

# 07 - 6A05 Attention deficit hyperactivity disorder

## 6A05 Attention deficit hyperactivity disorder

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders functioning and adaptive behaviour. If the diagnostic requirements of a disorder of intellectual development are met, and coordinated motor skills are significantly below what would be expected based on level of intellectual functioning and adaptive behaviour, both diagnoses may be assigned. Boundary with autism spectrum disorder In autism spectrum disorder, there may be reluctance to participate in tasks requiring complex motor coordination skills, such as ball sports, which is better accounted for by a lack of interest rather than any specific deficits in motor coordination. Boundary with attention deficit hyperactivity disorder Co-occurrence of developmental motor coordination disorder and attention deficit hyperactivity disorder is common. Both diagnoses may be assigned if the diagnostic requirements for each are met. However, some individuals with attention deficit hyperactivity disorder may appear to be clumsy (e.g. bumping into obstacles, knocking things over) due to distractibility and impulsivity. Developmental motor coordination disorder should not be diagnosed in such cases. Boundary with diseases of the nervous system, diseases of the musculoskeletal system or connective tissue, and sensory impairment Motor skills may be affected by diseases of the nervous system (e.g. cerebral palsy, muscular dystrophy), diseases of the musculoskeletal system or connective tissue, sensory impairment (especially severe visual impairment) or joint hypermobility, which are established by appropriate physical and laboratory examination. A diagnosis of developmental motor coordination disorder should not be assigned when the difficulties with motor coordination are solely attributable to one of these conditions. Some children with developmental motor coordination disorder show atypical motor activity (usually suppressed), such as choreiform movements of unsupported limbs or mirror movements.<sup>5</sup> These “overflow” movements are not considered diseases of the nervous system per se, and do not exclude the diagnosis of developmental motor coordination disorder. Boundary with effects of psychosocial deprivation Extreme psychosocial deprivation in early childhood can produce impairments in motor functions. Depending on the onset, level of severity and duration of the deprivation, motor functioning may improve substantially after the child is moved to a more positive environment. However, some deficits may persist even after a sustained period in an environment that provides adequate stimulation for

development, and a diagnosis of developmental motor coordination disorder may be appropriate in such cases if all diagnostic requirements are met. Attention deficit hyperactivity disorder Essential (required) features • A persistent pattern (e.g. over at least 6 months) of inattention symptoms and/or a combination of hyperactivity and impulsivity symptoms that is outside the limits of normal variation expected for age and level of intellectual development is required for diagnosis.

Symptoms vary according to chronological age and disorder severity. Chorieform movements are involuntary, irregular and unpredictable movements that make it appear as if the affected person is dancing, twisting, restless, clumsy or fidgety. 6A05 Neurodevelopmental disorders | Attention deficit hyperactivity disorder

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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Specifiers to describe predominant characteristics of clinical presentation • The characteristics of the current clinical presentation should be described using one of the following specifiers, which are meant to assist in recording the main reason for the current referral or services. Predominance of symptoms refers to the presence of several symptoms of either an inattentive or hyperactive-impulsive nature, with few or no symptoms of the other type. Attention deficit hyperactivity disorder, predominantly inattentive presentation • All diagnostic requirements for attention deficit hyperactivity disorder are met, and inattentive symptoms predominate. Attention deficit hyperactivity disorder, predominantly hyperactiveimpulsive presentation • All diagnostic requirements for attention deficit hyperactivity disorder are met, and symptoms of hyperactivity-impulsivity predominate. Attention deficit hyperactivity disorder, combined presentation • All diagnostic requirements for attention deficit hyperactivity disorder are met, and both hyperactive-impulsive and inattentive symptoms are clinically significant aspects of the current clinical presentation, with neither clearly predominating. Attention deficit hyperactivity disorder, other specified presentation Attention deficit hyperactivity disorder, presentation unspecified 6A05.0 6A05.1 6A05.2 6A05.Y 6A05.Z Neurodevelopmental disorders | Attention deficit hyperactivity disorder

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hyperactivity disorder can also strain interpersonal relationships across the lifespan, including those with family members, peers and romantic partners. Individuals with attention deficit hyperactivity disorder often have greater difficulty regulating their behaviour in the context of groups than in one-on-one situations. • Attention deficit hyperactivity disorder often co-occurs with other neurodevelopmental disorders, including developmental speech and language disorders and primary tics and tic disorders, which are classified in Chapter 8 on diseases of the nervous system but cross-listed under neurodevelopment disorders. Attention deficit hyperactivity disorder is associated with an increased risk of obsessive-compulsive disorder and gaming disorder, and with elevated rates of epilepsy. Emotional dysregulation, low frustration tolerance and subtle clumsiness and other minor (“soft”) neurological abnormalities in sensory and motor performance in the absence of any identifiable brain pathology are also common in attention deficit hyperactivity disorder. Neurodevelopmental disorders | Attention deficit hyperactivity disorder

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders • Attention deficit hyperactivity disorder is associated with an increased risk of physical health problems including accidents. • Acute onset of hyperactive behaviour in a school-aged child or adolescent should raise the possibility that symptoms are better accounted for by another mental disorder or by a medical condition. For example, abrupt onset of hyperactivity in adolescence or adulthood may indicate an emergent primary psychotic or bipolar disorder. • Although attention deficit hyperactivity disorder tends to run in families, with evidence of high heritability, the predominant symptom pattern in attention deficit hyperactivity disorder in a given individual often changes over time and cannot be predicted based on the predominant symptoms of other family members. Boundary with normality (threshold) • Inattention, hyperactivity and impulsivity symptoms are present in many children, adolescents and adults, especially during certain developmental periods (e.g. early childhood). The diagnosis of attention deficit hyperactivity disorder requires that these symptoms be persistent across time, pervasive across situations and significantly out of keeping with developmental level, and have a direct negative impact on academic, occupational or social functioning. Course features • Nearly half of all children diagnosed with attention deficit hyperactivity disorder will continue to exhibit symptoms into adolescence. Predictors of persistence into adolescence and adulthood include co-occurring childhood-onset mental, behavioural and neurodevelopmental disorders, lower intellectual functioning, poorer social functioning and behavioural problems. • Attention deficit hyperactivity disorder symptoms tend to remain stable throughout adolescence, with approximately one third of individuals diagnosed in childhood continuing to experience impairment in adulthood. • Although symptoms of hyperactivity become less overt during adolescence and adulthood, individuals may still experience difficulties with inattention, impulsivity and restlessness. Developmental presentations • Adolescents and adults may only seek clinical services after 12 years of age, once symptoms become more limiting with increasing social, emotional and academic demands or in the context of an evolving co-occurring mental, behavioural or neurodevelopmental disorder that results in an exacerbation of attention deficit hyperactivity disorder symptoms. Neurodevelopmental disorders | Attention deficit hyperactivity disorder

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how caregivers respond to them. • The assessment of hyperactivity should take into account cultural norms of age and gender appropriate behaviour. For example, in some countries hyperactive behaviour may be seen as a sign of strength in a boy (e.g. “boiling blood”) while being perceived very negatively in a girl. • Symptoms of inattention or hyperactivity-impulsivity may occur in response to exposure to traumatic events and grief reactions during childhood, particularly in highly vulnerable and disadvantaged populations, including in post-conflict areas. In these settings, clinicians should consider whether the diagnosis of attention deficit hyperactivity disorder is warranted. Sex- and/or gender-related features • Attention deficit hyperactivity disorder is more prevalent among males. • Females are more likely to exhibit inattentive symptoms whereas males are more likely to exhibit symptoms of hyperactivity and impulsivity, particularly at younger ages. Boundaries with other disorders and conditions (differential diagnosis) Boundary with disorders of intellectual development Co-occurrence of attention deficit hyperactivity disorder and disorders of intellectual development is common, and both diagnoses may be assigned if warranted. However, symptoms of inattention and hyperactivity (e.g. restlessness) are common in children without attention deficit hyperactivity disorder who are placed in academic settings that are out of keeping with their intellectual abilities. A diagnosis of attention deficit hyperactivity disorder in individuals with disorders of intellectual development requires that attention deficit hyperactivity disorder symptoms are disproportionate to the individual’s level of intellectual functioning. Boundary with autism spectrum disorder Specific abnormalities in attention (e.g. being overly focused or easily distracted), impulsivity and physical hyperactivity are often observed in individuals with autism spectrum disorder, and may sometimes dominate the clinical presentation. Unlike individuals with autism spectrum disorder, those with attention deficit hyperactivity disorder do not exhibit the persistent deficits in initiating and sustaining social communication and reciprocal social interactions, or the persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities that are the defining features of autism spectrum disorder. However, co-occurrence of these disorders is common. Neurodevelopmental disorders | Attention deficit hyperactivity disorder

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Boundary with developmental learning disorder Individuals with developmental learning disorder without attention deficit hyperactivity disorder may exhibit symptoms of inattention and hyperactivity when asked to focus on specific academic activities that correspond to their areas of difficulty (i.e. reading, mathematics or writing). If difficulty in sustaining attention on academic tasks or appropriately modulating activity level occurs only in response to these tasks, and there is evidence of limitations in acquisition of academic skills in the specific corresponding area, a diagnosis of developmental learning disorder and not attention deficit hyperactivity disorder should be assigned. Boundary with developmental motor coordination disorder Co-occurrence of attention deficit hyperactivity disorder and developmental motor coordination disorder is common, and both diagnoses may be assigned if warranted. However, apparent clumsiness in some individuals with attention deficit hyperactivity disorder (e.g. bumping into obstacles, knocking things over) that is due to distractibility and impulsivity should not be diagnosed as developmental motor coordination disorder. Boundary with mood disorders and anxiety and fear-related disorders Attention deficit hyperactivity disorder can co-occur with mood disorders and anxiety and fear-related disorders, but inattention, hyperactivity and impulsivity can also be features of these disorders in individuals without attention deficit hyperactivity disorder. For example, symptoms such as restlessness, pacing and impaired concentration can be features of a depressive episode, and should not be considered as part of the diagnosis of attention deficit hyperactivity disorder unless they have been present since childhood and persist after the

resolution of the depressive episode. Inattention, impulsivity and hyperactivity are typical features of manic and hypomanic episodes. At the same time, mood lability and irritability may be associated features of attention deficit hyperactivity disorder. Late adolescent or adult onset, episodicity and intensity of mood elevation characteristic of bipolar disorders are features that assist in differentiation from attention deficit hyperactivity disorder. Fidgeting, restlessness and tension in the context of anxiety and fear-related disorders may resemble hyperactivity. Furthermore, anxious preoccupations or reaction to anxiety-provoking stimuli in individuals with anxiety and fear-related disorders can be associated with difficulties concentrating. To qualify for an attention deficit hyperactivity disorder diagnosis in the presence of a mood disorder or an anxiety or fear-related disorder, inattention and/or hyperactivity should not be exclusively associated with mood episodes, be solely attributable to anxious preoccupations, or occur specifically in response to anxiety-provoking situations.

**Boundary with intermittent explosive disorder** Attention deficit hyperactivity disorder and intermittent explosive disorder are both characterized by impulsive behaviour. However, intermittent explosive disorder is specifically characterized by intermittent severe impulsive outbursts or aggression rather than ongoing generalized behavioural impulsivity that may be seen in attention deficit hyperactivity disorder.

**Boundary with oppositional defiant disorder** Individuals with attention deficit hyperactivity disorder often have difficulty following instructions, complying with rules and getting along with others, but these difficulties are primarily accounted for by symptoms of inattention and/or hyperactivity and impulsivity (e.g. failure to follow long and complicated instructions, difficulty remaining seated or staying on task). In contrast, noncompliance in individuals with oppositional defiant disorder is characterized by deliberate defiance or disobedience and not by problems with inattention or with controlling behavioural impulses or inhibiting inappropriate behaviours. However, co-occurrence of these disorders is common.

**Boundary with conduct-dissocial disorder** In adolescents and adults with attention deficit hyperactivity disorder, some behaviours that are manifestations of impulsivity such as grabbing objects, reckless driving or impulsive decision-making – such as suddenly walking out of jobs or relationships – may bring the individual in conflict with Neurodevelopmental disorders

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