BUILDING A SOLID PLATFORM FOR THE *DIAGNOSTIC CLASSIFICATION OF MENTAL HEALTH AND DEVELOPMENTAL DISORDERS OF INFANCY AND EARLY CHILDHOOD* (*DC: 0–5*)

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Two points are relevant in framing this commentary. The first is to emphasize that this special issue of the *Infant Mental Health Journal* provides a useful introduction to the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (*DC: 0–5*) clinical system, with selective reviews that were a basis for four of the initiated changes from the *DC: 0–3R*. However, the reports do not provide, nor were they intended to provide, readers with a full overview or details of the new diagnostic system. The latter will await the publication and appreciation of the full *DC: 0–5* in late 2016. The second point, by way of full disclosure, is that I served as chair of the previous *DC* Task Force (*DC: 0–3R*) that is now being superseded. I chose not to be involved directly in the *DC: 0–5* Task Force's work. I provided requested feedback on some occasions, but was not involved in decision-making. That said, I welcomed the opportunity to respond to the editor's request for a brief commentary.

REVIEWS AND INITIATIVES

The introductory article by Zeanah and the members of the Task Force lays out cogently its history and rationale, including the fact that the *DC: 0–3R* was meant to be temporary—making use of clinical and research information at the time, but making way for this major revision which is now most welcome. Due to the constraints of time and available resources, our Task Force for the *DC: 0–3R* did not enjoy the rich interdisciplinary membership that the current Task Force has benefited from, and we were keenly aware of areas of uncertainty needing more information from practice and research. Among the most awkward part of our *DC: 0–3R* 2005 system was that we could not sufficiently include the rapidly growing information for disorders in the preschool period of 3 to 5 years of age; that, thankfully, has now been included in the new system. Interestingly, the multiaxial system has been retained even though it was recently eliminated in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and the International Classification of Diseases systems. The stated reason for keeping multiple axes is because of current evidence from practice and research for the huge importance of context in early development. The new *DC: 0–5* system also is to bring emphasis to dimensions by requiring that all diagnostic categories contain assessments of adaptive functioning, with ratings of degree of impairment of functioning. Given the ultimate aims of coordinating the *DC: 0–5* with the adult-oriented systems, it remains to be seen how retaining of the multiaxial system in the *DC: 0–5* will evolve.

Next, I take up two reviews that have, arguably, resulted in the largest and most needed changes in the *DC: 0–5*. Zeanah and Lieberman, in their article "Relational Pathology in Early Childhood," review the background for changes in the systems of the *DC: 0–3* and its "R" that many have considered its most innovative area. A background presumption has been that all early development and its disorders necessarily involve relationship issues. The conclusion from the review—especially from attachment research in which attachment security is acknowledged to be a relational construct, varying with specific caregivers and other relationships—is to move relationship-specific disorders to Axis I. Moreover, any symptom cluster category of Axis I, meeting the criteria for impairment and distress, presumably also could fall into a relationship-specific disorder category. Thus, it would seem that if there is a diagnosis of Axis I in this area, there also will be comorbidity. Axis II, dealing with relational context, has two scales: one dealing with the parent–child level and another with the wider context of relationships within family, friends, and teachers.

There are clear advantages to these system changes that can take into account the vast array of differences in family relationship structures and caregiving environments as well as allowing for

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INFANT MENTAL HEALTH JOURNAL, Vol. 37(5), 521–522 (2016)

View this article online at wileyonlinelibrary.com.
DOI: 10.1002/imhj.21594

relationship-specific diagnostic classifications on Axis I. There also are significant challenges. To what extent will clinician-observers be able to attend to the dyadic aspects of indicated relationships as compared with one side alone, as the authors review indicates has been true in the past? Is there sufficient room in the system such that subthreshold classifications in different categories (e.g., in eating or hyperactivity disorders) could add up and be classified as a relationship-specific disorder? In practice, will clinicians routinely do all the dimensional ratings suggested? It seems good, in this regard, to note that ZERO TO THREE is planning to resource major training efforts once *DC: 0–5* is published to overcome these and other challenges.

Soto, Kiss, and Carter review the strong longitudinal and intervention-based literature that now exists for autism spectrum disorder, indicating the importance of early childhood recognition and treatment. The absence of recognized criteria for diagnosis under 36 months is reviewed, as is the growing recognition of subthreshold symptoms appearing earlier that can benefit from treatment. Their rationale for including a diagnostic classification for the period of 9 to 36 months of age, to bring attention for treatment, is a cogent one. Recognizing that not all of these younger children will go on to develop later *DSM* criteria but that early intervention is valuable, they point to the recommended early childhood criteria of two social communication symptoms (rather than three), one repetitive/restrictive behavior symptom (rather than two), and evidence of impaired functioning. Compellingly, the authors provide, under each symptom cluster, a "limitations of data," indicating the need for more research that could sharpen criteria and improve early developmentally based criteria that could be generalized.

Gleason and Humphreys, based on their review, recommend adding two new diagnostic classifications for *DC: 0–5* regarding attention and hyperactivity disorders for very young children. In one classification, research is reviewed to include attention deficit hyperactivity disorder as a diagnostic category for children who are 3 to 5 years old, requiring persistent impairment of more than 6 months and occurring in more than one setting and relationship. In the other classification, research indicating overactivity disorder is reviewed, as a syndrome in children of 24 to 36 months that does not include an inattention cluster. For this as well, requirements of persistent impairment of functioning and occurring in more than one setting and relationship are included. For both of these diagnostic classifications, the authors emphasize the importance of holistic clinical judgments that include careful assessment of development in all its domains, child observation (including a physical exam), history from more than one informant, and evaluation of contextual factors. In other words, the use of these diagnostic categories, like all others, depends strongly on developmentally focussed clinical intervention that includes treatment planning. In this context, the authors found it important to note that psychopharmacological approaches to "trials of diagnostic intervention" for these conditions in the early years are not considered appropriate.

A fifth contribution, by Keren, reviews recent clinical research in early eating and feeding disorders and reaches the compelling conclusion that classification in this area for the *DC: 0–5* needs to be, like other disorders of the *DC: 0–5* and disorders in the *DSM*, based on observations and symptom syndromes rather than on inferred etiology. Thus, the etiology-based system of the *DC: 0–3R*, for which there was limited evidence found in the review, is being replaced by descriptive syndromes of eating problems, familiar to most pediatric and infant mental health clinicians. Among these, a newer category of overeating disorder is included for recognized clinical reasons. The review also indicates the importance of comorbidity with respect to eating disorders, along with needed longitudinal research for a variety of descriptive syndromes of "atypical eating disorders."

THE HARD PART: MAKING USE OF THE *DC: 0–5*

As indicated, the *Infant Mental Health Journal* is fortunate to have a cogent set of reviews of current research and available clinical knowledge that together provide a compelling background and rationale for some of the major changes initiated in the *DC: 0–5*. But now comes the hard part. This involves seeing how this scheme for diagnostic classification will be applied in a useful way for helping individual young children and their families. This, of course, is the task of the clinician in what is usually referred to as "clinical formulation." And there are issues about that. Although not within the direct scope of the task group for improving diagnostic classification with the *DC: 0–5*, the local clinical formulation task is mentioned repeatedly as an issue in the reviews and its recommendations. This issue arises when reviewers point to the importance of the clinician using "holistic judgments" in deciding among classifications and their criteria in particular instances with individual symptomatic children, and when they emphasize the importance of considering the varying relationships and contexts across axes of diagnostic classification. How this will occur and the importance of it for continuing knowledge about such application may result in some of the changes in the *DC: 0–5* being found useful, others not, as the authors imply.

Another issue alluded to in most of the reviews, but not answerable yet with information, is applying the *DC: 0–5* in different cultures. Culture will influence judgments about criteria and the potential use of categories. The system itself has paid considerable attention to encouraging clinicians to obtain culturally relevant contextual information, but how it will work is unknown, and surely, as attachment research and clinical work has shown, cultural context, dealing with shared meaning and interpretation, can profoundly influence the validity of how a scheme works.

In summary, much good work has been done by the authors, but as they indicate, much work remains in application and evaluating its usefulness for our mental health fields.