

DC:0-5™

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood

VERSION 2.0

ZERO TO THREE

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This bullet was added.

- “Feeding Behavior Disorders” have been renamed “Eating Disorders of Infancy/Early Childhood” to focus the attention on the infant’s/young child’s contribution to an activity that is necessarily interactive and that universally occurs within the context of a relationship. The number of defined disorders in this category has been substantially reduced and clustered into broader categories of Overeating Disorder, Undereating Disorder, and Atypical Eating Disorder.
- Numerical codes for DC:0–5 Clinical Disorders are provided to facilitate inclusion of DC:0–5 disorders in health care delivery and electronic medical records. Numerical coding provides consistency among various disorder lists and can prevent misunderstanding when translating diagnosis into other languages.
- Links to the corresponding DSM–5 and ICD–10 disorders are included in the text for each DC:0–5 Axis I disorder.
- Extensive revisions have been made to Axis II (Relational Context). The axis now includes two parts: a rating of the level of adaptation of the primary caregiving relationship(s) and a rating of the level of adaptation of the caregiving environment—that is, the broader family relational network (including coparenting) in which the infant/young child is developing.
- Axis III has been expanded to include illustrative examples of medical conditions that should be noted.
- Axis IV has maintained the Psychosocial and Environmental Stressors Checklist but has added categories and some specific stressors.
- Axis V has been extensively revised to focus on developmental competencies that integrate domains of emotional, social-relational, language-social communication, cognitive, and movement and physical development. A table of “Developmental Milestones and Competency Ratings” is included in Appendix A to aid practitioners.
- For each disorder, links are included between DC:0–5, DSM, and ICD codes. A complete crosswalk of all DC:0–5 disorders is available at www.zerotothree.org/dc05resources

A History of ZERO TO THREE’s Diagnostic Classification Efforts

DC:0–3, which was published in 1994 by ZERO TO THREE, was created to address the significant need for a systematic, developmentally based approach to the classification of mental health and developmental difficulties in the first 4 years of life (i.e., birth through 3 years old). The design and formation of DC:0–3 represented the first effort by a group of expert and extremely experienced clinicians to devise a useful scheme that would complement, but not replace, other approaches to diagnostic classification systems for older children and adults, such as the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.;

- Axis I: Clinical Disorders
- Axis II: Relational Context
- Axis III: Physical Health Conditions and Considerations
- Axis IV: Psychosocial Stressors
- Axis V: Developmental Competence

Cultural Considerations in Diagnosing Disorders in Infants/Young Children

Header
changed

Infants'/young children's behavior and expression of emotion are shaped from the moment they are born by family cultural values and practices that are often unconsciously held but that carry enormous power as parameters of what is right and wrong in raising an infant/young child. These values and practices imbue every aspect of caregiving, from concrete decisions, such as where and with whom the baby sleeps and when to start toilet training, to adult expectations about what the infant/young child is allowed or not allowed to say and do in different situations. For these reasons, diagnosing an infant/young child who is experiencing mental health problems must include developing an understanding and appreciation of the family's cultural background and the parents' socioeconomic conditions, national origin and history, immigration status, ethnic and racial identity, sexual orientation, religious and spiritual practices, and other sources of diversity.

The accuracy and usefulness of the diagnostic process are significantly enhanced when clinicians actively elicit parents' perceptions and causal explanations for the infant's/young child's mental health problems, and when clinicians inform themselves about the possible cultural influences shaping parents' views. The importance is particularly evident when the family and the clinician are from different cultural backgrounds and may not be familiar with each other's prevailing attitudes and beliefs about accepted child-rearing practices, but it is also necessary to avoid false assumptions of shared beliefs when clinicians come from a similar background. Given the growing cultural diversity of most societies, learning about the specific values and practices of the infant's/young child's family is now a central component of best clinical practice. In this sense, cultural sensitivity and cultural competence should be considered integral elements of clinical sensitivity and clinical competence.

Learning to incorporate cultural considerations into the diagnostic process is a long-term effort because cultural groups are more often than not characterized by internal heterogeneity within the group, and families are becoming increasingly multicultural. For example, people from the same race may differ in ethnicity, religion, socioeconomic status, educational attainment, and many other factors, and family members may have different demographic characteristics. In addition, individuals often see themselves as having several identities simultaneously because of the different prisms of the groups to which they belong. Cultural considerations must honor the dynamic nature of cultures as well

Table 1. Cultural Formulation for Use With Infants and Toddlers (continued)

<p><i>(continued)</i></p> <p>C. Parents’/Caregivers’ Beliefs about Parenting and Child Development. Note here any beliefs about parenting and child development not noted elsewhere, including range of views or discrepancies among parents/caregivers, such as: ceremonial practices (e.g., naming), beliefs about gender roles, disciplinary practices, goals and aspirations for child, belief systems about children and child development, sources parents/caregivers turn to for advice about parenting, beliefs about parenting/caregiving role, etc.</p>
<p>4. Cultural Features of the Relationship Between the Individual and the Clinician</p>
<p><i>Cultural Elements of the Relationship Between the Parents/ Caregivers and the Clinician</i></p> <p>Indicate differences in culture and social status between the child’s parents/ caregivers and the clinician and any problems these differences may cause in diagnosis and treatment. This may include differences in understanding the child’s distress, communication difficulties due to language, communication styles, or understanding about the involvement of others (e.g., extended kin) in the diagnosis and treatment process. Note how parents may perceive the role of the clinician and the parents’ level of comfort with help seeking. Also note how the parents’/caregivers’ past experience with clinicians or treatment/ service systems impacts on the current clinical relationship. These considerations are reflected in the Irving Harris Foundation Professional Development Network’s Diversity-Informed Infant Mental Health Tenets (Ghosh Ippen, Noroña, & Thomas, 2012).</p>
<p>5. Overall Cultural Assessment</p>
<p><i>Overall Cultural Assessment for Child’s Diagnosis and Care</i></p> <p>Summarize the implications of the components of the cultural formulation identified in earlier sections of the Outline for comprehensive diagnosis and care of the child and support of the parent/caregiver–child relationship.</p>

Added date.

Note: Table 1 used with permission, Michelle Sarche, Monica Tsethlikai, Leandra Godoy, Robert Emde, and Candace Fleming (2019). *Cultural Perspectives for Assessing Infants and Young Children*. University of Colorado Denver, Anschutz Medical Campus, and Arizona State University, Children’s National Health System.

and cause impaired functioning) are defined. Early Atypical Autism Spectrum Disorder involves impairing features of ASD but without the full symptom picture. Similarly, Overactivity Disorder of Toddlerhood affects young children who are impaired by symptoms of hyperactivity but do not necessarily meet criteria for ADHD. Each of these disorders derive from longitudinal data in high-risk samples of infants/young children, many of whom eventually manifest full criteria for ASD and for ADHD, respectively.

Three other developmental disorders are also defined: Global Developmental Delay, Developmental Language Disorder, and Developmental Coordination Disorder. These disorders may occur alone, but more often, they occur in combination with other neurodevelopmental disorders. For children with significant developmental delays, clinicians should use the child's mental age in considering Axis I diagnosis.

This sentence was added.

10.1 Autism Spectrum Disorder

Introduction

Autism Spectrum Disorder (ASD), a neurodevelopmental disorder, is characterized by severe impairments in social interaction and communication and by the presence of restrictive and repetitive behaviors. Accurate and early identification of ASD is critical, particularly given the high prevalence, family and societal costs, and recognized importance of early intervention.

Diagnostic Algorithm

All of the following criteria must be met.

A. Each of the following three social-communication symptoms must be present:

1. Limited or atypical social–emotional responsivity, sustained social attention, or social reciprocity as evidenced by at least one of the following:
 - a. Atypical social approach.
 - b. Reduced or limited ability to engage in reciprocal social games or activities that require turn-taking (e.g., peek-a-boo).
 - c. Reduced or limited ability to initiate joint attention to share interests or emotions or to seek information about objects of interest in the environment.
 - d. Infrequent or restricted responses to social interaction.
 - e. Rare and restricted, or lack of, initiation of social interaction.
2. Deficits in nonverbal social-communication behaviors as evidenced by at least one of the following:
 - a. Lack of or restricted integration of nonverbal and verbal behaviors.
 - b. Atypical use of eye contact and turning away from others in social contexts.

Changed from "all."

efforts. However, infants/young children with GDD show marked delays in **most** developmental domains, in contrast to infants/young children with specific learning or language disorders. GDD is associated with a broad range of mental health disorders.

Diagnostic Algorithm

All of the following criteria must be met.

A. Deficits in cognitive functioning, verbal and nonverbal problem solving, planning, symbolic reasoning, motor skills, social judgment, and learning, including preacademic skills in the preschool period, which is confirmed by standardized developmental or intellectual assessment with a norm-referenced assessment tool. These deficits are documented by a delay that is 2 standard deviations below the mean on a test of developmental/intellectual functioning (or within the standard error of 2 standard deviations below the mean; e.g., a standard score less than 75).

B. Deficits in adaptive behavior, which refers to the performance of age-expected communication, social, and daily living skills required for independent day-to-day adaptive functioning. Without supports, the adaptive deficits limit the infant's/young child's participation and engagement in one or more age-expected activities of daily life, such as home routines (e.g., self-care), playing with family members and other infants/young children (e.g., early education settings), and community experiences (e.g., playground). These deficits are documented by functioning that is 2 standard deviations below the mean in at least two areas of adaptive functioning.

Age: The infant/young child must be at least 6 months old.

Links to DSM–5 and ICD–10

DSM–5: Global Developmental Delay

ICD–10: Other Disorders of Psychological Development,
Global Developmental Delay (F88)

10.6 Developmental Language Disorder

Introduction

Developmental Language Disorder is diagnosed when the young child exhibits significant delays in expressive or receptive communication that are not due to sensory impairment (e.g., hearing loss), medical/neurological conditions (e.g., traumatic brain injury or acquired epileptic aphasia), or other neurodevelopmental disorders (e.g., Autism Spectrum Disorder or Global Developmental Delay). Language and communication skills should be selectively impaired in Developmental Language Disorder, even if other delays (e.g., motor or cognitive delays) are present. Often, the etiology of the Developmental Language

20 SENSORY PROCESSING DISORDERS

Sensory processing disorders are diagnosed when the infant/young child demonstrates behaviors that are believed to reflect abnormalities in regulating sensory input. The behaviors cause distress or impair the infant's/young child's functioning in daily activities. Sensory processing disorders affect individuals throughout infancy and early childhood, and there is evidence that these problems are stable in the first years of life.

There is now considerable empirical evidence that some infants/young children experience clinically significant and impairing responses to sensory stimuli that are independent of other psychopathological and neurodevelopmental conditions. These responses may be characterized by over-responsivity (e.g., heightened magnitude of response, faster latency of response, and slower habituation or recovery from response to sensory stimuli), under-responsivity (e.g., reduced magnitude of response, or slower latency to respond to sensory stimuli), or atypical responses to stimuli that may be characterized by extended sensory exploration of stimuli that is typically not noticed (e.g., licking walls or doorknobs). The sensory abnormalities must occur in more than one context (e.g., home, child care, community settings) and may involve one or more sensory domains (e.g., tactile, visual, auditory, vestibular, olfactory, taste, the sense of position of joints or pressure on muscles [proprioceptive sensation], and the sensations from internal organs [interoception]). Failure to process or respond to sensory information in an age-typical manner is associated with impairments for the infant/young child and his or her family.

The symptoms are not better accounted for by another mental disorder (e.g., Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Autism Spectrum Disorder, or Posttraumatic Stress Disorder) but may co-occur with other mental disorders (with the exception of Autism Spectrum Disorder because atypical sensory responsiveness is now a repetitive and restricted behavior criterion).

Phrase added

In contrast to regulatory disorders that were defined in the DC:0–3 and DC:0–3R, the focus on sensory processing disorders is exclusively on over- and under-responsiveness, with an “Other” category for less typical presentations. Difficulties in motor coordination are defined elsewhere and are not included in the criteria.

20.1 Sensory Over-Responsivity Disorder

Introduction

The central feature of Sensory Over-Responsivity Disorder is a persistent pattern of exaggerated, intense, or prolonged responses to sensory stimuli that are more severe, frequent, or enduring than are typically observed in individuals of similar age and developmental level. The sensory over-responsivity occurs in more than one context (e.g., home, child care/preschool, community settings)

Phrase added

and can involve one or more sensory domains (e.g., tactile, sound, vision, taste, olfactory, movement through space [vestibular sensation], sense of position of joints or pressure on muscles [proprioceptive sensation], and the sensations from internal organs [interoception]). Although individual differences in sensory sensitivity exist, it is defined as a disorder when there is evidence that the sensory over-responsivity causes significant distress or results in impairment for the infant/young child or his or her family. The sensory over-responsivity symptoms observed are not better accounted for by another mental disorder (e.g., Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Autism Spectrum Disorder [ASD], **or Posttraumatic Stress Disorder [PTSD]**) but may co-occur with other mental disorders.

Diagnostic Algorithm

All of the following criteria must be met.

A. The infant/young child displays a persistent and pervasive pattern of sensory over-responsivity that involves intense, negative reactions to one or more types of routine sensory stimuli (including tactile, visual, auditory, vestibular, olfactory, taste, proprioceptive, or interoceptive) in more than one context (e.g., home, child care, playground) and with different caregivers (if the infant/young child has more than one caregiver). The intensity of reactivity or the duration of reactivity is disproportionate to the intensity of the stimulus. Either criterion 1 or 2 below must be present:

1. The infant/young child shows intense emotional or behavioral responses when exposed to stimuli that evoke the sensation. The intensity and duration of the response are disproportionate to the intensity of the stimulus.
2. The infant/young child predictably tries to avoid contact with routine sensory stimuli that are aversive to him or her.

B. The infant/young child does not meet criteria for ASD. Symptoms are not better explained by Attention Deficit Hyperactivity Disorder.

C. Symptoms of the disorder, or caregiver accommodations in response to the symptoms, significantly affect the infant's/young child's and family's functioning in one or more of the following ways:

1. Cause distress to the infant/young child;
2. Interfere with the infant's/young child's relationships;
3. Limit the infant's/young child's participation in developmentally expected activities or routines;
4. Limit the family's participation in everyday activities or routines; or
5. Limit the infant's/young child's ability to learn and develop new skills or interfere with developmental progress.

Age: The infant/young child must be at least 6 months old.

Developmental Features

Infants/young children may show sensory over-responsivity symptoms—for example, crying excessively and having difficulty being soothed after exposure to loud noises or showing a consistent pattern of distress in response to being soothed by tactile, gentle movement (e.g., rocking) or other sensory experiences. As infants/young children get older, they may develop patterns of avoidance or opposition when asked to engage in activities that involve exposure to sensations to which they have adverse responses.

Prevalence

The prevalence of Sensory Over-Responsivity Disorder is unknown, but epidemiological data based on parent report of symptoms suggest prevalence between 5% and 16.5% associated with family impairment.

Course

The course of Sensory Over-Responsivity Disorder is unknown. However, there is moderate stability in Sensory Over-Responsivity Disorder symptoms between 1 and 8 years old, and, on average, all young children show an increase in sensory over-responsivity behaviors between 1 and 3 years old.

Risk and Prognostic Features

Infants who are born preterm or small for gestational age appear to be at elevated risk for Sensory Over-Responsivity Disorder. In addition, environmental conditions—including lack of movement/tactile stimulation in the early years (e.g., due to being raised in an orphanage), exposure to drugs or prenatal stress, cumulative risk, or community violence—appear to increase risk for Sensory Over-Responsivity Disorder. Furthermore, infants/young children with Global Developmental Delays or intellectual disabilities are at increased risk for Sensory Over-Responsivity Disorder. Finally, Sensory Over-Responsivity Disorder symptoms appear to be heritable.

Culture-Related Diagnostic Issues

As there is cultural variation in recognition of somatic symptoms across cultures, an infant's/young child's sensory symptoms must be evaluated in the context of the infant's/young child's family and community cultural beliefs and practices.

Gender-Related Diagnostic Issues

There are no known gender differences in rates of Sensory Over-Responsivity Disorder.

Differential Diagnosis

Given that atypical sensory responsivity is now a criterion for ASD, it is not possible to diagnose both ASD and Sensory Over-Responsivity Disorder. **It is necessary to determine if sensory over-responsivity is not better explained by PTSD or Other Trauma, Stress, and Deprivation Disorder.** In addition, it can be challenging to distinguish some anxiety responses from sensory responses (e.g., fear of vacuum cleaner). If the infant/young child is only bothered by

Sentence added

4. Limit the family's participation in everyday activities or routines; or
5. Limit the infant's/young child's ability to learn and develop new skills or interfere with developmental progress.

Duration: The fear, anxiety, or avoidance is persistent, typically lasting for at least 1 month.

Links to DSM–5 and ICD–10

DSM–5: Separation Anxiety Disorder

ICD–10: Separation Anxiety Disorder of Childhood (F93.0)

30.2 Social Anxiety Disorder (Social Phobia)

Diagnostic Algorithm

All of the following criteria must be met. Criteria can be met if the young child has demonstrated these behaviors in the past and exposure is currently avoided or intentionally limited by caregivers.

A. The young child exhibits marked and persistent fear of one or more social or performance situations that involve exposure to unfamiliar people or possible scrutiny by others commonly shown with peers and adults. The fear or anxiety is out of proportion to the threat posed by the social situation.

B. Exposure to the feared social situation almost invariably provokes anxiety in the young child, who may express anxiety by panicking, crying, tantruming, freezing, clinging, shrinking, or failing to speak in social situations with unfamiliar people.

C. The young child avoids the feared social or performance situation(s) or endures it with intense anxiety or distress.

"Social Phobia" was removed from this list

D. The fear is not better accounted for by other disorders, including Autism Spectrum Disorder, Separation Anxiety Disorder, or other anxiety disorders.

E. Symptoms of the disorder, or caregiver accommodations in response to the symptoms, significantly affect the young child's and family's functioning in one or more of the following ways:

1. Cause distress to the young child;
2. Interfere with the young child's relationships;
3. Limit the young child's participation in developmentally expected activities or routines;
4. Limit the family's participation in everyday activities or routines; or
5. Limit the young child's ability to learn and develop new skills or interfere with developmental progress.

Age: The young child is at least 24 months old.

5. Marked physiological reactions (e.g., sweating, agitated breathing, changes in color) at reminders of the traumatic event(s).
 6. Dissociative episodes, beginning after the traumatic event(s), in which the infant/young child freezes, stills, or stares and is unresponsive to environmental stimuli for seconds to minutes in response to reminders of the traumatic event(s).
- C. The infant/young child persistently attempts to avoid trauma-related stimuli through efforts to avoid people, places, activities, conversations, or interpersonal situations that are reminders of the trauma(s).
- D. The infant/young child experiences a dampening of positive emotional responsiveness that appears or intensifies after the trauma(s) and is revealed by at least one of the following:
1. Increased social withdrawal.
 2. Reduced expression of positive emotions.
 3. Markedly diminished interest or participation in activities such as play and social interactions.
 4. Increased fearfulness or sadness.
- E. After a traumatic event, an infant/young child may exhibit onset or intensification of signs of increased arousal, as revealed by at least two of the following:
1. Difficulty going to sleep, evidenced by strong bedtime protest, difficulty falling asleep, or repeated night waking unrelated to nightmares.
 2. Difficulty concentrating.
 3. Hypervigilance.
 4. Exaggerated startle response.
 5. Increased irritability, outbursts of anger or extreme fussiness, or temper tantrums.
- F. Symptoms of the disorder, or caregiver accommodations in response to the symptoms, significantly affect the infant's/young child's and family's functioning in one or more of the following ways:
1. Cause distress to the infant/young child;
 2. Interfere with the infant's/young child's relationships;
 3. Limit the infant's/young child's participation in developmentally expected activities or routines;
 4. Limit the family's participation in everyday activities or routines; or
 5. Limit the infant's/young child's ability to learn and develop new skills or interfere with developmental progress.

Age: The diagnosis should be made with caution in infants less than 12 months old. Misspelling
fixed

70.3 Complicated Grief Disorder of Infancy/ Early Childhood

Introduction

The death or permanent loss of an attachment figure represents a severe emotional stressor for an infant/young child. Infants/young children have not yet developed an understanding of the permanence of death and the involuntary nature of most deaths, and their effort to give meaning to the absence of the loved one reflects the cognitive capacities and limitations of their developmental stage. In infants, emotional distress and somatic manifestations—such as disturbances in feeding, sleeping, and digestive processes—predominate. Young children construct explanations for the **death or permanent loss** that may involve self-attributions, such as causing the attachment figure's death because of their anger or behavior. The infant's/young child's difficulty in creating a reality-based understanding of the **death/permanent loss** may result in pathogenic beliefs, such as being unlovable or negative emotions being dangerous, that have a deleterious effect on the infant's/young child's healthy developmental trajectory. The circumstances of the **death/permanent loss** and the availability of consistent and supportive alternative attachment figures are important factors in determining the course of the infant's/young child's mourning process. Most infants/young children are able to tolerate their intense distress, create a developmentally appropriate explanation of the death, and redirect their attachment to substitute adults when they are supported in these processes by their remaining primary caregivers. The category of Complicated Grief Disorder of Infancy/Early Childhood is designed for those infants/young children who show a significant and pervasive impairment of function following a **death/permanent loss** that lasts for at least 30 days and interferes with normative developmental activities.

Change s from death
to death/permanent
loss

Diagnostic Algorithm

All of the following criteria must be met.

A. Following the death or permanent loss of an attachment figure, the infant/young child exhibits at least two of the following symptoms:

1. The infant/young child persistently cries, calls, or searches for the lost person.
2. When encountering reminders of the loss, the infant/young child shows any of the following:
 - a. Detachment, including seeming indifferent toward reminders of the caregiver, such as a photograph or mention of the caregiver's name.
 - b. Selective "forgetting," including apparent lack of recognition of photographs or other reminders of the lost person.
 - c. Extreme sensitivity to any reminder of the lost person, including acute distress when a possession that belonged to the person is touched by another or is taken away.

Specify:

1. Whether the infant/young child was present during the events leading to the death
2. Whether the infant/young child was exposed to information about the circumstances of the death

Diagnostic Features

Complicated Grief Disorder of Infancy/Early Childhood is diagnosed only if the symptoms listed previously are present more days than not for at least 30 days. This pattern of pervasiveness and persistence differentiates this diagnosis from infants'/young children's normative grieving patterns, which may be characterized by intense distress, preoccupation with the whereabouts of the person who died, or other manifestations of grieving that are usually circumscribed in duration and do not interfere significantly with the infant's/young child's developmental course and everyday functioning. In preverbal infants/young children, symptoms are expressed somatically, behaviorally, or through emotional responses. The nature and severity of grief must exceed expected norms for the infant's/young child's developmental stage and cultural group and be impairing for the infant/young child.

Associated Features Supporting Diagnosis

The **death/permanent loss** of an attachment figure may have effects on infants/young children other than complex grief. The infant/young child may become fearful of becoming attached to other adults for fear that they will also die; may avoid activities because of fear that they may result in injury or death; and may show reduced interest in exploration, learning, and problem solving. Role reversal may occur, with young children becoming precociously solicitous about the well-being of caregivers because of fear for their safety. Separation anxiety is usually exacerbated following loss or permanent separation from an attachment figure.

Developmental Features

There are no systematic studies of the course of grief in infants/young children less than 3 years old, and there are very few studies involving preschool-age young children. Infants in the first year of life may be intensely distressed by permanent separation or loss of an attachment figure, which they are likely to express through crying, lack of soothability, sleep disruptions, and listlessness. Young children may develop self-attributions about causing the death, preoccupation with death and dying, worry about having caused the death, negative thoughts such as wishing to die to join the attachment figure, and anger or ambivalent attachment involving substitute caregivers.

Prevalence

No data are available about the prevalence of Complicated Grief Disorder of Infancy/Early Childhood.

Course

The long-term course of Complicated Grief Disorder of Infancy/Early Childhood is not known.

Risk and Prognostic Features

Clinical experience suggests that infants/young children who have surviving alternative attachment figures are less likely to develop a disorder than those who lose their only attachment figure. There is some indication that infants/young children who lost an attachment figure in infancy/early childhood may be more prone to react with depression in later life following the loss of a loved person.

Culture-Related Diagnostic Issues

There are no studies addressing cultural differences in the manifestation of Complicated Grief Disorder of Infancy/Early Childhood in infants/young children. A significant obstacle to these studies is the pervasive belief across different cultural groups that infants/young children will forget the person who died/lost if the person is not mentioned and if reminders of the person are removed from the infant's/young child's everyday environment.

Gender-Related Diagnostic Issues

No gender differences have been identified for this disorder in infants/young children.

Differential Diagnosis

The clinical picture of Complicated Grief Disorder of Infancy/Early Childhood includes specific and nonspecific symptoms. Specific symptoms are sudden onset of distressing symptoms following the loss, as described in the criteria for the disorder. Nonspecific symptoms are negative affect, including pervasive sadness, irritability, fearfulness, and emotional withdrawal. Onset or intensification of symptoms following the death or permanent loss is necessary to meet criteria for a diagnosis of Complicated Grief Disorder of Infancy/Early Childhood. A diagnosis of Adjustment Disorder involves primarily a nonspecific emotional or behavioral response to a traumatic or stressful event without symptoms involving preoccupation with loss or death.

Comorbidity

There are no studies documenting comorbidity of Complicated Grief Disorder of Infancy/Early Childhood. Features of Generalized Anxiety Disorder and Depressive Disorder of Early Childhood have been observed clinically.

Links to DSM–5 and ICD–10

DSM–5: Other Specified Trauma- and Stressor-Related Disorder
(Persistent Complex Bereavement Disorder)

ICD–10: Other Reactions to Severe Stress (F43.8)

Axis III

Physical Health Conditions and Considerations

Axis III should be used to note physical health conditions and considerations not described in Axis I. A comprehensive, diagnostic assessment includes evaluation of an infant's/young child's physical, cognitive, and developmental conditions in addition to mental health. These health conditions and considerations are generally elicited from medical documentation, family report, or collaboration with the medical provider when risk is identified. The clinical function of the Axis III condition is considered part of a comprehensive formulation. An Axis III condition has a variable influence on mental health status, increasing risk in some instances, promoting resilience in other instances, or at times having no substantial impact.

All aspects of infants'/young children's development are interrelated, and the domains of physical, neurodevelopmental, and mental health overlap and interact substantially. By convention, DC:0–5™ uses Axes I and II to focus on the observable emotional, behavioral, and relational patterns of infants/young children, and Axis III focuses on the physical health conditions. **Using this approach, Axis III also includes biological factors or processes that contribute to well-characterized syndromes including Fetal Alcohol Syndrome or Fragile X Syndrome.** As our understanding of the complex interactions among biological factors, environmental factors, and psychological processes deepens, it is acknowledged that the distinctions among these categories will likely blur further.

Sentence revised

Health conditions may influence mental health directly or indirectly. A health condition, the toxins causing the condition, or the medications used to treat the infant/young child may influence central nervous system functioning through congenital malformations, injuries, or insults. In addition., the experience of physical symptoms—including pain, itching, or respiratory distress—may affect emotional expression, sleep, and feeding patterns. Axis III includes specific attention to pregnancy and perinatal complications that can have direct influences on the infant's/young child's development. Indirectly, medical conditions may influence an infant's/young child's experiences by exposure to potentially traumatic medical procedures (even when they are lifesaving) and through the limitations on normative activities and interactions because of physical disabilities, fragile immune status, or schedule. Chronic or acute medical conditions may result in separations from primary caregivers and exposure to a high number of health caregivers and, thus, may influence the functioning of the family through fatigue, financial stressors, stress, and related means. Psychologically,

Header changed

PSYCHOSOCIAL AND ENVIRONMENTAL STRESSORS FOR THE IDENTIFIED INFANT/YOUNG CHILD

Word changed

This **list** provides the clinician with a framework for (1) identifying the multiple sources of stress experienced by an individual infant/young child and family and (2) noting their duration and severity. **Note: the items listed in each category are examples and the list is not exhaustive.**

Sentence added

To capture the cumulative severity of stressors, the clinician should identify all the sources of stress in an infant’s/young child’s circumstances. For example, an infant/young child who enters foster placement may be experiencing the impact of abuse, parental psychiatric illness, separation, and poverty. The greater the number of stressors involved, the greater the adverse impact on the infant/young child is presumed to be.

Find a printable copy of this table on www.zerotothree.org/dc05resources

Table number added and title changed

Table 4. Psychosocial and Environmental Stressors

(Complete information for all stressors that apply)

Stressors	Age of onset <i>(in months)</i>	Comments, including duration and severity
Challenges within the infant’s/young child’s family or primary support group		
Acculturation or language conflicts		
Birth of a sibling		
Change in primary caregiver		
Criminal activity within the household		
Death of a parent or important caregiver		
Death of another important person		
Death of other family member		
Domestic violence		
Emotional abuse		
Family social isolation		

Stressors	Age of onset <i>(in months)</i>	Comments, including duration and severity
Parent is victim of crime		
Parental arrest		
Parental deportation		
Parental incarceration or return from incarceration		
Undocumented immigration status		
Other		
Abduction (specify by family member or nonfamily member)		
Disaster (e.g., fire, hurricane, earthquake)		
Disease epidemic		
Terrorism		
War		
Other (specify)		

Order of
items
changed

Note: “Parent” refers to parenting figure(s).

By 15 months old

Competency Domain	Milestone	Milestone Rating	Comments	Competency Domain Rating
Emotional	Shows affection with kisses (without pursed lips).			
	Demonstrates cautious or fearful behavior such as clinging to or hiding behind caregiver.			
Social-Relational Removed an item that was duplicated	Seeks and enjoys attention from others, especially caregivers.			
	Engages in parallel play with peers.			
	Presents a book or toy when he or she wants to hear a story or to play.			
	Repeats sounds or actions to get attention.			
	Enjoys looking at picture books with caregiver.			
Language-Social Communication	Uses simple gestures such as shaking head “no” or waving “bye-bye.”			
	Responds to the gestures of others.			
	Enjoys looking at picture books with caregivers.			
	Makes sounds with changes in tone (sounds more like speech).			
	Uses complex communication skills integrating gestures, vocalizations, and eye contact (e.g., looking to parent while taking his or her hand to bring him or her to a desired toy).			

Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.

Appendix B

The Process of Revising and Updating DC:0–3R

Revising and Updating DC:0–3R

A 3-year plan for carrying out the revision and update of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised Edition* (DC:0–3R; ZERO TO THREE, 2005) was presented to and approved by the Executive Committee of ZERO TO THREE in January 2013. The plan included the following: a survey of DC:0–3R users, a review of clinical literature, drafting and eliciting comments on draft criteria, and additional communication with world-renowned clinical experts in particular areas of diagnosis and treatment. The plan also included connecting with various organizations—American Academy of Pediatrics, American Psychological Association, International Association for Child and Adolescent Psychiatry and Allied Professions, International Society for Traumatic Stress Studies, American Occupational Therapy Association, National Child Traumatic Stress Network, American Academy of Child and Adolescent Psychiatry, and Society for Research in Child Development—to establish official liaisons for the revision process.

The Diagnostic Classification Revision Task Force was formed whose members worked both independently and collaboratively, and conferred via conference calls, e-mail, and in-person meetings throughout the 3-year period. Members of the Diagnostic Classification Revision Task Force included the following: Charles H. Zeanah (chair), Alice Carter, Julie Cohen, Helen Egger, Mary Margaret Gleason, Miri Keren, Alicia Lieberman, Kathleen Mulrooney, and Cindy Oser. Robert Emde served as Special Advisor to the Task Force. Helen Egger had served on the Revision Task Force that revised the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0–3; ZERO TO THREE, 1994) in 2003–2005. Charles H. Zeanah and Alicia Lieberman served on the original Task Force that developed DC:0–3, and Charles H. Zeanah served as a member of the Childhood and Adolescent Disorders Work Group for the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013). Reflecting on the multidisciplinary nature of infant mental health, the Diagnostic Classification Revision Task Force members included individuals representing the professional disciplines of psychiatry, psychology, pediatrics, nursing, social work, and counseling.

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