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01 - Maltreatment as a cause of injury or death

Maltreatment as a cause of injury or death

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

Maltreatment as a cause of injury or death

Categories for maltreatment from Chapter 23 on external causes of morbidity or mortality are used when the purpose is to document the cause of an injury being treated or the cause of death. These categories are used along with a classification of the associated physical injury (e.g. fracture of nasal bones, burns of external body surface). Available maltreatment categories in Chapter 23 include: Physical maltreatment Sexual maltreatment Psychological maltreatment Other specified maltreatment Maltreatment, unspecified Unintentional neglect Assault by neglect Neglect with undetermined intent. The associated injury from Chapter 22 on injury, poisoning or certain other consequences of external causes is postcoordinated with the type of maltreatment presumed to have caused it. Mental, behavioural and neurodevelopmental disorders such as post-traumatic stress disorder and recurrent depressive disorder can clearly be the result of or be exacerbated by maltreatment, but they are not typically considered immediate causes of the types of injuries classified in Chapter 22. However, mental disorders are provided as postcoordination options for PJ22 Psychological maltreatment. For other maltreatment categories in Chapter 23, any applicable mental, behavioural and neurodevelopmental disorder diagnosis should be assigned separately. Additional dimensions of the maltreatment as a cause of injury can also be specified via postcoordination. These include activity when injured (e.g. paid work, educational activity), place of occurrence (e.g. home, school, education area), the perpetrator-victim relationship (e.g. spouse or partner, parent, stranger) and the gender of the perpetrator. As an illustration, below is a fully postcoordinated example of a Chapter 23 maltreatment code:

- PJ20 Physical maltreatment
- Associated with: NA02.3 Fracture of skull or facial bones
- Activity when injured: XE9ME Unpaid cleaning, cooking or maintenance at own place of residence
- Place of occurrence: XE266 Home
- Perpetrator-victim relationship: XE454 Spouse or partner
- Gender of perpetrator, male: XE5YG
- Context of assault and maltreatment: XE0UM Altercation

The full postcoordinated code is: PJ20&XE9ME&XE266&XE454&XE5YG&XE0UM/NA02.3. (See discussion of ICD-11 diagnostic coding, p. 30, in the introductory section on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders.)

PJ20 PJ21 PJ22 PJ2Y PJ2Z PJ5B PF1B PH7B Relationship problems and maltreatment

02 - Relationship problems and maltreatment as fac

Relationship problems and maltreatment as factors influencing health status or health services

709 Relationship problems and maltreatment Relationship problems and maltreatment as factors influencing health status or contact with health services Categories for relationship problems and maltreatment from Chapter 24 on factors influencing health status or contact with health services are used when the purpose is to record one of three types of clinically significant relationship phenomena. These are: • to document a pattern of clinically significant relationship conflict with an intimate partner, parent or other caregiver; • to document a history over the individual's lifetime of maltreatment independent of a specific injury or other harm, which may refer to ongoing maltreatment or to past episodes – such as a history of child abuse – that are relevant to the individual's health status or encounters with the health system; or • to document a possible episode of maltreatment that is currently under clinical investigation. QE51.0 Relationship problems and maltreatment P Relationship distress with spouse or partner Relationship distress with spouse or partner is defined as substantial and sustained dissatisfaction with a spouse or intimate partner associated with significant disturbance in functioning. This diagnosis can be assigned to one or both parties in a dyad, depending on the context of the evaluation or treatment. Caregiver-child relationship problem Caregiver-child relationship problem is defined as substantial and sustained dissatisfaction within a caregiver-child relationship, including a parental relationship, associated with significant disturbance in functioning. This diagnosis can be assigned to one or both parties in a dyad, depending on the context of the evaluation or treatment. QE52.0 Available categories for history of maltreatment in Chapter 24 are: History of spouse or partner violence QE51.10 History of spouse or partner violence, physical QE51.11 History of spouse or partner violence, psychological QE51.12 History of spouse or partner violence, sexual QE51.13 History of spouse or partner violence, neglect. These diagnoses can be used to indicate ongoing or past

episodes of maltreatment by a spouse or partner when the focus of the evaluation is not related to a specific injury or death. If the history of maltreatment is not related to a spouse or partner relationship, categories from QE82 Personal history of maltreatment should be used instead. QE51.1 Available categories for intimate partner or caregiver-child relationship distress or conflict in Chapter 24 are:

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Available categories for examination or observation for suspected maltreatment in Chapter 24 are: Relationship problems and maltreatment | Personal history of maltreatment Personal history of maltreatment QE82.0 Personal history of physical abuse QE82.1 Personal history of sexual abuse QE82.2 Personal history of psychological abuse QE82.3 Personal history of neglect QE82.Y Other specified personal history of maltreatment QE82.Z Personal history of maltreatment, unspecified. These diagnoses can be used to indicate ongoing or past episodes of maltreatment by someone other than a spouse or partner (e.g. a parent, another relative, a stranger), when the focus of the evaluation is not related to a specific injury or death. If the history of maltreatment is related to a spouse or partner relationship, categories from QE51.1 History of spouse or partner violence should be used instead. The time in life (e.g. child under 5 years, adolescent, late geriatric) can be indicated using postcoordinated extension codes. QE82 Examination or observation for suspected maltreatment QA04.50 Examination or observation for suspected physical maltreatment QA04.51 Examination or observation for suspected sexual maltreatment QA04.52 Examination or observation for suspected psychological maltreatment QA04.53 Examination or observation for suspected neglect or abandonment QA04.5Y Other specified examination or observation for suspected maltreatment QA04.5Z Examination or observation for suspected maltreatment, unspecified. QA04.5 If maltreatment is confirmed based on the examination or observation, the diagnosis should generally be changed to one of the maltreatment categories in Chapter 24, if the evaluation is in relation to a specific injury, or otherwise to the applicable history or spouse or partner violence or personal history of maltreatment category in Chapter 24. In some circumstances, categories from Chapter 23 and Chapter 24 can be used together – for example, when there is an established history of maltreatment, and an injury resulting from that maltreatment is the focus of a current episode of care. However, examination or observation codes in Chapter 24 would typically not be assigned together with maltreatment categories from Chapter 23 explaining the cause of a specific injury.

03 - Relationship distress and current or past mal

Relationship distress and current or past maltreatment by spouse or partner

711 Relationship problems and maltreatment Relationship problems and maltreatment | Personal history of maltreatment As an illustration, below is a postcoordinated example of a Chapter 23 maltreatment code: • QE82.1 Personal history of sexual abuse • Time in life: XT7Q Early adolescence. The postcoordinated code is: QE82.1&XT7Q. (See discussion of ICD-11 diagnostic coding, p. 30, in the introductory section on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders.) CDDR for common forms of relationship problems and maltreatment Because of their importance and prevalence, CDDR have been developed for two sets of phenomena: • relationship distress and current or past maltreatment by spouse or partner; • problems in relationship between child and current or former caregiver, and current or past child maltreatment. These are among the most clinically important and impactful forms of relationship problems and maltreatment. The CDDR for these two groupings should be applied as appropriate in the context of the ICD-11 coding options for relationship problems and maltreatment. For example, physical abuse by an intimate partner could be classified as PJ20 Physical maltreatment from Chapter 23 or QE51.1 History of spouse or partner violence from Chapter 24, depending on the purpose of the assessment and nature of the situation. Relationship distress and current or past maltreatment by spouse or partner This section provides CDDR for the following categories: • to document the cause of an injury being treated or the cause of death: PJ20 Physical maltreatment, spouse or partner PJ21 Sexual maltreatment, spouse or partner PJ22 Psychological maltreatment, spouse of partner PF1B Assault by neglect • to document a pattern of either a clinically significant relationship conflict with a spouse or intimate partner, or a history of intimate partner maltreatment – including ongoing or past episodes – as factors that are relevant to the individual's health status and encounters with health services rather than in relationship to a specific injury or

death:

04 - QE51.0 Relationship distress with spouse or p

QE51.0 Relationship distress with spouse or partner

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders QE51.0 Relationship distress with spouse or partner QE51.1 History of spouse or partner violence QE51.10 History of spouse or partner violence, physical QE51.12 History of spouse or partner violence, sexual QE51.11 History of spouse or partner violence, psychological QE51.13 History of spouse or partner violence, neglect. Relationship distress with spouse or partner and different forms of intimate partner maltreatment can co-occur. As many of the categories in this section may be assigned together as necessary to describe the relevant clinical phenomena. General cultural considerations for relationship distress and maltreatment by spouse or partner • Presentations of relationship distress vary, depending on cultural constraints on their expression. In some cultures, women may be more attentive to relationship problems and therefore more likely report relationship distress. • The prevalence of the different forms of spouse or partner maltreatment (e.g. physical, sexual, psychological) vary widely by country, based on the social acceptance, detection and consequences of abusive behaviours. General sex- and/or gender-related features for relationship distress and maltreatment by spouse or partner • Although men and women are both affected by relationship distress, women's health may be more influenced by relationship distress, whereas men's health may be more influenced by relationship status (i.e. being in an intimate partner relationship or not). • Gender differences are country- and culture-specific. Overall, women are at much higher risk of victimization by maltreatment by their spouses or intimate partners. Relationship distress with spouse or partner Essential (required) features • Substantial and sustained dissatisfaction with the intimate relationship (e.g. pervasive unhappiness with the relationship, significant thoughts of divorce/separation) is required for diagnosis. • The dissatisfaction is associated with disturbance in at least one major area of functioning such as: • behaviour (e.g. persistent and intense conflicts, pervasive withdrawal or neglect, lack of positive behaviours); Relationship problems and maltreatment | Relationship distress and current or past maltreatment by spouse or partner QE51.0

713 Relationship problems and maltreatment • cognition (e.g. pervasive negative attributions of partner's intent); • emotion (e.g. persistent and intense anger, sadness or apathy); • physical health (e.g. pain and other physical symptoms not fully explained by a medical condition); •

interpersonal interaction (e.g. social isolation, decreased involvement in social activities); • major life role activities (e.g. work, school, caregiving). Note: this category is assigned to the individual being evaluated. In situations in which a couple is being evaluated, it may be assigned to both parties if applicable. Additional clinical features • Relationship distress with spouse or partner is associated with increased risk of various mental disorders (e.g. depressive disorders, anxiety and fear-related disorders, disorders due to substance use), and risk of exacerbation of existing medical conditions. Boundary with normality (threshold) • Occasional relationship dissatisfaction and disagreements occur in most relationships. Relationship distress with a spouse or partner should only be assigned when relationship dissatisfaction or conflict is a pervasive pattern affecting the individual's functioning in at least one major area. Boundaries with other disorders and conditions (differential diagnosis) Boundary with spouse or partner maltreatment (physical, psychological, sexual, or neglect) Relationship distress with spouse or partner is not considered a form of maltreatment. However, if all diagnostic requirements are met for both relationship distress with spouse or partner and a maltreatment category, both may be assigned. Relationship problems and maltreatment | Relationship distress and current or past maltreatment by spouse or partner

05 - PJ20 Physical maltreatment, spouse or partner

PJ20 Physical maltreatment, spouse or partner, or

QE51.10 history of spouse or partner ...

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Physical maltreatment, spouse or partner, or history of spouse or partner violence, physical Essential (required) features • At least one non-accidental act of physical force (e.g. pushing or shoving, scratching, slapping, throwing something that could cause injury, punching, biting) is required for diagnosis. • The act causes (or exacerbates) at least one of the following: • any physical injury; • significant fear; • reasonable potential for significant physical injury. • The act was not for physical protection of the individual (e.g. to ward off a partner's punches) or partner (e.g. to prevent a partner from attempting suicide). Note: these categories are assigned to the victim, not the perpetrator. In cases of mutual violence in which the couple is being evaluated, they may be assigned to both parties if applicable. If PJ20 Physical maltreatment is diagnosed, the perpetrator should be specified as a spouse or partner using the extension code XE454 (PJ20&XE454). On the ICD-11 platform, the option to specify the perpetrator-victim relationship appears in the context of the assault field. Additional clinical features • Intimate partner physical abuse is, by definition, associated with an increased risk of physical injury and need for medical attention. • Intimate partner physical abuse is associated with an increased risk of poor physical health and the development of a chronic disease. • Intimate partner physical abuse is associated with higher rates of depressive disorders, post-traumatic stress disorder and disorders due to substance use, as well as suicidality. • A pattern of recurrent acts, or the intent to

assert control or power, are not required features for assigning a diagnosis of intimate partner physical abuse. The diagnosis only requires at least one act of violence that causes or exacerbates at least one negative impact. • Most children (i.e. approximately 75%) living in households with clinically significant intimate partner physical abuse witness it. Exposure to parental or caregiver intimate partner violence places children at significantly greater risk of a range of mental disorders, negative affect/distress and negative cognitions, as well as social and academic difficulties. PJ20 / QE51.10 Relationship problems and maltreatment | Relationship distress and current or past maltreatment by spouse or partner

715 Relationship problems and maltreatment Boundary with normality (threshold) • Acts of physical aggression (e.g. grabbing a partner's arm) that do not cause injury or significant fear are relatively common in intimate relationships. In contrast, the acts of physical violence and associated impacts characteristic of intimate partner physical abuse are not part of healthy functioning relationships. Course features • Intimate partner physical abuse may lessen and remit over time. However, for many affected relationships, intimate partner physical abuse reoccurs and sometimes increases in frequency or severity. • The risk of intimate partner physical abuse increases in the context of external stressors (e.g. job loss) or when the victim is disabled. Developmental presentations • In general, adolescents and young adults are at greater risk of being victims of intimate partner physical abuse because the rate of physically violent acts against intimate partners among perpetrators tends to decrease across the lifespan. Boundaries with other disorders and conditions (differential diagnosis) Boundary with relationship distress with spouse or partner Intimate partner physical abuse may be, but is not always, associated with relationship distress with spouse or partner. If all diagnostic requirements are met for both relationship distress with spouse or partner and maltreatment or history of spouse or partner violence, both may be assigned. Relationship problems and maltreatment | Relationship distress and current or past maltreatment by spouse or partner

06 - PJ21 Sexual maltreatment, spouse or partner, PJ21 Sexual maltreatment, spouse or partner, or QE51.12 history of spouse or partner ...

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Sexual maltreatment, spouse or partner, or history of spouse or partner violence, sexual

Essential (required) features

- At least one of the following acts is required for diagnosis:
- the use of physical force to compel participation in a sex act against the partner's will, or when the partner is incapable of consent (whether or not the act is completed);
- the use of physical or psychological aggression to coerce the partner to participate in a sex act.
- The act is against the expressed wishes of the partner.
- The act causes significant distress to the partner.

Note: these categories are assigned to the victim, not the perpetrator. If PJ21 Sexual maltreatment is diagnosed, the perpetrator should be specified as a spouse or partner using the extension code XE454 (PJ21&XE454). On the ICD-11 platform, the option to specify the perpetrator-victim relationship appears in the context of the assault field.

Additional clinical features

- Intimate partner sexual abuse is associated with an increased risk of physical injury and need for medical attention.
- Intimate partner sexual abuse is associated with an increased risk of poor physical health and of development of a chronic disease.
- Intimate partner sexual abuse is associated with increased risk of various mental disorders (e.g. depressive disorders, anxiety and fear-related disorders, disorders due to substance use), as well as suicidality.

Boundary with normality (threshold)

- Sexual violation and coercion are not part of healthy functioning relationships.

PJ21/
QE51.12 Relationship problems and maltreatment | Relationship distress and current or past

maltreatment by spouse or partner

07 - PJ22 Psychological maltreatment, spouse or partner, or QE51.11 History of spouse or partner ...

717 Relationship problems and maltreatment Developmental presentations • In general, adolescents and young adults are at greater risk of being victims of intimate partner sexual abuse because the rate of sexually abusive acts among perpetrators tends to decrease across the lifespan. Boundaries with other disorders and conditions (differential diagnosis) Boundary with relationship distress with spouse or partner Intimate partner sexual abuse may be, but is not always, associated with relationship distress with spouse or partner. If all diagnostic requirements are met for both relationship distress with spouse or partner and maltreatment or history of spouse or partner violence, both may be assigned. Psychological maltreatment, spouse or partner, or history of spouse or partner violence, psychological Essential (required) features • Verbal or symbolic acts with the potential to cause psychological harm to the victim are required for diagnosis, such as: • berating, disparaging, degrading, humiliating the partner; • interrogating the partner; • restricting the partner's ability to come and go freely; • obstructing the partner's access to assistance (e.g. police aid, legal help, protective resources, medical resources, mental health resources); • threatening the partner; • harming, or threatening to harm, people/things that the partner cares about; • restricting the partner's access to or use of economic resources; • isolating the partner from family, friends or social support resources; • stalking the partner; • trying to make people think that the partner is "crazy", including for suggesting that they are a victim of psychological maltreatment. • The acts cause (or exacerbate) at least one of the following: • significant fear; • significant psychological distress; • somatic symptoms that interfere with normal functioning; Relationship problems and maltreatment | Relationship distress and current or past maltreatment by spouse or partner PJ22/ QE51.11

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders • significant self-imposed restrictions in engaging in one or more major life activities (e.g. work, education, religion, medical or mental services, contact with family members) to avoid recurrence of the acts. Note: these categories are assigned to the victim, not the perpetrator. If PJ22 Psychological maltreatment is diagnosed, the perpetrator should be specified as a spouse or partner using the extension code XE454 (PJ22&XE454). On the ICD-11 platform, the option to specify the perpetrator-victim relationship appears in the context of the assault field. Additional clinical features • Intimate partner psychological abuse typically represents a pattern of behaviours. However, it may be diagnosed based on a single episode if it is sufficiently impactful (e.g. harming a pet to punish the partner). • Intimate partner psychological abuse at a clinically significant level is associated with increased risk of seeking medical attention, as well as an increased risk of poor health and of development of a chronic disease. • Intimate partner psychological abuse is associated with higher rates of depressive disorders, post-traumatic stress disorder and disorders due to substance use, as well as suicidality. Boundary with normality (threshold) • Acts of psychological aggression (e.g. disparaging one's partner) that do not cause significant distress are relatively common in intimate relationships. In contrast, the verbal and symbolic acts and their associated impacts that constitute intimate partner psychological abuse are not characteristic of healthy functioning relationships. Course features • Intimate partner psychological abuse commonly emerges in adolescence and early adulthood, but is prevalent across the lifespan. • The risk of intimate partner psychological abuse increases in the context of external stressors (e.g. job loss). Relationship problems and maltreatment | Relationship distress and current or past maltreatment by spouse or partner

08 - PF1B Assault by neglect or QE51.13 History of PF1B Assault by neglect or QE51.13 History of spouse or partner violence, neglect

719 Relationship problems and maltreatment Boundaries with other disorders and conditions (differential diagnosis) Boundary with relationship distress with spouse or partner Intimate partner psychological abuse may be, but is not always, associated with relationship distress with spouse or partner. If all diagnostic requirements are met for both relationship distress with spouse or partner and maltreatment or history of spouse or partner violence, both may be assigned. Assault by neglect or history of spouse or partner violence, neglect Essential (required) features • At least one egregious act or omission by an adult's caregiver that deprives an intimate partner who is incapable of self-care of needed or adequate food, shelter, hygiene or necessary services is required for diagnosis. Examples of self-care incapacity include physical, psychological, intellectual and cultural (e.g. inability to manage activities of rudimentary daily living due to living in a foreign culture) limitations. • The act or omission causes significant physical injury or other significant negative consequences to health (e.g. development of an illness directly linked to the neglect, malnutrition) or reasonable potential for significant injury or negative consequences to health. Note: this category is assigned to the victim, not the perpetrator. If PF1B Assault by neglect is diagnosed, the perpetrator should be specified as a spouse or partner using the extension code XE454 (PF1B&XE454). On the ICD-11 platform, the option to specify the perpetrator-victim relationship appears in the context of the assault field. Depending on the specific situation, PB5B Unintentional neglect or PH7B Neglect with undetermined intent may be diagnosed rather than PF1B Assault by neglect. Additional clinical features • Neglect at a clinically significant level is associated with increased risk of various mental disorders (e.g. depressive disorders, anxiety and fear-related disorders, post-traumatic stress disorder), suicidality and various medical conditions (e.g. bed sores, malnutrition). PF1B / QE51.13 Relationship problems and maltreatment | Relationship distress and current or past maltreatment by spouse or partner

09 - Problems in relationship between child and ca

Problems in relationship between child and caregiver and current or past child maltreatment

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Boundary with normality (threshold) • Small lapses in caregiving to partners who are incapable of self-care are common, and a diagnosis of history of spouse or partner violence, neglect, should not be assigned on this basis. In contrast, egregious acts or omissions that cause significant physical injury or reasonable potential for such injury much less common and, if all diagnostic requirements are met, warrant the diagnosis. Problems in relationship between child and current or former caregiver and current or past child maltreatment This section provides CDDR for the following categories: • to document the cause of an injury being treated or the cause of death: PJ20 Physical maltreatment of a child PJ21 Sexual maltreatment of a child PJ22 Psychological maltreatment of a child PF1B Assault by neglect • to document a pattern of either a clinically significant relationship conflict in the relationship of a child with a current or former caregiver, or a history of child maltreatment – including ongoing or past episodes – as factors that are relevant to the individual’s health status and encounters with health services rather than in relationship to a specific injury or death: QE52.0 Caregiver-child relationship problem QE82.0 Personal history of physical abuse as a child QE82.1 Personal history of sexual abuse as a child QE82.2 Personal history of psychological abuse as a child QE82.3 Personal history of neglect as a child. Caregiver-child relationship problem and different forms of child maltreatment may co-occur. As many of the categories in this section may be assigned together as necessary to describe the relevant clinical phenomena. Problems in relationship between child and current former caregiver and current or past child maltreatment

10 - QE52.0 Caregiver child relationship problem

QE52.0 Caregiver-child relationship problem

721 Relationship problems and maltreatment Caregiver-child relationship problem Essential (required) features • Substantial and sustained dissatisfaction with the caregiver-child relationship (including adolescents) is required for diagnosis; this may be manifested in: • a pervasive sense of unhappiness with the relationship; • for the child, repeated running away, persistent thoughts of running away or fantasies of having another caregiver; • for the caregiver, wishing the child were totally different or had not been born, or thoughts of relinquishing care of the child; • the child allying themselves strongly with one parent and rejecting a relationship with the other parent, without evidence of maltreatment by the rejected parent – this primarily occurs in the context of a high-conflict relationship between two parents, including separation or divorce. • The dissatisfaction is associated with disturbance in at least one major area of functioning, such as the following: • behaviour (e.g. persistent and intense conflicts, pervasive withdrawal or neglect; lack of positive behaviours; failure to socialize child through nonexistent or poorly enforced limits; poor monitoring of the child's activities; overinvolvement in child's activities; child concealment of activities; child's persistent rejection, denigration and criticism of the caregiver); • cognition (e.g. pervasive negative attributions of caregiver or child intent); • emotion (e.g. persistent and intense anger, contempt, sadness or apathy); • physical health (i.e. exacerbation of medical or psychological symptoms or significant interference with provision of medical or psychological care); • interpersonal interaction (e.g. social isolation, decreased involvement in social activities); • major life role activities (e.g. work, school, caregiving). Note: behaviours associated with each area will vary according to the developmental stage of the child or adolescent, as well as the cultural context. This category should only be considered as applicable within a child or adolescent's primary caregiving relationships, which may include relationships with parents, grandparents or other significant long-term caregivers. This category may be assigned to either the child or the caregiver, depending on who is being evaluated. In situations in which a caregiver-child dyad is being evaluated, substantial and sustained relationship dissatisfaction, if present, is commonly – although not always – experienced by both parties. The diagnosis may be assigned to both parties if applicable. Additional clinical features • Problems in caregiver-child relationships are associated with the development of oppositional defiant disorder and conduct-dissocial disorder. QE52.0 Problems in relationship between child and current former caregiver and current or past child

maltreatment

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Boundary with normality (threshold) • Temporary fluctuations in parenting behaviours due to stress or illness are common. For example, a parent undergoing serious medical treatment may be unable temporarily to meet a child's needs appropriately. Similarly, more focused conflicts with caregivers are common among adolescents. Caregiver-child relationship problem should only be assigned if the relationship distress is substantial and sustained, and affects functioning. Course features • Caregiver-child relationship problem has a variable course. In some cases, relationship distress has a chronic course; in other cases, it may show substantial improvement over time. Developmental presentations • Young children are more likely to present with attachment problems (insecure or disorganized patterns), difficulty separating from parents or caregivers, or physical complaints than psychological symptoms. Psychological symptoms are more likely among older children and adolescents. • In infants or young children, distress may be exhibited by persistent withdrawal from the caregiver, freezing behaviours or heightened reactivity around the caregiver. Significant impact may be evidenced by a lack of appropriate developmental progression or even a loss of skills in an infant or young child. • For children or teens, distress may be exhibited by physical aggression, poor cooperation or oppositional behaviour with the affected caregiver, or by refusal to interact with the affected caregiver. • Older caregivers, such as grandparents, may be more vulnerable to problems in their relationships with high-energy children. Sex- and/or gender-related features • Although both the nature of the parental acts and their impact can vary by gender, boys and girls are equally likely to experience a caregiver-child relationship problem. Problems in relationship between child and current former caregiver and current or past child maltreatment

11 - PJ20 Physical maltreatment of child or QE82.0

PJ20 Physical maltreatment of child or QE82.0 Personal history of physical abuse as a child

723 Relationship problems and maltreatment Boundaries with other disorders and conditions (differential diagnosis) Boundary with child maltreatment (physical abuse, sexual abuse, psychological abuse, neglect) Caregiver-child relationship problem includes parenting behaviours that are within the normal range given the sociocultural context but that nonetheless have a negative impact on the child. Some caregiving behaviours may be appropriate for many children, but not for the specific child. These caregiver behaviours do not meet the diagnostic requirements for any child maltreatment category. In contrast, in child psychological maltreatment, one or more verbal or symbolic acts of parenting are clearly outside cultural norms, and are - or have reasonable potential to be - harmful to the child. If diagnostic requirements for both caregiver-child relationship problem and a form of child maltreatment are met, both may be assigned. Boundary with oppositional defiant disorder Oppositional defiant disorder is characterized by a pattern of markedly noncompliant, defiant and disobedient disruptive behaviour that is not typical for individuals of comparable age and developmental level. Similar behaviours may be observed in the context of caregiver-child relationship problem, but these are often confined to the specific caregiver-child relationship. In addition, in caregiver-child relationship problem there is often evidence that caregiver behaviours are not optimal for the child. However, if diagnostic requirements for both caregiver-child relationship problem and oppositional defiant disorder are met, both may be assigned. Boundary with reactive attachment disorder and disinhibited social

engagement disorder Reactive attachment disorder and disinhibited social engagement disorder are characterized by a history of grossly insufficient care associated with markedly abnormal attachment behaviours exhibited towards adult caregivers, with onset prior to the age of 5 years. Similar abnormal attachment behaviours may be observed in caregiver-child relationship problem. However, if all diagnostic requirements for reactive attachment disorder or disinhibited social engagement disorder are met, a diagnosis of caregiver-child relationship problem is typically not warranted. Physical maltreatment of child or personal history of physical abuse as a child Essential (required) features • At least one non-accidental act of physical force (e.g. pushing or shoving, slapping, punching, throwing something that could cause injury) towards a child or adolescent is required for diagnosis. Problems in relationship between child and current former caregiver and current or past child maltreatment PJ20 / QE82.0

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders • The act causes (or exacerbates) at least one of the following: • any physical injury (e.g. bruises, cuts, sprains, broken bones, loss of consciousness, pain that lasts for several hours); • significant fear; • reasonable potential for significant physical injury. • The act was not committed for physical self-protection (e.g. to ward off an adolescent's punches) or to protect the child or adolescent (e.g. to prevent a small child from running into a busy street or to prevent an adolescent from attempting suicide). Note: these categories are assigned to the victim, not the perpetrator. If PJ20 Physical maltreatment is diagnosed, the perpetrator-victim relationship (e.g. parent, other relative, stranger) should be specified using the extension codes provided on the ICD-11 platform in the context of the assault field. Similarly, if QE82.0 Personal history of physical abuse is diagnosed, the time of life for current or past episodes (e.g. child aged under 5 years, early adolescence) can be specified using the extension codes provided. Additional clinical features • Physical abuse of a child or adolescent can occur as an isolated incident. However, it can also occur as a pattern of parental or caregiver behaviour. If identified in a child or adolescent, it is important to evaluate whether past injuries were due to child physical abuse. • There are numerous injury types that when presented in a child are likely to have been caused by physical abuse. These include classic metaphyseal lesion (bucket handle fracture of the long bone); femur – metaphyseal and spiral fractures; humerus – metaphyseal and spiral fractures; rib fractures; spinous process fracture; skull – diastatic, across suture lines; subdural/epidural injury; patterned burns; patterned bruising; retinal haemorrhage (bilateral, multilayer). Many other injuries may also be caused by physical abuse of a child. • Child physical abuse is associated with a variety of mental disorders, including depressive disorders, adjustment disorder, anxiety and fear-related disorders, post-traumatic stress disorder, oppositional defiant disorder and conduct-dissocial disorder, as well as attentional problems, academic problems and suicidality. • Among younger children, disturbances in attachment, difficulty separating from parents or caregivers and vague physical complaints (stomach pain, headache) are more common results of physical abuse than psychological symptoms. Boundary with normality (threshold) • Physical discipline (e.g. spanking following perceived negative behaviours of the child) does not necessarily meet the diagnostic requirements for child physical abuse. Physical discipline is differentiated from child physical abuse by its impact. If physical discipline results in injury, has a reasonable potential for causing physical injury or elicits significant fear, a diagnosis of child physical abuse may be warranted. Problems in relationship between child and current former caregiver and current or past child maltreatment

12 - PJ21 Sexual maltreatment of child or QE82.1 P

PJ21 Sexual maltreatment of child or QE82.1 Personal history of sexual abuse as child

725 Relationship problems and maltreatment Developmental presentations • For infants or young children, distress associated with physical abuse may be exhibited by persistent withdrawal from the caregiver, freezing behaviours or heightened reactivity around the caregiver. The child may also exhibit an insecure or disorganized pattern of attachment. A significant impact of physical abuse may be evidenced by lack of appropriate developmental progression or even a loss of skills in infant or young child. Vague physical complaints (stomach pain, headache) are also common. • Symptoms of mental disorders are more likely among older children and adolescents who experience physical abuse. Distress may also be manifested in physical aggression, poor cooperation or oppositional behaviour towards the relevant caregiver; refusal to interact with that caregiver; thoughts of running away or fantasies of having another caregiver; inhibition, withdrawal or low self-esteem. Sex- and/or gender-related features • Although the impact of physical abuse can vary by gender (e.g. externalizing versus internalizing symptoms), boys and girls are equally likely to be victims. Sexual maltreatment of child or personal history of sexual abuse as child Essential (required) features • At least one of the following acts involving an adult and a child is required for diagnosis: • physical contact of a sexual nature between child and an adult – for example, vaginal or anal penetration (or attempted penetration), oral-genital or oral-anal contact, fondling (directly or through clothing); • non-contact exploitation, involving an adult forcing, tricking, enticing, threatening or pressuring a child to participate in acts for anyone's sexual

gratification without direct physical contact between the child and the perpetrator – for example, exposing a child’s genitals, anus or breasts; having a child masturbate or watch masturbation; having a child participate in sexual activity with a third person (including child prostitution); having a child pose, undress or perform in a sexual fashion (including child pornography). Note: these categories are assigned to the victim, not the perpetrator. If PJ21 Sexual maltreatment is diagnosed, the perpetrator-victim relationship (e.g. parent, other relative, stranger) should be specified using the extension codes provided on the ICD-11 platform Problems in relationship between child and current former caregiver and current or past child maltreatment PJ21/ QE82.1

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders in the context of the assault field. Similarly, if QE82.1 Personal history of sexual abuse is diagnosed, the time of life for current or past episodes (e.g. child aged under 5 years, early adolescence) can be specified using the extension codes provided. Additional clinical features • Child sexual abuse is associated with a variety of mental disorders, including depressive disorders, adjustment disorder, anxiety and fear-related disorders, post-traumatic stress disorder, oppositional defiant disorder and conduct-dissocial disorder, as well as attentional problems, academic problems and suicidality. • Sexual abuse that includes physical contact and penetration can result in genital or anal injuries, sexually transmitted diseases and pregnancy. Boundary with normality (threshold) • Mutual sex play between age mates is not considered sexual abuse. Sexual activity between adolescent partners should not be diagnosed as child sexual abuse. Developmental presentations • Among younger children who experience sexual abuse, disturbances in attachment (insecure or disorganized patterns, difficulty separating from parents or caregivers, and vague physical complaints such as stomach pain or headache) are more common than psychological symptoms. • Among older children and adolescents, psychological symptoms and externalizing behaviours are more common reactions to sexual abuse. Sex- and/or gender-related features • Sexual abuse of girls is generally more common than sexual abuse of boys, although this varies by country and culture. Problems in relationship between child and current former caregiver and current or past child maltreatment

13 - PJ22 Psychological maltreatment of child or Q

PJ22 Psychological maltreatment of child or

QE82.2 Personal history of psychological abuse as child

727 Relationship problems and maltreatment Psychological maltreatment of child or personal history of psychological abuse as child Essential (required) features • Verbal or symbolic acts with the potential to cause psychological harm to a child or adolescent are required for diagnosis. Examples include: • berating, disparaging, degrading, humiliating the child; • threatening the child (e.g. indicating or implying future physical harm, abandonment, sexual assault); • harming or abandoning – or threatening to harm or abandon – people or things that the child cares about, such as pets, property, loved ones (e.g. exposing a child to spouse or partner maltreatment); • confining the child (e.g. tying a child's arms or legs together; binding a child to a chair, bed or other object; confining a child to a small enclosed area such as a closet); • scapegoating the child (i.e. blaming child for things for which they cannot possibly be responsible); • coercing the child to inflict pain on themselves; • disciplining the child excessively through physical or non-physical means (e.g. extremely high frequency or duration), without necessarily meeting diagnostic requirements for physical maltreatment. • The acts cause (or exacerbate) at least one of the following: • significant fear; • significant psychological distress; • somatic symptoms that interfere with normal functioning; • significant avoidance or reluctance to engage in one or more major life activities (e.g. work, education, religion, medical or mental services, contact with family members) to avoid recurrence of the acts. Note: these categories are assigned to the victim, not the perpetrator. If PJ22 Psychological maltreatment is diagnosed, the perpetrator-victim relationship (e.g. parent, other relative, stranger) should be specified using the extension codes provided on the ICD-11 platform in the context of the assault field. Similarly, if QE82.2 Personal history of psychological abuse is diagnosed, the time of life for current or past episodes (e.g. child aged under 5 years, early adolescence) can be specified using the extension codes provided. Additional clinical features

- Child psychological abuse typically represents a pattern of parental or caregiver behaviours. However, it may be diagnosed based on single episode if it is sufficiently impactful (e.g. harming a pet to punish the child).

PJ22 / QE82.2 Problems in relationship between child and current former caregiver and current or past child maltreatment

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

- Child psychological abuse is associated with a variety of mental disorders, including depressive disorders, adjustment disorder, anxiety and fear-related disorders, posttraumatic stress disorder, oppositional defiant disorder and conduct-dissocial disorder, as well as attentional problems, academic problems and suicidality. Boundary with normality (threshold)
- Child psychological abuse is characterized by one or more verbal or symbolic acts, generally outside the sociocultural norms for parenting, that are – or have reasonable potential to be – harmful to the child. In contrast, whereas normal discipline may be upsetting to children, unlike psychological maltreatment it does not cause psychological harm, have the potential to cause psychological harm, result in somatic symptoms or interfere with functioning. Developmental presentations
- For infants or young children, distress associated with psychological abuse may be exhibited by persistent withdrawal from the caregiver, freezing behaviours or heightened reactivity around the caregiver. The child may also exhibit an insecure or disorganized pattern of attachment. A significant impact of psychological abuse may be evidenced by lack of appropriate developmental progression or even a loss of skills in infant or young child. Vague physical complaints (stomach pain, headache) are also common.
- Symptoms of mental disorders are more likely among older children and adolescents who experience psychological abuse. Distress may also be manifested in physical aggression, poor cooperation or oppositional behaviour towards the relevant caregiver; refusal to interact with that caregiver; thoughts of running away or fantasies of having another caregiver; inhibition, withdrawal or low self-esteem. Sex- and/or gender-related features
- Although the nature of parental acts (e.g. restriction versus humiliation) and the impact of psychological abuse can vary by gender, boys and girls are equally likely to be victims.

Problems in relationship between child and current former caregiver and current or past child maltreatment

14 - PF1B Assault by neglect or QE82.3 Personal hi

PF1B Assault by neglect or QE82.3 Personal history of neglect as a child

729 Relationship problems and maltreatment Boundaries with other disorders and conditions (differential diagnosis) Boundary with caregiver-child relationship problem Psychological maltreatment should be distinguished from caregiver-child relationship problem, which – unlike psychological maltreatment – is characterized by parenting behaviours that are within the normal range for the sociocultural context but may still have a negative impact on the child. Assault by neglect or personal history of neglect as a child Essential (required) features • At least one confirmed or suspected egregious act or omission by a child or adolescent's caregiver that deprives the child of needed age-appropriate care is required for diagnosis (e.g. abandonment, lack of appropriate supervision; exposure to physical hazard; failure to provide necessary education, health care, nourishment, shelter, clothing). • The act or omission causes or exacerbates at least one of the following impacts: • significant physical injury or reasonable potential for significant injury; • other significant negative consequences to health (e.g. development of an illness directly linked to the neglect, malnutrition) or reasonable potential for significant negative consequences to health; • significant fear or psychological distress; • reasonable potential for significant psychological harm (e.g. development of a mental disorder) or for significant disruption of the child's physical, psychological, cognitive or social development); • somatic symptoms that interfere with normal functioning. Note: this category is assigned to the victim, not the perpetrator. If PF1B Assault by neglect is diagnosed, the perpetrator-victim relationship (e.g. parent, other relative, stranger) should be specified using the extension codes provided on the ICD-11 platform in the context of the assault field. Perpetrator should be specified as a parent, other relative, unrelated caregiver, or official or legal authority using the available extension codes. Depending on the specific situation, PB5B Unintentional neglect or PH7B Neglect with undetermined intent may be diagnosed rather than PF1B Assault by neglect. If QE82.3 Personal history of neglect is diagnosed, the time of life for current or past episodes (e.g. child aged under 5 years, early adolescence) can be specified using the extension codes provided. PF1B / QE82.3 Problems in relationship between

child and current former caregiver and current or past child maltreatment

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Additional clinical features • Victims of child neglect can present with severe (chronically untreated) dental caries, ear infections or other typical childhood illnesses. • Child neglect is associated with a variety of mental disorders, including depressive disorders, adjustment disorder, anxiety and fear-related disorders, post-traumatic stress disorder, oppositional defiant disorder, conduct-dissocial disorder, attentional problems, academic problems and suicidality. Boundary with normality (threshold) • Parents or other caregivers may provide less than optimal care for their children for brief periods due to caregiver illness or stress. However, normal caregiving requires that they make other arrangements if their own caregiving will be compromised for more than a brief period. If a child is in danger, or is suffering significant harm as a result of inadequate caregiving, the omissions in caregiving should be diagnosed as neglect. Developmental presentations • Children of any age can experience neglect. Neglected children may appear mature for their age, but may also exhibit stunted growth due to lack of adequate nutrition or other developmental deficits. • Failure to meet developmental milestones can be a marker of neglect, as can attachment problems (insecure or disorganized patterns), difficulty separating from parents or caregivers, social skills deficits, behaviour problems and scholastic problems. Course features • Although one incident is sufficient to meet the diagnostic requirements, incidents of child neglect often occur as part of a persistent pattern, which substantially increases the risk of mental disorders, medical conditions and disrupted development. Problems in relationship between child and current former caregiver and current or past child maltreatment

731 Relationship problems and maltreatment Sex- and/or gender-related features • Although its impact can vary by gender, boys and girls are equally likely to be victims of neglect. Boundaries with other disorders and conditions (differential diagnosis) Boundary with caregiver-child relationship problem Neglect is characterized by egregious acts or omissions that result in – or have significant potential to result in – negative impacts. A diagnosis of caregiver-child relationship problem is generally more appropriate for children of caregivers who are emotionally neglectful (e.g. not engaging in positive interactions with the child) but have not committed egregious acts or omissions that deprive the child or adolescent of age-appropriate care. Boundary with reactive attachment disorder and disinhibited social engagement disorder Both reactive attachment disorder and disinhibited social engagement disorder are considered to result from a history of grossly insufficient care in early childhood, including persistent disregard for the child's basic emotional or physical needs. They can occur in the context of repeated changes of foster care or rearing in institutional settings that prevent the formation of stable selective attachments, as well as in dyadic caregiver relationships. The insufficient care would meet the diagnostic requirements for neglect and possibly also for other forms of maltreatment. Both reactive attachment disorder and disinhibited social engagement disorder are characterized by markedly abnormal attachment behaviours towards adult caregivers that are evident by the age of 5 years. In reactive attachment disorder, there is a persistent and pervasive pattern of inhibited, emotionally withdrawn behaviour, including minimal seeking of comfort when distressed and rare or minimal response to comfort when it is offered. In disinhibited social engagement disorder, there is a persistent and pervasive pattern of markedly abnormal social behaviours, in which the child displays reduced or absent reticence in approaching and interacting with unfamiliar adults. If the diagnostic requirements are

met for reactive attachment disorder or disinhibited social engagement disorder, that diagnosis should be assigned. An additional diagnosis of assault by neglect or personal history of neglect may be assigned if it is relevant to the particular clinical situation. Problems in relationship between child and current former caregiver and current or past child maltreatment

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