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Guest Editorial

Child and adolescent psychiatric disorders and ICD-11

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Summary

An important change in ICD-11 is the lifespan approach, whereby previous child and adolescent disorders have been amalgamated with adult disorders. There have been changes in the definition/descriptions of neurodevelopmental and disruptive disorders, some of which may have an impact on service development.

Keywords

Diagnosis and classification; child and adolescent psychiatry; neurodevelopmental disorders; conduct disorders; diagnostic medicine.

In spring 2024 the World Health Organization published *Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders* (the CDDR).[1] This is likely to mark the end of the long process of updating ICD-10.[2]

This editorial addresses changes in ICD-11 and the clinical descriptions and diagnostic requirements for disorders that usually start during childhood and adolescence, including neurodevelopmental and disruptive disorders.[3] As with other conditions, changes have been driven by new research findings as well as clinical experience and practice over recent years.

ICD-11: the lifespan approach

An important change in ICD-11 from ICD-10 has been its lifespan approach, with the loss of a separate section on child and adolescent disorders. Childhood disorders are now grouped with adult disorders, and variations in child presentations noted as appropriate.

The lifespan approach is in line with the fact that psychiatric disorders as manifested in children and young people are usually diagnosable using adult criteria, with the growing evidence that many psychiatric disorders seen in adults start in childhood or adolescence, and with developmental childhood disorders such as autism and attention-deficit hyperactivity disorder (ADHD) being increasingly recognised and managed in adult mental health clinics.

This approach may be expected to stimulate further research aimed at establishing and refining the clinical manifestations of neurodevelopmental disorders in adults, including possible overlap with personality disorder diagnoses. In practice it may contribute to increased referrals and have implications for adult mental health services and practitioners.

The amalgamation of child and adult disorders and presentations has resulted in new conditions requiring clinical validation. One example is avoidant/restrictive food intake disorder (ARFID), a reformulation of feeding disorder of infancy and early childhood, with the recognition that avoidant and restrictive eating symptoms can occur across the lifespan. The same would apply to new disorders such as complex post-traumatic stress disorder in children and adolescents. The amalgamation has additionally resulted in disorders characteristic of childhood, such as reactive attachment/disinhibited social engagement disorder – regarded as a result of markedly inadequate early institutional-type upbringing and where the primary manifestations are anomalies in social bonds and behaviour – to be placed somewhat uneasily in the section on disorders associated with stress.

Comorbidity and complexity of child and adolescent psychiatric disorders

The demise of ICD-10's child and adolescent section means the discontinuation of disorders such as 'mixed disorder of conduct and emotions'. ICD-11 allows diagnostic comorbidity, and hybrid problems such as these can be diagnosed as comorbid, for example as anxiety disorders presenting alongside oppositional defiant disorders.

Comorbidity

Diagnostic comorbidity allows the coexistence in individual children of different types of neurodevelopmental disorder, as well as of others, such as emotional and/or disruptive disorders. This will be welcomed by clinicians, given the high levels of psychiatric comorbidity among children and young people attending child and adolescent mental health services (CAMHS), particularly those with developmental disorders. Alongside earlier ICD versions, comorbidity of childhood disorders was documented by means of a multiaxial classification that included psychiatric, neurodevelopmental, intellectual and associated medical and psychosocial conditions, all highly relevant to child and adolescent psychiatric disorders.[4] ICD-11 comorbidities may be regarded as a partial substitute for the axial system, leaving it to clinicians to weigh up the contribution of different comorbidities to presentations and to work out which one to prioritise for treatment. Priority is likely to be given to relieving the most distressing, impairing and possibly life-threatening symptoms and conditions, while taking due account of how their manifestations are influenced or determined by coexisting disorders.

Complexity

An additional means for ICD-11 to document clinically relevant case complexity is, as in DSM-5, through the introduction of diagnostic specifiers. These outline homogeneous subgroupings of children who share clinical features likely to be relevant for management. For example, the diagnosis of autism may be specified by the presence or absence of associated intellectual disability or of language disorder, and conduct disorders by the presence or not of callous-unemotional traits.

Although there is empirical and clinical support for these specifiers, future scrutiny should help clarify their use in practice. An illustration is the new conduct disorder specifier 'childhood onset'. This is linked to research evidence of poorer outcomes in children where the disorder is manifested prepubertally. However,

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it may obviously not always be appropriate to use this specifier in young children, automatically assuming a poor prognosis, without a full assessment of specific clinical and contributory factors.

Impairment of function

In line with DSM-5, central to the identification of psychiatric disorder and a key diagnostic feature is the presence of impairment of function, disorders causing 'significant impairment in personal, family, social, educational, or other important areas of functioning'. As for other conditions, when it comes to developmental disorders such as autism spectrum disorder or ADHD, over and above the presence of noticeable social and attention/activity idiosyncrasies, impairment involves developmental delays or symptoms that are marked and persistent enough to cause problems in everyday life as well as significant limitations in abilities.

Within a disease continuum framework for medical and mental disorders, lack of impairment in children and adults who display symptoms or delays does not preclude the introduction of appropriate early interventions. However, the concept of functional impairment helps set a threshold for clarifying and seeking the level of specialist intervention required.

The CDDR

The classification of child psychiatric disorders remains central to communication between all those involved with services, including clinicians, families, researchers and policymakers. Diagnosis may be expected to become increasingly a requirement across different countries, to help define and account for the work of services and for service developments. The detailed diagnostic descriptions in the ICD-11 CDDR, which address boundaries with normality, differential diagnosis from other disorders and diagnostic specifiers, may be particularly helpful for CAMHS.

Staff in CAMHS work in multidisciplinary teams with a range of professional backgrounds that are predominantly non-medical. Clinicians have different levels of experience, expertise and commitment to the practice of diagnosing mental disorders. In this context, the detailed nature of the CDDR can assist clinic staff in unifying criteria and enhancing diagnostic validity and reporting across professions and countries. The increased awareness and concern about child and adolescent mental health problems, alongside the heightened demand for mental health services for these age groups, may be expected to lead to new service developments carrying with them increased expectations of standardised case reporting.

Neurodevelopmental disorders

ICD-11 has introduced several changes in terminology for the neurodevelopmental disorders. Unlike ICD-10 they now include 'intellectual disability' – previously 'mental retardation' – and 'attention deficit hyperactivity disorder' (ADHD) – previously 'hyperkinetic disorder'.

ICD-10's 'Pervasive developmental disorders' are now renamed 'Autism spectrum disorder'. These amalgamate all levels of intellectual functioning and incorporate childhood autism and Asperger syndrome under a single category. Given the clear different presentations and needs of individuals with autism according to intellectual function, some may regret the loss of the distinct Asperger syndrome/high functioning category, a diagnosis which is part of day-to-day vocabulary and identity. Autism now applies to the whole intellectual spectrum, but when linked to low intellectual functioning it is acknowledged in ICD-11 by a corresponding specifier.

A noteworthy change for the diagnosis of autism is the removal of language anomalies as a key autistic feature. The key autistic diagnostic anomalies have been reduced from three to two, namely difficulties involving deficits in social communication and reciprocal social interactions, and persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities. Added prominence is also given to lifelong excessive and persistent hypersensitivity or hyposensitivity to sensory stimuli, and the CDDR now describes the manifestations of the disorder in adulthood.

Disruptive behaviour or dissocial disorders

ICD-11's 'Disruptive behaviour or dissocial disorders' replaces ICD-10's 'Conduct disorders' and includes 'oppositional defiant disorder' (ODD) and 'conduct-dissocial disorder' across the lifespan.

ODD has seen the novel introduction of two specifiers: (a) with and without chronic irritability and anger, irritability being linked to a later risk of depression and anxiety, and (b) with or without limited prosocial emotions (i.e. callous-unemotional traits, such as limited empathy or sensitivity, remorse, shame or guilt).

An important differentiation from DSM-5 is ICD-11's irritability qualifier. This has some commonality with but also diverges from DSM-5's new 'disruptive mood dysregulation disorder' (DMDD), a condition DSM groups within the 'Depressive disorders' chapter. The ICD-11 working group chose the specifying option instead, as it considered there was insufficient evidence for DMDD as a separate mood disorder and because of the high rates of overlap with others, notably oppositional defiant disorder.[5] DMDD is, however, attracting research interest, and future research may help reconcile the different classificatory approaches.

Cultural issues

In recognition of the potential influence of societal values, customs and traditions on the manifestations of mental disorders, the ICD-11 CDDR includes a 'culture-related features' section. As regards autism, these features highlight cultural variations in norms of social communication, such as societies where it is normative for children to avoid direct eye contact out of deference, which could otherwise be interpreted as a manifestation of impairment in social interactions. It is noted that in some countries hyperactive behaviour may be seen as a sign of strength in boys but perceived negatively in girls, and that cultures that value obedience highly may have a lower threshold for considering a child's behaviour to be non-compliant, defiant or disobedient.

From under- to over-diagnosis of neurodevelopmental disorders

Classificatory systems follow the taxonomical, dichotomous tradition and describe key symptoms constituting clinical entities that open the way to evidence-based treatments. They do have limitations and they have been and remain a work in progress. Because of this and for training, conceptual, ideological and practical reasons, including the essentially multidisciplinary nature of the work, adoption by CAMHS can be highly variable.

Against this background there has recently been in some countries a noticeable increase in individuals seeking diagnosis of, or indeed self-diagnosing, neurodevelopmental disorders such as autism and ADHD.[6] The neurodiversity movement has emerged as a challenge to classificatory systems that are seen to focus on deficits and can be associated with stigma.

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In practice, the increased societal recognition of neurodiversity at all levels of severity has been associated with an increase in potentially overwhelming referrals to mental health services. It becomes clear that service providers will need to acquire a greater understanding of the needs and challenges affecting neurodivergent children and adults, and rethink appropriate service provision.

A future development of expanded early neurodiversity diagnostic/subsyndromal support services, run by CAMHS and paediatric services collaboratively, could help fill some of the gap. Meanwhile, traditional child and adolescent psychiatric involvement and practice may be expected to continue to focus on the presence of characteristic, well-differentiated clinical features that cause substantial impairment and situations where professional recognition of a disorder either in isolation or – importantly – as comorbid with other psychiatric disorders offers the best chances of appropriate management.

Conclusions

ICD-11 represents a new attempt to join up the classification of child, adolescent and adult conditions into a single system and to incorporate new clinical and empirical knowledge. Although it is expected that ICD-11 will be introduced universally, in practice it will take time for individual countries to adapt their administrative systems to routine use. This may be an opportunity for CAMHS to appraise and familiarise themselves with ICD-11 changes and innovations and may open the way to research that will eventually help redefine the next ICD version.

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Data availability

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Declaration of interest

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References

1 World Health Organization. *Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders*. WHO, 2024.

2 Reed JF, First MB, Kogan CS, Hyman SE, Gureje O, Gaebel W, et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. *World Psychiatry* 2019; **18**: 3–19.

3 Garralda ME. Child and adolescent psychiatric disorders. In *Making Sense of the ICD-11: For Mental Health Professionals* (ed P Tyrer): 86–96. Cambridge University Press, 2023.

4 .Scott S. Classification of psychiatric disorders in childhood and adolescence: building castles in the sand? *Adv Psychiatr Treat* 2002; **8**: 205–13.

5 Evans SC, Roberts MC, Keeley JW, Rebello TJ, de la Peña F, Lochman JE, et al. Diagnostic classification of irritability and oppositionality in youth: a global field study comparing ICD-11 with ICD-10 and DSM-5. *J Child Psychol Psychiatry* 2021; **62**: 303–12.

6 David AS, Deeley Q. Dangers of self-diagnosis in neuropsychiatry. *Psychol Med* 2024; **54**: 1057–60.

https://doi.org/10.1192/bjp.2024.200 Published online by Cambridge University Press