

Sarah Groß

One of the fundamental problems of diagnosing psychopathology in infancy is summed up in a quote by Stern: “The new, as yet unknown patient is not a person so much as an—albeit asymmetrical—relationship” (Stern 1998, p. 11). Gergely and Watson (1996) also question whether an intrinsic disorder in infancy or young childhood can in fact exist independent of a dysfunctional parent–infant relationship, given the strong dependence of the infant’s emotional development on its physical and psychological environment. Focusing on the infant’s syndrome goes against the grain of the facts and clinical findings of developmental psychology (Emde 2003), since the infant’s psychosomatically organized affect regulation system is inseparable from the co-regulatory function of the primary caregiver. Doing nothing more than coding behavior runs the risk of overly relegating parental psychological strain, as well the information garnered through investigator empathy, to the sidelines.

2.1 Diagnosing Subjective Aspects

The subjective psychological strain on parents is of practical significance insofar as, while a family with good psychosocial resources can cope well with moderate crying, a vulnerable family may require urgent intervention to resolve the problem, which, in the worst case, can lead to abuse.

When a disorder is found to not be in the child alone, the primary caregiver, usually the mother, quickly develops a sense of guilt that she has done something wrong.

S. Groß, Dipl.Psych. (✉)
Psychoziale Beratungsstelle, Studentenwerk Heidelberg, University of Heidelberg,
Gartenstr. 2, Heidelberg 69115, Germany
e-mail: sarah_gross@gmx.de

Communication requiring particular attention during interviews with parents: Parents can be relieved of the sole responsibility for the emergence of a regulatory disorder, since an infant brings its own temperament traits into the equation; thus, the parent's behavior may have been wholly unproblematic with another child. Due to absent or negative feedback from the infant, interaction often becomes increasingly dysfunctional as parents become increasingly insecure (a "vicious circle" according to Papoušek et al. 2010). In this context, skill appreciation is important as early on as in the diagnostic phase, in order that the diagnostic assessment remains resource-oriented and endows the parents with greater trust in their intuitive skills, despite the required search for symptoms and possible causes.

2.2 Diagnostic Interviews

Also in parent–infant counseling or psychotherapy, the initial interview is of central importance. Where possible, it is conducted with both parents in the presence of the infant. Sufficient time in a child-friendly room should be planned to ask questions about current behavioral problems and their previous history from the perspective of both parents and to experience interaction between family members. Assuming an essentially appreciative and supportive stance takes into account not only the strain on, but also the resources of, an infant and their parents, and serves to build the relationship on which further treatment will be based. Depending on the reason for presentation, a differential, disorder-specific diagnosis is indicated, as discussed in greater detail in later chapters on individual disorders.

Case Study 1 The parents of 25-month-old Katharina presented to the parent–infant/toddler counseling service, reporting loud crying as a symptom. Already in infancy, Katharina had cried excessively; she had now started crying whenever she did not get her own way. The parents had had their daughter examined by a pediatrician and were alarmed that this had resulted in them being sent for "counseling." They had always suspected a physical cause during infancy; however, since this could not be the sole explanation, they feared that their daughter would be given a "psychological diagnosis" or that they as parents had done something wrong.

2.2.1 General Diagnosis

Since somatic (motor and vegetative) functions and reaction patterns in the infant are closely linked with their experience and behavior, a well-coordinated interdisciplinary approach is required. Close collaboration with pediatricians in the identification of organic disease ensures early recognition of somatic disorders. It is important to ascertain and understand current symptoms on the basis of a thorough developmental history-taking. In order to be able to reliably assess abnormal behavior, one effectively needs to be guided by the normal developmental stages and often sudden developmental spurts, as well as their range of variation. It may be

necessary to include a variety of other professional groups, such as speech therapists, to evaluate developmental status.

Information, offered either spontaneously or requested in the context of history-taking, is gathered on the following aspects:

- Etiology of the disorder (onset and duration of current symptoms).
- Course of pregnancy and birth.
- Emotional status during pregnancy.
- Developmental stages of the infant.
- Parental attitude toward the infant.
- Current stressors.
- Parental origin and childhood biography.

At the same time, particular attention should be paid to stressful prenatal, perinatal, and postnatal experiences, such as a physically or psychologically difficult pregnancy, serious complications during birth, postpartum disorders in the mother, as well as disease in the child. Previous miscarriages, stillbirths, and prolonged periods of infertility should also be included in the history.

Pitfalls in practice: Even though the cause of the disorder may appear obvious, it is important not to assume one-dimensional cause-and-effect relationships too hastily. It is often the accumulation of several stressors that contributes to the development of a regulatory disorder.

Communication requiring particular attention during interviews with parents: Talking about stressors can bring relief to the parents as early on as in the diagnostic phase and set the initial processing of stressful experiences (e.g., associated with the birth) in motion, processes for which there is little time in the hectic daily routine with an infant or toddler.

Case Study 1 Continued Katharina's mother cried a lot as she spoke of the stressful early days when she felt rejected by her daughter; Katharina had cried constantly when put to the breast and had only stopped when the mother finally gave up her attempts at breastfeeding. During this part of the interview, the father and Katharina were busy playing, and the family's sense of relief at feeling accepted with their difficulties was tangible.

2.2.2 Psychodynamic Diagnosis

The family's openness to transference, which influences relationships within the family, as well as within the family-and-therapist system in the here and now, can also be diagnostically helpful. The interactional intensity of the family also evokes countertransferences in the therapists. The transference-countertransference process in the initial interview primarily helps in understanding the unconscious scene of the parents with their child and in formulating a psychodynamic focus.

When using transference–countertransference dynamics for diagnostic purposes, a distinction can be made between past unconscious and present unconscious (Reich and Cierpka 2005). The past remains active and influences current relational wishes and conflicts without those affected being aware of this association. Impulses originating from the past unconscious (wishes, fears, memories) are distressing and therefore result in two groups of adjustment processes: since the past needs to be reconciled with the present, it is modified to that effect. If this is not achieved, or not fully achieved, a second adjustment takes place, with the result that the actualized impulse also becomes either distorted or completely suppressed by the individual's defense mechanism, e.g., a reversal to the opposite. This second round of censorship creates the present unconscious, since the present wishes that originated in the past are no longer consciously accessible. The present unconscious serves to maintain current inner equilibrium. To this end, psychosocial compromises are made, which become apparent in interpersonal defense processes, a couple's collusive patterns, and in parent–child interaction.

Case Study 1 Continued At the start of the initial interview, the therapists had the impression that the mother, who was clearly eager to find help, saw them as the rescuers she has longed for, while the father expressed himself in more apologetic terms and apparently feared an apportioning of blame (transference). Over the course of the interview, the therapists noticed that, in the context of parent–child interaction, the mother was quick to react by setting verbal boundaries before fully understanding what it actually was that Katharina wanted. The therapists were aware that they assumed a negative stance towards the mother during this phase (countertransference).

Psychodynamic diagnosis focuses in particular on the entanglement of parental interaction and parental fantasies about their child. The parents' primary relational experiences often play a role in the unconscious attribution of significance through parental projections; these experiences are then reenacted with the child.

The ability of parents to respond appropriately hinges on their ability to attribute sense and meaning to their child's signals. This process of mentalization is closely linked with the capacity to reflect and differentiate their own internal states and those of others. A distorted attribution of meaning suggests (suppressed) inner notions and conflicts and opens the way to as yet unprocessed biographical experiences ("ghosts in the nursery"; Fraiberg et al. 1975). A diagnosis is made of the situations in which—and to what extent—the parents are able to cope with feelings of stress, e.g., when their infant cries excessively, without having to react immediately. This ability of the parents was described by Bion (1962), among others, as "containment."

Case Study 1 Continued When Katharina turned once again to her mother with demands during the course of the interview, Katharina's mother was asked by the therapists to pause before reacting. She should not feel that she had to respond immediately, and Katharina should be distracted for long enough by her father to give her time for her mentalization processes, time which was lacking in real interaction

due to the mother's prompt boundary-setting. When asked about her feelings, the mother was able to express the considerable distress she felt in such situations. In the search for causes of her great fear of being completely dominated by the demands of her 2-year-old daughter, biographical links to her relationship with her own parents became obvious: her parents had lived in a state of such perpetual conflict that a hostile atmosphere had prevailed as far back as Katharina's mother could remember and her parents had always made heavy emotional demands on their daughter; now she had become a mother herself and felt obliged to "take care of" family members in both generational directions.

Communication requiring particular attention during interviews with parents: Parents need to interpret their infant's signals and, the younger the infant, the more unclear these are. Therefore, it is inevitable that these interpretations will be influenced by the parents' own relational experiences and their psychodynamic processing. When parents admit this to themselves free of guilt, the conscious perception of distorted interpretations based on the parents' own issues becomes far more feasible.

Psychodynamic hypotheses are often derived from the counseling setting with the family; parents sometimes report their own experiences directly. When asking parents about their own experiences, a cautious approach should be adopted, since parents always want to do as good a job, if not better, than their parents and fear passing on negative experiences from the outset, like a family curse.

2.2.3 Interactional and Relational Diagnosis

Diagnosing Intuitive Parenting Skills How good are the parents' intuitive parenting skills?

Parents seem to understand their infant in a very particular way (intuitive parenthood, primary motherliness). They think about their child (reverie), empathize with them, and are particularly attentive to their infant's signals (e.g., hunger, fatigue). How geared up are the parents for communication with their infant?

Behavioral observations and video-supported micro-analysis of preverbal communication between parents and infants have revealed a behavioral willingness on the part of parents to instinctively provide their infant with specially tailored support in its early maturation, adaptation, and learning processes (see Chap. 1). The concept of intuitive parenting skills refers to the adaptive behavioral adjustments that parents and other caregivers typically make intuitively and without conscious control or intention when they communicate with their infant at the preverbal age. As such, they:

- Are based on innate biological predispositions.
- Are universal and largely independent of age, gender, biological parenthood, and culture.

- Serve the phylogenetically older bonding system by providing the infant with protection and a sense of security and promoting the development of a secure bond.
- Are also intended to complement and compensate for the abilities and limitations of early childhood perception, assimilation of experiences, and behavioral regulation, and are tailored according to age and situation.
- Thus serve species-specific forms of human biological adaptation, i.e., the specific ability of man to integrate, symbolically represent, and exchange experiences and pass these on from generation to generation via communication and language.
- Promote the early development of these species-specific abilities in preverbal communication with infants.

How does one recognize good parenting skills?

In the case of strongly manifest intuitive skills, parents wishing to interact with their baby position their face at a distance of at least 20 cm central to their infant's field of vision and, when the infant's gaze turns and fixes them, they respond with an animated eyebrow flash.

They react instinctively, promptly (with latencies in the millisecond range), and contingent on their infant's gaze allocation, facial expression, and sounds.

They speak to their infant in "baby talk" (higher-pitched voice, slower tempo, pronounced/exaggerated melodics). They affirm their infant's facial expressions and sounds, mimic them, and provide models for their infant to mimic in return (as a "biological mirror" or "biological feedback"). They reduce their tempo, repeat themselves, and pause to give their infant the opportunity to respond.

Guided by their infant's signals, parents provide their baby with regulatory support that is tailored to his or her individual competencies by:

- Stimulating, soothing, and consoling their baby.
- Dosing the type and intensity of stimulation to their infant's receptiveness and tolerance limits.
- Providing emotional reassurance, safety, and a secure basis in stressful situations.
- Compensating for what the infant cannot yet accomplish alone, and providing them with a framework within everyday interaction and dialogue in which they can test and practice their maturing skills in self-efficacy and self-regulation.

Case Study 2 A 6-week-old infant, crying due to overfatigue, was initially being rocked on its mother's lap. The mother appeared to be under considerable strain. The infant could not be soothed. After the subject of rocking was raised with the mother, she became pensive and calmer and modified her behavior. Her voice softened and her movements slowed. The infant relaxed, nestled itself to its mother, and fell asleep. The mother also visibly recovered from the strain her infant's crying had been putting on her. She was happy and clearly experienced the sense that her baby felt safe with her. This feedback boosted her confidence in her intuitive skills.

A distinction needs to be made in interactional and communication dynamics between manifest behavior and latent, unconscious background dispositions. If the latent background is filled with tension and conflict, the parents will not have the

appropriate resources at their disposal to soothe their infant, or to stimulate it in a manner conducive to development.

Communication requiring attention during interviews with parents: With regard to parents, attention should be paid to their intuitive communicative competence and emotional relatedness, as well as to potentially distorted perceptions in dealing with their infant. If marked impairment is observed here, parents should be asked in particular detail about experiences of separation and loss in their previous history (e.g., miscarriage), motherhood constellation themes (e.g., fear of failure; Stern 1998), and psychological symptoms (e.g., postnatal depression).

Important diagnostic considerations in the infant: These include infant arousability, self-soothing and communication behaviors, response to new phenomena, showing initiative and exploratory behavior, distractibility, and emotional state. The diagnostic session should offer ample time to not only gather information, but also to observe parent–infant interaction during the short pauses automatically occasioned by the infant’s needs.

The therapist should not put themselves under pressure to gather as much information as possible, but should instead allow periods during the diagnostic phase to “endure” the infant’s negative states, such as crying or need for attention, and use these periods for observation. When the diagnostician interacts with the infant themselves, they should take care that the parents do not experience a sense of inferiority should the infant respond positively to the investigator, while they themselves receive only scant positive feedback in deadlocked interaction situations that have the nature of a vicious circle.

2.2.4 Diagnosing Couple and Family Dynamics

The initial interview usually involves at least one parent and the affected infant, but can often involve an entire family system. Numerous interactions between parents, as well as grandparents and siblings that may also be present, can be observed in the sense of a scenic understanding of important indicators of family dynamics. The development in quality of parenting, i.e., coping with the transition from couple to family, should be included in the diagnostic process while taking parental biography and associated unconscious conflicts into consideration. Attention should also be paid to the family’s cultural and social background (Cierpka 2005).

Case Study 1 Continued

The father attempted to prevent Katharina’s cries of protest at his wife’s boundary-setting by explaining the restrictions in long sentences. Katharina already started crying after the first sentence, which prompted the father to make his explanations even longer and more forceful.

2.3 Diagnostic Systems

In the course of the diagnostic process, one gathers copious information that influences the therapeutic approach. In order to structure this information, diagnostic systems much like those used in other age groups have been developed.

The diagnostic systems for infant developmental stage, infant–parent interaction, and family diagnosis are described in Cierpka (2012). Only classification systems for the standardized description and summarization of the various symptoms of regulatory disorders are presented below.

The fundamental principle of independence from etiological assumptions supported in the ICD-10 (*Deutsches Institut für Medizinische Dokumentation u. Information* 2010) and the DSM-V (American Psychiatric Association 2013) becomes all the more problematic the younger the diagnosed patients are (Wiefel et al. 2007). The exclusion of parental behavior is the main point of criticism leveled at the use of the classical systems and their adaptation for early childhood. Dimensional, relationship-based models reflect the dynamic process of multiple influencing factors in early childhood better than categorical systems. A perspective on the prevention of and early intervention in psychological disorders should be adopted more vigorously at this young age rather than in later childhood and adolescence. Therefore, it is more important to identify factors that expose an infant to increased developmental risk—including the risk of developing psychopathologies—than to detect the presence of intrapsychic disorders, particularly since the classification of categorical diagnoses, most notably in infants under the age of 2 years, is not supported by sufficient empirical evidence (von Gonthard 2010; Schmidt and Poustka 2007).

Classification System Criteria

According to Egger and Emde (2011), classification systems for the first year of life should, at best, fulfill the following criteria stipulating that they ought to:

- Include the full spectrum of early behavioral, emotional, developmental, and relational symptoms, disorders, and impairments.
- Reflect a multidisciplinary, behavior-based orientation aimed at early intervention and prevention.
- Provide links as to how psychopathology and psychiatric impairments are characterized in later life.

Despite all their shortcomings, objective classification instruments are indispensable to early detection, scientifically sound treatment planning, and evaluation, as well as to forming a basis for the submission of claims to health insurance bodies.

2.3.1 ICD-10 and DSM-V

Regulatory disorders in early childhood, with the exception of feeding disorder (F98.2; see also Chap. 5), have not as yet been included in the ICD-10 (International Classification of Diseases 2010) as stand-alone disorders. The developmental dynamics during the first 3 years of life have also not been taken sufficiently into consideration in multiaxial classification schemes (MAS; Remschmidt et al. 2006) for psychological disorders in childhood and adolescence according to ICD-10 (von Gontard 2010). Likewise, “restrictive eating and feeding disorders” were the only regulatory disorders to be included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V, APA) published in 2013 (see Chap. 5).

Due to the lack of alternatives in ICD-10, early childhood regulatory disorders are generally coded as an adjustment disorder (F43.2; von Hofacker et al. 2007), despite the fact that the age criteria for this disorder are inappropriate.

2.3.2 Zero To Three

Zero To Three (DC:0–3R) (2005) was developed for the classification of disorders in infants and young children up to the age of 3 years. In addition to the infant’s diagnostic profile, factors that contribute to the occurrence or perpetuation of their problems and areas in which intervention is required are categorized on five axes. Depending on the axis, severity is also dimensionally rated.

Dimensions and Categories of the Zero To Three Classification (2005)

Axis I: Clinical disorders

Categorical assignment to the following diagnoses:

- 100 Post-traumatic stress disorder
- 150 Deprivation/maltreatment disorder
- 200 Disorders of affect: prolonged bereavement, four specific anxiety disorders, depressive disorders, and mixed disorder of emotional expressiveness
- 300 Adjustment disorder
- 400 Regulation disorders of sensory processing
- Subgroups: hypersensitive type (fearful/cautious type and negative defiant type), hyposensitive/under-responsive type and sensory stimulation seeking/impulsive type
- 500 Sleep behavior disorder
- 600 Feeding behavior disorder

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700 Disorders of relating and communicating, including developmental disorders

800 Other disorders according to DSM IV or TR ICD-10

Information-gathering: History-taking interview; questionnaires and behavioral diaries can be used as a complement

Axis II: Relationship classification

Parent–infant relationship global assessment scale (PIR-GAS): Ratings between 0 (abusive) and 100 (well adapted) to achieve a global evaluation of the functionality of the parent–infant relationship on the basis of the following criteria:

- General functional level in the parent/infant
- Distress level in the parent/infant
- Flexibility to adaptation in the parent/infant
- Level of conflict and conflict-solving in the parent/infant
- Effect of relationship quality on the infant's developmental progress

Relationship problems checklist (RPCL) designed to assign the type of relationship problem to the following categories:

- Over-involved or under-involved
- Anxious/tense, angry/hostile
- Verbally abusive
- Physically abusive
- Sexually abusive

Information-gathering: Both are instruments designed to help the diagnostician formulate an external evaluation on the basis of observed behavior between the parent and infant (play interaction and other interaction in the interview setting), as well as on the basis of the parent's subjectively reported experiences.

Axis III: Medical and developmental disorders and conditions

Information-gathering: The diagnosis is established by pediatricians and disease-specific specialist physicians. The following information should be gathered in the history-taking interview: disease type/frequency/duration, age at onset, hospitalizations, and further treatment of current symptoms.

Axis IV: Psychosocial stressors

Psychosocial stressor score, three-tiered scale (no, mild, or severe risk) to evaluate the effect of the risk on the child, again using a three-tiered scale (mild, moderate, or severe effects)

Information-gathering: Both ratings are evaluated by the diagnostician on the basis of information provided on stressors in the history-taking interview.

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Axis V: Emotional and environmental functioning

A six-tiered scale to rate the extent of emotional and social functioning in the following developmental areas:

- Attention/regulation (from 0 to 3 months)
- Relationship formation and mutual engagement (from 3 to 6 months)
- Interactive intentionality and reciprocity (from 4 to 10 months)
- Complex gestures and problem-solving (from 10 to 18 months)

Information-gathering: Ratings are based on the observed behavior between parents and the infant (play interaction and other interaction), as well as the parents' subjective reports on their infant's abilities in relation to the expected stage of development.

With the help of the DC:0-3R Revision Task Force, Zero to Three is once again tackling an update and revision of the DC:0-3R. The DC:0-3R Revision Task Force will consider changes to DC:0-3R, making content-related decisions with input from the clinical and research literature, users worldwide, and feedback from recognized experts in particular areas.

The term "regulation disorder" is more narrowly defined in Zero to Three than in the German-language literature and refers to constitutional difficulties in the appropriate regulation of emotions and behavior in response to sensory stimuli. Excessive crying in the first 3 months of life is not classified as a disorder, but rather as a stress syndrome. One can diagnose this behavior under regulatory disorders of sensory processing, since it is associated with difficulties in the regulation of physiological, sensory, motor, and affective processes. On the other hand, excessive crying cannot be classified as a distinct diagnosis like isolated sleep disorder and isolated feeding disorder, where no disorder of sensory processing is present. Likewise, a sleep disorder can only be diagnosed as a stand-alone disorder from the age of 12 months.

Case Study 1 Continued Using axis I, Katharina could be diagnosed with a regulatory disorder (negative/defiant type). This implicitly assumed that her crying was associated with a difficulty to remain calm in the presence of multiple or strong environmental stimuli, as well as internal stimuli such as physical arousal or sensations, i.e., she was not able to regulate her arousal level well on her own. Axis II on relationship classification was used to evaluate the aspect of co-regulation or soothing by her parents. According to axis III, closer attention needed to be paid to Katharina's verbal development. Katharina was possibly still finding it difficult to express herself and reacted with frustration when her mother failed to take sufficient time to understand her wishes before forbidding them; moreover, she was unable to understand the long explanations provided by her father.

2.3.3 Guidelines of the German Society for Child and Adolescent Psychiatry and Psychotherapy

Likewise in Germany, a working group set up under the auspices of the German Association of Scientific Medical Societies (*Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaft*, AWMF) and the German Society for Child and Adolescent Psychiatry and Psychotherapy (*Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie und Psychotherapie*) has been tasked with drawing up guidelines for the diagnosis of regulatory disorders in infancy and young childhood (Schmidt and Poustka 2007; von Hofacker et al. 2007). These guidelines are based on the principles of evidence-based medicine and provide guidance in the areas of classification, disorder-specific diagnosis, multiaxial assessment, and subsequent intervention. Somatic, behavioral, and relational aspects should be taken into consideration at all levels of the diagnostic processes.

Some regulatory disorders are not interpreted as specific disorders as such, but rather as varying manifestations of an underlying generalized problem of infant behavioral regulation within the context of the parent–infant relationship.

Although based on a dimensional rather than a categorical understanding of disease, the guidelines permit classification according to the main symptoms listed in the box.

Classification Dimensions and Categories of the German Society for Child and Adolescent Psychiatry and Psychotherapy Guidelines (According to von Hofacker et al. 2007)

- **I Regulatory disorders**

Excessive crying up to the age of 6 months: Phases of crying and fussing are defined as excessive primarily on the basis of parental distress and the infant's failure to respond to soothing strategies. The severity of excessive crying is classified according to whether it fulfills, or not, the "rule of threes" (Wessel et al. 1954): crying/fussing lasts on average more than 3 h per day on average more than 3 days a week for at least 3 weeks.

Sleep disorders: In addition to the parent's subjective perception of the sleep disturbance as a problem, the following objective criteria are applied—Sleep-onset disorder: falling asleep only with parental help past the age of 6 months, sleep-onset time averagely in excess of 30 min. Sleep maintenance disorder: waking more than three times a night on average at least four times a week, combined with the inability to fall asleep again without parental help, and/or nighttime waking periods lasting more than 20 min on average.

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Feeding disorders with/without failure to thrive: Feeding interaction perceived by the parents as problematic over an extended period of time (>1 month). Criteria beyond the age of 3 months include: average duration of individual feeding sessions >45 min and/or intervals of <2 h between meals.

Disinterest in play, chronic fussiness.

Persistent and excessive shyness, excessive clinginess, pronounced anxiety, possibly also a tendency toward social withdrawal in the developmental course, elective mutism.

Excessive defiance.

Aggressive/oppositional behavior.

Anhedonia (joylessness) and lack of interest, distress, depressed mood, passivity, and apathy.

- **II Impaired parent–infant relationship:** A distinction is made between an uncomplicated regulatory disorder in the absence of a relational disorder, an isolated regulatory disorder accompanied by a relational disorder, and a generalized regulatory disorder accompanied by a relational disorder.

III Comorbid disorders accompanying a regulatory disorder:

Comorbid disorders may include organic disease, suspected attachment disorder, or post-traumatic stress disorder in infancy and early childhood.

In order for a diagnosis to be established, infant behavioral regulation needs to have been impaired in one or more areas for at least 1 month in a way that is grossly inappropriate in terms of the current developmental phase. Several diagnoses may be established. The guidelines have recently been revised and published in a significantly more detailed form.

Case Study 1 Continued In the further course, Katharina's excessive crying was followed by excessive defiance. As a result of these persisting difficulties, dysfunctional interaction patterns (the mother's hasty setting of boundaries, the father's overly long verbal explanations) had crept in and, in the long run, were straining the relationships between father, mother, and infant. Alone the diagnostic process was able to bring relief to the parents, since they were able to express in words what they had been feeling anyway and were better able understand their own feelings of unease, as well as those of Katharina, due to the greater "insight" they gained into themselves.

The severity of a regulatory disorder is measured according to its duration (persistence), the number of areas of dysregulated interaction (pervasiveness), the extent to which the child and parent are impaired in their accomplishment of infant developmental tasks, as well as the degree of strain on the parent–child relationship.

2.4 Behavior Diaries

There are many different types of behavior diaries to record an infant or young child's varying states. Chapter 4, "Sleep Disorders," provides an example of a crying/sleeping/feeding diary to illustrate the diagnosis of sleep disorders. The diary is given in table format: the lines are intended for infant behavior, while the columns break the day down into 24 h and then again into 15-min intervals. Over a period of several days, the parents record the duration of breastfeeding/feeding, agitation/fussing, crying, and sleep by marking the box for the relevant 15-min interval. There are several questions to answer at the bottom of the table relating to, e.g., how long the infant needed to fall asleep and how often it woke up during the night.

Case Study 1 Continued Prior to the initial interview, Katharina's parents had recorded her behavior over a 4-day period in a diary they had been sent for this purpose. As they were filling in the diary, they themselves noticed that crying phases were more frequent directly after picking Katharina up from the day care center in the early afternoon and again around dinner time. The personnel at the day care center had marked numerous crying phases particularly when Katharina had had only a short midday nap due to being easily woken by the noises of the other children in the sleeping area. These diagnostic findings suggested the need to adjust Katharina's daily structure to her needs, such as quiet periods of undivided attention from a parent during the critical phases of her day, or a somewhat earlier bedtime.

2.5 Questionnaires and Interviews to Gather Data on Behavioral Abnormalities and Regulatory Disorders

As part of a multimodal approach, parent questionnaires are intended as another way to gather data on regulatory skills in early childhood, or as a screening instrument to diagnose an impairment to these skills.

The **Child Behavior Checklist CBCL 1.5–5** (Achenbach and Rescorla 2000b), a questionnaire intended for use with children aged 1.5–5 years, measures emotional difficulties as well as internalizing and externalizing behavioral problems with the aid of 99 items (Achenbach and Rescorla 2000a). By using a cutoff value for the overall problem score, the questionnaire is able to screen for clinical abnormality in a child. The German-language version of the forerunner to this, the CBCL 2–3 (Achenbach et al. 1987) for children aged 2–3 years, tests the factor structure of the factor analytically derived syndrome scales for behavioral dimensions (Fegert 1996). The **Questionnaire to measure early childhood temperament traits as judged by the parents** (Pauli-Pott et al. 2003)—a translation of the English-language Infant Behavior Questionnaire IBQ (Rothbart 1981)—is often used to measure temperament as an aspect of early childhood regulatory disorders. The parent that spends more time with the child (usually the mother) answers questions on the following areas of temperament:

- Positive emotionality
- Inclination toward introversion and anxiety
- Inclination toward temper tantrums
- Irritability
- Motor activity
- Soothability

The German-language crying, feeding, sleep questionnaire (Groß et al. 2013) covers 53 items altogether: three to gather data on the “rule of threes” (Wessel et al. 1954), 24 on crying, fussing, and sleeping, 13 on feeding, 12 items relating to co-regulation, i.e., soothing strategies used by parents when their infant cries, when it should sleep, and when it wakes up at night, as well as whether medical advice relating to the infant has already been sought. The questionnaire also includes questions on the triad (von Hofacker et al. 2007; Papoušek 2010) of: (1) problems of behavioral regulation in early childhood (e.g., duration of crying, time to sleep onset), (2) dysfunctional communication patterns in contexts relevant to the behavioral problems (soothing strategies, bedtime rituals), and (3) stress syndrome in the primary caregiver (interpretations and explanatory approaches for the child’s problematic behavior by the parents, strain due to the child’s problematic behavior). The three scales were developed in a factor-analytic manner and yielded high internal consistency. Using these scales, it is possible to calculate an overall score enabling a general evaluation of self-regulatory skills. Evaluation results from 704 infants aged up to 1 year indicate that this diagnostic approach has good validity (Groß et al. 2013).

Conclusion

The present chapter deals with a number of perspectives that approach the diagnosis of regulatory disorders from different angles, including: diagnosis of the infant; the intuitive skills of the parents; interaction; transference and counter-transference; factors in the parental biographies; as well as family diagnosis.

The use of standardized diagnostic instruments in the area of regulatory disorders is not yet well established. The guidelines and classification systems are also undergoing constant further development in interaction with their English-language counterparts. Future developments need to be not only individual-centered (infant or primary caregiver) but also interaction-centered (parent–infant relationship).

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