
DISRUPTIVE BEHAVIOR IN THE VERY YOUNG CHILD: *DIAGNOSTIC CLASSIFICATION: 0–3* GUIDES IDENTIFICATION OF RISK FACTORS AND RELATIONAL INTERVENTIONS

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ABSTRACT: The high prevalence of disruptive behavior in children, ages 0–4 years old, who present to early childhood psychiatry clinics, and the urgency of intervening early are focusing our attention on how to identify specific risk factors and guide relational intervention. *Diagnostic Classification: 0–3 (DC: 0–3)* has been found to be helpful in this work. Preliminary data from the first 64 children, who presented to the Early Development Program with a primary concern of disruptive behavior, was collected using a standardized assessment protocol, the *Diagnostic and Statistical Manual, Fourth Edition (DSM IV)* and the *DC: 0–3*. Descriptive, correlational, and group comparison data suggest that *DC: 0–3*'s Axis I and II and the Parent–Infant Relationship Global Assessment Scale (PIR-GAS) help to identify specific biopsychosocial risk factors, especially regarding the quality and nature of the parent–child relationship. A brief case is presented to illustrate how the *DC: 0–3*, used in conjunction with standardized assessment tools, guides relational intervention strategies. The development of behavioral difficulties in young children has become an expanding focus of empirical investigation and theory formulation. The high prevalence of disruptive behavior (84% of children ages 0–4 years old who present to the Early Development Program), the associated intense frustration and concern families experience, and the urgency to intervene early are focusing our attention on the use of diagnostic and assessment tools that can guide case formulations and intervention approaches.

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RESUMEN: El alto predominio de conductas de rompimientos en niños de 0–4 años, quienes se presentan a su temprana niñez a clínicas psiquiátricas, y la urgencia de intervenir a tiempo y preventivamente llevan nuestra atención a cómo identificar factores específicos de riesgo y cómo guiar esta intervención de parentesco para este grupo heterogéneo de niños pequeños. *Clasificación de diagnóstico: 0–3 (DC: 0–3) De Cero a Tres, 1994*) ha sido de gran ayuda en este trabajo. La información preliminar de los primeros 64 niños, de 0–4 años, que se presentaron al Programa de Desarrollo Temprano, una clínica psiquiátrica para la temprana niñez, con una primaria preocupación de conducta de rompimiento, fue recogida usando un protocolo de evaluación estandarizado, instrumentos estandarizados, el *Manual de diagnóstico y estadística, cuarta edición (DSM IV)*, y *DC: 0–3*. La información descriptiva, de coparentesco y de grupo sugiere que los Ejes I y II de *DC: 0–3* y la Escala global de evaluación padre/madre-infante relación (PIR-GAS) ayudan a identificar específicos factores biosociales de riesgo, especialmente en relación con la calidad y la naturaleza de la relación paterno/maternal-infantil dentro de la cual el niño se desarrolla. Se presenta un caso breve para mostrar cómo *DC: 0–3*, usado en conjunto con herramientas extendidas de evaluación, guía las estrategias de la intervención de parentesco. El desarrollo de dificultades de conducta en niños jóvenes se ha convertido en un expandido punto de atención de la investigación empírica y de la formulación de teorías. El alto predominio de conductas de rompimiento (84% de los niños de 0–4 años que se presentan al Programa de Desarrollo Temprano), la experiencia de intensa frustración y preocupación familiar que se asocia con esa conducta, y la urgencia de una temprana y preventiva intervención están enfocando nuestra atención en el uso de las herramientas de evaluación que pueden guiar nuestras formulaciones de casos y acercamientos de intervención.

RÉSUMÉ: La grande fréquence de comportements perturbateurs chez les enfants, âgés de 0–4 ans, présentés dans des cliniques de psychiatrie de la petite enfance, et le besoin urgent qu'il y a à intervenir tôt et de façon préventive nous obligent à tourner notre attention sur la manière d'identifier les facteurs de risque et de guider une intervention relationnelle pour ce groupe hétérogène de jeunes enfants. La Classification Diagnostique: 0–3 (DC: 0–3) (Zéro à Trois, 1994) s'est avérée être utile pour ce travail. Les données préliminaires des 64 premiers enfants présentés au Programme de Développement Précoce pour troubles perturbateurs du comportement ont été rassemblées en utilisant une protocole d'évaluation standardisé, le *Manuel Diagnostique et Statistique, Quatrième édition (DSM IV)* et le *DC: 0–3*. Les données descriptives, corrélationnelles et de comparaison de groupe suggèrent que l'Axe I et II du *DC: 0–3* et l'Echelle d'évaluation globale parent-bébé ("Parent-Infant Relationship Global Assessment Scale—PIR-GAS, en anglais) aident à identifier des facteurs spécifiques de risque biopsychosocial, surtout en ce qui concerne la qualité et la nature de la relation parent-enfant. Un bref cas est présenté pour illustrer la manière dont le *DC: 0–3*, utilisé en conjonction avec des instruments d'évaluation standardisés, guide les stratégies d'intervention relationnelle. Le développement des difficultés de comportement chez les jeunes enfants est devenu un centre de plus en plus important d'attention de recherches empiriques et de formulation de théorie. La grande fréquence de comportement perturbateur (84% des enfants d'âge 0–4 ans présentés au Programme de Développement Précoce), la frustration intense associée à ce comportement et l'expérience des familles concernées, et enfin le besoin urgent d'intervenir tôt nous forcent à porter notre attention sur l'utilisation des instruments d'évaluation qui peuvent guider nos formulations de cas et nos approches de l'intervention.

ZUSAMMENFASSUNG: Die große Anzahl von Kinder, die wegen expansiven Verhaltensstörungen im Alter von 0–4 Jahren in kinderpsychiatrischen Ambulanzen vorgestellt werden, sowie die Dringlichkeit einer frühen und vorbeugenden Intervention zwingen uns, uns auf die Identifikation der spezifischen Risikofaktoren zu konzentrieren und entsprechende Eingriffe durchzuführen. Die diagnostische Klassifikation: 0–3 ((DC: 0–3) Zero to Three, 1994 Deutsche Übersetzung im Springer Verlag, 1998) war für diese Arbeit hilfreich. Es werden vorläufige Daten der ersten 64 Kindern dargestellt, die 0–4 Jahre alt waren und mit dem Vorstellungsgrund der expansiven Verhaltensstörung dem Frühentwicklungsprogramm, einer psychiatrische Ambulanz, vorgestellt wurden. Die Daten wurden mittels einer standardisierten diagnostischen Prozedur, standardisierten Instrumenten, dem diagnostischen und statistischen Manual der amerikanischen, psychiatrischen Gesellschaft in der 4. Auflage (DSM IV) und dem *DC: 0–3* erhoben. Deskriptive, korrelierende und Gruppenvergleichsdaten weisen darauf hin, daß die 1. und 2. Achse und

die Eltern-Kleinkind Beziehung globale Einschätzungsskala (PIR-GAS), helfen mit bio-psychoziale Risikofaktoren einzuschätzen, insbesondere die Qualität und die Art der Eltern-Kind Beziehung in der das Kind aufwächst. Eine kurze Falldarstellung wird dazu verwendet, um zu zeigen wie DC: 0-3 in Verbindung mit den standardisierten Diagnoseinstrumenten verwendet wird und wie dadurch entsprechende Interventionen gesteuert werden. Der Entwicklung von Verhaltensschwierigkeiten bei Kleinkindern wurde wachsendes Interesse der empirischen Forschung und der Theoriebildung zuteil. Die Häufigkeit der expansiven Verhaltensstörung (84% der Kinder zwischen 0 und 4 Jahren, die in der Ambulanz für Frühentwicklung vorgestellt wurden), die damit verbundene intensive Frustration und Sorge in der Familie, die Dringlichkeit früh und präventiv zu intervenieren, zwingen uns zu vermehrten Konzentration durch die Verwendung von Diagnosehilfsmitteln, die unsere diagnostische Formulierung und die Intervention anleiten können.

抄録：幼児精神医学クリニックに来る 0-4歳児に破壊的行動がよく見られ、早期かつ予防的介入を緊急に必要とすることから、われわれは、このヘテロジナスな小児群に関し、特定のリスク要因をいかに同定し、関係的介入をいかに手引きしたらよいかに焦点を合わせて来た。Diagnostic Classification:0-3(DC:0-3, 1994) は、この作業を進める上で役に立った。幼児精神医学クリニックであるEarly Development Program へ破壊的行動を主問題として訪れた 0-4歳児64名に関し、標準化された評価プロトコル、標準化された評価法、DSM-IV, DC:0-3を使い、予備的データを集めた。記述的、相関的、グループ比較データによれば、DC:0-3の第1, 2軸とParent-Infant Global Assessment Scales (PIR-GAS)は、特定の生物・心理・社会的リスク要因、特に、幼児が育った親子関係の質と性状を同定する助けとなる。標準化された評価法と合わせてDC:0-3を使うことにより、いかに関係性介入戦略を導けるかを示すため、短い症例をあげた。幼児の行動上の問題の展開が、最近、経験的検索と理論的定式化の大きな焦点となっている。破壊的行動の頻度の高さ (Early Development Program を訪れる 0-4歳児の84%)、それを巡って家族が体験する強烈なフラストレーションと気掛かり、そして、早期かつ予防的介入の緊急性ゆえに、われわれは、症例の定式化と介入アプローチを導いてくれる、評価法の使い方に焦点を合わせている。

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The development of behavioral difficulties in young children has become an expanding focus of empirical investigation and theory formulation (Campbell, 1995; Fonagy, 1996; Jensen et al., 1997). The high prevalence of disruptive behavior (84% of children ages 0 to 4 years old who present to the Early Development Program [EDP]), the associated intense frustration and concern families experience, and the urgency of intervening early and preventively are focusing our attention on the use of diagnostic and assessment tools that can guide our case formulations and intervention approaches. Because the parent-child relationships within which these children are developing provide the most powerful protective opportunity (Lieberman & Zeanah, 1995; Werner & Smith, 1982), we especially focus on relational intervention.

Understanding the nature and quality of the parent-child relationship within which the young child is developing plays an important role in formulating a diagnostic profile and focusing intervention strategies. Recent integration of theory and research suggest that, as a young child incorporates a "schema of being with" a primary caregiver, the composite experience (Stern, 1995) is recorded by the brain with the creation of synaptic pathways, reinforced by repetition in a "use dependent" way (Perry, Pollard, Blakley, Baker, & Vigilante, 1995), creating the organizational template for the young child's future development.

It is recognized that the young child's sense of self and sense of self in relationship to others develops within the social-emotional matrix of the parent-child relationship (Winnicott, 1965; Stern, 1985). Sameroff and Emde (1989) underscored the strength and importance of relationships in the life of a young child, stating that the "relationship frames all individual experience" (p. 34). Lieberman and Zeanah (1995) emphasize the importance of the primary attachment relationship as a risk and protective factor in the promotion of the young child's mental health. Fraiberg, Adelson, and Shapiro (1975) have described "ghosts" of unrecognized

or unresolved conflictual childhood experiences of being parented that may translate into compromised parenting often characterized by attribution of negative intention to their young child's behavior (Clark, Seidl, & Paulson, 1997).

Recent research by Oppenheim, Emde, and Warren (1997) underlines the importance of the early experience of parent-child relationships in children with behavioral difficulties. They show that in a nonclinical group of 4- and 5-year-olds, the narrative stories of children with more parent-reported behavioral symptoms reflect schemas of their mother figures as less positive, less able to provide discipline, and more negative than do those of children with fewer parent-reported behavioral symptoms.

The caregiving environment provides the relational matrix in which the young child's biological potential dynamically unfolds and becomes encoded in the brain (Perry et al., 1995). Development progresses in the ongoing transactions between the mutually influencing determinants of biology, caregiving and attachment quality, and the child's experience of self and other within the relational matrix of family, community, and culture.

METHOD

Sample

The preliminary results described below are based on the 64 children who presented to the EDP between November, 1990 and March, 1996 with disruptive behavior as a primary concern. Of the 64 children presenting with disruptive behavior, 61% presented with behavioral difficulties only and 39% presented with behavioral difficulties and delays. Those children presenting with behavioral difficulties alone or with behavioral difficulties and delay included 8% between the ages of 12 and 23 months, 42% between the ages of 24 and 35 months, and 50% between the age of 36 and 47 months. Twenty-eight percent were girls and 72% boys.

Referral sources, ethnicity, payor mix, maternal education, and marital status of children presenting with disruptive behaviors and their families approximate the hospital demographics. Referral sources include 54% from pediatrics or pediatric subspecialists, 22% from psychiatry or psychology together, 16% from social work, education or speech and language specialists, and 8% from self-referral. The children who presented with disruptive behavior were 64% Caucasian, 25% African-American, 5% Latino and 5% multiracial. Sixty-seven percent were insured by Medicaid and 33% were insured by private insurance or HMOs. Twenty-three percent of the mothers had completed less than a high school education; 39% had completed high school; 14% had completed some college; 11% had completed college or college and some graduate work; and the educational status of the others was unknown. Thirty-three percent of the children had parents who were never married; 45% had parents who were married; 19% had parents who were separated or divorced; and the marital status of the others was unknown.

Procedure

The assessment and intervention approaches presented here were developed in two clinical, training and research programs that the authors direct. Data were collected from the EDP, based in the Department of Child and Adolescent Psychiatry within Cardinal Glennon Children's Hospital, an urban training site of St. Louis University School of Medicine. Many of the relational assessment and intervention approaches were developed in the Parent-Infant and Early Childhood Clinic (PIECC), based in the Department of Psychiatry, University of Wisconsin Medical School. A brief description of the EDP assessment/intervention process, which utilizes many of these approaches and the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3)* (Zero to Three, 1994),

frames how we are addressing diagnosis and relational intervention with young children and their families.

Assessment/intervention is conceptualized as a unified process and is an evolving collaboration with the family in an effort to establish a mutual understanding of core concerns and to facilitate relationships that support the child's healthy development. The process begins with a 2-hour videotaped initial evaluation session, which includes a family interview that explores the family's explicit and implicit concerns and expectations of the child and his or her behavior and structures observation of parent-child interactions during the interview and in family and parent-child play sessions, using the Parent-Child Early Relational Assessment (PCERA) (Clark, 1985). (American Academy of Child and Adolescent Psychiatry, 1997; Clark, Paulson, & Conlin, 1993; Thomas, Guskin, & Klass, 1997.)

During the second session, often using videotape vignettes of the first session as a stimulus for discussion, the clinician explores with the parents the behavioral, affective, and perceptual aspects of the parent-child relationship, including the meaning of the child and his or her behavior to the parents (Clark et al., 1993b). Together the parents and clinician begin thinking through possible approaches to elicit and support more functional behavior and enhance the quality of the parent-child relationship. Further assessment/intervention sessions are scheduled as needed with the parents, specific parent-child dyads, and the entire nuclear family or extended family. Additional developmental assessments of hearing, speech and language, motor, sensory-motor, or cognitive functioning are also often needed.

Measures

Standardized measures that support clinical inquiry include: The *Child Behavior Checklist for Ages 2-3* (CBCL 2-3) (Achenbach, Edelbrock, & Howell, 1987), a commonly used parent-report symptom checklist with 99 problem behaviors that parents endorse as "Very True or Often True," "Somewhat or Sometimes True," or "Not True" over the past 2 months. When scored, the CBCL yields a total problem behavior score and six subscale scores, for example, Anxious/Depressed and Aggressive Behavior.

The Parent-Child Early Relational Assessment (PCERA) (Clark, 1985) has both objective and subjective components and uses videotape ratings to assess the affective and behavioral quality of the parent-child interaction. It includes 65 parent, child, and dyadic items and a video replay interview with parents to focus on areas of concern and areas of strength in the parent-child relationship (Clark et al., 1993b).

The diagnostic profile is developed using: *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-3) (Zero to Three, 1994) as an extension of the *Diagnostic and Statistical Manual, Fourth Edition (DSM-IV)* (APA, 1994). DC: 0-3 offers empirically derived, more age-appropriate descriptions of symptoms found in children under age 4 years. In addition, DC: 0-3, especially Axis I, Primary Diagnosis, and Axis II, Relationship Classification, used in conjunction with the Parent-Infant Relationship Global Assessment Scale (PIR-GAS), organizes clinical observations of specific biopsychosocial risk and protective factors that appear associated with the development of behavior problems in young children. These include environmental and socioeconomic stressors, constitutional and maturational difficulties, and parent-child relationship difficulties and strengths helpful in guiding intervention with the heterogeneous group of young children presenting with disruptive behaviors (Zero to Three, 1994).

DC: 0-3 is an evolving system of classification intended as an extension of the *DSM-IV* (APA, 1994). The multiaxial system includes five axes designed to focus attention on key aspects of the child's experience. In this paper we focus on our use of Axes I and II. Axis I,

Primary Diagnosis, describes the disorder within the child, the internal experience of distress and/or the dysfunctional expressed behavior. Axis II, Relationship Classification, describes the behavioral quality, affective tone, and psychological aspects of the relationship of the child with one or more primary caregivers (Zero to Three, 1994).

Axis I, the Primary Diagnosis, (Table 1) includes five diagnostic groups that we have empirically found most helpful in describing very young children who present to the EDP with disruptive behaviors: Traumatic Stress Disorder (100), Disorders of Affect (200), Adjustment Disorder (300), Regulatory Disorders (400) and Disorders of Relating and Communicating (700). Regulatory Disorders, a new construct that arises out of clinical and research experience (DeGangi, DiPietro, Greenspan, & Porges, 1991; DeGangi, Porges, Sickel, & Greenspan, 1993), describes the subset of young children whose behavioral difficulties appear to arise primarily from their constitutional and maturational delays and processing difficulties. In this paper, we focus on the three most common Axis I diagnoses, which best describe young children presenting to the EDP with disruptive behaviors.

Traumatic Stress Disorder (100), recognizes symptoms arising from ongoing trauma, not just from past trauma. Traumatic Stress Disorder requires an identified trauma (experienced or witnessed, actual or threatened injury to self or other). In addition, the diagnosis requires symptoms lasting at least 1 month in each of four categories: re-experiencing, numbing of responsiveness, increased arousal, and new fears or aggression (Zero to Three, 1994).

Disorders of Affect (200) focuses on the child's ongoing difficulties experiencing and expressing developmentally appropriate emotions. The child's affective symptoms often present as interactive difficulties that arise in the context of a child's relationship with a primary caregiver. These interactive difficulties have generalized over time and situation to characterize the child's interactive style and expectations of self and of external relationships. Several Disorders of Affect are useful in diagnosing children with disruptive behaviors, including Anxiety Disorders (201), Mood Disorder: Depression (203), Mixed Disorder of Emotional Expressiveness (204), and Reactive Attachment Deprivation/Maltreatment Disorder (206). Mixed Disorder of Emotional Expressiveness (204) is especially helpful to describe children with disruptive behaviors who display a constricted range of affect, disturbed intensity of affect, and/or reversed or inappropriate affect (Thomas & Harmon, in press; Zero to Three, 1994).

Regulatory Disorders (400), a new construct, defines constitutional and maturational delays and difficulties (including sensory, sensory-motor, and organizational processing difficulties) associated with distinctive patterns of poorly regulated behavior. Regulatory Disorder, Type I, Hypersensitive children are described as hypersensitive to various stimuli, including loud sounds, small changes in texture, or busy environments. These children appear to demonstrate their need for control by being either fearful and cautious or negative and defiant. Regulatory Disorder, Type II, Under-reactive children are described as either withdrawn and difficult to

TABLE 1. *Diagnostic Classification: 0–3 Axis I*

100	Traumatic Stress Disorder
200	Disorders of Affect
300	Adjustment Disorder
400	Regulatory Disorders
500	Sleep Behavior Disorder
600	Eating Behavior Disorder
700	Disorders of Relating and Communicating

Adapted with permission from *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*, Zero to Three/National Center for Infants, Toddlers and Families.

TABLE 2. *Diagnostic Classification: 0–3 Axis II*

900	Relationship Classification	
901		Overinvolved
902		Underinvolved
903		Anxious/Tense
904		Angry/Hostile
905		Mixed
906		Abusive

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engage or self-absorbed. Regulatory Disorder, Type III, Motorically Disorganized, Impulsive children are often described as “hyperactive.” These children are characteristically hyposensitive to environmental stimuli and have motor delays or motor processing difficulties. They may become hyperactive in attempting to seek stimulation. Regulatory Disorders, Type IV, Other, are not easily classified as one of the first three types (Thomas & Harmon, in press; Zero to Three, 1994).

DC: 0–3 provides guidelines for prioritizing certain diagnoses over others (Table 2). For example, Traumatic Stress Disorder is considered first if a specific trauma or repeated trauma is associated with disordered behavior. In complex cases, the most prominent features are prioritized for the primary diagnosis. Less prominent, but significant features are considered as comorbid diagnoses (Zero to Three, 1994). The process of defining the most prominent features of the presenting problem guides the clinician in intervention as well as diagnosis (Thomas & Tidmarsh, 1997).

Axis II, Relationship Classification (900), (Table 3) describes the nature and quality of the relationship of the child with one or more primary caregivers. When a child’s disruptive difficulties appear to arise from a disordered primary relationship and are not generalized to the child’s relationships outside of that primary relationship, an Axis I diagnosis is not assigned; instead, the Axis II, Relationship Disorder becomes the primary diagnosis. The PIR-GAS is used with Axis II to assess the level of strength or disturbance in a specific relationship from well adapted (90) to grossly impaired (10). Ratings from 80 to 90 describe well adapted or

TABLE 3. *Diagnostic Classification: 0–3 Guidelines*

1. If clear trauma, consider first Traumatic Stress Disorder (100).
2. If clear constitutional/maturational difficulty associated with maladaptive behavior, consider Regulatory Disorders (400).
3. If problems are mild, of short duration (less than 4 months), and clear stressor, consider Adjustment Disorder (300).
4. If no trauma, no constitutional/maturational difficulty, no clear stressor, and symptoms are not mild, not of short duration, consider Disorders of Affect (200).
5. If multiple delays, including communication and social relatedness, are extreme and recognizable in their own right, consider Disorders of Relating and Communicating (700) and Reactive Attachment Deprivation/Maltreatment Disorder (206); these take precedence over Regulatory Disorders and Traumatic Stress Disorder.
6. If the only difficulty involves a relationship and there are no symptoms independent of that relationship, do not use Axis I; use Axis II Relationship Classification.
7. If complex situation, consider the most prominent characteristic or contributing feature.

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adapted relationships. Ratings from 40 to 79 imply a tendency toward disorder. Ratings below 40 describe frankly disordered relationships (Clark et al., 1997; Thomas & Harmon, in press; Thomas & Tidmarsh, 1997; Zero to Three, 1994).

RESULTS

Caregivers, including parents, grandparents, foster parents and child-care personnel, describe children's behavioral difficulties in many ways including hyperactivity, poor attention, impulsivity, temper tantrums, irritability, aggression, defiance and self-harming behaviors. Sixty-four children (84% of the total 76) presented to the EDP between November, 1990 and March, 1996 with disruptive behavior as a chief concern. Of these 64 children, the primary *DC: 0–3* diagnoses were Traumatic Stress Disorder (100) for 15 children (23%); Disorders of Affect (200) for 26 (41%); and Regulatory Disorders (400) for 19 (30%). The four most common *DSM-IV* diagnoses assigned to these children were Adjustment Disorder for 17 (30%), Oppositional Defiant Disorder for 9 (14%), Dysthymia for 9 (14%), and Attention-Deficit Hyperactivity Disorder (ADHD) for 8 (13%).

Forty-nine of the 64 children had data from the CBCL 2–3 (Achenbach et al., 1987) completed by parents at the time of the initial evaluation and were also given a *DC: 0–3* diagnosis of Traumatic Stress Disorder (100), Disorder of Affect (200), or Regulatory Disorder (400). Multivariate analysis of variance (MANOVA) was used to examine differences among the three diagnostic groups on the CBCL subscales and the results were nonsignificant, $F(12, 82) = 1.58; p > .10$. Because it appeared that the three major *DC: 0–3* diagnostic groups differed minimally when examining CBCL child symptoms alone, we examined the same 49 children using the three *DC: 0–3* diagnostic categories together with multiple parent-reported parental and environmental problems. Chi-square analyses yielded a significant relationship between parent-reported drug involvement of fathers and *DC: 0–3* diagnostic category, $\chi^2(2, N = 49) = 6.70; p < .05$. Sixty-nine percent of children with Traumatic Stress Disorder had fathers with a history of drug abuse, as compared to 36% of children with Disorders of Affect and 21% of children with Regulatory Disorders. Using correlational analyses, marital conflict was found to be significantly associated with higher CBCL Anxiety/Depression subscale scores, $r(49) = .25; p < .05$ (one-tailed).

These significant associations with parental and environmental problems suggested that we look at the PIR-GAS, together with the Axis I, Primary Diagnosis. The PIR-GAS denotes the level of strength or disturbance of a specific relationship from well adapted (90) to grossly impaired (10). Ratings from 80 to 90 describe well-adapted or adapted relationships. Ratings from 40 to 79 imply a tendency toward disorder. Ratings below 40 describe frankly disordered relationships (Zero to Three, 1994).

We next compared the *DC: 0–3* Axis I diagnoses [Traumatic Stress Disorder (100), Disorders of Affect (200), and Regulatory Disorders (400)] with dyads' PIR-GAS scores. Chi-square analyses yielded a marginally significant relationship between PIR-GAS scores and *DC: 0–3* diagnostic category, $\chi^2(4, N = 49) = 7.90; p < .10$. Sixty-nine percent of the children who were in dyads with disordered relationships (PIR-GAS scores 0–39) had a diagnosis of Disorders of Affect, whereas 19% of the children had a diagnosis of Traumatic Stress Disorder and 12% of the children had a diagnosis of Regulatory Disorders. In contrast, 67% of the children who were in dyads with adapted relationships (PIR-GAS scores 80–90) had a diagnosis of Regulatory Disorders, whereas 33% of the children had a diagnosis of Disorders of Affect and none of the children had a diagnosis of Traumatic Stress Disorder. Those children who were in relationships that had a tendency toward disorder (PIR-GAS scores 40–79) were evenly distributed between *DC: 0–3* diagnostic categories. We also found that lower scores

on the PIR-GAS (more disordered parent–child relationships) were marginally associated with higher levels of parent-reported child aggression on the CBCL, $r^s(49) = -.23$; $p < .06$ (one-tailed).

ILLUSTRATIVE CASE: RELATIONAL ASSESSMENT AND INTERVENTION

The case below illustrates how *DC: 0–3*'s Axis I, Primary Diagnosis, Axis II, Relationship Classification, the PIR-GAS and the PCERA (Clark, 1985) together guide relational intervention approaches for young children presenting with disruptive behavior and their families.

Presenting Concerns

Tommy was 36 months old when referred for head banging and aggressive behavior. Tommy banged his head and hit other children when he was angry at home or at the child care center he attended. Tommy also banged his head when his mother cried. Temper tantrums, self-harming behaviors, and sleep and eating problems began at about age 13 months when marital conflict began and increased in frequency and intensity at about 18 months with the birth of Tommy's brother.

Developmental History

The pregnancy was intensely wanted but not expected and significant for maternal marijuana use. The mother reports that Tommy's temperament as a baby was "easy." He was bottle fed and ate well until age one; at about the time marital conflict began, he became a "picky eater." He continued to have a poor appetite and to be underweight. Tommy walked at 15 months. He spoke single words at 18 months and two-word sentences at 30 months.

Social History

Since the birth of Tommy's brother a year and a half ago, the parents have been frequently separated because of extreme conflict. The mother, age 33, was physically abused by her mother and had two psychiatric hospitalizations for depression before age 11. During her teenage years she was a heavy user of alcohol and intravenous drugs. She continued to regularly use marijuana and was on SSI for her cognitive disability. The father reported little about his early relationships, but said that as a child he was treated for a behavior disorder. He was a regular user of marijuana and alcohol.

Developmental Assessment

Developmental pediatric examination showed mild hypotonia and several resolving hematomas on his forehead, apparently related to head banging. Auditory evaluation showed possible mild decreased sensitivities for the frequencies of spoken language. Tommy had below age level skills on tasks of auditory comprehension and receptive and expressive language. Stanford–Binet mental age was 2.8.; IQ was 74. Vineland Scales of Adaptive Functioning showed significant delay in communication and mild delays in self-help, socialization, and motor skills. Occupational and physical therapy assessments showed poor muscle tone. Gross motor development was at 22 months and fine motor development at 21 months.

Observations and Assessment of Relational Strengths and Concerns

Behavioral quality and affective tone of interactions. The interactions of Tommy and his mother were videotaped and observed during the initial family interview and then, using the PCERA (Clark, 1985), videotaped and assessed in a structured-task, free-play, and a brief separation/reunion episode. The father was present during the interview only. Tommy's younger brother was present for all but the separation/reunion episode. During the structured task and free play, the mother's affect and energy level were somewhat constricted. She often told Tommy what to do next and occasionally extended his attempts to communicate, commented on, or asked questions about his activities. She tried very hard to teach Tommy block building and color matching and was at times able to focus his attention to the task. However, she was not able to attune to Tommy's emotional needs or interests, focusing more on those of his brother. The quality of interactions of Tommy and his father was not formally assessed because the father refused to be involved in the process after the first interview.

On his part, Tommy was alert and interested in exploring the play materials. His affect was constricted, sober, and serious most of the time. He asserted himself very little. His communicative competence was low due to expressive language and articulation difficulties. He was compliant with his mother's requests, for example, calling Big Bird on the phone as she suggested, but he did not elaborate on her idea. His level of representational play was less than expected for his age. His fine and gross motor skills were also delayed.

The affective tone of the dyad was characterized by some flatness, little enthusiasm, but some times of brief mutual engagement, especially if Tommy followed his mother's lead. Little reciprocal dialogue or turn-taking was evidenced, however.

In the separation/reunion episode, Tommy did not acknowledge either his mother's leaving the room or her return. He played with the blocks, arranging and building, and continued to do so without interruption or change in his affect or level of involvement in his play.

Psychological involvement. The meaning of Tommy and his behavior to his mother was explored in an interview. Mother described Tommy as "spoiled" and wanting his way all of the time. She experienced Tommy as "very smart," in contrast to her own cognitive limitations. Her belief that Tommy was more intelligent than she appeared to interfere with her sense of competence in her parenting role and with her awareness of his delays.

Parental Report of Child Symptoms

On the CBCL, although the mother reported more externalizing than internalizing symptoms, she reported Tommy's depressive symptoms, self-harming behaviors, sleep and eating problems, as well as his anger and defiance.

Biopsychosocial Formulation

Tommy's disordered affective and behavioral expressiveness reflected his "schema of being with" parents whose interactional patterns were chronically disordered in association with addiction and depression. When his parents were irritable and unable to attune to Tommy's needs, he appeared to constrict his affect and interactions to avoid aggravating them. When he became frustrated, he demanded the attention he needed with temper tantrums and self-harming be-

haviors. This may represent identification with the aggressive behaviors of his parents and with his mother's depressive state. These inappropriate affects and behaviors generalized over time and beyond the family relationships into the child care setting. *DC: 0–3's* Mixed Disorder of Emotional Expressiveness, one of the Disorders of Affect, best described Tommy's irritable mood and disturbing behaviors, which were more salient than his co-presenting somber mood and sleep and appetite disturbances.

Tommy has witnessed his parent's fighting but shows no clear re-experiencing phenomenon and, therefore, Traumatic Stress Disorder cannot be diagnosed, but must be ruled out. Constitutional difficulties, including language and motor delays, certainly contribute to Tommy's frustration but at this time appear less contributory than his affective and behavioral responses to the disordered family relationships; therefore, Regulatory Disorder is a consideration to be ruled out via ongoing assessment within the treatment process. On Axis II, the disturbed relationship with the mother is described as a Tendency toward Relationship Disorder—Mixed (Overinvolved-behaviorally and Underinvolved-affectively). The relationship with the father appeared angry and hostile, but is not formally described because of his minimal involvement in the assessment/intervention process and his moving out of the family environment.

DC: 0–3 Diagnoses

- Axis I: Mixed Disorder of Emotional Expressiveness (204)
 Rule out Traumatic Stress Disorder (100)
 Rule out Regulatory Disorder, Type III, Motorically Disorganized, Impulsive (403)
- Axis II: Tendency toward Relationship Disorder—Mixed (Overinvolved-behaviorally and Underinvolved-affectively)
 PIR-GAS = 40 (with mother)

Relationally Focused Biopsychosocial Interventions

Physical safety and emotional security of both children is the first concern. As the mother felt safe within the therapeutic relationship, she reported that the children were not themselves abused, but were witnesses to domestic violence. She understood from the therapist that marital conflict and drug dependence interfered with the children's sense of emotional security.

Marital conflict, the mother's own safety, and parental drug abuse were the first targets of intervention. The mother initiated drug treatment and the father, refusing treatment, moved out of the home. With ongoing help, the mother began to feel better about herself, especially with regard to her parenting role.

Psychological interventions focusing centrally on family relationships use representational and interactional approaches. Relational therapy kept the mother central, including the father when willing and the brother intermittently. The therapist guided the mother's exploration of her explicit and implicit concerns about Tommy and his brother. As the mother gained trust in the therapist, she described her fear that she would abuse her children and reflected on her own abuse as a child. She became aware that she had used marijuana to regulate her mood. Now drug free, the mother was able to be more expressive and attuned to Tommy's needs and interests. She was more able to enjoy playing with Tommy alone and with his brother. With the therapist's help, she began structuring regular individual play sessions with the boys at

home. Both within the therapy and at home the therapist supported the mother's setting clear expectations and limits for Tommy's behavior. The therapist placed special emphasis on helping the mother identify and respond to Tommy's feeling states. The therapist assisted the mother in understanding Tommy's feelings by at times speaking for the him, thus amplifying his attempts to communicate his feelings.

As the family relationships improved, Tommy's sleep problem and picky eating disappeared. Rapid change in the social context and in the mother's sense of competence in her parenting role precluded the need for pharmacological treatment of Tommy's Disorder of Affect. As the mother learned more about Tommy's developmental needs and the advantage of specific treatments, she eagerly enrolled him in an early intervention program that incorporated speech and language and occupational and physical therapies.

DISCUSSION

The high prevalence of disruptive behavior in children under 4 years old who present to our early childhood psychiatry clinics and the urgency of intervening early and preventively are focusing our attention on how new diagnostic tools can assist in identification of specific environmental and constitutional risk factors and the development of relationally focused interventions.

Identification of specific risk factors is especially important for very young children who have a limited repertoire of behavioral responses to stress. Hyperactive, aggressive, and defiant behaviors appear to be a final common pathway for expression of internal distress in a heterogeneous group of children with a variety of biological and psychosocial risk factors. Our preliminary data suggests that similar behavioral symptoms are reported for children with a broad range of internally distressing experiences and risk factors. Descriptive diagnoses that rely on lists of these nonspecific behavioral symptoms (for example, *DSM-IV*'s ADHD, Oppositional Defiant Disorder, and Disruptive Behavior Disorder, NOS) identify overlapping, heterogeneous groups of very young children with behavioral difficulties.

DC: 0–3, which is intended as a developmentally appropriate extension of the *DSM-IV* for use with very young children, goes beyond purely descriptive diagnoses to identify on Axis I and Axis II specific risk factors that guide intervention strategies. For example, (1) Traumatic Stress Disorder (100) identifies environmental risk factors that guide the clinician to social interventions that facilitate the child's safety and sense of security; (2) Regulatory Disorders (400) identify constitutional, maturational, and interactional risk factors that guide the clinician to medical and developmental assessments and relational interventions; (3) Disorders of Affect (200) identify interactional risk factors that have generalized over time and situation, and (4) Relationship Disorders (900) identify interactional risk (including affective, behavioral, and psychological components) that resides within a specific relationship. Interactional risk factors guide the clinician to formulating relationship-focused interventions.

Interactional risk factors are identified by *DC: 0–3* using the PIR-GAS, Axis I and Axis II. Our preliminary data suggests that interactional risk, as rated on the PIR-GAS, appears to be greater with Axis I Disorders of Affect than with Traumatic Stress Disorder or Regulatory Disorders. Identifying the extent of relational concerns using the PIR-GAS and the quality and nature of interactional risk using the Axis II Relationship Classification, helps the clinician to formulate relationally focused interventions. The PCERA (Clark, 1985) provides depth to the relational diagnostic profile by identifying areas of strength and concern in the parent–child relationships and also by identifying the meaning of the child and the child's behavior to the parent. This facilitates increased specificity of relational intervention strategies.

DC: 0–3 also provides a decision tree that helps prioritize some diagnoses and associated

specific risk factors over others. For example, Traumatic Stress Disorder and Regulatory Disorders, which respectively identify potentially life-threatening environmental risk and constitutional/maturational risk, take priority, in this order, over Disorders of Affect. In addition, concerns specific to one primary relationship, and not yet generalized over time and situation, may be diagnosed with the primary diagnosis as a Relationship Disorder on Axis II, implying that the difficulties reside within the relationship, not within the child as is denoted with an Axis I diagnosis.

Our descriptive and correlational data reinforce Winnicott's (1965) assertion that the family relational context is central to the child's development. This preliminary data suggests that, in this age group, the more disordered parent-child relationships as rated on the PIR-GAS are associated with higher parent-reported Aggressive Behavior subscale scores on the CBCL. Our data also suggests that marital conflict is significantly associated with higher parent-reported Anxiety/Depression subscale scores on the CBCL. A focus on the level of strength and concern within the parent-child relationships as rated on the PIR-GAS, the quality and nature of the parent-child relationships as rated on Axis II and as further specified with the PCERA (Clark, 1985), and on additional specific environmental risk (for example, difficulties within the marital or primary relationship of the parents) must play a central role in formulating intervention strategies focused on the social matrix within which the child is developing.

Given the growing empirically defined understanding that family relational context is central to the development of the infant and young child's biological potential and with our preliminary data as additional support for this understanding, interventions must focus on enhancing family relationships. Relational strategies that help to guide family or dyadic therapy include: (1) keeping parents and other primary caregivers central; (2) responding to parents' emotional needs so that they can respond to those of their child; (3) creating and facilitating safe, predictable, and responsive parent-regulated, therapeutic and home environments in which families can explore alternative ways of interacting; (4) enhancing parents' understanding and responsiveness to the child's developmental needs using, as needed, additional medical and developmental screening and interventions; (5) structuring mutually enjoyable interactions for the parents and child that enrich everyday family experience; (6) facilitating experiences that enhance the parents' sense of competence in their parenting role and the child's sense of developing competencies; and (7) exploring with the parents their representations of their own childhood relationship experiences to facilitate accurate perceptions, age-appropriate expectations, and positive parental attributions of the child.

Relationship-focused intervention keeps caregivers central. When parents bring their young child for mental health services, they often feel vulnerable and self-blaming. Intervention begins with an appreciation of the caregiver's concerns and emotional responses to frustrations with the child and external stressors (American Academy of Child and Adolescent Psychiatry, 1997; Thomas & Tidmarsh, 1997). The parent's and the child's individual needs are addressed, allowing each to bring more to the interaction (Clark, Keller, Fedderly, & Paulson, 1993).

Physical safety and emotional security, which include predictability and parental responsiveness, are the first targets of interactional interventions. Parents are often more willing to address marital conflict and parental psychiatric symptoms in the context of the child's treatment than to seek help for themselves. This is important because marital conflict and parental psychiatric symptoms create a sense of uncertainty for a young child and, if untreated, are strongly predictive of young children's persistent aggressive behaviors (Campbell, 1995). Helping to develop the parents' capacity to set clear, consistent limits is an early target of intervention because for children and parents, clear expectations and limits create a structure that augments a sense of predictability and security. Child care centers and therapeutic programs provide additional structures and parenting supports. With safety and security, the child relaxes

and begins to explore the environment and increases his or her sense of competency and autonomy (Clark et al., 1993a; Thomas & Tidmarsh, 1997).

Developmental testing and intervention, required when delay is suspected, often augment relational interventions. Most frequently needed services include hearing, speech/language, cognitive, and occupational and physical therapy assessments and treatments, plus referral to birth to three and early childhood education programs. Psychiatric medications are used adjunctively when severe symptoms are unresponsive to other interventions (American Academy of Child and Adolescent Psychiatry, 1997; Thomas & Tidmarsh, 1997).

Relational interventions that target change in the parent–child interactions or in caregiver mental representations have been found equally effective (Stern, 1995). Most often, both approaches are used together. Often, interactive approaches that directly target parent–child interactions facilitate the parent in structuring mutually enjoyable times that promote a sense of relationship success for the parent and the child. Interactional approaches highlight positive behaviors occurring in the parent–child dyad (Clark et al., 1993a; McDonough, 1993; Thomas & Tidmarsh, 1997). For parents who are psychologically receptive, a representational approach can be helpful. Representational approaches highlight the parents' mental representations of their past and present relationships and of their direct experience of the child within the therapeutic context. The aim is to facilitate the parents' accurate expectations and positive attributions of the child (Lieberman & Pawl, 1993). The clinician's review of videotaped parent–child interactions with the parents often facilitates interactional and representational approaches (Clark et al., 1993a). Individual and dyadic psychotherapies may be expanded to include the whole family.

In summary, our preliminary data using the *DC: 0–3* suggests that very young children presenting to psychiatric clinics with disruptive behaviors are a heterogeneous group of children, many of whom can best be understood as suffering from trauma, constitutional/maturational or interactional difficulties, and combinations of these specific risk factors or stressors. *DSM-IV*'s purely descriptive diagnoses do not adequately describe the difficulties of these very young children who, in response to a broad array of risk factors, display a small repertoire of salient disruptive behaviors. *DC: 0–3*'s Axes I and II and the PIR-GAS provide diagnostic tools that help to differentiate this heterogeneous group of young children through identification of specific risk factors that guide intervention. In particular, interactional risk, highlighted by *DC: 0–3*'s PIR-GAS and Axis II Relationship Classification and a relational assessment approach such as the PCERA, enhance the focus and the specificity of our relational interventions with very young children and their families. *DC: 0–3* provides a promising diagnostic tool for beginning to clarify specific risk factors that may contribute to development of disruptive behaviors in children ages 0 to 4 years old.

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