

07 - Trauma and Stressor Related Disorders

Trauma- and Stressor- Related Disorders

295

F94.1 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, adjustment disorders, and prolonged grief disorder. 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 are 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disorders share a common etiology, the former is expressed as an internalizing disorder with depressive symptoms and withdrawn behavior, while the latter is marked by disinhibition and externalizing behavior. Finally, it has long been recognized that whereas grief, despair, and general dysphoria can be a part of the normal grieving process after the death of a loved one, the expression of such emotions is sometimes abnormally excessive in duration and/or intensity. The diagnosis of prolonged grief disorder has been introduced in this chapter to meet this clinical concern. **Reactive Attachment Disorder Diagnostic Criteria 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.
4. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
5. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
6. 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. Diagnostic Features Reactive attachment disorder 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

Environmental. 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. Diagnostic assessment is enhanced by multiple sources of input, supporting that the symptoms are apparent across contexts. Associated Features 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. The disorder is uncommon, usually occurring in less than 10% of neglected children, even in cases of severe neglect. 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. Remediation and symptomatic recovery may occur through normative caregiving environments; however, in the absence of enhanced caregiving, the signs of the disorder may persist, at least for several years. Persistent signs of reactive attachment disorder in early adolescence may be associated with problems in social functioning. Less is known about the clinical presentation of reactive attachment disorder in older children, and the diagnosis should be made with caution in children older than 5 years. Risk and Prognostic Factors 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 for children with the disorder appears to depend on the quality of the caregiving environment following serious neglect.

Autism spectrum disorder. Culture-Related Diagnostic Issues There is limited information on reactive attachment behavior in young children from diverse cultural backgrounds around the world. Cultural expectations of attachment behaviors and caregiving practices may influence development of and concern about these patterns of behaviors and their presentations in different settings. Caution should be exercised in making the diagnosis of reactive attachment disorder in cultural contexts in which attachment has not been studied. Symptoms of reactive attachment disorder may be more common in situations where attachment figures have experienced extensive trauma, such as war-zone settings; attachment styles may also vary among migrant and refugee children during the resettlement period. Variations in nurturing care practices may influence risk of reactive attachment disorder. 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 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 autism 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 autism 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 autism 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. Structured observations can help discriminate between the two disorders.

Intellectual developmental disorder (intellectual disability). Depressive disorders. F94.2
Developmental delays often accompany reactive attachment disorder, but they should not be confused with the disorder. Children with intellectual developmental disorder 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. 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 stereotypies, often co-occur with reactive attachment disorder. Medical conditions, such as severe malnutrition, may accompany signs of the disorder. Internalizing symptoms also may cooccur with reactive attachment disorder. A relationship between reactive attachment disorder and externalizing behavior problems or attention-deficit/hyperactivity disorder (ADHD) has been suggested but not clearly established. Disinhibited Social Engagement Disorder Diagnostic Criteria 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 attentiondeficit/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. 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 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 engagement disorder is unknown. Nevertheless, the disorder appears to be rare, occurring in a minority of children, even those who have experienced

Temperamental. Environmental. severe early deprivation. In low-income community populations in the United Kingdom, the prevalence is up to 2%. 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. As noted by research among children with a history of institutional care, 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. Signs of disinhibited social engagement disorder have been described from the second year of life through adolescence among children raised in institutional settings, and even into young adulthood. There are some differences in manifestations of the disorder from early childhood to older ages. At the youngest ages, across many cultures, children typically show reticence when interacting with strangers, which is nonpathological, even if they are raised in institutions and foster care. Young children with the disorder, however, fail to show reticence to approach and are found to engage with, and even accompany, unfamiliar adults without hesitation, as shown by research among children with a history of institutionalized care. In preschool children raised in institutional settings in the United Kingdom or the United States, verbal and social intrusiveness appeared most prominent, often accompanied by attention-seeking behavior;

preschool children raised in institutional settings across several countries have displayed a pattern of engaging in physical contact with strangers. Verbal and physical overfamiliarity continued through middle childhood, sometimes accompanied by inauthentic expressions of emotion. In adolescence, indiscriminate behavior may extend to peers. Relative to healthy adolescents, adolescents with the disorder have more “superficial” peer relationships and more peer conflicts. Adult manifestations of the disorder appear to be similar but may include excessive self-disclosure and reduced stranger awareness.

Risk and Prognostic Factors There is some evidence from research with international adoptees in the United States that both blunted reward sensitivity and decreased inhibitory control are associated with indiscriminate social behavior. Serious social neglect is a diagnostic requirement for disinhibited social engagement disorder. The rationale for this requirement includes research finding a strong association between neglect and features of the disorder. Other factors also have been implicated, such as multiple placement disruptions, borderline personality disorder in the mother, and aberrant caregiving behaviors and low quality of care. All of these contribute to the insufficient care criterion. Still, the majority of severely neglected children do not develop the disorder. 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.

Genetic and physiological. Course modifiers. **Attention-deficit/hyperactivity disorder.** F43.10 Various neurobiological factors have been associated with symptoms of the disorder, but findings concerning the nature of such factors and their specific tie to the disorder remain preliminary. Caregiving quality seems to moderate the course of disinhibited social engagement disorder, at least in young children. Nevertheless, even after placement in normative caregiving environments, some children show persistent signs of the disorder, through adolescence and into adulthood.

Culture-Related Diagnostic Issues There is limited cross-cultural information on disinhibited social engagement disorder. Cultural expectations of children’s social behaviors may affect their level of disinhibition toward strangers. The absence of reticence that is characteristic of disinhibited social engagement disorder should exceed culturally accepted norms.

Functional Consequences of Disinhibited Social Engagement Disorder Disinhibited social engagement disorder significantly impairs young children’s abilities to relate interpersonally to adults and peers. Both general social functioning and social competence may be impaired, along with increased risk for peer conflicts and victimization.

Differential Diagnosis Children with disinhibited social engagement disorder can be distinguished from those with ADHD accompanied by social impulsivity, as the former do not show difficulties with attention or hyperactivity.

Comorbidity Conditions associated with neglect, including cognitive delays, language delays, and stereotypies, may co-occur with disinhibited social engagement disorder. Autism spectrum disorder may also co-occur. In younger children and in middle childhood, disinhibited social engagement disorder often co-occurs with ADHD and externalizing disorders; this co-occurrence has been proposed to relate to common impairments in cognitive inhibitory control.

Posttraumatic Stress Disorder Diagnostic Criteria **Posttraumatic Stress Disorder in Individuals Older Than 6 Years** 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:
5. 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.
6. 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.
7. 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.
8. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
9. 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:
10. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
11. 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:
8. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
9. Reckless or self-destructive behavior.
10. Hypervigilance.
11. Exaggerated startle response.
12. Problems with concentration.
13. 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 posttraumatic 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 in 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:
3. Directly experiencing the traumatic event(s).
4. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.
5. 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:
6. 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.
7. 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.

8. 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.
9. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
10. 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
11. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).
12. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s). Negative Alterations in Cognitions
13. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
14. Markedly diminished interest or participation in significant activities, including constriction of play.
15. Socially withdrawn behavior.
16. 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:
17. 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).
18. Hypervigilance.
19. Exaggerated startle response.
20. Problems with concentration.
21. 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 posttraumatic stress disorder, and the individual experiences persistent or recurrent symptoms of either of the following:
22. 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).
23. 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). **Diagnostic Features** The essential feature of posttraumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to one or more traumatic events. The clinical presentation of PTSD varies. In some individuals, fear-based reexperiencing, emotional, and behavioral symptoms may predominate. In others, anhedonic or dysphoric mood states and negative cognitions may be most prominent. In some other individuals, arousal and reactive-externalizing symptoms are prominent, while in yet others, dissociative symptoms predominate. Finally, some individuals exhibit combinations of these symptom patterns. The following discussion of specific criteria for PTSD refers to specific criteria for adults; criteria for children 6 years or younger may differ in criterion numbering given differences in applicable criteria for this age group. The traumatic events in Criterion A all involve actual or threatened death, serious injury, or sexual violence in some way but differ in how the individual is exposed to them, which can be through directly experiencing the traumatic event (Criterion A1), witnessing in person the event as it occurred to others (Criterion A2), learning that the event occurred to a family member or a close friend (Criterion A3), or indirect exposure in the course of occupational duties, through being exposed to grotesque details of an event (Criterion A4). The disorder may be especially severe or long-lasting when the stressor is interpersonal and intentional (e.g., torture, sexual violence). The directly experienced traumatic events in Criterion A include, but are not limited to, exposure to war as a combatant or civilian, actual or threatened physical assault in which the threat is perceived as imminent and realistic (e.g., physical attack, robbery, mugging, childhood physical abuse), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war, natural or human-made disasters, and severe motor vehicle accidents. Sexual trauma includes, but is not limited to, actual or threatened sexual violence or coercion

(e.g., forced sexual penetration; alcohol/drug-facilitated nonconsensual sexual penetration; other unwanted sexual contact; and other unwanted sexual experiences not involving contact, such as being forced to watch pornography, exposure to the display of genitals by an exhibitionist, or being the victim of unwanted photography or videotaping of a sexual nature or the unwanted dissemination of these photographs or videos). Being bullied may qualify as a Criterion A1 experience when there is a credible threat of serious harm or sexual violence. 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. Qualifying events of this type include life-threatening medical emergencies (e.g., an acute myocardial infarction, anaphylactic shock) or a particular event in treatment that evokes catastrophic feelings of terror, pain, helplessness, or imminent death (e.g., waking during surgery, debridement of severe burn wounds, emergency cardioversion). Witnessed events (Criterion A2) 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. For example, this would include parents witnessing their child in an acute life-endangering incident (e.g., a diving accident) or a medical catastrophe during the course of their child's illness or ongoing treatment (e.g., a life-threatening hemorrhage). Indirect exposure through learning about an event (Criterion A3) is limited to events affecting close relatives or friends that were violent or accidental (i.e., death from natural causes does not qualify). Such events include murder, violent personal assault, combat, terrorist attack, sexual

violence, suicide, and serious accident or injury. The indirect exposure of professionals to the grotesque effects of war, rape, genocide, or abusive violence inflicted on others occurring in the context of their work duties can also result in PTSD and thus is considered to be a qualifying trauma (Criterion A4). Examples include first responders exposed to serious injury or death and military personnel collecting human remains. Indirect exposure can also occur through photos, videos, verbal accounts, or written accounts (e.g., police officers reviewing crime reports or conducting interviews with crime victims, drone operators, members of the news media covering traumatic events, and psychotherapists exposed to details of their patients' traumatic experiences). Exposure to multiple traumatic events is common and can take many forms. Some individuals experience different types of traumatic events at different times (e.g., sexual violence during childhood and natural disaster as adults). Others experience the same type of traumatic event at different times or in a series committed by the same person/people over an extended period (e.g., child sexual or physical assault; physical or sexual assault by an intimate partner). Others may experience numerous traumatic events that are the same or different during an extended hazardous period such as deployment or living in a conflict zone. When one is assessing the PTSD criteria in individuals who have experienced multiple traumatic events across their lives, it may be useful to determine if there is a specific, discrete example that the individual considers to be the worst given that the symptomatic expressions of PTSD Criterion B and Criterion C specifically refer to the traumatic event (e.g., recurrent, involuntary, and

intrusive distressing recollections of the traumatic event). However, if it is difficult for the individual to identify a worst example, it is appropriate to consider the entire exposure as meeting Criterion A. In addition, some discrete events may incorporate several traumatic event types (e.g., an individual involved in a mass casualty incident sustains a major injury, witnesses someone else being injured, and then learns that a family member was killed in the incident). 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 intrusive, vivid, sensory, and emotional components that are distressing and not merely ruminative. 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 typically last a few seconds and rarely are of a longer duration, 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, ranging from brief visual or other sensory intrusions about part of the traumatic event without loss of reality orientation to a partial loss of awareness of present surroundings to a complete loss of awareness. 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 be expressed behaviorally 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 or somatic reactions 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 also 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 avoided. The individual commonly makes deliberate efforts to avoid thoughts, memories, or feelings (e.g., by utilizing distraction or suppression techniques, including substance use, to avoid internal reminders) (Criterion C1), and to avoid activities, conversations, objects, situations, or people who arouse recollections of it (Criterion C2). Negative alterations in cognitions or mood associated with the traumatic event begin or worsen after exposure to the event. These negative alterations can take various forms, including an inability to remember key and emotionally painful aspects of the traumatic event. Such memory loss is typically attributable to dissociative amnesia and is not attributable to head injury or impaired encoding of the memory due to drug or alcohol use (Criterion D1). Individuals with PTSD often report that the traumatic event has irrevocably altered their lives and their view of the world. This is characterized by persistent and exaggerated negative beliefs and expectations regarding important aspects of life applied to themselves, others, the world, or the future (Criterion D2) (e.g., “Bad things will always happen to me”; “The world is dangerous, and I can never be adequately protected”; “I can’t trust anyone ever again”;

“My life is permanently ruined”; “I have lost any chance for future happiness”; “My life will be cut short”). 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, dysphoria, 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), may feel detached or estranged from other people (Criterion D6), or may experience a persistent inability to feel positive emotions (especially happiness, joy, satisfaction, or emotions associated with intimacy, tenderness, and sexuality) (Criterion D7). Negative alterations in arousal and reactivity also begin or get worse after exposure to the event. Individuals with PTSD may exhibit irritable or angry behavior and may engage in aggressive verbal or physical behavior with little or no provocation (e.g., yelling at people, getting into fights, destroying objects) (Criterion E1). They may also engage voluntarily in reckless or self-destructive behavior that is dangerous, that shows a disregard for the physical safety of themselves or others, and that could directly result in serious physical harm or death (Criterion E2). Examples include, but are not limited to, dangerous driving (e.g., drunk driving, driving at dangerously high speeds), excessive alcohol or drug use, having risky sex (e.g., unprotected sex with a partner whose HIV status is unknown, high number of sexual partners), or self-directed violence including suicidal behaviors. Criterion E2 does not include circumstances in which individuals must engage in dangerous situations as a part of their job (e.g., armed forces members in combat situations or first responders in emergency situations) and take reasonable safety precautions to reduce their risk or when individuals engage in behaviors that may be unwise, unhealthy, or financially harmful but pose no direct risk of immediate serious physical harm or death (e.g., pathological gambling, poor financial decisions, binge eating, unhealthy lifestyles). PTSD is often characterized by a heightened vigilance for 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). Startle responses are involuntary and reflexive (automatic, instantaneous), and stimuli that evoke exaggerated startle responses

(Criterion E4) need not be related at all to the traumatic event. Startle responses are distinguished from the cued physiological arousal responses in Criterion B5, for which there needs to be at least some level of conscious appraisal that the stimulus producing physiological responses is related to the trauma. 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). The diagnosis of PTSD requires that the duration of the symptoms in Criteria B, C, D, and E be more than 1 month (Criterion F). For a current diagnosis of PTSD, Criteria B, C, D, and E must all be met for more than 1 month, for at least the past month. For a lifetime

diagnosis of PTSD, there must be a period of time lasting more than 1 month during which Criteria B, C, D, and E have all been met for the same 1-month period of time. A significant subgroup of individuals with PTSD experience persistent dissociative symptoms of either depersonalization (detachment from their bodies) or derealization (detachment from the world around them). This can be indicated by using the "with dissociative symptoms" specifier. Associated Features 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 involves the violent death of someone with whom the individual had a close relationship, symptoms of both prolonged grief disorder and PTSD may be present. Prevalence The national lifetime prevalence estimate for PTSD using DSM-IV criteria is 6.8% for U.S. adults. Lifetime prevalence for U.S. adolescents using DSM-IV criteria has ranged from 5.0% to 8.1% and a past 6-month prevalence of 4.9% for adolescents. While definitive, comprehensive population-based data using DSM-5 are not available, findings are beginning to emerge. In two U.S. national epidemiological studies, lifetime DSM-5 PTSD prevalence estimates ranged from 6.1% to 8.3%, and the national 12-month DSM-5 prevalence estimate was 4.7% in both studies. National lifetime DSM-IV PTSD estimates from World Mental Health Surveys in 24 countries varied substantially among countries, income country groups, and WHO regions but was 3.9% overall. In conflict-affected populations worldwide, the point prevalence of PTSD with functional impairment is 11% after adjustment for age differences across studies. 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. Racial differences, based on DSM-IV data, show higher rates of PTSD among U.S. Latinx, African Americans, and American Indians compared with Whites. Potential reasons for these prevalence variations include differences in predisposing or enabling factors, such as exposure to past adversity and racism and discrimination, and in availability or quality of treatment, social support, socioeconomic status, and other social resources that facilitate recovery and are confounded with ethnic and racialized

background. 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 full 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. The clinical expression of reexperiencing can vary across development. Developmental variations in clinical expression inform the use of different criteria in children 6 years and younger and in individuals who are older. Young children may report new onset of frightening dreams without content specific to the traumatic event. Children age 6 and younger may develop PTSD as a result of severe emotional abuse (e.g., threat of abandonment), which can be perceived as life-threatening. During treatment for life-threatening illness (e.g., cancer, solid organ transplantation), the experience of young children of the severity and intensity of the treatment may contribute to risk of developing posttraumatic stress symptoms; the self-appraisal of threat may also contribute to the risk of developing posttraumatic stress symptoms in adolescents. Before age 6 years, young children are more likely to express reexperiencing symptoms through play that refers directly or symbolically to the trauma (see PTSD criteria for children 6 years and younger). 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 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, thrillseeking, or high-risk behaviors. In older individuals, the disorder is associated with negative health perceptions, primary care utilization, and suicidal thoughts. In addition, declining health, worsening cognitive functioning, and social isolation may exacerbate PTSD symptoms.

Temperamental. Environmental. Genetic and physiological. Environmental. Temperamental. Risk and Prognostic Factors Risk factors for PTSD can operate in many ways, including predisposing individuals to trauma or to extreme emotional responses when exposed to traumatic events. Risk

(and protective) factors are generally divided into pretraumatic, peritraumatic, and posttraumatic factors. Pretraumatic Factors High-risk factors include childhood emotional problems by age 6 years (e.g., externalizing or anxiety problems) and prior mental disorders (e.g., panic disorder, depressive disorder, PTSD, or obsessive-compulsive disorder [OCD]). Individual differences in premorbid personality may influence the trajectory of response to trauma and treatment outcomes. Personality traits associated with negative emotional responses such as depressed mood and anxiousness represent risk factors for the development of PTSD. Such traits might be captured in measures of negative affectivity (neuroticism) on standardized personality scales. Premorbid trait impulsivity tends to be associated with externalizing manifestations of PTSD and comorbidities of the externalizing spectrum, including substance use disorder or aggressive behavior. As documented among U.S. civilians and veterans, these risk factors 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); lower intelligence; ethnic discrimination and racism; and a family psychiatric history. Social support prior to event exposure is protective. The risk of developing PTSD following traumatic exposure has been demonstrated to be modestly heritable in twin studies and molecular studies. Genome-wide association data from a large multiethnic cohort support the heritability of PTSD and demonstrate three robust genome-wide significant loci that vary by geographic ancestry. Susceptibility to PTSD may also be influenced by epigenetic factors. Genome-wide association data from U.S. veterans identify eight significant regions in Americans of European descent associated with intrusive reexperiencing symptoms of PTSD; data from the United Kingdom also support these associations. Peritraumatic Factors These include severity (dose) of the trauma, 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, fear, panic, and other peritraumatic responses that occur during the trauma and persist afterward are risk factors. Posttraumatic Factors 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. Posttraumatic experiences such as forced migration and high levels of daily stressors may contribute to different conditional risks of PTSD across cultural contexts. Exposure to racial and ethnic discrimination has been associated with a more chronic course among African American and Latinx adults. Social support (including family stability, for children) is a protective factor that moderates outcome after trauma. Culture-Related Diagnostic Issues Different demographic, cultural, and occupational groups have different levels of exposure to traumatic events, and the relative risk of developing PTSD following a similar level of exposure (e.g., religious persecution) may also vary across cultural, ethnic, and racialized groups. 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), exposure to racial and ethnic discrimination, and other cultural factors (e.g., acculturative stress in migrants) may influence the risk of onset and severity of PTSD across cultural groups. Some communities are exposed to pervasive and ongoing traumatic environments, rather than isolated Criterion A events; in these communities, the predictive power of individual traumatic events for the development of PTSD may diminish. In

cultures where social image (e.g., maintaining a family's "face") is emphasized, public defamation or shaming may magnify the impact of Criterion A events. Some cultures may attribute PTSD syndromes to negative supernatural experiences. The clinical expression of the symptoms or symptom clusters of PTSD can vary culturally in both adults and children. In many non-Western groups, avoidance is less commonly observed, whereas somatic symptoms (e.g., dizziness, shortness of breath, heat sensations) are more common; other symptoms that vary cross-culturally are distressing dreams, amnesia not related to head injury, and reckless but nonsuicidal behavior. Negative moods, especially anger, are common cross-culturally in individuals with PTSD, as are distressing dreams and sleep paralysis. Across cultures, somatic symptoms are frequent, occurring in both children and adults, especially after sexual trauma. Symptoms that vary cross-culturally in relation to PTSD among children include intrusive thoughts, diminished participation in activities, inability to experience positive emotions, irritability, aggression, and hypervigilance. Distressing dreams, flashbacks, psychological distress upon exposure to trauma cues, and efforts to avoid memories and thoughts are common in children with PTSD across cultures. In certain cultural contexts, it may be normative to respond to traumatic events with negative beliefs about oneself or with spiritual attributions that may appear exaggerated to others. For example, blaming oneself may be consistent with ideas of karma in South and East Asia, destiny or "spoiled medicine law" in West Africa, and cultural differences in locus of control and conceptions of self. In many populations around the world, there are cultural concepts of distress that resemble

Adjustment disorders. PTSD and are characterized by diverse manifestations of psychological distress attributed to frightening or traumatic experiences. Thus, cultural concepts of distress influence the expression of PTSD and the range of its comorbid disorders (see "Culture and Psychiatric Diagnosis" in Section III). Sex- and Gender-Related Diagnostic Issues PTSD is more prevalent among women than among men across the life span. Lifetime prevalence of PTSD ranges from 8.0% to 11.0% for women and 4.1% to 5.4% for men based on two large U.S. population-based studies using DSM-5 criteria. Some of the increased risk for PTSD in women appears to be attributable to a greater likelihood of exposure to childhood sexual abuse, sexual assault, and other forms of interpersonal violence, which carry the highest risk for development of PTSD. Women in the general population also experience PTSD for a longer duration than do men. However, other factors likely contributing to the higher prevalence in women include gender differences in the emotional and cognitive processing of trauma, as well as effects of reproductive hormones. When responses of men and women to specific stressors are compared, gender differences in risk for PTSD persist. On the other hand, PTSD symptom profiles and factor structures are similar between men and women. Association With Suicidal Thoughts or Behavior Traumatic events such as childhood abuse or sexual trauma increase an individual's suicide risk in both civilians and veterans. PTSD is associated with suicidal thoughts, suicide attempts, and death from suicide. The presence of PTSD has been associated with an increased likelihood of transitioning from suicidal thoughts to a suicide plan or attempt, and this effect of PTSD occurs independently of the increased risk of mood disorders on the likelihood of suicidal behaviors. Among adolescents there is also a significant relationship between PTSD and suicidal thoughts or behavior even after adjustment for the effects of comorbidity. Functional Consequences of Posttraumatic Stress Disorder PTSD is associated with high impairment in social, occupational, and physical functioning; reduced quality of life; and physical health problems. Impaired functioning 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 In adjustment disorders, the stressor can be of any severity or type rather than a stressor involving exposure to actual or threatened death, serious injury, or sexual violence as 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

Other posttraumatic disorders and conditions. Acute stress disorder. Anxiety disorders and obsessive-compulsive disorder. Major depressive disorder. Attention-deficit/hyperactivity disorder. Personality disorders. Dissociative disorders. 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). Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to PTSD. The PTSD diagnosis requires that trauma exposure precede the onset or exacerbation of pertinent symptoms. 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 that meet criteria for another mental disorder may warrant a separate diagnosis (e.g., dissociative amnesia) in addition to PTSD. 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. 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 depression may or may not be preceded by a traumatic event and should be diagnosed if full criteria have been met. 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. However, if full criteria for PTSD are also met, both diagnoses may be given. Both ADHD and PTSD may include problems in attention, concentration, and learning. In contrast to ADHD, where the problems in attention, concentration, and learning must have their onset prior to age 12, in PTSD the symptoms have their onset following exposure to a Criterion A traumatic event. In PTSD, disruptions in the individual's attention and concentration can be attributable to alertness to danger and exaggerated startle responses to reminders of the trauma. 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 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.

Functional neurological symptom disorder (conversion disorder). Psychotic disorders. Traumatic brain injury. F43.0 New onset of somatic symptoms within the context of posttraumatic distress might be an indication of PTSD rather than functional neurological symptom disorder. 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. PTSD 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. Some types of traumatic events increase risk of both PTSD and traumatic brain injury (TBI) because they can produce head injuries (e.g., military combat, bomb blasts, child physical abuse, intimate partner violence, violent crime, motor vehicle or other accidents). In such cases, individuals presenting with PTSD may also have TBI, and those presenting with TBI may also have PTSD. Individuals with PTSD who also have TBI may have persistent postconcussive symptoms (e.g., headaches, dizziness, sensitivity to light or sound, irritability, concentration deficits). However, such symptoms may also occur in 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. TBI-related memory problems concerning the traumatic event are typically attributable to injury-related inability to encode the information, whereas PTSD-related memory problems typically reflect dissociative amnesia. Sleep difficulties are common to both disorders. Comorbidity Individuals with PTSD are more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder, such as depressive, bipolar, anxiety, or substance use disorders. PTSD is also associated with increased risk of major neurocognitive disorder. In a U.S.-based study, women were more likely to develop PTSD following a mild TBI. 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. Acute Stress Disorder Diagnostic Criteria 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 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
5. 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.

6. 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.
7. 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.
8. 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
9. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings). Dissociative Symptoms
10. 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).
11. 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
12. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
13. 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
14. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
15. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
16. Hypervigilance.
17. Problems with concentration.
18. 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 (Criterion A), which are the same type as described in PTSD Criterion A (for more information, see "Diagnostic Features" for PTSD). 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. Presentations may include intrusion symptoms, negative mood, dissociative symptoms, avoidance symptoms, and arousal symptoms (Criterion B1-B14). 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. Intrusion

symptoms (Criterion B1–B4) are the same as described in PTSD Criterion B1–B5 (for discussion of these symptoms, see “Diagnostic Features” for PTSD; note that acute stress disorder Criterion B4 comprises PTSD Criterion B4 and B5). Individuals with acute stress disorder may have a persistent inability to feel positive emotions (e.g., happiness, joy,

satisfaction, or emotions associated with intimacy, tenderness, sexuality) but can experience negative emotions such as fear, sadness, anger, guilt, or shame (Criterion B5). 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) (Criterion B6). 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 (Criterion B7). Stimuli associated with the trauma are persistently avoided. The individual commonly makes deliberate efforts to avoid thoughts, memories, or feelings (e.g., by using distraction or suppression techniques, including substance use, to avoid internal reminders) (Criterion B8), and to avoid activities, conversations, objects, situations, or people who arouse recollections of it (Criterion B9). It is very common for individuals with acute stress disorder to experience problems with sleep onset and maintenance, which may be associated with nightmares and safety concerns or with generalized elevated arousal that interferes with adequate sleep (Criterion B10). Individuals with acute stress disorder may exhibit irritable behavior and may even engage in aggressive verbal or physical behavior with little or no provocation (e.g., yelling at people, getting into fights, destroying objects) (Criterion B11). Acute stress disorder is often characterized by a heightened vigilance for 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 B12). Concentration difficulties (Criterion B13) include difficulty remembering familiar facts (e.g., forgetting one’s telephone number) or daily events (e.g., having recently read part of a book or newspaper) or attending to focused tasks (e.g., following a conversation for a sustained period of time). Individuals with acute stress disorder may be very reactive to unexpected stimuli, displaying a heightened startle response or jumpiness to loud noises (e.g., in response to a telephone ringing) or unexpected movements (Criterion B14). Startle responses are involuntary and reflexive (automatic, instantaneous), and stimuli that evoke exaggerated startle responses (Criterion B14) need not be related to the traumatic event. The full symptom picture must last for at least 3 days after the traumatic event but should not last longer than 1 month (Criterion C). Symptoms that occur immediately after the event but resolve in less than 3 days would not meet criteria for acute stress disorder. Associated Features 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 (TBI), 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 research conducted in Australia, the United Kingdom, and the United States, acute stress disorder was identified in less than 20% of cases following traumatic events that do not involve interpersonal assault—for example, motor vehicle accidents, mild TBI, severe burns, and industrial accidents. Higher rates (i.e., 19%–50%) were usually found following interpersonal traumatic events (e.g., assault, rape).

Development and Course By definition, 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. Longitudinal analyses indicate that acute stress symptoms can remit, remain constant, or worsen over time, largely 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

Temperamental. Environmental. Genetic and physiological. 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 Risk factors include prior mental disorder, high levels of negative emotional responses such as depressed mood and anxiousness (also termed negative affectivity or neuroticism), greater perceived severity of the traumatic event, and an avoidant coping style. A tendency to make catastrophic appraisals of the traumatic experience, often characterized by exaggerated appraisals of future harm, guilt, or hopelessness, is strongly predictive of acute stress disorder. 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. 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, pain complaints). Acute stress reactions may be shaped by cultural values and norms regarding the expression of extreme emotions, even in extraordinary situations. Cultural concepts 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. For more information regarding cultural concepts of distress, refer to the Section III chapter "Culture and Psychiatric Diagnosis."

Sex- and Gender-Related Diagnostic Issues

Acute stress disorder is more prevalent among women than among men in studies across multiple countries. The increased risk for the disorder in women may be attributable to a greater likelihood of exposure to the types of traumatic events with a high conditional risk for acute stress disorder, such as rape, other interpersonal violence, and childhood trauma, including sexual abuse. Other factors likely contributing to the higher prevalence in women include gender differences in the emotional and cognitive processing of trauma. Sex-linked

Adjustment disorders. Panic disorder. Dissociative disorders. Posttraumatic stress disorder. Obsessive-compulsive disorder. Psychotic disorders.

neurobiological differences in stress response

as well as sociocultural factors may also contribute to women's increased risk for acute stress disorder.

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

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. 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. 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. 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. Acute stress disorder is distinguished from PTSD because the symptom pattern in acute stress disorder must resolve within 1 month of the traumatic event. If the symptoms persist for more than 1 month and meet criteria for PTSD, the diagnosis is changed from acute stress disorder to PTSD. 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. Flashbacks in acute stress disorder must be distinguished from illusions,

Traumatic brain injury. 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. 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 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 and are not better explained by prolonged grief disorder.

E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months. Specify whether: F43.21 With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant. F43.22 With anxiety: Nervousness, worry,

jitteriness, or separation anxiety is predominant. F43.23 With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant. F43.24 With disturbance of conduct: Disturbance of conduct is predominant. F43.25 With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant. F43.20 Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder. Specify if: Acute: This specifier can be used to indicate persistence of symptoms for less than 6 months. Persistent (chronic): This specifier can be used to indicate persistence of symptoms for 6 months or longer. By definition, symptoms cannot persist for more than 6 months after the termination of the stressor or its consequences. The persistent specifier therefore applies when the duration of the disturbance is longer than 6 months in response to a chronic stressor or to a stressor that has enduring consequences. Specifiers By definition, an adjustment disorder must resolve within 6 months of the termination of the stressor or its consequences. However, the symptoms may persist for a prolonged period (i.e., longer than 6 months) if they occur in response to a persistent stressor (e.g., a chronic disabling other medical condition) or to a stressor that has enduring consequences (e.g., the financial and emotional difficulties resulting from a divorce). The duration of the symptoms of an adjustment disorder can be indicated by using the acute or persistent (chronic) specifiers. The acute specifier is used to indicate persistence of symptoms for less than 6 months. The persistent (chronic) specifier is used to indicate persistence of symptoms for 6 months or longer. This latter specifier therefore applies when the duration of the disturbance is longer than 6 months in response to a persistent stressor or to a stressor that has enduring consequences. Diagnostic Features

Environmental. 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 and the grief reaction does not meet criteria for prolonged grief disorder. 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 in the United States with a principal diagnosis of an adjustment disorder ranges from approximately 5% to 20%. Rates of adjustment disorder may be higher in women, as noted by research in Denmark. In Australian, Canadian, Israeli, and U.S. hospital psychiatric consultation settings, an adjustment disorder was often the most common diagnosis in the 1990s, frequently reaching 50%. Development and Course By definition, the disturbance in adjustment disorders begins within 3 months of onset of a stressor. 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.

By definition, if symptoms persist beyond 6 months after the stressor or its consequences have ceased, the diagnosis of adjustment disorder would no longer apply. Risk and Prognostic Factors Persons from disadvantaged life circumstances experience a high rate of stressors and may be at increased risk for adjustment disorders. Culture-Related Diagnostic Issues Because the nature, meaning, and experience of the stressors and the evaluation of the response to stressors may vary across cultures, cultural context is key in determining whether the

Major depressive disorder. Posttraumatic stress disorder and acute stress disorder. adjustment response is maladaptive. Migrants and refugees may experience stressful major contextual and cultural changes that can make this assessment challenging. Suffering is assumed to be an intrinsic aspect of normal life in some cultural contexts, such that distressful reactions to stressful life events may not be viewed as maladaptive or worthy of treatment. Self-immolation is also a risk associated with adjustment disorder in some cultural contexts. Association With Suicidal Thoughts or Behavior Adjustment disorders are associated with an increased risk of suicide attempts and suicide. Among migrant populations, including Turkish migrants in Western Europe and South Asian or South East Asian migrants in Gulf countries, adjustment disorder was found to be among the most common diagnoses associated with suicide-related behavior. 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 another medical condition (e.g., decreased compliance with the recommended medical regimen; increased length of hospital stay). Differential Diagnosis 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. 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 profiles for PTSD and acute stress disorder differentiate 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. Because adjustment disorder cannot persist for more than 6 months after termination of the stressor or its consequences, cases in which symptoms occurring in response to a traumatic event that fall short of the diagnostic threshold for PTSD and that persist for longer than 6 months should be diagnosed as other specified trauma- and stressor-related disorder. An adjustment disorder should also be diagnosed for individuals who have not been exposed to a traumatic event meeting Criterion A for PTSD, but who otherwise exhibit the full

Personality disorders. Bereavement. Psychological factors affecting other medical conditions. Normative stress reactions. F43.8 symptom profile of either acute stress disorder or PTSD. 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. Clinically significant acute bereavement-related distress may sometimes be diagnosed as an adjustment disorder if the bereavement is judged to be out of proportion to what would be expected or significantly impairs self-care and interpersonal relations. When such symptoms persist for more than 12 months after the death, the diagnosis is either prolonged grief disorder if full criteria are met or else other specified trauma- and stressor-related disorder. 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). 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 condition. 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 condition. Prolonged Grief Disorder Diagnostic Criteria A. The death, at least 12 months ago, of a person who was close to the bereaved

individual (for children and adolescents, at least 6 months ago). B. Since the death, the development of a persistent grief response characterized by one or both of the following symptoms, which have been present most days to a clinically significant degree. In addition, the symptom(s) has occurred nearly every day for at least the last month:

1. Intense yearning/longing for the deceased person.
2. Preoccupation with thoughts or memories of the deceased person (in children and adolescents, preoccupation may focus on the circumstances of the death). C. Since the death, at least three of the following symptoms have been present most days to a clinically significant degree. In addition, the symptoms have occurred nearly every day for at least the last month:
3. Identity disruption (e.g., feeling as though part of oneself has died) since the death.
4. Marked sense of disbelief about the death.
5. Avoidance of reminders that the person is dead (in children and adolescents, may be characterized by efforts to avoid reminders).
6. Intense emotional pain (e.g., anger, bitterness, sorrow) related to the death.

7. Difficulty reintegrating into one's relationships and activities after the death (e.g., problems engaging with friends, pursuing interests, or planning for the future).
8. Emotional numbness (absence or marked reduction of emotional experience) as a result of the death.
9. Feeling that life is meaningless as a result of the death.
10. Intense loneliness as a result of the death. D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. E. The duration and severity of the bereavement reaction clearly exceed expected social, cultural, or religious norms for the individual's culture and context. F. The symptoms are not better explained by another mental disorder, such as major depressive disorder or posttraumatic stress disorder, and are not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition. Diagnostic Features Prolonged grief disorder represents a prolonged maladaptive grief reaction that can be diagnosed only after at least 12 months (6 months in children and adolescents) have elapsed since the death of someone with whom the bereaved had a close relationship (Criterion A). Although in general

this time frame reliably discriminates normal grief from grief that continues to be severe and impairing, the duration of adaptive grief may vary individually and cross-culturally. The condition involves the development of a persistent grief response characterized by intense yearning or longing for the deceased person (often with intense sorrow and frequent crying) or preoccupation with thoughts or memories of the deceased, although in children and adolescents, this preoccupation may focus on the circumstances of the death. The intense yearning/longing or the preoccupation has been present most days to a clinically significant degree and has occurred nearly every day for at least the last month (Criterion B). Moreover, since the death, at least three additional symptoms have been present most days to a clinically significant degree and have occurred nearly every day for at least the past month. These symptoms include identity disruption since the death (e.g., feeling as though part of oneself has died) (Criterion C1); a marked sense of disbelief about the death (Criterion C2); avoidance of reminders that the person is dead, which in children and adolescents may be characterized by efforts to avoid reminders (Criterion C3); intense emotional pain (e.g., anger, bitterness, guilt) since the death (Criterion C4); having difficulty reintegrating into personal relationships and activities since the death (e.g., problems engaging with friends, pursuing interests, or planning for the future) (Criterion C5); emotional numbness (absence or marked reduction of emotional experience) as a result of the death (Criterion C6); feeling that life is meaningless as a result of the death (Criterion C7); or intense loneliness as a consequence of the death (Criterion C8). The symptoms of prolonged grief disorder must result in clinically significant distress or impairment in social, occupational, or other important areas of functioning in the bereaved individual (Criterion D). The nature, duration, and severity of the bereavement reaction must clearly exceed expected social, cultural, or religious norms for the individual's culture and context (Criterion E). Although there are variations in how grief can manifest, the symptoms of prolonged grief disorder occur across genders and in diverse social and cultural groups. Associated Features Individuals with symptoms of prolonged grief disorder often experience maladaptive cognitions about the self, guilt about the death, and diminished future life expectancy and life goals. Somatic complaints commonly accompany the condition and may be related to comorbid depression and anxiety, social identity disruption, and increased health care visits; the somatic symptoms may be associated with those that were experienced by the deceased

(e.g., changes in appetite). Harmful health behaviors related to decreased self-care and concern are also common in individuals with symptoms of prolonged grief disorder. Hallucinations about the deceased (e.g., hearing the deceased person's voice) may occur during normal grief but may be more common in individuals with symptoms of prolonged grief disorder; hallucinations experienced by individuals with prolonged grief disorder symptoms may be associated with disruptions of social identity and purpose related to the death (e.g., confusion about one's role in life, feeling of meaninglessness). Other associated features of prolonged grief disorder include bitterness, anger, or restlessness; blaming others for the death; and decreased sleep quantity and quality.

Prevalence The prevalence of DSM-5 prolonged grief disorder in adults is unknown. Meta-analysis of studies across four continents that used a different definition for prolonged grief disorder with at least a 6-month duration postloss suggests a pooled prevalence of 9.8%; however, there was substantial methodological heterogeneity across studies (e.g., in symptom definitions, measures, duration of bereavement), which affected the prevalence findings. Populations with elevated exposure to trauma may have higher prevalence rates. Mean prevalence of prolonged grief presentations may be higher in high-income Western countries than in high- and upper-middle-income Asian countries, but recent studies in China have revealed higher rates and substantial variation. Prevalence of persistent complex bereavement disorder (included in DSM-5 Section III, "Conditions for Further Study") among bereaved U.S. youth in the community was estimated at 18%.

Development and Course There are limited data on the course of prolonged grief disorder across the life span. Symptoms usually begin within the initial months after the death, although there may be a delay before the full syndrome appears. Preliminary evidence suggests that course may be especially prolonged among parents after the death of a child. The course of prolonged grief disorder may be complicated by comorbid posttraumatic stress disorder, which is more common in situations of bereavement following the violent death of a loved one (e.g., murder, suicide) when grief for the bereaved may be accompanied by personal life threat and/or witnessing of violent and potentially gruesome death. Older age may be associated with a higher risk of developing the disorder after the death of a loved one. Older adults with prolonged grief disorder symptoms may be at elevated risk for progressive cognitive decline. In children, distress may be expressed in play and behavior, developmental regressions, and anxious or protest behavior at times of separation and reunion. Young children may experience symptoms of prolonged grief disorder in specific ways because of their age. The loss of a primary caregiver may be particularly traumatic for a young child, given the disorganizing effects of the caregiver's absence. Young children may protest or become angry when daily care activities are performed differently than by the deceased (e.g., cooking, discipline, bedtime rituals). They may express intense insecurity about their future, often manifested as worries about the health and safety of caregivers and about themselves, with repeated questions about death. They may engage in searching for the deceased because they do not understand the permanence of death. Young children tend toward somatic manifestations such as disturbances in sleep, eating, digestion, and level of energy. They may express yearning in thought and play as a wish, literally, to physically reunite with the deceased to overcome the painful physical separation (e.g., to climb a ladder to heaven or lie in the ground next to a parent). Young children typically do not understand or describe numbing, whereas adolescents may describe "not feeling anything." In children and adolescents, ongoing preoccupation with the circumstances of the death might involve focusing on distressing aspects of physical deterioration over the course of a fatal

Environmental. illness and/or the inability of a caregiver to perform vital caregiving functions. Identity disruption may include feeling profoundly different from others, often in response to loss reminders (e.g., making Mother's Day cards at school, watching a friend enjoy a hobby with a sibling). Children and adolescents may verbally, in their behavior, or through emotional withdrawal show reluctance to join adults in activities that serve as loss reminders. They may experience intense emotional pain over feeling deprived ("robbed") of the deceased's help with ongoing developmental tasks (e.g., onset of menses). Separation distress may be predominant in younger children, and distress over disruptions in social identity (e.g., confusion about purpose in life) and risk for comorbid depression can increasingly manifest in older children and adolescents. Failure to achieve age-appropriate developmental milestones and transitions is a manifestation of failure to reintegrate into life roles. For older children and adolescents, feeling that life is meaningless without the person who died may include giving up on developmental aspirations ("It's not worth trying if they can't be here"), not caring about risky behavior ("So what if I get hurt or die?"), or feeling that their future is "ruined." Older children and adolescents may be apprehensive over sharing a similar fate as the deceased, including premature death. Loneliness may be intensified by keeping grief private, sometimes over not wanting to add to the distress of a grieving caregiver or to avoid presumed stigma from peers. Risk and Prognostic Factors Risk for prolonged grief disorder symptoms is heightened by increased dependency on the deceased prior to the death, by the death of a child, by violent or unexpected deaths, and by economic stressors. The disorder has a higher prevalence following the death of a spouse/partner or child compared with other kinship relationships to the deceased. Disturbances in caregiver availability and support increase the risk for bereaved children. Culture-Related Diagnostic Issues The symptoms of prolonged grief disorder are observed across cultural settings, but grief responses may manifest in culturally specific ways, including in expected duration, and show historical variation. For example, across cultures, nightmares about the deceased may be especially distressing because of their attributed significance; the prevalence of hallucinations of the deceased or of grief-related somatic symptoms may vary; and indirect expressions of prolonged grief disorder-related functional impairment (e.g., unhealthy behaviors like drinking or poor self-care) may be more prevalent than direct expressions of grief. The inability to carry out funerary rituals in some cultures may worsen symptoms of prolonged grief disorder, possibly because of interpretation of their impact on the spiritual status of the deceased. Some studies suggest higher prevalence of the symptoms of prolonged grief disorder in African Americans relative to non-Hispanic Whites; the cause for these elevations requires further study in areas such as differential exposure to sudden or violent death. Differences in mourning practices may contribute to the cultural prescription or prohibition of specific grief expressions, and cultural norms about the social status of the bereaved may affect grief intensity

Normal grief. and duration, such as different levels of support or societal sanction toward remarriage depending on the gender of the bereaved. Diagnosis of the disorder requires that the persistent and severe responses go beyond cultural norms of grief responses and not be better explained by culturally specific mourning rituals. Sex- and Gender-Related Diagnostic Issues Some studies find higher disorder prevalence or symptom severity among bereaved women, but other studies conclude the gender disparity is small and/or not statistically significant. Association With Suicidal Thoughts or Behavior Individuals with symptoms of prolonged grief disorder are at heightened risk for suicidal ideation, even after adjustment for the effect of major depression and PTSD. The association of prolonged grief disorder symptoms and suicidal ideation is consistent across the life span and cross-nationally. However, the existing literature does not establish

whether suicidal ideation associated with symptoms of prolonged grief disorder is linked to a higher incidence of suicidal behavior. Stigma, isolation, thwarted belongingness, avoidance, and psychological distress in bereaved individuals are associated with suicidal ideation. Compared with individuals whose bereavement is due to nonviolent causes, individuals whose prolonged grief disorder symptoms are the result of a violent loss (e.g., homicide, suicide, accident) are at greater risk for suicidal ideation. Similarly, individuals who experience the death of a child, especially if the child is younger than 25, are more likely to develop prolonged grief disorder symptoms that are associated with suicidal ideation. Functional Consequences of Prolonged Grief Disorder Symptoms of prolonged grief disorder are associated with impairments in work and social functioning and with harmful health behaviors, such as increased tobacco and alcohol use. They are also associated with marked increases in risks for serious medical conditions, including cardiac disease, hypertension, cancer, immunological deficiency, and reduced quality of life. Long-term developmental consequences among children and adolescents include premature school withdrawal, diminished educational aspirations, and reduced academic attainment; young women in particular may be hesitant to marry as they transition to adulthood. Impaired cognitive functioning may be associated with symptoms of prolonged grief disorder, especially in middleage and older adults. Differential Diagnosis Prolonged grief disorder is distinguished from normal grief by the presence of severe grief reactions that persist at least 12 months (6 months in children or adolescents) after the death of a person who was close to the bereaved individual. It is only when severe levels of grief response persist for the specified duration following the death, interfere with the individual's capacity to function, and exceed cultural, social, or religious norms that prolonged grief disorder is diagnosed. In evaluating the requirement for clinically significant symptoms to be present most days over the past month, it should be noted that marked increases in grief severity can be seen in normal grieving around calendar

Depressive disorders. Posttraumatic stress disorder. Separation anxiety disorder. Psychotic disorder. days that are reminders of the loss, such as the anniversary of the death, birthdays, wedding anniversaries, and holidays; this exacerbation of grief severity does not by itself, in the absence of persistent grief at other times, constitute evidence of prolonged grief disorder. Prolonged grief disorder, major depressive disorder, and persistent depressive disorder share several symptoms, including low mood, crying, and suicidal thinking. However, in prolonged grief disorder the distress is focused on feelings of loss and separation from a loved one rather than reflecting generalized low mood. Major depressive disorder may also be preceded by the death of a loved one, with or without comorbid prolonged grief disorder. Individuals who experience bereavement as a result of violent or accidental death may develop both PTSD and prolonged grief disorder. Both conditions can involve intrusive thoughts and avoidance. Whereas intrusions in PTSD revolve around the traumatic event (which may have caused the death of a loved one), intrusive memories in prolonged grief disorder focus on thoughts about many aspects of the relationship with the deceased, including positive aspects of the relationship and distress over the separation. Unlike avoidance in PTSD, which is manifested by avoidance of memories, thoughts, or feelings associated with the traumatic event that led to the death of the loved one (e.g., memories of the fatal automobile accident that killed the loved one), the avoidance in prolonged grief disorder is of reminders that the loved one is no longer present (e.g., avoidance of activities carried out together with the deceased). Moreover, reexperiencing memories in PTSD tend to be more perceptual, with the individual reporting that the memory feels like it is occurring in the "here and now," which tends not to be the case in prolonged grief disorder. In prolonged grief disorder, there is also a

yearning for the deceased, which is absent in PTSD. Separation anxiety disorder is characterized by anxiety about separation from current attachment figures, whereas prolonged grief disorder involves distress about separation from a deceased person. Hallucinations about the deceased (e.g., seeing the deceased in a favorite chair) or transient sensations about the presence of the deceased (e.g., by touch, voice, or sight) are common cross-culturally during normal grief, may be experienced as reassuring, and often occur while the individual is falling asleep (hypnagogic). To receive a diagnosis of psychotic disorder, individuals with prolonged grief disorder must also endorse other symptoms of psychosis, such as delusions, disorganized thinking, or negative symptoms. Comorbidity The most common comorbid disorders with symptoms of prolonged grief disorder are major depressive disorder, PTSD, and substance use disorders. PTSD is more frequently comorbid with prolonged grief disorder symptoms when the death occurred in violent or accidental circumstances. Separation anxiety disorder involving major living attachment figures may be comorbid with symptoms of prolonged grief disorder. Other Specified Trauma- and Stressor-Related Disorder

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 response to trauma with PTSD-like symptoms”). 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. Persistent response to trauma with PTSD-like symptoms (i.e., symptoms occurring in response to a traumatic event that fall short of the diagnostic threshold for PTSD and that persist for longer than 6 months, sometimes referred to as “subthreshold/partial PTSD”).
4. Ataque de nervios: See “Culture and Psychiatric Diagnosis” in Section III.
5. Other cultural syndromes: See “Culture and Psychiatric Diagnosis” in Section III.

Unspecified Trauma- and Stressor-Related Disorder 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- and 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).

Revision #1

Created 2026-01-04 19:28:31 UTC by Omar Ayman

Updated 2026-01-04 19:28:31 UTC by Omar Ayman