DEFINING RELATIONAL PATHOLOGY IN EARLY CHILDHOOD: THE *DIAGNOSTIC CLASSIFICATION OF MENTAL HEALTH AND DEVELOPMENTAL DISORDERS OF INFANCY AND EARLY CHILDHOOD DC:0–5* APPROACH

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ABSTRACT: Infant mental health is explicitly relational in its focus, and therefore a diagnostic classification system for early childhood disorders should include attention not only to within-the-child psychopathology but also between child and caregiver psychopathology. In this article, we begin by providing a review of previous efforts to introduce this approach that date back more than 30 years. Next, we introduce changes proposed in the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood DC:0–5* (ZERO TO THREE, in press). In a major change from previous attempts, the *DC:0–5* includes an Axis I "Relationship Specific Disorder of Early Childhood." This disorder intends to capture disordered behavior that is limited to one caregiver relationship rather than cross contextually. An axial characterization is continued from the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood DC:0–3R* (ZERO TO THREE, 2005), but two major changes are introduced. First, the *DC:0–5* proposes to simplify ratings of relationship adaptation/maladaptation, and to expand what is rated so that in addition to characterizing the child's relationship with his or her primary caregiver, there also is a characterization of the network of family relationships in which the child develops. This includes coparenting relationships and the entire network of close relationships that impinge on the young child's development and adaptation.

Keywords: parent–child relationship, relationship disorders, relationship psychopathology, infant mental health

RESUMEN: La salud mental infantil posee un ámbito relacional en cuanto a su enfoque y, por tanto, cualquier sistema de clasificación de diagnóstico de trastornos en la temprana niñez debe incluir no sólo la sicopatología interna del niño, sino también la sicopatología entre el niño y quien le cuida. En este ensayo, comenzamos revisando los esfuerzos previos para introducir este acercamiento que data de más de 30 años. Seguidamente introducimos los cambios propuestos en *DC:0-5*. En un significativo cambio con respecto a intentos previos, *DC:0-5* incluye un Eje I "Trastorno Específico de la Relación en la Temprana Niñez." Este trastorno intenta captar la desordenada conducta que se limita a la relación con un cuidador en vez de la relación inter-contextualmente. Una caracterización axial continúa a partir de *DC:0-3R*, pero dos cambios significativos se introducen. Primero, DC:0-5 propone simplificar los puntajes de adaptación y mal-adaptación en la relación, y expandir lo que se evalúa de manera que además de caracterizar la relación del niño con quien primariamente le cuida, se da también la caracterización del contorno de relaciones familiares dentro del que el niño se desarrolla. Esto incluye las relaciones de crianza compartida y el grupo entero de relaciones cercanas que tienen un efecto en el desarrollo y adaptación del pequeño niño.

Palabras claves: relación progenitor niño, trastornos en la relación, sicopatología de la relación, salud mental infantil

RÉSUMÉ: La santé mentale du nourrisson est explicitement relationnelle dans son orientation, et par conséquent un système de classification diagnostique pour les troubles de la petite enfance devrait prêter attention non seulement à la psychopathologie au-sein-de-l'enfant mais aussi à la psychopathologie entre l'enfant et la personne en prenant soin. Dans cet article nous commençons par passer en revue les efforts qui ont été déployés afin d'introduire cette approche qui date d'il y a plus de 30 ans. Ensuite, nous présentons les changements proposés dans le DC:0-5. Dans ce qui constitue l'un des

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grands changements par rapports aux versions précédentes, le DC:0-5 incorpore un Axe I “Trouble de la Petite Enfance Spécifique à une Relation”. Ce trouble se donne pour but de capturer les comportements désordonnés qui sont limités à la relation avec une personne prenant soin de l’enfant, plutôt que trans-contextuellement. Une caractérisation axiale s’inscrit dans la lignée du DC:0-3R, mais deux changements importants sont présentés. Tout d’abord, le DC:0-5 propose de simplifier les évaluations de l’adaptation/la maladaptation de la relation, et d’étendre que ce qui y est évalué de telle façon qu’en plus de caractériser la relation de enfant avec la personne qui s’en occupe il existe aussi une caractérisaion du réseau de relations familiales au sein desquelles l’enfant se développe. Ceci comprend les relations de co-parentage et le réseau entier de relations proches qui empiètent sur le développement et l’adaptation du jeune enfant.

Mots clés: relation parent enfant, trouble de la relation, psychopathologie de la relation, santé mentale du nourrisson

ZUSAMMENFASSUNG: Die psychische Gesundheit von Säuglingen hat einen deutlichen Beziehungsfokus und daher sollte ein diagnostisches Klassifikationssystem für Störungen der frühen Kindheit nicht nur die Psychopathologie des Kindes selbst, sondern auch die Psychopathologie zwischen Kind und Bezugsperson umfassen. Der Artikel beginnt mit einem Review der bisherigen Bemühungen, diesen bereits mehr als 30 Jahre alten Ansatz einzuführen. Nachfolgend stellen wir die in der DC: 0–5 vorgeschlagenen Änderungen vor. Eine wichtige Änderung früherer Versuche umfasst die Aufnahme der Achse I "Beziehungsspezifische Störungen der frühen Kindheit" in die DC:0-5. Diese Störung beabsichtigt gestörtes Verhalten zu erfassen, das sich auf die Beziehung zu einer Bezugsperson beschränkt und eher nicht kontextübergreifend ist. Eine axiale Charakterisierung wie bei der DC: 0–3R wird fortgesetzt, allerdings werden zwei wesentliche Änderungen eingeführt. Erstens, die DC:0-5 schlägt vor, Ratings der Beziehungsanpassung /-fehlanpassung zu vereinfachen und die Bewertung zu erweitern, sodass es zusätzlich zu einer Charakterisierung der Beziehung des Kindes zu seiner/ihrer Hauptbezugsperson auch eine Charakterisierung des familiären Beziehungsnetzwerks, in dem sich das Kind entwickelt, geben soll. Dazu gehört die Beziehung zwischen den Eltern und das gesamte Netzwerk enger Beziehungen, die auf die Entwicklung und Anpassung des Kleinkinds Einfluss nehmen.

Stichwörter: Eltern-Kind-Beziehung, Beziehungsstörungen, Beziehungspsychopathologie, psychische Gesundheit von Säuglingen

抄録: 乳幼児精神保健の焦点は、明白に関係的であり、そのために早期児童期の障害のための診断分類システムには、子ども自身の中within-the-childの精神病理ばかりでなく、子どもと養育者の間の精神病理も含められるべきである。この論文では、私たちは、30年以上前にさかのぼるこのアプローチを導入するための努力のレビューを提供することから始める。次に、私たちは*DC:0-5*に提案した変更を紹介する。以前の試みからの主要な変更として、*DC:0-5*には第1軸「早期児童期の関係性に特異的な障害」が含まれる。この障害は、さまざまなコンテクストにまたがるのではなく、一人の養育者との関係性に限定されている障害のある行動を捉えることを目的とする。軸による特徴付けは*DC:0-3*から継続しているが、二つの主要な変更が導入されている。第一に、DC:0-5は関係性の適応/不適応という単純化した評価を提案しており、加えて子どもの主要な養育者との関係性を特徴付けられるように、評価した物を拡張することも提案している。また、その中で子どもが育つ家族の関係性のネットワークの特徴付けもある。これには、共同養育の関係性と、幼い子どもの発達と適応に影響を与える近い関係性のネットワーク全体が含まれる。

キーワード: 親子関係性, 関係性障害, 関係性精神病理, 乳幼児精神保健

摘要: 關係明確是幼兒心理健康的重點, 因此診斷幼兒疾病分類系統, 不僅應包括孩子精神病理學, 也須重視孩子和照顧者之間的精神病理學。在本文中, 我們首先審查以往的研究, 引進這種做法可以追溯到30年以上。接下來, 我們介紹*DC:0-5*的修改建議。*DC:0-5* 包括“幼兒期的具體關係障礙”, 與以往建議相比, 有重要的改變。這種分類旨在捕捉僅限於一名護理人員關係的異常行為, 而非泛情境關係障礙。從*DC:0-3R*繼續一個軸向特徵, 但引入了兩個重大變化。首先, *DC:0-5*建議簡化關係適應/適應不良的評分, 並擴展評分的範圍, 除了描述孩子與他/她的主要照顧者的關係, 也描述在家庭網絡關係中孩子的發展。這包括共同撫養關係和衝擊幼兒發展和適應的密切關係網絡。

關鍵詞: 親子關係, 關係障礙, 關係病理學, 幼兒心理健康

الهدف: الصحة النفسية للرضيع علائقية بشكل جوهري ولذلك فإن أي نظام تصنيف تشخيصي لاضطرابات الطفولة المبكرة يجب أن يشمل الانتباه ليس فقط للتشخيص النفسي للطفل ولكن في ضوء العلاقة بين الطفل ومقدم الرعاية . في هذا البحث نبدأ بتقديم مراجعة للمجهودات السابقة التي أبرزت هذا الاتجاه الذي يعود لأكثر من 30 سنة مضت . ثم بعد ذلك نعرض للتغييرات المقترحة في تصنيف DC: 0-5. من التغييرات الأساسية عن الإصدارات السابقة يحتوي DC:0-5 على اضطراب في الطفولة المبكرة من نمط AXIS I ويختص بعلاقة معينة ويهدف تضمين هذا الاضطراب إلى وصف السلوك المرتبط بعلاقة معينة للطفل مع أحد مقدمي والرعاية وليس بوجه عام . ويستمر التوصيف المحوري من إصدار DC:0-3R ولكن مع تغيرين أساسيين . أولا يقترح DC-05 تعديل تقييمات تكيف وعدم تكيف العلاقة وتوسيع ما يتم تقييمه بحيث يتم توصيف علاقة الطفل مع مقدم الرعاية وكذلك توصيف شبكة علاقات العائلة التى ينمو فيها الطفل . هذا يشمل علاقات الأبوة المشتركة وكل شبكة العلاقات القريبة التي تطبع أثرها على نمو الطفل وتكيفه .

كلمات مفتاحية : علاقة الطفل والأب – اضطرابات العلاقة – الأمراض النفسية للعلاقة – الصحة النفسية للرضيع

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For many years, psychopathology in infancy and early childhood has been a controversial topic focused on the meaning of atypical infant behaviors, either as indicators of risk for subsequent psychopathology or as symptoms of present psychiatric disorders. Increasingly, however, manifestations of psychopathology in very young children are believed to reflect deviant developmental trajectories associated with significant distress and impaired functioning. Some surprising similarities between psychopathological conditions in younger and older children have been noted (Egger & Angold, 2006), but important differences also have been described (Sameroff & Emde, 1989).

Although few would dispute that relational processes are integrally involved with the mental health of individuals, and especially children, a thornier question is whether there are instances in which the relational processes rather than the individual may be "disordered." Traditionally, psychopathology has been understood to exist *within* individuals rather than *between* individuals. A paradigm shift in clinical psychology and psychiatry was introduced by the conceptualization of family systems and family therapy approaches that evolved from this conceptualization (Keeney, 1982), but these approaches have remained peripheral to the dominant definitions of individual psychopathology.

The roots of the field of infant mental health are explicitly relational; that is, they are focused on understanding young children's development and their manifestations of psychopathology within the context of their relationships with caregivers. Many major figures in our field have staked out explicitly relational frameworks. Winnicott's (1960) oft-quoted declaration, "There is no such thing as an infant, meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (p. 585), was one of the first. Bowlby (1953) similarly asserted that "... essential for mental health is that an infant and young child should experience **a** warm, intimate and continuous relationship with his mother (or mother substitute ...) in which both find satisfaction and enjoyment" (p. 13). More specifically, a clinical perspective on relational pathology was presented in Fraiberg and collaegues's (1975) case studies of infant maladaptive behaviors associated with disturbances in the mother–infant relationship, which originated in turn in the mother's conflicted relationships during childhood, or "ghosts in the nursery." Each of these pioneers believed that a relational focus was necessary for understanding young children's development and provided a path for ameliorating their pain.

In this article, we present a new conceptualization of disordered child–parent relationship disorders and a relational context for understanding psychiatric disorders in young children. The approach we outline has evolved from many discussions and reviews of the literature conducted by the ZERO TO THREE Task Force charged with revising the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood DC:0–3R* (ZERO TO THREE, 2005). We provide a review of previous efforts in this area and the rationale for our proposal, which includes a revised relational axis and a newly described "Relationship Specific Disorder of Early Childhood."

EMPIRICAL BACKGROUND

Infant mental health clinicians have consistently advocated for understanding young children's emotional functioning in the context of their primary relationships. The most systematic research on parent–child relationships has come from the study of young children's quality of attachment to their caregivers. This research has provided very strong empirical support for specificity in the emotional quality of relationships that infants establish with different caregivers. In this section, we highlight research underpinning this evidence.

The Strange Situation Procedure (SSP; Ainsworth, Blehar, Waters, & Wall, 1978) has long been considered the "gold standard" for assessing infant quality of attachment because the child's behavior during reunion with the caregiver after a brief separation has been shown to predict concurrent and later behavioral patterns associated with adaptive or maladaptive socioemotional functioning. A major strength of the SSP is that the findings are firmly anchored in extensive home observations conducted over several hours twice a month and then analyzed in relation to the infant's behavior in the laboratory (Ainsworth et al., 1978). Some studies have examined attachment to two different caregivers (e.g., mothers and fathers) and have found that the same child may have different patterns of attachment quality with different caregivers (Green & Goldwyn, 2002; van IJzendoorn & Wolff, 1997). This suggests that the dimension of security versus insecurity of attachment is not a child trait but rather a manifestation of how the child experiences each parent's emotional availability and behavior.

Main, Kaplan, and Cassidy (1985) introduced the *Adult Attachment Interview* (AAI) as a measure of attachment quality in adults analogous to the SSP patterns of attachment in infants, providing a way to assess concordance/discordance in the patterns of attachment of the parent and the child. Adult attachment patterns are derived from individual differences in narrative discourse that are revealed in responses to systematic probes about adults' recalled experiences with their own parents. Infant attachment patterns in the SSP, on the other hand, are derived from behavioral differences demonstrated by the young child toward the attachment figure, as compared to a stranger in response to separation distress. What links these two assessments, beyond a focus on attachment, is that each of them reveals the adult's or child's attempts to regulate negative emotions during a mild to moderate attachment salient stressor, including the flexibility/inflexibility of attention strategies associated with that emotion regulation.

For example, *securely attached* infants typically demonstrate distress during separation directly to their caregivers and use the attachment figure, but not the stranger, for comfort and resolution of their distress. Once reassured by contact with the caregiver, they generally resume exploration of the environment. Similarly, adults classified as *autonomous* (i.e., secure) report positive and negative experiences with their parents in a balanced way, neither avoiding nor overfocusing on challenging experiences with their parents. Infants with *avoidant* attachments, on the other hand, turn their attention away from their own internal distress and

focus externally on toys or the surrounding environment, much as adults classified as *dismissing* use their attention to avoid focusing on painful memories or insisting that they had no effect. Infants who are classified as *resistant* with their caregivers overfocus on caregivers at the expense of the surroundings, but they are unable to settle once distressed despite attempts by the caregiver to comfort them. Caregivers classified as *preoccupied* similarly describe relationship dissatisfaction with their parents, but seem so caught up by adverse experiences that they cannot seem to integrate their emotions and experiences. Thus, avoidant/dismissing, resistant/preoccupied, and secure/autonomous relationships involve reduced, exaggerated, and balanced activation of attachment needs and behaviors, respectively. Similarly, *disorganized* patterns of attachment in infants and *unresolved* in adults both involve lapses in strategies for obtaining closeness and comfort.

Based on attachment theory, we would predict that we could demonstrate a concordance between a parent's and a young child's patterns of attachment. In fact, several meta-analyses of studies of the AAI have confirmed the hypothesized substantial concordance between parents' attachment patterns in the AAI and their infants' attachment patterns in the SSP (van IJzendoorn, 1995; van IJzendoorn & Bakermans-Kranenberg, 1996, 2008).

Importantly, AAI patterns in parents can be used to predict their infants' attachments to them. For example, in a study of 100 first-time-pregnant couples, the AAI was administered prenatally to mothers and fathers, and SSPs were administered at 12 or 18 months (Steele, Steele, & Fonagy, 1996). Mothers' prenatal patterns, derived from narrative characteristics of their descriptions of the relationships with their own parents, predicted their infants' attachment patterns to them more than 1 year later. Fathers' attachment patterns, measured prenatally, predicted their infants' attachments to them more than 1 year later. Mothers' attachment patterns also showed a modest prediction of infants' attachment to that of their fathers more than 1 year later, but fathers' attachment patterns did not predict infants' attachments to their mothers. These findings provide support for relationship specificity. A meta-analysis of 14 studies comparing attachment of infants to mothers and to fathers found a significant, but modest, concordance and concluded that these relationships, as illustrated in the Steele et al. (1996) study, were largely independent (van IJzendoorn & Wolff, 1997).

Another line of research concerns parents' representations of their own infants. Using the *Working Model of the Child Interview* (WMCI; Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994), investigators demonstrated concordance between parents' representations of their infants and infants' patterns of attachment in the SSP. The predicted patterns of concordance were that parents with *balanced* representations would have infants with secure attachments to them, parents with *disengaged* representations would have infants with avoidant attachments, and parents with *distorted* representations would have resistant classifications. Research has shown strong links between balanced/secure and disengaged/avoidant, with less consistent relations between distorted/resistant (Vreeswijk, Maas, & Van Bakel, 2012). Furthermore, in a recent study, mothers' WMCI classifications fully mediated the relation between mothers' prenatal AAIs and infant SSPs at 12 months (Madigan, Hawkins, Plamondon, Moran, & Benoit, 2015).

These results speak to specificity in mother–infant relationships, especially because mothers' prenatal representations assessed with the WMCI predicted infant quality of attachment to mothers at infant age 12 months (Benoit, Parker, & Zeanah, 1997). Further, Crawford and Benoit (2009) showed that a disrupted scale applied to prenatal WMCI interviews predicted infant disorganized attachment at 12 months of age. In other words, these two studies have indicated that mothers who were interviewed about their child's personality and their relationship with their child before they had even met the child revealed narrative characteristics that were predictively related to the patterned organization of the child's attachment behaviors with them in the SSP more than 1 year later.

Note that the literature on early attachment has focused on individual differences in patterns of attachment, but has made no claim about these differences indicating disordered behavior. On average, approximately 40 to 45% of infants in low-risk samples are classified as being insecurely attached. Although insecure attachment is associated with higher likelihood of later psychopathology, the association is not strong enough to warrant the conclusion that insecure attachment is itself a form of relational psychopathology (Sroufe, 1997). Even disorganized attachment, which has the strongest concurrent and predictive relation to psychopathology—at least regarding externalizing and dissociative psychopathology (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010; Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012; van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999)—is not in and of itself evidence of a disorder. This is because, in part, disorganized attachment is tied to behavior in the SSP, and may be designated based on subtle behaviors during reunion, such as approaching a caregiver with closed eyes or interrupting an approach and stopping. To be a disorder, we expect to see a pattern of symptomatic behavior that is evident in naturalistic settings and associated with significant child distress and/or impaired functioning. By this standard, the single observation provided by an SSP would not by itself reflect a clinical disorder. On the other hand, many children whose classification with their caregivers is disorganized will have clinical disorders, but identifying those disorders will require more than observations from one standardized laboratory paradigm.

Thus, the literature on attachment patterns between young children and their caregivers has provided a template to identify relationship patterns that warrant clinical attention as well as clear evidence for the early specificity of the relationships that infants and young children establish with their different primary caregivers.

RELATIONSHIP DISTURBANCES: AN INITIAL TAXONOMY

A major impetus for considering parent–child relationship disorders was the publication of *Relationship Disturbances in Early Childhood* (Sameroff & Emde, 1989). This work derived from a

FIGURE 1. Model for conceptualizing components of the caregiver–child relationship. From "A Model for Conceptualizing the Role of the Mother's Representational World in Various Mother-Infant Therapies," by N. Stern-Bruschweiler and D.N. Stern 1989, *Infant Mental Health Journal*, 10, p. 142. Copyright 1989 by Michigan Association for Infant Mental Health.

year of collaboration at the Center for Advanced Studies in the Behavioral Sciences at Stanford University among a group of distinguished early childhood investigators. They developed a then-novel hypothesis, articulated by Sroufe (1989), that most psychiatric problems in children less than 3 years old, though poignantly expressed in child behavior, are best conceptualized as relational. Drawing upon several decades of developmental research, they argued that "If the individual is not a suitable level of analysis for infant development, neither is the individual a suitable level of analysis for understanding infant behavioral disorders" (Sameroff & Emde, 1989, p. 222).

The investigators then proposed a continuum of relationship disturbances organized around the regulatory function that caregivers serve for young children. They argued that the mutual regulation of parent–child relationships was necessary for healthy infant development and well-being and that regulatory disturbances would reflect disturbances in the relationship (Anders, 1989). They proposed five patterns of disturbances that could disrupt the parent–child relationships: overregulated, underregulated, inappropriately regulated, irregularly regulated, and chaotically regulated (Anders, 1989).

Finally, they also proposed a continuum of parent–child relationship disturbances. First, they described *relationship perturbations* that were transient disruptions caused by stressors, but which were time-limited because of the adequacy of supports or the mildness of the stressor. Next, they defined *relationship disturbances* that involved inappropriate or insensitive regulation in interactions leading to intermediate duration problems generally limited to one domain of interaction. At the most severe level, they defined *relationship disorders* as rigidly entrenched, of longer term duration, and associated with maladaptive interactions across several domains (Anders, 1989). Further, they declared that relationship disorders meant that the individual was symptomatic because of a relationship experience, that recurrent patterns of interactions of the partners were inflexible/insensitive, and that symptoms were impairing in daily life and inhibiting the expected developmental progress of both partners (Sameroff & Emde, 1989).

This groundbreaking work made explicit what had been implicit in the clinical work that had preceded it—that the parent–child relationship could be and should be the unit of focus in interventions for young children and their caregivers. But, if so, what about assessment? Here, they asserted that assessment of the relationship should include its regulatory pattern, affective tone, and developmental phase (Anders, 1989). They also emphasized the various contexts in which relationships are embedded: historical, social, and cultural.

This was the most systematic and well-articulated effort to integrate observations from infant developmental research into clinical work with young children and families that had ever been proposed. Their classification not only provided a means of focusing clinical efforts on the dyad rather than the young child alone but also attempted to do so in a way that would allow for systematic characterizations of relational problems.

Despite its considerable importance in advancing the field, the approach articulated by this group had two major interrelated problems. First, despite the compelling case they made for regulation as a core feature of the relationship, translating it into clinical practice proved daunting. Consider the following clinical scenario: An intrusive caregiver repeatedly overstimulates her infant. The caregiver appears to be overregulating, but the infant is actually underregulated. Assuming that this pattern reflects a consistent characteristic of the relationship, how should it be classified? It is overregulated from the perspective of caregiver behavior, but underregulated from the standpoint of infant adaptation. This relates to the second problem of the approach, which is that the descriptions of relationship problems were focused primarily on caregiver behavior. This adult focus has plagued most attempts to define relational disturbances. It seems that we lack the words to describe problems *between* rather than *within* individuals. Even the construct of relationship is unclear. Are we describing something in the mind of the parent, something in the mind of the young child, or something external to each of these? Most measures of interaction mostly focus on caregiver behavior or on infant behavior, and include scores for each. Interactive patterns of the dyad are less well-characterized, even though it is widely acknowledged that the behavior of each partner influences the other.

Another contribution of the Stanford group was to call attention to the importance of representations and behaviors in understanding relationships between young children and their caregivers. Inspired in part by this important distinction, Stern-Bruschweiler and Stern (1989) provided a model for conceptualizing parent–infant/child relationships (Figure 1). In their model, the observable components of the parent–child relationship, representing recurrent patterns of interaction over time, are in the center of the figure. Outside are the representations of parent and child, reflecting the subjective experiences and anticipations of each partner. They also emphasized that this model should be viewed as an open system, so that a change in one component would be expected to change other components. Although originally developed as a way of understanding the "ports of entry" or targets of various infant mental health interventions, the model also is useful for determining components of assessment of parent–child relationships. This

TABLE 1. *Parent–Infant Relationship Global Assessment Scale*

DC:0–3 (1994)	*DC:0–3R* (2005)
90 Well Adapted	91–100 Well Adapted
80 Adapted	81–90 Adapted
70 Perturbed	71–80 Perturbed
60 Significantly Perturbed	61–70 Significantly Perturbed
50 Distressed	51–60 Distressed
40 Disturbed	41–50 Disturbed
30 Disordered	31–40 Disordered
20 Severely Disordered	21–30 Severely Disordered
10 Grossly Impaired	11–20 Grossly Impaired
	1–10 Documented Maltreatment

was another major breakthrough in providing a clinically useful frame of reference for infant mental health clinicians attempting to think relationally. Having a means of assessing relationships led to more intentional considerations of how to characterize and define relationship disorders between young children and their primary caregivers.

THE *DC:0–3*, AN INITIAL EFFORT AT RELATIONSHIP DIAGNOSIS

In 1994, a ZERO TO THREE task force, chaired by Stanley Greenspan and Serena Wieder, published a nosology of early childhood disorders, known as the *DC:0–3*. In this volume, a multiaxial system was introduced, with Axis II devoted to parent–child relationship disorders. Noting the importance of the parent–child relationship for young children's development, and recognizing the potential for relationship-specific disturbances, *DC:0–3* was the first nosology that clearly articulated relationship disorders between parents and young children. Although the entire manual was an effort to create meaningful diagnostic categories for young children that were not available in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*; American Psychiatric Association, 1994) or International Classification of Diseases, 10th Revision (World Health Organization, 1992), the inclusion of relationship disorders was perhaps its most distinctive contribution.

In the *DC:0–3*, both a continuous and a categorical approach were used for relationship disturbances. The Parent–Infant Relationship Global Assessment Scale (PIRGAS;) comprised a rating scale 10 (*grossly impaired*) to 90 (*well apdapted*) of relationship adaptation (modeled after the Global Assessment Scale and the Child Global Assessment Scale that defined Axis V in the *DSM-IV*). This scale operationalized the continuum of parent–infant relationship disturbances originally described by Anders (1989). The anchored points on the scale, listed in Table 1, were to be used by clinicians at the completion of a clinical assessment to indicate the level of a dyad's relationship adaptation. The idea was that a child's relationship problems might co-occur with symptomatic behaviors, but that they could be distinct. The approach asserted that "serious symptoms may be apparent in an infant without relationship pathology and relationships may be pathological without overt symptoms in the infant" (*DC:0–3*; ZERO TO THREE, p. 67).

The PIRGAS could be used to identify strengths as well as concerns, but for ratings of 40 and below (*disturbed* to *grossly impaired*), a classification of the type of relationship disorder was to be specified on Axis II. Ratings in this range designated severe and pervasive problems in the parent–child relationship that warranted a diagnosis.

To determine whether a relationship was disordered, clinicians were instructed to assess the behavioral quality of the interaction, the affective tone of the relationship, and the psychological involvement or the meaning of the child to the parent. The disordered relationship types defined in the *DC:0–3* included overinvolved, underinvolved, anxious/tense, angry/hostile, mixed, and abusive (including verbally physically and/or sexually abusive). For each, a description of behavioral quality of the interaction, affective tone, and psychological involvement were provided.

The strengths of the *DC:0–3*'s approach were notable. First, there was an explicit acknowledgment that relationship disorders were specific to a relationship. This was the radical departure from traditional nosologies that had been advocated by Sameroff and Emde's (1989) group. Different types of relationship disorders were not only specified in considerable detail but there also was an explicit recognition that relationship disturbances were arrayed along a continuum. PIRGAS ratings anticipated contemporary efforts in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*; American Psychiatric Association, 2013) and in the National Institute of Mental Health's *Research Domain Criteria* (Insel et al., 2010) to move beyond a categorical taxonomy. There also was comprehensive attention to many aspects of relationships—including perceptions, emotions, and behaviors and their organization and integration by both partners—that are central to clinical formulations and interventions.

On the other hand, there also were significant weaknesses in the *DC:0–3* approach. Despite efforts to be balanced, there was an overemphasis throughout the classifications on parent behaviors, with descriptions of infant behaviors often framed as reactions to parent behaviors. Furthermore, the relationship classifications were simultaneously overly inclusive and underdetailed because they listed numbers of criteria for each type, without specifying how many were necessary to make a diagnosis. The types that were specified retained the same problems as the classification proposed by Anders (1989) in that they focused more on caregiver behavior—or at best, caregiver behaviors and infant behaviors—rather than on dyadic properties. In addition, substantial work has documented that coparenting (McHale & Lindhal, 2011), which involves adults cooperating in the care of children, has important effects on their development. Focusing only on the primary caregiving relationship in the *DC:0–3R* left this important consideration unaddressed.

The PIRGAS also was problematic in that it contained an internal inconsistency in its metric. In what was intended to be a continuous scale of relationship adaptation, perturbations and

significant perturbations were included as transient reactions to stressors. Thus, there was no way to use this scale to designate milder, but persistent, relationship disturbances. Given that the PIRGAS involved a 9-point scale, the anchors for each level of adaptation also were limited.

Most concerning about the entire Axis II of the *DC:0–3*, given its novelty and seeming centrality to the field of infant mental health, is how little research it inspired. A smattering of studies have examined reliability and validity of the PIRGAS as a scale (Aoki, Zeanah, Heller, & Bakshi, 2002; Muller et al., 2013; Salomonsson & Sandell, 2011aa, 2011b), but there have been almost no attempts to assess the value of the typology of relationship disorders nor whether, for example, a rating of 40 on the PIRGAS is appropriate as a cutpoint for specifying relationship disorders.

For all of these problems, the introduction of the relationship as a central clinical focus in the *DC:0–3* was a vital contribution to the clinical enterprise of infant mental health.

CONTRIBUTIONS OF THE REVISED *DC:0–3*

More than a decade after the original manual appeared, another ZERO TO THREE task force was charged with revising and updating the *DC:0–3*, and the result of their work culminated with the publication of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition* (*DC:0–3R*; ZERO TO THREE, 2005). This work maintained both the continuous ratings of parent–child relationship adaptation and the typology of relationship disorders that had been introduced by the *DC:0–3*.

There were only minor changes in Axis II in the *DC:0–3R*. First, the PIRGAS was expanded to a 10-point scale, by adding a "documented maltreatment" rating (see Table 1) to incorporate ratings that involved abuse or neglect. The anchors of the PIRGAS were expanded a bit as well. Second, a Relationship Problems Checklist was introduced. This provided a rating of 0 (*no evidence*), 1 (*some evidence*), or 2 (*substantial evidence*) for each type of relationship disorder classification.

The text also was updated, and clinicians were instructed to include five aspects of the "relationship dynamic" (p. 41) when conducting assessments. These included overall functioning of parent and child, level of distress in both partners, adaptive flexibility of parent and child, and level of conflict and resolution between parent and child. In addition, clinicians were to consider the effect of the quality of the relationship on the child's developmental progress.

Thus, the revisions of Axis II in the *DC:0–3R* were helpful, but minor, and although some increased specification of details was provided, most of the same strengths and weaknesses evident in the *DC:0–3* were maintained.

THE *DIAGNOSTIC CLASSIFICATION OF MENTAL HEALTH AND DEVELOPMENTAL DISORDERS OF INFANCY AND EARLY CHILDHOOD DC:0–5,* A PROPOSED REVISION

The ZERO TO THREE Diagnostic Classification Revision Task Force solicited feedback in a number of ways from clinicians about Axis II and the challenge of how best to characterize relational problems between young children and their parents. Criticisms of the *DC:0–3R* included those already noted as well as that the diagnostic labels were pejorative, that the PIRGAS was insufficiently operationalized and challenging to use, and that it included too many points and too few anchors to define them.

We recognized that the challenges of revising the approach of the *DC:0–3* and the *DC:0–3R* were considerable. In reflecting on these challenges, we concluded that there are two reasons why considering parent–child relationships and relationship disturbances are important. The first reason is that the primary caregiver/young child relationship is often the central focus of clinical assessment and intervention; thus, relationship-specific psychopathology ought to be captured. The second reason is that the network of family relationships in which the young child develops is of considerable importance to the child's development and well-being. Based on these two principles, which we derived from clinical experience, research, and the work of of many others reviewed herein, we have recommended modifying the *DC:0–3* and the *DC:0–3R* approach substantially in several major ways.

First, we introduced a major departure from previous approaches by defining an Axis I disorder of "Relationship-Specific Disorder of Early Childhood" (see Table 2). This is an explicit acknowledgment of the fact that clinical disturbances in young children's behavior are often relationship-specific. Next, although

TABLE 2. *Provisional Criteria Relationship-Specific Disorder of Early Childhood*

Diagnostic Algorithm: A-C criteria must be met.

A. The child exhibits a persistent emotional or behavioral disturbance in the context of one particular relationship with one primary caregiver but not with other caregivers. Examples include (but are not limited to) the following:
1. Oppositional behavior
2. Aggression
3. Fearfulness
4. Self-endangering behavior
5. Food refusal
6. Sleep refusal
7. Role-inappropriate behavior with caregiver (e.g., over-solicitous or controlling behavior)
8. Self-endangerment

B. The symptomatology in A is expressed exclusively in one caregiving relationship.

C. Symptoms of the disorder (or caregiver accommodations in response to the symptoms) impact significantly the child and/or family functioning in one or more of the following ways:
1. Cause distress to the child;
2. Cause distress to family;
3. Limit the child's participation in developmentally-expected activities or routines;
4. Limit the family's participation in everyday activities or routines;
5. Limit the child's ability to learn and develop new skills, or interfere with developmental progress.

Specify: Caregiver(s) with whom symptomatology is manifest.

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we maintained Axis II to characterize the caregiving context for the child, we introduced several changes in how that should be characterized. We did not retain the relationship disorder typology from previous editions; instead, we limited Axis II characterizations of the caregiving contexts to ratings on two continuous scales. The first is used to rate the parent–child relationship level of adaptation/maladaptation, and the second is used to rate the family–child relationship level of adaptation/maladaptation. We maintained the continuous rating method, but replaced the PIRGAS with a new scale.

Relationship-Specific Disorder of Early Childhood

Stern (2008) noted that although we acknowledge relational complexity in infant mental health, we do not always make sufficient use of our understanding in clinical endeavors. Given that so much clinical work in infant mental health concerns understanding relationship-specific symptomatology, and given the significant empirical base for relationship-specific behavior in young children that exists, we may ask why nosologies have not considered relationship disorders to be a primary and Axis I disorder?

One reason is that the challenge of defining a disorder between two individuals rather than within an individual has been daunting for the field. Nevertheless, we concluded that an Axis I Relationship-Specific Disorder of Early Childhood is warranted for the *DC:0–5*. Our approach to the dilemma of how to define such a disorder was guided by two decisions. First, we defined a relationship disorder as manifest in infant/young child symptoms, but symptoms that are apparent only in one relationship. Thus, the child who is oppositional with parents and siblings would not qualify for a relationship disorder because the symptoms occur in multiple relationships. Of course, this same child might qualify for another Axis I disorder. Nevertheless, the relationship disorder must manifest in infant/young child symptoms that are impairing to the child and/or the family's functioning. Second, we did not specify the nature of child symptoms required for relationship. That is, any significant symptoms that impair the child's adaptation and are specific to a relationship with a caregiver will qualify as a relationship disorder. The child might have food refusal, aggressive behavior, fearfulness, role-inappropriate caregiving behavior, or any other symptom picture as long as it is limited to one caregiving relationship. This is in obvious contrast with the *DC:0–3* and the *DC:0–3R* approaches that specify the nature of symptoms required by both caregiver and child and limit the relationship disturbances to one of a small number of types.

What this disorder will not capture is presymptomatic young children who are experiencing disturbed relationships with their caregivers. That is, if the infant/young child is experiencing a relationship disturbance without overt symptomatology (i.e., is at risk for rather than already manifesting psychopathology), then this disorder is not applicable. Nevertheless, relational disturbances that place the infant/young child at risk can be captured by Axis II in the *DC:0–5*.

Axis II: Relational Context

Axis II is based on the premise that young children usually establish emotionally salient relationships with a small number of primary caregivers that they identify as their attachment figures, and that the network of caregiving relationships that envelops the developing young child has important affects of the child's experiences and behaviors. Independent ratings are made of the overall adaptation of each the infant/young child's primary caregiving relationships (Part A of Axis II) and a separate rating for the infant/young child's caregiving environment (Part B of Axis II).

The emotional quality of the dyadic relationship that the child establishes with each of his or her primary caregivers is characterized by the specific contributions that the child and the caregiver make to their perceptions and interactions with each other. In addition, because relationships affect relationships, the coparenting patterns that the caregivers establish with each other in relation to the child and the dyadic relationships between the child and each caregiver create a web of relationships that comprise the caregiving environment and have a profound impact on the child's development. Axis II encompasses both the dyadic relationship between the child and the primary caregiver(s) and the totality of the caregiving environment using the scales described next.

Part A: Caregiver–Child Relationship Adaptation. This scale is used to rate the relationship as it exists *between* the primary caregiver(s) and the child rather than within each of these two individuals. Although disturbances in relationships between young children and their attachment figures may derive from within the caregiver, from within the child, or from the unique fit between the two, the key consideration in using the scale is that the caregiver–child relationship is affected regardless of the etiology of the disturbance.

Adequate caregiving is presumed to derive from three overarching characteristics: (a) the caregiver's knowing and valuing the child as a unique individual, (b) the caregiver's consistent emotional availability, and (c) the caregiver's capacity to take the lead in providing care for the child (being effectively and empathically in charge). These caregiver characteristics provide the scaffold that enables the child to develop age-appropriate trust in the caregiver's capacity to respond to his or her physical and psychological needs. Clinicians may base their ratings on observations of the caregiver–child interaction and other manifestations of the child–caregiver subjective experience of each other. Because children develop different relationship patterns with different caregivers, it is important to conduct direct assessments of all the primary caregiver/child relationships.

The caregiving dimensions listed in Table 3 (Dimensions of Caregiving for Primary Caregiver/Child Relationship) are intended to guide the clinician's assessment of the relationship by systematically reviewing a number of clinically relevant dimensions. Similarly, because we know that infants and young children are powerful elicitors of behaviors, feelings, and perceptions in adults, there also is a listing of clinically relevant infant/young child characteristics

TABLE 3. *Dimensions of Caregiving for Primary Caregiver/Child Relationship*

Indicate how each item contributes to relationship quality.			
	Strength	Not a Concern	Concern
Ensuring physical safety			
Providing for basic needs (e.g., food, hygiene, clothing, housing, health care)			
Conveying psychological commitment to and emotional investment in the child			
Establishing structure and routines			
Recognizing and responding to the child's emotional needs and signals			
Providing comfort for distress			
Teaching and social stimulation			
Socializing			
Disciplining			
Engaging in play and enjoyable activities			
Showing interest in child's individual experiences and perspectives			
Engaging in reflectiveness regarding child's developmental trajectory			
Incorporating child's point of view in developmentally appropriate ways			
Tolerating ambivalent feelings in caregiver-child relationship			

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TABLE 4. *Infant/Young Child's Contribution to Relationship*

Indicate how each item contributes to relationship quality.			
	Strength	Concern/Strain?	Not a Strength/Concern
Temperamental dispositions			
Sensory profile			
Physical appearance			
Physical health (from Axis III)			
Developmental status (from Axes I and V)			
Mental health (from Axis I)			
Learning style			

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that the clinician is encouraged to use to inform the Axis II Part A rating of relationship adaptation (Table 4). The clinician is encouraged to consider for both caregiver and infant behaviors the degree to which they are culturally bound and to think carefully about family cultural values and practices that define young children's behaviors and endorse or proscribe specific parenting practices.

Four levels of adaptation are identified for a summary rating of the relationship. Level 1, *Well-Adapted to Good Enough Relationships*, describes relationships that are not of clinical concern. This level covers a broad range of relationships, from those that are functioning adequately for both partners on the caregiving dimensions to those that are exemplary. The "good enough" designation is worth emphasizing in that it is not necessary for the relationships to be exemplary at this level is not of clinical concern–only rarely will they be. Most will be characterized by typical ups and downs and struggles, but will be functionally adequate. At Level 2, *Strained to Concerning Relationships*, careful monitoring at least is definitely indicated, and intervention may be required. At Level 3, *Compromised to Disturbed Relationships*, the relationship disturbance is clearly in the clinical range, and intervention is indicated. Finally, at Level 4, *Disordered to Dangerous Relationships*, intervention is not only required but urgently needed due to the severity of the relationship impairment.

The levels are arrayed ordinally rather than continuously, meaning that each level becomes more problematic from 1 to 4, but the levels are not equidistant points in a continuum. In particular, Level 1 should contain most relationships in low-risk samples and should include a broad range of relationship adaptations.

The cultural values, practices, and beliefs of the family must be ascertained when deciding on a rating. In low-risk populations, Level 1 is expected to predominate, and the distribution of cases across different levels will be affected by the characteristics and circumstances of the children and caregivers being assessed. This scale should be used by trained infant mental health professionals in clinical settings, usually at the end of an assessment process.

The dimensions listed in Tables 3 and 4 are not formally connected to ratings but are intended as guides for clinicians to think through whether and which type of interventions might be recommended. There is no minimum number of dimensions that must be rated as concerning.

Part B: Caregiving Environment and Child Adaptation. Children construct different relationships with different caregivers, and the ratings of the caregiving environment are meant to specify the coordination, integration, and compatibility among the different caregiving relationships which the child experiences. The emotional quality of this web of caregiving relationships is an important predictor of the child's functioning, even when the caregivers do not live together. The caregiving dimensions listed in Table 5 are designed to guide the clinician's assessment of the caregiving environment. The clinician is encouraged to think carefully about family cultural values and practices. It is important to understand and accept cultural variations, but also to intervene to support the infant's/young child's development.

Just as with the primary caregiver/child relationship component of Axis II, the caregiving environment and child adaptation ratings including four levels of adaptation are identified for a summary rating of the network of caregiving relationships. Level 1, Well-Adapted to Good Enough Relationships, describes a

TABLE 5. *Dimensions of the Caregiving Environment*

Indicate how each contributes to the caregiving environment.			
	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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caregiving environment in which the quality of coparenting relationships are not of clinical concern. This level is meant to cover a broad range of relationships, from those that are functioning adequately among caregivers in relationship to the child to those that are exemplary in their level of coordination, collaboration, and compatibility. At Level 2, Strained to Concerning Relationships, there are likely to be indicators of conflict and/or insufficient communication and coordination among the caregivers regarding the care and upbringing of the child. In addition, the child is likely experiencing distress, tension, or uncertainty about how to negotiate interactions with the different caregivers and may show preferences that spark conflict among them. The strain or concern places the child's social and emotional trajectory at risk for compromise. At Level 3, Compromised to Disturbed Relationships, the family relationships are fraught with inappropriate levels of risk to safety, significant conflict, insufficient or irregular engagement, or significant imbalance. The level of disturbance indicates that the child's social and emotional trajectory has been compromised. Finally, at Level 4, Disordered to Dangerous Relationships, there is a clear and immediate need for clinical intervention because the relationship pathology among caregivers is severe and pervasive, with significant impairments in the provision of adequate protection and responsive caregiving, age-appropriate socialization, and/or support for exploration and learning, to the extent that these disturbances are seriously compromising the young child's development and threaten the child's physical or psychological safety.

INTEGRATING AXIS I AND II

Given that relational pathology may involve Axis I and/or Axis II, we consider briefly how the Axes are to be used in different situations. Relationship-specific disorder is to be used for a symptomatic child whose symptoms are limited to one particular relationship. When relationship-specific disorder is used, Axis II also should be coded. Part A of Axis II, caregiver-child relationship adaptation, should be Level 3 or 4 when the child meets criteria for a relationship disorder on Axis I. Part B of Axis II may be at any level, although Levels 2 to 4 may be more likely than is Level 1 in the context of a relationship-specific disorder. A child may have an Axis I disorder other than relationship-specific disorder and also have an Axis II rating of any of the levels. In this instance, the child would be symptomatic cross-contextually, but the caregiving environment—either the primary caregiving relationship or the broader caregiving environment—could range from highly adaptive to highly maladaptive. A child who does not meet criteria for any Axis I disorder could have an Axis II rating that ranges from Level 1 to Level 4 on either Part A, the primary caregiving relationship, or Part B, the broader caregiving environment of relationships. A child with no Axis I diagnosis and an Axis II rating of Level 1 would be a child for whom there is no clinical concern. An asymptomatic child with an Axis II rating of Level 2, 3, or 4 on either the primary caregiving relationship or the broader caregiving environment relationship ratings would be a child considered "at risk" for subsequent psychopathology.

SUMMARY AND THE WAY FORWARD

We detailed both the importance and the challenges of incorporating relational features into a diagnostic classification system. The *DC:0–5* represents the latest of several attempts that date back more than 30 years. In a major change from previous attempts, the *DC:0–5* includes an Axis I Relationship-Specific Disorder of Early Childhood. The diagnosis is made by focusing on symptomatic behavior in the child, but behavior that is expressed largely or exclusively in the context of one caregiving relationship. Much remains to be learned about the usefulness of this new disorder classification. Reliability and validity must be established, but the real test is whether it shapes treatment differently than would within-the-child disorders.

An axial characterization of young child/caregiver relationships is continued from the *DC:0–3R*, but also is different in two major ways. First, the PIRGAS has been replaced by a 4-point scale with more detailed relational anchors designed to guide clinical intervention. Second, in addition to characterizing the young child's relationship with his or her primary caregiver, there also is a characterization of the caregiving environment; that is, the network of family relationships in which the child develops. This includes coparenting relationships and the entire network of close relationships that impinge on the young child's development and adaptation. There already is considerable empirical evidence that family environments are powerful influences on young children's development. We hope that this contextualization of the young child's caregiving environment will receive the clinical attention that it warrants.

Our hope is that these new approaches to conceptualizing relationship psychopathology will receive careful empirical scrutiny and be revised as indicated. Careful evaluation of this approach represents an important challenge for researchers and a much-needed aid to practitioners.

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