



## Proposals for mental disorders specifically associated with stress in the International Classification of Diseases-11

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Mental disorders specifically associated with stress are exceptional in needing external events to have caused psychiatric symptoms for a diagnosis to be made. The specialty of stress-associated disorders is characterised by lively debates, including about the extent to which human suffering should be medicalised,<sup>1</sup> and the purported overuse of the diagnosis of post-traumatic stress disorder (PTSD).<sup>2</sup> Most common mental disorders are potentiated or exacerbated by stress and childhood adversity.<sup>3,4</sup> Moreover, the subjective narratives of many people with mental disorders emphasise such external events.<sup>5</sup> Clinicians might inadvertently gravitate towards diagnoses of disorders specifically associated with stress whenever a significant stressor can be identified, because this approach provides a way to understand the person's experience of symptoms, as a function of external events, that is more likely to be acceptable to the person.<sup>6</sup> What could be missed in such formulations is that mental disorders specifically associated with stress are characterised not only by an antecedent event, but also by a distinct clinical picture with core symptoms that differ from those of other mental disorders.

WHO is developing the International Classification of Diseases, version 11 (ICD-11), which is scheduled for approval in 2015. WHO is also responsible for the Mental Health Gap Action Programme (mhGAP), intended to assist with scaling up of mental health care, particularly in low-income and middle-income countries.<sup>7</sup> It has launched the mhGAP intervention guide, which provides assessment and management protocols for selected conditions in non-specialised health-care settings. In response to requests from health-care providers, WHO is developing a module for this guide with disorders specifically associated with stress that will use proposed ICD-11 definitions. These activities are also relevant to WHO's role in development of mental health policies related to humanitarian crises.

Changes in the category of mental disorders specifically associated with stress are important because of questions about the validity of surveys showing a high rate of these diagnoses in populations who have experienced natural or man-made disasters, and about whether these diagnoses are clinically useful in terms of leading to feasible and effective treatment. People with these disorders seek help in many health settings globally.<sup>8</sup> The high level of overlap and co-occurrence with other mental disorders often challenges mental health specialists,<sup>9</sup> while general medical services often note co-occurring somatic problems.<sup>10</sup>

The ICD-11 Working Group on this topic was asked to review scientific evidence and other information about use, clinical utility (as termed by WHO), and experience with relevant ICD-10 diagnoses in various health-care settings; to review proposals for the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) and consider how these may be suitable/useful for global applications; and to assemble proposals for ICD-11 with a focus on improving clinical utility.

The Working Group has recommended a separate grouping of disorders specifically associated with stress for ICD-11, rather than combining them with anxiety disorders as in ICD-10 or DSM-IV. Disorders specifically associated with stress have two key characteristics: they are identifiable on the basis of different psychopathology that is distinct from other mental disorders; and they arise in specific association with a stressful event or series of events. For each disorder in the grouping, the stressor is a necessary, although not sufficient, causal factor. The stressor could range from negative life events within the normal range of experience (in the case of adjustment disorder) to traumatic stressors of exceptional severity (in the case of PTSD and complex PTSD).

Among the controversies about existing formulations of PTSD are concerns about its overuse in populations exposed to natural or man-made disasters.<sup>7,8</sup> One problem has been the application of the diagnosis when populations are still being actively exposed to extreme stressors—eg, continuing conflict, uprooting to unsafe locations, or earthquake aftershocks—which makes differentiation between PTSD, adaptive fear reactions, and grief difficult, especially when the definition of PTSD includes non-specific symptoms. Moreover, there is a concern that an overemphasis on PTSD could contribute to clinicians failing to recognise other commonly occurring mental disorders, especially depression.<sup>11</sup> Nonetheless, the appropriate use of a clearly defined PTSD category is one aspect of progress in evidence-based mental health care in humanitarian settings.<sup>12</sup>

The Working Group has recommended a refocus on the diagnosis of PTSD on three core elements, and removal of non-specific symptoms that are also part of other disorders.<sup>13,14</sup> The proposed diagnostic guidelines need re-experiencing of the traumatic event, in which the event is not only remembered but experienced as occurring again; avoidance of reminders likely to produce re-experiencing of the traumatic event(s); and a perception of heightened current threat, as indicated by

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various forms of arousal.<sup>15</sup> These elements must have developed after exposure to an event of an extremely threatening or horrific nature, but the diagnosis is mainly based on symptom presentation rather than on determination of whether or not the event constitutes an eligible traumatic stressor. By contrast with ICD-10, functional impairment (in addition to the duration of symptoms) would be needed to help to differentiate PTSD from normal reactions to extreme stressors. The intention is to simplify the diagnosis and direct clinicians' attention to its core elements, and to use functional impairment rather than specific classes of stressors to enhance the threshold for diagnosis. As in ICD-10, the diagnosis could be made within 1 month of the event.

Complex PTSD is a new proposed category, reserved for extensive reactions typically arising from severe and prolonged stressors usually involving several or repeated adverse events.<sup>16</sup> The proposed diagnosis comprises the three core elements of PTSD, accompanied by enduring disturbances in the domains of affect, self, and interpersonal relationships. This construct is drawn from studies of survivor populations identifying symptom presentations that reflect sustained and pervasive disturbances in emotion regulation, in the experience of a diminished and defeated sense of self, and in difficulties maintaining relationships.<sup>17,18</sup> Complex PTSD is distinguishable from personality disorders by its restricted symptom profile and its responsiveness to specific treatments that differ from those for personality disorders and from those for PTSD.<sup>19</sup>

Another new category proposed for ICD-11 is prolonged grief disorder, describing intensely painful, disabling, and persistent responses to bereavement with specific symptoms such as pervasive yearning or preoccupation with the deceased and associated emotional pain.<sup>20</sup> The duration of the symptoms is clearly prolonged compared with what would be considered a normative grief reaction in view of the individual's cultural and religious background.<sup>21</sup> There are well validated treatment programmes that are specific to these symptoms<sup>22</sup> and are not the same as treatment for depression,<sup>23</sup> which also has a different symptom profile; a separate diagnosis will provide a more precise diagnostic indication. The Working Group's conclusion is that there is sufficient evidence for the validity, specificity, and treatability of this disorder to include it, with appropriate caveats about cultural and individual variability in expressions of grief and mourning. The Working Group did not support a previous DSM-5 proposal to include a bereavement-related subtype of adjustment disorder,<sup>24</sup> which accords with guidance provided for ICD-10,<sup>25</sup> because the defining characteristics and duration requirements of prolonged grief disorder are incompatible with the timeframe of adjustment disorder.

Adjustment disorder is defined as an emotional disturbance arising as a consequence of a significant life event. It has often been used as a provisional diagnosis or

residual category for people who do not meet thresholds for other disorders, particularly depressive and anxiety disorders. Although some commentators have advocated for elimination of this category,<sup>24</sup> the Working Group emphasised its significance within the range of disorders associated with stress, and as part of the continuum from normal to severe exposure. The Working Group noted that in a global sample of nearly 5000 psychiatrists, adjustment disorder was the seventh most frequently used category,<sup>26</sup> and that it ranked even higher among psychologists.<sup>27</sup> The ICD-11 proposal describes adjustment disorder more specifically as a maladaptive reaction to an identifiable stressor defined in terms of positive symptoms,<sup>28</sup> such as intrusive preoccupation with the stressor and inability to adapt. Symptoms typically emerge within a month of the onset of the stressor and tend to resolve in 6 months.

ICD-10 describes acute stress reaction as emotional, cognitive, and behavioural reactions that subside within days after an exceptionally stressful event, but implicitly labels it as pathological by placing it in the mental disorders chapter. The Working Group regarded such reactions as falling in the normal range, although they could merit clinical attention, and has recommended that acute stress reaction be moved to the ICD-11 chapter containing categories that represent reasons for clinical encounters that are not themselves disorders or diseases (the Z chapter in ICD-10). Humanitarian and other agencies could use this category to allocate immediate psychological assistance to people in need after traumatic events. In the context of many health systems, a diagnostic code in relation to provided health services is necessary, and this proposal is intended to facilitate short-term support without pathologising acute stress reactions.<sup>29</sup>

In conclusion, the Working Group has proposed the following changes from ICD-10: a separate grouping for disorders specifically associated with stress, tighter symptom requirements for PTSD, the addition of complex PTSD and prolonged grief disorder, and the description of adjustment disorder in terms of specific symptoms. Acute stress reaction is classified as a non-pathological response to an exceptional stressor that may require therapeutic intervention.

There are important differences between the proposals for ICD-11 and those for DSM-5, stemming from WHO's emphasis on clinical usefulness. According to the DSM-5 proposal, PTSD is operationalised by 20 symptoms grouped into four clusters, yielding more than 10000 combinations of symptoms by which a person can meet the minimum criteria for PTSD. The ICD-11 PTSD proposal is much simpler, and will be easier for clinicians to use and more feasible in low-resource and humanitarian settings. ICD-11 distinguishes a complex form of PTSD that could follow prolonged or multiple events. The American Psychiatric Association has decided against the inclusion of a separate diagnosis of Complex PTSD in DSM-5 but instead has expanded

PTSD to include additional aspects of disturbed emotionality and behaviour. In contrast with DSM-5, ICD-11 proposes tightening of the diagnostic requirements for adjustment disorder and elimination of the different subtypes. The earlier DSM-5 proposal for bereavement-related adjustment disorder has been withdrawn, leaving the ICD-11 proposal for prolonged grief disorder as the only one focused on pathological consequences of bereavement.

All proposals for ICD-11, including categories, definitions, and diagnostic guidelines, will be made publicly available for review and comment,<sup>30</sup> and will be subjected to field testing. We wish to emphasise that the present proposals represent a starting point, and look forward to a rich global exchange about how best to address problems of nosology in this area and show greater clinical usefulness in diverse global settings, including humanitarian settings after man-made and natural disasters.

#### Contributors

AM, CRB, RAB, MC, GMR, MvO, SW, MBF, and SS were the core writing group. AH, LJ, SAK, AEL, CR, DS, RS, YS, and IW discussed the text and gave feedback to the core writing group.

#### Conflicts of interest

AM, CRB, RAB, MC, AH, LJ, SAK, CR, DS, SCW, and YS are members of the WHO ICD-11 Working Group on the Classification of Disorders Specifically Associated with Stress, reporting to the WHO International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders. GMR, MvO, and SS are members of the WHO Secretariat, Department of Mental Health and Substance Abuse. AEL, RS, IW, and MBF are special invitees to Working Group meetings. However, the views expressed in this article are those of the authors and, except as specifically noted, do not represent the official policies or positions of the International Advisory Group or WHO.

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