Disorders specifically associated with stress

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Disorders Specifically Associated with Stress in ICD-11

6B40 Post-Traumatic Stress Disorder

6B41 Complex Post-Traumatic Stress Disorder

6B42 Prolonged Grief Disorder

6B43 Adjustment Disorder

6B44 Reactive Attachment Disorder

6B45 Disinhibited Social Engagement Disorder

6B4Y Other Specified Disorders Specifically Associated with Stress

Disorders unique to childhood (onset aged 1-5 years)

6B44 Reactive Attachment Disorder

Requires: a history of grossly insufficient care; emotionally withdrawn behaviour towards more than one caregiver, shown by minimal comfort-seeking and minimal response to comfort when offered

6B45 Disinhibited Social Engagement Disorder

Requires: a history of grossly insufficient care; lack of reticence with unfamiliar adults, shown by over-familiarity, lack of checking, willingness to go off with them

Previous issues with Adjustment Disorder

Conceptual basis unclear

Often used as an exclusion diagnosis

Multiple subtypes of uncertain value

Frequently used as “subsyndromal” diagnosis

Distinction from normal reactions remains difficult

Adjustment Disorder in ICD-11

A maladaptive reaction to an identifiable psychosocial stressor or multiple stressors (e.g., divorce, illness or disability, socio-economic problems, conflicts at home or work) that usually emerges within a month of the stressor

Characterized by

- **preoccupation with the stressor or its consequences**, e.g., excessive worry, recurrent and distressing thoughts about the stressor, or constant rumination about its implications
- **AND failure to adapt** to the stressor, e.g., chronic concentration or sleep problems

core symptoms

- **accompanied by** e.g., depressive or anxiety symptoms as well as impulsive 'externalizing' symptoms, particularly increased tobacco, alcohol, or other substance use

Causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning

Typically resolves within 6 months, unless stressor persists for a longer duration.

Symptoms are not of sufficient specificity or severity to justify the diagnosis of another Mental and Behavioural Disorder

The emergence of Prolonged Grief Disorder

Mounting evidence for some people grieving in an extreme or prolonged manner, more commonly after the death of one‘s own child, sudden or violent death, or in the absence of a farewell

Differentiation between symptoms of depressive disorder and specific prolonged grief symptoms

Existing proposals for Complicated grief (Shear) and Prolonged grief disorder (Prigerson) were first formulated in the 1990s

Evidence that anti-depressants ineffective, in contrast to specific treatments focused on psychological reactions to bereavement

Prolonged grief disorder in ICD-11

Following the death of a partner, parent, child, or other person close to the bereaved, a persistent and pervasive grief response characterized by

longing for the deceased OR
persistent preoccupation with the deceased } ***core symptoms***

accompanied by intense emotional pain, e.g. sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an ability to experience positive mood etc.

The grief response has persisted for an atypically long period of time following the loss (**more than 6 months at a minimum**) **and clearly exceeds expected social, cultural or religious norms** for the individual's culture and context

There is significant impairment in personal, family, occupational and other important areas of functioning

Previous issues with PTSD in ICD-10

The stressor requirement suggests that the event is likely to cause pervasive distress in almost anyone

Flashbacks are not defined but are equated with intrusive memories

The fact that onset may be delayed by many years is not recognised

Existing studies suggest it is more lenient than the corresponding DSM diagnosis, possibly because of the lack of any requirement for impairment

The relationship with F62.0 Enduring personality change after catastrophic experience is vague

Posttraumatic stress disorder in ICD-11

This disorder follows exposure to an extremely threatening or horrific event or series of events (this copes more flexibly with stalking, bullying etc.)

It consists of 3 core elements: (a) Re-experiencing: vivid intrusive memories, flashbacks, or nightmares that involve re-experiencing in the present, accompanied by fear or horror; (b) Avoidance: marked internal avoidance of thoughts and memories or external avoidance of activities or situations reminiscent of the traumatic event(s); (c) Sense of threat: a state of perceived current threat in the form of hypervigilance or an enhanced startle reaction. The symptoms must also last for several weeks and interfere with normal functioning

Why *these* three elements and six symptoms?

1) Flashbacks are unique to PTSD (Bryant et al., 2011) and traumatic re-experiencing and nightmares discriminate PTSD from other conditions (Brewin et al., 2009; Gootzeit & Markon, 2011). Avoidance of reminders is logically tied to the experienced trauma.

2) Factor analyses suggest hypervigilance and startle are specific to PTSD whereas other hyperarousal and numbing symptoms reflect dysphoria (Simms et al., 2002)

3) 5 of these 6 symptoms were found to be among the most highly predictive of a PTSD diagnosis in the *DSM-IV* Field Trial (Kilpatrick et al., 1998)

4) Clinicians identified 3 of these 6 as among the 4 most characteristic symptoms of PTSD (Keane et al., 1997)

On flashbacks and intrusive memories

Intrusive memories are characteristic of many disorders – what is different in PTSD is that they involve some degree of re-experiencing **in the present**. DSM-5 symptom B3 meets this requirement but B1 does not.

The measurement of B3 (“flashbacks”) has been handicapped by lack of any definition. DSM-5 and ICD-11 now agree that they can exist on a continuum. A flashback is effectively an intrusive memory that is relived in the present, whether this is a fleeting sense of ‘nowness’ or a complete loss of awareness of the current environment.

If the person has no conscious memory of the event ICD-11 allows this criterion to be met by an emotional response to reminders of it.

The emergence of Complex PTSD: EPCACE (ICD-10)

Enduring personality change, present for at least two years, following exposure to catastrophic stress. The stress must be so extreme that it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality. The disorder is characterized by a hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge" as if constantly threatened, and estrangement. Although unconnected to PTSD in ICD-10, it was noted that PTSD may precede this type of personality change.

The emergence of Complex PTSD: DESNOS (DSM-IV)

Disorders of Extreme Stress Not Otherwise Specified:
a pervasive pattern of maladjustment that may occur in response to persistent traumatization that occurs across settings, and frequently involves numerous types of trauma, or trauma of long duration

Mentioned in DSM-IV under “associated features” of PTSD and based on observations of Complex PTSD by Herman

The DSM-IV field trial data also found that nearly all of those who met criteria for DESNOS also met criteria for PTSD

Complex PTSD in ICD-11

Exposure: an extremely threatening or horrific event or series of events

Symptom pattern

core symptoms of PTSD (re-experiencing in the present, avoidance, sense of threat)

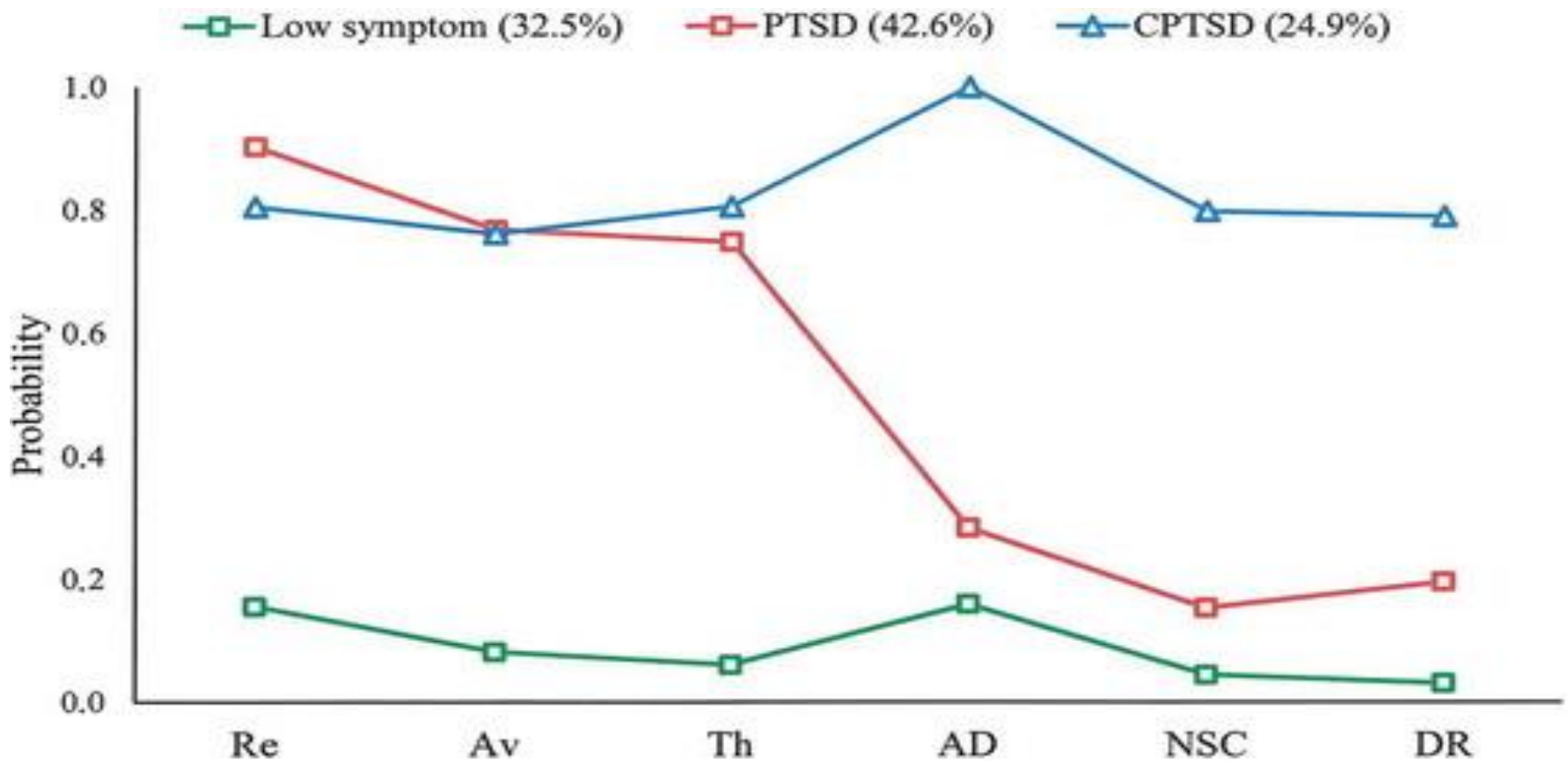
plus

persistent and pervasive impairments in:

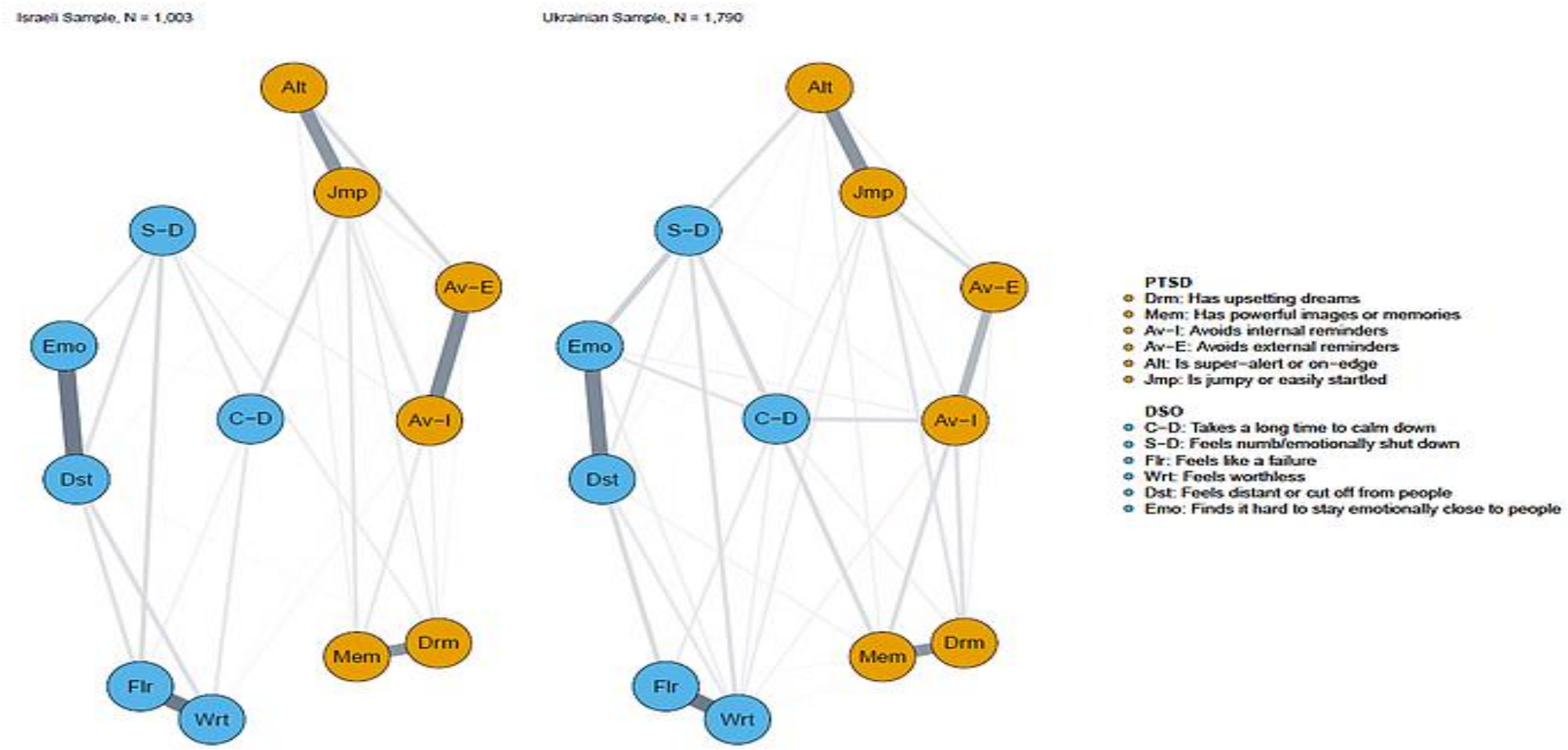
- **affective functioning**: Affect dysregulation, heightened emotional reactivity, violent outbursts, tendency towards dissociative states when under stress
- **self functioning**: Persistent beliefs about oneself as diminished, defeated or worthless; pervasive feelings of shame, guilt
- **relational functioning**: Difficulties in sustaining relationships or feeling close to others

plus functional impairment related to these symptoms

Distinguishing PTSD and Complex PTSD (Kazlauskas et al., 2018)



Network analysis of ICD-11 PTSD/CPTSD (McElroy et al., 2019)



Points to note

- Unlike the DESNOS (Disorders of Extreme Stress Not Otherwise Specified) diagnosis included in the DSM-IV Appendix, Complex PTSD does not *require* prolonged or chronic trauma, although it is expected this is the most common aetiology. It is based on symptom pattern.
- Also unlike DESNOS and EPCACE, the core pattern of PTSD symptoms is required, to distinguish it from other chronic disorders associated with early trauma such as borderline personality disorder

How borderline personality disorder differs

Unlike Complex PTSD, it:

- Does not require PTSD symptoms such as re-experiencing
- Is characterised by being frantic about being abandoned, having an unstable sense of self, having unstable relationships, impulsiveness, and self-harm and suicidal behaviour
- Is not characterised by an extremely negative sense of self, and avoidance of relationships

Conclusions from initial studies on 4 continents

Factor structure of ICD-11 PTSD generally fits the data well and outperforms DSM-5 in several comparisons. This is partly because its structure is simpler and was informed by previous factor analyses. There may be some specific samples (accident victims, incest survivors) where the fit is not so good

A taxometric analysis has suggested that cases and non-cases are distinct in ICD-11 whereas a DSM PTSD diagnosis represents more of a continuum. This is potentially very helpful for studies of biological markers

Conclusions from initial studies on 4 continents

The great majority of studies with adults and children have replicated the proposed distinction between PTSD and Complex PTSD using latent profile or latent class analyses, and there is preliminary evidence Complex PTSD can be successfully differentiated from Borderline Personality Disorder (Cloitre et al., 2014; Hyland et al., 2019; Knefel et al., 2016)

Childhood physical or sexual abuse, particularly within the family, is more strongly related to CPTSD than PTSD. CPTSD is also associated with higher levels of psychiatric burden than PTSD, including greater depression and dissociation

Conclusions from initial studies on 4 continents

In adults PTSD prevalence rates according to the DSM-IV and DSM-5 are broadly comparable with rates of PTSD + CPTSD in ICD-11 although there are consistently slightly lower rates under ICD-11. ICD-11 is more stringent than ICD-10

Nationally representative surveys have found:

ICD-11 PTSD 1.5% CPTSD 0.5% (Germany)

3.4% 3.5% (USA)

9.0% 2.6% (Israel)

5.0% 7.7% (Republic of Ireland)

Rates for community samples of children and young people appear very similar in DSM-IV/5 and ICD-11 (PTSD + CPTSD). ICD-11 identifies quite a lot of cases missed by DSM-5. The simpler formulation may be particularly appropriate here

Treating Complex PTSD

NICE PTSD Guideline (2018) suggests extra sessions needed

Controversy over whether phase-based treatments are necessary:

phase 1: stabilisation; phase 2: trauma processing; phase 3: reintegration

Lack of direct evidence, especially about phase 3

A few trials indicate that immediate trauma-focussed treatment (i.e., bypassing phase 1) could be effective for many patients with histories of multiple traumatisation, including child abuse

However, a child abuse history does not guarantee a person has CPTSD

Patients entering trials may not be representative

Assessing Disorders Specifically Associated with Stress

Adjustment Disorder New Module (Ben-Ezra et al, 2018)

International Adjustment Disorder Questionnaire (Shevlin et al, 2020) *

International Prolonged Grief Disorder Scale (Killykelly et al, 2020) *

The International Trauma Questionnaire (Cloitre et al, 2018) *

* Measures available from https://www.traumameasuresglobal.com

Summary

Diagnostic formulations are best examined against competing alternatives

The ICD-11 diagnoses are based on empirical evidence but are deliberately oriented to maximise clinical utility

The distinction between PTSD and CPTSD already has considerable support, and Prolonged Grief Disorder will be included in the DSM-5-TR

We need to identify and understand more about patients who meet DSM but not ICD requirements (or vice versa) for all these diagnoses

Although ICD-11 recognises a collectivistic dimension to trauma and the core of the disorders appears to be universal, there is much to learn about cultural variations in symptoms (Humayun & Somasundaram, 2018)

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