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149 Neurodevelopmental disorders other people and the law. In contrast, individuals with conduct-dissocial disorder typically lack the symptoms of inattention and hyperactivity, and exhibit a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms, rules or laws are violated. However, co-occurrence of these disorders is common. Boundary with personality disorder Individuals with attention deficit hyperactivity disorder often experience problems with psychosocial functioning and interpersonal relationships, including regulation of emotions and negative emotionality. If attention deficit hyperactivity disorder persists into adolescence and adulthood, it may be difficult to distinguish from personality disorder with prominent personality features of disinhibition, which includes irresponsibility, impulsivity, distractibility and recklessness, and from negative affectivity, which refers to a habitual tendency to manifest a broad range of distressing emotions including anxiety, anger, self-loathing, irritability and increased sensitivity to negative stimuli. The utility of assigning an additional diagnosis of personality disorder in situations where there is an established diagnosis of attention deficit hyperactivity disorder depends on the specific clinical situation. Boundary with disorders due to substance use and the effects of certain prescribed medications Abuse of alcohol, nicotine, cannabis and stimulants is common among individuals with attention deficit hyperactivity disorder – particularly adolescents and adults. However, the effects of these substances can also mimic the symptoms of attention deficit hyperactivity disorder in individuals without the diagnosis. Symptoms of inattention, hyperactivity or impulsivity are also associated with the effects of certain prescribed medications (e.g. anticonvulsants such as carbamazepine and valproate, antipsychotics such as risperidone, and somatic treatments such as bronchodilators and thyroid replacement medication). The temporal order of onset and the persistence of inattention, hyperactivity and impulsivity in the absence of intoxication or continued medication use are important in differentiating between attention deficit hyperactivity disorder and disorders due to substance use or the effects of prescribed medications. A review of current medications and informants who knew the individual before they started using the substances or medications in question are critical in making this distinction. Boundary with attentional symptoms due to other medical conditions A variety of other medical conditions may influence attentional processes (e.g. hypoglycaemia, hyperthyroidism or

hypothyroidism, exposure to toxins, sleep-wake disorders), resulting in temporary or persistent symptoms that resemble or interact with those of attention deficit hyperactivity disorder. As a basis for appropriate management, it is important to evaluate in such cases whether the symptoms are secondary to the medical condition or are more indicative of comorbid attention deficit hyperactivity disorder. Stereotyped movement disorder Essential (required) features • The persistent (e.g. lasting for several months) presence of voluntary, repetitive, stereotyped, apparently purposeless and often rhythmic movements (e.g. body rocking, hand flapping, head banging, eye poking and hand biting) that are not caused by the direct physiological effects of a substance or medication (including withdrawal) is required for diagnosis. 6A06 Neurodevelopmental disorders | Stereotyped movement disorder

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders • Stereotyped movements result in significant interference with the ability to engage in normal daily activities, or result in self-inflicted bodily injury severe enough to be an independent focus of clinical attention or that would result in self-injury if protective measures were not taken. • Onset occurs during the developmental period, typically at an early age. Specifiers related to self-injury A specifier should be applied with the diagnosis of stereotyped movement disorder to indicate whether it involves movements that result in physical harm to the individual. Stereotyped movement disorder without self-injury • Stereotyped movements do not result in physical harm to the affected individual even without the presence of protective measures. These behaviours typically include body rocking, head rocking, finger-flicking mannerisms and hand flapping. Stereotyped movement disorder with self-injury • Stereotyped movements result in harm to the affected individual that is severe enough to be an independent focus of clinical attention, or would result in self-injury if protective measures (e.g. helmet to prevent head injury) were not taken. These behaviours typically include head banging, face slapping, eye poking and biting of the hands, lips or other body parts. Stereotyped movement disorder, unspecified Additional clinical features • Co-occurrence of stereotyped movement disorder and disorders of intellectual development is common. 6A06.0 6A06.1 6A06.Z Neurodevelopmental disorders | Stereotyped movement disorder

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estimated to occur in 3–4% of children. • Stereotyped movement disorder commonly co-occurs with disorders of intellectual development and autism spectrum disorder. Sex- and/or gender-related features • Preschool-aged boys with autism spectrum disorder and with a disorder of intellectual development tend to have higher rates of co-occurring stereotyped movement disorder. Neurodevelopmental disorders | Stereotyped movement disorder

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Boundaries with other disorders and conditions (differential diagnosis) Boundary with autism spectrum disorder Repetitive and stereotyped motor movements such as whole-body movements (e.g. rocking), gait atypicalities (e.g. walking on tiptoes) and unusual hand or finger movements can be a characteristic feature of autism spectrum disorder, but are differentiated from stereotyped movement disorder by the presence of additional significant limitations in the capacity for reciprocal social interactions and social communication. Assignment of both diagnoses may be warranted if the stereotyped motor movements constitute a separate focus of clinical attention (e.g. due to self-injury). Boundary with obsessive-compulsive disorder In contrast to stereotyped movement disorder, repetitive behaviours (i.e. compulsions) observed in obsessive-compulsive disorder are typically more complex, and are aimed at neutralizing unwanted intrusive thoughts (i.e. obsessions) and reducing associated negative emotions (e.g. anxiety). Boundary with body-focused repetitive behaviour disorders Body-focused repetitive behaviour disorders (e.g. trichotillomania and excoriation disorder) are characterized by recurrent and habitual behaviours directed at the integument (e.g. hair and skin). In contrast, stereotyped movements in stereotyped movement disorder rarely include hair-pulling or skin-picking behaviour; if they do, the behaviour tends to be composed of coordinated movements that are patterned and predictable, utilizing the same muscle groups in a particular sequence to produce the behaviour. In addition, stereotyped movements are more likely to present very early in life (below 2 years of age), whereas body-focused repetitive behaviour disorders typically have an onset in later childhood or early adolescence. Boundary with Tourette syndrome and other tic disorders In contrast to tic disorders including Tourette syndrome, stereotyped movements in stereotyped movement disorder tend to be composed of coordinated movements that are patterned and predictable, and can be interrupted with distraction. Stereotyped movement disorder is further differentiated from tics and Tourette syndrome because the symptoms tend to emerge at a younger age, last longer than typical tics, lack a premonitory sensory urge, and may be experienced as enjoyable. Boundary with drug-induced dystonia (tardive dyskinesia). Drug-induced dystonia is a movement disorder (classified in Chapter 8 on diseases of the nervous system) that is most frequently caused by antipsychotic medication. It is also sometimes referred to as tardive dyskinesia. Symptoms may include involuntary oral or facial movements or, less commonly, irregular trunk or limb movements. A diagnosis of stereotyped movement disorder is not appropriate in such cases. Boundary with diseases of the nervous system Involuntary movements associated with diseases of the nervous system usually follow a typical pattern with the presence of pathognomic signs and symptoms. If stereotyped movements are associated with Lesch-Nyhan syndrome or another specific disease of the nervous system or neurodevelopmental disease, stereotyped movement disorder should not be diagnosed unless the movements become a separate focus of clinical attention. In such cases, both diagnoses may be assigned. Neurodevelopmental disorders | Stereotyped movement disorder

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