

04 - Using the CDDR for ICD 11 mental, behavioural and

- [01 - Components of the CDDR](#)
- [02 - Making an ICD 11 diagnosis using the CDDR](#)
- [03 - Other specified and unspecified categories](#)
- [04 - Other ICD 11 chapters relevant to diagnostic](#)
- [05 - ICD 11 diagnostic coding](#)
- [06 - Secondary parenting](#)

01 - Components of the CDDR

Components of the CDDR

21 Using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings Using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings This chapter provides a basic orientation to applying the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings. As previously indicated, the CDDR are not intended to function as a manual for conducting clinical assessments. Rather, they are to be applied in the context of clinicians' broader understanding of the disorders they are assessing and the clinical competencies they have gained through appropriate education, training and experience. This chapter also contains information on relevant aspects of diagnostic coding, some of which are the result of important innovations in how ICD-11 categories are represented and relate to one another. This material on coding relates to the entire ICD-11 and is not specific to the chapter on mental, behavioural and neurodevelopmental disorders. Coding is discussed here as it affects the implementation of the CDDR. This chapter includes a discussion of the following issues: • components of the CDDR; • making an ICD-11 diagnosis using the CDDR; • co-occurring and mutually exclusive diagnoses; • other specified and unspecified categories; • other ICD-11 chapters relevant to diagnostic formulation of mental, behavioural and neurodevelopmental disorders; and • ICD-11 diagnostic coding. Components of the CDDR A major improvement in the ICD-11 CDDR compared to the ICD-10 CDDG is the consistency of structure and information across major categories. The information provided for the main disorder categories in the CDDR is organized under the following headings: • Essential (required) features • Additional clinical features • Boundary with normality (threshold) • Course features • Developmental presentations • Culture-related features • Sex- and/or gender-related features • Boundaries with other disorders and conditions (differential diagnosis). The information provided is based on reviews of the available evidence, and is intended to be useful in making diagnostic judgements about individual patients. These sections do not provide a summary of all available information about the topic in question, but rather focus on issues that may be specifically relevant to assigning a diagnosis to an individual patient. If a particular heading (e.g. developmental presentations, sex- and/or gender-related information) is not provided for a specific disorder, this is because insufficient evidence was identified as a basis for making clinically

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders relevant and broadly applicable statements. The following sections give a brief description of the information provided in each section of the CDDR for the main

disorder categories. Essential (required) features This section provides guidance regarding the features needed to make the diagnosis confidently. The essential features represent those symptoms or characteristics that a clinician could reasonably expect to find in all cases of the disorder. In this sense, essential features resemble diagnostic criteria. However, artificial precision in diagnostic requirements, such as using exact counts of required symptoms and specific duration requirements as diagnostic cutoffs has generally been avoided unless these have been well established with appropriate global evidence. This allows for broader exercise of the professional's clinical judgement, depending on the characteristics of the patient – including cultural variations in presentation – and local circumstances. For example, it makes little sense to impose a rigid duration requirement of 6 months for a patient who has been experiencing the required symptoms for 5 months if the current visit represents the only opportunity that the patient is likely to have for appropriate treatment for the next year. This flexibility in language also allows the clinician to differentially weigh symptoms that are particularly severe and impairing, and to consider culturally specific “idioms of distress” that may differ somewhat in the way the patient understands and describes their experience but represent the same underlying phenomenon (e.g. somatic expressions of psychological distress).

Additional clinical features This section describes additional clinical features that are not diagnostically determinative but are associated with the disorder frequently enough that they can help the clinician to recognize variations in disorder presentation. This section is also used for alerting the clinician to the likelihood that certain clinically important associated symptoms or co-occurring disorders may be present and require assessment and treatment.

Boundary with normality (threshold) This section provides guidance regarding the differentiation of the disorder from normal variation in characteristics that may be continuous with, or similar to, the essential features of the disorder. This section often specifies aspects of the disorder that are indicative of its pathological nature and describes typical false-positives (i.e. clinical presentations that are similar in certain respects but are considered to be non-pathological). For many disorders, the differentiation from normality is based on the presence of significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Course features This section provides clinically relevant information regarding the typical course of the disorder, which is defined broadly to include information about age of onset, whether the disorder is persistent or episodic, its likely progression or remission over time, and its temporal relationship to life stressors and other disorders.

Developmental presentations This section describes how symptom presentations may differ according to the individual's developmental stage. Many disorders traditionally thought of as disorders of adulthood (e.g. depressive disorders) can present during childhood, and many disorders often thought of as disorders of childhood persist into adulthood, with alterations in their presentation. For example, presentations of attention deficit hyperactivity disorder in younger children often include excessive motor activity. In adolescents and adults with attention deficit hyperactivity disorder, the

02 - Making an ICD 11 diagnosis using the CDDR

Making an ICD-11 diagnosis using the CDDR

23 Using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings equivalent phenomenon is experiencing feelings of physical restlessness or a sense of discomfort with being quiet or sitting still. Also included in this section are developmental variations that are more common in older adults, among whom many mental disorders are often underdiagnosed. This section also contains information about different patterns of co-occurring conditions and risks for associated sequelae according to developmental stage. Culture-related features This section provides information regarding cultural considerations that should be considered when making the diagnosis. This includes cultural variations in prevalence and symptoms of disorders, sociocultural mechanisms that may account for this variation, and descriptions of cultural concepts of distress that are relevant to diagnosis and treatment decisions. See the section on cultural factors in the Introduction for additional information. Sex- and/or gender-related features This section covers sex- and/or gender-related diagnostic issues, including sex- and/or genderlinked differences in symptom presentation, community prevalence and presentation in clinical settings. Boundaries with other disorders and conditions (differential diagnosis) This section lists other disorders that should be considered in the differential diagnosis – particularly those that share presenting symptoms or features. For each of these disorders, this section describes the features that differentiate it from the index disorder, providing guidance to the clinician about how to make this differentiation. Issues related to the concurrent diagnosis of the disorder being distinguished from the index disorder are also discussed in this section. The boundary descriptions generally cover all information conveyed by exclusion terms on the ICD-11 MMS platform.³ Exclusion terms are often confusing to clinicians because they assume that they mean that the excluded condition cannot be diagnosed simultaneously with the index condition, which is not the case. Rather, an exclusion term in the ICD-11 MMS indicates that the condition excluded is not part of the condition described by the category, so that both conditions may be used at the same time if warranted. These considerations are covered more clearly and explicitly in the boundary descriptions found in this section of the CDDR. Making an ICD-11 diagnosis using the CDDR Consideration of essential (required) features The diagnostic process starts with a consideration of whether the presentation meets the diagnostic requirements laid out in the essential (required) features section of the CDDR for the diagnosis under consideration. There are

two types of essential features: those that must be present for the diagnostic requirements to be met and those that require a consideration of whether the symptoms may be better explained by other mental disorders that share presenting features. This aspect of the diagnostic evaluation includes a consideration of:

- particular symptoms that must be present (which may be expressed as a minimum number of symptoms from an item list – e.g. “Several of the following symptoms must be present”);
- the minimum amount of time that symptoms need to have been present (e.g. “present...for a period of at least several months”);
- frequency or proportion of the time that symptoms need to be present during that required period of time (e.g. “most of the time”, “most of the day, nearly every day”, “for more days than not”, “more than 1 hour per day”, “multiple incidents”);

3 ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) [website]. Geneva: World Health Organization; 2023 (<https://icd.who.int/browse11/l-m/en#/>).

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders

- in some cases, whether the onset of symptoms meets a particular diagnostic requirement (e.g. “characterized by the rapid and concurrent onset of several characteristic symptoms”); and
- whether the symptoms meet any stated requirement regarding their impact on the individual’s functioning (“symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning”) or have resulted in “significant distress”. As noted, the CDDR generally avoid artificial precision in quantifying the exact number of items that must be present from a list of symptoms or specifying a precise duration requirement. Too rigidly applied, these can create barriers – for example, due to cultural variation or in contexts where an individual may have limited opportunities to access care. The essential features attempt to describe the relevant clinical phenomena clearly in order to allow for flexible application of the CDDR in establishing the presence of each diagnostic item. It is up to the diagnosing health professional to make a judgement about its presence or absence, considering the entire context of the clinical presentation. If the essential features do not mention a required duration for the symptoms, it is assumed that the symptoms should have been present for at least one month in order to assign the diagnosis.

Consideration of other disorders that may share presenting features This aspect of the diagnostic evaluation includes whether the symptoms are best considered to be a manifestation of a disease or disorder classified outside of the mental, behavioural and neurodevelopmental disorders chapter (e.g. a sleep-wake disorder, a disease of the nervous system, or another medical condition). In cases where the symptoms are judged to be a direct pathophysiological consequence of a medical condition and the mental, behavioural or neurodevelopmental symptoms are a specific focus of clinical attention, a diagnosis of one of the secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere may be assigned, in addition to the appropriate diagnosis for the etiological medical condition. For example, depressive symptoms similar to those of a depressive episode that are judged to be due to hypothyroidism would warrant a diagnosis of secondary mood syndrome, with depressive symptoms in addition to hypothyroidism. However, certain disorders are diagnosed regardless of whether they are believed to be caused by a medical condition classified elsewhere, including neurocognitive disorders and certain neurodevelopmental disorders (i.e. disorders of intellectual development, autism spectrum disorder, stereotyped movement disorder). The evaluation also includes whether the symptoms are due to the effects of a substance or medication on the central nervous system. If so, a diagnosis of one of the substance-induced mental disorders (e.g. alcohol-induced delirium, amphetamine-induced psychotic disorder) is likely to be appropriate. Other categories specifically linked to substances or medications include catatonia induced by

substances or medications; amnesic disorder due to psychoactive substances, including medications; and dementia due to psychoactive substances, including medications. Finally, the diagnostic evaluation includes whether there are other ICD-11 mental, behavioural and neurodevelopmental disorders that share features with the disorder under consideration, that might better account for the symptomatic presentation. Whether a particular disorder that could account for the symptoms in fact better accounts for them is a clinical judgement. For example, the essential features of social anxiety disorder, which are characterized by marked and excessive fear or anxiety that occurs in social situations, includes the diagnostic requirement that “the symptoms are not better accounted for by another mental disorder (e.g. agoraphobia, body dysmorphic disorder, olfactory reference disorder)”. Each of these listed disorders may also involve the development of anxiety in social situations. For body dysmorphic disorder and olfactory reference disorder, the anxiety involves excessive self-consciousness about perceived defects in appearance or emitting an offensive body odour, respectively. In agoraphobia, the

25 Using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings anxiety is related to a fear of specific negative outcomes in social situations, such as panic attacks or other incapacitating (e.g. falling) or embarrassing (e.g. incontinence) physical symptoms. In making the clinical judgement of whether the symptoms of anxiety in social situations are better accounted for by one of these other disorders, the clinician takes into account factors such as the temporal sequence of the symptoms, which symptoms predominate, and the presence of other clinical features. Consideration of boundary with normality (threshold) For the most part, mental disorders occur on a severity continuum with no sharp division separating cases and non-cases (i.e. normality), making the differentiation between a mild case of the disorder and non-disordered normal variation potentially challenging. It is advisable to review this section because, in some cases, what might appear to be evidence of psychopathology may in fact be within the bounds of normality given the individual’s developmental stage and cultural context. This section of the CDDR also points out common false-positive presentations. Consideration of boundaries with other disorders and conditions (differential diagnosis) This section of the CDDR is an extension and expansion of the “consideration of other disorders that may share presenting features” element of the essential features and provides a more comprehensive review of other disorders that should be considered in the differential diagnosis. The clinician should consider whether any of the disorders listed might explain the presenting symptoms. Consideration of co-occurring and mutually exclusive diagnoses ICD-11 diagnoses are generally assigned for every disorder for which the diagnostic requirements are met; that is, co-occurring diagnoses are typically permitted. However, there are specific situations in which the diagnostic requirements may be met for more than one disorder, typically because of symptom overlap, but the CDDR recommend making only a single diagnosis. In most cases, this is noted in the essential features but, in some cases, it is noted in the description of the differential diagnosis for that disorder in the section on boundaries with other disorders and conditions. In the CDDR, recommendations against diagnosing two particular disorders together (i.e. cooccurrence) are generally made in one of the following ways. • “The symptoms do not meet the diagnostic requirements for ...”; “The symptoms do not occur exclusively during episodes of ...”; “The individual has never met the diagnostic requirements for ...”: these types of exclusionary statements are typically used if the symptomatic presentation of the disorder in question is already part of the definition of another disorder, and an additional diagnosis of the excluded disorder would be redundant. • The first case (“symptoms do not meet diagnostic requirement for”) prevents the assignment of both diagnoses if the diagnostic

requirements for both disorders are met at the same time, and generally indicates that the other disorder should be diagnosed instead. For example, the CDDR for bulimia nervosa indicate that the diagnosis should only be assigned if the symptoms do not meet the diagnostic requirements for anorexia nervosa, so that individuals who maintain an excessively low body weight by reducing their energy intake through purging behaviour would be assigned only a single diagnosis of anorexia nervosa rather than diagnoses of both anorexia nervosa and bulimia nervosa. The presence of bulimia-like behaviour is indicated with the binge-purge pattern specifier applied to the diagnosis of anorexia nervosa.

03 - Other specified and unspecified categories

Other specified and unspecified categories

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders • The second case (“symptoms do not occur exclusively during episodes of”) similarly prevents diagnosing the disorder in question if its symptoms only occur during episodes of another disorder. For example, the CDDR for dissociative amnesia indicate that it should not be diagnosed if the dissociative memory loss occurs only during episodes of trance disorder; the amnesic symptoms are features of trance disorder rather than a separate condition. • The third case (“individual has never met the diagnostic requirements for”) prevents a diagnosis from being made if there is currently, or a history of, another disorder. For example, the CDDR for schizotypal disorder indicate that, in order to assign the diagnosis, the individual’s past symptoms should never have met the diagnostic requirements for schizophrenia, schizoaffective disorder or delusional disorder. Similarly, recurrent depressive disorder is not diagnosed if the individual has ever experienced a manic, mixed or hypomanic episode. • “The symptoms are better accounted for by another mental disorder”: many essential features sections include the requirement that the symptomatic presentation is not better accounted for by another mental disorder. This is typically the case when the symptomatic requirements of one disorder are also a possible manifestation of another disorder. An example is the occurrence of significant anxiety symptoms that develop in anticipation of attending school. If the anxiety is entirely accounted for by fear of speaking in class and/or social interaction with peers, a diagnosis of social anxiety disorder would be most appropriate. On the other hand, if the anxiety is entirely accounted for by fear of being separated from attachment figures while at school, a diagnosis of separation anxiety disorder would be appropriate. However, if the anxiety is related to both fear of negative evaluation by peers and separation from attachment figures, and all other diagnostic requirements for both disorders are met, then both diagnoses may be assigned. These distinctions typically require clinical judgement, in this example, about the relevant “focus of apprehension” or stimuli or situations that trigger the anxiety. • Symptomatic presentations accounted for by another disorder can sometimes be assigned an additional diagnosis if the second diagnosis is a separate focus of clinical attention. Such recommendations may be noted in the section on boundaries with other disorders and conditions section. For example, stereotyped movements may be part of presentation of autism spectrum disorder: “repetitive and stereotyped motor movements, such as wholebody

movements...” are listed as examples of “persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities” in the essential features of autism spectrum disorder. In the boundary with stereotyped movement disorder in the CDDR for autism spectrum disorder, however, it is noted that “although such stereotyped movements are typical in autism spectrum disorder, if they are severe enough to require additional clinical attention – for example, because of self-injury – a co-occurring diagnosis of stereotyped movement disorder may be warranted”. • Finally, the boundaries with other disorders and conditions section may contain other recommendations regarding whether or not to diagnose more than one disorder. For example, in the CDDR for generalized anxiety disorder, the boundary with depressive disorders states that “generalized anxiety disorder may co-occur with depressive disorders, but should only be diagnosed if the diagnostic requirements for generalized anxiety disorder were met prior to the onset of or following complete remission of a depressive episode”. Other specified and unspecified categories By default, all groupings in ICD-11 contain what are called “residual categories”, which include “other specified” categories with ICD-11 codes ending in “Y” (e.g. 6C7Y Other specified impulse control disorders) and “unspecified” categories with ICD-11 codes ending in “Z” (e.g. 6A8Z Mood disorder, unspecified). Occasionally, residual categories are “suppressed”, or not listed, in the ICD-11 MMS because the other categories contained in the grouping are considered

04 - Other ICD 11 chapters relevant to diagnostic

Other ICD-11 chapters relevant to diagnostic formulation of mental, behavioural and neurodevelopment

27 Using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings to be exhaustive. For example, the grouping elimination disorders contains enuresis, encopresis and elimination disorder, unspecified; the other specified residual has been suppressed for this grouping and thus does not appear in the MMS. The CDDR include essential (required) features for other specified categories at the grouping level (e.g. other specified mood disorder, other specified dissociative disorder). A particular other specified diagnosis should be applied when the presentation is judged to be a clinically significant mental disorder falling within a particular grouping of disorders (e.g. mood disorders, dissociative disorders) because it shares primary clinical features with these disorders but does not fulfil the diagnostic requirements of any of the other available categories. For example, a presentation that included all of the essential features of schizophrenia but had not met the 1-month duration requirement would appropriately be diagnosed as other specified primary psychotic disorder. A presentation characterized by abnormal eating or feeding behaviours that did not correspond to the essential features of any of the specific feeding and eating disorders categories but resulted in significant risk or damage to health, significant distress or significant impairment in functioning could be diagnosed as other specified feeding and eating disorder. Sometimes, other specified diagnoses may refer to recognizable syndromes that have not been included as separate categories in ICD-11 – for example, because they are very rare or are not sufficiently widely recognized as disorders. Ganser syndrome, for

example, would be diagnosed as other specified dissociative disorder, and what is sometimes called “pathological demand avoidance” could be diagnosed as other specified disruptive behaviour or dissocial disorder if it did not meet the diagnostic requirements for oppositional defiant disorder. The characteristics of the presentation in other specified disorder should be specified in the clinical record. Unspecified categories are most commonly used by professional coders when the clinician has provided insufficient information in the clinical record to assign a more specific diagnosis. In clinical situations, unspecified categories are appropriate only when insufficient information is available to make a more definitive diagnosis and, if possible, should be changed when additional information becomes available. In contrast to other specified categories, which are used when the clinician knows what the disorder is but there is no precisely corresponding code, unspecified categories are used when the clinician has been unable to arrive at a precise diagnostic determination. For example, an individual presenting in a hospital emergency department who is exhibiting hallucinations and delusions in the absence of evidence of substance use, delirium or dementia might be assigned a diagnosis of schizophrenia or other primary psychotic disorder, unspecified, until a more complete assessment can be conducted. Unspecified categories should not be used as an administrative shortcut when a more specific diagnosis can be assigned; this results in a major loss of clinical and statistical information. Other ICD-11 chapters relevant to diagnostic formulation of mental, behavioural and neurodevelopmental disorders Categories from any of the other 24 chapters in ICD-11 may be comorbid with a mental, behavioural or neurodevelopmental disorder, and thus relevant to their diagnostic formulation. However, the following chapters warrant particular attention: Chapter 7. Sleep-wake disorders The ICD-11 chapter on sleep-wake disorders brings together ICD-10 nonorganic sleep disorders (F51) with “organic” sleep disorders (G47) that were classified in the ICD-10 chapter on diseases of the nervous system, as well as categories previously included in several other chapters (i.e. endocrine, nutritional and metabolic diseases; diseases of the respiratory system; certain

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders conditions originating in the perinatal period). Sleep-wake disorders previously included in the ICD-10 chapter on mental and behavioural disorders include nightmare disorder, sleepwalking disorder, sleep terrors and “nonorganic” versions of insomnia disorders, hypersomnia disorders and circadian rhythm sleep-wake disorders (disorders of the sleep-wake schedule in ICD-10). The unified ICD-11 chapter on sleep-wake disorders reflects the fact that the pathophysiology of most of these disorders is complex and includes both physiological and psychological/ behavioural components. ICD-11 abandons outdated and incorrect assumptions about the etiology of sleep-wake disorders – in particular, the obsolete distinction between “organic” and “nonorganic” disorders. The chapter is intended to enhance patient care and public health by creating a more visible and accurate system that will enhance clinician awareness and improve diagnostic accuracy and treatment. Placement of these conditions in a separate chapter on sleepwake disorders is in no way intended to indicate that they should not be diagnosed and treated by appropriately trained mental health professionals. Chapter 8. Diseases of the nervous system Diseases of the nervous system have a close relationship with mental, behavioural and neurodevelopmental disorders. Disorders in both chapters may affect cognition, emotional regulation or behaviour, and reflect dysfunctions in the psychological, biological or developmental processes. Given that mental, behavioural and neurodevelopmental disorders also affect the brain, in some instances the distinction between the two chapters is arbitrary and reflects professional tradition – especially the boundary between psychiatry and neurology – as much as biological or

phenomenological differences between the conditions listed in each. For some conditions, the psychological, behavioural or developmental syndrome is classified in the mental, behavioural and neurodevelopmental disorders chapter, while the underlying etiology may be classified in diseases of the nervous system. This includes disorders of intellectual development, autism spectrum disorder and stereotyped movement disorder in the neurodevelopmental disorders grouping; and delirium, mild neurocognitive disorder, amnesic disorder and dementia in the neurocognitive disorders grouping, all of which are diagnosed regardless of etiology. If the etiology is known, the corresponding diagnosis should also be assigned, which is often but not always in the chapter on diseases of the nervous system. The other neurodevelopmental disorders (e.g. developmental learning disorder, developmental speech or language disorder, developmental motor coordination disorder) are generally not diagnosed if the symptoms are fully accounted for by a disease of the nervous system. When mental, behavioural or neurodevelopmental syndromes are judged to be a direct pathological consequence of a disease of the nervous system and are a specific focus of clinical attention, a diagnosis from the grouping secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere may be assigned. For example, a psychotic syndrome with prominent visual hallucinations that is judged to be the direct pathophysiological consequence of Parkinson disease would be diagnosed as secondary psychotic syndrome, with hallucinations along with a diagnosis of Parkinson disease. Tic disorders and acquired aphasia with epilepsy (Landau-Kleffner syndrome) were classified in ICD-10 as emotional disorders with onset usually occurring in childhood and adolescence, but in ICD-11 have been moved to the chapter on diseases of the nervous system. In addition, movement disorders caused by medications (e.g. drug-induced parkinsonism, drug-induced dystonia), which are associated with certain medications commonly used to treat mental disorders, are included among the diseases of the nervous system.

29 Using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings Chapter 16. Diseases of the genitourinary system This chapter includes a grouping of premenstrual disturbances that may include significant mood symptoms, such as depressed mood and irritability, as well as somatic and cognitive symptoms that may also occur in mood disorders. In particular, premenstrual dysphoric disorder is secondary-parented in the mood disorders grouping of ICD-11, and the CDDR for this entity are provided in this volume. In addition, while nearly all sexual dysfunctions classified as diseases of the genitourinary system in ICD-10 have been moved to the new ICD-11 chapter on conditions related to sexual health (see the next section), pain syndromes that are more generally associated with genital organs or the menstrual cycle are classified in Chapter 16. Chapter 17. Conditions related to sexual health Analogously to sleep-wake disorders, the ICD-10 classification of sexual dysfunctions was based on a Cartesian separation of “organic” and “nonorganic” conditions. Sexual dysfunctions not caused by organic disorder or disease (F52), which also include “nonorganic” versions of the sexual pain disorders vaginismus and dyspareunia, were classified in the ICD-10 chapter on mental and behavioural disorders, and most “organic” sexual dysfunctions are classified in the chapter on diseases of the genitourinary system. These have been brought together in a new unified classification of sexual dysfunctions and sexual pain disorders in the ICD-11 chapter on conditions related to sexual health. This approach is consistent with current, more integrative clinical approaches in sexual health, and recognizes the large body of evidence that the origin and maintenance of sexual dysfunctions and sexual pain disorders most often involves the interaction of physiological and psychological/behavioural factors. Reformulated versions of all sexual dysfunctions from the ICD-10

mental and behavioural disorders chapter can be found in the ICD-11 chapter on conditions related to sexual health, except for ICD-10 excessive sexual drive – a condition most closely related to compulsive sexual behaviour disorder in ICD-11 – which is included in the grouping of impulse control disorders. As with sleep-wake disorders, placement of these conditions in a separate chapter on conditions related to sexual health is not intended to indicate that they should not be diagnosed and treated by appropriately trained mental health professionals. The ICD-11 chapter on conditions related to sexual health also includes gender incongruence, which represents a reformulation and renaming of ICD-10 gender identity disorders. There was substantial evidence that the nexus of stigmatization of transgender people and of mental disorders had contributed to a doubly burdensome situation for transgender and gender-variant people, and that stigma associated with the intersection of transgender status and mental disorders had contributed to precarious legal status, human rights violations and barriers to appropriate health care in this population. Although gender identity is clearly distinct from sex, this chapter appeared to offer the most broadly acceptable home for categories related to gender identity, while making it clear that they are no longer considered to be mental disorders. This position has been supported by a series of ICD-11 field studies. Gender incongruence was not proposed for elimination in ICD-11 because in many countries access to relevant health services is contingent on a qualifying diagnosis. Chapter 21. Symptoms, signs or clinical findings, not elsewhere classified The categories in this chapter are not considered to be disorders but rather provide descriptions of specific symptoms that may be used to describe the reason for a clinical encounter when a more precise diagnosis has not been established for various reasons. These categories may also be used to describe clinically important aspects of the individual's presentation when a diagnosis has been assigned.

05 - ICD 11 diagnostic coding

ICD-11 diagnostic coding

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders A part of this chapter is a detailed and comprehensive listing of mental or behavioural symptoms, signs or clinical findings, which also includes definitions for each. These often represent important problems in their own right (e.g. avolition, demoralization, apathy, thought blocking). The categories from this section can be used to describe the clinical presentation in the absence of a definitive mental, behavioural or neurodevelopmental disorder diagnosis. In addition, these categories can be useful when a mental disorder diagnosis has been assigned, and the symptom being described has implications for treatment but is not an essential feature of the disorder itself and does not meet the diagnostic requirements for a co-occurring disorder. A listing of mental or behavioural symptoms, signs or clinical findings included in this chapter, with their definitions, is provided as part of the CDDR (p. 677). Chapter 24. Factors influencing health status or contact with health services Categories from this chapter may be used when a person seeks mental health services for a reason other than for symptoms of a mental disorder (e.g. counselling for a problem associated with unemployment), or when the problem influences the person's health status but is not in itself a mental disorder. A number of categories in this chapter are relevant to mental health professionals because they: • represent a reason for a clinical encounter other than a mental disorder (e.g. counselling related to sexuality, counselling related to procreative management); • are a focus of intervention (e.g. relationship problems and maltreatment – see p. 707); • are important to consider in the differential diagnosis of mental disorders (e.g. uncomplicated bereavement, malingering); or • are factors that may significantly contribute to the initiation or maintenance of disorders in the mental, behavioural and neurodevelopmental disorders chapter, including recognized social determinants of mental health (i.e. problems associated with finances, problems associated with employment or unemployment, target of perceived adverse discrimination or persecution). A listing of factors influencing health status or contact with health services that are particularly relevant to mental health and mental health services is provided as part of the CDDR (p. 733). ICD-11 diagnostic coding Among the most important innovations of ICD-11 is its ability to capture much more clinical information associated with a particular diagnosis than was possible with ICD-10. Some of the ICD-11 coding features discussed in this section are designed for optimal use in the context of electronic information systems able to generate and interpret complex, multipart codes – for example, based on checklists completed by the health professional. However, some of these coding capabilities will also be useful to health professionals who are individually responsible for determining and

recording diagnoses and diagnostic codes. Even when coding itself is done by professional coders, as in some countries and health systems, it is important for health professionals to understand the information needed to generate the most accurate and useful codes so that they are better able to provide this information as a part of the medical record, even if it is recorded by hand. ICD-10 codes contained a letter of the alphabet in the first position, which indicated the chapter in which the category was classified. (The codes for ICD-10 mental and behavioural disorders all began with the letter “F”.) This was sufficient for the 22 chapters in ICD-10. All the other characters in the ICD-10 codes were limited to numbers, which imposed a limit of 10 subdivisions

31 Using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings at each level corresponding to each digit in the diagnostic code. Moreover, ICD-10 allowed for the coding of only limited disorder-specific clinical information within a diagnostic code via the provision of specifiers and subtypes that could be codified in the fourth, fifth or sixth characters in an ICD-10 code. ICD-11, like ICD-10 and its predecessors, also conveys diagnostic information based on the various positions and values of alphanumeric characters within a diagnostic code. The first character of an ICD-11 code indicates the top-level chapter; for example, if the first character is a “6”, the code is found in the mental, behavioural and neurodevelopmental disorders chapter. The second and third characters taken together indicate the diagnostic class or grouping (e.g. 6A7 for depressive disorders, 6B0 for anxiety and fear-related disorders). The fourth character typically indicates the specific disorder within that class (e.g. 6A70 for single episode depressive disorder, 6A71 for recurrent depressive disorder), but in cases in which these number more than 10, letters of the alphabet are used after the digits 0–9 are exhausted. For example, the fourth character in the ICD-11 codes for disorders due to substance use indicates the substance class. Because ICD-11 recognizes 14 different specific substance classes, the fourth character codes for the last four substance classes required resorting to letters (e.g. the code for disorders due to use of volatile inhalants is 6C4B.) The fifth character (following a decimal point) generally indicates subtypes or specifiers applicable to that diagnosis (e.g. 6A70.0 for single episode, mild; 6A70.1 for single episode, moderate, without psychotic symptoms; 6A70.2 for single episode, moderate, with psychotic symptoms). The ICD-11 codes for some disorders with more complicated systems for specifiers might require the use of a sixth character. For example, the fifth character for acute and transient psychotic disorder indicates whether it is the first episode (6A23.0) or one of multiple episodes (6A23.1). Indicating whether it is currently symptomatic or in remission requires a sixth character. That is, for 6A23.0 Acute and transient psychotic disorder, first episode, 6A23.00 is currently symptomatic; 6A23.01 is currently in partial remission; and 6A23.02 is currently in full remission. ICD-11 refers to this method of providing unique codes for all possible combinations of first or multiple episodes and currently symptomatic or partial remission or full remission for acute and transient psychotic disorder as “precoordination”. ICD-11 offers an additional coding convention that goes beyond just capturing clinical information within the confines of a single diagnostic code by allowing additional codes to be linked to the initial diagnostic code for the purpose of indicating additional clinically significant features. ICD-11 refers to this method of combining codes as “postcoordination”. One type of postcoordination used in the chapter on mental, behavioural and neurodevelopmental disorders involves appending codes that indicate specific symptomatic or course presentations that are applicable only to diagnoses within a particular diagnostic grouping. These include symptomatic manifestations of primary psychotic disorders; symptomatic and course presentations for mood episodes in mood disorders; prominent personality traits or patterns in personality disorders; and behavioural or psychological

disturbances in dementia. For example, the diagnostic codes indicating symptomatic and course presentations for mood episodes applicable only to mood disorders include the following • 6A80.0 indicates the presence of prominent anxiety symptoms during a mood episode. • 6A80.1 indicates that two or more panic attacks have occurred during a mood episode. • 6A80.2 indicates that a current depressive episode is persistent. • 6A80.3 indicates that a current depressive episode is characterized by melancholia. • 6A80.4 indicates a seasonal pattern of mood episode onset and remission. • 6A80.5 indicates a rapid cycling course (applicable only to bipolar type I and bipolar type II disorders).

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders

The diagnostic code 6A71.3/6A80.3, for example, indicates recurrent depressive disorder, current episode severe, without psychotic symptoms (6A71.3), with melancholia (6A80.3). Another form of postcoordination is through the use of “extension codes”, which are generic codes that can be applied across the categories in the different chapters of ICD-11. Extension codes for severity – none (XS8H), mild (XS5W), moderate (XS0T) and severe (XS25) – are used in several places in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders. Extension codes are appended to the diagnostic code they are modifying using an ampersand (&). For example, 6D80&XS0T is the code for dementia due to Alzheimer disease (6D80) of moderate severity (XS0T). Extension codes can also be used to indicate a provisional diagnosis (XY7Z) or to designate a differential diagnosis (XY75). For example, 6A02&XY7Z is the code to indicate a provisional diagnosis (XY7Z) of autism spectrum disorder (6A02). The coding for schizophrenia illustrates how a combination of precoordinated and postcoordinated codes, including extension codes for severity, can be used to characterize course and symptomatic manifestations more fully. Clinical course of schizophrenia is indicated using a combination of fifth-character codes (“0” for first episode, “1” for multiple episodes, “2” for continuous course) and sixth-character codes (“0” for currently symptomatic, “1” for in partial remission, “2” for in full remission). Dimensional profiles of current symptomatic manifestations can be indicated by adding codes from the symptomatic manifestations of primary psychotic disorders that represent specific symptom domains: • 6A25.0 for positive symptoms; • 6A25.1 for negative symptoms; • 6A25.2 for depressive mood symptoms; • 6A25.3 for manic mood symptoms; • 6A25.4 for psychomotor symptoms; and • 6A25.5 for cognitive symptoms. The above codes for symptomatic manifestations of primary psychotic disorders can be used in combination with extension codes to indicate the severity of each symptom domain, respectively, thus providing a symptomatic profile of the presenting symptoms for schizophrenia for a particular individual at a particular point in time. The web-based browser for ICD-11 for MMS4 can be used to construct the diagnostic coding for those disorders with complex combinations of specifiers and extensions. For example, schizophrenia, first episode, currently symptomatic with moderate positive symptoms, with severe negative symptoms, absent depressed mood symptoms, absent manic mood symptoms, mild psychomotor symptoms and severe cognitive symptoms yields the following combined diagnostic code: 6A20.00/6A25.0&XS0T/6A25.1&XS25/6A25.2&XS8H/6A25.3&XS8H/6A25.4&XS5W/6A25.5&XS25 As indicated, generating and interpreting this type of complex, multipart code will be most feasible for relatively sophisticated electronic health information systems. It is not expected that such complex codes will be used routinely by individual clinicians recording diagnoses by hand, for example. Coding of mental disorders caused by health conditions not classified under mental, behavioural and neurodevelopmental disorders ICD-11, as was the case with ICD-10, requires that two diagnostic codes be given for symptomatic presentations of mental disorders that are judged to be

a manifestation of a health condition (i.e. disorder, disease or injury) classified outside Chapter 6. ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) [website]. Geneva: World Health Organization; 2023 (<https://ICD.who.int/browse11/l-m/en#/>).

06 - Secondary parenting

Secondary parenting

33 Using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings One code from the mental, behavioural and neurodevelopmental disorders chapter indicates the mental disorder diagnosis, and a second code indicates the etiological medical condition. Note that the CDDR often use the generic term “medical condition” to refer to health conditions that are not mental disorders (i.e. not classified in the chapter on mental, behavioural and neurodevelopmental disorders). This is only a shorthand; it is not intended to suggest that mental, behavioural and neurodevelopmental disorders are not health conditions. The convention of double coding as it applies to the grouping of secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere involves assigning the code for the presumed underlying disorder or disease in combination with the code for the phenomenologically relevant secondary mental disorder. The earlier example of presentation consisting of depressive symptoms similar to those of a depressive episode that are judged to be due to hypothyroidism would be indicated by combining the diagnostic code for secondary mood syndrome, with depressive symptoms (6E62.0) with the appropriate diagnostic code from the hypothyroidism grouping – for example, transient congenital hypothyroidism (5A00.03), yielding the combination code 6E62.0/5A00.03. This coding convention also applies to neurocognitive disorders such as dementia due to different types of underlying diseases; for example, frontotemporal dementia requires two codes: 6D83 for the syndrome of frontotemporal dementia plus 8A23 frontotemporal lobar degeneration from Chapter 8 on diseases of the nervous system, yielding a combined code of 6D83/8A23. Importantly, the order of the codes being combined is not meaningful in this situation; it is not necessary to list the primary disorder first. That is, 6D83/8A23 has the same meaning as 8A23/6D83. Secondary parenting The ICD-11 classification is divided into 25 chapters, generally based on organ system (e.g. diseases of the digestive system), anatomic location (e.g. diseases of the ear and mastoid process), common pathophysiological process (e.g. certain infectious or parasitic disorders; neoplasms) or medical specialty (e.g. separating diseases of the nervous system from mental, behavioural and neurodevelopmental disorders). Many diseases in ICD-11 could have been placed in more than one chapter (e.g. pancreatic cancer could have been plausibly placed in either the diseases of the digestive system or the neoplasms chapter). ICD-11 acknowledges this fact by sometimes locating the same disorder in two (or more) chapters, with one of the chapters considered to be the “primary parent” and other chapter(s) termed “secondary parent(s)”. For example, the grouping of primary tics and tic disorders is listed in both Chapter 8 on diseases of the nervous system (within the movement disorders grouping) and the mental, behavioural and neurodevelopmental disorders chapter (within the neurodevelopmental disorders grouping). They are primary-parented in Chapter 8 on diseases of the nervous system and secondary-parented in the mental, behavioural and neurodevelopmental disorders chapter. The code number in both instances is the same and corresponds to the primary parent. For example,

the code for Tourette syndrome is 8A05.00. The “8” in the first digit of the code indicates that it is primary-parented in Chapter 8 on diseases of the nervous system. The same code (8A05.00) is retained when Tourette syndrome appears as a part of the grouping of neurodevelopmental disorders in Chapter 6.

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders