

Mental Health Diagnoses for Children 0–5

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What are the issues?

- ▶ Diagnostic systems are designed for older patients
 - ▶ Lack of understanding that 0–5 year olds have MH concerns
 - ▶ Interaction between development and psychopathology
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Diagnostic systems

- ▶ DSM–IV (Diagnostic and Statistical Manual of the American Psychiatric Association) and pending version V, and ICD–10 not congruent with developmental model
- ▶ DC:0–3R (Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood) more useful, though still a work in progress. Better reliability.

How can babies have MH problems?

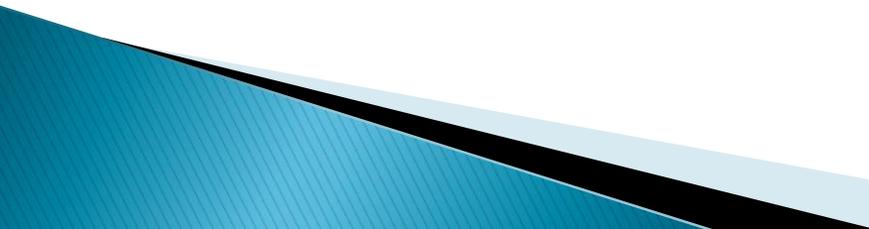
“A newborn human, at once competent and completely dependent, needs to learn to live in the interpersonal world of his or her family and broader community, while at the same time the family is getting to know this new individual. Considering how complex and delicate it is, it is not surprising that the process may go awry.” (Johnson & Appleyard, 2010)



Interaction between development and psychopathology

- ▶ Contributing factors include biological (i.e. prenatal exposures, genetic vulnerabilities, maternal biopsychosocial stresses) as well as emotional/interactional challenges
 - ▶ Disruption of efforts to accomplish necessary developmental tasks
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These tasks include:

- Forming relationships
 - Signaling needs
 - Developing an appropriate range of affect
 - Developing capacity to self-regulate biological needs
 - Developing strategies for handling separation, exploring the environment, tolerating frustration, delaying gratification, and engaging in social interaction
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How are disruptions of these processes expressed and described?

- ▶ Usual dimension in child MH, such as internalizing/externalizing, harder to use in 0–5, since young children less able to verbalize feelings/worries; distress typically must have behavioral component to be identified.
 - Sadness, anxiety, etc. may be expressed through withdrawal, tantrums, disruption of eating/sleeping, etc...
- ▶ Diagnoses below always need caution in identification, description, interpretation.

**So– somewhat arbitrary list of
common diagnostic labels...**



Affective and relationship disorders

- ▶ Anxiety disorders, including PTSD (witnessing and/or experiencing traumatic experience), separation anxiety, social phobia
- ▶ Depression; historically, “anaclitic depression” described in separated and/or institutionalized infants; currently, modified criteria being researched and validated with biological markers

- ▶ Bipolar disorder ??? Much debate about existence, possible age of onset, interaction with other disorders, treatment
 - ▶ Depression in preschoolers – age-adjusted criteria developed and validated in 3–6 y.o. i.e. “anhedonia” may show up as lack of play behavior, refusal to trick-or-treat, etc.
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Affective and relationship disorders (cont)

- ▶ Attachment disorders (controversial label; includes children who fail to form attachments and those with disturbed relationships.) Includes a wide range of behaviors, from self-endangerment to extreme difficulty separating.

- ▶ Term most appropriately used in light of research based on Ainsworth categories, (insecure attachment, disorganized attachment, non-attachment, etc) but many questions remain about clinical applications.
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“Reactive attachment disorder”

- ▶ Often misused; poor definitions and empirical support.

Aggressive and oppositional disorders

- How to distinguish from normative self-assertion of toddler?
 - Study found 14% of longitudinal sample showed increased physical aggression by 17 months; related to parenting dysfunction.
 - Appleyard et al. (2005) found cumulative risk factors predicted poor outcome.

- ▶ In practice, this is a major issue due to impact on child care, foster/adoption success, relationships. Very problematic when associated with violence in the child's home

Regulatory disorders

- ▶ Sleep behaviors: (severe early disruptions predict behavior problems at 3). Includes disruptions in amount, quality or timing, of sleep, nightmares
- ▶ Feeding behavior including FTT, usually multiple determinants. Very hard to treat without including behavioral/relational component, even if medical issues are present as well
- ▶ “Fussy baby/toddler” – extreme irritability may predict later affective dysregulation, and is a source of family distress and ?? Increased risk of maltreatment

ADHD

- ▶ Debate about when it can be diagnosed. Some data showing good prediction from age 3 to age 7–9.
 - ▶ More debate on treatment strategies, especially at what age to start medication
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Posttraumatic stress disorder

Alternative criteria have been developed with better evidence, adapted to developmental issues of young children (e.g. tantrums rather than “outbursts of anger” etc.) High rates of continued stress symptoms found in longitudinal study. Utility of CBT reported in children as young as 2.

Autism, Autistic Spectrum Disorder

- ▶ A developmental/neurologic disorder, but often screened for and diagnosed through pediatric/mental health collaboration. In NC, served through CDSA and preschool services.

NOTE:

- ▶ List does not match up exactly with a diagnostic system
- ▶ 0–2 and 3–4 year olds demonstrate different behaviors in similar situations
- ▶ Data about longitudinal continuity is lacking
- ▶ Data about co-occurrence of these disorders with parental challenges is lacking
- ▶ Evidence of effective interventions exists for only some of these disorders
- ▶ BUT this list describes many children needing help

References

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