

# Trauma- and Stressor-Related Disorders

Trauma- and stressor-related disorders include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. These include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders. Placement of this chapter reflects the close relationship between these diagnoses and disorders in the surrounding chapters on anxiety disorders, obsessive-compulsive and related disorders, and dissociative disorders.

Psychological distress following exposure to a traumatic or stressful event is quite variable. In some cases, symptoms can be well understood within an anxiety- or fear-based context. It is clear, however, that many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety- or fear-based symptoms, the most prominent clinical characteristics are anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms. Because of these variable expressions of clinical distress following exposure to catastrophic or aversive events, the aforementioned disorders have been grouped under a separate category: *trauma- and stressor-related disorders*. Furthermore, it is not uncommon for the clinical picture to include some combination of the above symptoms (with or without anxiety- or fear-based symptoms). Such a heterogeneous picture has long been recognized in adjustment disorders, as well. Social neglect—that is, the absence of adequate caregiving during childhood—is a diagnostic requirement of both reactive attachment disorder and disinhibited social engagement disorder. Although the two disorders share a common etiology, the former is expressed as an internalizing disorder with depressive symptoms and withdrawn behavior, while the latter is marked by disinhibition and externalizing behavior.

## Reactive Attachment Disorder

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### Diagnostic Criteria

**313.89 (F94.1)**

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- A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
  - 1. The child rarely or minimally seeks comfort when distressed.
  - 2. The child rarely or minimally responds to comfort when distressed.
- B. A persistent social and emotional disturbance characterized by at least two of the following:
  - 1. Minimal social and emotional responsiveness to others.
  - 2. Limited positive affect.
  - 3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.
- C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
  - 1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.

2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
  3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
- D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).
- E. The criteria are not met for autism spectrum disorder.
- F. The disturbance is evident before age 5 years.
- G. The child has a developmental age of at least 9 months.

*Specify if:*

**Persistent:** The disorder has been present for more than 12 months.

*Specify current severity:*

Reactive attachment disorder is specified as **severe** when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

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## Diagnostic Features

Reactive attachment disorder of infancy or early childhood is characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance. The essential feature is absent or grossly underdeveloped attachment between the child and putative caregiving adults. Children with reactive attachment disorder are believed to have the capacity to form selective attachments. However, because of limited opportunities during early development, they fail to show the behavioral manifestations of selective attachments. That is, when distressed, they show no consistent effort to obtain comfort, support, nurturance, or protection from caregivers. Furthermore, when distressed, children with this disorder do not respond more than minimally to comforting efforts of caregivers. Thus, the disorder is associated with the absence of expected comfort seeking and response to comforting behaviors. As such, children with reactive attachment disorder show diminished or absent expression of positive emotions during routine interactions with caregivers. In addition, their emotion regulation capacity is compromised, and they display episodes of negative emotions of fear, sadness, or irritability that are not readily explained. A diagnosis of reactive attachment disorder should not be made in children who are developmentally unable to form selective attachments. For this reason, the child must have a developmental age of at least 9 months.

## Associated Features Supporting Diagnosis

Because of the shared etiological association with social neglect, reactive attachment disorder often co-occurs with developmental delays, especially in delays in cognition and language. Other associated features include stereotypies and other signs of severe neglect (e.g., malnutrition or signs of poor care).

## Prevalence

The prevalence of reactive attachment disorder is unknown, but the disorder is seen relatively rarely in clinical settings. The disorder has been found in young children exposed to severe neglect before being placed in foster care or raised in institutions. However, even in populations of severely neglected children, the disorder is uncommon, occurring in less than 10% of such children.

## Development and Course

Conditions of social neglect are often present in the first months of life in children diagnosed with reactive attachment disorder, even before the disorder is diagnosed. The clinical features of the disorder manifest in a similar fashion between the ages of 9 months and 5 years. That is, signs of absent-to-minimal attachment behaviors and associated emotionally aberrant behaviors are evident in children throughout this age range, although differing cognitive and motor abilities may affect how these behaviors are expressed. Without remediation and recovery through normative caregiving environments, it appears that signs of the disorder may persist, at least for several years.

It is unclear whether reactive attachment disorder occurs in older children and, if so, how it differs from its presentation in young children. Because of this, the diagnosis should be made with caution in children older than 5 years.

## Risk and Prognostic Factors

**Environmental.** Serious social neglect is a diagnostic requirement for reactive attachment disorder and is also the only known risk factor for the disorder. However, the majority of severely neglected children do not develop the disorder. Prognosis appears to depend on the quality of the caregiving environment following serious neglect.

## Culture-Related Diagnostic Issues

Similar attachment behaviors have been described in young children in many different cultures around the world. However, caution should be exercised in making the diagnosis of reactive attachment disorder in cultures in which attachment has not been studied.

## Functional Consequences of Reactive Attachment Disorder

Reactive attachment disorder significantly impairs young children's abilities to relate interpersonally to adults or peers and is associated with functional impairment across many domains of early childhood.

## Differential Diagnosis

**Autism spectrum disorder.** Aberrant social behaviors manifest in young children with reactive attachment disorder, but they also are key features of autism spectrum disorder. Specifically, young children with either condition can manifest dampened expression of positive emotions, cognitive and language delays, and impairments in social reciprocity. As a result, reactive attachment disorder must be differentiated from autism spectrum disorder. These two disorders can be distinguished based on differential histories of neglect and on the presence of restricted interests or ritualized behaviors, specific deficit in social communication, and selective attachment behaviors. Children with reactive attachment disorder have experienced a history of severe social neglect, although it is not always possible to obtain detailed histories about the precise nature of their experiences, especially in initial evaluations. Children with autistic spectrum disorder will only rarely have a history of social neglect. The restricted interests and repetitive behaviors characteristic of autism spectrum disorder are not a feature of reactive attachment disorder. These clinical features manifest as excessive adherence to rituals and routines; restricted, fixated interests; and unusual sensory reactions. However, it is important to note that children with either condition can exhibit stereotypic behaviors such as rocking or flapping. Children with either disorder also may exhibit a range of intellectual functioning, but only children with autis-

tic spectrum disorder exhibit selective impairments in social communicative behaviors, such as intentional communication (i.e., impairment in communication that is deliberate, goal-directed, and aimed at influencing the behavior of the recipient). Children with reactive attachment disorder show social communicative functioning comparable to their overall level of intellectual functioning. Finally, children with autistic spectrum disorder regularly show attachment behavior typical for their developmental level. In contrast, children with reactive attachment disorder do so only rarely or inconsistently, if at all.

**Intellectual disability (intellectual developmental disorder).** Developmental delays often accompany reactive attachment disorder, but they should not be confused with the disorder. Children with intellectual disability should exhibit social and emotional skills comparable to their cognitive skills and do not demonstrate the profound reduction in positive affect and emotion regulation difficulties evident in children with reactive attachment disorder. In addition, developmentally delayed children who have reached a cognitive age of 7–9 months should demonstrate selective attachments regardless of their chronological age. In contrast, children with reactive attachment disorder show lack of preferred attachment despite having attained a developmental age of at least 9 months.

**Depressive disorders.** Depression in young children is also associated with reductions in positive affect. There is limited evidence, however, to suggest that children with depressive disorders have impairments in attachment. That is, young children who have been diagnosed with depressive disorders still should seek and respond to comforting efforts by caregivers.

## Comorbidity

Conditions associated with neglect, including cognitive delays, language delays, and stereotypes, often co-occur with reactive attachment disorder. Medical conditions, such as severe malnutrition, may accompany signs of the disorder. Depressive symptoms also may co-occur with reactive attachment disorder.

# Disinhibited Social Engagement Disorder

## Diagnostic Criteria

**313.89 (F94.2)**

- A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:
  1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.
  2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
  3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
  4. Willingness to go off with an unfamiliar adult with minimal or no hesitation.
- B. The behaviors in Criterion A are not limited to impulsivity (as in attention-deficit/hyperactivity disorder) but include socially disinhibited behavior.
- C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
  1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
  2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
  3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

- D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).
- E. The child has a developmental age of at least 9 months.

*Specify if:*

**Persistent:** The disorder has been present for more than 12 months.

*Specify current severity:*

Disinhibited social engagement disorder is specified as **severe** when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

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## Diagnostic Features

The essential feature of disinhibited social engagement disorder is a pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers (Criterion A). This overly familiar behavior violates the social boundaries of the culture. A diagnosis of disinhibited social engagement disorder should not be made before children are developmentally able to form selective attachments. For this reason, the child must have a developmental age of at least 9 months.

## Associated Features Supporting Diagnosis

Because of the shared etiological association with social neglect, disinhibited social engagement disorder may co-occur with developmental delays, especially cognitive and language delays, stereotypies, and other signs of severe neglect, such as malnutrition or poor care. However, signs of the disorder often persist even after these other signs of neglect are no longer present. Therefore, it is not uncommon for children with the disorder to present with no current signs of neglect. Moreover, the condition can present in children who show no signs of disordered attachment. Thus, disinhibited social engagement disorder may be seen in children with a history of neglect who lack attachments or whose attachments to their caregivers range from disturbed to secure.

## Prevalence

The prevalence of disinhibited social attachment disorder is unknown. Nevertheless, the disorder appears to be rare, occurring in a minority of children, even those who have been severely neglected and subsequently placed in foster care or raised in institutions. In such high-risk populations, the condition occurs in only about 20% of children. The condition is seen rarely in other clinical settings.

## Development and Course

Conditions of social neglect are often present in the first months of life in children diagnosed with disinhibited social engagement disorder, even before the disorder is diagnosed. However, there is no evidence that neglect beginning after age 2 years is associated with manifestations of the disorder. If neglect occurs early and signs of the disorder appear, clinical features of the disorder are moderately stable over time, particularly if conditions of neglect persist. Indiscriminate social behavior and lack of reticence with unfamiliar adults in toddlerhood are accompanied by attention-seeking behaviors in preschoolers. When the disorder persists into middle childhood, clinical features manifest as verbal and physical overfamiliarity as well as inauthentic expression of emotions. These signs appear particularly apparent when the child interacts with adults. Peer relationships are most affected in adolescence, with both indiscriminate behavior and conflicts apparent. The disorder has not been described in adults.

Disinhibited social engagement disorder has been described from the second year of life through adolescence. There are some differences in manifestations of the disorder from early childhood through adolescence. At the youngest ages, across many cultures, children show reticence when interacting with strangers. Young children with the disorder fail to show reticence to approach, engage with, and even accompany adults. In preschool children, verbal and social intrusiveness appear most prominent, often accompanied by attention-seeking behavior. Verbal and physical overfamiliarity continue through middle childhood, accompanied by inauthentic expressions of emotion. In adolescence, indiscriminate behavior extends to peers. Relative to healthy adolescents, adolescents with the disorder have more “superficial” peer relationships and more peer conflicts. Adult manifestations of the disorder are unknown.

## **Risk and Prognostic Factors**

**Environmental.** Serious social neglect is a diagnostic requirement for disinhibited social engagement disorder and is also the only known risk factor for the disorder. However, the majority of severely neglected children do not develop the disorder. Neurobiological vulnerability may differentiate neglected children who do and do not develop the disorder. However, no clear link with any specific neurobiological factors has been established. The disorder has not been identified in children who experience social neglect only after age 2 years. Prognosis is only modestly associated with quality of the caregiving environment following serious neglect. In many cases, the disorder persists, even in children whose caregiving environment becomes markedly improved.

**Course modifiers.** Caregiving quality seems to moderate the course of disinhibited social engagement disorder. Nevertheless, even after placement in normative caregiving environments, some children show persistent signs of the disorder, at least through adolescence.

## **Functional Consequences of Disinhibited Social Engagement Disorder**

Disinhibited social engagement disorder significantly impairs young children’s abilities to relate interpersonally to adults and peers.

## **Differential Diagnosis**

**Attention-deficit/hyperactivity disorder.** Because of social impulsivity that sometimes accompanies attention-deficit/hyperactivity disorder (ADHD), it is necessary to differentiate the two disorders. Children with disinhibited social engagement disorder may be distinguished from those with ADHD because the former do not show difficulties with attention or hyperactivity.

## **Comorbidity**

Limited research has examined the issue of disorders comorbid with disinhibited social engagement disorder. Conditions associated with neglect, including cognitive delays, language delays, and stereotypies, may co-occur with disinhibited social engagement disorder. In addition, children may be diagnosed with ADHD and disinhibited social engagement disorder concurrently.

# Posttraumatic Stress Disorder

## Diagnostic Criteria

**309.81 (F43.10)**

### Posttraumatic Stress Disorder

**Note:** The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

**Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

**Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

**Note:** In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

**Note:** In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
  3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
  4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
  5. Markedly diminished interest or participation in significant activities.
  6. Feelings of detachment or estrangement from others.
  7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
  2. Reckless or self-destructive behavior.
  3. Hypervigilance.
  4. Exaggerated startle response.
  5. Problems with concentration.
  6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

*Specify whether:*

**With dissociative symptoms:** The individual's symptoms meet the criteria for post-traumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

*Specify if:*

**With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

### **Posttraumatic Stress Disorder for Children 6 Years and Younger**

- A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
  2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.



**Note:** Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

**B.** Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

**Note:** Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

**Note:** It may not be possible to ascertain that the frightening content is related to the traumatic event.

3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to reminders of the traumatic event(s).

**C.** One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):

**Persistent Avoidance of Stimuli**

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).
2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

**Negative Alterations in Cognitions**

3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
4. Markedly diminished interest or participation in significant activities, including constriction of play.
5. Socially withdrawn behavior.
6. Persistent reduction in expression of positive emotions.

**D.** Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
2. Hypervigilance.
3. Exaggerated startle response.
4. Problems with concentration.
5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

**E.** The duration of the disturbance is more than 1 month.

- F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.
- G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

*Specify whether:*

**With dissociative symptoms:** The individual's symptoms meet the criteria for post-traumatic stress disorder, and the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts) or another medical condition (e.g., complex partial seizures).

*Specify if:*

**With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

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## Diagnostic Features

The essential feature of posttraumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to one or more traumatic events. Emotional reactions to the traumatic event (e.g., fear, helplessness, horror) are no longer a part of Criterion A. The clinical presentation of PTSD varies. In some individuals, fear-based re-experiencing, emotional, and behavioral symptoms may predominate. In others, anhedonic or dysphoric mood states and negative cognitions may be most distressing. In some other individuals, arousal and reactive-externalizing symptoms are prominent, while in others, dissociative symptoms predominate. Finally, some individuals exhibit combinations of these symptom patterns.

The directly experienced traumatic events in Criterion A include, but are not limited to, exposure to war as a combatant or civilian, threatened or actual physical assault (e.g., physical attack, robbery, mugging, childhood physical abuse), threatened or actual sexual violence (e.g., forced sexual penetration, alcohol/drug-facilitated sexual penetration, abusive sexual contact, noncontact sexual abuse, sexual trafficking), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war, natural or human-made disasters, and severe motor vehicle accidents. For children, sexually violent events may include developmentally inappropriate sexual experiences without physical violence or injury. A life-threatening illness or debilitating medical condition is not necessarily considered a traumatic event. Medical incidents that qualify as traumatic events involve sudden, catastrophic events (e.g., waking during surgery, anaphylactic shock). Witnessed events include, but are not limited to, observing threatened or serious injury, unnatural death, physical or sexual abuse of another person due to violent assault, domestic violence, accident, war or disaster, or a medical catastrophe in one's child (e.g., a life-threatening hemorrhage). Indirect exposure through learning about an event is limited to experiences affecting close relatives or friends and experiences that are violent or accidental (e.g., death due to natural causes does not qualify). Such events include violent per-

sonal assault, suicide, serious accident, and serious injury. The disorder may be especially severe or long-lasting when the stressor is interpersonal and intentional (e.g., torture, sexual violence).

The traumatic event can be reexperienced in various ways. Commonly, the individual has recurrent, involuntary, and intrusive recollections of the event (Criterion B1). Intrusive recollections in PTSD are distinguished from depressive rumination in that they apply only to involuntary and intrusive distressing memories. The emphasis is on recurrent memories of the event that usually include sensory, emotional, or physiological behavioral components. A common reexperiencing symptom is distressing dreams that replay the event itself or that are representative or thematically related to the major threats involved in the traumatic event (Criterion B2). The individual may experience dissociative states that last from a few seconds to several hours or even days, during which components of the event are relived and the individual behaves as if the event were occurring at that moment (Criterion B3). Such events occur on a continuum from brief visual or other sensory intrusions about part of the traumatic event without loss of reality orientation, to complete loss of awareness of present surroundings. These episodes, often referred to as "flashbacks," are typically brief but can be associated with prolonged distress and heightened arousal. For young children, reenactment of events related to trauma may appear in play or in dissociative states. Intense psychological distress (Criterion B4) or physiological reactivity (Criterion B5) often occurs when the individual is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g., windy days after a hurricane; seeing someone who resembles one's perpetrator). The triggering cue could be a physical sensation (e.g., dizziness for survivors of head trauma; rapid heartbeat for a previously traumatized child), particularly for individuals with highly somatic presentations.

Stimuli associated with the trauma are persistently (e.g., always or almost always) avoided. The individual commonly makes deliberate efforts to avoid thoughts, memories, feelings, or talking about the traumatic event (e.g., utilizing distraction techniques to avoid internal reminders) (Criterion C1) and to avoid activities, objects, situations, or people who arouse recollections of it (Criterion C2).

Negative alterations in cognitions or mood associated with the event begin or worsen after exposure to the event. These negative alterations can take various forms, including an inability to remember an important aspect of the traumatic event; such amnesia is typically due to dissociative amnesia and is not due to head injury, alcohol, or drugs (Criterion D1). Another form is persistent (i.e., always or almost always) and exaggerated negative expectations regarding important aspects of life applied to oneself, others, or the future (e.g., "I have always had bad judgment"; "People in authority can't be trusted") that may manifest as a negative change in perceived identity since the trauma (e.g., "I can't trust anyone ever again"; Criterion D2). Individuals with PTSD may have persistent erroneous cognitions about the causes of the traumatic event that lead them to blame themselves or others (e.g., "It's all my fault that my uncle abused me") (Criterion D3). A persistent negative mood state (e.g., fear, horror, anger, guilt, shame) either began or worsened after exposure to the event (Criterion D4). The individual may experience markedly diminished interest or participation in previously enjoyed activities (Criterion D5), feeling detached or estranged from other people (Criterion D6), or a persistent inability to feel positive emotions (especially happiness, joy, satisfaction, or emotions associated with intimacy, tenderness, and sexuality) (Criterion D7).

Individuals with PTSD may be quick tempered and may even engage in aggressive verbal and/or physical behavior with little or no provocation (e.g., yelling at people, getting into fights, destroying objects) (Criterion E1). They may also engage in reckless or self-destructive behavior such as dangerous driving, excessive alcohol or drug use, or self-injurious or suicidal behavior (Criterion E2). PTSD is often characterized by a heightened sensitivity to potential threats, including those that are related to the traumatic experience (e.g., following a motor vehicle accident, being especially sensitive to the threat potentially

caused by cars or trucks) and those not related to the traumatic event (e.g., being fearful of suffering a heart attack) (Criterion E3). Individuals with PTSD may be very reactive to unexpected stimuli, displaying a heightened startle response, or jumpiness, to loud noises or unexpected movements (e.g., jumping markedly in response to a telephone ringing) (Criterion E4). Concentration difficulties, including difficulty remembering daily events (e.g., forgetting one's telephone number) or attending to focused tasks (e.g., following a conversation for a sustained period of time), are commonly reported (Criterion E5). Problems with sleep onset and maintenance are common and may be associated with nightmares and safety concerns or with generalized elevated arousal that interferes with adequate sleep (Criterion E6). Some individuals also experience persistent dissociative symptoms of detachment from their bodies (depersonalization) or the world around them (derealization); this is reflected in the "with dissociative symptoms" specifier.

## **Associated Features Supporting Diagnosis**

Developmental regression, such as loss of language in young children, may occur. Auditory pseudo-hallucinations, such as having the sensory experience of hearing one's thoughts spoken in one or more different voices, as well as paranoid ideation, can be present. Following prolonged, repeated, and severe traumatic events (e.g., childhood abuse, torture), the individual may additionally experience difficulties in regulating emotions or maintaining stable interpersonal relationships, or dissociative symptoms. When the traumatic event produces violent death, symptoms of both problematic bereavement and PTSD may be present.

## **Prevalence**

In the United States, projected lifetime risk for PTSD using DSM-IV criteria at age 75 years is 8.7%. Twelve-month prevalence among U.S. adults is about 3.5%. Lower estimates are seen in Europe and most Asian, African, and Latin American countries, clustering around 0.5%–1.0%. Although different groups have different levels of exposure to traumatic events, the conditional probability of developing PTSD following a similar level of exposure may also vary across cultural groups. Rates of PTSD are higher among veterans and others whose vocation increases the risk of traumatic exposure (e.g., police, firefighters, emergency medical personnel). Highest rates (ranging from one-third to more than one-half of those exposed) are found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide. The prevalence of PTSD may vary across development; children and adolescents, including preschool children, generally have displayed lower prevalence following exposure to serious traumatic events; however, this may be because previous criteria were insufficiently developmentally informed. The prevalence of full-threshold PTSD also appears to be lower among older adults compared with the general population; there is evidence that subthreshold presentations are more common than full PTSD in later life and that these symptoms are associated with substantial clinical impairment. Compared with U.S. non-Latino whites, higher rates of PTSD have been reported among U.S. Latinos, African Americans, and American Indians, and lower rates have been reported among Asian Americans, after adjustment for traumatic exposure and demographic variables.

## **Development and Course**

PTSD can occur at any age, beginning after the first year of life. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before criteria for the diagnosis are met. There is abundant evidence for what DSM-IV called "delayed onset" but is now called "delayed expression," with the recognition that some symptoms typically appear immediately and that the delay is in meeting full criteria.

Frequently, an individual's reaction to a trauma initially meets criteria for acute stress disorder in the immediate aftermath of the trauma. The symptoms of PTSD and the relative predominance of different symptoms may vary over time. Duration of the symptoms also varies, with complete recovery within 3 months occurring in approximately one-half of adults, while some individuals remain symptomatic for longer than 12 months and sometimes for more than 50 years. Symptom recurrence and intensification may occur in response to reminders of the original trauma, ongoing life stressors, or newly experienced traumatic events. For older individuals, declining health, worsening cognitive functioning, and social isolation may exacerbate PTSD symptoms.

The clinical expression of reexperiencing can vary across development. Young children may report new onset of frightening dreams without content specific to the traumatic event. Before age 6 years (see criteria for preschool subtype), young children are more likely to express reexperiencing symptoms through play that refers directly or symbolically to the trauma. They may not manifest fearful reactions at the time of the exposure or during reexperiencing. Parents may report a wide range of emotional or behavioral changes in young children. Children may focus on imagined interventions in their play or storytelling. In addition to avoidance, children may become preoccupied with reminders. Because of young children's limitations in expressing thoughts or labeling emotions, negative alterations in mood or cognition tend to involve primarily mood changes. Children may experience co-occurring traumas (e.g., physical abuse, witnessing domestic violence) and in chronic circumstances may not be able to identify onset of symptomatology. Avoidant behavior may be associated with restricted play or exploratory behavior in young children; reduced participation in new activities in school-age children; or reluctance to pursue developmental opportunities in adolescents (e.g., dating, driving). Older children and adolescents may judge themselves as cowardly. Adolescents may harbor beliefs of being changed in ways that make them socially undesirable and estrange them from peers (e.g., "Now I'll never fit in") and lose aspirations for the future. Irritable or aggressive behavior in children and adolescents can interfere with peer relationships and school behavior. Reckless behavior may lead to accidental injury to self or others, thrill-seeking, or high-risk behaviors. Individuals who continue to experience PTSD into older adulthood may express fewer symptoms of hyperarousal, avoidance, and negative cognitions and mood compared with younger adults with PTSD, although adults exposed to traumatic events during later life may display more avoidance, hyperarousal, sleep problems, and crying spells than do younger adults exposed to the same traumatic events. In older individuals, the disorder is associated with negative health perceptions, primary care utilization, and suicidal ideation.

## Risk and Prognostic Factors

Risk (and protective) factors are generally divided into pretraumatic, peritraumatic, and posttraumatic factors.

### Pretraumatic factors

**Temperamental.** These include childhood emotional problems by age 6 years (e.g., prior traumatic exposure, externalizing or anxiety problems) and prior mental disorders (e.g., panic disorder, depressive disorder, PTSD, or obsessive-compulsive disorder [OCD]).

**Environmental.** These include lower socioeconomic status; lower education; exposure to prior trauma (especially during childhood); childhood adversity (e.g., economic deprivation, family dysfunction, parental separation or death); cultural characteristics (e.g., fatalistic or self-blaming coping strategies); lower intelligence; minority racial/ethnic status; and a family psychiatric history. Social support prior to event exposure is protective.

**Genetic and physiological.** These include female gender and younger age at the time of trauma exposure (for adults). Certain genotypes may either be protective or increase risk of PTSD after exposure to traumatic events.

## Peritraumatic factors

**Environmental.** These include severity (dose) of the trauma (the greater the magnitude of trauma, the greater the likelihood of PTSD), perceived life threat, personal injury, interpersonal violence (particularly trauma perpetrated by a caregiver or involving a witnessed threat to a caregiver in children), and, for military personnel, being a perpetrator, witnessing atrocities, or killing the enemy. Finally, dissociation that occurs during the trauma and persists afterward is a risk factor.

## Posttraumatic factors

**Temperamental.** These include negative appraisals, inappropriate coping strategies, and development of acute stress disorder.

**Environmental.** These include subsequent exposure to repeated upsetting reminders, subsequent adverse life events, and financial or other trauma-related losses. Social support (including family stability, for children) is a protective factor that moderates outcome after trauma.

## Culture-Related Diagnostic Issues

The risk of onset and severity of PTSD may differ across cultural groups as a result of variation in the type of traumatic exposure (e.g., genocide), the impact on disorder severity of the meaning attributed to the traumatic event (e.g., inability to perform funerary rites after a mass killing), the ongoing sociocultural context (e.g., residing among unpunished perpetrators in postconflict settings), and other cultural factors (e.g., acculturative stress in immigrants). The relative risk for PTSD of particular exposures (e.g., religious persecution) may vary across cultural groups. The clinical expression of the symptoms or symptom clusters of PTSD may vary culturally, particularly with respect to avoidance and numbing symptoms, distressing dreams, and somatic symptoms (e.g., dizziness, shortness of breath, heat sensations).

Cultural syndromes and idioms of distress influence the expression of PTSD and the range of comorbid disorders in different cultures by providing behavioral and cognitive templates that link traumatic exposures to specific symptoms. For example, panic attack symptoms may be salient in PTSD among Cambodians and Latin Americans because of the association of traumatic exposure with panic-like *khyâl* attacks and *ataque de nervios*. Comprehensive evaluation of local expressions of PTSD should include assessment of cultural concepts of distress (see the chapter "Cultural Formulation" in Section III).

## Gender-Related Diagnostic Issues

PTSD is more prevalent among females than among males across the lifespan. Females in the general population experience PTSD for a longer duration than do males. At least some of the increased risk for PTSD in females appears to be attributable to a greater likelihood of exposure to traumatic events, such as rape, and other forms of interpersonal violence. Within populations exposed specifically to such stressors, gender differences in risk for PTSD are attenuated or nonsignificant.

## Suicide Risk

Traumatic events such as childhood abuse increase a person's suicide risk. PTSD is associated with suicidal ideation and suicide attempts, and presence of the disorder may indicate which individuals with ideation eventually make a suicide plan or actually attempt suicide.

## Functional Consequences of Posttraumatic Stress Disorder

PTSD is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and high levels of medical utilization. Impaired function-

ing is exhibited across social, interpersonal, developmental, educational, physical health, and occupational domains. In community and veteran samples, PTSD is associated with poor social and family relationships, absenteeism from work, lower income, and lower educational and occupational success.

## Differential Diagnosis

**Adjustment disorders.** In adjustment disorders, the stressor can be of any severity or type rather than that required by PTSD Criterion A. The diagnosis of an adjustment disorder is used when the response to a stressor that meets PTSD Criterion A does not meet all other PTSD criteria (or criteria for another mental disorder). An adjustment disorder is also diagnosed when the symptom pattern of PTSD occurs in response to a stressor that does not meet PTSD Criterion A (e.g., spouse leaving, being fired).

**Other posttraumatic disorders and conditions.** Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to PTSD. The diagnosis requires that trauma exposure precede the onset or exacerbation of pertinent symptoms. Moreover, if the symptom response pattern to the extreme stressor meets criteria for another mental disorder, these diagnoses should be given instead of, or in addition to, PTSD. Other diagnoses and conditions are excluded if they are better explained by PTSD (e.g., symptoms of panic disorder that occur only after exposure to traumatic reminders). If severe, symptom response patterns to the extreme stressor may warrant a separate diagnosis (e.g., dissociative amnesia).

**Acute stress disorder.** Acute stress disorder is distinguished from PTSD because the symptom pattern in acute stress disorder is restricted to a duration of 3 days to 1 month following exposure to the traumatic event.

**Anxiety disorders and obsessive-compulsive disorder.** In OCD, there are recurrent intrusive thoughts, but these meet the definition of an obsession. In addition, the intrusive thoughts are not related to an experienced traumatic event, compulsions are usually present, and other symptoms of PTSD or acute stress disorder are typically absent. Neither the arousal and dissociative symptoms of panic disorder nor the avoidance, irritability, and anxiety of generalized anxiety disorder are associated with a specific traumatic event. The symptoms of separation anxiety disorder are clearly related to separation from home or family, rather than to a traumatic event.

**Major depressive disorder.** Major depression may or may not be preceded by a traumatic event and should be diagnosed if other PTSD symptoms are absent. Specifically, major depressive disorder does not include any PTSD Criterion B or C symptoms. Nor does it include a number of symptoms from PTSD Criterion D or E.

**Personality disorders.** Interpersonal difficulties that had their onset, or were greatly exacerbated, after exposure to a traumatic event may be an indication of PTSD, rather than a personality disorder, in which such difficulties would be expected independently of any traumatic exposure.

**Dissociative disorders.** Dissociative amnesia, dissociative identity disorder, and depersonalization-derealization disorder may or may not be preceded by exposure to a traumatic event or may or may not have co-occurring PTSD symptoms. When full PTSD criteria are also met, however, the PTSD "with dissociative symptoms" subtype should be considered.

**Conversion disorder (functional neurological symptom disorder).** New onset of somatic symptoms within the context of posttraumatic distress might be an indication of PTSD rather than conversion disorder (functional neurological symptom disorder).

**Psychotic disorders.** Flashbacks in PTSD must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in schizophrenia, brief psychotic disorder, and other psychotic disorders; depressive and bipolar disorders with

psychotic features; delirium; substance/medication-induced disorders; and psychotic disorders due to another medical condition.

**Traumatic brain injury.** When a brain injury occurs in the context of a traumatic event (e.g., traumatic accident, bomb blast, acceleration/deceleration trauma), symptoms of PTSD may appear. An event causing head trauma may also constitute a psychological traumatic event, and traumatic brain injury (TBI)-related neurocognitive symptoms are not mutually exclusive and may occur concurrently. Symptoms previously termed *postconcussive* (e.g., headaches, dizziness, sensitivity to light or sound, irritability, concentration deficits) can occur in brain-injured and non-brain-injured populations, including individuals with PTSD. Because symptoms of PTSD and TBI-related neurocognitive symptoms can overlap, a differential diagnosis between PTSD and neurocognitive disorder symptoms attributable to TBI may be possible based on the presence of symptoms that are distinctive to each presentation. Whereas reexperiencing and avoidance are characteristic of PTSD and not the effects of TBI, persistent disorientation and confusion are more specific to TBI (neurocognitive effects) than to PTSD.

## Comorbidity

Individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder (e.g., depressive, bipolar, anxiety, or substance use disorders). Comorbid substance use disorder and conduct disorder are more common among males than among females. Among U.S. military personnel and combat veterans who have been deployed to recent wars in Afghanistan and Iraq, co-occurrence of PTSD and mild TBI is 48%. Although most young children with PTSD also have at least one other diagnosis, the patterns of comorbidity are different than in adults, with oppositional defiant disorder and separation anxiety disorder predominating. Finally, there is considerable comorbidity between PTSD and major neurocognitive disorder and some overlapping symptoms between these disorders.

## Acute Stress Disorder

### Diagnostic Criteria

**308.3 (F43.0)**

- A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
  1. Directly experiencing the traumatic event(s).
  2. Witnessing, in person, the event(s) as it occurred to others.
  3. Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).

**Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.
- B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

#### Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.



2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

### **Negative Mood**

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

### **Dissociative Symptoms**

6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

### **Avoidance Symptoms**

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

### **Arousal Symptoms**

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
  11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
  12. Hypervigilance.
  13. Problems with concentration.
  14. Exaggerated startle response.
- C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.
- Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.
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## **Diagnostic Features**

The essential feature of acute stress disorder is the development of characteristic symptoms lasting from 3 days to 1 month following exposure to one or more traumatic events. Traumatic events that are experienced directly include, but are not limited to, exposure to war as a combatant or civilian, threatened or actual violent personal assault (e.g., sexual

violence, physical attack, active combat, mugging, childhood physical and/or sexual violence, being kidnapped, being taken hostage, terrorist attack, torture), natural or human-made disasters (e.g., earthquake, hurricane, airplane crash), and severe accident (e.g., severe motor vehicle, industrial accident). For children, sexually traumatic events may include inappropriate sexual experiences without violence or injury. A life-threatening illness or debilitating medical condition is not necessarily considered a traumatic event. Medical incidents that qualify as traumatic events involve sudden, catastrophic events (e.g., waking during surgery, anaphylactic shock). Stressful events that do not possess the severe and traumatic components of events encompassed by Criterion A may lead to an adjustment disorder but not to acute stress disorder.

The clinical presentation of acute stress disorder may vary by individual but typically involves an anxiety response that includes some form of reexperiencing of or reactivity to the traumatic event. In some individuals, a dissociative or detached presentation can predominate, although these individuals typically will also display strong emotional or physiological reactivity in response to trauma reminders. In other individuals, there can be a strong anger response in which reactivity is characterized by irritable or possibly aggressive responses. The full symptom picture must be present for at least 3 days after the traumatic event and can be diagnosed only up to 1 month after the event. Symptoms that occur immediately after the event but resolve in less than 3 days would not meet criteria for acute stress disorder.

Witnessed events include, but are not limited to, observing threatened or serious injury, unnatural death, physical or sexual violence inflicted on another individual as a result of violent assault, severe domestic violence, severe accident, war, and disaster; it may also include witnessing a medical catastrophe (e.g., a life-threatening hemorrhage) involving one's child. Events experienced indirectly through learning about the event are limited to close relatives or close friends. Such events must have been violent or accidental—death due to natural causes does not qualify—and include violent personal assault, suicide, serious accident, or serious injury. The disorder may be especially severe when the stressor is interpersonal and intentional (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase.

The traumatic event can be reexperienced in various ways. Commonly, the individual has recurrent and intrusive recollections of the event (Criterion B1). The recollections are spontaneous or triggered recurrent memories of the event that usually occur in response to a stimulus that is reminiscent of the traumatic experience (e.g., the sound of a backfiring car triggering memories of gunshots). These intrusive memories often include sensory (e.g., sensing the intense heat that was perceived in a house fire), emotional (e.g., experiencing the fear of believing that one was about to be stabbed), or physiological (e.g., experiencing the shortness of breath that one suffered during a near-drowning) components.

Distressing dreams may contain themes that are representative of or thematically related to the major threats involved in the traumatic event. (For example, in the case of a motor vehicle accident survivor, the distressing dreams may involve crashing cars generally; in the case of a combat soldier, the distressing dreams may involve being harmed in ways other than combat.)

Dissociative states may last from a few seconds to several hours, or even days, during which components of the event are relived and the individual behaves as though experiencing the event at that moment. While dissociative responses are common during a traumatic event, only dissociative responses that persist beyond 3 days after trauma exposure are considered for the diagnosis of acute stress disorder. For young children, reenactment of events related to trauma may appear in play and may include dissociative moments (e.g., a child who survives a motor vehicle accident may repeatedly crash toy cars during play in a focused and distressing manner). These episodes, often referred to as *flashbacks*, are typically brief but involve a sense that the traumatic event is occurring in the present rather than being remembered in the past and are associated with significant distress.

Some individuals with the disorder do not have intrusive memories of the event itself, but instead experience intense psychological distress or physiological reactivity when they are exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g., windy days for children after a hurricane, entering an elevator for a male or female who was raped in an elevator, seeing someone who resembles one's perpetrator). The triggering cue could be a physical sensation (e.g., a sense of heat for a burn victim, dizziness for survivors of head trauma), particularly for individuals with highly somatic presentations. The individual may have a persistent inability to feel positive emotions (e.g., happiness, joy, satisfaction, or emotions associated with intimacy, tenderness, or sexuality) but can experience negative emotions such as fear, sadness, anger, guilt, or shame.

Alterations in awareness can include *depersonalization*, a detached sense of oneself (e.g., seeing oneself from the other side of the room), or *derealization*, having a distorted view of one's surroundings (e.g., perceiving that things are moving in slow motion, seeing things in a daze, not being aware of events that one would normally encode). Some individuals also report an inability to remember an important aspect of the traumatic event that was presumably encoded. This symptom is attributable to dissociative amnesia and is not attributable to head injury, alcohol, or drugs.

Stimuli associated with the trauma are persistently avoided. The individual may refuse to discuss the traumatic experience or may engage in avoidance strategies to minimize awareness of emotional reactions (e.g., excessive alcohol use when reminded of the experience). This behavioral avoidance may include avoiding watching news coverage of the traumatic experience, refusing to return to a workplace where the trauma occurred, or avoiding interacting with others who shared the same traumatic experience.

It is very common for individuals with acute stress disorder to experience problems with sleep onset and maintenance, which may be associated with nightmares or with generalized elevated arousal that prevents adequate sleep. Individuals with acute stress disorder may be quick tempered and may even engage in aggressive verbal and/or physical behavior with little provocation. Acute stress disorder is often characterized by a heightened sensitivity to potential threats, including those that are related to the traumatic experience (e.g., a motor vehicle accident victim may be especially sensitive to the threat potentially caused by any cars or trucks) or those not related to the traumatic event (e.g., fear of having a heart attack). Concentration difficulties, including difficulty remembering daily events (e.g., forgetting one's telephone number) or attending to focused tasks (e.g., following a conversation for a sustained period of time), are commonly reported. Individuals with acute stress disorder may be very reactive to unexpected stimuli, displaying a heightened startle response or jumpiness to loud noises or unexpected movements (e.g., the individual may jump markedly in the response to a telephone ringing).

## Associated Features Supporting Diagnosis

Individuals with acute stress disorder commonly engage in catastrophic or extremely negative thoughts about their role in the traumatic event, their response to the traumatic experience, or the likelihood of future harm. For example, an individual with acute stress disorder may feel excessively guilty about not having prevented the traumatic event or about not adapting to the experience more successfully. Individuals with acute stress disorder may also interpret their symptoms in a catastrophic manner, such that flashback memories or emotional numbing may be interpreted as a sign of diminished mental capacity. It is common for individuals with acute stress disorder to experience panic attacks in the initial month after trauma exposure that may be triggered by trauma reminders or may apparently occur spontaneously. Additionally, individuals with acute stress disorder may display chaotic or impulsive behavior. For example, individuals may drive recklessly, make irrational decisions, or gamble excessively. In children, there may be significant separation anxiety, possibly manifested by excessive needs for attention from

caregivers. In the case of bereavement following a death that occurred in traumatic circumstances, the symptoms of acute stress disorder can involve acute grief reactions. In such cases, reexperiencing, dissociative, and arousal symptoms may involve reactions to the loss, such as intrusive memories of the circumstances of the individual's death, disbelief that the individual has died, and anger about the death. Postconcussive symptoms (e.g., headaches, dizziness, sensitivity to light or sound, irritability, concentration deficits), which occur frequently following mild traumatic brain injury, are also frequently seen in individuals with acute stress disorder. Postconcussive symptoms are equally common in brain-injured and non-brain-injured populations, and the frequent occurrence of postconcussive symptoms could be attributable to acute stress disorder symptoms.

## Prevalence

The prevalence of acute stress disorder in recently trauma-exposed populations (i.e., within 1 month of trauma exposure) varies according to the nature of the event and the context in which it is assessed. In both U.S. and non-U.S. populations, acute stress disorder tends to be identified in less than 20% of cases following traumatic events that do not involve interpersonal assault; 13%–21% of motor vehicle accidents, 14% of mild traumatic brain injury, 19% of assault, 10% of severe burns, and 6%–12% of industrial accidents. Higher rates (i.e., 20%–50%) are reported following interpersonal traumatic events, including assault, rape, and witnessing a mass shooting.

## Development and Course

Acute stress disorder cannot be diagnosed until 3 days after a traumatic event. Although acute stress disorder may progress to posttraumatic stress disorder (PTSD) after 1 month, it may also be a transient stress response that remits within 1 month of trauma exposure and does not result in PTSD. Approximately half of individuals who eventually develop PTSD initially present with acute stress disorder. Symptom worsening during the initial month can occur, often as a result of ongoing life stressors or further traumatic events.

The forms of reexperiencing can vary across development. Unlike adults or adolescents, young children may report frightening dreams without content that clearly reflects aspects of the trauma (e.g., waking in fright in the aftermath of the trauma but being unable to relate the content of the dream to the traumatic event). Children age 6 years and younger are more likely than older children to express reexperiencing symptoms through play that refers directly or symbolically to the trauma. For example, a very young child who survived a fire may draw pictures of flames. Young children also do not necessarily manifest fearful reactions at the time of the exposure or even during reexperiencing. Parents typically report a range of emotional expressions, such as anger, shame, or withdrawal, and even excessively bright positive affect, in young children who are traumatized. Although children may avoid reminders of the trauma, they sometimes become preoccupied with reminders (e.g., a young child bitten by a dog may talk about dogs constantly yet avoid going outside because of fear of coming into contact with a dog).

## Risk and Prognostic Factors

**Temperamental.** Risk factors include prior mental disorder, high levels of negative affectivity (neuroticism), greater perceived severity of the traumatic event, and an avoidant coping style. Catastrophic appraisals of the traumatic experience, often characterized by exaggerated appraisals of future harm, guilt, or hopelessness, are strongly predictive of acute stress disorder.

**Environmental.** First and foremost, an individual must be exposed to a traumatic event to be at risk for acute stress disorder. Risk factors for the disorder include a history of prior trauma.

**Genetic and physiological.** Females are at greater risk for developing acute stress disorder.

Elevated reactivity, as reflected by acoustic startle response, prior to trauma exposure increases the risk for developing acute stress disorder.

## Culture-Related Diagnostic Issues

The profile of symptoms of acute stress disorder may vary cross-culturally, particularly with respect to dissociative symptoms, nightmares, avoidance, and somatic symptoms (e.g., dizziness, shortness of breath, heat sensations). Cultural syndromes and idioms of distress shape the local symptom profiles of acute stress disorder. Some cultural groups may display variants of dissociative responses, such as possession or trancelike behaviors in the initial month after trauma exposure. Panic symptoms may be salient in acute stress disorder among Cambodians because of the association of traumatic exposure with panic-like *khyâl* attacks, and *ataque de nervios* among Latin Americans may also follow a traumatic exposure.

## Gender-Related Diagnostic Issues

Acute stress disorder is more prevalent among females than among males. Sex-linked neurobiological differences in stress response may contribute to females' increased risk for acute stress disorder. The increased risk for the disorder in females may be attributable in part to a greater likelihood of exposure to the types of traumatic events with a high conditional risk for acute stress disorder, such as rape and other interpersonal violence.

## Functional Consequences of Acute Stress Disorder

Impaired functioning in social, interpersonal, or occupational domains has been shown across survivors of accidents, assault, and rape who develop acute stress disorder. The extreme levels of anxiety that may be associated with acute stress disorder may interfere with sleep, energy levels, and capacity to attend to tasks. Avoidance in acute stress disorder can result in generalized withdrawal from many situations that are perceived as potentially threatening, which can lead to nonattendance of medical appointments, avoidance of driving to important appointments, and absenteeism from work.

## Differential Diagnosis

**Adjustment disorders.** In acute stress disorder, the stressor can be of any severity rather than of the severity and type required by Criterion A of acute stress disorder. The diagnosis of an adjustment disorder is used when the response to a Criterion A event does not meet the criteria for acute stress disorder (or another specific mental disorder) and when the symptom pattern of acute stress disorder occurs in response to a stressor that does not meet Criterion A for exposure to actual or threatened death, serious injury, or sexual violence (e.g., spouse leaving, being fired). For example, severe stress reactions to life-threatening illnesses that may include some acute stress disorder symptoms may be more appropriately described as an adjustment disorder. Some forms of acute stress response do not include acute stress disorder symptoms and may be characterized by anger, depression, or guilt. These responses are more appropriately described as primarily an adjustment disorder. Depressive or anger responses in an adjustment disorder may involve rumination about the traumatic event, as opposed to involuntary and intrusive distressing memories in acute stress disorder.

**Panic disorder.** Spontaneous panic attacks are very common in acute stress disorder. However, panic disorder is diagnosed only if panic attacks are unexpected and there is anxiety about future attacks or maladaptive changes in behavior associated with fear of dire consequences of the attacks.

**Dissociative disorders.** Severe dissociative responses (in the absence of characteristic acute stress disorder symptoms) may be diagnosed as derealization/depersonalization disorder. If severe amnesia of the trauma persists in the absence of characteristic acute stress disorder symptoms, the diagnosis of dissociative amnesia may be indicated.

**Posttraumatic stress disorder.** Acute stress disorder is distinguished from PTSD because the symptom pattern in acute stress disorder must occur within 1 month of the traumatic event and resolve within that 1-month period. If the symptoms persist for more than 1 month and meet criteria for PTSD, the diagnosis is changed from acute stress disorder to PTSD.

**Obsessive-compulsive disorder.** In obsessive-compulsive disorder, there are recurrent intrusive thoughts, but these meet the definition of an obsession. In addition, the intrusive thoughts are not related to an experienced traumatic event, compulsions are usually present, and other symptoms of acute stress disorder are typically absent.

**Psychotic disorders.** Flashbacks in acute stress disorder must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in schizophrenia, other psychotic disorders, depressive or bipolar disorder with psychotic features, a delirium, substance/medication-induced disorders, and psychotic disorders due to another medical condition. Acute stress disorder flashbacks are distinguished from these other perceptual disturbances by being directly related to the traumatic experience and by occurring in the absence of other psychotic or substance-induced features.

**Traumatic brain injury.** When a brain injury occurs in the context of a traumatic event (e.g., traumatic accident, bomb blast, acceleration/deceleration trauma), symptoms of acute stress disorder may appear. An event causing head trauma may also constitute a psychological traumatic event, and traumatic brain injury (TBI)-related neurocognitive symptoms are not mutually exclusive and may occur concurrently. Symptoms previously termed *postconcussive* (e.g., headaches, dizziness, sensitivity to light or sound, irritability, concentration deficits) can occur in brain-injured and non-brain injured populations, including individuals with acute stress disorder. Because symptoms of acute stress disorder and TBI-related neurocognitive symptoms can overlap, a differential diagnosis between acute stress disorder and neurocognitive disorder symptoms attributable to TBI may be possible based on the presence of symptoms that are distinctive to each presentation. Whereas reexperiencing and avoidance are characteristic of acute stress disorder and not the effects of TBI, persistent disorientation and confusion are more specific to TBI (neurocognitive effects) than to acute stress disorder. Furthermore, differential is aided by the fact that symptoms of acute stress disorder persist for up to only 1 month following trauma exposure.

## Adjustment Disorders

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### Diagnostic Criteria

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- A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
  1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
  2. Significant impairment in social, occupational, or other important areas of functioning.
- C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.

- D. The symptoms do not represent normal bereavement.
- E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

*Specify whether:*

**309.0 (F43.21) With depressed mood:** Low mood, tearfulness, or feelings of hopelessness are predominant.

**309.24 (F43.22) With anxiety:** Nervousness, worry, jitteriness, or separation anxiety is predominant.

**309.28 (F43.23) With mixed anxiety and depressed mood:** A combination of depression and anxiety is predominant.

**309.3 (F43.24) With disturbance of conduct:** Disturbance of conduct is predominant.

**309.4 (F43.25) With mixed disturbance of emotions and conduct:** Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.

**309.9 (F43.20) Unspecified:** For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

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## Diagnostic Features

The presence of emotional or behavioral symptoms in response to an identifiable stressor is the essential feature of adjustment disorders (Criterion A). The stressor may be a single event (e.g., a termination of a romantic relationship), or there may be multiple stressors (e.g., marked business difficulties and marital problems). Stressors may be recurrent (e.g., associated with seasonal business crises, unfulfilling sexual relationships) or continuous (e.g., a persistent painful illness with increasing disability, living in a crime-ridden neighborhood). Stressors may affect a single individual, an entire family, or a larger group or community (e.g., a natural disaster). Some stressors may accompany specific developmental events (e.g., going to school, leaving a parental home, reentering a parental home, getting married, becoming a parent, failing to attain occupational goals, retirement).

Adjustment disorders may be diagnosed following the death of a loved one when the intensity, quality, or persistence of grief reactions exceeds what normally might be expected, when cultural, religious, or age-appropriate norms are taken into account. A more specific set of bereavement-related symptoms has been designated *persistent complex bereavement disorder*.

Adjustment disorders are associated with an increased risk of suicide attempts and completed suicide.

## Prevalence

Adjustment disorders are common, although prevalence may vary widely as a function of the population studied and the assessment methods used. The percentage of individuals in outpatient mental health treatment with a principal diagnosis of an adjustment disorder ranges from approximately 5% to 20%. In a hospital psychiatric consultation setting, it is often the most common diagnosis, frequently reaching 50%.

## Development and Course

By definition, the disturbance in adjustment disorders begins within 3 months of onset of a stressor and lasts no longer than 6 months after the stressor or its consequences have ceased. If the stressor is an acute event (e.g., being fired from a job), the onset of the disturbance is usually immediate (i.e., within a few days) and the duration is relatively brief (i.e., no more than a few months). If the stressor or its consequences persist, the adjustment disorder may also continue to be present and become the persistent form.

## Risk and Prognostic Factors

**Environmental.** Individuals from disadvantaged life circumstances experience a high rate of stressors and may be at increased risk for adjustment disorders.

## Culture-Related Diagnostic Issues

The context of the individual's cultural setting should be taken into account in making the clinical judgment of whether the individual's response to the stressor is maladaptive or whether the associated distress is in excess of what would be expected. The nature, meaning, and experience of the stressors and the evaluation of the response to the stressors may vary across cultures.

## Functional Consequences of Adjustment Disorders

The subjective distress or impairment in functioning associated with adjustment disorders is frequently manifested as decreased performance at work or school and temporary changes in social relationships. An adjustment disorder may complicate the course of illness in individuals who have a general medical condition (e.g., decreased compliance with the recommended medical regimen; increased length of hospital stay).

## Differential Diagnosis

**Major depressive disorder.** If an individual has symptoms that meet criteria for a major depressive disorder in response to a stressor, the diagnosis of an adjustment disorder is not applicable. The symptom profile of major depressive disorder differentiates it from adjustment disorders.

**Posttraumatic stress disorder and acute stress disorder.** In adjustment disorders, the stressor can be of any severity rather than of the severity and type required by Criterion A of acute stress disorder and posttraumatic stress disorder (PTSD). In distinguishing adjustment disorders from these two posttraumatic diagnoses, there are both timing and symptom profile considerations. Adjustment disorders can be diagnosed immediately and persist up to 6 months after exposure to the traumatic event, whereas acute stress disorder can only occur between 3 days and 1 month of exposure to the stressor, and PTSD cannot be diagnosed until at least 1 month has passed since the occurrence of the traumatic stressor. The required symptom profile for PTSD and acute stress disorder differentiates them from the adjustment disorders. With regard to symptom profiles, an adjustment disorder may be diagnosed following a traumatic event when an individual exhibits symptoms of either acute stress disorder or PTSD that do not meet or exceed the diagnostic threshold for either disorder. An adjustment disorder should also be diagnosed for individuals who have not been exposed to a traumatic event but who otherwise exhibit the full symptom profile of either acute stress disorder or PTSD.

**Personality disorders.** With regard to personality disorders, some personality features may be associated with a vulnerability to situational distress that may resemble an adjustment disorder. The lifetime history of personality functioning will help inform the interpretation of distressed behaviors to aid in distinguishing a long-standing personality disorder from an adjustment disorder. In addition to some personality disorders incurring vulnerability to distress, stressors may also exacerbate personality disorder symptoms. In the presence of a personality disorder, if the symptom criteria for an adjustment disorder are met, and the stress-related disturbance exceeds what may be attributable to maladaptive personality disorder symptoms (i.e., Criterion C is met), then the diagnosis of an adjustment disorder should be made.



**Psychological factors affecting other medical conditions.** In psychological factors affecting other medical conditions, specific psychological entities (e.g., psychological symptoms, behaviors, other factors) exacerbate a medical condition. These psychological factors can precipitate, exacerbate, or put an individual at risk for medical illness, or they can worsen an existing condition. In contrast, an adjustment disorder is a reaction to the stressor (e.g., having a medical illness).

**Normative stress reactions.** When bad things happen, most people get upset. This is not an adjustment disorder. The diagnosis should only be made when the magnitude of the distress (e.g., alterations in mood, anxiety, or conduct) exceeds what would normally be expected (which may vary in different cultures) or when the adverse event precipitates functional impairment.

## Comorbidity

Adjustment disorders can accompany most mental disorders and any medical disorder. Adjustment disorders can be diagnosed in addition to another mental disorder only if the latter does not explain the particular symptoms that occur in reaction to the stressor. For example, an individual may develop an adjustment disorder, with depressed mood, after losing a job and at the same time have a diagnosis of obsessive-compulsive disorder. Or, an individual may have a depressive or bipolar disorder and an adjustment disorder as long as the criteria for both are met. Adjustment disorders are common accompaniments of medical illness and may be the major psychological response to a medical disorder.

## Other Specified Trauma- and Stressor-Related Disorder

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**309.89 (F43.8)**

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This category applies to presentations in which symptoms characteristic of a trauma- and stressor-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the trauma- and stressor-related disorders diagnostic class. The other specified trauma- and stressor-related disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific trauma- and stressor-related disorder. This is done by recording "other specified trauma- and stressor-related disorder" followed by the specific reason (e.g., "persistent complex bereavement disorder").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Adjustment-like disorders with delayed onset of symptoms that occur more than 3 months after the stressor.**
  2. **Adjustment-like disorders with prolonged duration of more than 6 months without prolonged duration of stressor.**
  3. **Ataque de nervios:** See "Glossary of Cultural Concepts of Distress" in the Appendix.
  4. **Other cultural syndromes:** See "Glossary of Cultural Concepts of Distress" in the Appendix.
  5. **Persistent complex bereavement disorder:** This disorder is characterized by severe and persistent grief and mourning reactions (see the chapter "Conditions for Further Study").
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# Unspecified Trauma- and Stressor-Related Disorder

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**309.9 (F43.9)**

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This category applies to presentations in which symptoms characteristic of a trauma- and stressor-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the trauma- and stressor-related disorders diagnostic class. The unspecified trauma- or stressor-related disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific trauma- and stressor-related disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

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