

## DIAGNOSTIC CLASSIFICATION OF MENTAL HEALTH AND DEVELOPMENTAL DISORDERS OF INFANCY AND EARLY CHILDHOOD (DC:0-5): IMPLEMENTATION CONSIDERATIONS AND CLINICAL REMARKS

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The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5)* gave infant mental health specialists a tool to describe behavioral symptoms during infancy, earlier often ignored as minor or transient baby problems. In a new form, called the *DC: 0-5*, the tool now aims to describe mental health problems during the first 6 years of life. In my commentary, I discuss some implications of the proposed changes.

First, I address the never-ending question regarding why a specific diagnostic classification system for young children is at all needed. The answer remains unchanged. Clinicians need to tell the world that mental health problems in young children do exist and that it is our responsibility to reduce their negative influence on early development. When *DC: 0-3* was launched, it was described as a complement to other diagnostic systems; clinicians were encouraged to refer to the *Diagnostic and Statistical Manual of Mental Disorders* or the *International Classification of Diseases (ICD)* when possible. The *DC: 0-3* focused on specific characteristics of infant problems that other systems had not described, and also acknowledged that some of these were early manifestations of problems also described among older children. The *DC: 0-5* is meant to be the general single source for describing infant mental health problems in children under 6 years of age, including disorders also described in other systems. While attractive as an aim, the implementation of *DC: 0-5* depends on how it is received by healthcare organizations around the world. In a society where healthcare is financed by governmental sources, as in Scandinavia, a classification system has to provide guidance on where resources are most effectively used. Today, the *ICD-10* is used to register mental health disorders in all age groups, including infancy and early childhood, despite poor criteria for younger ages. In those

regions where the *DC: 0-3R* has been implemented, the *ICD-10* is still prescribed, but the *DC: 0-3R* is used for treatment planning. It is unlikely that the *ICD-10* will be abandoned as the designated classification system in the near future, with the consequence that the *DC: 0-5* will probably be used as a clinical complement. Since the *DC: 0-5* is not yet available, it is an open question whether clinicians will find it worthwhile to use two separate systems for describing similar problems during the older preschool ages, one for the records and one for treatment planning.

② Second, the proposed new categorical diagnoses are attention deficit hyperactivity disorder (ADHD) for describing hyperactivity, impulsivity, and inattention in children older than 36 months, and overactivity disorder (OAD) for ADHD symptoms in children 24 to 36 months. Clinicians working with children during the preschool years have argued that subthreshold symptoms hampering later development also can be identified among toddlers. Simultaneously, other clinicians have discussed how the specificity of behavior symptoms during the early years might not be acknowledged if the same nosology is used for all ages. In the review behind the proposed ADHD and OAD diagnoses, the authors discuss the risk of pathologizing behavior that might be described as exacerbations of typical behavior; however, they also state that impairing signs of hyperactivity and impulsivity can be identified as early as 18 months. Parental reports as the single source of information regarding impairment might be problematic, however. Parents' expectations on what is typical toddler behavior vary and are related to their earlier experiences, their life situation, and often their own well-being. To ensure that the child has significant problems, the authors propose a "two-setting criterion" for impairment, but why not a "two-reporter criterion?" Most 2-year-old children are in preschool, and teacher-reports would add valuable information. An overactive toddler might not be impaired in a safe and supportive setting with a sensitive caregiver who can facilitate the child's learning on how to regulate his or her activity and impulses.

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Considering the established association between parental stress, family problems, traumatic experiences, and children's ADHD symptoms, the rationale behind the criterion of functional impairment needs to be further discussed. Who carries the problem, who is impaired, and who needs help? The authors advise us not to delay the "identification of neurodevelopmental processes for which we have safe and effective interventions" (p. 1). They argue against medication and propose parent management training as the first choice of intervention. This is in line with what many Scandinavian clinicians believe; there are individual differences in levels of activity and impulsivity within the range of typical development, but those with severe problems need to be identified early so that the caregiving environment can be supported. It is important to be aware of the risk of "labeling the child" as being pathologically overactive and impulsive instead of seeing that the caregiver has a nonoptimal life situation and fails to support his or her child's individual needs.

Third, the relationship between Axis I and Axis II in the DC system needs to be reexamined. In the DC: 0-5, an Axis I relationship disorder is proposed, and Axis II is reserved for contextual information only. Collecting all primary diagnoses in Axis I makes the system more user-friendly, but this might be at the cost of losing specific Axis II relationship information. As indicated earlier, a clinical problem may rest in the child, the caregiver,

or the context. The relationship between the child and his or her caregiver is asymmetric because the caregiver is responsible for being available to offer sensitive care. A child with a relationship disorder describes a caregiving failure, in that it discloses a context in which the caregiver has failed in his or her mission to meet the child's needs. Clinical work with young children must emphasize early identification of problems, but focus even more on identifying situations at risk for problems so that preventive measures can be planned. To have all primary classifications in Axis I will probably facilitate epidemiological research, but if the power of the multiaxial system is reduced, value of the DC: 0-5 for treatment planning is limited. If the DC: 0-5 is to become a useful instrument for clinicians working in the first line who meet families in need of help, a scale for classifying relationships such as the DC: 0-3R Parent-Infant Relationship Global Assessment is needed. In the future, efforts should be concentrated on developing the metric qualities of the scale than on withdrawing it. There is a fear that if Axis II gets the role of being secondary to Axis I, many children living in nonoptimal environments will stay unidentified.

To conclude, the final form of the DC: 0-5 needs to be made public before we can fully discuss how it will serve researchers and clinicians involved in supporting preschool children and their families. However, the information given so far is promising, and users are looking forward to receiving the full system.