

Research Diagnostic Criteria For Infants And Preschool Children: The Process And Empirical Support

Task Force On Research Diagnostic Criteria: Infancy And Preschool¹

¹Task Force on Research Diagnostic Criteria: Infancy and Preschool:

Michael Scheeringa, M.D., M.P.H. (Chair), Tulane University School of Medicine, New Orleans

Thomas Anders, M.D., University of California-Davis School of Medicine

Neil Boris, M.D., Tulane University School of Public Health and Tropical Medicine, New Orleans

Alice Carter, Ph.D., University of Massachusetts, Boston

Irene Chatoor-Koch, M.D., Children's National Medical Center, Washington, DC

Helen Egger, M.D., Duke University Medical Center, Durham)

Robert Harmon, M.D., University of Colorado School of Medicine, Denver

Kate Keenan, Ph.D., Department of Psychiatry, University of Chicago

Joan Luby, M.D., Washington University School of Medicine, St. Louis

Jean Thomas, M.D., Children's National Medical Center, Washington, DC

Lauren Wakschlag, Ph.D., Department of Psychiatry, University of Chicago

Susan L. Warren, M.D., George Washington University, Washington, DC

Harry Wright, M.D., University of South Carolina School of Medicine, Columbia

Charles Zeanah, M.D., Tulane University School of Medicine, New Orleans

Nonvoting representatives: Cheryl Boyce, Ph.D. (NIMH); Rebecca del Carmen-Wiggins, Ph.D. (NIMH); Della Hann, Ph.D. (NIMH); and Serena Wieder, Ph.D. (Zero to Three).

Citation

Task Force on Research Diagnostic Criteria: Infancy and Preschool (2003). Research diagnostic criteria for infants and preschool children: The process and empirical support. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 1504-1512.

DOI: 10.1097/01.chi.0000091504.46853.0a

Author Note: Accepted June 9, 2003.

Funding for the meetings of this task force came largely from the Work Group on Research of the American Academy of Child and Adolescent Psychiatry. The American Psychiatric Association helped to support the organization phase of the Task Force. The Task Force thanks Adrian Angold, M.R.C.Psych., and E. Jane Costello, Ph.D., for their consultation on this project.

Correspondence to Michael Scheeringa, M.D., 1430 Tulane Ave., #8448, New Orleans, LA, 70112; email: mscheer@tulane.edu.

ABSTRACT

Systematic research on psychiatric disorders in infants and preschool children (0–5 years old) has lagged considerably behind that for older children, adolescents, and adults. The first step in facilitating such research is developing clearly specified diagnostic criteria that can be reliably applied within standardized assessments across multiple samples. In 2000–2002, a task force of independent investigators developed the Research Diagnostic Criteria-Preschool Age (RDC-PA) for the first time in this age group, with the goal of promoting systematic research on psychiatric disorders. This paper reviews the history of research on psychopathology in early childhood, summarizes the studies on validity, and describes the process behind this effort.

INTRODUCTION

The publication of the *DSM-III* (American Psychiatric Association, 1980) has been widely credited with catalyzing an enormous growth of research on psychiatric disorders (American Psychiatric Association, 1998). The greatest contribution of the *DSM-III* in this regard was the use of clearly specified diagnostic criteria, which stimulated research on reliability and validity that previously had been far more difficult. However, very young children did not benefit equitably from this growth, and a tremendous gap exists between the amount of systematic research on young children and that on older populations. The *Diagnostic Classification: 0–3* book (Zero to Three, 1994) was the first systematic effort to define disorders of early childhood. However, it was uneven with regard to clarity of criteria and the boundaries of different disorders (Stafford et al., 2003). Perhaps as a result, substantial new research has not followed from it. From 2000 to 2002, a multidisciplinary, independent task force of researchers has been engaged in an effort to develop research diagnostic criteria for psychiatric disorders. This effort is analogous to the development of research diagnostic criteria that occurred in general psychiatry to address the low reliability of diagnoses (Spitzer et al., 1978). Further justification of this effort is that the period of infancy and early childhood has been identified as one of the six areas that define the research agenda for the next decade of progress in the developmental aspects of nosology (Pine et al., 2002). This paper describes the process of that effort and summarizes the empirical support behind the final recommendations.

While there can be no doubt that infants and preschool children can suffer a variety of severe psychiatric impairments (Zeanah, 2000), whether to study them as categorical or dimensional constructs has been a source of contention. A dimensional strategy has been debated before (Cantwell and Rutter, 1994; Quay, 1986) and continues to be considered as *DSM-V* is being planned (Kupfer et al., 2002). While this debate, and the unique diagnostic issues for infant and preschool children, cannot be fully covered here, the stated purpose of this task force was to address the gap in research on the validation of disorders between young children and older populations by creating testable and developmentally sensitive criteria consistent with the *DSM-IV* approach to conceptualizing psychopathology. Critics of this effort are likely to revive the contention that it is mistaken to diagnose young children because it assumes that they suffer from “disease entities” (Burke, 2003). Instead, young children’s symptoms are viewed as either transient responses to environmental adversity or normal developmental differences between individuals. These same doubts were raised years ago when researchers began studying older children and adolescents, but empirical data collection has demonstrated that diagnoses serve an essential function in research and practice (Pine et al., 2002). We urge readers to view our effort not as an attempt to reify classificatory or etiologic notions of psychopathology, but as the absolutely necessary step of introducing reliability into one method of empirical data collection in the field’s evolving understanding of mental health in early childhood.

HISTORY OF THE STUDY OF DISORDERS IN INFANTS AND PRESCHOOL CHILDREN

Since there have been no clearly operationalized criteria defining disorders, no standardized diagnostic interviews that cover all disorders have existed that could be used with preschool children. Therefore, the state of knowledge of psychiatric symptoms and signs in very young children has come from four types of

studies. First, the most common method, has been to assess young children with parent-report dimensional scales; as such, this has been limited to identifying “problem behaviors” rather than diagnostic entities. These efforts were comprehensively summarized by Campbell (1995), who concluded that 10% to 15% of preschool children have mild to moderate problems. Second, many studies that have been large-scale and used standardized interviews included only the upper age range of preschool children (5-year-olds typically, but sometimes 3- and 4-year-olds). Judgments about preschool children are difficult in most of these studies because the preschool children are mixed in with much older children. Third, there have been several medium- to small-size studies made up exclusively of infant and/or preschool children that have used best-estimate diagnoses (Dunitz et al., 1996; Earls, 1982; Lavigne et al., 1996), but their results are tempered by the lack of a systematic diagnostic interview to ensure adequate coverage of symptoms, frequency, severity, and duration, as well as replicability.

A fourth type of study is one in which the validity of a disorder or group of disorders has been specifically tested. These typically have been programmatic studies by individual investigators or sites that have each focused on one (or two) disorders. These have provided support for the diagnostic validity of attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), major depressive disorder (MDD), posttraumatic stress disorder (PTSD), reactive attachment disorder (RAD), sleep disorders, and feeding disorders (Table 1).

Table 1 is organized around issues of reliability and validity. Spitzer and Williams (1980) suggested four types of validity for assessing the overall validity of a disorder that have stood the test of time: (1) “face validity is the extent to which the description of a particular category seems, on the face of it, to describe accurately the characteristic features of persons with a particular disorder” (p. 1037); (2) “descriptive validity is the extent to which the characteristic features of a particular mental disorder are unique to that category, relative to other mental disorders and conditions” (p. 1037) (more commonly referred to as discriminant validity in the psychometrics literature [Anastasi and Urbina, 1997]); (3) “predictive validity is the extent to which knowledge that a person has a particular mental disorder is useful in predicting some aspects of the future for that person, such as subsequent course of the illness, complications, and response to treatment” (p. 1038); and (4) “construct validity is the extent to which evidence supports a theory that is helpful in explaining the etiology of a disorder or the nature of the pathophysiological process” (p. 1039). Models have been described previously for assessing these types of validity (Robins and Guze, 1970). These considerations were modified somewhat for children and adolescents (Cantwell and Rutter, 1994). Reliability of the methods of assessment is a final important issue because research on the validity of a disorder is restricted by the degree to which it can be identified reliably (Spitzer and Williams, 1980). The critical types of reliability are test–retest and interrater.

Included in Table 1 are all of the known studies designed to test the validity of a *DSM*-based disorder in an infant, toddler, or preschool sample. Thus, studies in which samples included preschoolers but did not analyze the validity data separately for that population were not included (e.g., Lahey et al., 1994). The table also does not include studies that did not analyze groups by separate diagnoses. For example, there have been numerous excellent studies on disruptive behavior disorders that combined ODD and CD and/or ADHD. The studies listed under the discriminant, predictive, and construct validity columns contribute to face validity but are not repeated under that column to save space. Finally, to keep the table focused, studies that treated disorders as comorbid disorders to a primary disorder were listed only in the row for their primary disorder.

In sum, this represents over 40 empirical studies. We cite these as evidence for the existence of psychopathology as defined by the conventional nosology and as the source of data used by the task force in deliberations on the criteria. As can be seen from the table, varying levels of empirical support exist for different disorders. The disruptive behavior disorders (ADHD, ODD, and CD) have received the most attention, from multiple sites, and have studies that support each type of validity. Young children can be validly and reliably detected with these syndromes as worded. This same conclusion can be drawn for MDD, but follows from

only three studies at one site. To the contrary, the work on PTSD suggested many developmental changes to the wording of criteria, and a reduction in the number of avoidance and numbing symptoms was required for the diagnosis. The work on RAD has had to focus on developing clearly specified criteria since these did not previously exist, and looking at preliminary face validity and reliability. Researchers on RAD have also had to address major conceptual issues regarding the salient exclusionary criteria and testing an expanded number of proposed types of attachment disorders. The sleep disorders have been rigorously studied for over 20 years and can be distinguished as either sleep-onset or night-waking disorders, but these subtypes have not been incorporated into the *DSM-IV*. The six feeding disorders represent a significant departure from the one feeding disorder in *DSM-IV* both in number and conceptualization. They have been described mainly from a single site, and the support for their face validity is overly dependent on case reports at this time. Almost all of this work could be enriched by multisite replications with larger samples and shared measures.

THE PROCESS

The aim of this task force was to facilitate systematic research on disorders in infant and preschool-age children (0–5 years) by developing clear criteria for a number of disorders. This was a circumscribed effort that was focused on a single end product. When clinical- or research-based evidence suggested that the existing nosology did not adequately capture the phenomenology of a particular disorder in young children, the existing criteria were reviewed in terms of developmental appropriateness, and criteria subsequently were modified or created to be developmentally sensitive based on empirical research or clinical expertise. This process was initiated in 2000 by the Committee on Pre-School Children of the American Psychiatric Association (APA). An independent task force of researchers with broad clinical and developmental expertise who had made contributions to the empirical understanding of diagnoses in this age group (see appendix) met to develop operationalized diagnostic criteria for relevant disorders in children under 6 years old. The group received initial support from the APA and major support from the American Academy of Child and Adolescent Psychiatry (AACAP), but neither organization influenced, owns, or endorsed the criteria. The primary purpose of these criteria is to provide a systematic means for generating research on the validity of these disorders, rather than providing a definitive standard.

Guiding Principles for the Task Force

It was recognized that the aim to develop operationalized criteria was challenged by four factors unique to the infancy and preschool period. First, language and cognitive capacities are absent, emerging, or evolving in complexity, which makes it difficult to ascertain when a child has the developmental capacity for symptoms that derive from those capacities. Second, these same developmental changes might make the manifestation of some symptoms appear different at different developmental stages, consistent with the concept of multi-finality (Cicchetti and Rogosch, 1996). Third, when language and cognitive capacities are not yet mature, this severely limits the ability of the child to report on his or her own symptoms. This limits an investigator's access to the child's internal world and subjective experiences. It also becomes a source for potential informant bias because the caregiver is the main or only source of diagnostic information. Fourth, two factors suggest that both caregivers and investigators may systematically underestimate the degree of psychopathology in young children. Because of their smaller size, young children simply can be more easily managed. Also, because of resistance to the notion that young children can manifest mental disorders, adults tend to dismiss clinical problems as normative developmental perturbations (Wakschlag and Danis, in press). Hence, the following guidelines were established at the outset to provide structure to the deliberations on criteria:

1. *Closely Adhere to the DSM-IV.* Existing *DSM-IV* criteria were not to be modified unless empirical data existed to justify a change for this age group. In the absence of empirical data, criteria were modified if the wording

was inconsistent with clinical expertise or inappropriate in light of the developmental capacities of this age period. Although we recognized the need to achieve greater developmental sensitivity in some criteria, this rule provided a barricade to reinvent existing criteria or create new symptoms based on anecdotal evidence. This strategy has the advantage of potentially allowing age-related comparisons with the vast literature on diagnoses in older age groups.

2. Do Not Infer Internal States. The internal thoughts and feelings of young children often cannot be ascertained because of their limited cognitive and verbal capacities. To maximize the accuracy and reliability (i.e., validity) of diagnoses, as a rule, if a child is not able to report on internal thoughts and/or feelings due to limited cognitive or verbal capacities, then these cannot be inferred by “guessing.” This means that some symptoms that are easily investigated in older children simply cannot be rated in young children. Alternatively, some symptoms had to be modified so that behaviors, not internal states, are rated.

3. Do Not Include Parental Behaviors That Cause Symptoms in Children. Consistent with the *DSM-IV* philosophy, our goal was to describe disorders in children as “syndromes—that is, clusters of symptoms that covary together” (Kupfer et al., 2002, p. xvi), rather than etiologically (with some exceptions). The caregiving context is tremendously important in children and adolescents, and it may be uniquely salient in infants and young children. However, identifying parental behaviors as etiological factors in operationalized diagnostic criteria is an enormously complex task. This stance may be modified in the future if empirical data emerge that provide a clear and convincing case for including parental behaviors in a classification scheme.

4. Maintain a Clear Distinction Between Symptoms and Disability/Impairment. Nearly every psychiatric disorder includes a criterion of impairment in functioning, or disability, caused by the symptoms. However, symptoms do not necessarily equate with disability, and disability does not always neatly correlate with symptom severity (Angold et al., 1999). An important measurement issue that we faced was wording of the criteria to maintain this distinction. When assessing any age group, it is tempting to fall back on the existence of disability as evidence that a behavior is really a psychiatric symptom. When dealing with preschool children, in whom the definition of symptomatic behaviors can be quite similar to developmentally expectable behaviors (e.g., temper tantrums, emotional lability, limited attention span, high activity level, sleep disruptions, picky eating preferences, fears, and phobias), it is especially tempting to fall back on the disability test. Therefore, wording in the criteria was selected to avoid confounding symptoms and disability. One overall disability criterion was required for each disorder, as in *DSM-IV*.

An additional consideration was that the domains for measuring impairment in young children are relatively restricted. We cannot measure workplace or school functioning. The main spheres of functioning for young children are relations with parents and with siblings and/or peers. Further, impaired functioning can often be compensated for by caregivers who alter their routine around the child, which may mask the impairment. For example, a 3-year-old child with separation anxiety disorder may have little impairment as long as the parent modifies his or her own activities to avoid a separation. In this example, the parent’s functioning is restricted more than the child’s. It is not clear yet how to incorporate an assessment of parental behavior into the impairment criterion for the child.

Research Diagnostic Criteria-Preschool Age

This effort has culminated in a list of diagnostic criteria titled Research Diagnostic Criteria-Preschool Age (RDC-PA) (appendix). The RDC-PA covers 19 disorders. The participants thoroughly reviewed 13 disorders from the *DSM-IV*. Two of these disorders were replaced by expanded classifications: feeding disorder of infancy or early childhood was replaced by six proposed disorders; and primary insomnia was replaced by two proposed disorders. The majority of *DSM-IV* symptoms and algorithms were not modified. There were 87 symptoms in the 13 *DSM-IV* disorders that were thoroughly reviewed word for word. Fifty-one percent ($n = 44$) of the symptoms were not changed at all. Another 34% ($n = 30$) were developmentally modified, with the original meaning left intact. Only 15% ($n = 13$) were deleted on the grounds of being developmentally

inappropriate. For example, the “sense of a foreshortened future” symptom in PTSD requires cognitive abstraction capacities about the long-range future that are not developed in this age group. Twenty-two new symptoms were added, mostly in the expanded feeding and sleep disorders. Ten experimental symptoms were listed as candidates for further study but not included in the criteria for diagnoses. For example, “loss of previously acquired developmental skills, such as language or toileting” is an experimental item listed under PTSD because it has been found empirically to be a common symptom in traumatized young children (Scheeringa et al., 2001). In addition, four anxiety disorders (agoraphobia without history of panic disorder, social phobia, obsessive compulsive disorder, and generalized anxiety disorder) were considered by consensus to have face validity (i.e., they exist) but were not reviewed because there are no empirical data in this age group.

A new disorder of inhibition/avoidance was proposed for further study based in part on the extensive research on the construct of behavioral inhibition in young children. It has been shown that behavioral inhibition can be validly measured in young children (Kagan et al., 1984), is heritable (Robinson et al., 1992), is stable in a subset (Hirshfeld et al., 1992), occurs more frequently in at-risk children of anxious parents (Rosenbaum et al., 2000), and is significantly associated with the later development of anxiety disorders (Hirshfeld et al., 1992). One logical question is whether behavioral inhibition is a temperament trait that may serve as a risk factor for later disorder, or a disorder in and of itself (Biederman et al., 1995). We decided to include this as a potential disorder to promote investigations of this question.

It is evident that the criteria are best supported in many disorders for use in 3- to 5-year-old children, and less is generally known for 0- to 2-year-old children. For example, the criteria for the disruptive behavior disorders are clearly more salient for the former age group. On the other hand, some disorders, such as the feeding disorders, are clearly more salient for the latter age group. The decision was made not to create separate criteria for these two age groups and to rely on the rigor and/or training of individual researchers and clinicians to remain vigilant to this breach.

The feeding disorders aroused the most controversy within the task force. First, the sheer number of them (six) raised concerns about excessive splitting. However, it has long been apparent that too many diverse conditions have been lumped under one *DSM* feeding disorder of infancy and the ambiguous failure-to-thrive literature (e.g., Woolston, 1983). Second, five of the six disorders are based on an etiology; this is relatively uncommon in nosologies and thus invites special attention. Such skepticism is expected as most clinicians would not have the opportunity to see feeding disorders unless they consulted to medical inpatient units. However, there are clear precedents for etiologically based disorders in the *DSM-IV*, and an etiology-based nosology is the highest level of nosology (Kupfer et al., 2002). The case for etiology becomes more compelling when the distinction denotes a different prognosis and the need for different treatments and different preventions, as have all been argued for with the different feeding disorders (Chatoor, 2002). Third, there have been no group studies with systematic diagnostic interviews. Although true, this situation is less likely to be rectified if the criteria that form the basis for such interviews are never created. In the end, despite the lack of unanimous agreement on how to present the feeding disorders, and some sharply dissenting viewpoints, the majority of the task force favored the current scheme. Bipolar disorder is a current topic of controversy in older children based on research that is detecting relatively high rates of the disorder (Biederman et al., 2000). There are now purported cases of preschool children in the literature (Mota-Castillo et al., 2001; Pavuluri et al., 2002). Developmentally sensitive studies are needed in children under 6 years to determine whether and/or how mania can manifest.

CONCLUSIONS

While there is an enormous gap in diagnostic validity between younger and older children, there is a wealth of empirical information on infants and pre-school children. The field is now at a point where face validity of many disorders is no longer an issue, as it might have been just 10 years ago. The next step is a

more systematic and large-scale effort to study psychiatric disorders in infants and preschool children. The criteria proposed in the RDC-PA are meant to be a catalyst to facilitate this research. One ideal outcome would be that all of the relevant disorders in standard nosologies (*DSM* and *ICD*) would have empirically supported, age-appropriate guidelines for the life span. In due time, it is hoped that better validation of disorders will lead to epidemiological surveys, treatment efficacy studies, and studies of differential correlates of disorders such as neurobiological, family, and genetic variables. Table 1 clearly marks the gaps that need to be filled. Fortunately, the NIMH has recognized this need, and a program announcement was issued in 2000 (PA-00-094) to indicate this as an area of priority funding.

This effort is bound to generate renewed interest and controversy in the “proper” diagnosis of very young children. An additional complicating matter is the lack of consensus on the optimal procedures for assessing the presence of criteria. Clearly, defining a symptom is one thing and knowing how to measure it is quite another (see Spitzer and Williams, 1980). This is further problematical because relatively little diagnostic information can be obtained directly from the children. The task of developing a consensus on the appropriate methods of assessment is contingent on the existence of valid diagnostic criteria. Given the relative dearth of attention to this topic in the past, any systematic collection of data that informs such questions, as opposed to expert opinion, ought to be welcomed.

It is possible that secondary uses of this effort will include impacts on diagnostic considerations by clinical practitioners, policy-makers, insurers, and administrators of mental health programs. These criteria are in no way endorsed for immediate usage in clinical practice and for insurance reimbursement plans. On the other hand, these criteria were developed with careful attention to empirical research that can be supported with published data. These are areas of vital concern in regards to the well-being of young children that can only benefit from a stronger research base from which to make informed decisions.

REFERENCES

- American Psychiatric Association (1980), *Diagnostic and Statistical Manual, 3rd edition (DSM-III)*. Washington, DC: American Psychiatric Association
- American Psychiatric Association (1998), *DSM-IV Sourcebook, Volume 4* (p 2). Washington, DC: American Psychiatric Association
- Anastasi A, Urbina S (1997), *Psychological Testing, 7th ed.* Upper Saddle River, NJ: Prentice-Hall
- Anders TF, Keener MA (1985), Developmental course of nighttime sleep wake patterns in full-term and premature infants during the first year of life: I. *Sleep* 8:173–192
- Anders TF, Keener MA, Kraemer H (1985), Sleep wake state organization, neonatal assessment and development in premature infants during the first year of life: II. *Sleep* 8:193–206
- Anders TF, Sostek AM (1976), The use of time lapse video recording of sleep-wake behavior in human infants. *Psychophysiology* 13:155–158
- Angold A, Costello EJ, Farmer EMZ, Burns BJ, Erkanli A (1999), Impaired but undiagnosed. *J Am Acad Child Adolesc Psychiatry* 38:129–137
- Azarian A, Skriptchenko-Gregorian V, Miller TW, Kraus RF (1994), Child hood trauma in victims of the Armenian earthquake. *J Contemp Psychotherapy* 24:77–85
- Benoit D, Coolbear J (1998), Post-traumatic feeding disorders in infancy: behaviors predicting treatment outcome. *Infant Ment Health J* 19:409–421
- Benoit D, Green D, Arts-Rodas D (1997), Posttraumatic feeding disorders. *J Am Acad Child Adolesc Psychiatry* 36:577–578
- Benoit D, Zeanah CH, Boucher C, Minde KK (1992), Sleep disorders in early childhood: association with insecure maternal attachment. *J Am Acad Child Adolesc Psychiatry* 31:86–93
- Biederman J, Mick E, Faraone SV, Spencer T, Wilens TE, Wozniak J (2000), Pediatric mania: a developmental subtype of bipolar disorder? *Biol Psychiatry* 48:458–466

- Biederman J, Rosenbaum JF, Chaloff J, Kagan J (1995), Behavioral inhibition as a risk factor for anxiety disorders. In: *Anxiety Disorders in Children and Adolescents*, March JS, ed. New York: Guilford, pp 61–81
- Boris NW, Zeanah CH, Larrieu JA, Scheeringa MS, Heller SS (1998), Attachment disorders in infancy and early childhood: a preliminary investigation of diagnostic criteria. *Am J Psychiatry* 155:295–297
- Burke MG (2003), Depression in preschool children (letter). *J Am Acad Child Adolesc Psychiatry* 42:263–264
- Burnham MM, Goodlin-Jones BL, Gaylor EE, Anders TF (2002), Night- time sleep-wake patterns and self-soothing from birth to one year of age: a longitudinal intervention study. *J Child Psychol Psychiatry* 43:713–725
- Campbell SB (1995), Behavior problems in preschool children: a review of recent research. *J Child Psychol Psychiatry* 36:113–149
- Cantwell DP, Rutter M (1994), Classification: conceptual issues and substantive findings. In: *Child and Adolescent Psychiatry: Modern Approaches, 3rd ed*, Rutter M, Taylor E, Hersov L, eds. London: Blackwell Scientific, pp 3–21
- Chatoor I (1989), Infantile anorexia nervosa: a developmental disorder of separation and individuation. *J Am Acad Psychoanalysis* 17:43–64
- Chatoor I (2002), Feeding disorders in infants and toddlers: diagnosis and treatment. *Child Adolesc Psychiatr Clin North Am* 11:163–183
- Chatoor I, Egan J, Getson P, Menvielle E, O'Donnell R (1988), Mother– infant interactions in infantile anorexia nervosa. *J Am Acad Child Adolesc Psychiatry* 27:535–540
- Chatoor I, Ganiban J, Colin V, Plummer N, Harmon RJ (1998a), Attachment and feeding problems: a reexamination of nonorganic failure to thrive and attachment insecurity. *J Am Acad Child Adolesc Psychiatry* 37:1217–1224
- Chatoor I, Ganiban J, Harrison J, Hirsch R (2001), Observation of feeding in the diagnosis of posttraumatic feeding disorder of infancy. *J Am Acad Child Adolesc Psychiatry* 40:595–602
- Chatoor I, Ganiban J, Hirsch R, Borman-Spurrell E, Mrazek DA (2000), Maternal characteristics and toddler temperament in infantile anorexia. *J Am Acad Child Adolesc Psychiatry* 39:743–751
- Chatoor I, Getson P, Menvielle E et al. (1997), A feeding scale for research and clinical practice to assess mother-infant interactions in the first three years of life. *Infant Ment Health J* 18:76–91
- Chatoor I, Hirsch R, Ganiban J, Persinger M, Hamburger E (1998b), Diagnosing infantile anorexia: the observation of mother-infant interactions. *J Am Acad Child Adolesc Psychiatry* 37:959–967
- Cicchetti D, Rogosch FA (1996), Equifinality and multifinality in developmental psychopathology. *Dev Psychopathol* 8:597–600
- Crowell J, Keener M, Ginsburg N, Anders T (1987), Sleep habits in toddlers 18 to 36 months old. *J Am Acad Child Adolesc Psychiatry* 26:510–515
- Dunitz M, Scheer PJ, Kvas E, Macari S (1996), Psychiatric diagnoses in infancy: a comparison. *Infant Ment Health J* 17:12–23
- DuPaul GJ, McGoey KE, Eckert TL, VanBrakle J (2001), Preschool children with attention-deficit/hyperactivity disorder: impairments in behavioral, social, and school functioning. *J Am Acad Child Adolesc Psychiatry* 40:508–515
- Earls F (1982), Application of *DSM-III* in an epidemiological study of preschool children. *Am J Psychiatry* 139:242–243
- Gaylor EE, Goodlin-Jones BL, Anders TF (2001), Classification of young children's sleep problems: a pilot study. *J Am Acad Child Adolesc Psychiatry* 40:61–67
- Goodlin-Jones BL, Burnham MM, Gaylor EE, Anders TF (2001), Night waking, sleep-wake organization, and self-soothing in the first year of life. *J Dev Behav Pediatr* 22:226–233
- Goodlin-Jones BL, Eiben LA, Anders TF (1997), Maternal well-being and sleep-wake behaviors in infants: an intervention using maternal odor. *Infant Ment Health J* 18:378–393
- Greenberg MT, Speltz ML, Deklyen M, Endriga MC (1991), Attachment security in preschoolers with and

- without externalizing behavior problems: a replication. *Dev Psychopathol* 3:413–430
- Greenberg MT, Speltz ML, Deklyen M, Jones K (2001), Correlates of clinic referral for early conduct problems: variable- and person-oriented approaches. *Dev Psychopathol* 13:255–276
- Halpern LF, Anders TF, Garcia-Coll C, Hua J (1994), Infant temperament: is there a relation to sleep wake states and maternal nighttime behavior? *Infant Behav Dev* 17:255–263
- Hirshfeld DR, Rosenbaum JF, Biederman J et al. (1992), Stable behavioral inhibition and its association with anxiety disorder. *J Am Acad Child Adolesc Psychiatry* 31:103–111
- Kagan J, Reznick JS, Clarke C, Snidman N, Garcia-Coll C (1984), Behavioral inhibition to the unfamiliar. *Child Dev* 55:2212–2225
- Keenan K, Shaw DS, Walsh B, Delliquadri E, Giovannelli J (1997), *DSM-III-R* disorders in preschool children from low-income families. *J Am Acad Child Adolesc Psychiatry* 36:620–627
- Keenan K, Wakschlag LS (2000), More than the terrible twos: the nature and severity of disruptive behavior problems in clinic-referred preschool children. *J Abnorm Child Psychol* 28:33–46
- Kupfer DJ, First MB, Regier DA (2002), *A Research Agenda for DSM-V*. Washington, DC: American Psychiatric Association
- Lahey BB, Applegate B, Barkley RA et al. (1994), *DSM-IV* field trials for oppositional defiant disorder and conduct disorder in children and adolescents. *Am J Psychiatry* 151:1163–1171
- Lahey BB, Pelham WE, Stein MA et al. (1998), Validity of *DSM-IV* attention-deficit/hyperactivity disorder for younger children. *J Am Acad Child Adolesc Psychiatry* 37:695–702
- Laor N, Wolmer L, Mayes LC et al. (1996), Israeli preschoolers under Scud missile attacks. *Arch Gen Psychiatry* 53:416–423
- Laor N, Wolmer L, Mayes LC, Gershon A, Weizman R, Cohen DJ (1997), Israeli preschool children under Scuds: a 30-month follow-up. *J Am Acad Child Adolesc Psychiatry* 36:349–356
- Lavigne JV, Gibbons RD, Christoffel KK et al. (1996). Prevalence rates and correlates of psychiatric disorders among preschool children. *J Am Acad Child Adolesc Psychiatry* 35:204–214
- Luby JL, Heffelfinger A, Mrakotsky C, Brown K, Hessler M, Spitznagel E (in press), Alterations in stress cortisol reactivity in depressed preschoolers relative to psychiatric and no disorder comparison groups. *Arch Gen Psychiatry*
- Luby JL, Heffelfinger AK, Mrakotsky C et al. (2003a), The clinical picture of depression in preschool children. *J Am Acad Child Adolesc Psychiatry* 42:340–348
- Luby JL, Heffelfinger AK, Mrakotsky C, Hessler MJ, Brown KM, Hildebrand T (2002), Preschool major depressive disorder: preliminary validation for developmentally modified *DSM-V* criteria. *J Am Acad Child Adolesc Psychiatry* 41:928–937
- Luby JL, Mrakotsky C, Heffelfinger A, Brown K, Hessler M, Spitznagel E (2003b), Modification of *DSM-IV* criteria for depressed preschool children. *Am J Psychiatry* 160:1169–1172
- Marcus DM (1989), The pre-school child at risk: an eating disorder. *Child Adolesc Soc Work J* 6:65–71
- Minde K, Faucon A, Falkner S (1994), Sleep problems in toddlers: effects of treatment on their daytime behavior. *J Am Acad Child Adolesc Psychiatry* 33:1114–1121
- Minde K, Popiel K, Leos N, Falkner S, Parker K, Handley-Derry M (1993), The evaluation and treatment of sleep disturbances in young children. *J Child Psychol Psychiatry* 34:521–533
- Mota-Castillo M, Torruella A, Engels B, Perez J, Dedrick C, Gluckman M (2001), Valproate in very young children: an open case series with a brief follow-up. *J Affect Disord* 67:193–197
- Ohmi H, Kojima S, Awai Y et al. (2002), Post-traumatic stress disorder in pre-school aged children after a gas explosion. *Eur J Pediatr* 161:643–648
- Pavuluri MN, Janicak PG, Carbray J (2002), Topiramate plus risperidone for controlling weight gain and symptoms in preschool mania. *J Child Adolesc Psychopharmacol* 12:271–273
- Pine DS, Alegria M, Cook EH et al. (2002), Advances in developmental science and *DSM-V*. In: *A Research Agenda for DSM-V*, Kupfer DJ, First MB, Regier DA, eds. Washington, DC: American Psychiatric

- Association, pp 85–122
- Quay HC (1986), A critical analysis of *DSM-III* as a taxonomy of psychopathology in childhood and adolescence. In: *Contemporary Directions in Psychopathology: Towards the DSM-IV*, Millon T, Klerman GL, eds. New York: Guilford, pp 151–165
- Robins E, Guze SB (1970), Establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. *Am J Psychiatry* 126:107–111
- Robinson JL, Kagan J, Reznick JS, Corley R (1992), The heritability of inhibited and uninhibited behavior: a twin study. *Dev Psychol* 28:1030–1037
- Rosenbaum JF, Biederman J, Hirshfeld-Becker DR et al. (2000), A controlled study of behavioral inhibition in children of parents with panic disorder and depression. *Am J Psychiatry* 157:2002–2010
- Ross C, Blanc H, McNeil C, Eyberg S, Hembree-Kigin T (1998), Parenting stress in mothers of young children with oppositional defiant disorder and other severe behavior problems. *Child Study J* 28:93–110
- Sadeh A (1994), Assessment of intervention for infant night waking: parental reports and activity-based home monitoring. *J Consult Clin Psychol* 62:63–68
- Sadeh A, Acebo C, Seifer R, Aytur S, Carskadon MA (1995), Activity-based assessment of sleep wake patterns during the 1st year of life. *Infant Behav Dev* 18:329–337
- Sadeh A, Lavie P, Scher A (1994), Sleep and temperament: maternal perceptions of temperament of sleep-disturbed toddlers. *Early Educ Dev* 5:311–322
- Scheeringa MS, Peebles CD, Cook CA, Zeanah CH (2001), Toward establishing procedural, criterion and discriminant validity for PTSD in early childhood. *J Am Acad Child Adolesc Psychiatry* 40:52–60
- Scheeringa MS, Zeanah CH (1995), Symptom differences in traumatized infants and young children. *Infant Ment Health J* 16:259–270
- Scheeringa MS, Zeanah CH, Drell MJ, Larrieu JA (1995), Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. *J Am Acad Child Adolesc Psychiatry* 34:191–200
- Scheeringa MS, Zeanah CH, Myers L, Putnam FW (2002), *Heart Rate and RSA Reactivity in Traumatized Preschool Children*. Symposium presented at the International Society for Traumatic Stress Studies 18th Annual Meeting, Baltimore, November 9
- Scheeringa MS, Zeanah CH, Myers L, Putnam FW (2003), New findings on alternative criteria for PTSD in preschool children. *J Am Acad Child Adolesc Psychiatry* 42:561–570
- Speltz ML, DeKlyen M, Greenberg MT, Dryden M (1995), Clinic referral for oppositional defiant disorder: relative significance of attachment and behavioral variables. *J Abnorm Child Psychol* 23:487–507
- Speltz ML, Greenberg MT, Deklyen M (1990), Attachment in preschoolers with disruptive behavior: a comparison of clinic-referred and nonproblem children. *Dev Psychopathol* 2:31–46
- Speltz ML, McClellan J, DeKlyen M, Jones K (1999), Preschool boys with oppositional defiant disorder: clinical presentation and diagnostic change. *J Am Acad Child Adolesc Psychiatry* 38:838–845
- Spitzer RL, Endicott J, Robins E (1978), Research diagnostic criteria. *Arch Gen Psychiatry* 35:773–782
- Spitzer RL, Williams JBW (1980), Classification of mental disorders and *DSM-III*. In: *Comprehensive Textbook of Psychiatry*, Vol 4, Kaplan H, Freedman AM, Sadock BJ, eds. Baltimore: Williams & Wilkins, pp 1035–1072
- Stafford B, Zeanah CH, Scheeringa M (2003), Exploring psychopathology in early childhood: PTSD and attachment disorders in DC: 0-3 and *DSM-IV*. *Infant Ment Health J* 24:398–409
- Tikotzky L, Sadeh A (2001), Sleep patterns and sleep disruptions in kindergarten children. *J Clin Child Adolesc Psychol* 30:581–591
- Wakschlag LS, Danis B (in press), Assessment of disruptive behavior in young children: a clinical-developmental framework. In: *Handbook of Infant and Toddler Mental Health Assessment*, del Carmen R, Carter AS, eds. New York: Oxford
- Wilens TE, Biederman J, Brown S et al. (2002), Psychiatric comorbidity and functioning in clinically referred preschool children and school-age youths with ADHD. *J Am Acad Child Adolesc Psychiatry* 41:262–268

Willcutt EG, Hartung CM, Lahey BB, Loney J, Pelham WE (1999), Utility of behavior ratings by examiners during assessments of preschool children with attention-deficit/hyperactivity disorder. *J Abn Child Psychol* 27:463–472

Woolston JL (1983), Eating disorders in infancy and early childhood. *J Am Acad Child Psychiatry* 22:114–121

Zeanah CH (2000), *Handbook of Infant Mental Health*. New York: Guilford Zero to Three (1994), *Diagnostic Classification: 0-3*. Washington, DC: Zero to Three: National Center for Infants, Toddlers, and Families

TABLE 1

Studies That Demonstrated Validity and/or Reliability for a Disorder in a 0–5 Years Sample.

Disorder	Reliability	Face Validity	Descriptive Validity	Predictive Validity	Construct Validity
Attention-deficit/hyperactivity disorder	Speltz et al., 1999; Keenan and Wakschlag, 2000; Wilens et al., 2002	Keenan et al., 1997; Keenan and Wakschlag, 2000; Lahey et al., 1998	Keenan et al., 1997; Keenan and Wakschlag, 2000; Wilens et al., 2002	Speltz et al., 1999	DuPaul et al., 2001; Ross et al., 1998; Wilens et al., 2002; Willcutt et al., 1999
Oppositional defiant disorder	Speltz et al., 1999; Keenan and Wakschlag, 2000	Keenan et al., 1997; Keenan and Wakschlag, 2000	Keenan et al., 1997; Keenan and Wakschlag, 2000; Ross et al., 1998	Speltz et al., 1999	Greenberg et al., 1991, 2001; Keenan and Wakschlag, 2000; Ross et al., 1998; Speltz et al., 1990, 1995
Conduct disorder	Speltz et al., 1999; Keenan and Wakschlag, 2000	Keenan et al., 1997; Keenan and Wakschlag, 2000; Ross et al., 1998	Keenan et al., 1997; Keenan and Wakschlag, 2000		Keenan and Wakschlag, 2000
Major depressive disorder	Luby et al., 2002	Luby et al., 2002, 2003a,b	Luby et al., 2003a,b	Luby et al., 2003b	Luby et al., 2002, in press
Posttraumatic stress disorder	Scheeringa et al., 1995, 2001, 2003	Azarian et al., 1994; Ohmi et al., 2002; Scheeringa et al., 1995, 2001, 2003	Scheeringa et al., 2003		Laor et al., 1996, 1997; Scheeringa and Zeanah, 1995; Scheeringa et al., 2002
Reactive attachment disorder	Boris et al., 1998	Boris et al., 1998			
Sleep-onset protodyssomnia and night-waking protodyssomnia	Anders & Sostek, 1976; Minde et al., 1993 (video); Sadeh, 1994 (actigraph); Sadeh et al., 1995; Tikotzky and Sadeh, 2001	Crowell et al., 1987; Gaylor et al., 2001; Goodlin-Jones et al., 2001; Sadeh et al., 1995		Anders and Keener, 1985; Burnham et al., 2002; Gaylor et al., 2001	Anders et al., 1985; Benoit et al., 1992; Burnham et al., 2002; Goodlin-Jones et al., 1997; Halpern et al., 1994; Minde et al., 1994; Sadeh, 1994 (waking only); Sadeh et al., 1994
Feeding disorder of state regulation		(Chatoor, 1989, 2002)			Chatoor et al., 1997
Feeding disorder of caregiver–infant reciprocity		(Chatoor, 2002); (Chatoor, 1989); (Marcus, 1989)			Chatoor et al., 1997
Infantile anorexia	Chatoor et al., 1998b	(Chatoor, 2002); Chatoor et al., 1998b, 2001	Chatoor et al., 2001		Chatoor et al., 1988, 1998a,b, 2000, 2001
Sensory food aversion		(Chatoor, 2002)			

Feeding disorder associated with concurrent medical condition		(Chatoor, 2002)			
Posttraumatic feeding disorder		Chatoor et al., 2001	Chatoor et al., 2001		Benoit and Coolbear, 1998; Benoit et al., 1997; Chatoor et al., 2001

Note: Case reports are in parentheses.

RESEARCH DIAGNOSTIC CRITERIA – PRESCHOOL AGE (RDC-PA)

August 17, 2002

The diagnostic criteria are listed below in the format numbering system of the DSM-IV. If a symptom criterion was not modified from the DSM-IV wording, it was not restated here for visual clarity to highlight the changes. The overall functional impairment criterion for each disorder was not addressed and is not listed here. Exclusionary criteria were not listed unless they were modified. The reader is referred to the DSM-IV for all of these unmodified items that are not listed here.

Deviations from the DSM-IV wording are in *italics*.

Boxed messages are not part of the criteria.

DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD, OR ADOLESCENCE

ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS

The determination of clinical significance of the symptoms for the attention-deficit and disruptive behavior disorders during the preschool period is challenging because typical variation in these domains is quite broad. Empirical data and clinical experience suggest that these proposed criteria are most applicable to 3-5 year old children, whereas information is more sparse about how well they apply to children younger than 3 years of age. The DSM-IV algorithms for the number of symptoms needed to meet the diagnoses are listed as a reference point but we emphasize that further research is needed to confidently establish the algorithm(s) for all ages.

Attention-Deficit/Hyperactivity Disorder

Diagnostic Features

This disorder is characterized by persistent and developmentally inappropriate short attention span and/or impulsivity and hyperactivity for a period of at least 6 months. A 6-month duration requirement may represent an inconveniently long time for confirming a diagnosis relative to the age of this population. A shorter duration may make more practical sense for research protocols (and clinical service delivery). How much this requirement ought to be shortened, if at all, awaits empirical data gathering. It should be noted that 3 DSM-IV inattention items (A1a “careless mistakes”; A1g “loses things”; and A1i “forgetful”), 1 DSM-IV hyperactivity item (A2e “driven by a motor”), and 1 DSM-IV impulsivity item (A2g “blurts out answers”) were considered by the task force to be developmentally inappropriate items. However, these items were not dropped because empirical studies have shown that preschool children can be diagnosed with these criteria and this algorithm, and no symptom utility studies have been conducted that could support their removal.

Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

No change from DSM-IV.

Experimental Symptoms:

1. Modified A1d. Often does not follow through on instructions and fails to finish *tasks or chores*

(not due to oppositional behavior or failure to understand instructions).

2. Modified A1f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (*e.g., being read to, engaging in a craft activity*).

3. Modified A2b. Often leaves seat *in situations* in which remaining seated is expected.

4. Modified A2c. Often runs about or climbs excessively in situations in which it is inappropriate (*e.g., dangerous situations*).

5. *An absence of or very limited ability to have sustained periods of calm, well-controlled activity.*

Conduct Disorder

Diagnostic Features

Conduct disorder is characterized by a repetitive and persistent pattern of behavior that violates norms and rules and the basic rights of others. The diagnosis of CD rests on the assumption that a child knowingly violates rules, a supposition that requires both knowledge of the rules and intent to break them. Most preschool children are generally able to understand the concept of rules and can control their behavior accordingly.

The duration requirement was shortened from 12 months to 6 months. This decision was made because 12 months is a disproportionate amount of a child's life span in this population relative to older children. Because preschoolers are not skilled in verbal negotiation, they may make threats (*e.g., I won't be your friend*) as a means of resolving disputes. Bullying and threatening should be endorsed positively only when threats and intimidation are persistent patterns of behavior and involve threats of aggression or cruelty (*e.g., social ostracism*). Infrequent, reactive mild aggression towards peers or objects is common during this period. Atypical aggression is more frequent and may be severe (*e.g., kicking, biting, and choking*). The effect of physical constraints on the manifestation of symptoms during this period must be considered. For example, most preschool children are not likely to have access to firearms or knives, but may use rocks or sticks to hurt someone.

Six of the 15 DSM-IV symptoms were modified and 5 symptoms were not. Four DSM-IV symptoms were deleted because they were inappropriate in relation to the developmental capacities of this age group (A10 "broken into someone else's house, building, or car"; A13 "stays out at night"; A14 "run away"; and A15 "truant"). Since only 1 new symptom was added, this makes fewer possible symptoms available for children to meet the diagnosis.

Diagnostic criteria for Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the *past 6 months*.

Aggression to people and animals

No change from DSM-IV.

Frequently initiates physically aggressive behavior towards others.

Has used an *object* that can cause serious physical harm to others *in an aggressive act on more than one occasion*.

No change from DSM-IV.

No change from DSM-IV.

Has bullied or threatened someone in order to take something that doesn't belong to them.

Has forced someone into inappropriate sexual activity (e.g., forcing another child to remove his/her clothes or touching or fondling another child's genitals).

(New) Often reacts to frustration with aggressive behavior towards others.

Destruction of property

Has *repeatedly* engaged in *destructive* fire setting.

No change from DSM-IV.

Deceitfulness or theft

No change from DSM-IV.

Has stolen items of *any value on more than one occasion (do not include taking food from in the home)*.

Experimental symptom:

Is often verbally aggressive (e.g., swearing or threats of violence) towards adults.

Oppositional Defiant Disorder

Diagnostic Features

This disorder is characterized by a pattern of negativistic, hostile, and defiant behavior. The DSM-IV states that, since oppositional behavior is common during the preschool period, the diagnosis of ODD should be made with caution. As with older children, clinically significant oppositional defiant behavior in preschool children can be distinguished from typical behaviors in terms of the persistence, pervasiveness, severity and extent to which the behavior interferes with normative developmental functioning. For example, periodic tantruming in response to limit setting from which the child recovers relatively quickly is typical during this period. Atypical tantrums often occur multiple times per day, are intense and prolonged, and are elicited by both positive and negative social situations.

Diagnostic criteria for Oppositional Defiant Disorder

No change from DSM-IV.

Experimental symptom:

Has significant difficulty recovering from emotional upset.

FEEDING AND EATING DISORDERS OF INFANCY OR EARLY CHILDHOOD

The DSM-IV section titled Feeding and Eating Disorders of Infancy or Early Childhood contains 3 disorders – Pica, Rumination Disorder, and Feeding Disorder of Infancy or Early Childhood. Pica and Rumination Disorder have been well described in DSM-IV for very young children and no modifications were felt necessary. We suggest replacing Feeding Disorder of Infancy or Early Childhood with 6 proposed disorders. Each of these feeding disorders presents with different clinical symptoms, and requires different interventions.

The 6 proposed disorders all involve a clinical judgement about **growth deficiency**. The following definitions provide guidelines for determining when an individual meets the threshold for inadequate weight gain. These definitions are provided only as suggested guidelines for the clinician since it is unreasonable to specify a single standard for minimally normal weight that applies to all individuals of a given age and height. **Growth deficiency may be defined in the following ways:**

Acute malnutrition according to Waterlow criteria (1977) reflects current or “acute” nutritional status. The reference “normal” is 50th percentile weight for height (National Center for Health Statistics: Hamill et al., 1979). Current weight divided by this number gives the percent of ideal body weight. Mild, moderate and severe acute malnutrition correspond with 80-89%, 70-79%, and less than 70% of ideal body weight respectively.

Chronic malnutrition according to Waterlow criteria defines stunting of linear growth. The child’s actual height is divided by the height that corresponds to the 50% NCHS percentile for age of the child or “ideal height”. Mild, moderate, and severe chronic malnutrition correspond with 90-95%, 85-89%, and less than 85% of ideal height respectively.

Additional parameters of faltering growth:

A. The z-score helps characterize anthropometric data of children below the 5th percentile and allows nutritional status to be expressed across different indicators. The mean is equal to zero, and the 5th percentile is equal to –1.64. A z-score of less than –1.64 suggests faltering growth.

B. The child’s weight has deviated two major percentiles in a 2- to 6-month period. This measure is particularly helpful for children who start out tall, grow at the 50th or more percentile for weight and height, and then show a downward bend in their growth pattern.

Feeding Disorder Of State Regulation

Diagnostic Features

Infants with this disorder typically exhibit state regulation problems that interfere with their ability to feed effectively. For example, such infants have difficulties reaching and maintaining a state of alert calmness, and are too sleepy, too excited or distressed to feed. Young infants with immature central nervous systems or medical illnesses, such as cardiac or pulmonary disease, may be at greatest risk for this disorder. Such infants may tire quickly and terminate feedings without taking adequate amounts of milk to grow. Some mothers can compensate for their infant's poor state regulation by helping their infant's reach and maintain calm, alert arousal states via reducing external stimuli. However, mothers who are depressed, anxious, or overwhelmed with stressors may have difficulty dealing with the infant's irritability or unresponsiveness. As such, they may inadvertently intensify the infant's state-regulation difficulties and feeding difficulties.

Diagnostic criteria for Feeding Disorder of State Regulation

A. Has difficulty reaching and maintaining a calm state of alertness for feeding; is either too sleepy or too agitated and/or distressed to feed.

B. The feeding difficulties start in the newborn period.

C. Shows significant failure to gain weight or exhibits weight loss.

Feeding Disorder Of Caregiver-Infant Reciprocity

Diagnostic Features

Most infants with this disorder are detected when they become acutely ill and require emergency treatment. The infants are weak, feed poorly, and avoid eye contact. When picked up, they scissor their legs and hold up their arms in a surrender posture to balance their heads, which appear too heavy for their weak bodies. When held, they do not cuddle like healthy well-fed infants but draw up their legs or appear hypotonic.

Frequently, the mothers are distrustful and difficult to engage, elusive and avoidant of any contact with professionals.

When questioned about their infants' feeding and growth, they seem unaware that there is a problem, and may report that their infants sleep for long periods of time without requiring feeding. Some mothers may admit to propping bottles for feeding and to spending minimal time with their infants. However, the pattern of these infants tends to improve if given consistent attention by a caregiver who engages with the infant during feeding and play.

Diagnostic criteria for Feeding Disorder of Reciprocity

A. Shows a pattern of lack of developmentally appropriate signs of social reciprocity (e.g., visual engagement, smiling, or babbling) with the primary caregiver during feeding.

B. Shows significant growth deficiency

C. The growth deficiency and lack of relatedness are not due solely to a physical disorder, or a pervasive developmental disorder.

Infantile Anorexia

Diagnostic Features

Infants with this feeding disorder are usually referred for a psychiatric evaluation due to their food refusal and growth failure. The infants' food refusal usually becomes of concern between six months and three years, most commonly between 9 and 18 months of age, during the transition to spoon- and self-feeding. However, some parents report that even during

the first few months of life these infants were distracted by external stimuli and became disinterested in feeding. They consumed only small amounts of milk and had to be fed frequently. Often, by the end of the first year of life, when infants are transitioned to spoon- and self-feeding, these infants take only a few bites of food, and then refuse to eat any more. They may refuse to open their mouths for feeding, throw food and feeding utensils, and frequently try to climb out of the high chair or leave the table to play. Most parents report that these infants hardly shown any signals of hunger and seem more interested in exploring and playing than eating. Usually, the parents become increasingly concerned about the infants' poor food intake and they may try to regulate the infants' food intake by coaxing, distracting, offering different food, feeding during play, feeding at night, threatening, and even force-feeding to get their infants to eat more. However, the parents report that these methods worked only temporarily, if at all, and that they were unable to increase their infants' food intake.

Initially, the infants fail to gain adequate weight. After several weeks or months of poor food intake, their linear growth slows down and they develop chronic malnutrition. In most cases, their heads continue to grow at a normal rate. As the children grow older, their bodies appear proportionate, small and thin, but have relatively larger heads. However, once the children begin to eat adequately, they grow better and have the potential for catch-up growth until the end of puberty, when their growth rate declines.

Diagnostic criteria for Infantile Anorexia

A. Refusal to eat adequate amounts of food for at least one month.

B. Onset of the food refusal before 3 years of age.

C. Does not communicate hunger signals, lacks interest in food, but shows strong interest in exploration and/or interaction with caregiver.

D. Shows significant growth deficiency.

E. The food refusal did not follow a traumatic event.

F. The food refusal is not due to an underlying medical illness.

Sensory Food Aversions

Diagnostic Features

Sensory food aversions are common and occur along a spectrum of severity. Some children refuse to eat only a few types of food and the parents accommodate the child's food preferences. Others may refuse most foods and cause serious parental concern. The diagnosis of a feeding disorder should only be made if the food selectivity results in nutritional deficiencies, and/or has led to oral motor delay.

Within this disorder, food refusal is related to the texture, taste, or smell of particular foods. When specific foods are placed in the infants' mouths, the infants' aversive reactions range from grimacing to gagging, vomiting, or spitting out the food. Sensory aversions become apparent when infants are introduced to baby food or table food with a variety of tastes and textures. After an initial aversive reaction, the infants usually refuse to continue eating that particular food, and they become distressed if forced to do so. Some infants generalize their reluctance to eat one food to other foods that look or smell similarly (e.g. an aversion to green beans may generalize to all green vegetables). Parents frequently report that these children are reluctant to eat new foods. Some children may even refuse to eat any food that has touched another food on the plate, while others will only eat food prepared by a specific restaurant or company. Older children with sensory food aversions may experience social anxiety when their peers discover that they eat only certain foods, and some older children may avoid social situations that include eating.

If infants refuse many foods or whole food groups (e.g. vegetables and fruits), their limited diet may lead to specific nutritional deficiencies (e.g. protein, vitamins, zinc, iron). If infants reject foods that require significant chewing (e.g. meats, hard vegetables or fruits), they will fall behind in their oral motor development due to lack of experience with chewing. Frequently, the infants' refusal to eat a variety of foods creates parental concern and conflict within their families at mealtime.

In addition to their sensitivity to certain foods, many of these children experience hypersensitivities in other sensory areas as well. For example, parents frequently report that these infants become distressed when asked to walk on sand or grass, and that they do not like to wear socks, certain types of fabric, or labels on clothing. Many of these children are also hypersensitive to odors and sounds.

Diagnostic criteria for Sensory Food Aversions

Consistently refuses to eat specific foods with specific tastes, textures, and/or smells.

Onset of the food refusal during the introduction of a different type of food (e.g. may drink one type of milk but refuse another; may eat carrots, but refuse green beans; may drink milk but refuse baby food).

Eats without difficulty when offered preferred foods.

The food refusal causes specific nutritional deficiencies or delay of oral motor development.

Feeding Disorder Associated with Concurrent Medical Condition

Diagnostic Features

Infants with medical conditions that cause pain or respiratory distress may develop feeding problems. Some medical conditions are not readily diagnosed and food refusal may be the leading symptom. For example, food allergies can be difficult to diagnose in this young age group and silent reflux is often overlooked by pediatricians because the infant does not vomit, the leading symptom of reflux. Infants with gastro-esophageal reflux can typically drink one to two ounces of milk before reflux is activated. However, once reflux occurs, some infants show signs of discomfort (e.g. wiggling, arching, crying) and push the bottle away. These infants are usually well engaged with their caretakers and willing to feed, but they refuse to continue feeding when they appear to experience pain or discomfort. Some infants can calm themselves and resume feeding until they experience a new episode of pain. However, some infants cry in distress and become increasingly agitated while their caretakers try to continue feeding. Some infants with respiratory distress may feed for a while and take a few ounces until they tire out and stop feeding. In general, these infants consume inadequate amounts of food, fail to gain weight, or lose weight. Although medical management frequently improves the infants' feeding difficulties, the feeding disorder does not completely resolve with treatment of the medical condition.

Diagnostic criteria for Feeding Disorder Associated with Concurrent Medical Condition

Readily initiates feeding, but shows distress over the course of feeding and refuses to continue feeding.

Has concurrent medical condition that is believed to cause the distress.

Medical management improves but does not fully alleviate the feeding problem.

Failed to gain adequate weight or may even lose weight.

Post-traumatic Feeding Disorder

Diagnostic Features

Parents may report that their infants refused to eat any solid foods after an incident of choking, or one or more episodes of severe gagging. Some parents may have observed that the food refusal followed intubation, the insertion of nasogastric feeding tubes, or major surgery requiring vigorous oropharyngeal suctioning. Depending on the mode of feeding that the infants appear to associate with the traumatic event(s), some may refuse to eat solids, but will continue to drink from the bottle, whereas others may refuse to drink from the bottle, but are willing to eat solids (e.g. an infant who choked on a cheerio may refuse to eat solids, but drinks from the bottle; and an infant who experienced reflux while drinking from the bottle may refuse the bottle, but will continue to eat from the spoon). Reminders of the traumatic event(s), e.g. a bottle or a highchair, may cause intense distress. Some infants already become fearful and distressed when they are positioned for feedings and presented with feeding utensils and food. They resist being fed by crying, arching, and refusing to open their mouths. If food is placed in their mouths, they intensely resist swallowing any food. They may gag or vomit, let the food drop out, actively spit out food, or store food in their cheeks and spit it out later. The fear of eating seems to override any awareness of hunger, and infants who refuse all food, liquids and solids, require acute intervention due to dehydration and starvation.

Diagnostic criteria for Post-traumatic Feeding Disorder

Food refusal follows a traumatic event or repeated traumatic insults to the oropharynx or gastrointestinal tract (e.g. choking, severe vomiting, reflux, insertion of nasogastric or endotracheal tubes, suctioning) that trigger intense distress in the infant.

Consistently refusal to eat manifests in one of the following ways:

1. Refuses to drink from the bottle, but may accept food offered by spoon. (Although consistently refuses to drink from the bottle when awake, may drink from the bottle when sleepy or asleep).
2. Refuses solid food, but may accept the bottle.
3. Refuses all oral feedings.

Reminders of the traumatic event(s) cause distress as manifested by one or more of the following:

1. Shows anticipatory distress when positioned for feeding.
 2. Shows intense resistance when approached with bottle or food.
3. Shows intense resistance to swallow food placed in the infant's mouth.
- D. The food refusal poses an acute or long-term threat to the child's nutrition.

OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE

Separation Anxiety Disorder

Diagnostic Features

Minor modifications of the DSM-IV criteria were proposed for this disorder. These changes were almost all driven by the fact that young children are relatively less verbal than older children and cannot as easily express internal fears that are inherent to many of these symptoms. Three of the symptoms were modified to make them less dependent on verbalizations. One symptom was added about "persistent preoccupation" with worry about separation that is not dependent on verbalizations. The symptom about school refusal was modified to include day care settings. A note was added to the disability criterion to emphasize that if a parent has gone to great lengths to modify their routines to accommodate the child's anxieties, and as a result the child may not have the opportunity to demonstrate separation anxiety anymore, this still counts as a disability.

Diagnostic criteria for Separation Anxiety Disorder

A. No change from DSM-IV.

- (1) No change from DSM-IV.
- (2) No change from DSM-IV.
- (3) No change from DSM-IV.

(4) Persistent reluctance or refusal to go to school or elsewhere because of fear of separation.

Note: In young children, this may appear as:

- (a) fear or subjective anxious affect related to leaving home for daycare/school,
- (b) anticipatory fear or subjective anxious affect related to daycare/school situation, or
- (c) the child stays out of daycare/school because of fear/anxiety/emotional disturbance.

(5) No change from DSM-IV.

(6) No change from DSM-IV.

(7) Repeated nightmares involving the theme of separation. *Note: In preverbal or barely verbal children, there may be frightening dreams without recognizable content.*

(8) Repeated complaints or expression of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated.

(New) Persistent preoccupation worrying about the whereabouts of attachment figures (e.g., looking out a window or stopping play).

B. No change from DSM-IV.

C. No change from DSM-IV.

- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning. *Note: In young children, the disturbance may cause the parent to significantly modify their behavior to modify the child's behaviors.*
- E. No change from DSM-IV.

Reactive Attachment Disorder

Diagnostic Features

This disorder was substantially modified from the DSM-IV definition. The two main patterns, inhibited and disinhibited have been maintained, but a revised menu of symptoms was added for each along with proposed algorithm cutoffs. The wording was modified in a number of ways to make it more clearly reflect discriminating attachment behaviors. The pervasive developmental disorders (PDD) were maintained as possible exclusionary diagnoses, but mental retardation was eliminated since individuals with less severe forms of mental retardation may show attachment behaviors. Lastly, the criterion for pathogenic care was eliminated because an emphasis on pathogenic care too narrowly focuses on maltreatment syndromes. This shift allows for the disorder to be considered in children under less extreme situations, such as children in stable, albeit unhealthy, relationships without gross abuse or neglect. This disorder describes the behavior of young children, that is, those in the first 4 or 5 years of life. It is not clear what (if any) behaviors or symptoms constitute attachment disorders in middle childhood, adolescence or adulthood.

Diagnostic criteria for Reactive Attachment Disorder

A pattern of markedly disturbed and developmentally inappropriate attachment behaviors in which the child rarely or minimally turns preferentially to a discriminated attachment figure for comfort, support, protection and nurturance. The disorder is manifest as (1), (2), or (3):

(1) An inhibited, emotionally withdrawn pattern in which the child rarely or minimally directs attachment behaviors towards any adult caregivers, as manifest by three of the following:

Rarely or minimally seeks comfort when distressed.

Rarely or minimally responds to comfort offered when distressed.

Limited positive affect and excessive levels of irritability, sadness, or fear.

Reduced or absent social and emotional reciprocity (e.g., reduced affect sharing, social referencing, turn-taking, and eye contact).

(2) A disinhibited, indiscriminate pattern in which the child directs attachment behavior non-selectively, as manifest by two of the following:

(a) Demonstrates overly familiar behavior and reduced or absent reticence around unfamiliar adults.

(b) Rarely or minimally checks back with adult caregiver after venturing away even in unfamiliar settings.

(c) Willing to go off with an unfamiliar adult with minimal or no hesitation.

(3) A mixed pattern of inhibition and disinhibition characterized by two or more criteria from (1) and (2).

B. Does not meet the criteria for PDD.

C. The child has a developmental age of at least 9 months.

MOOD DISORDERS

Major Depressive Disorder

Diagnostic Features

Similar to older children and adults, preschool children with a clinical depressive syndrome are characterized by the typical symptoms such as sadness or irritability and anhedonia. They also demonstrate vegetative signs such as changes in sleep and appetite. However, it is important to note that the age appropriate manifestations of these symptoms must be assessed. Based on empirical results, minor modifications to the DSM-IV criteria are suggested below. The two-week criterion was modified to read that the symptoms had to be present “more days than not for at least 2 weeks” because clinically depressed children in studies did not always show a solid block of sadness every day for two weeks. Preoccupation with death and/or suicidality was deemed a clinical symptom in preschool children if it was persistently present in play (in addition to the possibility that it was verbally expressed). It should also be noted that the most specific symptom of depression in preschool children was anhedonia, assessed as having “no fun”. The most sensitive symptom was sadness/irritability. The greater normative fluctuation in mood states developmentally seem to give rise to a clinical picture in which periods of depressed mood are interrupted by periods of euthymia.

Diagnostic criteria for Major Depressive Disorder

A. Five of the following symptoms present *more days than not* for at least 2 weeks and must include one of the first two symptoms:

- (1) Depressed mood most of the day, *more days than not*, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: in children and adolescents, can be irritable mood.
- (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, *more days than not* (as indicated by either subjective account or observation made by others)
- (3) No change from DSM-IV.
- (4) No change from DSM-IV.
- (5) No change from DSM-IV.
- (6) No change from DSM-IV.
- (7) No change from DSM-IV.
- (8) No change from DSM-IV.

Measurement note for A8: Separately track (1) concentration versus (2) indecisiveness.
--

(9) No change from DSM-IV.

(New) *Persistent engagement in activities or play with themes of death or suicide.*

ANXIETY DISORDERS

There are 9 main anxiety disorders in the DSM-IV. This group modified the criteria for one disorder (PTSD), and believed that the criteria did not warrant change for one disorder (specific phobia). Three disorders (panic disorder with agoraphobia, panic disorder without agoraphobia, and acute stress disorder) were not addressed by this group because it was not clear that very young children experienced these. No statement was made that these were entirely impossible to exist in young children due to the lack of developmental capacities that have not yet emerged. Rather, these simply have not been documented or observed by clinicians in this age group. The remaining 4 disorders (social phobia, agoraphobia without history of panic disorder, obsessive-compulsive disorder, and generalized anxiety disorder) have been documented in children under 6 years of age but not enough empirical data has accumulated to justify and/or provide guidance on whether or how to modify them at this point.

Posttraumatic Stress Disorder

Diagnostic Features

The type of traumatic event that leads to the development of PTSD symptoms in preschool children may be similar to but also quite different from the types of events experienced by older children and adults. The most common traumatic events

for preschool children appear to be physical abuse, sexual abuse, witnessing domestic violence, and accidental injuries (usually involving automobiles). Witnessing violence against a primary caregiver may be uniquely distressing for young children because of their greater dependence on caregivers. Dog and other animal attacks are typically extremely terrifying and literally life-threatening to small children. Invasive medical procedures may also be experienced as more life-threatening relative to older children.

The traditional triad of symptoms – reexperiencing, avoidance/numbing of responsiveness, and hyperarousal – are unmistakable in young children who become symptomatic following traumatic events. Twelve of the 17 DSM-IV symptom criteria were modified slightly to make them either more developmentally-sensitive to this age group or less dependent on internal thoughts and feelings and more dependent on behavioral observations. The wording of 3 items were not changed. Two items (C3 “inability to recall”; and C7 “sense of a foreshortened future”) were dropped because they are developmentally-inappropriate.

One reexperiencing symptom and two hyperarousal symptoms are required, identical to the DSM-IV. Empirical studies have demonstrated that the avoidance/numbing of responsiveness cluster of symptoms is the cluster most difficult for preschool children to meet. This is primarily because the DSM-IV requires three items from this cluster and two of the items -sense of a foreshortened future, and psychogenic amnesia for part of the event - cannot be assessed due to limited cognitive and abstraction capacities in this age group. The item “Feeling of detachment or estrangement from others” was replaced because these internalized, abstract notions are not fully emerged in young children. The requirement for this cluster was changed from three symptoms to one symptom.

Diagnostic criteria for Posttraumatic Stress Disorder

A.1. No change from DSM-IV.

A.2. The person’s response involved intense fear, helplessness, or horror. Note: in children, this may be expressed instead by disorganized or agitated behavior. *Note: In preverbal children, this may not be known.*

B. One (or more) re-experiencing symptoms is needed:

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play *or repetitive behaviors* may occur in which themes or aspects of the trauma are expressed.

Measurement note for B1: Track recurrent recollections in three different ways: verbally, play, and non-play behaviors.

(2) Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content *that may be either fixed and repetitive or different and flexible each time.*

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: in young children, trauma-specific reenactment may occur. *Young children who dissociate may appear frozen or stilled. These children are unresponsive to significant stimuli across multiple sensory domains.*

(4) Intense psychological distress, *or behaviors indicative of distress*, at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. *Note: In young children, an internal cue may not be known.*

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. *Note: In young children, an internal cue may not be known.*

C. One (or more) avoidance/numbing of responsiveness symptom is needed:

(1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma. *Note: In young children, do not infer the presence of thoughts of feelings without verbalized verification from the child.*

(2) No change from DSM-IV.

(4) Markedly diminished interest or participation in significant activities. *Note: In young children, this may be manifest in play, social interactions, and daily routines.*

(5) *Increased social withdrawal.*

(6) Restricted range of affect *in play, social interaction, and daily routines* (e.g., unable to have loving feelings).

D. Two (or more) increased arousal symptoms are needed:

- (1) *Increased* difficulty falling or staying asleep, or *bedtime protest*.
- (2) *Increased* irritability, outbursts of anger, or *extreme fussiness or temper tantrums*.
- (3) *Increased* difficulty concentrating.
- (4) No change from DSM-IV.
- (5) No change from DSM-IV.

Experimental Symptoms

1. *Night terrors. The child starts from sleep with a panicky scream, has agitated motor movements, is unresponsive and inconsolable, and shows signs of autonomic arousal such as racing heart rate, rapid breathing, and sweating. The episodes tend to occur in the first third of the night and last from one to five minutes. The contents of any dreams are not known to the child the next day.*
2. *New aggression*
3. *New separation anxiety*
4. *New fears without obvious links to the traumas (e.g., fear of toileting alone, fear of the dark, etc.)*
5. *New oppositional defiance*
6. *Purposeless, repetitive behaviors without affect*
7. *Loss of previously acquired developmental skills, e.g., toileting, speech, etc.*

SLEEP DISORDERS

DSM-IV does not adequately set criteria for the common sleep problems that affect toddlers and young children. A developmentally appropriate classification that relates to the category of dyssomnias in DSM-IV is proposed. The syndrome of difficulty in initiating sleep is labeled sleep onset protodyssomnia and the syndrome of difficulty in maintaining sleep is labeled night waking protodyssomnia. This proposed nosology controls for duration and severity by further defining each of the two protodyssomnias as a perturbation, disturbance, or disorder. Perturbations are part of normal development. Interventions are not indicated. Disturbances are considered risk conditions. If no intervention occurs, they may likely progress to disorder. Disorders require more active intervention. If untreated, it is hypothesized, disorders may likely progress to full-blown DSM-IV disorders and/or generalize into a broader array of behavioral symptoms and diagnoses. No changes were suggested for the parasomnias and other DSM-IV sleep disorders. Due to the nature of rapidly changing sleep patterns in young children, guidelines from empirical studies are presented to help distinguish perturbations, disturbances, and disorders. Protodyssomnias ought to designate disorder level problems.

Perturbation	1 episode per week
Disturbance	2-4 episodes per week for more than 1 month
Disorder	5-7 episodes per week for more than 1 month

Sleep Onset Protodyssomnia

Diagnostic features

Sleep onset problems are reflected in either the time it takes to fall asleep, a need for the parent to stay in the room for sleep onset, and/or a need for reunions with the parent (parent leaves the room and comes back due to bids from the child).

Diagnostic criteria for Sleep Onset Protodyssomnia

A. *The following symptom must be present for at least four weeks and involve 5-7 episodes per week.*

B. Significant difficulty falling asleep.

Measurement note: When gathering data, quantify the following variables. Results from empirical studies are included below as suggested cut-offs.

- (1) the number of minutes needed to fall asleep
 - 12-24 months of age: >30 minutes to fall asleep
 - >24 months of age: >20 minutes to fall asleep
- (2) whether the parent remains in the room for sleep onset
- (3) the number of reunions, i.e., repeated bids, protests or struggles to go to bed.
 - 12-24 months of age: 3 or more reunions
 - >24 months of age: 2 or more reunions

C. (The impairment criterion is in a state of uncertainty because of the need for empirical data on whether to include (1) restriction of parental activities, (2) difficult to arouse the child during the day, and (3) falling asleep spontaneously during the day)

D. This disorder should not be diagnosed in children under 12 months of age because stable sleep patterns do not typically emerge until then.

Night Waking Protodyssomnia

Diagnostic features

Night waking problems are reflected in either awakenings that require parental intervention and/or removal to the parental bed.

Diagnostic criteria for Night Waking Protodyssomnia

A. The following symptom must be present for at least four weeks and involve 5-7 episodes per week.

B. Significant difficulty staying asleep.

Measurement note: When gathering data, quantify the following variables. Results from empirical studies are included below as suggested cut-offs.

- (1) the number of minutes spent awake after awakening:
 - 12-24 months of age: combined time of >10 minutes
 - 24-36 months of age: combined time of >20 minutes
 - >36 months of age: combined time of >30 minutes
- (2) whether the parent removes the child with each awakening
- (3) the number of awakenings per night:
 - 12-24 months of age: 3 or more awakenings per night (combined time >10 minutes)
 - 24-36 months of age: 2 or more awakenings per night (combined time >20 minutes)
 - >36 months of age: 2 or more awakenings per night (combined time >30 minutes)

C. (The impairment criterion is in a state of uncertainty because of the need for empirical data on whether to include (1) restriction of parental activities, (2) difficult to arouse the child during the day, and (3) falling asleep spontaneously during the day)

D. This disorder should not be diagnosed in children under 12 months of age because stable sleep patterns do not typically emerge until then.

Criteria Set Provided for Further Study

Disorder of Inhibition/Avoidance

Diagnostic Features

This set of criteria is provided for further study to encourage data collection on this well-known phenomenon. While there is a substantial research literature on shy and inhibited youngsters, there is less available data to connect it to clinical-level psychopathology. Many of the features of this construct overlap with social phobia. One difference between the two is that social phobia is limited to anxiety about interactions with other persons. The proposed disorder of inhibition/avoidance is not limited to personal interaction and is relevant to anxiety triggered by other types of novel stimuli and situations, which may be important for younger children. Another difference is that social phobia requires the individual to fear humiliation or embarrassment. Since young children may not consciously experience or express these emotions, the children's behaviors are emphasized, rather than their feelings that may be more difficult to identify.

Diagnostic criteria for Disorder of Inhibition/Avoidance

- A. Excessive shrinking from contact with and persistent reluctance to approach unfamiliar people or novel stimuli (new toys, smells, tastes, or situations).*
- B. Exposure to unfamiliar people or to novel stimuli almost invariably provokes the behaviors in A which may also be expressed by crying, tantrums, freezing or shrinking from the situations.*
- C. Desire for social involvement with familiar people (family members and peers the person knows well), and generally warm and satisfying relations with family members and other familiar figures.*
- D. The situations in A are avoided or else endured with intense anxiety or distress.*
- E. Disability criterion: The avoidance, anxious anticipation, or distress in the situation interfere significantly with the child's normal routine, functioning...*
- F. Symptoms occur for a period of 3 months or longer.*
- G. The avoidance is not due to the direct physiological effects of a substance (e.g., a medication) or a general medical condition and is not better accounted for by another mental disorder.*