive Function

What do you observe about *Caregiving Dimensions*? (Part A: Table 1)

What do you notice about *Child Characteristics*? (Part A: Table 2)

Axis II: Assessing the Relationship

Part A: Caregiving Dimension Levels of Adaptive Function

Level 2: Strained to Concerning Relationships

- Careful monitoring; intervention may be required
- Some worrisome patterns of interaction or subjective experience
  - Some adaptive qualities are present
- Relationship is beginning to be:
  - conflicted, insufficiently engaged, or inappropriately balanced
- Concern about dyad's capacity for:
  - adequate emotionally availability and regulation
  - responding to needs for comfort and protection
  - support for appropriate exploration

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Axis II: Assessing the Relationship

Part A: Caregiving Dimension Levels of Adaptive Function

- What do you observe about *Caregiving Dimensions*? (Part A: Table 1)
- What do you notice about *Child Characteristics*? (Part A: Table 2)

Axis II: Assessing the Relationship

Part A: Caregiving Dimension Levels of Adaptive Function

Level 3: Compromised to Disturbed Relationships

- Clearly in the clinical range; intervention is indicated because of:
  - risk to the infant's/young child's safety
  - persistent distress
- Relationship is fraught with:
  - inappropriate levels of risk to safety; significant conflict
  - insufficient or irregular engagement; significant imbalance
- Definite problems with the dyad's emotional communication and social reciprocity that compromise the infant's/young child's regulation.
- Impaired ability to:
  - respond to needs for comfort and protection
  - support appropriate exploration
- Adaptive qualities are mostly lacking; social–emotional trajectory is at risk

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Axis II: Assessing the Relationship

Part A: Caregiving Dimension Levels of Adaptive Function

Level 4: Disordered to Dangerous Relationships

- Intervention is required and urgent
- Relationship pathology is severe and pervasive with:
  - overt conflict,
  - seriously insufficient engagement, or role reversal
- Impairments in the dyad's capacity to 1) engage adequate protection, 2) express emotional availability and regulation, 3) express and respond to needs for comfort and caregiving, or 4) support age-appropriate exploration and learning
- Adaptive qualities are lacking
- Mandated reporting should be considered

ZERO TO THREE, 2021, pp. 140–145

Axis II: Assessing the Relationship

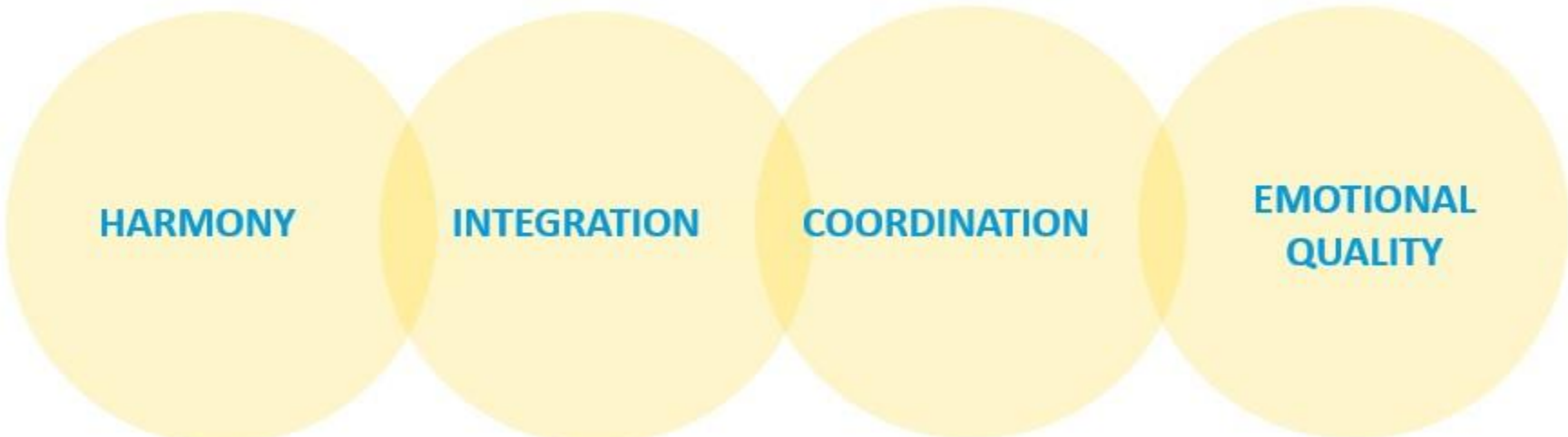
Part A: Caregiving Dimension Levels of Adaptive Function

- What do you observe about *Caregiving Dimensions*? (Part A: Table 1)
- What do you notice about *Child Characteristics*? (Part A: Table 2)

Axis II: Relational Context

Part B: Caregiving Environment

Observations of affective tone and adult interactions influence the infant's/young child's emotion regulation, trust in relationships, and freedom to explore.



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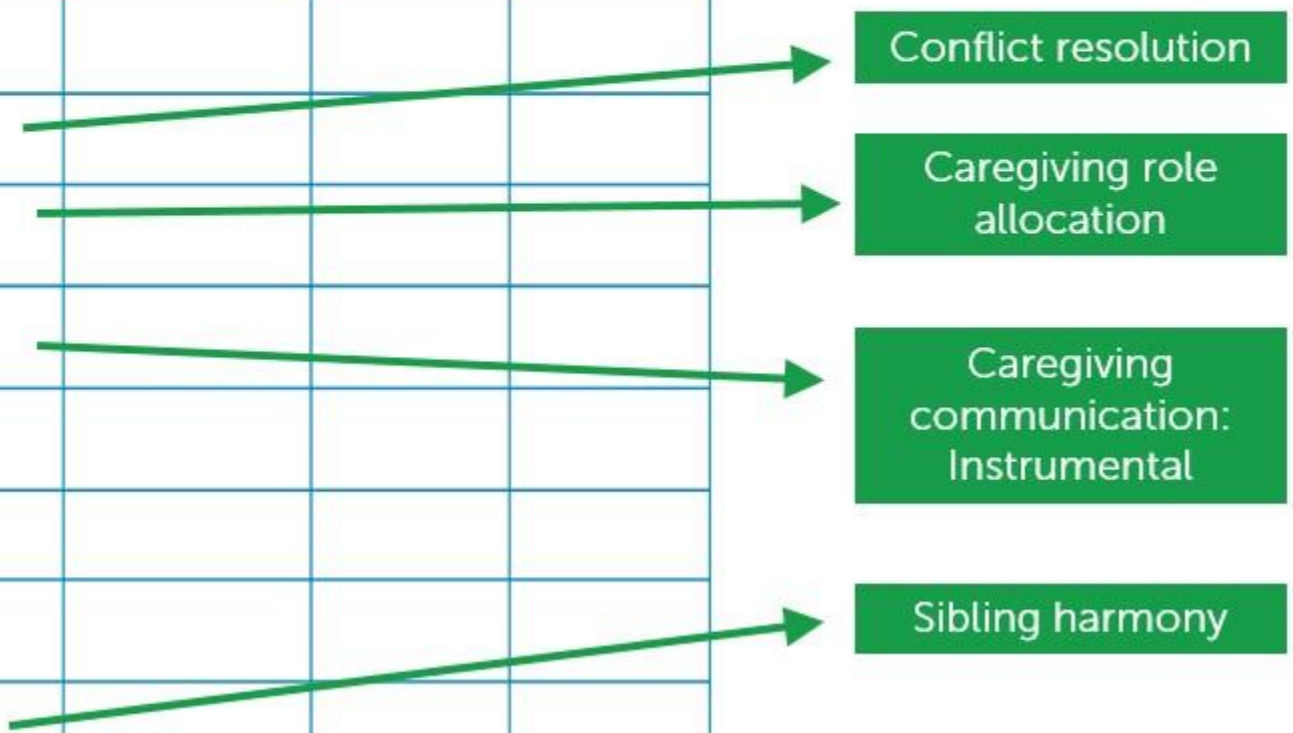
Axis II: Relational Context

Part B: Caregiving Environment

Table 3. Dimensions of Caregiving Environment

Caregiving Dimensions	Strength	Not a Concern	Concern
Problem solving			
Conflict resolution			
Caregiving role allocation			
Caregiving communication: Instrumental			
Caregiving communication: Emotional			
Emotional investment			
Behavioral regulation and coordination			
Sibling harmony			



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Axis II: Relational Context

Part B: Caregiving Environment Levels of Adaptive Functioning

Level 1. Well-Adapted to Good-Enough Caregiving Environments

- No clinical concern

Level 2. Strained to Concerning Caregiving Environments

- Careful monitoring is indicated; intervention may be required

Level 3. Compromised to Disturbed Caregiving Environments

- Clearly in the clinical range and intervention is indicated

Level 4. Disordered to Dangerous Caregiving Environments

- Intervention is not only required but urgently needed because of the severity of the relationship impairment

ZERO TO THREE, 2021, pp. 145–148

Axis II: Relational Context

Part B: Caregiving Environment Levels of Adaptive Functioning

Level 1: Well-Adapted to Good-Enough Caregiving Environment

- Relationships among the caregivers function adequately or better
  - ups and downs may exist
  - conflicts are not characteristic, strains adequately repaired
- Caregivers:
  - have a solid repertoire of problem-solving strategies
  - have a mutually satisfying allocation of caregiving roles
  - collaborate adequately with each other in coparenting
- Infant/young child typically shows comfort and ease in interacting with the different caregivers

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Axis II: Relational Context

Part B: Caregiving Environment Levels of Adaptive Functioning

Level 2: Strained to Concerning Caregiving Environment

- Relationships show:
  - some worrisome patterns of interaction
  - signs of conflict, insufficient communication, and coordination
- The infant/young child:
  - experiences distress negotiating interactions with different caregivers
  - may show preferences that spark conflict among them
- Concern about the caregivers':
  - misalignment of expectations
  - coordinated emotional availability with the infant/young child
  - responding to needs for comfort and protection
  - age-appropriate socialization
- Some important adaptive qualities are present in the relationship

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Axis II: Relational Context

Part B: Caregiving Environment Levels of Adaptive Functioning

Level 3: Compromised to Disturbed Caregiving Environment

- Relationships at this level are fraught with:
  - risk to safety,
  - significant conflict,
  - insufficient or irregular engagement, or significant imbalance.
- The infant's/young child's social and emotional trajectory has become or is at risk of being compromised.
- Problems with the caregivers':
  - role allocation
  - mutual support in responding to the infant's/young child's: needs for comfort and protection, age-appropriate socialization. willingness to engage in play and exploration

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Axis II: Relational Context

Part B: Caregiving Environment Levels of Adaptive Functioning

Level 4: Disordered to Dangerous Caregiving Environment

- An unquestionable urgency about intervening to address serious and potentially dangerous relationship conflicts
- Relationship pathology among caregivers is severe and pervasive
- Significant impairments in provision of adequate protection and responsive caregiving
- Relationships are fraught with significant overt conflict, insufficient engagement, or significant role reversal
- Relationship disturbances seriously compromise the infant's/young child's development and threaten the infant's/young child's physical or psychological safety
- Mandated reporting should be considered BUT may or may not be indicated

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Axis II: Relational Context

Part B: Caregiving Environment Levels of Adaptive Functioning

- What do you observe about the *Caregiving Environment*? (Part B: Table 3)
- What do you notice about the child's adaptation?

Case 1
Axis II—Relational Context

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Note: Many slides used throughout the DC:0–5 Training were developed by the Diagnostic Classification Revision Task Force and appeared in presentations at the ZERO TO THREE 2015 National Training Institute and the 2016 World Association for Infant Mental Health Congress.

Calm and Connected

Axis I: Clinical Disorders

Module 5 | Version 4.0

DC:0–5 Diagnostic 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 Disorders

Axis I: Disorder Format

- Introduction
- Diagnostic Algorithm (Criteria)
  - Age
  - Duration
- Diagnostic Features
- Associated Features Supporting Diagnosis
- Developmental Features
- Prevalence
- Course
- Risk and Prognostic Features
- Culture-Related Diagnostic Issues
- Gender-Related Diagnostic Issues
- Differential Diagnosis
- Comorbidity
- Links to DSM-5 and ICD-10

Neurodevelopmental Disorders

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

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Neurodevelopmental Disorders

- Contributing factors:
  - genetic factors
  - environmental neurotoxins
  - medical complications
  - social factors
- Prevalence 15%
- Early and intensive intervention recommended

Early Atypical Autism Spectrum Disorder (EAASD)

Description: Severe social–communication abnormalities and restricted and repetitive symptoms; children who evidence early signs of impairment and symptoms of ASD, but do not yet meet full criteria

Age: 9 months to 36 months

Duration: No duration criteria

Developmental Features: Individual variation in developmental trajectories; both social–communication and repetitive and restricted behaviors may appear in the first year of life

Differential Diagnosis: Global Developmental Delay; Cognitive Delay; Reactive Attachment Disorder

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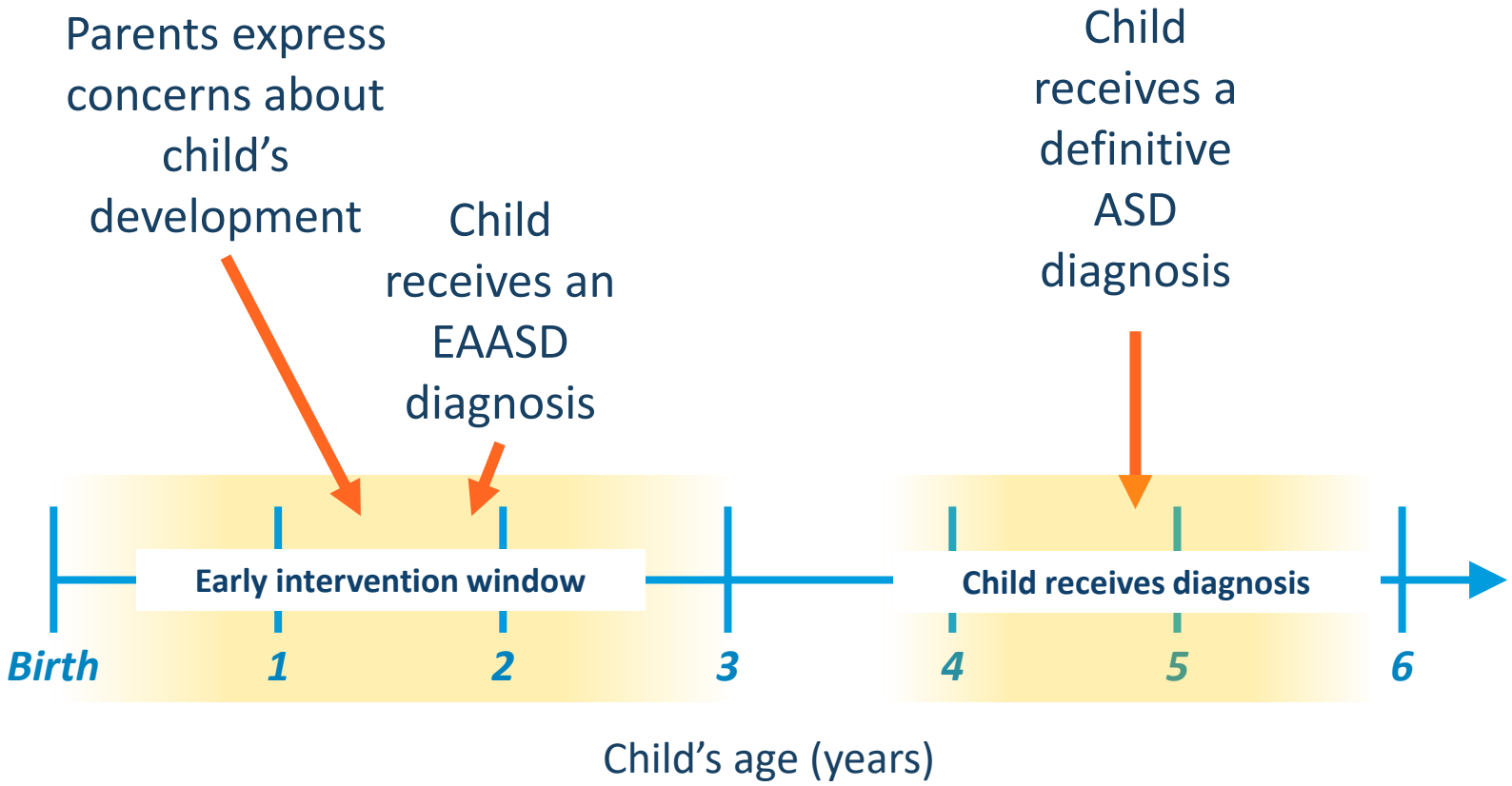
Overview of DC:0–5 ASD & EAASD Diagnostic Criteria

- Social–Communication (SC) symptoms:
  - Limited or atypical social–emotional responsivity, sustained social attention, and/or social reciprocity
  - Deficits in nonverbal social–communication behaviors
  - Peer interaction difficulties

- Restricted/Repetitive Behaviors (RRBs):
  - Stereotyped or repetitive babbling/speech, motor movements, or use of objects
  - Insistence on sameness/ritualized behaviors
  - Restricted interests
  - Atypical sensory behaviors

The Diagnostic Timeline

Long delays between first concerns and ASD diagnosis



Overactivity Disorder of Toddlerhood (OADT)

Description: Pervasive, persistent, extreme, developmentally inappropriate hyperactivity and impulsivity

Age: 24 months to 36 months

Duration: Symptoms present for at least 6 months

Developmental Features: Hyperactive–impulsive cluster more common

Differential Diagnosis: Typical development; PTSD; Relationship Specific Disorder; Mood Disorder; Anxiety Disorder; Developmental Delay; Sensory Disorder or Physical Health Condition

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Sensory Processing Disorders (SPDs)

- Sensory Over-Responsivity Disorder
- Sensory Under-Responsivity Disorder
- Other Sensory Processing Disorder

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Sensory Over-Responsivity Disorder

Description: Persistent pattern of exaggerated, intense, or prolonged responses to sensory stimuli that are more severe, frequent, or enduring than are typically observed in individuals of similar age and developmental level

Age: At least 6 months old

Duration: Symptoms present for at least 3 months

Developmental Features: Cries excessively; difficulty being soothed; may develop patterns of avoidance or opposition as child gets older

Differential Diagnosis: ASD; PTSD or Other Trauma, Stress, and Deprivation Disorder

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Sensory Processing Disorders (SPDs)

In Summary – Session 2

- Axis V, II and I
- Applied Axes V and II to Case 1

Session 2 Wrap-Up

DC:0-5™ Clinical Training

ZERO TO THREE | LEARN DC:0-5

Session 3– Clinical Disorders Clinical Case Application

Anxiety Disorders

- Separation Anxiety Disorder
- Social Anxiety Disorder (Social Phobia)
- Generalized Anxiety Disorder
- Selective Mutism
- Inhibition to Novelty Disorder
- Other Anxiety Disorder of Infancy/Early Childhood

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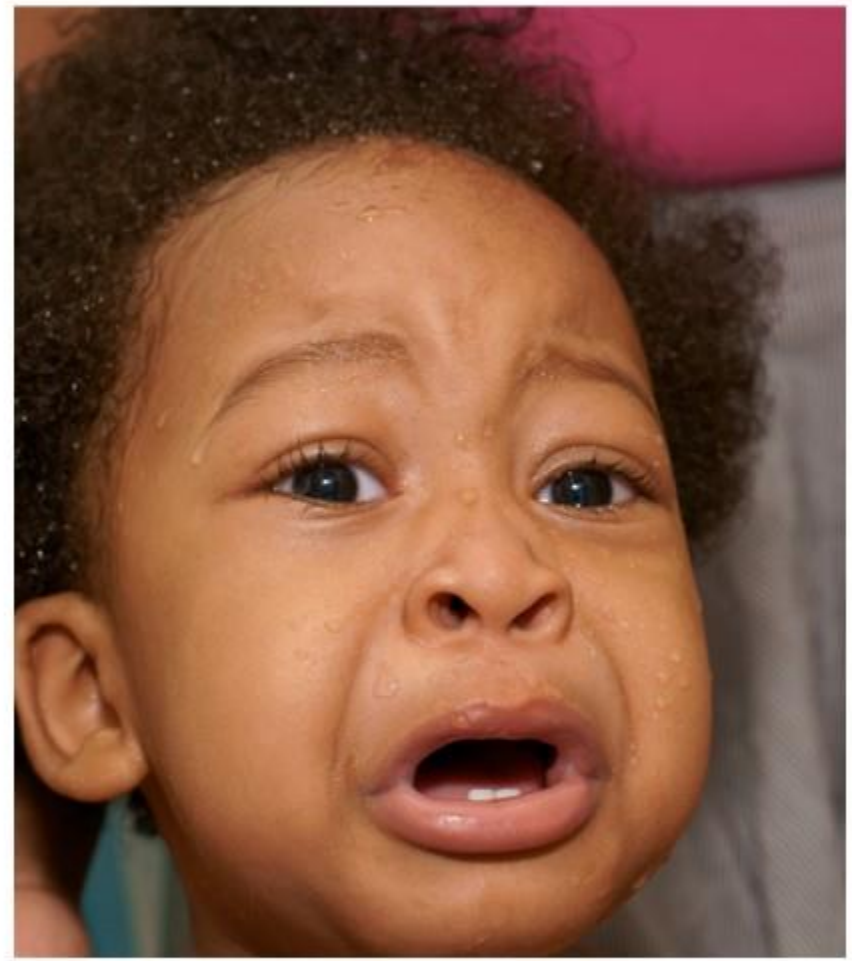
Anxiety Disorders—Challenges

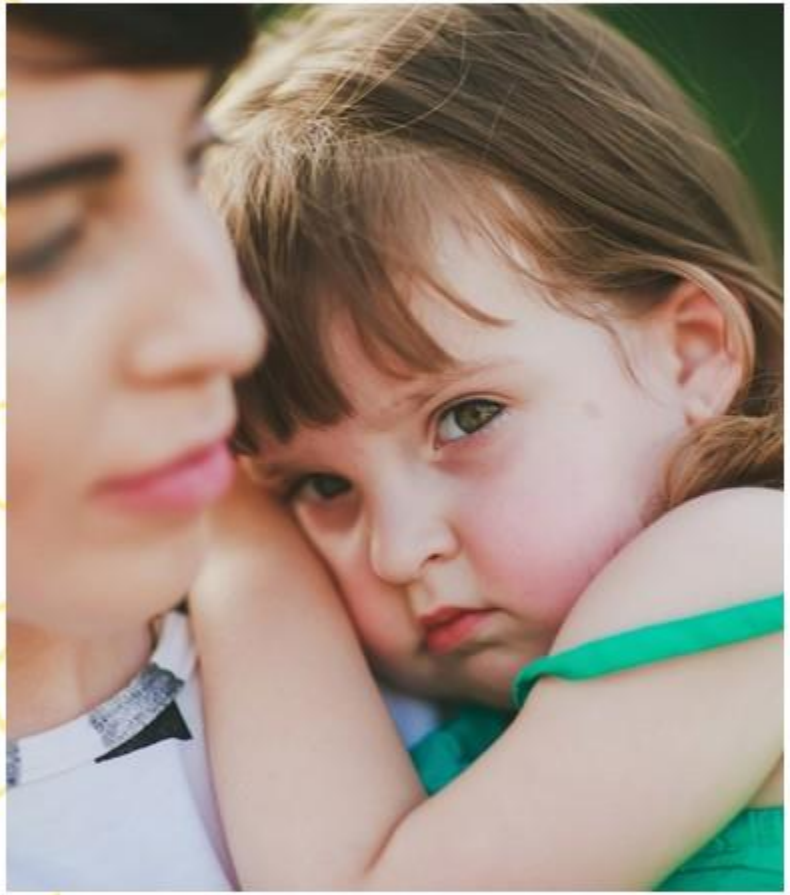
Young children are less able to verbally describe internal experience and emotions.

Must assess the young child's emotional state based on:

- young child's behaviors and distress
- adult report and observation
- observational assessments
- young child self-report (when developmentally possible)



Inhibition to Novelty Disorder



Description: Overall and pervasive difficulty in approaching new situations, toys, activities, and persons; may appear to be extremely shy and may exhibit negative emotionality

Age: 18 months to 24 months

Duration: Symptoms present for at least 1 month

Developmental Features: Unlikely that criteria can be met until 18 months old; increased risk for later emerging anxiety disorders, such as Generalized Anxiety Disorder and Social Anxiety Disorder (Social Phobia)

Differential Diagnosis: PTSD; Adjustment Disorder

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Mood Disorders

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

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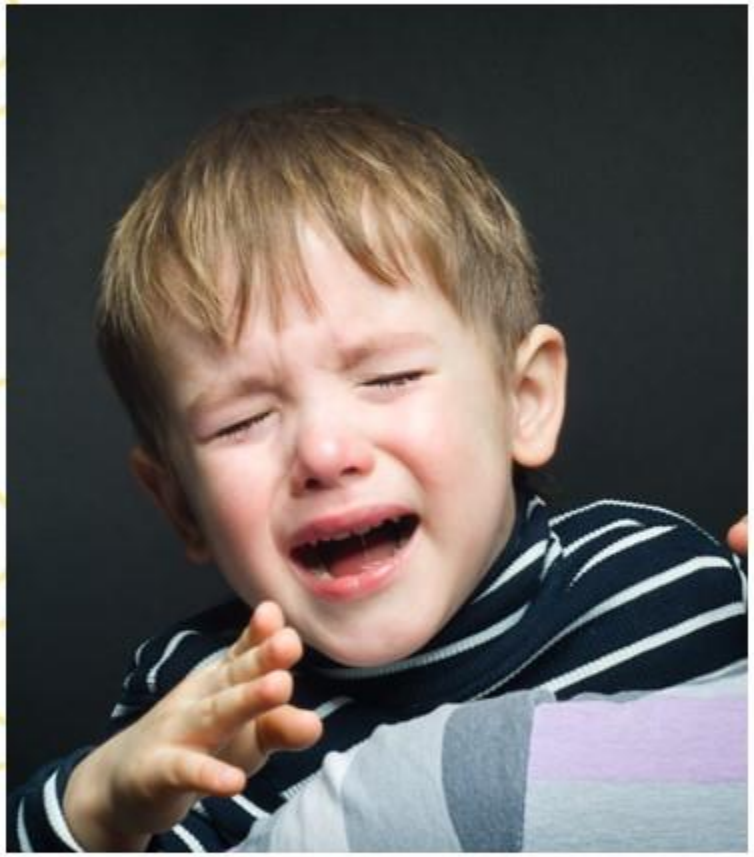
Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA)



Description: Severe, frequent, and intense temper tantrums coupled with persistent irritable or angry mood

Age: At least 24 months old

Duration: Present for at least 3 months

Developmental Features: Dysregulation of emotions; temper tantrums for children, ages 3–5; increased likelihood of aggression, depression, anxiety, and functional impairment in school-age children

Differential Diagnosis: Relationship Specific Disorder, Reactive Attachment Disorder, Adjustment Disorder, PTSD, Major Depressive Disorder, Generalized Anxiety Disorder, Sleep disorder, limited or delayed language, ASD, Hearing Disorder, Sensory Over-Responsivity Disorder, medications

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Comments on DDAA

Obsessive Compulsive and Related Disorders

- Obsessive Compulsive Disorder
- Tourette's Disorder
- Motor or Vocal Tic Disorder
- Trichotillomania
- Skin Picking Disorder of Infancy/Early Childhood
- Other Obsessive Compulsive and Related Disorder

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Obsessive Compulsive and Related Disorders—Challenges

- Must distinguish normative range from impairing symptomatic behavior
- Tourette's Disorder and Motor or Vocal Tic Disorder
  - require duration of 12 months
- Trichotillomania and Skin Picking Disorder
  - hair pulling and skin picking must be observed

Obsessive Compulsive Disorder

Description: Uncontrollable, repetitive, ritualistic thoughts and behaviors that cause distress and impairment with obsessions, compulsions, or both

Age: At least 24 months old

Duration: Present for at least 3 months

Developmental Features: When obsessions and compulsions are so rigid, pervasive, and distressing, they adversely affect the child's development

Differential Diagnosis: Major Depressive Disorder; Eating Disorder that may present with ASD or Cognitive Delays; abrupt onset may be related to a medical disorder such as PANDAS

Sleep, Eating, and Crying Disorders

- Sleep Disorders
  - Sleep Onset Disorder
  - Night Waking Disorder
  - Partial Arousal Sleep Disorder
  - Nightmare Disorder of Early Childhood
- Eating Disorders
  - Overeating Disorder
  - Undereating Disorder
  - Atypical Eating Disorder
- Crying Disorder
  - Excessive Crying Disorder
- Other Sleep, Eating, and Crying Disorders

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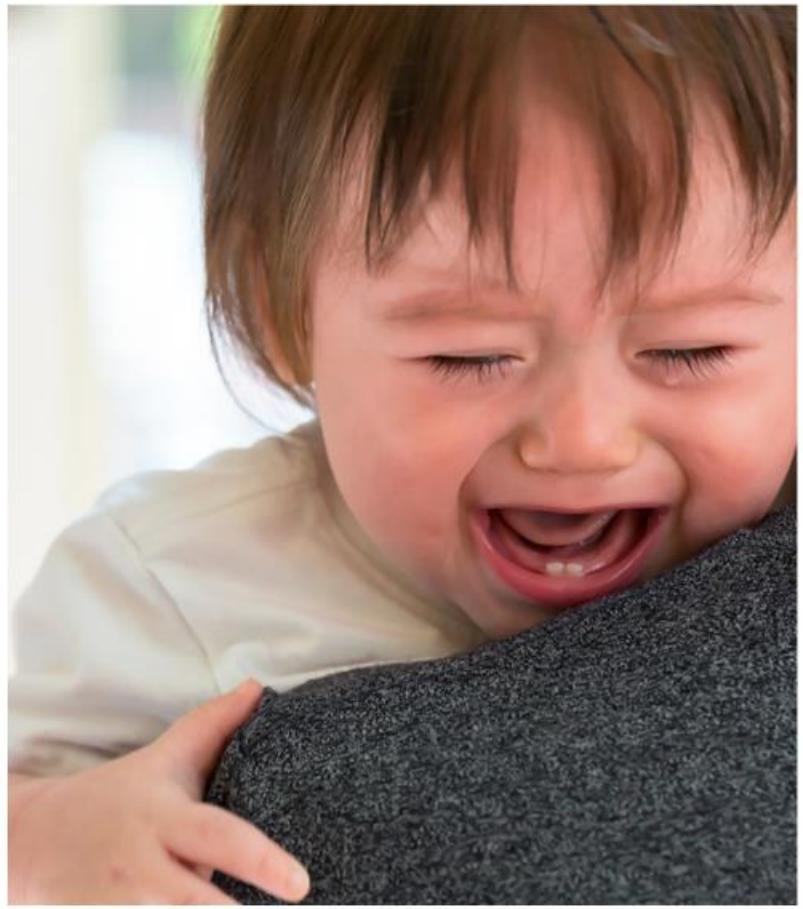
Sleep, Eating, and Crying Disorders—Challenges

- Disturbances in basic physiological activities necessary for healthy development and even survival
- Assessing impaired functioning is complicated by differences in caregivers' tolerance and cultural beliefs



Excessive Crying Disorder

Description: Unexplained crying, inconsolability, and fussiness even after infant's/young child's needs for food, physical closeness, safety and regulation have been met by caregivers; may be referred to as "infant colic"

Age and Duration: Linked to the preverbal period of develop and more specifically to the first year of life

Differential Diagnosis: Difficult temperament; Sensory Processing Disorder; Depression; Deprivation Disorder; Physical Abuse such as "Shaken Baby Syndrome"; Relationship Specific Disorder; not better explained by medical condition

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Trauma, Stress, and Deprivation Disorders

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

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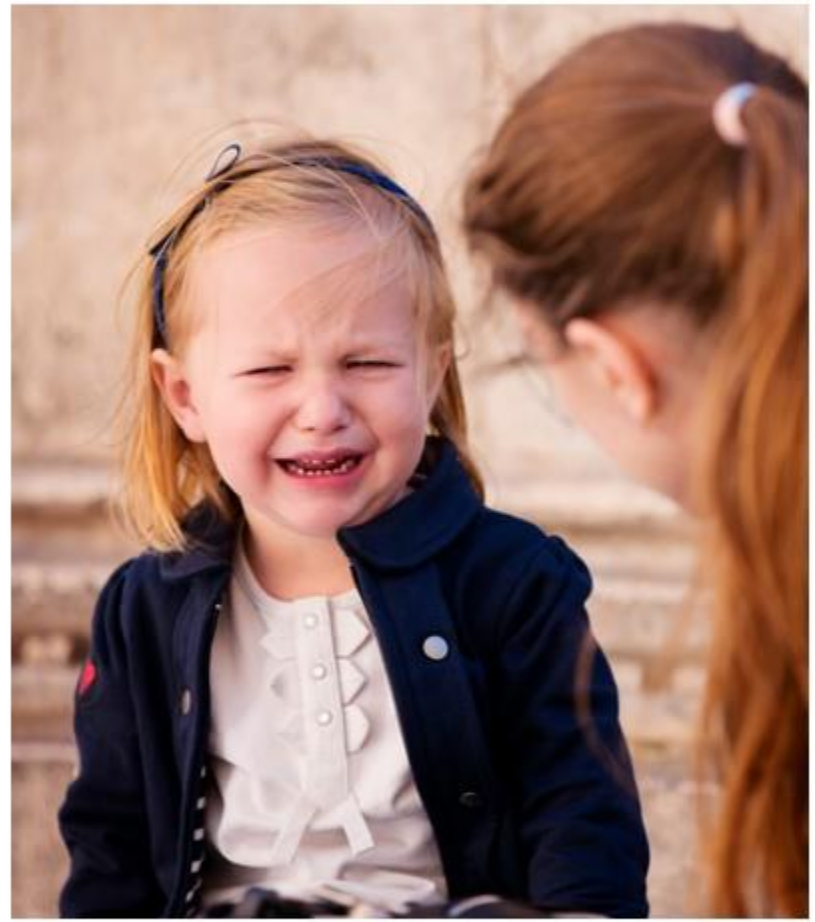
Trauma, Stress, and Deprivation Disorders—Challenges

- Nonspecific behaviors such as aggression, irritability, and reduced positive expression of emotions
- Must assess for losses, stressors, and trauma
- NOT all children exposed to stressors, trauma, or deprivation will develop symptoms
- Symptoms displayed may vary with the age
- Challenging to identify in the first year of life



Complicated Grief Disorder of Infancy and Early Childhood

Description: Significant and pervasive impairment of function characterized by severe impairments in social interaction and communication and/or presence of restrictive and repetitive behavior, as a result of the death or permanent loss of an attachment figure

Age: No minimum age

Duration: Symptoms must be present for at least 30 days

Developmental Features: Fearful of forming attachment to other adults for fear that they will also die, leave, disappear; avoidance of activities because of fear of injury or death; reduced interest in exploration, learning and problem solving; role reversal; separation anxiety

Differential Diagnosis: Relationship Specific Disorder

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Complicated Grief Disorder of Infancy/Early Childhood

Relationship Disorders

- Relationship Specific Disorder of Infancy/Early Childhood

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Relationship Specific Disorder of Infancy/Early Childhood

Description: Persistent emotional or behavioral disturbance in the context of one caregiving relationship

Age: No age restrictions

Duration: Symptoms must be present for at least 1 month

Developmental Features: Symptoms vary with the age; better documented in infants than preschool-age children as preschool children may re-create relationship patterns in new relationships outside of their primary caregiver relationship(s)

Differential Diagnosis: May appear similar to many different Axis I disorders but is distinguished by the relationship specificity of the symptoms

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Conceptual Framework

Diagnosis asserts that disordered parent–child relationships may be an etiology of child symptoms and form the basis for treatment

Let's Practice

36-month-old lives alone with mom, attends early childhood education (ECE) program	**No relationship specific disorder**
24-month-old lives alone with mom, does not attend ECE program	**No relationship specific disorder**
42-month-old lives with both parents	**Relationship specific disorder with each parent**
10-month-old lives with both parents	**Relationship specific disorder with mom**

Case 1

Axis I–Clinical Disorder(s) Case Summary

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Note: Many slides used throughout the DC:0–5 Training were developed by the Diagnostic Classification Revision Task Force and appeared in presentations at the ZERO TO THREE 2015 National Training Institute and the 2016 World Association for Infant Mental Health Congress.

DC:0–5 in Relation to DSM-5 and ICD-10

Module 6 | Version 4.0

DC:0–5 Relationship With DSM-5 and ICD-10

	Diagnostic Focus	Incorporation of Cultural Factors	Multi-axial	Developmental Range	Discrete Diagnostic Codes for Billing
DC:0–5	Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood	Integrates cultural considerations throughout text, includes adaptation of Cultural Formulation for Use With Infants and Toddlers table	Yes	Birth through 5 years old	Yes; aligns diagnoses with ICD-10 codes
DSM-5	Diagnostic Statistical Manual of Mental Disorders, 5th Edition	Attends to cultural influences, includes Cultural Outline and Cultural Interview	No	Focuses mainly on adult psychopathology, children and adolescents more than 5 years old	No; aligns diagnoses with ICD-9 and ICD-10 codes
ICD-10	International Classification of Diseases, Tenth Revision	International focus and framework	No	Infancy through adulthood	Yes; authorized through World Health Organization

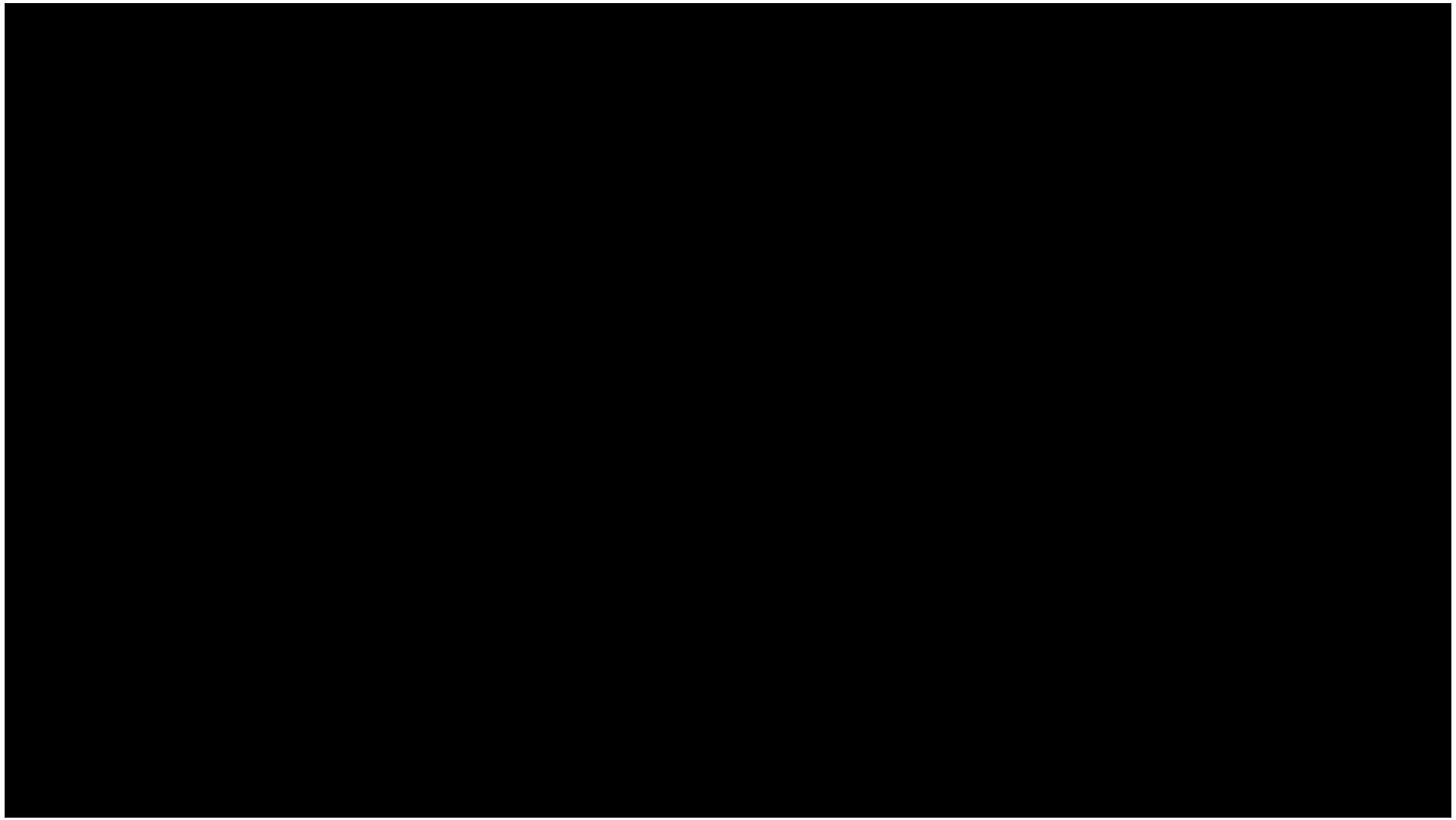
DC:0–5 Crosswalk

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

DC:0–5™ Disorder Name	DSM-5 Disorder Name	ICD-10 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

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

Thinking About Diagnostic Formulation



Case 2
Application of DC:0–5

Take a Moment to …

Take Inventory: Why am I here?

Notice Emotions: How do I feel about diagnosing infants and young children?

Actively Engage: What is my learning style? How will I participate?

Link: How will this content inform or benefit my work?

Integrate: How will I integrate this information into my own scope of work?

*Coined by Jeree Pawl and adapted by Carmen Rosa Noroña

In Summary – Session 3

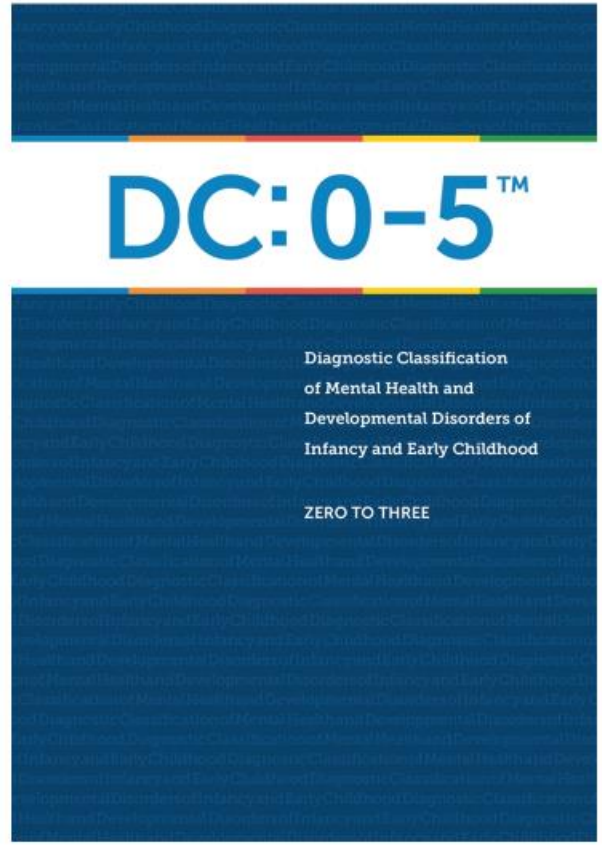
- Axis 1
- Applied Axis I to Case 1
- Reviewed relationship and crosswalk to DSM-5 and ICD 10
- Considered Cultural Aspects of Case 2
- Applied Axes 1-V to Case 2
- Moment to reflect on training and personal learning

Questions?

Additional Information

For additional information, please refer to: https://www.zerotothree.org/dc05resources

For additional training information, please refer to: https://www.zerotothree.org/resources/1198-contact-us-about-dc-0-5-training



Diagnostic Classification Revision Task Force Members

Task Force Members:

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- Julie Cohen, MSW (ZERO TO THREE)
- Helen Egger, MD (New York University/Langone Health)
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- Alicia Lieberman, PhD (University of California, San Francisco)
- Kathleen Mulrooney, MA, LPC (ZERO TO THREE)
- Cindy Oser, RN, MS (ZERO TO THREE)

2013–2016

- Research
- Web-based survey of 20,000 users of DC:0–3 worldwide.
- E-mail invitations with links to the survey instrument

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Thank You

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