

ASSESSMENT AND DIAGNOSIS IN EARLY CHILDHOOD

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Welcome, Introductions and Acknowledgements

- The Original DC:0-3 and the Colorado Connection
 - Dr. Robert Emdee
 - Dr. Robert Harmon
- Project BLOOM – 2006 Training of Trainers
- Zero to Three Training of Trainers
- Dr. Karen Frankel and the Irving Harris Program in Child Development and Infant Mental Health
- Dr. Beth Limberg, DC:0-3R National Trainer
- DC:0-5 Timeline

The Context for Infant and Early Mental Health Practices

Betsy Rogers, LCSW, IMH-E® (IV) Clinical
Irving Harris Infant Mental Health Fellow



Learning Objectives for Today

- Process for diagnosing very young children
- Advantages and disadvantages of diagnosis
- Multi-axial diagnostic system of DC: 0-3R
- DC: 0-3R checklists and rating scales
- Distress in the context of development and relationships
- Philosophy of Intervention

Scope of Today's Training

- This training is intended to introduce participants to the use of DC:0 - 3R
- True and lasting competence will come with:
 - Conducting multiple, thorough assessments
 - Regularly consulting with supervisors and colleagues
 - Experts
 - Same-level colleagues

Think of a Child



- What do you wonder about? What questions do you have?
- What are the child's presenting concerns?
- How would you assess the child's overall development? How did you, or how would you assess overall development?
- Do you believe that the diagnosis you have chosen, fully encompasses the clinical picture and presenting problems? If not, what is missing?
- Does the current diagnosis guide your treatment effectively?
- Have you been able to see this child in their natural settings and with their primary care providers? If not, what makes this difficult?

INTRODUCTION AND PHILOSOPHY

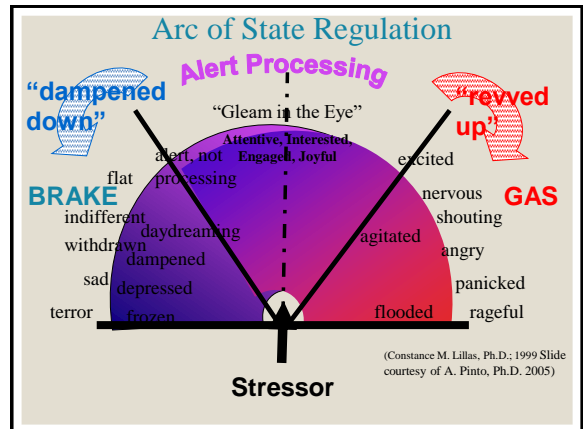
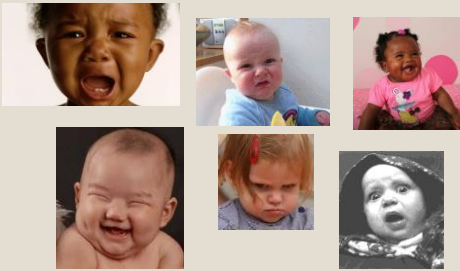


Definition of Infant Mental Health from Zero to Three

- The developing capacity of the child from birth to three to experience, regulate, and express emotions;
- Form close and secure interpersonal relationships;
- Explore the environment and learn
- All within the context of family, community, and cultural expectations for young children

ZERO TO THREE: National Center for Infants, Toddlers and Families

The developing capacity of the child from birth to three to experience, regulate, and express emotions;

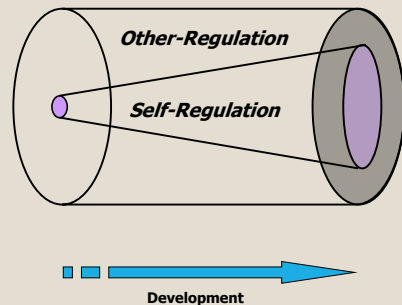


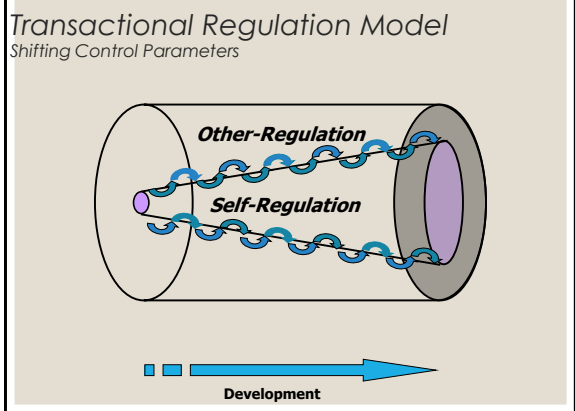
Form close and secure interpersonal relationships;



3. Regulation Model ^(EE)

Slide courtesy of Dr. Jay Browne & Dr. Ayelet Talmi





Definition of Infant Mental Health

- Synonymous with healthy social and emotional development (within the scope of normal development)
- Happy Baby Video

Definition of Infant Mental Health Practice

"Infant mental health clinicians work to

- 1) enhance the development of very young children and
- 2) alleviate their suffering"

Charles Zeanah, M.D., & Paula Doyle Zeanah, Ph.D. [Zero to Three Bulletin](#)

We refer when behavior ...

- Is unusual for the child
- Causes parents & others to see the child as "difficult"
- Makes satisfying interactions difficult
- Is seen in multiple settings by a number of people
- Persists

Parlakian & Seibel, 2002. *Building Strong Foundations.*

Assessment Philosophy

Assessments should include:

- Multiple areas of development
- Individual differences and regulatory patterns
- The quality of the relationship that develops between infants and caregivers
- The context in which the infant lives
 - Family Relationships
 - Family Culture
 - The Immediate Environment – neighborhood, community
 - The Larger Culture

Challenges of Assessment with Infants and Young Children

- There are rapid changes in development
- The “developmental appropriateness” of behaviors changes over time
- The environmental context influences the child's developmental progress

Assess the Infant's Psychological and Developmental Status



- Temperament
- Progress to developmental milestones
- Socio-emotional milestones
- Medical problems, neuropsychological deficits
- Resiliency, strengths, talents

Assess the Quality of Relationships



- Affective tone
- Rhythms, expectancies, contingencies
- Flow, efficacy, coordination
- Comfort seeking, secure base, exploration
- Social referencing, relating to others

Assess the Infant in Context

- Parent's psychologies
 - mental status; psychiatric diagnoses
 - personality issues; substance abuse history
- Family as a care-giving system
- Cultural, community, and ethnicity influences
 - Community Trauma
 - Historical Trauma

Intervention Philosophy

“There is no such thing as a baby – there is a baby and someone.” DW Winnicott

Infant mental health professionals must consider the complexity of infant and family relationships.

Challenges of Diagnosing

- Complexity of early childhood development
- “Labeling”
- Experience of the assessor
- Assess individuals; diagnose disorders

Benefits of Diagnosing

- Speak the same language
- Conduct research
- Provide appropriate services for families
- Diagnostic process and formulation should guide clinical treatment

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R)

Dr. Noelle Hause, EdD, LPC, IMH-E(IV) Clinical
Irving Harris Infant Mental Health Fellow



Original Task Force convened by Zero To Three: National Center for Infants, Toddlers and Families (1987-2003) Purpose:

- To focus on the **first 3-4 years**
- To provide a **developmentally sensitive** diagnostic tool for young children
- To consider the impact of **relationships**
- To consider problems/behaviors **not captured by other classification systems**
- To **complement other systems** (e.g., DSM, ICD)

DC: 0-3R

DC:0-3R

- **AXIS I:**
 - Clinical disorders
- **AXIS II:**
 - Relationship classification
- **AXIS III:**
 - Medical & developmental disorders and conditions
- **AXIS IV:**
 - Psychosocial stressors
- **AXIS V:**
 - Emotional and social functioning

Diagnostic Considerations

- Primary (working) diagnosis
- Rule/out diagnoses
- Co-morbidity (Co-occurring)



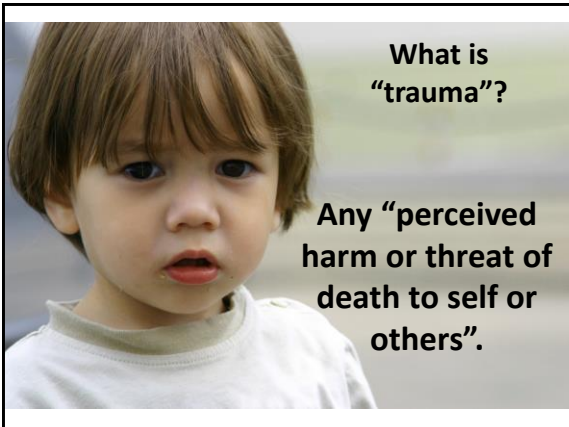
Axis I: Clinical Disorders

- 100 - Posttraumatic Stress Disorder
- 150 - Deprivation / Maltreatment Disorder
- 200 - Disorders of Affect
- 300 - Adjustment Disorder
- 400 - Regulation Disorders of Sensory Processing
- 500 - Sleep Behavior Disorder
- 600 - Behavior Disorder
- 700 - Disorders of Relating & Communicating
- 800 - Other Disorders (DSM or ICD)



AXIS I: 100. POSTTRAUMATIC STRESS DISORDER

Diagnostic Classification: 0-3R



AXIS I: 100. POSTTRAUMATIC STRESS DISORDER

- Symptoms result from a single event, connected series of traumatic events, or chronic, lasting stress
- Child may directly experience or witness an event(s) that involve(s) **actual or threatened** death, serious injury, or threat to the psychological or physical integrity **of the child or others**
- Considerations: child's developmental level, temperament, and caregiver's ability to help the child cope

AXIS I: 100. POSTTRAUMATIC STRESS DISORDER

Must meet all 5 criteria:

1. Exposure to a traumatic event
2. Re-experiencing traumatic event(s) (at least 1) (Example: Post-traumatic play)
3. Numbing of responsiveness or interference with development (Example: Restricted range of affect)
4. Symptoms of increased arousal (Example: Sleep problems)
5. Symptom pattern persists for at least one month

AXIS I: 100. POSTTRAUMATIC STRESS DISORDER

Associated features:

- May temporarily lose previously acquired developmental skills
- Aggressive with peers, adults, or animals
- Fears not present before traumatic event (i.e., separation anxiety, fear of toileting alone)
- Sexual and aggressive behaviors **that are not age-appropriate**

Axis I:150. DEPRIVATION/ MALTREATMENT DISORDER

- Experienced deprivation and maltreatment
- Disturbed & **developmentally inappropriate attachment behaviors**--Child rarely/ minimally turns to attachment figure for comfort, support, protection & nurturance

Three patterns:

1. Emotionally Withdrawn or Inhibited Pattern
2. Indiscriminate or Disinhibited Pattern
3. Mixed Pattern



Diagnostic Classification: 0-3R

AXIS I: 200. DISORDERS OF AFFECT

- 210. Prolonged Grief/Bereavement
- 220. Anxiety Disorders
- 230. Depression of Infancy & Early Childhood
- 240. Mixed Disorder of Emotional Expressiveness

Diagnostic Classification: 0-3R

210. Prolonged Grief/Bereavement



220. Anxiety Disorders

General characteristics of all anxiety disorders

- **Distress**
- **Pervasive** across two or more activities or within two or more relationships Is **uncontrollable**, at least some of the time
- **Impairs** the child's or the family's functioning and/or the child's expected development
- **Persists**

- AXIS 221. Separation Anxiety Disorder
- AXIS 222. Specific Phobia
- AXIS 223. Social Anxiety Disorder
- AXIS 224. Generalized Anxiety Disorder
- AXIS 225. Anxiety Disorder NOS



AXIS I: 300. ADJUSTMENT DISORDER

Must meet all 5 criteria:

- Presence of an environmental stressor(s)
- Disturbance of affect or behavior appears within 1 month
- Does not meet criteria for PTSD, Disorders of Affect, Disorders of Relating & Communicating
- Symptoms persist for more than 2 weeks



Diagnostic Classification: 0-3R

Jared is a 3 year old boy who attends a community child care center. There are 15 children in his class. His teachers report that he has a **difficult time sitting and paying attention in circle time**. When the teachers give the children free time, Jared often **moves from center to center** and usually **avoids the art area and quiet areas**. The teachers describe him as a **risk taker**, as he often **climbs to the top of the playground equipment and jumps to the ground or jumps off of a moving swing**. He has **difficulty taking turns, plays rough with others, and frequently touches his peers**.

At home, his parents describe him as having **frequent temper tantrums, being rough with his baby brother, unable to sit through a meal and accident prone or "reckless"**. Once he gets "worked up" or excited it is **difficult for him to settle down**.

What DSM-V diagnostic criteria does his symptoms fit?

AXIS I: 400. REGULATION DISORDERS OF SENSORY PROCESSING



Diagnostic Classification: 0-3R

AXIS I: 400. REGULATION DISORDERS OF SENSORY PROCESSING

- Difficulties in **regulating emotions/ behaviors** in response to sensory stimulation, *leading to* impairment in development and functioning
- Behavior patterns exhibited across settings and within multiple relationships

7 Sensory Domains:

- | | |
|-------------------------|--|
| • auditory | sound & hearing |
| • visual | sight & light |
| • tactile | touch |
| • proprioceptive | deep pressure, vibration, muscle & joint |
| • vestibular | movement & gravity |
| • olfactory | smell |
| • gustatory | taste |



AXIS I: 400. REGULATION DISORDERS OF SENSORY PROCESSING

- **Requires presence of the following:**
 - Sensory processing difficulties
 - Motor Difficulties
 - Specific Behavioral Pattern
- Three types:
 - 410. Hypersensitive
 - 420. Hyposensitive/ under-reactive
 - 430. Sensory stimulation-seeking/ Impulsive



Axis I: 410. RDSP Hypersensitive

- Aversive responses to sensory stimuli (e.g., light touch, loud noises, bright lights, unfamiliar smells and tastes, rough textures) and/or movement in space
- Two characteristic behavior patterns:
 - Type A: Fearful/Cautious
 - Type B: Negative/Defiant



411: RDSP Type A: Fearful/ Cautious

- **Sensory Reactivity Patterns:**
 - Over-reactivity to sensory stimuli
- **Motor Patterns:**
 - Impacts ability to manipulate/ interact with environment
 - Resulting in functional deficits in motor development
- **Behavioral Patterns:**
 - Excessive cautiousness, inhibition, fearfulness

412. RDSP Type B: Negative/Defiant

- **Sensory Reactivity Patterns:**
 - Over-reactivity to sensory stimuli
- **Motor Patterns:**
 - Same as Type A: Fearful/Cautious
- **Behavioral Patterns:**
 - Tends to avoid or be slow to engage in new experiences and generally is aggressive only when provoked



Axis I: 420. RDSP Hyposensitive/Under-reactive

Child requires sensory input to be engaged, is quiet, watchful and withdrawn.

Sensory Reactivity Patterns:

Under-reactivity to:

- | | |
|--------|----------------|
| sounds | movement |
| smell | taste |
| touch | proprioception |



AND

lack of responsivity to sensation and/or social overtures

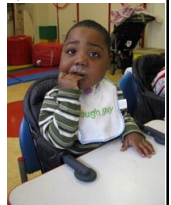
Axis I: 420. RDSP Hyposensitive/Under-reactive, cont

- **Motor Patterns:**

Limited exploration	Restricted play repertoire
Lethargic	Poor motor planning
Clumsy	Repetitive sensory activities

Poorly developed body schema due to under-reactivity to tactile and proprioceptive input
- **Behavioral Patterns:**

Lack of interest in exploring objects, playing games, or engaging in social interactions; apathetic appearance; fatigability; withdrawal from stimuli; inattentiveness



Axis I: 430. RSDP Sensory Stimulation-Seeking/Impulsive

Actively seeking high intensity, frequent input to satisfy sensory needs and to be engaged

• Sensory Reactivity Patterns:

Under-reactivity to:

- | | |
|----------------|----------|
| touch | sound |
| smell | taste |
| proprioception | movement |



craving for high-intensity sensory stimuli, which may lead to destructive or high-risk behaviors

Axis I: 430. RSDP Sensory Stimulation-Seeking/Impulsive

- **Motor Patterns:**
 - High need for motor discharge
 - Diffuse impulsivity
 - Accident prone without clumsiness
- **Behavioral Patterns:**
 - High activity levels
 - Seeks constant contact with people/objects
 - Seeks stimulation through deep pressure
 - Recklessness; disorganized behavior as a consequence of sensory stimulation



Jared is a 3 year old boy who attends a community child care center.

There are 15 children in his class. His teachers report that he has a **difficult time sitting and paying attention in circle time (high need for motor discharge)**. When the teachers give the children free time, Jared often **moves from center to center (disorganized behavior as a consequence of sensory stimulation)** and usually **avoids the art area and quiet areas (craving for high intensity sensory stimulus)**. The teachers describe him as a **risk taker (craving for high intensity sensory stimulus)**, as he often **climbs to the top of the playground equipment and jumps to the ground or jumps off of a moving swing (recklessness, daring)**. He has **difficulty taking turns, plays rough with others (aggressive, preoccupied with aggressive themes in pretend play)**, and frequently **touches his peers. (seeking constant contact with people and objects)**.

At home, his parents describe him as having **frequent temper tantrums, being rough with his baby brother (aggressive), unable to sit through a meal (high need for motor discharge, diffuse impulsivity) and accident prone or "reckless" (accident prone)**. Once he gets "worked up" or excited it is **difficult for him to settle down may be excitable, disorganized behavior as a consequence of sensory stimulation)**.

Based on this description, what diagnosis might you consider?

AXIS I: 500. SLEEP BEHAVIOR DISORDER

Only use for problems **after 12 months of age**, once stable sleep patterns emerge

510. Sleep-Onset Disorder

520. Night-Waking Disorder



Axis I: 600. Feeding Behavior Disorder

6 subcategories:

- 601 Feeding Disorder of **State Regulation**
- 602 Feeding Disorder of **Caregiver-Infant Reciprocity**
- 603 Infantile Anorexia
- 604 Sensory Food Aversions
- 605 Feeding Disorder Associated with Concurrent Medical Condition
- 606 Feeding Disorder Associated with **Insults to the Gastrointestinal Tract**



AXIS I: 700. DISORDERS OF RELATING AND COMMUNICATING

Referred to as Pervasive Developmental Disorders

Axis I: 710. Multi-system Developmental Disorder (MSDD)

- MSDD does not require the range of difficulties observed in children with Autistic Disorder
- MSDD overlaps with DSM-IV TR categories of PDD-NOS and the recent concept of the broader autistic phenotype
- MSDD retained as a DC:0-3R classification *only to be used for children under age two years*
- If a child under age 2 clearly meets criteria for a DSM-V PDD diagnosis, the DSM-V criteria should be used

Axis I: 800. Other Disorders (DSM-IV TR or ICD 10)

Should be used for other mental health-related classifications not found in DC: 0-3R that are found in DSM-V.

Axis I: Clinical Disorders

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- 200 Disorders of Affect
- 300 Adjustment Disorder
- 400 Regulation Disorders of Sensory Processing
- 500 Sleep Behavior Disorder
- 600 Feeding Behavior Disorder
- 700 Disorders of Relating & Communicating
- 800 Other Disorders (DSM or ICD)

Considerations

Are symptoms generalized across settings? and relationships? or specific to a particular situation or relationship?

The same symptoms can be characteristic of different diagnosis. This is important because different diagnosis require different types of intervention.

How is development impacted? May temporarily lose previously acquired developmental skills.

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R)

Sue Ammen, Ph.D., IFECMH-SP/Mentor

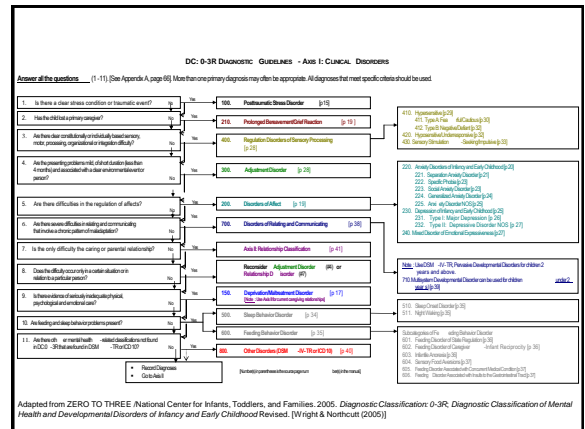


Diagnostic Decision Tree

- See Appendix A, page 66
- Answer all the questions 1-11.
- More than one primary diagnosis may often be appropriate. All diagnoses that meet specific criteria should be used.

When the Bough Breaks - Kallen

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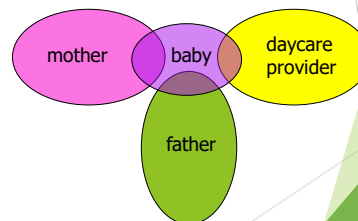
Diagnostic Classification: 0-3R AXIS II: RELATIONSHIP CLASSIFICATION

Observing Parent-Child Relationships



Axis II: Relationship Classification

Infants often have relationships with more than one caregiver.



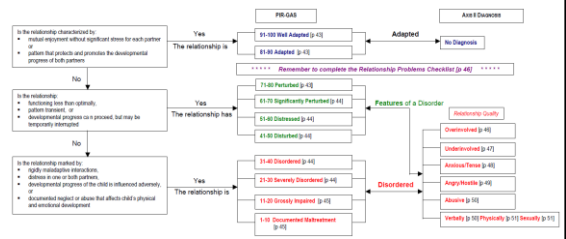
Parent-Child Relationship

- Two tools to determine Relationship Classifications
 - Parent-Infant Relationship Global Assessment Scale (PIR-GAS)
 - Relationship Problems Checklist (RPCL)
- PIR-GAS is a Global Assessment
 - Adaptability & Flexibility
- RPCL Classification (problems)
 - Level of Involvement
 - Emotional Quality of Interaction
 - Abuse & Neglect



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DC: 0-3R DIAGNOSTIC GUIDELINES – AXIS II: RELATIONSHIP CLASSIFICATION



Adapted from DSM-5 (© 2013) (© 2013). Diagnostic classification of mental health and developmental disorders of infancy and early childhood. Revision 3.0 (© 2013). Washington, DC: Zero to Three Press.
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PIR-GAS: Adaptability & Flexibility

- Parent
 - Ability to adapt to changing developmental needs of infant
- Parent-Infant
 - Degree to which challenges to relationship are transient
- Infant
 - Ability to respond flexibly to parent's efforts



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Parent Infant Relationship Global Assessment Scale (PIR-GAS)

- 91-100 Well adapted
- 81-90 Adapted
- 71-80 Perturbed
- 61-70 Significantly perturbed
- 51-60 Distressed
- 41-50 Disturbed
- 31-40 Disordered
- 21-30 Severely disordered
- 11-20 Grossly impaired
- 1-10 Documented maltreatment



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DC: 0-3R DIAGNOSTIC GUIDELINES - AXIS II: RELATIONSHIP FUNCTIONING

Parent Infant Global Assessment Scale (PIRGAS Rating)	Relationship Ratings for Each Caregiver						
	A	B	C	D	E	F	G
Overtly involved							
Underinvolved							
Anxious / Tense							
Angry / Hostile							
Verbally (Psychologically) Abusive							
Physically Abusive							
Sexually Abusive							

Rating	Description	Caregiver List	
		Name	Relationship
91-100	Well Adapted	A	
81-90	Adapted	B	
71-80	Perturbed	C	
61-70	Significantly Perturbed	D	
51-60	Distressed	E	
41-50	Disturbed	F	
31-40	Disordered	G	
21-30	Severely Disordered		
11-20	Grossly Impaired		
1-10	Documented Maltreatment		

Relationship Problems Check List (RPCL)

Observe...



- Behavioral quality of the interaction
- Affective tone
- Psychological involvement

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Axis II: Relationship Classification



- Over involved
- Under involved
- Anxious/Tense
- Angry/Hostile
- Abusive
 - Verbally Abusive
 - Physically Abusive
 - Sexually Abusive

Level of Involvement

- ▶ Genuine Involvement
- ▶ Over-involvement
- ▶ Under-involvement



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Genuine Involvement

- ▶ Parent
 - ▶ Responsive to child's cues, supporting infant's goals and desires
 - ▶ Comforts & protects infant
 - ▶ Scaffolds infant's learning
- ▶ Parent-Infant
 - ▶ Interactions are mutually enjoyable
- ▶ Infant
 - ▶ Appears easily regulated



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Overinvolved

Physical or psychological over-involvement

- ▶ Parent
 - ▶ Dominates, interfering with infant's goals & desires
 - ▶ Makes developmentally inappropriate demands
- ▶ Infant
 - ▶ Appears diffuse, unfocused, or undifferentiated
 - ▶ Displays submissive, overly compliant behaviors or defiant behaviors
 - ▶ May lack motor skills or language expressiveness



Underinvolved

Sporadic or infrequent genuine involvement

- ▶ Parent
 - ▶ Insensitive or unresponsive
 - ▶ Ignores, rejects, or fails to comfort infant
 - ▶ Does not protect infant adequately
 - ▶ Misses or misinterprets child's cues
 - ▶ Inconsistency between expressed attitude about infant & quality of interaction
- ▶ Parent-Infant
 - ▶ Interactions are disengaged
- ▶ Infant
 - ▶ Appears physically or psychological uncared for
 - ▶ Delayed or precocious motor and language skills



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Emotional Quality of Interaction

- ▶ Mutual Engagement
- ▶ Anxious & Tense
- ▶ Angry & Hostile



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Mutual Engagement

Relaxed, mutually enjoyable interaction

- ▶ Parent
 - ▶ Regulates child's physical & emotional experience
- ▶ Parent-Infant
 - ▶ Emotional reciprocity
 - ▶ Able to repair mistakes
- ▶ Infant
 - ▶ Explores environment, referencing parent in new situations
 - ▶ Seeks help from parent



Anxious & Tense

Tense, constricted, with little sense of relaxed enjoyment or mutuality

- ▶ Parent
 - ▶ Heightened sensitivity to infant's cues
 - ▶ Expresses frequent concerns of infant, may appear overprotective
 - ▶ Awkward & tense handling of infant
 - ▶ Some verbally or emotionally negative interactions
- ▶ Parent-Infant
 - ▶ Poor fit between parent expectations & who the child is
- ▶ Infant
 - ▶ Unusually compliant & anxious



Angry & Hostile

Harsh & abrupt, often lacking emotional reciprocity

- ▶ Parent
 - ▶ Insensitive to infant cues, may view child as demanding
 - ▶ Abrupt handling of infant
 - ▶ May taunt or tease child
- ▶ Infant
 - ▶ Frightened, anxious, inhibited, impulsive, or diffusely aggressive
 - ▶ Defiant or resistant
 - ▶ Demanding or aggressive behaviors
 - ▶ Fearful, vigilant, and avoidant behaviors
 - ▶ Tendency towards concrete behavior



Abuse & Neglect

- ▶ Neglect
- ▶ Verbal or Emotional Abuse
- ▶ Physical Abuse
- ▶ Sexual Abuse
- ▶ Domestic Violence



Neglect

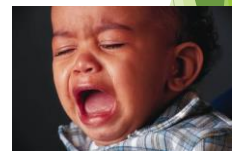
failure to provide basic care: food, clothing, shelter, medical care, protection

- ▶ Parent
 - ▶ Insensitive to infant's cues
 - ▶ Unresponsive, fails to comfort infant
 - ▶ Does not protect infant adequately
 - ▶ Does not provide basic care
- ▶ Parent-Infant
 - ▶ Interactions are disengaged
- ▶ Infant
 - ▶ Appears physically or psychologically uncared for
 - ▶ Delayed or precocious motor and language skills

Verbally Abusive

Severe abusive emotional content, unclear boundaries, overcontrol by parent

- ▶ Parent
 - ▶ Content of verbal or emotional abuse severely belittles, blames, attacks, controls, or rejects child
- ▶ Infant
 - ▶ Varied response: constricted affect to vigilance to severe acting out behaviors



Physically Abusive

Severe physical abuse, unclear boundaries, over-control by parent

▶ Parent

- ▶ Physically harms child
- ▶ Regularly fails to meet infant's essential needs (food, medical care, opportunity to rest)

▶ Infant

- ▶ Varied response: constricted affect to vigilance to severe acting out behaviors



Sexually Abusive

Lack of regard for physical boundaries; extreme sexual intrusiveness

▶ Parent

- ▶ Sexually seductive & overstimulating behavior with infant, in order to gratify parent's sexual needs

▶ Infant

- ▶ May exhibit sexually driven behaviors (exposing self, touching self or others)

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Axis II: Relationship Classification

Relationship Problems Checklist (RPCL)

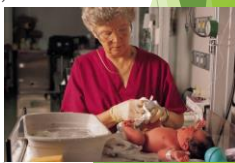
Relationship Quality	No Evidence	Some Evidence; Needs further investigation	Substantial Evidence
Overinvolved		✓	
Underinvolved			✓
Anxious / Tense		✓	
Angry / Hostile			✓
Verbally Abusive		✓	
Physically Abusive	✓		
Sexually Abusive	✓		

Diagnostic Classification: 0-3R

AXIS III: MEDICAL AND DEVELOPMENTAL DISORDERS AND CONDITIONS

Axis III: Medical & Developmental Disorders & Conditions

- ▶ Physical, medical, neurological, developmental diagnoses from other diagnostic systems, including specific classifications used by
 - ▶ speech/language pathologists,
 - ▶ occupational therapists,
 - ▶ physical therapists,
 - ▶ special educators, and
 - ▶ primary health providers



Medical & Developmental Disorders & Conditions

▶ Special Considerations

- ▶ Premature birth
- ▶ Prenatal drug exposure
- ▶ Heart or lung problems
- ▶ Gastrointestinal problems
- ▶ Head trauma or loss of consciousness
- ▶ Anoxia (loss of oxygen)
- ▶ Vision problems
- ▶ Ear infections or hearing problems



Medical & Developmental Disorders & Conditions

- ▶ Important to note because:
 - Symptoms of mood disorder may be due to endocrine disorders
 - Abrupt onset irritability, restlessness or motor coordination difficulties may be due to heavy metal toxicity
 - Abrupt onset obsessions or compulsions may be due to PANDAS (associated with strep)
 - Irritability, frustration, behavioral dysregulation may be due to hearing / speech / language problems

Axis IV: Psychosocial Stressors

- ▶ Identify / evaluate psychosocial & environmental stressors that influence symptoms and disorders in children
- ▶ Impact of a stressful event or enduring stress depends on:
 - ▶ Severity of stressor
 - ▶ Developmental level of child
 - ▶ Availability and capacity of caregivers

Axis IV: Psychosocial Stressors

- ▶ Severity of stressor
 - ▶ Duration
 - ▶ Suddenness of initial stress
 - ▶ Frequency
 - ▶ Unpredictability of recurrence



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Axis IV: Psychosocial Stressors

- ▶ Developmental level of child
 - ▶ Chronological age
 - ▶ Social emotional history
 - ▶ Biological vulnerability to stress
 - ▶ Ego strength



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Axis IV: Psychosocial Stressors

- ▶ Availability & capacity of caregiver
 - ▶ To act as buffer
 - ▶ To help child understand
 - ▶ To cope with stressor



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Psychosocial and Environmental Stressor Checklist (Sample Version)

(Complete information for all stressors that apply)

	Age of Onset (in months)	Comments, including duration and severity
Challenges to child's primary support group		
<ul style="list-style-type: none"> • Birth of a sibling • Death of a parent • Domestic violence 		
Challenges in the social environment		
<ul style="list-style-type: none"> • Inadequate social support for the family • Single parenting 		
Educational / Child care challenges		
<ul style="list-style-type: none"> • More than 9 hours/day in out-of-home care • Multiple changes in child care provider 		
Housing Challenges Economic Challenges Occupational Challenges Health-care Access Challenges		Health of Child Legal/Criminal Justice Challenges Other Challenges and Stressors

Diagnostic Classification: 0-3R

AXIS V: EMOTIONAL AND SOCIAL FUNCTIONING

Axis V: Emotional and Social Functioning

- ▶ Reflects child's emotional and social functioning with important caregivers, in relation to expectable patterns of development
- ▶ Capacities for Emotional and Social Functioning Rating Scale:
 - ▶ Attention and regulation (birth - 3 mos.)
 - ▶ Mutual engagement (3 - 6 mos.)
 - ▶ Intentional two-way communication (4 - 10 mos.)
 - ▶ Complex gestures & problem solving (10 - 18 mos.)
 - ▶ Symbols express thoughts & feelings (18 - 30 mos.)
 - ▶ Connecting symbols, abstract thinking (30 - 48 mos.)

Axis V: Emotional and Social Functioning

- ▶ Observe the play & interaction with each caregiver
- ▶ Rate each of the capacities:
 1. Functions at age level; full range of affect
 2. At age level, but is vulnerable to stress or has constricted range of affect
 3. Functions immaturely; has capacity but not at age level
 4. Functions inconsistently or intermittently unless special structure/support is provided
 5. Barely demonstrates capacity, even with support
 6. Has not achieved capacity

DC: 0-3R DIAGNOSTIC GUIDELINES - AXIS V: EMOTIONAL AND SOCIAL FUNCTIONING

Observe the quality of the infant or young child's play with each of the significant people in his or her life then choose the rating that best fits the child's functioning with respect to each of the capacities listed below in interaction with each caregiver. Primary caregivers may be biological, foster, and adoptive parent(s), as well as grandparents, members of the extended family, and caregivers outside the family.

Emotional and Social Functioning Capacities	Functioning Rating (1-6, 0 for Lack of Capacity)							
	A	B	C	D	E	F	G	H
Attention and regulation (p. 63) From: Does the infant notice and attend to what is going on in the world through all the senses? To: Does the infant stay sufficiently regulated to attend and interact, without over or under-reading to external or internal stimuli? <i>(Typically observable between birth to 3 months)</i>								
Forming relationships/mutual engagement (p. 65) From: Does the infant develop a relationship with an emotionally available caregiver for soothing, security and pleasure? To: Is the child able to experience the full range of positive and negative emotions while remaining engaged in a relationship? <i>(Typically observable between 3 and 6 months)</i>								
Intentional two-way communication (p. 65) From: Does the infant use simple gestures, including purposeful demonstrations of affect, to start reciprocal "conversations"? To: Does the parent/child use a simple sequence of gestures? <i>(Typically observable between 4 to 10 months)</i>								
Complex gestures and problem solving (p. 65) From: Has the toddler learned how to use emerging motor skills and language to get what he needs or wants? To: Does the parent/child use words as well as gestures for communication and problem solving? <i>(Typically observable between 10 and 18 months)</i>								
Use of symbols to express thoughts and feelings (p. 65) From: Does the child begin to use play and language to express thoughts, ideas, and feelings through symbols? To: Does the child project her own feelings onto the characters and actions of her imaginative play? <i>(Typically observable between 18 and 30 months)</i>								
Connecting symbols logically, abstract thinking (p. 65) From: Does the child connect and elaborate sequences of ideas logically and use logically interconnected ideas in conversation? To: Does the child understand abstract concepts, reflect on feelings, and articulate lessons that he has learned from an experience? <i>(Typically observable between 30 and 48 months)</i>								

Notes	Caregiver List		
	Name	Relationship	
1. Not applicable: Child is below the age level normally expected to have achieved.	A		
2. Not applicable: Child is vulnerable to stress or constricted range of affect or both.	B		
3. Functions well but the capacity is not at an age appropriate level.	C		
4. Functions immaturely unless special structure or environment support is available.	D		
5. Barely demonstrates this capacity.	E		
6. Has not achieved this level.	F		
7. Not applicable: Child is below the age level normally expected to have achieved.	G		

Adapted from ZERO TO THREE (National Center for Infants, Toddlers, and Families, 2005, Diagnostic Classification: 0-3R; Diagnostic Classification of Aberrant Health and Developmental Disorders of Infancy and Early Childhood/Revised, (Wright & Norhout, 2008))

Think of a Child



ZERO TO THREE Information

- ▶ DC: 0-3R and DC:0-3 Casebook as well as other related publications may be ordered
- ▶ www.zerotothree.org (Bookstore)