

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.

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

Diagnostic Criteria

- 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.

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

309.89 (F43.8)

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

309.9 (F43.9)

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).

Dissociative Disorders

Dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior. Dissociative symptoms can potentially disrupt every area of psychological functioning. This chapter includes dissociative identity disorder, dissociative amnesia, depersonalization/derealization disorder, other specified dissociative disorder, and unspecified dissociative disorder.

Dissociative symptoms are experienced as a) unbidden intrusions into awareness and behavior, with accompanying losses of continuity in subjective experience (i.e., “positive” dissociative symptoms such as fragmentation of identity, depersonalization, and derealization) and/or b) inability to access information or to control mental functions that normally are readily amenable to access or control (i.e., “negative” dissociative symptoms such as amnesia).

The dissociative disorders are frequently found in the aftermath of trauma, and many of the symptoms, including embarrassment and confusion about the symptoms or a desire to hide them, are influenced by the proximity to trauma. In DSM-5, the dissociative disorders are placed next to, but are not part of, the trauma- and stressor-related disorders, reflecting the close relationship between these diagnostic classes. Both acute stress disorder and posttraumatic stress disorder contain dissociative symptoms, such as amnesia, flashbacks, numbing, and depersonalization/derealization.

Depersonalization/derealization disorder is characterized by clinically significant persistent or recurrent depersonalization (i.e., experiences of unreality or detachment from one’s mind, self, or body) and/or derealization (i.e., experiences of unreality or detachment from one’s surroundings). These alterations of experience are accompanied by intact reality testing. There is no evidence of any distinction between individuals with predominantly depersonalization versus derealization symptoms. Therefore, individuals with this disorder can have depersonalization, derealization, or both.

Dissociative amnesia is characterized by an inability to recall autobiographical information. This amnesia may be localized (i.e., an event or period of time), selective (i.e., a specific aspect of an event), or generalized (i.e., identity and life history). Dissociative amnesia is fundamentally an inability to recall autobiographical information that is inconsistent with normal forgetting. It may or may not involve purposeful travel or bewildered wandering (i.e., fugue). Although some individuals with amnesia promptly notice that they have “lost time” or that they have a gap in their memory, most individuals with dissociative disorders are initially unaware of their amnesias. For them, awareness of amnesia occurs only when personal identity is lost or when circumstances make these individuals aware that autobiographical information is missing (e.g., when they discover evidence of events they cannot recall or when others tell them or ask them about events they cannot recall). Until and unless this happens, these individuals have “amnesia for their amnesia.” Amnesia is experienced as an essential feature of dissociative amnesia; individuals may experience localized or selective amnesia most commonly, or generalized amnesia rarely. Dissociative fugue is rare in persons with dissociative amnesia but common in dissociative identity disorder.

Dissociative identity disorder is characterized by a) the presence of two or more distinct personality states or an experience of possession and b) recurrent episodes of amnesia. The