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Guest Editorial

Controversies in trauma- and stress-related disorders

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Summary

The release of ICD-11 has resulted in an expansion of diagnostic entities for trauma- and stress-related disorders. This resulted, at least temporarily, in discrepancies with the DSM-5. This situation is outlined and a look is taken at the potential diagnosis of 'continuous traumatic stress reaction'.

Keywords

PTSD; complex PTSD; prolonged grief disorder; adjustment disorder; ICD-11.

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The implementation of the Eleventh Revision World Health Organization's International Classification of Diseases (ICD-11), is progressing. National health agencies around the world are actively engaged in implementing the system over the next few years. Australia and China are well advanced with their national implementations. Other countries, and therefore other language groups, are making significant progress with the translation and official national adaptation of ICD-11.

The ICD-11 creates a completely new historical situation for mental health sciences and psychiatry. The diagnostic reference system most often used for research, DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders: version 5–text revision), categorises some of the mental disorders in a different way and also applies different definitions for many categories. This is particularly evident for trauma- and stress-related disorders.

The ICD-11 includes four primary categories under the umbrella term of 'Disorders Specifically Associated with Stress'. These are: post-traumatic stress disorder (PTSD), complex PTSD, adjustment disorder and prolonged grief disorder (PGD). In addition, two childhood conditions that result from severe psychological distress are also included. In 2013 the corresponding section in DSM-5 initially included, in addition to the same two childhood conditions, PTSD, acute stress disorder and adjustment disorder. PGD was added in the 2022 DSM-5-TR.

These differences can rightly be seen as controversial, as they inevitably lead to different approaches to diagnosis and sometimes even to treatment. How these differences have arisen, what they essentially consist of and how clinicians can orient themselves is the subject of this editorial. Many of the insights provided here have been drawn from a recently published book chapter where some of these questions have been discussed in greater depth.[1]

Key differences among PTSDs and their origins

The most striking difference is the existence of complex PTSD in ICD-11.[2] The DSM-5 has so far chosen not to include this diagnosis. Instead, it expanded the definition of PTSD and at the same time introduced a dissociative subtype. The expansion entailed the introduction of an additional symptom group: in addition to the familiar intrusive, avoidance and hyperarousal symptoms, there are now also 'negative changes in cognitions and mood'. The subtype 'with dissociative symptoms' includes all those patients who in addition frequently experience short or long periods of depersonalisation or derealisation.

Before discussing the implications of these differences, we provide a brief history of the development of the two diagnoses. Beginning in 1980, the DSM has striven for a relatively precise classification, based on data and expert opinion, that was well-suited to research on this new condition. The ICD has also relied on data and consensual expert opinion but has placed greater emphasis on clinician judgement than on specific criteria. In 2010, with the development of ICD-11, a more systematic data-based approach was adopted. In view of the impossibility (in terms of current knowledge) of establishing a classification of mental health based on neurobiology, an iterative process of categorisation based on currently available data was deemed the most appropriate approach. As part of this process, surveys with clinicians from all regions of the world were initiated to explore their mental maps of diagnostic categories and, simultaneously, whether they perceived there to be potential missing diagnoses. Across all mental disorders, the most frequently requested diagnosis by these thousands of clinicians worldwide was complex PTSD with 12% making this request.[3] It was therefore taken seriously by the WHO ICD-11 committees. A diagnosis for pathological grief was also high on this list of clinical needs.

In ICD-11 a core-feature approach was employed for the first time with the disorders specifically associated with stress. This is based on the assumption that classifications can be made on the basis of a limited number of highly typical features that will effectively discriminate one diagnosis from another. The DSM approach, on the other hand, has attempted to provide a detailed description of all the features likely to be associated with a specific diagnosis, even if these overlap with other disorders. It necessitates the use of lengthy criteria-based symptom lists, with different components that are combined according to a set of rules. Even without the subtypes the text of DSM-5 comprises one and a half pages describing eight different diagnostic criteria for PTSD including the specification of a traumatic event and 20 individual symptoms.

Re-experiencing in ICD-11 PTSD is characterised by 'reliving in the present', and may take the form of traumatic dreams or daytime intrusive memories accompanied by a sense of 'nowness' (this can vary from a fleeting sensation to a fully immersive flashback). This is in contrast to the broader definition of intrusions that applies in the DSM-5-TR. It is notable that intrusive memories are often present in other disorders, as well as in survivors of trauma who are resilient and do not have PTSD. The avoidance symptom group is identical in ICD-11 and DSM-5-TR. The broad hyperarousal symptom group, which is referred to as 'marked alterations in arousal and reactivity' in DSM-5-TR, has been narrowed down to increased startle and hypervigilance to specifically reflect a sense of ongoing threat.

What are the specific features that are additionally required to diagnose complex PTSD in ICD-11? The following criteria are indicative of complex PTSD:

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(a) problems of affect regulation, such as increased emotional reactivity to minor stressors or dissociative symptoms under stress;
(b) persistent negative beliefs about oneself, such as seeing oneself as diminished, defeated or worthless;
(c) persistent difficulties in maintaining relationships or feeling close to others.

It should be noted that the entire symptom pattern typically occurs after persisting or repeated traumatic events, but exceptionally also after one-off traumatic events. The type and nature of the trauma does not determine the diagnosis; rather, it is the symptom pattern that is of consequence.

Particularly severe trauma sequelae are likely to be diagnosed as complex PTSD in ICD-11 and as PTSD of the dissociative subtype in DSM-5-TR. The available evidence indicates a substantial overlap between complex PTSD and dissociative symptoms.[4] With regard to treatment, there are a variety of ways in which severe trauma presentations may be approached, focusing initially on memory, emotion regulation, identity or dissociative symptoms, or alternatively on social relationships. At present it is unclear whether some treatment strategies can be generally recommended or whether the approach is best tailored to the needs and choices of each patient.

Controversies regarding further stress-related diagnoses

As mental health professionals, it is likely that you will have observed that the introduction of PGD has led to a public debate about whether it is acceptable to 'pathologise grief'. The US psychiatrist Allen Francis also criticised this in the aforementioned book *Making Sense of the ICD-11*.[1] He advanced several arguments against this approach, including the contention that such a condition should not be treated with pills. It is important, however, to consider the potential long-term psychological effects of bereavement. One example is parents who, after the loss of a child, are unable to care for their remaining children and are no longer emotionally attuned to them. This can have a profound impact on both the parents themselves and the surviving children.

The pathological effects of grief have been extensively researched over the past 20 years. Studies have consistently demonstrated that a serious disorder requiring treatment occurs in approximately 10% of adult bereaved individuals. However, there are certain differences between PGD in ICD-11 and DSM-5, for example in the period post-bereavement after which a diagnosis can be assigned. According to ICD-11 this is after around 6 months whereas according to DSM-5-TR it is only after 12 months. The rationale for this requirement in ICD-11 was derived from the largest longitudinal study available at the time,[5] whereas the DSM-5-TR adopted a more conservative approach that allowed for some cultural expectations of a 12-month mourning period. The ICD-11 requires at least one core feature, consisting of either persistent and pervasive yearning for or preoccupation with the dead person accompanied by signs of emotional pain. The DSM-5-TR additionally requires three out of a further eight associated perceptions, emotions and behaviours such as disbelief about the death, avoidance of reminders and intense loneliness. Both ICD-11 and DSM-5-TR require evidence of functional impairment (or clinically significant distress in the case of DSM-5-TR), and that the bereavement reaction clearly exceeds social, cultural or religious norms.

Additionally, the ICD and DSM diverge in their descriptions of adjustment disorder. In ICD-11 this disorder was defined for the first time through the identification of core features rather than as a diagnosis of exclusion (i.e. in the absence of other diagnoses), an approach that persists in the DSM-5-TR. The first core feature is preoccupation, i.e. mental fixation on critical life events or severe long-term stresses, such as a sudden job loss, the break-up of a relationship or the news that one's own child has engaged in serious criminal activity. The second core feature involves a failure to adapt, expressed, for example, through substance misuse or not being able to alleviate newly developed sleep disorders. The many subtypes of adjustment disorder recognised in ICD-10 and DSM-5-TR have been abolished in ICD-11.

The ICD-11 definition of adjustment disorder provides a robust foundation for both clinical application and the investigation of its underlying biopsychosocial mechanisms. The disorder has the potential to play a significant role in understanding mental health issues experienced by migrants and refugees, for example, and could provide a focus for future research on populations exposed to high levels of stress.

Conclusions and future directions

In summary, clinicians who wish to work with precise diagnoses of stress-related disorders according to the major international classification systems now have a choice between two reference systems. This may be unsettling, as many of us would like to have 'the one truth' at our disposal. However, these two options enable critical reflection and provide an incentive for further development and differentiation.

One of the main aims of ICD-11 was to make diagnosis easier and more accessible to busy mental health professionals (and non-mental health professionals) throughout the world. Accordingly, the main trauma- and stress-related disorders in ICD-11 rely on specifying a small number of distinguishing core features. Already in textbooks these are referred to as 'narrow definitions'. Extensive psychometric evidence indicates that this approach has successfully demonstrated PTSD and complex PTSD to correspond to two coherent but separate disorders,[6] and similar research on PGD and adjustment disorder is ongoing.

In the case of PTSD/complex PTSD it has become clear that fewer people are diagnosed under ICD-11 than under DSM-5, and that there are a substantial minority of people who meet the diagnostic requirements for either ICD-11 or DSM-5 but not both.[7] On the negative side this introduces uncertainty about whether the disorder should be diagnosed in a particular individual, with ICD-11 proposing that some presentations may be more accurately attributed to other conditions such as anxiety, depression or physical stress disorders. On the positive side, we have learned that there are people with significant post-traumatic symptoms and functional disability who may be identified by ICD-10 but not by DSM-5, and *vice versa*. Study of these individuals is likely to be highly informative about the nature of PTSD and about the strengths and weaknesses of both current systems.

With the continued evolution of both classification systems it is becoming increasingly clear that there are a family of PTSDs that appear similar but have different timecourses or risk factors. In addition to PTSD, complex PTSD and the dissociative subtype, the delayed-onset form of the disorder differs in a number of ways from immediate-onset PTSD.[8] Delayed onsets are particularly associated with members of the military and the emergency services and often reflect a cumulative build-up of traumatic stress over months or years rather than a response to a sudden overwhelming event.

These observations are relevant to civilian populations who may also be exposed to continuous high levels of traumatic stress that exist in the present rather than the past. The ICD-11 working group were requested to create a trauma disorder that reflected the experience of these groups. These conditions include ongoing wars and occupations, but have also been associated with living in

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residential areas or shanty towns with the highest rates of violence and crime. This enquiry was received positively. However, a critical mass of research was lacking, for example, on the main symptoms in which this continuous traumatic suffering manifests itself.

To date, research groups have initiated studies outside the DSM and ICD systems to explore 'continuous traumatic stress reactions' under the very special ethical conditions involved in conducting research on individuals whose lives are currently being threatened. Preliminary findings suggest that symptoms only partially overlap with those of PTSD and include exhaustion/indifference and anger/betrayal as well as fear/hopelessness.[9] Important questions remain about whether or at what point such symptoms might cease to be normal responses to extreme stress, and whether they should best be captured by diagnoses or, like acute stress reactions in ICD-11, by codes that reflect non-diagnostic factors that have an impact on health status. Research is also urgently needed on the balance of social and medical interventions that will be most effective in alleviating suffering.

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