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Disorders specifically associated with stress in the ICD-11

Gerrit van Wyk MA Clin Psych, Jane Masson BA (Hons), Bianca Burridge BA (Hons), Aramantha Duffy BA (Hons), Heidi Liebenberg BA (Hons)

Introduction

The ICD-11 is currently due for publication in 2017. In this essay we endeavour to summate what is currently proposed for the classification of stress disorders in the ICD-11, providing a comparative analysis with the classifications of stress disorders in the ICD-10 (published in 1992) and DSM-5 (published in 2013). In doing so, we delineate the reasoning behind the proposed changes and differences in the ICD-11.

It must be noted that this document details the most up-to-date information on the ICD-11 in October 2015, and it is possible that more changes may occur closer to the publication date of the ICD-11, as more research is done guiding the final classifications.

As a precursor to comparisons between ICD and DSM classifications, let us begin with a brief overview of broader differences between these systems. This will later help illuminate how differences in the guiding principles of these overarching systems have influenced differences in the respective systems' diagnoses of stress disorders.

Differences between the ICD and DSM classification systems

The ICD, or International Classification of Disease (ICD) is, as its name suggests, designed for *global* use. Produced by the World Health Organisation (WHO), one of the most key guiding principles for the ICD is globally applicability; and a second essential and concordant guiding principle for the ICD is clinical utility.

While the Diagnostic and Statistical Manual of Mental Disorders (DSM), produced by the American Psychiatric Association, is predominantly used in middle to high income countries, the ICD is aimed to be an easily accessible document in low-income countries, in addition to middle and high income countries. Accordingly, clinical utility and ease of use is given more weight in the ICD than it is in the DSM, which is known to be more research-driven than the ICD.

The DSM is primarily research-oriented, requiring what the chairman of the DSM-5 stress-disorders work group referred to as a "large burden of proof to change any DSM-IV criterion" and is therefore generally more conservative when it comes to diagnostic changes than the ICD (Friedman, 2014: 1). This difference is also bolstered by the fact that the ICD is more poorly resourced than the DSM and has thus not been able to generate the same degree of research data as the DSM.

With this brief background in the differences between the ICD and DSM in mind, let us now turn to the proposed classifications of stress-disorders in the ICD 11, to compare how they differ from those in the DSM-5 and ICD-10.

Stress-disorders in the ICD-11

The ICD-11 workgroup has proposed a new distinct section called “Disorders specifically associated with stress” to separate the diagnoses which specifically require experiencing a stressful event in their aetiology as a prerequisite for a diagnosis.

Diagnoses included in this section are PTSD, Complex PTSD, Adjustment Disorder and Prolonged Grief Disorder. Although both the degree of severity of the stressor and the resulting pathology may differ in magnitude, the mutual notion of an external event having caused the psychiatric symptoms makes these disorders alike (Maercker et al., 2013). By re-grouping these diagnoses according to their commonality it is hoped that the classification and clinical utility of what was previously described as a ‘mixed bag’ of disorders, will be improved (Maercker et al., 2013).

The proposed diagnoses under this umbrella - that is, PTSD, Complex PTSD, Adjustment Disorder, and Prolonged Grief Disorder - will be discussed in turn, explicating the reasons for including new disorders and for not including Acute Stress Disorder under this category. The formulation of the diagnoses proposed for the ICD-11 will also be compared with the diagnostic criteria in the ICD-10 and DSM-5.

1) Post-traumatic stress disorder (PTSD)

Proposals to change the diagnostic composition of PTSD in the ICD-11 were guided by the ICD’s key principals of clinical utility and global applicability as well as several critiques of both the ICD-10 and the DSM-IV PTSD criteria sets. These criteria sets have been criticised for their broadly composed symptom clusters – indeed the DSM-IV criteria set, with its 17 symptoms, can yield more than 10 000 different combinations of the symptoms which could result in a diagnosis (Maercker et al. 2013a). These classifications have also borne high levels of co-morbidity – their symptoms especially overlapping with symptoms of depression and various anxiety disorders (symptoms such as irritability, trouble concentrating, loss of interest, sleep problems) (Stammel, et al., 2015; Stein et al., 2014).

The overuse of previous diagnostic systems’ PTSD criteria in populations afflicted by extreme stressors (such as large scale man-made or natural disasters) is a third major critique (Summerfield, 2001; Stammel, et al., 2015). Critics such as Derek Summerfield (2001) contend that in these populations alleged symptoms of PTSD cannot be differentiated from normal stress responses. This is particularly salient with use of the ICD-10 criteria which exclude significant functional impairment as a necessary requirement for a diagnosis – thus blurring the lines between what can be classified as a normal or pathological stress response and resulting in approximately double the prevalence of PTSD when diagnosing with the ICD-10 in comparison with the DSM-5 (Kilpatrick, 2013).

Accordingly, the ICD-11 work group for disorders specifically associated with stress has tightened the proposed diagnostic criteria for PTSD (Tyrer, 2014). The diagnostic composition for PTSD has been refocused only on a small number of symptoms – six in total, two for each of the three main criteria (re-experiencing, avoidance and perceived current threat). These symptoms were identified as the fundamental characteristics of PTSD;

and other associated symptoms which are present in the ICD-10, DSM-IV and DSM-5, were excluded from the diagnostic criteria (Maercker, et al., 2013b). To quote Andreas Maercker (chair of the ICD-11 stress disorders work group) and his colleagues in their proposal for the diagnostic criteria for PTSD (2013a):

> "The first core element consists of re-experiencing the traumatic event(s) in the present, as evidenced by vivid intrusive memories accompanied by fear or horror, flashbacks, or nightmares. ... The second core element is avoidance of these intrusions, as evidenced by marked internal avoidance of thoughts and memories, or external avoidance of activities or situations reminiscent of the traumatic event(s). The third core element is an excessive sense of current threat, as evidenced either by hypervigilance or by exaggerated startle, two arousal symptoms that tend to cluster together."

This formulation makes diagnosis a lot simpler for clinicians than any previous formulations, as it presents a clear image of the core elements of PTSD and eliminates associated features characteristic of many other mental disorders. Having a less complicated set of diagnostic criteria was a key goal for the work group in order to maximise effective global use (especially use in low income and non-English speaking countries) (Stammel, et al., 2015; O'Donnel, et al., 2014). Moreover, by reducing the diagnostic criteria to only these core elements of PTSD and excluding symptoms that were found to be less important or symptoms which overlapped with other disorders, the ICD-11 proposal will also reduce co-morbidity (Stammel, et al., 2015).

The threshold for obtaining a diagnosis of PTSD has also been increased by stipulating that symptoms must cause significant impairment to an individual's functioning (significantly impairing personal, family, social, educational, occupational or other important aspects of functioning), where, as already mentioned, this condition was absent from the ICD-10 criteria (Maercker, et al., 2013a).

Comparison with the DSM-5

As in the ICD-11, in the DSM-5 PTSD was moved from the Anxiety Disorders category to a new separate stress-related disorders category (Friedman, 2013). However, the six symptom approach used for the ICD-11 PTSD criteria is a stark contrast to the approach used in the DSM-5. The DSM-5 has opted for the opposite strategy of the ICD, providing four very comprehensive symptom clusters, and a total of twenty symptoms which can be typically found (Stammel, et al., 2015).

Three primary reasons explain these very different formulations of the PTSD criteria. Firstly, the differences in approach between the two systems played a large role. As explained in the first section of this paper, while the ICD stresses clinical utility and global applicability, the DSM is primarily research-oriented, requiring a large research backing to change any DSM-IV criterion (Friedman, 2014: 1). It is hardly surprising, therefore, that the DSM-5 did not exclude any of the 17 symptoms making up the DSM-IV criteria (although some were re-formulated). The second reason is the differences in clinical presentation that the ICD-11 and the DSM-5 workgroups decided to focus on. While the ICD-11 workgroup chose to look at PTSD exclusively as a stress-induced fear-based anxiety disorder, the DSM-5 workgroup chose to characterise PTSD in a broader manner – such that the criteria cover

anhedonic/dysphoric, externalising and dissociative phenotypes of the disorder in addition to the original fear-based anxiety disorder (Friedman, 2014).

The third reason accounting for the contrasting narrow and broad approaches is the DSM and ICD's major differences in treatment of Complex PTSD-type symptoms. The ICD-11 will make a major leap in this regard, including Complex PTSD as a separate diagnosis, while the DSM-5 has not. With the high threshold for any changes to the DSM-IV criteria, the DSM-5 workgroup concluded that there was not enough evidence supporting Complex PTSD (or the DSM-IV's variation of this construct, DESNOS) as a separate diagnosis. Instead, the DSM-5 has provided a very comprehensive profile for PTSD; incorporating additional symptoms characteristic of DESNOS/Complex PTSD as well as a new dissociative subtype (Friedman, 2013). In Friedman's (2013) words:

> "...a number of key DESNOS symptoms are now included in the DSM-5 criteria, especially the D cluster (negative cognitions and mood) symptoms such as persistent erroneous blame of self or others, negative expectations about the future, and persistent negative mood. In addition, externalizing behaviors, such as irritable, aggressive, impulsive, self-destructive, and suicidal behavior, now included in the E (hyperarousal and reactivity) cluster, are much closer to DESNOS than was the case with the DSM-IV criteria. Finally, inclusion of the dissociative subtype provides a specific diagnostic niche for individuals who have PTSD as well as some additional dissociative symptoms that are clinically significant."

The DSM-5 criteria for PTSD will thus more fully encompass Complex PTSD than the criteria for the DSM-IV; while the ICD-11 will present two separate narrowly defined diagnoses.

2) Complex PTSD (CPTSD)

The proposal for a Complex PTSD-type classification was first articulated by Herman (1992), who explained the possible effect of protracted traumatic stressors on self-organisation – beyond PTSD symptomotology. Since then there has been controversy over whether or not Complex PTSD should be distinguished as a separate diagnosis. Critics are concerned about the utility of the diagnosis and its distinction from other diagnoses – particularly PTSD and BPD, with which its symptom presentation overlaps (Wolf, et al., 2015). Indeed, it was these reasons which resulted in the workgroup for the DSM-IV excluding their variation of this construct, called "disorders of extreme stress, not otherwise specified" (DESNOS) and the workgroup of the DSM-5 excluding CPTSD (Wolf, et al., 2015). However, in both the DSM-IV and the DSM-5, some DESNOS/CPTSD symptoms are included in the "associated features" section of the PTSD chapter; and, as already mentioned in the previous section, the DSM-5 re-characterised PTSD to more fully encompass CPTSD phenotypes.

In their proposal for changes in stress related disorders in the ICD-11, Maercker and Perkonigg (2013: 2) state that "In the ICD-11 proposal, the clinical utility of a separate complex PTSD diagnosis is regarded as given with the new reduced PTSD definition that focuses on core PTSD symptoms of re-experiencing, avoidance, and hyperarousal." As such, Complex PTSD will be included as a new, distinct classification in the ICD-11, reserved for extensive reactions usually stemming from severe protracted stressors (Maercker, et al., 2013b). Having already included 'Enduring Personality Change After Catastrophic Experience', a diagnosis similar to CPTSD, but included under Personality

Disorders, in the ICD-10, it is less surprising that the ICD-11 will take the leap and include Complex PTSD in its new stress-based section.

The ICD-11 work group argue that CPTSD and Borderline Personality Disorder (BPD) can be distinguished for several reasons (Maercker, et al., 2013a). Firstly, the nature of the constellation of symptoms differ - BPD is strongly characterised by shifting identity and fear of abandonment, while CPTSD does not require fear of abandonment and identity is consistently negative rather than shifting (Maercker, et al., 2013a). There are also differences in the risk of self-harm (far more prevalent in BPD); and BPD does not necessitate the presence of PTSD type symptoms or a precursory traumatic event (both of which are key parts of CPTSD). Moreover, there are differences in the treatments required to work effectively with each disorder (Maercker, et al., 2013a).

The proposed diagnosis of CPTSD in the ICD-11 is comprised of the three core elements of PTSD (re-experiencing, avoidance and perceived current threat) as well as additional disturbances in three domains – affect dysregulation, negative self-concept, and interpersonal difficulties (Maercker, et al., 2013a, b).

In the affect domain, symptoms will include heightened emotional reactivity, lack of emotions, dissociation, violent outbursts and reckless or self-destructive behaviour – all of which stem from difficulties in emotion regulation (Maercker, et al., 2013a). The negative self-concept domain includes symptoms of negative beliefs about oneself (as worthless, diminished or defeated) as well as feelings of shame, guilt, or failure. The interpersonal difficulties domain is primarily exemplified by difficulties feeling close to others, manifesting in avoidance or lack of interest in relationships; or, in the case that the individual occasionally does have close relationships, she/he will have difficulties maintaining those relationships (Maercker, et al., 2013a).

For a diagnosis of CPTSD, individuals need to meet the criteria for a diagnosis of PTSD and in addition display at least one symptom of each of the above additional three domains. While the PTSD symptoms (fear-based reactions) are tied directly to trauma-related stimuli, the three additional Complex PTSD disturbances are pervasive and enduring in nature, appearing in contexts and relationships which are not necessarily bound to trauma-related stimuli (Cloitre, et al., 2013).

Complex PTSD in the ICD-11 will replace the ICD-10 classification of ‘Enduring Personality Change After Catastrophic Experience’ which was often used to describe patients who had experienced prolonged extreme stressors. ‘Enduring Personality Change After Catastrophic Experience’ (EPCACE) failed to attract research interest and was difficult to establish due to its “unclear demarcation from personality disorders” (Maercker & Perkonigg, 2013: 2). EPCACE is described as follows in the ICD-10 (WHO, 1992):

> “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. Post-traumatic stress disorder (F43.1) may precede this type of personality change.”

Being published in 1992, it goes without saying that research on and understanding of Complex PTSD has advanced dramatically over the last 13 years since the ICD-10 was published. As such, several studies over this period have been able to give a far clearer

clinical picture of the disorder – as can be seen when comparing the ICD-11's more comprehensively defined version of CPTSD with the ICD-10's EPCACE.

EPCACE encompasses an overlapping clinical picture with CPTSD in the ICD-11 – including one PTSD-type fear based symptom ("a chronic feeling of "being on edge" as if constantly threatened"), one negative self-concept symptom ("feelings of emptiness or hopelessness") and a few symptoms characteristic of interpersonal difficulties ("a hostile or distrustful attitude toward the world", "social withdrawal", "estrangement"). However, by comparison with CPTSD, interpersonal difficulties are over-emphasised, negative-self concept symptoms under-emphasised and affect dysregulation – integral to the CPTSD phenotype – is barely accounted for. The selection of the these three domains as well as their specific symptoms was guided by extensive research – including most prominently the DSM-IV field trials and a consensus survey on Complex PTSD (Coitre, et al., 2011) in which expert clinicians in the field specified the most frequent and impairing symptoms of the disorder (Cloitre et al., 2011; Cloitre, et al., 2013).

Another major difference between the ICD-10's EPCACE and the ICD-11's CPTSD is the treatment of PTSD. As mentioned above, EPCACE includes only one clear symptom of PTSD but also states that PTSD *may* precede the disorder. By comparison, fully meeting the criteria for PTSD is an essential part of the criteria for CPTSD in the ICD-11. This incorporation of PTSD symptoms as a core component of CPTSD is supported by the data from the DSM-IV field trials, which revealed that almost all individuals in their sample who met the criteria for DESNOS also met the criteria for PTSD (Cloitre, et al., 2013, see Roth et al., 1997).

3) Adjustment disorder (AD)

The ICD-11 classifies adjustment disorder, or AD, as the failure to adapt to a stressful event or life change to the extent that there is a clinically significant impairment in daily functioning (Maercker et al., 2013). The maladaptive response typically begins within a month of the onset of the stressor, and subsides within 6 months or as the result of the removal of the stressful stimulus (Maercker et al., 2013). Symptoms typically involve pervasive preoccupation with the stressor in the form of distressing thoughts and excessive worry (Casey, 2009). As a result, individuals tend to experience a loss of interest in previously pleasurable activities, difficulties concentrating and sleep disturbances, causing disruption to their social and occupational functioning (Maercker et al., 2013). AD specifically focuses on the pathological reaction in response to *common* challenges associated with the normal adaptation process (Casey, 2009). However, a diagnosis does not require consideration of the degree of severity of the stressor, and can be used to describe extreme traumatic distress when the symptoms do not otherwise meet the criteria for PTSD (Maercker et al., 2013)

These diagnostic criteria put forth for AD in the ICD-11 represent a major revision from the ICD-10 (Tyrer, 2014), owing in large part to the long-standing controversy and criticisms surrounding the clinical utility of the disorder in its previous form (Maercker et al., 2013). Specifically, it is proposed that the disorder be re-grouped under the heading "disorders specifically associated with stress", symptom specifications be substantially tightened and the subtypes of AD present in the ICD-10 be omitted (Casey & Doherty, 2012; Tyrer, 2014).

The tightening of AD symptom specifications

AD has been recognized as a psychological diagnosis since the first edition of the DSM in 1952. The disorder has a long history within the ICD system as well, first appearing in the 9th revision in 1978 (Casey & Doherty, 2009). Nevertheless, AD remains one of the most poorly defined mental disorders due to its relative absence of distinctive symptoms (Maercker et al., 2013).

Failing to meet the criteria for another psychiatric condition is core criterion for an AD diagnosis according to the ICD-10, a bar that is set very low given that a diagnosis of major depressive disorder, for example, only requires an individual to experience five symptoms over a two-week period (Casey, 2009). Furthermore, the ICD-10 provides only a very vague description of AD, specifying little besides that the disorder requires exposure to a stressor, and that the symptoms typically dissipate within a 6-month period (Maercker et al., 2013). The DSM specifies a couple of additional requirements for a diagnosis of AD to be made: first, the symptoms must be clinically significant in that they are markedly in excess of an expected or 'normal' reaction to the stressor, and secondly, the symptoms must result in substantial impairment in social or occupational functioning (First, 2009). However, no such requirements are present in the ICD-10. With no assistance provided as to the disposition or pattern of AD symptoms, the boundary between adaptive and maladaptive stress is therefore not delineated so as to accurately distinguish between a normal stress response and a diagnosis of AD (Maercker et al., 2013). Resultantly, the AD diagnosis has come under fire for "medicalising problems of living" (Wilson, 2008:3)

Furthermore, despite the fact that other disorders specifically associated with stress are among the most widely utilized psychiatric classifications worldwide, AD is under recognised by clinicians, (Casey & Doherty, 2012). Recent years have seen AD most commonly used as a provisional or 'fall back' diagnosis for those individuals who display symptoms but do fully satisfy the criteria for an anxiety or depressive disorder (Casey, 2009; Maercker et al., 2013).

The ICD-11 working group has attempted to respond to these problems through substantial tightening of AD symptom specifications. As outlined above, the new ICD-11 proposal focuses on the conceptualization of AD as a maladaptive reaction to a stressful event (Maercker et al., 2013). Furthermore, in order to distinguish AD from a non-pathological stress response, a core requirement of the proposed diagnostic criteria is that the individual is in substantial distress, and that their standard of daily living is significantly impaired (Maercker, Einsle & Kollner, 2007). Specific features of the disorder have been outlined (for example the failure to adapt, ruminating on the stressor, problems sleeping and concentrating and lack of impulse control) to address the controversy surrounding the indefinite symptomatology of AD, and these symptoms must now be present in order for a diagnosis to be made (Maercker et al., 2013).

The omission of AD subgroups

The ICD-10 identifies 7 subtypes of AD, according to the specific pattern of symptoms experienced (Wilson, 2008). However, the ICD-11 working group has recommended the omission of these subtypes on the basis that there exists no evidence for their clinical utility or validity, and that they are not relevant to the prognosis or treatment of the disorder

(Maercker et al., 2013; Wilson, 2008). The use of subtypes is thought to be misleading given that it masks the underlying commonality of the disorder through affording focus only to the central idiom of suffering (Maercker et al., 2013).

4) Acute stress reaction (ASR)

The ICD-11 defines acute stress reaction, or ASR as the emotional, behavioural and psychological symptoms that may develop in response to an extreme traumatic stressor (Maercker et al., 2013). ASR requires exposure to a situation that represents a physical, social, emotional or security-related threat to the individual, such as a natural disaster, rape or assault (Bryant, Friedman, Spiegel, Ursano & Strain, 2010). Following exposure to the stressor, the individual experiences an intense emotional reaction, typically characterized by symptoms such as confusion, sadness anxiety, re-experiencing, avoidance, hyper-arousal and/or numbness (Bryant et al., 2010). These symptoms appear within a few hours or days of the stressor, and generally subside a week later, or as the result of the removal/reversal of the traumatic stimulus (Maercker et al., 2013).

This conceptualization of ASR in the ICD-11 represents a radical departure from that of its predecessor, in that it no longer defines ASR as pathological, and instead frames it as a transient and culturally sanctioned response (Maercker et al., 2013). Rather than being considered indicative of a disorder, ASR symptoms are characterized as within the range of reactions deemed 'normal' in the wake of a catastrophic stressor and it is thought that they will subside within 7 days (Maecker et al., 2013). In light of this new classification of ASR as non-pathological, the ICD-11 working group proposes that it be moved out of the chapter on mental and behavioural disorders, and placed instead in the chapter for other conditions that may be reasons for mental healthcare encounters (Currently the 'Z' code in the ICD-10) (Maercker et al., 2013).

Acute Stress Disorder in the DSM

Existing in parallel to ASR is acute stress disorder (ASD), a diagnosis found in both the DSM-IV and DSM-V. Like ASR, ASD denotes an intense emotional reaction following exposure to a catastrophic stressor. Symptoms are similarly characterized by reliving, avoidance and anxiety, along with the presence of three or more dissociative symptoms (Bryant et al., 2010).

ASD was first introduced in DSM-IV, as a means for describing the symptoms of acute stress that may precede a PTSD diagnosis (Bryant et al., 2010). There is considerable overlap between the ASD and PTSD diagnoses, which only differ significantly in the former's larger emphasis on dissociative symptoms (Bryant et al., 2010). However, since the DSM requires an individual to be symptomatic for a month before a diagnosis of PTSD can be made, the ASD diagnosis was included in an attempt to 'fill the gap' in explaining symptoms during the initial month following a trauma (Spiegel, Koopmen, Cardena & Classen, 1996). ASD symptoms may therefore last for a minimum of two days, and a maximum of four weeks. An additional goal of the ASD diagnosis was to act as a predictor of later PTSD, through identifying those individuals whose symptoms indicate an acute and severe, rather than transient, response to trauma (Spiegel et al., 1996).

In recent years, evidence has largely suggested that ASD does not accurately identify individuals who will go on to develop PTSD (Bryant, 2012; Maercker et al., 2013). For example, a landmark review of over twenty-two studies assessing ASD as a predictor of PTSD found that roughly only half of trauma survivors diagnosed with PTSD met the criteria for ASD during the initial month following the trauma, suggesting that the predictive power of ASD may lack sufficient sensitivity (Bryant, 2012). Nevertheless, the recently released DSM-V has retained the ASD diagnosis. Monetary concerns are thought to be the main reason for this continued inclusion as, in the United States, government funded treatment is not provided for non-disordered individuals (Maercker et al., 2013).

The transition: Acute stress reaction as a non-disordered response

In comparison to the DSM working group, the World Health Organisation, which publishes the ICD, takes the stance that disease definition must be considered separately from issues of healthcare reimbursement and policy (Reed, Dua & Saxena, 2011). The above considerations were therefore deemed insufficient to warrant retaining ASR as a clinical disorder in the ICD-11 (Maercker et al., 2013). Furthermore, the diagnostic criteria for PTSD do not require a minimum time limit in either the ICD-10, or the proposed ICD-11 (Maercker et al., 2013). It is therefore possible to make a diagnosis of PTSD at any time following the occurrence of a traumatic stressor, provided that the symptoms are severe and pervasive enough to meet the diagnostic criteria. This absence of a 'gap of time' in which PTSD cannot be diagnosed, essentially eliminates the need for ASR diagnosis in the ICD (Maercker et al., 2013). The current climate, in which requests are frequently made by clinicians to limit the number of diagnoses present in diagnostic systems (Evans et al., 2013), lends credence to this decision.

5) Prolonged Grief disorder (PGD)

In the category of stress-related disorders, perhaps the most radical change proposed in the forthcoming edition of the ICD is the proposal to include prolonged grief disorder as a new diagnosis (Maercker et al., 2013). Prolonged grief disorder, or PGD, describes a response to bereavement that is abnormally pervasive, debilitating and distressing in nature (Prigerson et al., 2009). The individual experiences impairment in daily functioning; typically characterized by the frequent yearning for, or continuous preoccupation with the deceased, difficulty accepting the loss and feelings of anger, guilt and isolation (Maercker et al., 2009). Most importantly, in order for a diagnosis of PGD to be made the symptoms must persist beyond the time period of grieving deemed normative within the individual's culture (usually around 6 months) (Maercker et al., 2009).

Although clinicians have long been aware of the problems associated with prolonged grief, the inclusion of a related diagnosis in previous editions of the ICD and DSM has been rejected on the grounds that grief is an expected and culturally sanctioned response (Jordan & Litz, 2014). Historically, both classification systems have ignored the notion that grief may be pathological in and of itself, typically focusing instead on delineating between a 'normal' grieving period and a diagnosis of major depressive disorder (Prigerson et al., 2009). In both the ICD-10 and DSM-IV, bereavement has been included only as a possible reason for seeking mental healthcare (Jordan & Litz, 2014).

Evidence supporting the PGD diagnosis

The past two decades have seen a shift towards to rigorous research into the clinical features of prolonged grief (Jordan & Litz, 2014), ultimately resulting in the decision to include prolonged grief disorder in the ICD-11. Whilst the majority of grief-stricken individuals report at least a partial reduction in their symptoms after the 6 month mark, numerous studies have identified a subsection of bereaved individuals with grief symptoms severe and pervasive enough to meet the criteria for a PGD diagnosis (Prigerson et al, 2009; Maercker et al., 2013; Bonnano et al., 2007; Boelen, van den Bout & van den Hout, 2006). Furthermore, research has shown a consistent distinction between 'normal' grief symptoms and prolonged grief symptoms, with only the latter found to be associated with clinically significant impairment (Latham & Prigerson, 2004; Prigerson et al., 2009). Even after controlling for the effects of anxiety and depression, PGD symptoms have been found to be associated with increased suicidal ideations and tendencies, substance abuse, high blood pressure, cardiovascular disorders, cancer and sleep disturbances (Latham & Prigerson, 2004).

Additionally, studies have indicated that the specific symptoms associated with prolonged grief are not adequately described by other ICD and DSM diagnoses (Maercker et al., 2013), pointing to the presence of a distinct condition. For example, yearning for the deceased, a core symptom of PGD, is unrelated to anxiety or depression (Prigerson et al., 2009; Maercker et al., 2013). Cognitions such as being overwhelmed by the loss or wishing to die with one's loved one, have also been found to be specific to PGD (Boelen, van den Bout & van den Hout, 2006). As well as a unique set of symptoms, research has shown PGD to have several distinct clinical correlates, including a history of separation anxiety during childhood, parental abuse, an insecure attachment style and a lack of preparation for the death (Vanderwerker et al., 2006; Johnson et al, 2007).

Prolonged grief in DSM-V

A diagnostic code for prolonged grief problems - Persistent Complex Bereavement-Related Disorder (PCBRD) has been included in the section DSM-V dedicated to emerging measures and models (Boelen & Prigerson, 2012). Whilst it has not yet been formally adopted as a clinical diagnosis, PCBRD has been catalogued for further research and evaluation, with a view towards including it in a later DSM revision (Boelen & Prigerson, 2012). The DSM-V diagnosis of PCBRD overlaps significantly with the PGD diagnosis, but requires the presence of a unique symptom - difficulty positively reminiscing about the deceased, as well as a 12-month symptomatic period before the diagnosis can be made (Jordan & Litz, 2014).

Conclusion

The ICD-11, due to be published in 2017, has proposed many changes to the diagnoses of stress-related disorders seen in the ICD-10 and the DSM-5. The ICD-11 work-group has suggested a separate grouping for stress-related diagnoses, namely 'Disorders specifically associated with stress'. This essay has discussed the proposed formulation of each disorder

incorporated under the new heading, as well as why 'Acute Stress *Reaction'* (the new, un-pathologised version of Acute Stress Disorder) was not included in this category. The discussion of each disorder outlined the proposed diagnostic criteria and analysed how these criteria differed from the ICD-10 and DSM-5.

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