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UBMHP6029-Psychopathological Classifications and Provisions

Component 2: Written Report

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A Critical Examination of 6A02 autism spectrum disorder in ICD-11: Classification, Diagnosis, Treatment, Rehabilitation, Current Debates and Recommendations

1. Introduction

Psychopathological classification systems such as ICD-11 aim to provide a standardised framework for the diagnosis of autism spectrum disorder (ASD); however, their scientific credibility remains contested. While the shift to a spectrum-based model reflects greater diagnostic flexibility and inclusivity, it does not resolve fundamental issues relating to validity, cultural bias, and the medicalisation of neurodiversity. In particular, the continued reliance on biomedical assumptions positions autism as deviation from normative functioning, shaping both diagnostic criteria and intervention priorities.

This report argues that, despite structural advancements, ICD-11 remains limited by conceptual tensions between medical and neurodiversity frameworks, which undermine its ability to support equitable and effective practice. These tensions are further reflected in broader debates surrounding diagnostic inflation and the expansion of psychiatric categories, raising questions about the boundaries between disorder and variation. Consequently, classification systems must be understood not as neutral tools, but as frameworks that actively shape how autism is defined, interpreted, and managed within clinical and policy contexts, influencing both access to services and lived experiences of diagnosis.

2. Classification and Diagnosis

2.1 ICD-11 Classification

Although ICD-11 adopts a spectrum-based model and aims to standardise diagnostic criteria across clinical contexts, it stays grounded in a biomedical framework that frames autism through deviation from normative functioning. However, the emphasis on standardisation reveals a critical limitation: increased reliability does not necessarily indicate diagnostic accuracy.

Clinicians may consistently apply criteria, yet still misclassify behaviours, highlighting a fundamental gap between reliability and validity. This shapes diagnostic and intervention priorities, where impairment reduction is central, creating tension with neurodiversity perspectives that view autism as variation rather than deficit (Kapp, 2019; Pellicano and den Houting, 2022).

This raises broader concerns about whether diagnostic frameworks like ICD-11 identify discrete conditions or impose structured interpretations onto inherently variable human behaviour.

2.2 Diagnostic Criteria

ICD-11 defines ASD through two core domains; however, framing these as ‘deficits’ reinforces a normative standard of functioning that positions autistic traits as inherently impaired rather than context-dependent differences (World Health Organization, 2019; Kapp, 2019). This deficit-based framing not only shapes clinical interpretation but also risks marginalising alternative conceptualisations, particularly those advanced by neurodiversity perspectives.

Although the inclusion of sensory sensitivities aligns with contemporary research, the breadth of these criteria may increase heterogeneity within the diagnosis, potentially undermining reliability and diagnostic consistency (Hadad and Yashar, 2022), raising concerns about whether such criteria meaningfully distinguish pathology from variation.

2.3 Diagnostic Process

The diagnostic process typically involves a multidisciplinary assessment; however, its reliance on subjective clinical judgement introduces variability that can compromise diagnostic consistency and equity across services (National Autistic Society, 2024). While ICD-11’s emphasis on clinical judgement allows flexibility, it simultaneously increases inter-rater variability, raising concerns about the reliability and fairness of diagnostic outcomes across different contexts (World Health Organization, 2024; NHS England, 2023).

This variability is particularly evident in cases such as the “female autism phenotype,” where individuals may engage in social camouflaging that obscures observable traits during assessment. Consequently, autistic women are more likely to be misdiagnosed or diagnosed later in life, reflecting systemic limitations in how diagnostic criteria are applied in practice (Hull et al., 2020).

Furthermore, increasing demand for autism assessments has resulted in prolonged waiting times, restricting timely access to diagnosis and support (NHS Digital, 2025), which suggests that structural pressures within healthcare systems further undermine the equity and effectiveness of the diagnostic process.

2.4 Language and Neurodiversity

ICD-11's use of the term 'autism spectrum disorder' reflects a medicalised framing that prioritises impairment, with the parallel use of 'condition' representing a semantic shift that leaves underlying deficit-based assumptions intact (World Health Organization, 2024; World Health Organization, 2025). In contrast, neurodiversity frameworks conceptualise autism as difference rather than disorder, locating challenges within social and environmental barriers rather than intrinsic deficits (Pellicano and den Houting, 2022).

This divergence exposes a fundamental misalignment between clinical classification and lived experience, particularly where neurodiversity-informed approaches are not reflected in practice (Curnow et al., 2023). Consequently, these competing frameworks do not merely coexist but actively shape diagnostic interpretation and access to support, reinforcing the view that classification systems embed specific value assumptions rather than operating as neutral descriptors (Greaves-Lord et al., 2022; Pellicano and den Houting, 2022; Kapp, 2019).

3. Treatment and Rehabilitation

3.1 Treatment Approaches

While treatment for ASD is typically framed as improving communication, functioning, and quality of life, this framing reflects implicit assumptions about normative functioning that may not align with neurodiversity-informed perspectives (Lord et al., 2020; Kapp, 2019). Consequently, interventions such as speech and language therapy and occupational therapy are not value-neutral but embedded within expectations of behavioural adaptation to dominant social norms (Lord et al., 2020).

Although early intervention is associated with improved outcomes, many behavioural approaches have been criticised for privileging neurotypical conformity, raising ethical concerns regarding autonomy, identity preservation, and the medicalisation of difference (Kapp, 2019). This tension is particularly evident in approaches such as ABA, which illustrate broader conflicts between behavioural modification and neurodiversity-informed care (Wilkenfeld and McCarthy, 2020; Kapp, 2019).

While ABA may enhance functional communication and adaptive skills when carefully individualised and ethically implemented (Lord et al., 2020), such benefits remain contingent on how intervention goals are defined and whose standards they reflect. The evidence base is therefore inherently contested, suggesting that treatment outcomes are shaped not only by intervention efficacy but also by underlying value systems that prioritise conformity over

diversity, thereby reinforcing the medical-model assumptions embedded within diagnostic frameworks.

3.2 Rehabilitation in ICD-11 and Practice

ICD-11 does not provide detailed rehabilitation guidelines, reflecting a broader limitation in classification systems that prioritise diagnosis over long-term support (World Health Organization, 2024). In practice, rehabilitation includes educational, vocational, and social interventions aimed at promoting independence (World Health Organization, 2024; NHS England, 2023).

However, this separation highlights a structural disconnect, where systems defining need do not adequately guide sustained support. Despite policy emphasis on person-centred care (NHS England, 2023), access remains inconsistent, particularly for autistic adults (Curnow et al., 2023; NHS Digital, 2025). This suggests that rehabilitation outcomes are shaped as much by systemic inequalities as by individual need, raising concerns about whether classification translates into equitable long-term care.

3.3 Effectiveness and Limitations

Despite a range of available interventions, the evidence base remains methodologically limited, particularly for autistic adults, with small samples, limited use of randomised controlled trials, and short-term outcome measures reducing generalisability (Curnow et al., 2023). The predominance of child-focused and Western samples further undermines developmental and cultural validity (Pellicano and den Houting, 2022), resulting in weak evidence for adult-focused outcomes such as quality of life and autonomy.

Prolonged waiting times for diagnosis and intervention also restrict access to support, contributing to fragmented and insufficiently tailored provision (NHS Digital, 2025). Consequently, intervention practices reflect not neutral clinical decisions, but the operationalisation of medical-model assumptions embedded within diagnostic systems, demonstrating how theoretical frameworks directly shape therapeutic outcomes (World Health Organization, 2024; Kapp, 2019; Pellicano and den Houting, 2022; Lord et al., 2020).

4. Current Debates and Emerging Issues

4.1 Medical Model vs Neurodiversity

The medical and neurodiversity frameworks reflect fundamentally competing assumptions about autism, shaping whether intervention prioritises symptom reduction or environmental

adaptation (Pellicano and den Houting, 2022; Kapp, 2019). ICD-11 embeds deficit-based assumptions, constraining the integration of neurodiversity perspectives within clinical practice (World Health Organization, 2024).

However, this opposition reveals a deeper limitation: neither framework fully captures the complexity of autism, producing an ongoing tension between clinical intervention and respect for autonomy (Kapp, 2019; Pellicano and den Houting, 2022). Consequently, this debate extends beyond theory, functioning as a structural force that shapes classification systems, service provision, and policy priorities in autism care (Pellicano and den Houting, 2022; Kapp, 2019; World Health Organization, 2024).

4.2 Reclassification Issues

The shift to a spectrum-based model in ICD-11 increases diagnostic inclusivity and reflects the diversity of autistic presentations; however, it also introduces significant limitations. The removal of distinct subtypes risks obscuring meaningful differences in support needs, identity, and clinical presentation (Greaves-Lord et al., 2022).

Consequently, individuals may face barriers to accessing appropriate services where needs are insufficiently differentiated, raising concerns about whether a single diagnostic category can adequately capture the heterogeneity of autism (Greaves-Lord, Skuse and Mandy, 2022).

This highlights a fundamental tension within the spectrum model: while it resolves rigid categorical boundaries, it simultaneously reduces diagnostic specificity. As such, ICD-11 may prioritise inclusivity at the expense of clinical precision, suggesting that classification systems must balance accessibility with the accurate identification of individual needs (Greaves-Lord, Skuse and Mandy, 2022; World Health Organization, 2024).

4.3 Impact on Practice and Policy

Although policy frameworks emphasise accessibility and equality (World Health Organization, 2024), their implementation remains uneven, exposing a persistent gap between policy intent and service delivery (NHS England, 2023). Long waiting times, limited adult provision, and regional disparities continue to undermine effectiveness (National Autistic Society, 2024; NHS Digital, 2025), reflecting structural constraints rather than isolated inefficiencies (Curnow et al., 2023).

Moreover, ICD-11's deficit-based framework reinforces a medicalised model that shapes both clinical judgement and policy priorities, contributing to unequal access and outcomes (World Health Organization, 2024; Pellicano and den Houting, 2022; Kapp, 2019). Crucially, this gap translates into practical, but conceptual, arising from unresolved tensions within autism

classification that translate into inconsistent and often contradictory priorities across healthcare systems.

5. Recommendations

Improving ASD support requires structural reform across diagnosis, intervention, and research. The main barrier is not ICD-11 but unequal access to services, limiting timely diagnosis and support (NHS England, 2023; NHS Digital, 2025). Without this, reforms will not be equitable.

1. Immediate priority: diagnostic system capacity and access

The most urgent reform is addressing structural delays within diagnostic pathways, where prolonged waiting times, workforce shortages, and regional variability continue to restrict equitable access to diagnosis and post-diagnostic support (NHS Digital, 2025; NHS England, 2023).

These systemic constraints create delayed identification, particularly for adults and under-recognised groups, undermining the intended accessibility of ICD-11's spectrum-based approach. Without enforceable national standards, increased workforce capacity, and consistent regional implementation, broader policy reforms are unlikely to produce measurable improvements in outcomes or service equity.

2. Secondary priority: intervention reframing

Commissioning frameworks should progressively shift from symptom-reduction and behavioural normalisation models towards neurodiversity-informed outcomes such as autonomy, participation, sensory wellbeing, and quality of life (Pellicano and den Houting, 2022; Kapp, 2019). This requires a fundamental redefinition of effectiveness within NHS evaluation systems, which remain aligned with functional adaptation metrics.

Ethical critiques of behavioural interventions, particularly Applied Behaviour Analysis (ABA), further highlight concerns regarding conformity-based outcomes and the need to prioritise self-determination in service design (Wilkenfeld and McCarthy, 2020). However, such reframing must still ensure that support for functional communication and daily living needs is not reduced.

3. Long-term priority: research redesign

Research should adopt participatory, longitudinal, and co-produced methodologies involving autistic individuals in study design, governance, and interpretation. Current evidence is limited by child-centric samples, short-term designs, and underrepresentation of autistic adults, restricting external validity and real-world applicability (Curnow et al., 2023). Co-production

improves both ethical integrity and epistemic validity by aligning research priorities with lived experience (Pellicano and den Houting, 2022; Kapp, 2019).

Without resolving the structural tension between medical and neurodiversity frameworks, reforms at the level of diagnosis, intervention, and research risk remaining fragmented and unable to produce coherent system-wide improvement (Pellicano and den Houting, 2022; Kapp, 2019; NHS England, 2023; World Health Organization, 2024).

6. Conclusion

ICD-11 (6A02) represents a shift towards a more flexible, spectrum-based approach to autism classification; however, it remains grounded in biomedical assumptions that position autism as deviation from normative functioning, shaping both diagnostic and intervention priorities (World Health Organization, 2024; Kapp, 2019). Despite attempts to improve consistency, persistent inequalities in access, prolonged waiting times, and regional variation continue to undermine its practical effectiveness, particularly for autistic adults (NHS Digital, 2025; NHS England, 2023), revealing a structural gap between classification and service delivery.

Moreover, ongoing tensions between biomedical and neurodiversity frameworks highlight deeper conceptual limitations, as impairment-focused models risk prioritising behavioural conformity over autonomy and quality of life (Pellicano and den Houting, 2022; Kapp, 2019).

This suggests that classification systems do not merely describe autism but actively shape how it is understood, supported, and governed (Kapp, 2019; Pellicano and den Houting, 2022), indicating that meaningful progress requires not only theoretical development, but also systemic reform aligned with neurodiversity-informed principles.

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