



World Health Organization

# **Trauma and Stress-Related Disorders: Developments for ICD-11**

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**and materials prepared and provided by Geoffrey Reed, PhD,  
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## Continuing Medical Education Commercial Disclosure Requirement

- I, Andreas Maercker, have the following commercial relationships to disclose:
  - Aardorf Private Psychiatric Hospital, Switzerland, advisory board
  - Springer, book royalties

# Members of the Working Group

- Christopher Brewin (UK)
- Richard Bryant (AU)
- Marylene Cloitre (US)
- Asma Humayun (PA)
- Lynne Myfanwy Jones (UK/KE)
- Ashraf Kagee (ZA)
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- Dayanandan Somasundaram (LK)
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## Organizational representatives

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- Renato Olivero Souza (ICRC)
- Inka Weissbecker (Intern. Medical Corps)

## WHO scientists and consultant

- Geoffrey Reed
- Mark van Ommeren
- Michael B. First

# WHO Constituencies

## 1. Member Countries

- Required to report health statistics to WHO according to ICD
- ICD categories used as basis for eligibility and payment of health care, social, and disability benefits and services

## 2. Health Workers

- Multiple mental health professions
- ICD must be useful for front-line providers of care in identifying and treating mental disorders

## 3. Service Users

- ‘Nothing about us without us!’
- Must provide opportunities for substantive, early, and continuing input

# ICD Revision Orienting Principles

1. Highest goal is to help WHO member countries **reduce disease burden of mental and behavioural disorders:** relevance of ICD to public health
2. Focus on **clinical utility:** facilitate identification and treatment by global front-line health workers
3. Must be undertaken in **collaboration with stakeholders:** countries, health professionals, service users/consumers and families
4. Integrity of the ICD classification system depends on its **independence from pharmaceutical and other commercial influence**

## Key Goal for ICD-11

To serve as a vehicle for reducing the treatment gap by **facilitating accurate identification and more effective treatment** of people with mental health needs at the point **where they are most likely to come into contact with the health care system**

# **Key Characteristics of Revision Process**

- **Global & Multilingual**
- **Multidisciplinary**
- **Clinical utility first**
- **Transparent**
- **Independent of conflicts of interest**

# Global and Multilingual Development

- To create a more open and representative process
- To enable active participation of non-Anglophone scientists and practitioners
- To identify and manage a range of linguistic issues important in the development of a global classification



# Multidisciplinary: Importance of Primary Care

- Worldwide, University educated professionals (psychiatrists, psychologists) provide only a tiny proportion of mental health services
- When people with mental disorders do receive treatment, they are far more likely to receive it in primary care settings
- Mental health specialists alone cannot address treatment gap
- A primary focus of the ICD revision is to provide a **version of ICD-11 mental disorders classifications that is feasible and clinically useful for primary care settings**

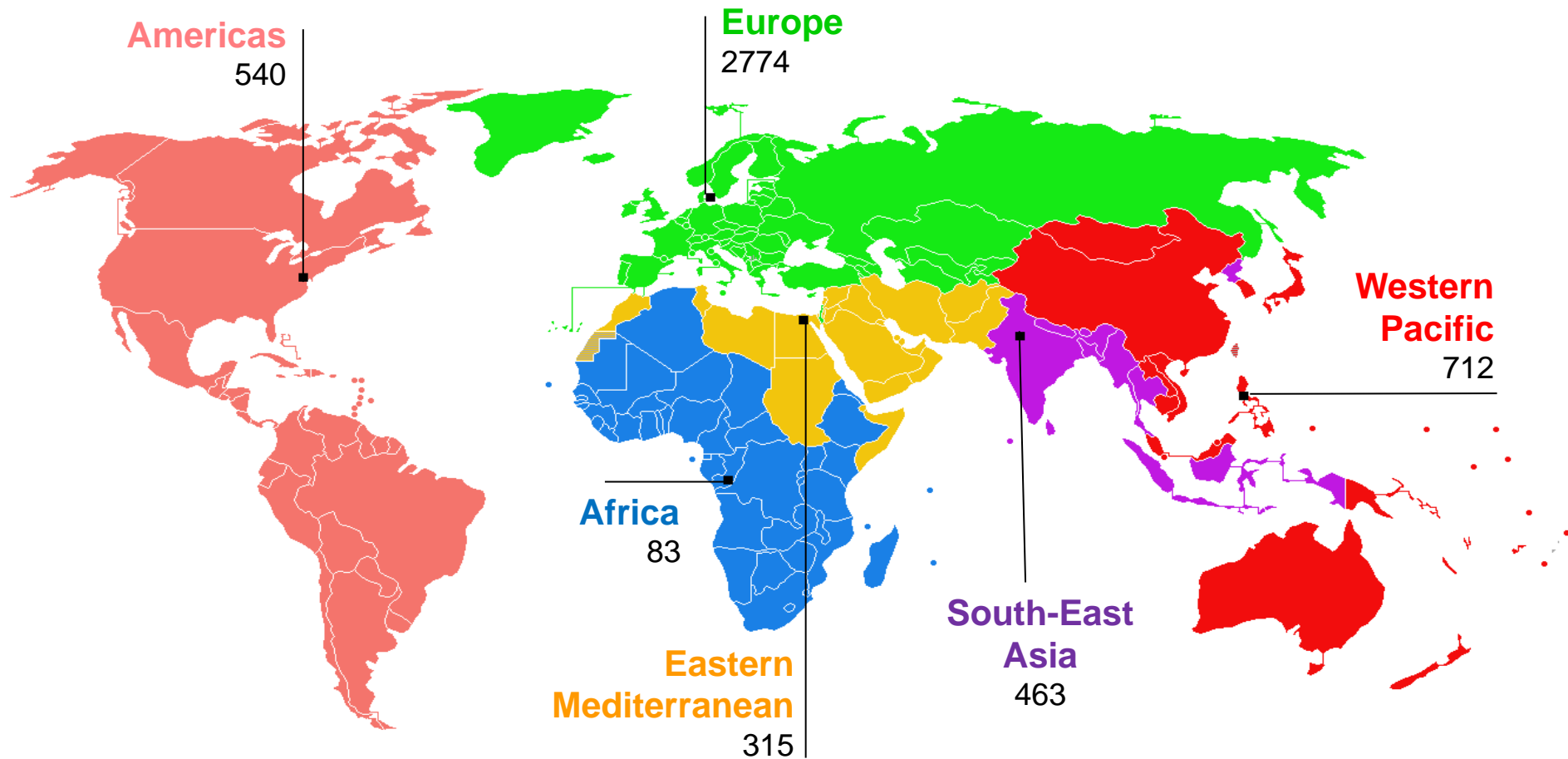
# Clinical Utility as Organizing Principle

- The ideal: scientific validity **and** clinical utility
- At present, neuroscience and genetics evidence does not support major changes for individual conditions or provide definitive support for specific structure
- WHO views current revision as major opportunity to improve **utility** of the system

# Process of Drafting

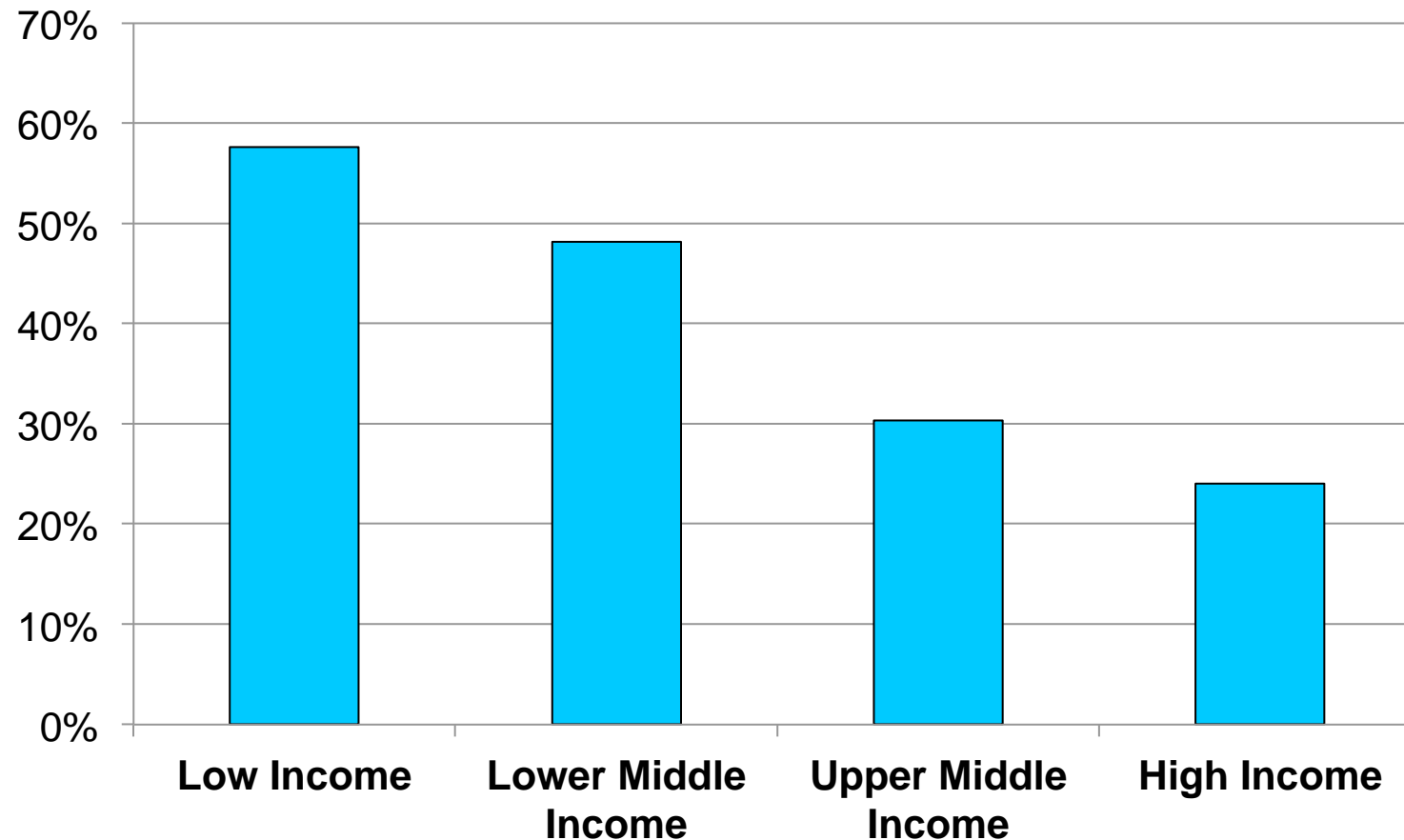
- **Review** global scientific literature, particularly in low and middle-income countries
- **Analyze** country and regional modifications
- **Examine** existing use and current practice
- **Assess** user opinions and experience (regional meetings, surveys)
- **Conduct** field studies

# Preparatory Surveys on Psychiatrists and Psychologists



**Psychiatrists (WPA-study): 4887; Psychologists (IUPsyS-study): 4675**

# Online Response Rate by Country Income Level



# Most frequently used diagnoses across ICD-10 internationally

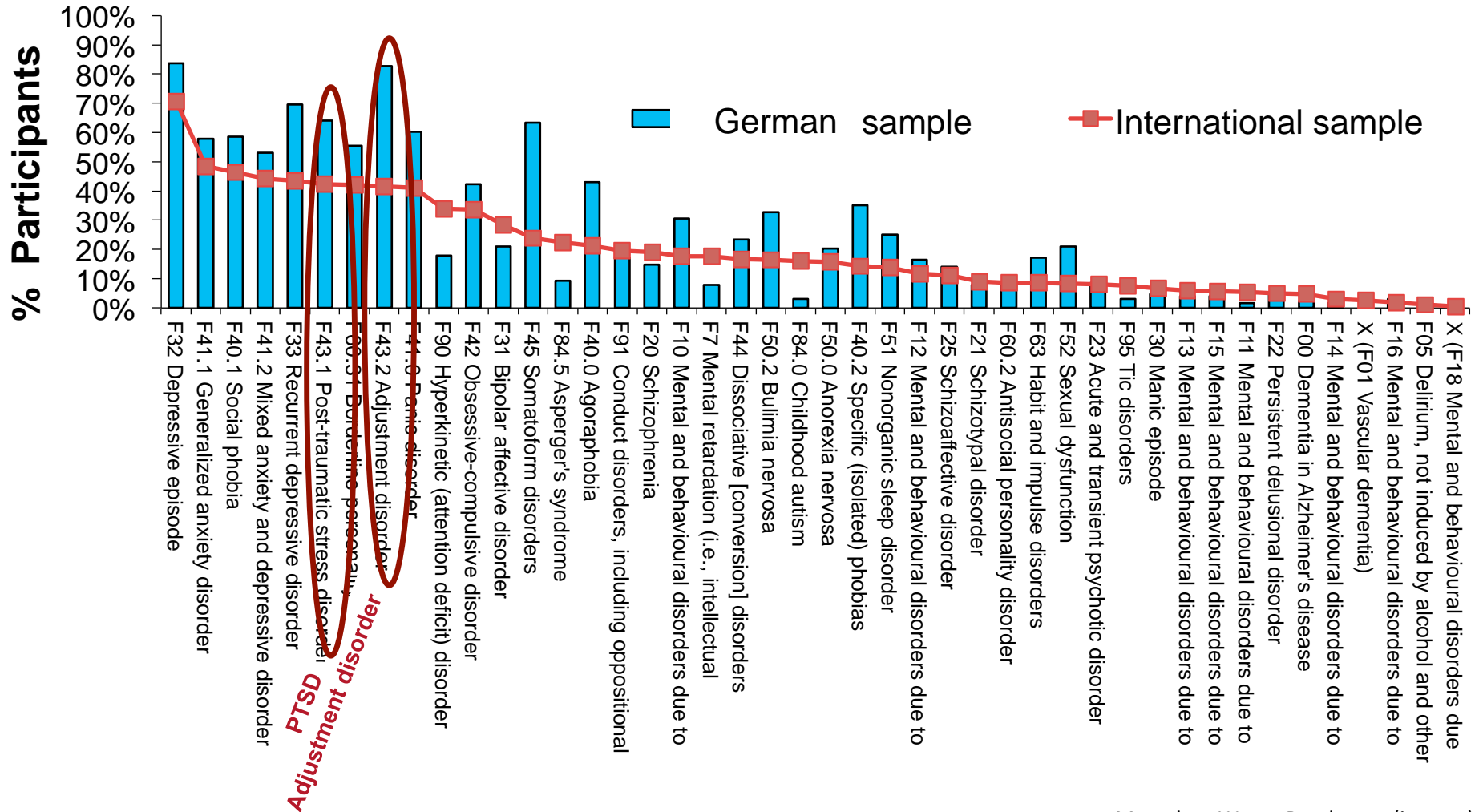
Q21 - 'Of the ICD-10 diagnostic categories listed below, please indicate which ones you use once a week or more in your day-to-day clinical practice.'



Adjustment disorder

PTSD

# Most frequently used diagnoses across ICD-10 German Clinical Psychologists



# Task: Integration of relevant disorders

## ICD-10

### F43

- Acute Stress Reaction
- Posttraumatic Stress Disorder (PTSD)
- Adjustment Disorders (7 subtypes)

### F62.0

- Enduring personality change after traumatic experiences

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### F94


- Reactive attachment disorder in childhood
- Disinhibited attachment disorder in childh.

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### Z63.4

- Death of family member

## ICD-11



one new category:  
Disorders specifically associated  
with stress



# Key questions

- How should the **stressor or trauma criterion** for Post-Traumatic Stress Disorder and Acute Stress Reaction be revised?
- Should the diagnosis “**Enduring Personality Changes after Catastrophic Experience**” be preserved? And/or should the proposed diagnose Complex PTSD be included?
- Should the proposed diagnose **Prolonged Grief Disorder** be included?
- Can Adjustment Disorder be conceptualized as a stress-response syndrome based on **positive symptoms**?

# **Review of scientific literature:**

## **Paper in PubMed (at beginning of term)**

- **PTSD: 5424**
  - **Adjustment disorders: 292**
  - **Acute stress reaction: 236**
  - **Enduring personality change after catast. experiences: 13**
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- **Prolonged (complicated) grief disorder: 211**
  - **Complex PTSD: 40**
  - **Developmental trauma disorder: 3**

# Beta Version Proposal (May 2012)

Sorting Label and Proposed ICD-11 Category Name	ICD-10 Code(s)	ICD-10 Category Name(s)
<b>05 F DISORDERS SPECIFICALLY ASSOCIATED WITH STRESS</b>	F43 + F62.0 + parts of F94	Reaction to severe stress, and adjustment disorders
05 F 00 Traumatic stress disorders	F43.1 + F62.0	New grouping
05 F 00 0 Post-traumatic stress disorder	F43.1	Post-traumatic stress disorder
05 F 01 1 Complex post-traumatic stress disorder	F62.0	Enduring personality change after catastrophic experience
05 F 01 Prolonged grief disorder	--	New category
05 F 02 Adjustment disorder	F43.2	Adjustment disorders
05 F 03 Attachment disorders	Parts of F94	New grouping
05 F 03 0 Reactive attachment disorder	F94.1	Reactive attachment disorder of childhood
05 F 03 1 Disinhibited social engagement disorder	F94.2	Disinhibited attachment disorder of childhood
<b>Z Xx y Acute Stress Reaction</b>	<b>Z63.4</b>	<b>Reorganization</b>

# Participate in upcoming ICD-11 Field Studies

All of you are kindly asked to

- sign up to participate in the Global Practice Network for internet-based field studies; **available now** in English, Spanish, French, Japanese, Arabic
- First internet-based study to focus on disorders specifically associated with stress; participation of ISTSS members highly important
- Provide individual comments on initial proposals to be posted on WHO website by December 2012; will be updated as proposals are modified, comment to be taken throughout revision process
- Participate in clinic-based evaluative field studies beginning early 2013
- Once registered in the GCPN, you will receive survey requests ***no more than once a month***, and each survey will take ***approximately 20 minutes*** to complete.
- For more information:

**Spencer Evans: [evanss@who.int](mailto:evanss@who.int)**



International society for traumatic stress studies 28<sup>th</sup> meeting  
November 1-3, 2012, Los Angeles, USA

## Major conceptual change of acute stress reaction

Yuriko Suzuki

National Center of Neurology and Psychiatry

National Institute of Mental Health



International Society  
for Traumatic Stress Studies

**ISTSS 28th  
Annual Meeting**

**Beyond Boundaries:**  
Innovations to Expand Services and  
Tailor Traumatic Stress Treatments

**November 1 – 3, 2012**

Pre-Meeting Institutes, October 31, 2012

JW Marriott Los Angeles at L.A. Live • Los Angeles, CA USA



## Continuing Medical Education Commercial Disclosure Requirement

I, Yuriko Suzuki, have no commercial  
relationships to disclose.

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- ▶ The presenter is a member 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.
  - ▶ However, the views expressed in this presentation are those of the authors and, except as specifically noted, do not represent the official policies or positions of the International Advisory Group or the World Health Organization.

# Topics

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1. Current definition of Acute Stress Reaction (ASR) in ICD-10
2. Problems of Acute Stress Reaction in ICD-10  
Difference between ASR and ASD
3. Proposed definition of Acute Stress Reaction
4. F code or Z code: Pathological/normal reaction
5. Timeframe issue
6. Differential diagnosis



# 1. Current definition of ASR in ICD-10

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- ▶ Exposure to an exceptional mental or physical stressor
- ▶ Immediate onset of symptoms (within one hour)
- ▶ Variety of symptoms, but fugue, daze and dissociation is described as typical symptom
- ▶ If the stressor is transient or can be relieved, the symptoms must begin to diminish after not more than eight hours. If the stressor continues, the symptoms must begin to diminish after not more than 48 hours.
- ▶ Synonyms:
  - ▶ acute crisis reaction
  - ▶ combat fatigue
  - ▶ crisis state
  - ▶ psychic shock

## 2. Problems of ASR in ICD-10

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- ▶ The transient reaction is the normative immediate reaction in some people to exceptional stress.
- ▶ A need for a **non-pathological** category to define those who present as help seekers with a wide variety of transient emotional and somatic reactions in the immediate aftermath of acute stressful events.
- ▶ Recent concern that the normal emotional reactions overly taken as pathology in the wake of disaster mental health intervention.
- ▶ Limited clinical utility due to the narrow timeframe: it is unlikely that people with the condition which will naturally recover within few days seek for medical help.
- ▶ Limited evidence-base



# Difference between ASR and ASD

	<b>Acute stress reaction (ICD)</b>	<b>Acute stress disorder (DSM)</b>
Aim	Management of acute reactions	Early detection and intervention of PTSD
Cause	Various stressors	Traumatic experience (Event criteria )
Duration	48hours, natural recovery is expected in due course	2 days to 4 weeks
Function	Not mentioned	Necessary for diagnosis

What is known:

- Originally, ASD was defined to promote early detection and intervention of PTSD.
- However, reviews of the extensive research on ASD have cast doubt on the notion that ASD is a good predictor of later PTSD (Bryant et al., 2011), because many cases do not meet the dissociation criteria.



### 3. Proposed definition of ASR (1)

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- ▶ A transient normative reaction, given the severity of the stressor
- ▶ In response to exceptional physical and/or mental stress. Clear and direct temporal association should be present between the extreme stressful event and reaction.
- ▶ E.g. natural catastrophe, accident, battle, criminal assault, rape), or an unusually sudden and threatening change in the social position and/or network of the individual, such as multiple bereavement

### 3. Proposed definition of ASR (2)

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- ▶ The symptoms show great variation, but do not meet the definitional requirements of a mental disorder.
    - ▶ Symptoms include being in daze, a sense of confusion, sadness, anxiety, anger, despair, overactivity, cessation of activity and social withdrawal. Autonomic signs of panic anxiety (tachycardia, sweating, flushing) are commonly present and may be the presenting feature.
  - ▶ The symptoms usually appear within hours to days of the impact of the stressful stimulus or event, and should begin to subside within a week.
  - ▶ Functioning fully recovers within four weeks of the stressor ceasing.
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## 4. F code or Z code: Pathological/normal reaction

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- ▶ Z code sends message that this is a normative and common reaction but not universal.
- ▶ Placement of acute stress reaction in Z code would allow public health care workers to be trained to recognize and assist those with such reactions, without the deleterious consequences that could follow from pathologizing them.
- ▶ Such reactions often benefit from practical social interventions rather than medical ones (e.g., psychological first aid) .



## 5. Timeframe issue (1)

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- ▶ They appear within hours to days of the impact of the stressful stimulus or event and begin to subside within a week after exposure, or following removal from the threatening situation in cases where this is possible.
- ▶ Where the stressor continues or cannot by its nature be reversed, the symptoms may persist but are usually greatly attenuated within approximately one month.



## 5. Timeframe issue (2)

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- ▶ The timeframe helps to distinguish acute stress reactions from pathological reactions that may predict more severe disorder.
- ▶ If symptoms do not begin to diminish within about a week after their onset, consideration should be given to a diagnosis of adjustment disorder or post-traumatic stress disorder.



# 6. Differential diagnosis

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## ▶ PTSD

- ▶ the reactions persist beyond several weeks and are characterized by re-experiencing the trauma, avoidance behavior and hyperarousal, resulting in substantial functional impairment.

## ▶ Adjustment Disorders

- ▶ Usually related to stressors of lesser severity than those that precipitate Acute Stress Reaction.
- ▶ Adjustment disorder should be diagnosed when the specific reactions persist beyond several weeks and are characterized by ongoing preoccupation with the stressor and failure-to-adapt symptoms (e.g., concentration difficulties, sleeping problems).

## ▶ Dissociative disorders

- ▶ Dissociative disorders are distinguished from acute stress reaction in that the dissociative symptoms persist over the longer term and include marked symptoms of amnesia, fugue, or stupor.



# Summary

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- ▶ Acute stress reaction is to be situated in Z code to make it clear that the transient reaction is the normative immediate reaction in some people to exceptional stress.
- ▶ With the proposed ASR, there is a departure from ASD in DSM because the extensive research on ASD have cast doubt on the utility of ASD as a predictor of later PTSD.
- ▶ Recently there are growing concern that the normal emotional reactions overly taken as pathology in the wake of disaster mental health intervention.
- ▶ The timeframe helps to distinguish acute stress reactions from pathological reactions that may predict more severe disorder, such as PTSD, adjustment disorder.
- ▶ More evidence on the proposed definition and utility in relation to practical services are awaited.

# Prolonged Grief Disorder

Ashraf Kagee, Stellenbosch University

Richard Bryant, University of New South Wales

Lynne Jones, Harvard University

# Prolonged Grief Disorder

- A new category
- A disorder specifically associated with stress
- **Synonyms: Complicated grief (disorder); traumatic grief (disorder); bereavement-related disorder; unresolved grief; prolonged grief; unresolved grief; pathological grief.**

# Definition

- Beyond 6 months of the death of a person close to the bereaved, there is severe and pervasive yearning or longing for the deceased, or a persistent preoccupation with the deceased or the death.
- Symptoms may also include difficulty in accepting the death, feeling they have lost a part of their self, anger about the loss, guilt, blame, or difficulty in engaging with social or other activities, as well as crying spells.
- The persistent grief response is beyond expected social or cultural norms, and causes significant disruption to the person's functioning.

# Diagnostic Guidelines

- The person has experienced bereavement following the death of a close other person
- There is persistent and severe separation distress that is characterized by yearning, sadness, or longing for the deceased and associated emotional pain or there is a persistent preoccupation with the circumstances of the death .

# Diagnostic guidelines

The person may also experience

- Bitterness about the loss
- Difficulty accepting the loss
- Reduced sense of self or identity (e.g., feeling a part of oneself has died)
- Avoidance of reminders of the loss

# Diagnostic guidelines

- Inability to trust other people
- Difficulty progressing with activities or developing friendships
- Feeling that life is meaningless
- Preoccupation with the circumstances of the death



# Diagnostic guidelines

- Numbness (absence of emotion since the loss)
- Negative appraisals of his or her ability to cope without the loved one, difficulties in recalling positive memories of the deceased, an inability to experience positive mood.
- Patients may oscillate between excessive preoccupation with the deceased and avoidance of reminders of the deceased.

# Diagnostic guidelines

- The severe grief responses persist for at least 6 months following the death.
- The persistent grief reactions interfere with normal functioning
- The persistent grief reactions are beyond the normative response within the cultural context.

# Risk factors

- A history of childhood separation anxiety
- Controlling parents
- Parental abuse or death
- A close kinship relationship to the deceased (e.g., parents)
- Insecure attachment styles
- Dependency on the deceased
- Lack of preparation for the death
- Inability to perform appropriate funeral rites
- Absence of body as actual risk factors for PGD.

# Other basis specification

- Converging evidence of a distinct syndrome characterized by persistent grieving for a deceased person and marked social, psychological, and medical impairments.
- Minimum duration of 6 months since the death of the deceased person is based on numerous studies indicating this timeframe is predictive of longer-term dysfunction.

# Other basis specification

- Constellation of symptoms has been observed to form a syndrome that is distinct from depression and anxiety.
- The construct of PGD has been observed across cultures.

# Other basis specification

- The symptoms of PGD not responsive to pharmacological or psychological treatments for depression
- They are responsive to psychological treatments specifically targeted towards symptoms of PGD.

# Functional properties

- Symptoms are of a level of severity that they limit the person's capacity to engage in social or other activities.
- The symptoms are associated with impairment in social activities in particular because of excessive reliance on the deceased.
- This symptom in the definition also promotes separation between normal and persistent grief response.

# Temporal Qualifier

- Not to be diagnosed within 6 months of the bereavement.
- Convergent evidence attests to 6 months being the most common timeframe that distinguishes normal grief responses and those that are predictive of long-term persistent grief reactions that are associated with health, psychological, and social impairment.



# Severity Qualifier

- Many bereaved people will experience grief reactions beyond 6 months after the bereavement, especially on anniversaries of the death or other significant dates in the deceased person's life (e.g., birthday).
- PGD is only diagnosed when grief reactions are both severe to the point of interfering with one's capacity to function and persistent over time.

## PGD is distinguished from:

- Major Depressive Disorder by emphasis on yearning for deceased, absence of features of psychotic depression, and psychomotor retardation.
- Posttraumatic stress disorder by emphasis on the loss of the deceased rather than fear or horror of traumatic event.

- **Major depression**

Pervasive sad mood

Pervasive sense of guilt

Rumination about past failures or misdeeds

- **Complicated grief**

Sadness related to missing the deceased

Guilt focused on interactions with the deceased

Preoccupation with positive thoughts of the deceased; Intrusive images of the person dying; Avoidance of situations and people related to reminders of the loss.

- **PTSD**

Triggered by physical threat.

Primary emotion is fear.

Nightmares are common.

Painful reminders linked to traumatic event.

## **Complicated grief**

Triggered by loss.

Primary emotion is sadness.

Nightmares are rare.

Painful reminders more pervasive and unexpected.

Yearning and longing for person who has died.

# Differentiation from Normality

- Most people will display marked grief symptoms following the death of someone close to them. This is considered a normal response.
- Prolonged Grief Disorder should only be diagnosed if the requisite symptoms are persisting in a significantly distressing manner more than 6 months after the death, and these reactions are impairing their capacity to function.

# Developmental Presentations

- In children the loss of a primary attachment figure (e.g., parent, caregiver) can be perceived as traumatic and may lead to distressing memories/fantasies of the deceased.
- Yearning may be expressed in play and behavior, including behaviours that involve separation themes.

# Culture-Related Features

- Diagnosis needs to recognize culturally-appropriate norms of grieving, and interpretation of prolonged abnormal responses should only be made if the response is aberrant from the cultural norm.

# Culture-Related Features

- In most cultural contexts there are specific rituals to deal with death and grief, including funeral ceremonies. Inability or non-performance of these rituals or ceremonies can lead to prolonging of the grief, complications and guilt.



# Culture-Related Features

- Absence of bodies to perform last rites or lack of closure due to uncertain death such as after disappearance can lead to prolonged grief.

# Comparison with DSM V

- ICD 11: **Beyond 6 months of the death** of a person close to the bereaved, there is severe and pervasive yearning or longing for the deceased, or a persistent preoccupation with the deceased or the death.
- DSM V: The individual experienced the death of a close family member or close friend **at least 12 months ago**. Symptoms are experienced more days than not and to a clinically significant degree.

# **Redefining Adjustment Disorder**

**Asma Humayun, Islamabad, for the**

**Working group ICD 11:**

**Disorders specifically associated with stress**

# ICD 10..

## Adjustment Disorder

is among the most widely used diagnosis  
amongst psychiatrists worldwide

*Reed GM, Correia JM, Esparza P, Saxena S, Maj M. The WPA-WHO Global Survey of Psychiatrists' Attitudes Towards Mental Disorders Classification. World Psychiatry. 2011;10(2):118-31.*

## Some concerns about ICD 10 definition are:

1. AD is an ill-defined disorder (often described as “waste-basket” of the psychiatric classification scheme)
2. The required presence of these preceding events and the thematic links between the events and the symptoms is missing

### *References:*

1. Baumeister H, Maercker A, Casey P. Adjustment Disorder with Depressed Mood. *Psychopathology*. 2009;42(3):139-47.
2. Strain JJ, Diefenbacher A. He adjustment disorders: the conundrums of the diagnoses. *Compr Psychiat*. 2008;49(2):121-30.
3. Semprini F, Fava GA, Sonino N. The Spectrum of Adjustment Disorders: Too Broad to be Clinically Helpful. *CNS Spectr*. 2010;15(6):382-8.

3. AD has been mostly used as a 'residual category' for patients who do not meet the diagnostic criteria for depressive or anxiety disorders, or as a provisional diagnosis when it is not clear whether or not a posttraumatic or mood disorder will emerge

***References:***

1. *Reed GM, Correia JM, Esparza P, Saxena S, Maj M. The WPA-WHO Global Survey of Psychiatrists' Attitudes Towards Mental Disorders Classification. World Psychiatry. 2011;10(2):118-31.*
2. *Stein DJ, Seedat S, Iversen A, Wessely S. Post-traumatic stress disorder: medicine and politics. Lancet. 2007;369(9556):139-44.*

## Main points of the proposal include:

- 1 Use an evidence based framework to link AD as part of the spectrum of stress response i.e., from normal adaptation to more complex pathological responses.
- 2 Describe the role of the stressor
- 3 Outline specific criteria based on stress responses without restricting its clinical use
- 4 Review the clinical utility of its sub-types
- 5 Define bereavement related presentations as a separate category (thereby excluding it from AD)

## Role of stressor

AD is described **in continuity with normal adaptation processes** but to differentiated from them by the associated intensity of distress and impairment.

It is a **transient disorder** which usually emerge within a month of the stressor and tends to resolve in 6 months unless the stressor persists for a longer duration

The **severity of stressor is not a consideration** for diagnosis but AD may result from extreme traumatic events when symptoms do not meet the criteria for PTSD.

The presentation of AD might be influenced by the nature of the stressor event (e.g., single, repeated cumulative or long-term events) or previous experiences



## New specific criteria based on stress responses

AD is characterized by symptoms of:

**Preoccupation** like excessive worry, recurrent and distressing thoughts or constant rumination. The distress worsens with any reminder of the stressor(s). The person often avoids stimuli, thoughts, feelings or discussions associated with the stressor(s).

There is **failure to adapt** with loss of interest in work, social life, caring for others, leisure activities. The individual might have difficulty in concentrating, sleeping or engaging in familiar activities.

other **broad range of clinical presentations** include symptoms of anxiety, depression or impulse control problems e.g., acting out or risk of substance abuse. Impulsivity may even endanger the person security because of self-harm or suicidality. None of these symptoms is of sufficient severity or prominence in its own right to justify a more specific diagnosis.

## Sub types:

1. There is no evidence for the clinical utility of the sub-types in ICD-10; the characteristic feature is often the mixture of emotional/behavioral symptoms. The over-specified characteristic of a mental disorder only adds to complexity of a diagnostic system.

*(Reed GM. Toward ICD-11: Improving the Clinical Utility of WHO's International Classification of Mental Disorders. Professional Psychology: Research and Practice 2010, Vol. 41, No. 6, 457–464)*

2. Although internalizing or externalizing symptoms may predominate, they often coexist. Introducing subtypes may put the emphasis on the dominant idiom of distress and may be partially misleading. Subtypes are not helpful in terms of treatment and are not associated with a specific prognosis.

*(Beltran RO, Llewellyn GM, Silove D. Clinicians' understanding of International Statistical Classification of Diseases and Related Health Problems, 10th Revision diagnostic criteria: F62.0 enduring personality change after catastrophic experience. Compr Psychiat. 2008;49(6):593-602)*

## Summary definition

Adjustment disorder is a maladaptive reaction to identifiable psychosocial stressor(s) or life change(s). It is characterized by preoccupation with the stressor and failure to adapt, as exhibited by a range of symptoms interfering with everyday functioning, such as difficulties concentrating or sleep disturbance. Symptoms of anxiety, depression, or impulse control/conduct problems are commonly present. The symptoms emerge within a month of the onset of the stressor(s) and tend to resolve in 6 months unless the stressor persists for a longer duration. It causes significant distress and impairment of social or occupational functioning.

## ICD 11 - Adjustment Disorder

1. Specific criteria based on stress responses
2. No subtypes
3. Symptoms appear within a month of the stressor
4. It must cause significant distress and impairment of social/ occupational functioning
5. Bereavement related disorder is a separate category

## DSM 5 – Adjustment Disorders

**Unspecified** behavioural & emotional symptoms

**With** subtypes (unclearly based on psychopathology + aetiology+ other diagnosis)

Symptoms appear within **3** months of the stressor

It must cause significant distress **and/or** impairment of social/ occupational functioning

**Bereavement** is included in this category