CHAPTER 28

# Relationship-Specific Disorder of Early Childhood

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

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

The roots of the field of infant mental health are explicitly relational—that is, focused on understanding young children's development and their manifestations of psychopathology within the context of their relationships with caregivers. We note in this regard, many major pioneers in our field have staked out explicitly relational frameworks. Bowlby's (1953) comprehensive World Health Organization review asserted that "essential for mental health is that an infant and young child should experience a warm, intimate and continuous relationship with his mother (or mother substitute . . . ) in which both find satisfaction and enjoyment" (p 13). Winnicott's (1960) often quoted declaration, "There is no such thing as an infant, meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (p. 585), was one of the first. In a seminal paper on "ghosts in the nursery," Fraiberg, Adelson, and Shapiro (1975) launched clinical treatment of parent–infant relational pathology. They used in-depth case studies to demonstrate that disturbances in the mother–infant relationship were reenactments of the mother's conflicted relationships during her own childhood. Each of these luminaries believed that a relational focus was necessary for understand-

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ing young children's development and provided a path for ameliorating their pain.

In this chapter, we present a newly defined parent–child relationship disorder that was introduced in DC:0–5 (Zero to Three, 2016). Although there have been some previous attempts to define relationship disorders (Beach et al., 2006), we limit ourselves to tracing the efforts in early childhood.

## Empirical Background

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

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

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

For example, *securely attached* infants typically demonstrate distress during separation directly to their caregivers and use the attachment figure, but not the stranger, for comfort and resolution of their distress. Once reassured by contact with the caregiver, they generally resume exploration of the environment. Similarly, adults classified as *autonomous* (i.e., secure) report positive and negative experiences with their parents in a balanced way, neither avoiding nor overfocusing on challenging experiences with their parents. Infants with *avoidant* attachments, on the other hand, turn their attention away from their own internal distress and focus externally on toys or the surrounding environment, much as adults classified as *dismissing* use their attention to avoid focusing on painful memories or insisting that they had no effect. Infants who are classified as *resistant* with their caregivers overfocus on caregivers at the expense of the surroundings, but they are unable to settle once distressed, despite attempts by the caregiver to comfort them. Caregivers classified as *preoccupied* similarly describe relationship dissatisfaction with their parents but seem so caught up by adverse experiences that they cannot seem to integrate their emotions and experiences. Thus, avoidant/dismissing, resistant/preoccupied, and secure/autonomous relationships involve reduced, exaggerated, and balanced activation of attachment needs and behaviors, respectively. Similarly, *disorganized* patterns of attachment in infants and *unresolved* in adults both involve lapses or breakdowns in "strategies" for obtaining closeness and comfort.

Based on attachment theory, we would predict that we could demonstrate a concordance between a parent's and a young child's patterns

of attachment. In fact, several meta-analyses of studies of the AAI have confirmed the hypothesized substantial concordance between parents' attachment patterns in the AAI and their infants' attachment patterns in the SSP (van IJzendoorn, 1995; van IJzendoorn & Bakermans-Kranenberg, 1996, 2008).

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

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

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

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

tifying those disorders will require more than observations from one standardized laboratory paradigm.

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

## Relationship Disturbances: An Initial Taxonomy

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

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

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

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

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

Despite its considerable importance in advancing the field, the approach articulated by this group had two major interrelated problems. First, despite the compelling case they made for regulation as a core feature of the relationship, translating it into clinical practice proved daunting. Consider the following clinical scenario. An intrusive caregiver repeatedly overstimulates her infant. The caregiver appears to be overregulating, but the infant is actually underregulated. Assuming this pattern reflects a consistent characteristic of the relationship, how should it be classified? It is overregulated from the perspective of caregiver behavior but under-regulated from the standpoint of infant adaptation. This relates to the second problem of the approach, which is that the descriptions of relationship problems were focused primarily on caregiver behavior. This adult focus has

plagued most attempts to define relational disturbances. It seems that we lack the words to describe problems *between* rather than *within* individuals. Even the construct of relationship is unclear. Are we describing something in the mind of the parent, in the mind of the young child, or something external to each of these? Most measures of interaction mostly focus on caregiver behavior or on infant behavior and include scores for each. Interactive patterns of the dyad are less well characterized, even though it is widely acknowledged that the behavior of each partner influences the other.

Another contribution of the Stanford group was to call attention to the importance of representations and behaviors in understanding relationships between young children and their caregivers. Inspired in part by this important distinction, Stern-Bruschweiler and Stern (1989) provided a model for conceptualizing parent–infant/child relationships (Figure 28.1). In their model, the observable components of the parent–child relationship, representing recurrent patterns of interaction over time, are in the center of the figure. Outside are the representations of parent and child, reflecting the subjective experiences and anticipations of each partner. They also emphasized that this model should be viewed as an open system, so that a change in one component would be expected to change other components. Though originally developed as a way of understanding the "ports of entry" or targets of various infant mental health interventions, the model is also useful for determining components of assessment of parent–child relationships (see Larrieu, Middleton, Kelley, & Zeanah, Chapter 16, this volume). This was another major breakthrough in providing a clinically useful frame of reference for infant mental health clinicians attempting to think relationally. Having a means of assessing relationships led to more intentional considerations of how to characterize and define relationship disorders between young children and their primary caregivers.

## Relational Attachment Disorders

Soon after the Stanford group's effort, Lieberman and Pawl (1988, 1990) described a case series of serious attachment disturbances between young children and their parents. These included patterns of recklessness and accident proneness, inhibition of exploration, and precocious competence in self-care. Noting that from an attachment theory perspective, parents are expected to function as a secure base for their children, they designated these relationship-specific disturbances as "secure-base distortions." Their initial reports were followed by more case examples of secure-base distortions, though they were designated somewhat differently (see Table 28.1). A fourth category of vigilance/hypercompliance was added in subsequent reports (Lieberman & Zeanah, 1995; Zeanah, Boris, & Lieberman, 2000; Zeanah, Mammen, & Lieberman, 1993).

As noted in Table 28.1, each of the relationship specific patterns involves distortions of the caregiver's role of providing a secure base from which the young child ventures out to explore and a safe haven to whom the child returns for nurturance and protection: Recklessness/self-endangerment describes the young child exploring without checking back (and a presumed failure to internalize self-protective tendencies), excessive clinging/inhibition describes the child's failure to venture out and explore, precocious competence/role reversal describes inversions of the parent–child relationship in which the caregiving burden is shifted to the young child. The vigilance/hypercompliance subtype of attachment disorder describes a pattern of behavior in which the child responds fearfully and immediately to parental directives, as if to minimize any conflict or displays of noncompliance with the parent.

Beyond case reports, however, the empirical base of these disorders is quite limited. Boris, Zeanah, Larrieu, Scheeringa, and Heller (1998) found that among clinic-referred young children,

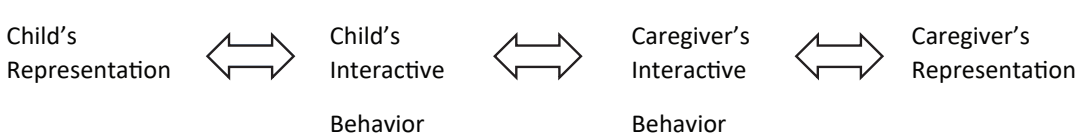


**FIGURE 28.1.** Model for conceptualizing components of the caregiver–child relationship. From Stern-Bruschweiler and Stern (1989). Copyright 1989 by John Wiley & Sons. Reprinted with permission.

**TABLE 28.1. Attachment Relationship Disturbances: Secure-Base Distortion Classifications**

| | Failure to check back | Failure to explore | Role inappropriate/ role reversal | Fear of caregiver |
|---|---|---|---|---|
| Lieberman & Pawl (1988, 1990) | Recklessness and accident proneness | Inhibition of exploration | Precocious competence in self-care | |
| Lieberman & Zeanah (1995); Zeanah, Boris, & Lieberman (2000); Zeanah, Mammen, & Lieberman (1993) | Attachment disorder with self-endangerment | Attachment disorder with clinging/ inhibition | Attachment disorder with role reversal | Attachment disorder with vigilance/ hypercompliance |

those diagnosed with attachment disorders, including secure-base distortions, were rated as having more disturbed relationships with their parents. In addition, Schechter and Willheim (2009) found that secure-base distortions rated by the mothers of 12- to 48-month-old children had an internal consistency of .75. Considering secure-base distortions as a unified construct, they found that roughly one-third of the variance of secure-base behavior in these young children were accounted for by the severity of mothers' posttraumatic stress disorder (PTSD) symptomatology. In another sample, Schechter and colleagues (2017) showed moderate positive correlations between secure-base distortion ratings of young children's and mothers' PTSD symptomatology and partner violence. Though these limited data provide support for the idea that these behaviors reflect attachment relational disturbances, they raise questions about the distinctiveness of the different secure-base distortions described clinically.

## Another Early Effort at Relationship Diagnosis: DC:0–3

In 1994, a Zero to Three task force, chaired by Stanley Greenspan and Serena Wieder, published a nosology of early childhood disorders, known as the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0–3; Zero to Three, 1994). In this volume, a multiaxial system was introduced, with Axis II devoted to the parent–child relationship disorders. The rationale for this effort was that infant mental health is explicitly relational in its focus; therefore, a diagnostic classification system for early childhood disorders should include attention not only to within-the-child psychopathology but also to between child and caregiver psychopathology. DC:0–3 was the first nosology that clearly articulated relationship disorders between parents and young children. Though the entire manual was an effort to create meaningful diagnostic categories for young children that were not available in DSM-IV (American Psychiatric Association, 1994) or *International Classification of Diseases* (ICD-10; World Health Organization, 1992), the inclusion of relationship disorders is perhaps its most distinctive contribution.

In DC:0–3, both continuous and categorical approaches were used for relationship disturbances. The Parent–Infant Relationship Global Assessment Scale (PIRGAS) comprised a 9-point rating scale of relationship adaptation (modeled after the Global Assessment Scale and the Child Global Assessment Scale that defined Axis V in DSM-IV). This scale operationalized the continuum of parent–infant relationship disturbances originally described by Anders (1989). The anchored points on the scale, listed in Table 28.2, were to be used by clinicians at the completion of a clinical assessment to indicate the level of a dyad's relationship adaptation. The idea was that a child's relationship problems might co-occur with symptomatic behaviors but that they could be distinct. The approach asserted that "serious symptoms may be apparent in an infant without relationship pathology and relationships may be pathological without overt symptoms in the infant" (Zero to Three, 1994, p. 67).

The PIRGAS could be used to identify strengths as well as concerns, but for ratings of 40 and below (*disturbed to grossly impaired*), a classification of the type of relationship dis-

**TABLE 28.2. Parent–Child Relationship Adaptation**

| DC:0–3 (1994) | DC:0–3R (2005) | DC:0–5 (2016) |
|---|---|---|
| 90 Well adapted | 91–100 Well adapted | Well adapted to good enough |
| 80 Adapted | 81–90 Adapted | Strained to concerning |
| 70 Perturbed | 71–80 Perturbed | Compromised to disturbed |
| 60 Significantly perturbed | 61–70 Significantly perturbed | Disordered to dangerous |
| 50 Distressed | 51–60 Distressed | |
| 40 Disturbed | 41–50 Disturbed | |
| 30 Disordered | 31–40 Disordered | |
| 20 Severely disordered | 21–30 Severely disordered | |
| 10 Grossly impaired | 11–20 Grossly impaired | |
| | 1–10 Documented maltreatment | |

order was to be specified on Axis II. Ratings in this range designated severe and pervasive problems in the parent–child relationship that warranted a diagnosis.

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

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

On the other hand, there were also significant weaknesses in the DC:0–3 approach. Despite efforts to be balanced, there was an overemphasis throughout the classifications on parent behaviors, with descriptions of infant behaviors often framed as reactions to parent behaviors. Instead of describing dyadic relational properties, the definitions focused most on caregiver behaviors and somewhat on infant behaviors.

The PIRGAS also was problematic in that it contained an internal inconsistency in its metric. In what was intended to be a continuous scale of relationship adaptation, perturbations and significant perturbations were included as transient reactions to stressors. Thus, there was no way to use this scale to designate milder but persistent relationship disturbances. Given that the PIRGAS involved a 9-point scale, the anchors for each level of adaptation also were limited.

Most concerning about the entire Axis II of DC:0–3 given its novelty and seeming centrality to the field of infant mental health, is how little research it inspired. A smattering of studies has examined reliability and validity of the PIRGAS as a scale (Aoki, Zeanah, Heller, & Bakshi, 2002; Boris et al., 1998; Muller et al., 2013; Salomonsson & Sandell, 2011a, 2011b), but there have been almost no attempts to assess the value of the typology of relationship disorders or whether, for example, a rating of 40 on

the PIRGAS is appropriate as a cutoff point for specifying relationship disorders.

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

## Contributions of DC:0–3R

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

There were only minor changes in Axis II in DC:0–3R. First, the PIRGAS was expanded to a 10-point scale, by adding a "documented maltreatment" rating (see Table 28.2) to incorporate ratings that involved abuse or neglect. The anchors of the PIRGAS were expanded a bit as well. Second, a Relationship Problems Checklist was introduced. This provided a 3-point rating of *no evidence, some evidence,* or *substantial evidence* for each type of relationship disorder classification.

The text was also updated, and clinicians were instructed to include five aspects of the "relationship dynamic" (Zero to Three, 2005, p. 41) when conducting assessments. These included overall functioning of parent and child, level of distress in both partners, adaptive flexibility of parent and child, and level of conflict and resolution between the parent and child. In addition, clinicians were to consider the effect of the quality of the relationship on the child's developmental progress.

Thus, the revisions of Axis II in DC:0–3R were helpful but minor, and though some increased specification of details were provided, most of the same strengths and weaknesses evident in DC:0–3 were maintained. A 2013 survey of mental health practitioners inviting comments on DC:0–3 and DC:0–3R elicited a number of comments, suggestions that the diagnostic labels of relationship disorders were pejorative, that the PIRGAS was insufficiently operationalized and challenging to use, and that it included too many scale points and too few anchors to define them. These comments were solicited by another Zero to Three Diagnostic Classification Revision Task Force that led to changes in DC:0–5 (Zero to Three, 2016)

## A New Approach: DC:0–5

The relational focus of DC:0–5 (Zero to Three, 2016) is evident in two ways. First is the substantially revised Axis II that is used to evaluate the young child's relational context. Second, for the first time, there is an explicit disorder describing relationship-specific psychopathology. Although we are focusing on the latter, we describe the former briefly and comment on its use.

### *The Young Child's Relational Context in DC:0–5*

In infant mental health, the young child–primary caregiver relationship is often the central focus of clinical assessment and intervention. In fact, even symptoms and disorders that are clearly be defined as within the child are potentially powerfully impacted by the child's primary caregiver.

Furthermore, the network of family relationships in which the young child develops are of considerable importance to the child's development and well-being. The relationship context axis of DC:0–5 is based on the premise that young children usually establish emotionally salient relationships with a small number of primary caregivers whom they identify as their attachment figures, and that the network of caregiving relationships that envelops the developing young child has important affects of the child's experiences and behaviors. The two components of the relational context that are rated independently on this axis are (1) the overall adaptation of each of the infant/young child's primary caregiving relationships and (2) a separate rating for the infant/young child's broader caregiving environment.

The emotional quality of the dyadic relationship that the child establishes with each of his or her primary caregivers is characterized by the specific contributions that the child and the caregiver make to their perceptions and interactions with each other. In addition, because relationships affect relationships (see Emde, 1991), the coparenting patterns that the caregivers establish with each other in relation to the child

and the dyadic relationships between the child and each caregiver create a web of relationships that comprise the caregiving environment and have a profound impact on the child's development. Thus, the infant's relational context is formally evaluated with regard both to the dyadic relationship between child and primary caregiver(s) and the totality of the caregiving environment.

### *Relationship-Specific Disorder of Early Childhood*

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

One reason is that the challenge of defining a disorder between two individuals rather than within an individual has been daunting for the field. Nevertheless, a potential breakthrough was provided by the DC:0–5 Axis I disorder of "relationship-specific disorder of early childhood." This nosology responded to the dilemma of how to define such a disorder with two new approaches to the problem. The first was defining a relationship disorder as manifesting in infant/young child symptoms, but symptoms that are only apparent only in one relationship. Thus, the child who is oppositional with parents and siblings would not qualify for a relationship disorder because the symptoms occur in multiple relationships. Of course, this same child might qualify for another Axis I disorder. Nevertheless, the relationship disorder must manifest in infant/young child symptoms that are impairing to the child and/or the family's functioning. Second, specifying the nature of child symptoms required for the diagnosis of a relationship-specific disorder is not required; that is, any significant symptoms that impair the child's adaptation and are specific to a relationship with a caregiver qualify as a relationship disorder. The child might have food refusal, aggressive behavior, fearfulness, role-inappropriate caregiving behavior, or any other symptom picture as long as it is limited to one caregiving relationship. This is in obvious contrast with the DC:0–3 and DC:0–3R approaches that specified the nature of symptoms required by both caregiver and child, and limited the relationship disturbances to one of a small number of types.

What this disorder will not capture is presymptomatic young children who are experiencing disturbed relationships with their caregivers; that is, if the infant/young child is experiencing a relationship disturbance without overt symptomatology—in other words, is at risk for rather than already manifesting psychopathology—then this disorder is not applicable.

CLINICAL VIGNETTE

Sarah, an 18-month-old girl, was developing well in all areas until her father left the family abruptly and announced that he wanted a divorce from Sarah's mother. In the months that followed the father's departure, Sarah saw him once a week for 6–8 hours. This new schedule was in sharp contrast with the previous close and intimate relationship that Sarah had enjoyed with her father, who had been the one to give her breakfast in the morning and take her to child care. In response to this change, Sarah alternated among demonstrations of longing for her father when they were apart; a mixture of approach, avoidance, and rejection during reunions; intense distress upon separation at the end of a visit; and frequent anger at the father during the time they spent together. When apart from her father, Sarah often went from room to room in the house saying, "Da-da? Da-da?" as if searching for him. She averted her face and ran away from him when he came to pick her up, only to run toward him and cling to his legs soon afterward, then push him away when he tried to pick her up. During their time together, Sarah was largely affectionate and playful but frequently became suddenly angry, biting or hitting her father for no apparent reason. These changes in Sarah's relationship with her father impaired daily functioning, as shown in her refusal to eat breakfast and her mother's ensuing worry that she would become malnourished. However, Sarah's secure relationship with her mother and other important figures remained essentially unchanged, and Sarah's symptoms did not raise to the level required for other diagnoses. These considerations led to a relationship-specific disorder diagnosis.

### *The Relational Context of Early Childhood*

DC:0–5 also encourages clinicians to evaluate the child's relational context. Two scales are

used: the first to rate the relationship as it exists *between* the primary caregiver(s) and child—the caregiver–infant/young child relationship adaptation—and the second, to rate the quality of the young child's caregiving environment—caregiving environment and infant/young child adaptation. The former is about the proximal, experience-near caregiving relationship, and the latter is about the coordination, integration, and compatibility among the different caregiving relationships the child experiences. The emotional quality of this web of caregiving relationships is an important predictor of the child's functioning, even when the caregivers do not live together.

Each of these aspects of the young child's caregiving environment is rated with a 4-point ordinal scale, with each point anchored as a range of levels of adaptation: (1) *well adapted to good enough,* (2) *strained to concerning,* (3) *compromised to disturbed,* and (4) *disordered to dangerous*. These ratings, however, are made whether or not the child has a disorder, including relationship-specific disorder.

In the case of Sarah described earlier, the Caregiver–Infant/Young Child Relationship Adaptation scale was used to score Sarah's relationship with her mother and with her father. Sarah's relationship with her mother was rated (1) *well adapted to good enough* because the mother had been able to remain emotionally attuned to the child's needs in spite of her own grief at the disintegration of her marriage and nuclear family. Sarah's relationship with her father was rated (3) *compromised to disturbed* because although Sarah was able to maintain affection and pleasure in interactions with the father, her responses of avoidance, conflict, anger, and separation anxiety predominated during the time they spent together. The father, in turn, was deeply aware of the pain his departure had inflicted on his daughter, but he could not use this emotional understanding consistently to support the child. Instead, he alternated between reassuring her of her love and persistently attempting to hug her and hold her in spite of Sarah's pushing him away. He often told her that he was also angry with her and imitated her own behavior toward him, including saying to her, "Then I am leaving"—a response that triggered frantic crying in the child.

Given that relational pathology may exist with or without disorders being present, DC:0–5 specifies how the relational context relates to relationship-specific disorder of early childhood. Relationship-specific disorder is to be used for a symptomatic child whose symptoms are limited to one particular relationship. When relationship-specific disorder is used, the relational context also is to be coded. The caregiver–child relationship adaptation should be Level 3 (*compromised to disturbed*) or 4 (*disordered to dangerous*) when the child meets criteria for a relationship-specific disorder. The caregiving environment rating may be at any level, though Levels 2–4 may be more likely than Level 1 in the context of a relationship-specific disorder. For a child with another disorder with symptoms that are expressed cross-contextually, the caregiving environment—either the primary caregiving relationship or the broader caregiving environment—could range from highly adaptive to highly maladaptive. An asymptomatic child with a rating of Level 2, 3, or 4 on either the primary caregiving relationship or the broader caregiving environment relationship ratings would be considered to be "at risk" for subsequent psychopathology.

The Caregiving environment rating for Sarah and her parents was (3) *compromised to disturbed*. Sarah's mother had difficulties regulating her affect toward Sarah's father due to her own pain and her empathy for her child. She responded by becoming curt and critical toward him during child exchanges, refusing his requests to see the child more often on the grounds that this would disrupt Sarah's routine, and minimizing the time spent on separation and reunion with the father to help Sarah with the transition. The father often criticized the mother in front of Sarah when speaking with others, and at those times Sarah looked very sad and subdued, stopped her play, and often moved away from her father. The mother and father were not able to create a supportive reciprocal stance to help their daughter during this difficult period in each of their lives.

## Summary and the Way Forward

The shift to relational pathology in early childhood has a several-decades-long history that has detailed both the importance and the challenges of including this conceptualization into a diagnostic classification system. The DC:0–5 represents the latest of several attempts that date back more than 30 years. In a major change from previous attempts, DC:0–5 includes an

Axis I "relationship-specific disorder of early childhood." The diagnosis is made by focusing on symptomatic behavior in the child, but behavior that is expressed largely or exclusively in the context of one caregiving relationship. Much remains to be learned about the usefulness of this new disorder. Reliability and validity must be established, but the real test is whether it shapes treatment differently than within-the-child disorders would.

An axial characterization of young child–caregiver relationships was continued from earlier efforts in DC:0–5, but the latest version also is different in two major ways. First, a 4-point scale with more detailed relational anchors is designed to guide clinical intervention. Second, in addition to characterizing the young child's relationship with his or her primary caregiver, there is also a characterization of the caregiving environment, that is, network of family relationships in which the child develops. This includes coparenting relationships (McHale & Lindhal, 2011) and the entire network of close relationships that impinge on the young child's development and adaptation. There is already considerable empirical evidence that family environments are powerful influences on young children's development, and that this contextualization of the young children's caregiving environment will receive the clinical attention it warrants.

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

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