

The Interdisciplinary Diagnostics of Autism Spectrum Disorder Using DC:0-5™: A Case Report

Междисциплинарная диагностика расстройства аутистического спектра с использованием DC:0-5™: клинический случай

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Case report

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ABSTRACT

BACKGROUND: The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5™) is widely used in many Western countries. For Russian specialists, such classification represents a relatively new tool for the comprehensive diagnosis of mental disorders in children from birth to the five-year-old threshold. The purpose for presenting this case study report is to showcase the practical application of the DC:0-5™.

AIM: This study aims to illustrate the diagnostic process according to the DC:0-5™ criteria using the example of a specific clinical case report involving the collaborative efforts of two specialists: a child psychiatrist and a clinical child psychologist.

METHODS: DC:0-5™ consists of five axes. The main axis focuses on clinical diagnosis criteria for mental disorders, considering their age specificity. The remaining four axes allow one to take into account and specify data related to biological, social, and psychological factors, which play a crucial role in understanding the causes and characteristics of a mental disorder in a child.

RESULTS: In the examined case, an analysis of symptoms by means of the Clinical Disorders axis revealed that they were consistent with the diagnostic criteria for autism spectrum disorder. The use of the remaining axes supplemented the clinical diagnosis with specific details about the adverse physical health factors in the child, a high cumulative stress burden, significant developmental delays in the emotional, speech, and social dimensions, as well as dysfunction in the mother-child dyad. Since the parents declined medication for their son, this information proved crucial in developing a support program for both the child and the family.

CONCLUSION: The comprehensive diagnostic approach using the DC:0-5™ axes proved highly effective, not only in psychiatric diagnosis but also in establishing goals and objectives for subsequent intervention. Its application in psychiatric, clinical psychology, and corrective educational practices has the potential to make support for children in their early years a more personalized and family-oriented undertaking.

АННОТАЦИЯ

ВВЕДЕНИЕ: Распространенная во многих западных странах Диагностическая классификация нарушений психического здоровья и развития в младенчестве и раннем детстве (Diagnostic classification of mental health and

developmental disorders of infancy and early childhood, DC:0-5™) является для российских специалистов достаточно новым инструментом комплексной диагностики психических расстройств у детей от рождения до пяти лет. Представление клинического случая имело целью проиллюстрировать применение DC:0-5™ на практике.

ЦЕЛЬ: Продемонстрировать проведение диагностики по критериям DC:0-5™ на примере конкретного клинического случая при совместном участии двух специалистов — детского психиатра и детского клинического психолога.

МЕТОДЫ: DC:0-5™ состоит из пяти осей. Основная ось клинического диагноза содержит критерии психических расстройств с учетом их возрастной специфики. Четыре дополнительные оси позволяют учесть и конкретизировать данные о влиянии биологических, социальных и психологических факторов, играющих важную роль в понимании причин и особенностей психического расстройства у ребенка.

РЕЗУЛЬТАТЫ: В рассматриваемом случае анализ симптоматики по оси клинических расстройств показал ее соответствие диагностическим критериям расстройства аутистического спектра. Использование остальных осей дополнило клинический диагноз конкретизированной информацией о неблагоприятных факторах физического здоровья ребенка, высоком уровне кумулятивной стрессовой нагрузки на него, выраженном отставании в развитии в эмоциональной, речевой и социальной сферах, нарушениях функционирования материнско-детской диады. С учетом отказа родителей от медикаментозного лечения сына эти данные оказались важными для разработки программы помощи ребенку и семье.

ЗАКЛЮЧЕНИЕ: Комплексная диагностика с применением осей DC:0-5™ показывает свою высокую эффективность, как в плане постановки психиатрического диагноза, так и в плане определения целей и задач последующего вмешательства. Использование ее в коррекционно-педагогической, клинко-психологической и психиатрической практике способно сделать помощь детям первых лет жизни более персонализированной и семейно-ориентированной.

Keywords: *DC:0-5™; autism spectrum disorder; case report*

Ключевые слова: *DC:0-5™; расстройство аутистического спектра; клинический случай*

INTRODUCTION

A significant milestone in the interdisciplinary diagnosis of early mental health disorders is the development and implementation of DC:0-5™ (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood) [1]. Created by leading global experts for ages spanning from infancy to five years, this classification has now been translated and published in numerous foreign countries. In Russia, the translated version was published in 2022 [2] and it has already found application in domestic psychological and psychiatric practice [3, 4]. DC:0-5™ includes cross-references to ICD-10 and DSM-5, allowing it to serve as a complementary diagnostic tool.

Diagnosis using DC:0-5™ involves an evaluation across five axes [5]. In addition to the primary axis addressing clinical disorders, it includes four supplementary axes that consider various factors crucial for understanding the development of mental disorders in young children. These factors include aspects of family dynamics, the

cumulative stress burden on the child and family, and indicators of the child's biological health and maturity for his age. The interdisciplinary data gathered contribute to the provision of more adequate and comprehensive care in each specific case [6].

The aim of this article is to illustrate the diagnostic process as outlined based on DC:0-5™ criteria using the example of a specific clinical case report involving the collaborative efforts of two specialists: a child psychiatrist and a clinical child psychologist.

CASE REPORT

Patient

The boy, Pavel (name changed), was 3 years and 1 month old at the time of the first visit. His parents, both 44 years old, have college degrees. The mother, before Pavel's birth, was the owner of a small business. Currently, she is a housewife. The father, an engineer by training, is involved in that field. There are no other children in the

family. The family is well-off and resides in the suburbs of the Moscow region in good housing conditions.

Parents complaints at the initial visit: speech delay, stubbornness, disobedience, refusal to communicate, as well as the presence of fear and stereotypical behaviors.

Medical history

The family had endured a tragic experience in the year leading up to the pregnancy and throughout, involving the disappearance, extended search, and eventually news of the death of their eldest teenage son. The pregnancy itself was unplanned, and the mother, in part, made the decision to carry it to term as an emotional attempt to cope with the loss of her eldest child.

The delivery occurred spontaneously at 34 weeks, with a birth weight of 5,84lb and an Apgar score of 6–7 points. The infant was fed on formula milk, and both the boy and his mother spent the first month post-birth in the hospital. The child was discharged with a diagnosis of cerebral ischemia and CNS (central nervous system) oppression syndrome and subsequently put on outpatient neurologist follow-up.

During the first 10–11 months, the parents raised no concerns about the child's development. The baby was calm, he ate and slept well, smiled frequently, could laugh, displayed no fear of loud noises, and enjoyed watching apartment renovation work. According to his mother, he made her happy. The child achieved milestones such as sitting independently at 9 months, crawling at 10 months, standing without support at 11 months, and walking at 11,5 months. He started babbling around 8 months. Due to delayed motor development, at 9 months, a neurologist recommended intensive outpatient treatment, including injections (the parents could not tell the specific drugs) and massage, during which the boy became very agitated and cried often.

After 11 months, Pavel started experiencing problems with sleep, accompanied by the emergence of a significant timidity level. At 12 months, he began rocking in his crib. Throughout his second and third years, the boy remained highly agitated, reacting intensely to every sound. He could cry for hours due to noise from the neighboring apartment and required prolonged rocking to fall asleep until the age of three. Pavel developed a fear of strangers, crying and hiding from them. He had intense fear of his grandfather, who accompanied him to medical procedures; Pavel vomited in the car. A few months after it first appeared,

the rocking behavior occurred whenever the child was dissatisfied and later extended to include stereotypical behavior such as falling to his knees and banging his head on the floor or against the wall. The parents also noted Pavel's persistent urge to play with running water, spending extended periods pretending to wash dishes, watching the washing machine for hours, or standing on the windowsill to observe the movement of tree branches. He resisted any attempt to wash his hair and started biting his nails to the point of causing skin damage. He became highly irritable when faced with restrictions, often shouting and attempting to hit. He did not produce his first words by the age of 12–15 months. On a neurologist's prescription at a children clinic, Pavel underwent treatment with stimulant and sedative medications, including periciazine, which resulted in uncontrollable vomiting, leading to the discontinuation of the drug. At 18 months, Pavel underwent outpatient removal of a superficial hemangioma on his scalp without his mother's presence. This sudden, albeit brief, separation, along with the medical procedure, induced extreme fear in the child. Shortly afterward, Pavel was attacked by a dog, causing a terrible fright and involuntary defecation. First word-like sounds appeared briefly around the age of 2, used during play but not in communication. At 2.5 years, Pavel inserted a cherry pit into his nose, leading to choking and requiring a medical intervention. Following the incident, speech in play disappeared.

Over the last two years, relations in the family have been marked by the mother's deep concerns primarily for her son's physical health, her frequent irritation in response to Pavel's "abnormal" behavior and the instances of anger outbursts directed at both her husband and son. Concurrently, Pavel consistently exhibited protest behavior, manifesting as screaming, crying, attempts to hide, and hitting an adult or banging his head in response to requests from his mother. Notably, the child did not engage in communication with his peers or adults beyond the immediate family circle and displayed no interest in interacting with other children.

Status: The child underwent an examination during a home visit with the presence of both parents, conducted by two specialists — a child psychiatrist and a clinical child psychologist.

Physical development was age-appropriate. He had no external stigmas of dysembryogenesis. Establishing contact with the child proved challenging due to his reluctance to communicate and desire to hide, which

lasted more than half an hour. Through the application of techniques to establish contact, the boy became more cooperative, agreeing to stay in the same room with the adults. However, he kept his distance, avoided eye contact, and did not engage in communication. Simultaneously, he attentively listened to his parents' narrative about him. Unfazed by their son's presence, the parents provided a detailed account of his illness and gave their opinion about his condition. Pavel communicated with his parents using gestures and some syllables, but he seemed to understand their speech well. When his parents tried to interact with him, he mostly refused to comply with their requests, expressing dissatisfaction through yelling before retreating to another room. There, he turned on children songs at high volume while rocking his body. According to his mother the boy exhibits this behaviour with consistency. A brief episode was organized where Pavel played with his father. The child's game actions involved repetitive combinations of construction kit parts, accompanied by a hushed, unaddressed mooing sound. Despite his father's persistent attempts to provide guidance in the game, Pavel remained unresponsive, ignoring his efforts. Upon his father's request, Pavel effortlessly and accurately identified objects, animals, and letters in pictures, showcasing his recent accomplishment of learning the entire alphabet in just five days, as reported by his father.

A conversation with the parents and observation of the manner of interaction in the family revealed several distinctive features. Throughout the discussion, the mother appeared predominantly anxious, expressing concerns for her son and seeking ways to help him. However, many of her proposed solutions had little to do with Pavel's current condition, such as deliberations on the ideal age for school enrollment or strategies for future university admission. She communicated readily with specialists and was talkative. Her interactions with her son mainly comprised comments, reprimands, or criticism, seemingly ignored by Pavel. Although Pavel occasionally attempted to attract his mother's attention through sounds or gestures, none of them were noticed by her. The mother confessed to frequently yelling at the child, persistent irritability, and occasional outbursts of rage, leading to physical punishment with a belt. In contrast, the father's interactions with his son looked gentle and calm. The father's attitude was characterized by his desire to explain in detail to his 3-year-old son the consequences of various dangers, such as touching electrical outlets

or disregarding traffic rules, etc. The parents exhibited a seemingly well-grounded relationship with each other. Both expressed reservations about resorting to drug treatment for Pavel, fearing potential allergic reactions, and consequently opted against it.

PRELIMINARY STAGE OF INTERVENTION

The child's mother received a recommendation to consult a psychiatrist, leading to a diagnosis of Recurrent depressive disorder, current episode moderate (F33.1). The attending physician noted the chronic nature of depression, emphasizing its polymorphic manifestation with symptoms including anxiety, apathy, and suicidal thoughts. A prolonged course of antidepressants was prescribed, and she adhered to the medication regimen diligently. Furthermore, psychoeducational discussions were conducted with both parents and separately with the mother, focusing on the parent-child relationship.

Upon reevaluation three months later, improvements were noted in both the mother's and the child's conditions, primarily having to do with emotional stabilization. The mother reported a cessation of her anger attacks, while the child displayed increased calmness, with improved interaction with other relatives. Notably, the child began imitating sounds and producing the first words in his speech. While Pavel's inclination towards negativism persisted, he ceased banging his head in a sign of protest. Overall, the intensity of stereotypical actions diminished, although they surged again as anxiety heightened. Increased sensitivity to sounds persisted.

QUALIFICATION OF THE CASE USING DC:0-5™ DIAGNOSTIC CRITERIA

The qualification process for the clinical case comprised several stages: 1) evaluation of the child's medical history and qualification of his mental state; 2) assessment of the stress level for the child and family, the developmental milestones the child achieved and family relationship context, using standard tabular DC:0-5™ forms; and 3) discussion of the results and collaborative development of recommendations for therapeutic intervention. The first stage was performed by a child psychiatrist; the second, by a clinical psychologist, with both contributing to the third stage. To present the data, the recommended sequence of axis evaluation from DC:0-5™ was followed: starting with axis III, followed by axes IV, V, II, and finally, axis I.

Axis III: Physical Health Conditions and Considerations

The analysis of the case revealed influences on the health status of factors such as prematurity, low birth weight, and hypoxic brain injury during childbirth. These factors led to the child being hospitalized in the first month of life with a diagnosis of cerebral ischemia and central nervous system oppression syndrome. Additionally, there was a high likelihood of perinatal encephalopathy with a minor

delay in motor development, supported by long-term outpatient follow-up and neurological prescriptions (the parents were unable to provide details of the neurological diagnosis made at the polyclinic). The child's good general physical condition and satisfactory development until 10–11 months suggested a mild form of perinatal encephalopathy. The removal of a superficial infantile hemangioma from the scalp at 18 months did not directly affect the child's health.

Table 1. Psychosocial and environmental stressor checklist

Stressors	Age of onset	Comments, including duration and severity
Presence of psychological trauma in a significant adult	Before birth	Ongoing, high-intensity stress for the entire family
Mental illness in a family member (maternal depression)	Before birth	Throughout pregnancy and until present time
Exposure to stressors due to psychological trauma in mother during pregnancy	Before birth	Throughout pregnancy, high-intensity stress for the mother
Painful or frightening medical procedures	9 months	For two months, high-intensity stress for the child
Physical violence against a child (punishment)	12 months	Until now
Separation of the child from his mother (during a medical procedure) and the procedure itself	18 months	Short-term, sudden, high-intensity stress
Animal attack	18 months	Short-term, sudden, high-intensity stress

Table 2. Competency domain rating summary table

Competency Domain Rating	Emotional	Social-Relational	Language-Social Communication	Cognitive	Movement and Physical
Exceeds developmental expectations	-	-	-	-	-
Functions at age-appropriate level	-	-	-	-	V
Competencies are inconsistently present or emerging	-	-	V	V	-
Not meeting developmental expectations (delay or deviance)	V	V	-	-	-

Table 3. Dimensions of Caregiving (mother)

Dimensions of Caregiving	Contribution to Relationship Quality		
	Strength	Not a concern	Concern
Ensuring physical safety	V	-	-
Providing for basic needs (e.g., food, hygiene, clothing, housing, health care)	V	-	-
Conveying psychological commitment to and emotional investment in the infant/young child	-	-	V
Establishing structure and routines	V	-	-
Recognizing and responding to the infant's/young child's emotional needs and signals	-	-	V
Providing comfort for distress	-	-	V
Teaching and social stimulation	-	-	V
Socializing	-	-	V
Disciplining	-	V	-
Engaging in play and enjoyable activities	-	-	V
Showing interest in the infant's/young child's individual experiences and perspectives	-	-	V
Demonstrating reflective capacity regarding the infant's/young child's developmental trajectory	-	-	V
Tolerating ambivalent feelings in the caregiver–infant/young child relationship	-	-	V

Axis IV: Psychosocial and Environmental Stressors

The axis contains a detailed list of stressors that may be associated with the child's mental state. Each identified stress factor was assessed for its duration, severity, and suddenness. The specialist is asked to fill out the relevant form from the manual (Table 1).

Axis V: Developmental Competence

DC:0-5™ involves the evaluation of a child's development across 5 domains (Table 2). Data can be gathered through diverse channels, including discussions with parents, observations of the child during interactions and play, developmental charts, and standardized tests.

Axis II: Relational Context

The specialist is asked to fill out the standard tabular form "Dimensions of Caregiving" (Table 3) and draw a conclusion about the level of adaptive functioning in each dyad, as well as the need for intervention.

The adaptive functioning of the mother-child dyad was classified as the third level, encompassing relationships that ranged "from being at risk to being disturbed". This level suggests that the existing relationship may have a negative impact on the child's condition and development; therefore, therapeutic intervention is indicated.

The length of this article does not allow for a detailed assessment of Pavel's relationship with his father. It is worth noting, however, that the functioning of the father-child dyad was categorized at a relatively more favorable but still somewhat problematic second level, characterized by a relationship "from tense to concerning". Consequently, ongoing observation is recommended in this case, not excluding intervention.

Axis I: Clinical Disorders

Analysis of the child's symptoms on Axis I resulted in a diagnosis of autism spectrum disorder (ASD), meeting all the necessary diagnostic criteria outlined in DC:0-5™ for this condition. Specifically, within the domain of social communication (the first diagnostic category), the child exhibits at least four symptoms out of the required three for diagnosis: atypical social approach, limited ability to initiate joint attention, atypical use of eye contact, and lack of interest in peers. In the second diagnostic category, restrictive and repetitive behavior is represented by three symptoms out of the required two: stereotyped motor movements and use of objects and toys, atypical fixation on

item or topic of interest, and atypical responsivity to sensory inputs. These identified symptoms have a significant impact on both the child and family functioning, meeting another essential criterion for the disorder. Among the associated features that support a diagnosis according to DC:0-5™ criteria, developmental and speech delays, prematurity, and low birth weight may be noted. Furthermore, this case aligns with the point of view outlined in ICD-10 and reflected in DC:0-5™ regarding the frequent co-occurrence of ASD with anxiety and phobic disorders.

RECOMMENDATIONS FOR THERAPEUTIC INTERVENTION

Considering the parents' rejection of medication therapy for their son, a care program was recommended. This program involves ongoing observation of the child and mother by a psychiatrist, implementation of measures to enhance mother-child interaction, sensory integration courses, incorporation of the Floortime approach, and corrective pedagogical strategies. The Floortime approach consists of daily, brief episodes of non-directive play between a parent and a child, including techniques to promote social-emotional interaction. These techniques are imparted to the parent by a specialist [7]. Specific targets for clinical and psychological intervention were identified through a comprehensive diagnosis across the DC:0-5™ axes.

DISCUSSION

The use of DC:0-5™ Axis I, which contains clear criteria for 42 early psychopathological syndromes, has shown its usefulness as a tool for diagnostic clinicians in assessing young children. However, the development of therapeutic interventions solely based on Axis I can pose challenges for child psychiatrists. This difficulty may arise primarily due to age-related constraints on drug treatment and/or, as observed in the analyzed case, the parents' decision to reject it. Furthermore, a clinical diagnosis *per se* does not provide insights into the pathogenesis of a specific condition of the patient.

This information is gleaned through a meticulous look into the history (Axis III and IV) and analysis of supplementary examination findings (Axis V and II). In the discussed case, Axis III unveiled unfavorable biological factors affecting the child's physical health, though these factors did not have a direct impact on the onset and course of the primary mental disorder. Simultaneously, Axis IV identified

numerous stressors that could indirectly influence the emergence and progression of ASD symptoms. Some stressors demonstrated a clear temporal relation to the initial and subsequent phases of ASD symptoms. For instance, a notable decline in the child's mental state at 10–11 months of age appeared to be associated with intensive, painful, and fright-inducing medical procedures. Axis V data indicated a significant delay in emotional development, as well as social and interpersonal relationships. The results of the Axis II examination revealed notable disruptions in the functioning of the mother-child dyad. The structured and tabular presentation of indicators on this axis facilitates the identification of areas that could be used to optimize the maternal behavior.

The persistent depression experienced by the mother, detected in an additional psychiatric assessment, may be a contributing factor encumbering her interaction with the child. The prescription of an antidepressant treatment, coupled with psychoeducational interventions, resulted in a noticeable improvement in mother-child interaction and a degree of progress in the child's development. It is crucial to highlight that these improvements occurred without any specific therapy targeting the child himself. This once again underscores the significance of the close connection between a young child and his/her mother, to the extent that his/her mental health can improve merely through the stabilization of the mother-child relationship [8].

On the further development of corrective actions, it is useful to consider a factor still relatively overlooked in Russian infant psychiatry. We are referring to an ASD criterion used in Axis I, also present in the DSM-5™, known as atypical responsivity to sensory inputs. This aspect is evident in the described case, involving sensory changes in the auditory, tactile, and potentially vestibular and proprioceptive domains. The pathogenetic role of sensory changes in the clinical presentation of ASD and their correction is being actively investigated both abroad [7, 9, 10] and in Russia [11, 12].

Transitioning from this specific case discussion to the potential wider implementation of DC:0-5™ in Russian practice, several noteworthy considerations emerge. Primarily, there is a notable absence of organizational capacity to conduct interdisciplinary assessments during routine outpatient visits. Typically, child psychiatrists and clinical psychologists perform assessments separately, posing a challenge for any subsequent collaborative evaluation and reducing objectivity. To address this issue,

a potential solution could be to integrate the methodologies of both specialists and leverage modern technologies, such as widely available video recording. Moreover, when employing DC:0-5™, it becomes essential to take into consideration the disparities in established diagnostic approaches between Western and Russian psychiatric, psychological, and correctional pedagogical schools. However, for psychiatrists, this challenge is somewhat alleviated by the inclusion in the DC:0-5™ clinical axis of references for each diagnosis to its counterpart in ICD-10. For instance, the diagnosis of "autism spectrum disorder" according to DC:0-5™ aligns with the diagnosis of "Childhood autism" (F84.0) in ICD-10, although the criteria for this disorder in early age are not comprehensively covered in the latter.

CONCLUSION

In the examined case, an analysis of symptoms by means of the Clinical Disorders axis revealed that they were consistent with the diagnostic criteria for autism spectrum disorder, specifically, the presence of prerequisite symptoms in the categories of social communication and restrictive and repetitive behaviors. Employing a comprehensive diagnostic approach with the use of the remaining axes supplemented the clinical diagnosis with specific details about the adverse physical health factors in the child, a high cumulative stress burden, significant developmental delays in the emotional, speech, and social domains, as well as dysfunction in the mother-child dyad. The diagnosis conducted across the DC:0-5™ axes facilitated the development of a care program for the child and family. This program is grounded in ongoing observation of the family by a psychiatrist, corrective and pedagogical measures, sensory integration courses, and optimization of mother-child interactions.

In essence, the application of a comprehensive diagnosis using the DC:0-5™ axes has demonstrated its utility, both in establishing a psychiatric diagnosis and in delineating the goals and objectives for subsequent intervention. Its application in psychiatric, clinical psychology, and corrective educational practices undoubtedly has the potential to make support for children in their early years more personalized and family-oriented undertaking.

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