Chapter 5

Disorders Specifically Associated with Stress

Chris R. Brewin & Andreas Maercker

Post-Traumatic Stress Disorder (PTSD)

Essential and Associated Features

Post-traumatic stress disorder (PTSD) follows an event or situation that in the judgement of the clinician has been experienced by the individual as extremely threatening or horrific. Such events are not limited to those generally regarded as traumatic but may, if the result is that the person comes to experience extreme fear or horror, include experiences such as being repeatedly stalked, bullied, rejected, or humiliated.[1] Experiencing threatening delusions and hallucinations, and the atypical processing of the social and sensory world associated with conditions such as Autism Spectrum Disorder, may result in other types of experiences qualifying because they are subjectively experienced with extreme fear or horror.[2]

A PTSD diagnosis also requires the simultaneous presence of three core elements. The first element is evidence that the traumatic event is being re-experienced in the present. That is, the individual has the experience that the traumatic event is happening again in the 'here and now'. The re-experiencing may occur either in the form of nightmares that closely recapitulate the themes of the event (without necessarily reproducing it exactly), or in the form of daytime intrusive memories and flashbacks. The second core element is evidence of deliberate avoidance of the traumatic event, either in the form of internal avoidance of thoughts and memories, or of external avoidance of people, conversations, activities, or situations reminiscent of the event. The third core element is evidence of persistent perceptions of heightened current threat, for example as indicated by hypervigilance or by an enhanced startle reaction to stimuli such as unexpected noises. At least one symptom corresponding to each element must last for at least several weeks. Symptoms must also be accompanied by significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

Many other symptoms (e.g., irritability, sleep problems, impaired concentration) will commonly be encountered but are not unique to PTSD; they may indicate a co-occurring condition. Although fear and horror will be present to some degree, other emotions such as anger, shame, or guilt are often more prominent.

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Relation to Normality and Other Disorders

Most people who experience extremely threatening or horrific events do not develop a disorder. They may exhibit PTSD symptoms, but these are likely to subside quickly. If symptoms persist after a stressor that did not produce extreme fear or horror, other diagnoses should be considered. Depression, for example, is often accompanied by intrusive memories, but these are not usually re-experienced in the present. If the requirements for other disorders are not met, a diagnosis of Adjustment Disorder can be assigned. A variety of dissociative symptoms can occur following exposure to an extremely threatening or horrific event, including somatic symptoms and trance or fugue states, and a Dissociative Disorder may be considered as an alternative or co-occurring diagnosis if these symptoms are prominent. Both PTSD and Prolonged Grief Disorder may occur in individuals who experience bereavement as a result of the death of a loved one under traumatic circumstances. Unlike in PTSD, in which the individual re-experiences the event or situation associated with the death, in Prolonged Grief Disorder the person may be preoccupied with memories of the circumstances surrounding the death but does not re-experience them as occurring again in the here and now.

The disorders that most commonly co-occur with PTSD are Depressive Disorders, Anxiety or Fear-Related Disorders, and Disorders Due to Substance Use. Rates of comorbidity are very high, particularly with depression. Studies investigating the correlates of different latent factors of PTSD have found that symptoms characteristic of anxiety and depression appear to be more strongly related to those factors reflecting general dysphoria rather than to the more specific aspects of PTSD reflecting re-experiencing, active avoidance, and hyperarousal.[3]

Relation to ICD-10 and DSM-5

PTSD in ICD-10 had a similar focus on re-experiencing symptoms, but was a less specific disorder and did not require evidence of impairment. There were concerns about whether its high prevalence was realistic, and prevalence is reduced in ICD-11.[3] A DSM-5 diagnosis has a narrower definition of trauma exposure and requires the presence of four types of symptom, with a minimum of 6 out of 20 symptoms. Whereas ICD-11 focuses on those symptoms that distinguish PTSD from other disorders, DSM-5 seeks to provide a more comprehensive account of those symptoms that are commonly encountered, even though many are shared with other disorders. The prevalence of PTSD as measured by ICD-11 is usually slightly lower than when it is measured using DSM-5.[3]

The DSM-5 diagnosis of PTSD can be based on over half a million different combinations of symptoms,[4] which reduces its utility for scientific research. In contrast, ICD-11 PTSD can be assessed using as few as two symptoms per core element,[5] such that only 27 combinations of symptoms yield a diagnosis. It is hoped that in addition the greater specificity of ICD-11 PTSD will lead to it being recognized and treated more easily.

Complex PTSD

Essential and Associated Features

In Complex PTSD (CPTSD), all diagnostic requirements for PTSD are met. In addition, CPTSD is characterized by three additional core elements describing disturbances in self-organization, all of which must be present.[6] The first element is severe and

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persistent problems in affect regulation. This can be reflected in hyper-reactivity, for example difficulty recovering from minor stressors, having violent outbursts, or behaving recklessly, or in hypo-reactivity, for example emotional numbing, difficulty experiencing pleasure or positive emotions (anhedonia), and dissociation (e.g., feeling outside of one's body, feeling the world is unreal, gaps in memory). The second element consists of pervasive and persistent beliefs about oneself as being diminished, defeated, or worthless, accompanied by feelings of shame, guilt, or failure related to the traumatic event. The third element involves persistent and pervasive difficulties in sustaining relationships and in feeling close to others, as reflected, for example, in avoidance of relationships, ending relationships when difficulties or conflicts emerge, or deriding the value or importance of relationships. These symptoms cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

Although CPTSD is a disorder that most commonly develops following prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, domestic violence, repeated childhood sexual or physical abuse), chronic trauma is a risk factor, not a requirement, for the diagnosis of Complex PTSD. Thus, CPTSD may be diagnosed following a single traumatic event, and PTSD following chronic or prolonged trauma. This approach recognizes the importance of multiple risk and resilience factors arising from personal attributes, environmental resources, and biological variables.

Associated features of CPTSD include suicidal ideation or behaviour and substance abuse, which may be related to emotion regulation difficulties. There is a substantial subgroup with psychotic symptoms.[7] Somatic complaints may be present but can also be a more direct result of the traumatic events themselves. Pervasive dissociation may be present, including fugue states and a complete loss of awareness of the current environment occurring in therapy sessions and in everyday situations such as crossing roads.

Response to Criticism of Allen Frances

Allen Frances (in Chapter 2 of this book) suggests that ICD-11 Complex PTSD is simply a severe form of ICD-11 PTSD. This has been tested using factor mixture modelling, a technique that combines dimensional (factor analysis) and categorical (mixture modelling) analysis. Two recent studies have confirmed that ICD-11 PTSD and Complex PTSD form distinct latent classes and do not simply differ on a severity dimension. The term 'Complex PTSD' is also popular and found to be useful by clinicians. In ICD-11, it has a number of features that clearly demarcate from earlier versions, including being easier to define and measure. There is every reason to think that over time the ICD-11 version of Complex PTSD will come to be preferred to previous versions, bringing with it important advantages in diagnostic specificity.

Relation to Normality and Other Disorders

Personality Disorders are also typified by pervasive problems in functioning related to the self and interactions with others. They differ in that the presence of the symptoms must have persisted over an extended period (generally 2 years or more) and is not specifically tied to a traumatic stressor. Symptom duration may be shorter in Complex PTSD, which also, unlike Personality Disorders, requires the presence of a traumatic stressor and consequent PTSD symptoms.

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A diagnosis of Personality Disorder can include a qualifier for 'borderline pattern'. This pattern describes similar domains of disturbance to Complex PTSD but the nature of the problems is different and the two conditions can be discriminated empirically.[8,9] In the Borderline pattern, self-concept difficulties reflect an instability in identity with shifting overly positive or overly negative self-appraisals, whereas in Complex PTSD the self-concept is stable but persistently negative. Relational difficulties in the context of the Borderline Pattern are characterized by volatile patterns of interactions with alternating over-idealization or denigration of the other person, whereas in Complex PTSD relational difficulties are characterized by a persistent tendency to avoid relationships and distancing in times of difficulties.

Following an experience of a traumatic event, individuals with Complex PTSD may experience a variety of dissociative symptoms including somatic symptoms and trance or fugue state. These symptoms are also experienced by individuals with PTSD but are more strongly associated with and occur at substantially higher levels of severity among those with Complex PTSD.[10] The presence of persistent experiences of a fugue or trance state may warrant an additional diagnosis of Dissociative Disorder diagnosis.

Relation to ICD-10 and DSM-5

The ICD-10 included the condition 'Enduring personality change after catastrophic experience' (EPCACE) that also described disturbances in self-organization that can sometimes result from multiple, chronic, or repeated traumatic events. In contrast to EPCACE, CPTSD does not require exposure to chronic trauma or a demonstrable personality change, but it does require the presence of more specific symptoms, including PTSD symptoms. There is preliminary evidence that CPTSD is more readily distinguished by clinicians than EPCACE.[11] DSM-5 does not recognize CPTSD. Alternative formulations of Complex PTSD such as Disorders of Extreme Stress Not Otherwise Specified (DESNOS) have been considered by the DSM-IV and DSM-5 but insufficient evidence was found to support them. DSM-5 PTSD includes a number of the symptoms of ICD-11 CPTSD.

Prolonged Grief Disorder

Essential and Associated Features

Prolonged Grief Disorder (PGD) describes a disturbance in which, following the death of a person close to the bereaved, there is persistent and pervasive yearning or longing for the deceased, or a persistent preoccupation with the deceased. Yearning and longing are the unbidden, repetitive desires for a cherished person from the past, often using imagery to conjure the deceased in the present.[12] These symptoms extend beyond 6 months after the loss, and the disorder is sufficiently severe to cause significant impairment in the person's functioning. Importantly, the disturbance goes far beyond expected social or cultural norms and depends on cultural and contextual factors.

The associated features are related to the preoccupation with the deceased or with the circumstances of the death, which may sometimes oscillate between preoccupation and avoidance of reminders. Intense emotional pain in PGD is often manifested by bitterness about the loss, sadness, guilt, anger, denial, or blame. Persons with PGD often have difficulty accepting the death and feel as if they have lost a part of themselves. Specific other symptoms may be apparent, for example an inability to experience positive mood, emotional numbness and difficulty experiencing feelings, or the feeling that life is meaningless. PGD has been

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associated with marked occupational and social impairment[13] that may be expressed, for example, by difficulty progressing with activities, or by withdrawal, or difficulty in engaging with social or other activities.

Relation to Normality and Other Disorders

An individual who experiences a grief reaction that is within a normative period in their cultural and religious context is considered a normal griever and should not be given a diagnosis of prolonged grief disorder. Thereafter, it is the intensity of the grief symptoms and whether they significantly impair the person's life that determine whether this diagnosis should be assigned. In this context, it is important to take into account whether other people who share the grieving person's cultural or religious mindset (e.g., family, friends, community) may view the reaction to the loss or the duration of the reaction as abnormal. Therefore, cultural considerations about the person's frame of reference and the normative length of the grieving phase in the respective culture are key.[14]

Response to Allen Frances

Allen Frances' criticism can be countered. He states in Chapter 2 that 'there can never be a uniform expiration date on normal grief – and ICD-11 should not have felt empowered to impose one. People grieve in their own ways, for periods of time that vary widely depending on the person; the nature of the loss; and relevant cultural practices.' In the ICD-11 revision, we recognized that time definitions are not ideal in coding psychopathology. We have therefore chosen soft definitions such as 'usually/at least etc.' For PGD, it has been emphasized that the time criterion – approximately 6 months – can be varied according to the cultural circumstances of the reference population. Accordingly, the European or Christian (actually Catholic) 'year of mourning' can be varied in national versions of ICD-11, for example, in the US or German-language versions. The time criterion 'approximately 6 months' was established after intensive best-practice-based discussions, especially by the non-Western representatives (Asia, Africa, South America) of the working group. In China, Japan, and Korea, by the way, the new diagnosis was unanimously strongly welcomed and seen as a missing component of psychopathology. There are over two dozen publications on it from these countries.

Frances also claims in Chapter 2, 'Mislabelling grief as mental disorder stigmatizes the grievers; exposes them to unneeded psychiatric medication; and insults the dignity of their loss.' ICD-11 has been developed with psychiatrists, clinical psychologists, social workers, and psychiatric nurses. Therefore, it is quite wrong to assume prescribing medication automatically to the patients in question. Many professional groups would be very reluctant to prescribe. Loss of dignity on this diagnosis would be strongly denied by our Asian colleagues. On the contrary: they think that globally many of the conditions automatically diagnosed as full-scale depressive disorders might actually be grief sequelae conditions and so reduce drug prescribing.

The two main diagnoses that can overlap with PGD are PTSD and depression. Whereas both PGD and PTSD can involve intrusive memories of the deceased, PTSD memories tend to be focused on fearful events that trigger marked avoidance; in contrast, PGD can also involve intrusive memories of the deceased, but these typically evoke sadness and the person can also have positive memories of the deceased. Whereas both depression and PGD involve dysphoric mood, depression is marked by a constant dysphoric mood state; PGD, on the other hand, involves sadness that is typically elicited by reminders of the loss.[15]

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Relation to ICD-10 and DSM-5

The diagnosis Prolonged Grief Disorder was not available in ICD-10. As a result, people with the condition were usually given an imprecisely formulated diagnosis of depression or, in a few cases, were diagnosed with adjustment disorder. In ICD-11, PGD can be seen as a sister diagnosis of adjustment disorder.

In the original version of the DSM-5, published in 2013, no diagnosis of persistent grief disorder was included, but a proposed diagnosis was added to the Appendix in recognition that the construct required further research (termed Persistent Complex Bereavement Disorder). The editorial revision of the DSM-5 in 2020 included PGD as a new diagnosis.[16] Its criteria largely overlap with those in ICD-11 insofar as they place core emphasis on yearning and preoccupation for the deceased with associated indicators of disruption. It departs from the ICD-11 definition in some key ways. The DSM-5 criteria require the person to have persistent yearning for at least 12 months after the death (6 months for children), and at least three of a possible eight symptoms that extend beyond those outlined in ICD-11: these include emotional numbness and intense loneliness.

Adjustment Disorder

Essential and Associated Features

Adjustment disorder (AjD) is a maladaptive reaction to identifiable psychosocial stressors or life changes characterized by the two symptom groups of preoccupation with the stressor and failure to adapt. Preoccupation with the stressor can be defined as stressor-related factual thinking, which is time-consuming and associated with negative emotions.[17] Failure to adapt may be manifested by a range of symptoms that interfere with everyday functioning, such as difficulties concentrating or sleeping. The symptoms emerge within a month of the onset of the stressor or stressors and tend to resolve in 6 months unless the stressor persists for a longer duration. In order to be diagnosed, adjustment disorder must be associated with significant distress and significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

Associated features consist of symptoms of depression (e.g., depressed mood, hopelessness), anxiety (e.g., a state of anxiety when thinking about the stressful situation), and impulsivity (e.g., quickly losing temper, feeling restless and nervous), and are conceptualized as associated features of AjD.

Relation to Normality and Other Disorders

First, AjD must be distinguished from normal stress responses. Then it must be differentiated from other mental disorders such as mood disorders and anxiety disorders. This can be challenging since there is symptom overlap between AjD and these conditions. The symptoms may represent a depressive episode in evolution. However, in AjD the onset of symptoms is clearly related to a stressor and the presence of a stressor is essential to making the diagnosis. In contrast, anxiety and depressive disorders can develop without any stressor but some stressful event is frequently reported. In these, a stressor is not essential. Moreover, symptoms of depression and anxiety in AjD may also be less severe. It is important to also recognize that not everybody who experiences a traumatic event develops PTSD and, if the full criteria are not met, AjD may be a more appropriate diagnosis. In addition, AjD has to be distinguished

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from Prolonged Grief Disorder, which is characterized by a pattern of yearning or longing symptoms for the deceased or by a persistent preoccupation with the circumstances of the death.

Response to Allen Frances

In Chapter 2, Allen Frances argues that adjustment disorder could be used frequently instead of PGD and advises practitioners not to 'follow any ICD-11-induced fad to suddenly pathologize what is one of humanity's most ubiquitous, basic, and essential life experiences'.

In responding to this, we are not indifferent to possible overlap with other conditions. Our colleague Richard Bryant, from Australia, has argued the case for PGD cogently:

> There has been accumulating evidence over many years validating prolonged grief disorder as a specific and identifiable condition that can severely impact a minority of bereaved people. There are many factor-analytic studies indicating that the construct of persistent yearning and emotional pain, together with its associated symptoms, is a well-defined syndrome, and that this syndrome is distinct from other related disorders such as depression and adjustment disorder.[18]

There is a great deal more information from worldwide studies that cannot be included in this chapter due to lack of space.

Relation to ICD-10 and DSM-5

The ICD-10 definition of AjD was often criticized because it did not include positive diagnostic criteria, as is now the case with the symptoms of preoccupation and failure to adapt. It was a diagnosis of exclusion only, which made it a 'wild card' in the diagnostic process, albeit unsatisfactory for scientific and public health reasons.[19] For example, in some countries such as the Netherlands the ICD-10 AjD diagnosis was no longer sufficient to be used for health insurance or social welfare legislation. The introduction of the ICD-11 AjD diagnosis was not accompanied by increased AjD prevalence rates compared to ICD-10, instead the rates appear comparable in population studies.[20]

There are commonalities between the diagnostic criteria for AjD in DSM-5 and ICD-11 in terms of the presence of a stressor in close temporal relationship to the onset of symptoms. Beyond that, there are few similarities. The time from the stressor to the onset of symptoms is different; DSM-5 requires symptoms or impairment, whereas ICD-11 requires both. The criteria in DSM-5 are very broad, in contrast to ICD-11 where they are much more specific. DSM-5 retains the subtypes, while ICD-11 does not. Finally, DSM-5 still regards AjD as a disorder without positive symptom specification and thus, unlike ICD-11, as a subthreshold disorder. These differences are likely to lead to research developments that may diverge from the approach of DSM-5, particularly in terms of the introduction of a more distinct characterization of the core features of AjD and its elevation to full threshold status.

Reactive Attachment Disorder and Disinhibited Social Engagement Disorder

The ICD-11 includes two disorders unique to childhood with onset ages between 1 and 5 years, both arising from a history of grossly insufficient care. The degree of deprivation implies that these disorders may often be accompanied by a more global impact on cognition (e.g., working memory deficits), behaviour (e.g., temper tantrums), and affective

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functioning (e.g., difficulty regulating emotions). Although defined as disorders of early childhood, there is growing interest in the extent to which the same symptoms may be manifest in school-age children and adolescents, particularly those with a history of institutional care.[21,22] At this later age, the disorders are also likely to be comorbid with other psychiatric disorders and psychosocial problems.[23]

The requirement for Reactive Attachment Disorder (RAD) in ICD-11 is a pattern of emotionally withdrawn behaviour towards more than one caregiver, shown by minimal comfort-seeking and minimal response to comfort when offered. In ICD-10, RAD was characterized more broadly in terms of persistent abnormalities in social relationships, which could include fearfulness and hypervigilance, poor social interaction with peers, aggression towards self and others, misery, and growth failure. In DSM-5, RAD is described as a chronic pattern of being emotionally withdrawn and inhibited, which is demonstrated by rarely seeking or being responsive to comfort when distressed. Moreover, there is other evidence of emotional disturbance such as episodes of irritability, fearfulness, or sadness that are out of proportion to the situation.

The requirement for Disinhibited Social Engagement Disorder in ICD-11 is a lack of reticence with unfamiliar adults, shown by over-familiarity, lack of checking, and willingness to go off with them. This is similar to ICD-10, which mentioned diffuse, non-selectively focused attachment behaviour, attention-seeking, indiscriminately friendly behaviour, and poorly modulated peer interactions. Likewise, DSM-5 specifies a pattern of behaviour in which a child shows reduced or absent reticence in approaching and interacting with unfamiliar adults, overly familiar verbal or physical behaviour, diminished or absent checking back with adult caregiver after venturing away, and willingness to go off with an unfamiliar adult with minimal or no hesitation.

Other Specified Disorders Specifically Associated with Stress

This category may be used for individuals exposed to stress or trauma who present with symptoms similar to other Disorders Specifically Associated with Stress, but do not fulfil the diagnostic requirements for any of them. The diagnosis requires that the symptoms are not better accounted for by another mental disorder such as anxiety disorder or depression, and that they are accompanied by significant distress or functional impairment.

General Discussion

The changes made in ICD-11 reflect several decades of experience concerning the strengths and weaknesses of previous diagnoses subsumed under the category of stress and trauma-related disorders. The PTSD diagnosis, first introduced in 1980, has been extraordinarily successful in raising the profile of traumatic stress and changing the landscape of psychopathology and psychological intervention. Among its limitations are an evidence base heavily reliant on observations of groups such as domestic violence survivors and military veterans. Over the years, it has undergone several revisions to the way traumatic stressors are defined and to its constituent symptoms. Concerns have been raised about the complexity of the diagnosis and about its ability to adequately reflect the impact of experiences such as early childhood trauma. ICD-11 addresses both these concerns by simplifying the diagnosis and distinguishing PTSD and Complex PTSD.

These changes represent a very distinct alternative to the way PTSD is diagnosed using successive versions of the DSM. To date, there is substantial empirical evidence for the

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factorial validity of PTSD and Complex PTSD and for the distinction between them.[24,25] Most of the symptoms are familiar, but the narrowing of the focus on re-experiencing in the present rather than any kind of intrusive thought or memory may take some time to be fully appreciated.[11] Ultimately, the utility of this new approach awaits verification through everyday clinical practice. One important issue will be to determine who would have received a PTSD diagnosis under the DSM but not under ICD-11, and whether their symptoms are better captured by another disorder.

Evidence from community samples suggests that the number of children diagnosed with DSM-based PTSD is very similar to the number receiving either a PTSD or CPTSD diagnosis in ICD-11.[3] Despite this, the overlap in case identification is modest and more needs to be understood about which children receive a DSM but not an ICD-11 diagnosis, and vice versa.[26] Relatively little is known about the differences in functioning of the DSM-IV, DSM-5 pre-school, and ICD-11 criteria in samples of younger and preadolescent children.[27] Importantly, the distinction between PTSD and CPTSD appears to be equally valid in samples of children.[28,29]

With regard to PGD, the available evidence highlights the importance of having a specific diagnosis to identify people with persistent and severe grief reactions. Such a diagnosis can facilitate provision of optimal treatment for chronically distressed people after bereavement. Considering the number of people who are bereaved globally each year, it can be estimated that millions of people may suffer from PGD, and so it is important to be able to develop simple and accurate methods of identifying these individuals in order for strategies to be implemented to alleviate their potentially debilitating distress.

Adjustment disorder too has been changed from its ill-defined state to a thoroughly contemporary diagnosis based on basic psychological research and defined by positive criteria. Again, the utility of the proposals awaits clinical verification.

The advent of the new disorders specifically associated with stress under ICD-11 will require new measurement tools. To date, a number of questionnaires have been developed, including the International Trauma Questionnaire,[5] the International Prolonged Grief Disorder Scale,[30] the International Adjustment Disorder Questionnaire,[31] and the Adjustment Disorder New Module.[32] These are freely available from the website www.traumameasuresglobal.com. In the future, corresponding clinical interviews will be a matter of priority.

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