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BMHP6029-

Psychopathological Classifications and Provisions

Lecture: Bianca Sanfilipo

Component 2: Written Assignment

ICD-11 Chapter 6: Code 6A05 Classification and Diagnosis of ADHD)

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Introduction

ICD-11 Chapter 6 code 6A05 is attention-deficit/hyperactivity disorder (ADHD), a neurodevelopmental disorder that is characterised by inattention and/or hyperactivity–impulsivity throughout the lifespan (Chaulagain et al., 2023). Recognition, assessment and support are more than clinical symptoms they impact on educational, occupational, and social participation. However, ADHD can be difficult to view as just a disorder as the neurodiversity perspective considers it as a variation in the human brain, and some individuals may suffer significant impairment (Swanepoel, 2024). This tension poses a challenge to balancing access to treatment with identity, autonomy and strengths-based support. This report critically reviews the classification and diagnosis of ADHD, provision and treatment in history and the present, rehabilitation, current debates and policy implications (Young et al., 2021). It suggests that, despite better life expectancy recognition, uncertainty in diagnosis and structural inequality and competing views still limit provision of equality.

1. ICD-11 Classification and Diagnosis of ADHD

1.1 ICD-11 Classification and Terminology

ADHD is coded in ICD-11 Chapter 6 as a neurodevelopmental disorder (6A05), defined as having a persistent pattern of inattention and/or hyperactivity–impulsivity that causes significant impairment (Faraone et al., 2021). Predominantly inattentive, predominantly hyperactive–impulsive, combined, other specified and unspecified are the presentations. These differences contribute to the assessment of individuals, but presentation may vary with age and context and it is not assumed that these are fixed categories (Chaulagain et al., 2023). The term “disorder” allows easy identification of the disorder and also provides easy access to services, but can also lead to stigma and a deficit view of the disorder (World Health Organization, 2025). While it is important to validate identity with the description of ADHD as a condition or neurodevelopmental variation, it is also important to not downplay true impairment and support needs (Swanepoel, 2024).

1.2 Diagnostic Requirements and Process

The symptoms are greater than those expected for age and intellectual functioning, occur prior to age 12 and persist for at least 6 months and impair functioning across settings (Faraone et al., 2021). Assessment should be based on a range of specialist interviews and developmental history, observation, rating scales and relevant family, education or employment information. Rating scales are used to organise evidence, but they are not able to diagnose independently as answers are influenced by the context and the informant expectations (Chaulagain et al., 2023). The functional implications need to be evaluated and

the clinician needs to differentiate between ADHD and anxiety, depression, autism, trauma, learning problems, sleep disturbances and substance use, and be aware of the potential for co-occurrence. Delayed recognition can occur for women, due to less consistency with disruptive male stereotypes (Young et al., 2020). Where assessment is not sufficiently robust, however, normal behavioural differences can be medicalized (World Health Organization, 2025; Adamou et al., 2024).

1.3 Diagnostic Strengths and Limitations

The lifespan approach in ICD-11 helps to identify adults who may have had difficulties as children that were not recognised. (Attoe and Climie, 2023) However, they will not all be the same as far as symptoms, strengths and supports are concerned. Judgements of clinically significant impairment (CSI) is also influenced by cultural expectations and environmental demands (Chaulagain et al., 2023). Diagnosis offers administrative clarity, but categorises a dimensional trait into categories (Swanepoel, 2024). The value of its worth is therefore to enable presentation of proportional, person-centred support, and not to be a code of identity.

2. Historical and Contemporary Provision

2.1 Historical Development of ADHD Classification

Traditionally, ADHD has been understood primarily as children's hyperactivity, with a focus on disruptive behaviour that is often observed in boys and less apparent in girls that are inattentive (Young et al., 2020). This earlier categorisation was thus limited to a more restricted behavioural issue, and not a diverse neurodevelopmental journey into adulthood. Adopting the broader and more lifespan-oriented framework of ICD-11, from ICD-10 hyperkinetic disorders to ICD-11's "lifespan" approach, demonstrates an increased acceptance of the need to consider symptoms, impairment and support needs across the lifespan (Faraone et al., 2021). However, the growing recognition of different ADHD presentations and adult ADHD raises questions about whether scientific understanding has improved or diagnostic boundaries have simply widened. While modern classification has been fixing past omissions, women and adults might still be undiagnosed due to assumptions that have been embedded in services and expectations from working with children, and from childhood presentations (Attoe and Climie, 2023).

2.2 Contemporary Service Provision

Ideally, contemporary provision involves a specialist assessment along with input from psychiatrists, psychologists, nurses, GPs, occupational therapists, educators and social care professionals (Young et al., 2020). This may include the use of CAMHS, shared-care prescribing, adjustments and accommodations to learning and working environments. Despite

the formal recognition of the lifespan approach in current classification (Young et al., 2021), a lack of geographical consistency and weak transition between child and adult services in practice (long waiting list) is a barrier to the approach (Asherson et al., 2022). There can also be further obstacles for women, minority communities and disadvantaged groups related to professional bias, costs, and cultural misinterpretation and/or the lack of community services. While person-centred and neurodiversity-informed practice is an improvement, services are not always coordinated, accessible and sustained following a diagnosis (Sedgwick-Müller et al., 2022).

3. Treatment and Rehabilitation

3.1 Pharmacological Treatment

There are several medications that can be used to manage core symptoms of ADHD, such as stimulants (methylphenidate and lisdexamfetamine), and others that can be used when stimulants are not appropriate (atomoxetine and guanfacine) (Nazarova et al., 2022). The choice of therapy should be based on impairment, physical health, co-occurring problems, and past responses and personal preferences. While medication can increase concentration, impulse control and daily functioning, there is not as much certainty as there is for short-term effectiveness for long-term benefits (Chaulagain et al., 2023). There is therefore a need for baseline evaluation, titration and monitoring these effects on appetite, sleep and the cardiovascular system and emotional changes. A regular review of benefits, adverse effects, medication adherence and whether medication is still supporting individual priorities should be conducted (Faraone et al., 2021). It is crucial that the decision about medications is shared decision making as inaccessible environments and discrimination and/or unmet psychological needs cannot be solved through medication (Cortese et al., 2018).

3.2 Psychological and Psychosocial Interventions

Psychoeducation, cognitive behavioural therapy, behavioural programmes and parent training can enhance understanding, emotional regulation, organization, and coping skills (Nazarova et al., 2022). Consistent strategies at home and at school may be beneficial for children, and support for adults in relation to employment, relationships and independent living. Generally, the interventions help in coping and functioning and do not remove the neurodevelopmental traits and therefore realistic goals are essential (Chaulagain et al., 2023). A lack of provision, however, and the long waiting lists can mean that people are sent away with medicines with no therapeutic support. So psychological interventions are most credible when coupled to environmental adjustments and not as a way of enforcing neurotypical behaviour (Swanepoel, 2024).

3.3 Rehabilitation, Recovery and Practical Support

The focus of rehabilitation is not just on reducing symptoms it's about autonomy, participation and personally meaningful quality of life (Sedgwick-Müller et al., 2022). This can involve making changes to the education, the workplace, coaching, occupational assistance and support with routines or relationships. Transitions from child to adult services are particular moments for continuity and may lead to services becoming fragmented (Young et al., 2021). The focus of strengths-based planning should include creativity, energy and intense interests, but not romanticise impairment. Coordination of provision is not to be assumed when the diagnosis is made and thus success should be measured by educational, social and occupational participation as well as by symptom improvement (Faraone et al., 2021).

4. Current Debates and Emerging Issues

4.1 Medical Model and Neurodiversity Debate

The medical model treats ADHD as a disorder because impairment can justify access to diagnosis, treatment and support (Faraone et al., 2021). Yet deficit-centred language can imply that difference lies within the individual, overlooking how environments convert variation into disability. Neurodiversity presents ADHD as natural neurological variation and draws attention to strengths, identity and autonomy (Swanepoel, 2024). However, celebrating strengths becomes harmful if it romanticises distress or suggests clinical assistance is unnecessary. The positions can be combined: diagnosis secures support, while neurodiversity-informed practice challenges stigma and requires inclusion (Sedgwick-Müller et al., 2022).

4.2 Diagnostic and Reclassification Controversies

Categorical diagnosis creates a threshold for services, although ADHD traits and impairments are dimensional and vary across the lifespan (Chaulagain et al., 2023). This creates uncertainty about where difference ends and disorder begins. Claims of overdiagnosis sit uneasily beside missed recognition among women, girls and adults whose inattention, masking or distress do not match disruptive stereotypes (Attoe and Climie, 2023). Social-media discussion may improve awareness, but self-identification cannot replace assessment of development, impairment and alternative explanations. Overlap with autism, anxiety, trauma and mood disorders weakens simple diagnostic boundaries, while changing presentations challenge the idea of a stable category (Faraone et al., 2021). Future classification may need dimensional measures without abandoning categories required for clinical decisions and resources.

4.3 Treatment, Practice and Policy Debates

Medication can reduce symptoms, but services may privilege prescribing above psychological, occupational and environmental support (Nazarova et al., 2022). Improved attention does not automatically remove exclusion, damaged confidence or inaccessible institutions. Long waiting lists, regional inequality, teams and fragmented child-to-adult transitions mean diagnosis may arrive late or without post-diagnostic care (Young et al., 2021). Women and diverse communities may encounter professional misunderstanding, while private assessment can deepen socioeconomic inequality (Cortese et al., 2018). Education and employment policies should guarantee reasonable adjustments, yet provision often depends on local resources and advocacy (Sedgwick-Müller et al., 2022). The central weaknesses are inconsistent assessment, fragmented services, narrow treatment pathways and limited inclusion, requiring coordinated practice, commissioning and research reform (Asherson et al., 2022).

5. Recommendations for Practice, Policy and Research

5.1 Improve Diagnostic Assessment

Assessments must be life span, culturally appropriate, gender responsive and have a developmental history, evidence from settings and differential diagnosis (Young et al., 2020). If training practitioners to identify masking and inattentive presentations led to a reduced threshold for clinically significant impairment, it would be more harmful to women than beneficial. If training practitioners to identify masking and inattentive presentations meant that there would be a lowered threshold for clinically significant impairment, it would be more harmful than helpful to women (Adamou et al., 2024).

5.2 Develop Integrated Services

There needs to be shared pathways, waiting-time targets and a transition between child and adult services between specialist and primary care (Young et al., 2021). Commissioning should minimise geographical variation, as the point of recognising ADHD as a lifelong condition is not if the support is not there when the child needs it.

5.3 Balance Treatment with Neurodiversity-Informed Rehabilitation

Treatment involves both medication and psychological, educational, occupational and environmental support which depends on priorities (Nazarova et al., 2022). Co-production with individuals with ADHD and strengths-based language can acknowledge identity without denying disability or offering care as an alternative to neurodiversity.

5.4 Strengthen Research and Policy

Long-term treatment outcomes, diagnostic thresholds and functioning in culturally diverse community and adults should be explored along with narrow samples of women in research (Chaulagain et al., 2023). Policy should translate this into enforceable reasonable adjustments, and post-diagnostic support, as measured by participation and quality of life with a change in symptom.

Conclusion

Overall, ICD-11 has reinforced the ADHD as a life span neurodevelopmental disorder and offered a broader range of possibilities to recognise diverse presentations throughout childhood and adulthood. There are, however, subjective judgments of impairment, cultural and gender bias, and symptom overlap and dimensionality of ADHD that limit the use of diagnostic categories. A balance should thus be maintained between the medical framework's ability to provide the necessary assessment and support, and the necessary respect for identity, strengths and autonomy, as provided by an understanding of neurodiversity. Diagnosis and medication is not enough for effective provision. Clinical treatment, psychological support, rehabilitation and reasonable environmental adjustments should be coordinated and available via person-centred, accessible, and coordinated services nationally to practice and policy.

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