6B40 Post-traumatic stress disorder

Essential (required) features

- Exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature is required for diagnosis. Such events include, but are not limited to, directly experiencing natural or human-made disasters, combat, serious accidents, torture, sexual violence, terrorism, assault or acute life-threatening illness (e.g. a heart attack); witnessing the threatened or actual injury or death of others in a sudden, unexpected or violent manner; and learning about the sudden, unexpected or violent death of a loved one.
- Following the traumatic event or situation, the development of a characteristic syndrome lasting for at least several weeks consists of all three of the following core elements.
  - The traumatic event is re-experienced in the present: it is not just remembered but is experienced as occurring again in the here and now. This typically occurs in the form of vivid intrusive memories or images; flashbacks, which can vary from mild (there is a transient sense of the event occurring again in the present) to severe (there is a complete loss of awareness of present surroundings); or repetitive dreams or nightmares that are thematically related to the traumatic event. Re-experiencing is typically accompanied by strong or overwhelming emotions, such as fear or horror, and strong physical sensations. Re-experiencing in the present can also involve feelings of being overwhelmed or immersed in the same intense emotions that were experienced during the traumatic event, without a prominent cognitive aspect, and may occur in response to reminders of the event. Reflecting on or ruminating about the event and remembering the feelings experienced at that time are not sufficient to meet the re-experiencing requirement.
  - Reminders likely to produce re-experiencing of the traumatic event are deliberately avoided. Deliberate avoidance may take the form either of active internal avoidance of thoughts and memories related to the event, or external avoidance of people, conversations, activities or situations reminiscent of the event. In extreme cases, the person may change their environment (e.g. move to a different city or change jobs) to avoid reminders.
  - There are persistent perceptions of heightened current threat – for example, as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. Hypervigilant people constantly guard themselves against danger, and feel themselves or others close to them to be under immediate threat either in specific situations or more generally. They may adopt new behaviours designed to ensure safety (e.g. not sitting with their back to the door, repeatedly checking in vehicles' rear-view mirrors).
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Common symptomatic presentations of post-traumatic stress disorder may also include general dysphoria, dissociative symptoms, somatic complaints, suicidal ideation and behaviour, social withdrawal, excessive alcohol or drug use to avoid re-experiencing or manage emotional reactions, anxiety symptoms including panic, and obsessions or compulsions in response to memories or reminders of the trauma.
- The emotional experience of individuals with post-traumatic stress disorder commonly includes anger, shame, sadness, humiliation or guilt, including survivor guilt.

Boundary with normality (threshold)

- A history of exposure to an event or situation of an extremely threatening or horrific nature does not in itself indicate the presence of post-traumatic stress disorder. Many people experience such stressors without developing a disorder. Rather, the presentation must meet all diagnostic requirements for the disorder.

Course features

- Onset of post-traumatic stress disorder can occur at any time during the lifespan following exposure to a traumatic event.
- Onset of post-traumatic stress disorder symptoms typically occurs within 3 months following exposure to a traumatic event. However, delays in the expression of post-traumatic stress disorder symptomology can occur even years after exposure to a traumatic event.
- The symptoms and course of post-traumatic stress disorder can vary significantly over time and among individuals. Recurrence of symptoms may occur after to exposure to reminders of the traumatic event or as a result of experiencing additional life stressors or traumatic events. Some individuals diagnosed with post-traumatic stress disorder can experience persistent symptoms for months or years without reprieve.
- Nearly half of individuals diagnosed with post-traumatic stress disorder will experience complete recovery of symptoms within 3 months of onset.

Developmental presentations

- Post-traumatic stress disorder can occur at all ages, but responses to a traumatic event – that is, the core elements of the characteristic syndrome – can manifest differently depending on age and developmental stage.
- Emerging cognitive capacities and limited verbal abilities for self-reporting in young children (e.g. under 6 years of age) make it more difficult to assess for the presence of re-experiencing, active avoidance of internal states and perceptions of heightened current threat. Assessments of symptoms should not be based exclusively on child-reported internal symptoms, but should include caregiver reports of observable behavioural symptoms emerging after traumatic experiences.
- In younger children, evidence of the core symptoms supporting a diagnosis of post-traumatic stress disorder often manifests behaviourally, such as in trauma-specific re-enactments that may occur during repetitive play or in drawings, frightening dreams without clear content or night terrors, or uncharacteristic impulsivity. However, children may not necessarily appear distressed when talking about or playing out their traumatic recollections, despite substantial impact on psychosocial functioning and development. Other manifestations of post-traumatic stress disorder in preschool-aged children may be less trauma-specific and include both inhibited and disinhibited behaviours. For example, hypervigilance may manifest as increased frequency and intensity of temper tantrums, separation anxiety, regression in skills (e.g. verbal skills, toileting), exaggerated age-associated fears or excessive crying. External avoidance or expressions of recollection of traumatic experiences may be evidenced by a new onset of acting out, protective or rescue strategies, limited exploration or reluctance to engage in new activities, and excessive reassurance-seeking from a trusted caregiver.
- Limited capacity to reflect on and report internal states may also be characteristic of some school-aged children and adolescents. Furthermore, children and adolescents may be more reluctant than adults to report their reactions to traumatic events. In such cases, greater reliance on changes in behaviour such as increased trauma-specific re-enactments or overt avoidance may be necessary.
- Children or adolescents may deny feelings of distress or horror associated with re-experiencing, and rather report no affect or other types of strong or overwhelming emotions as a part of re-experiencing, including those that are non-distressing.
- In adolescence, reluctance to pursue developmental opportunities (e.g. to gain autonomy from caregivers) may be a sign of psychosocial impairment. Self-injurious or risky behaviours (e.g. substance use or unprotected sex) occur at elevated rates among adolescents and adults with post-traumatic stress disorder.
- Assessment can be complicated in children and adolescents when loss of a parent or caregiver is associated with a traumatic event or an intervention. For example, a chronically abused child who is removed from the home may place greater emphasis on the loss of a primary caregiver than on aspects of the experience that might objectively be considered more threatening or horrific.
- Among older adults with post-traumatic stress disorder, symptom severity may decline over the life-course – especially re-experiencing. However, avoidance of situations, people, activities or conversations about the event, as well as hypervigilance, typically persist. Older people may dismiss their symptoms as a normal part of life, which may be related to shame and fear of stigma.

Culture-related features

- The salience of particular post-traumatic stress disorder symptoms may vary across cultures. For example, in some groups anger may be the most prominent symptom related to traumatic exposure, and the most culturally appropriate way of expressing distress. In other cultural contexts, nightmares may have elaborate cultural significance that increases their importance in assessing for the characteristic symptoms of post-traumatic stress disorder.
- Symptoms central to post-traumatic stress disorder in some cultures may not be included in descriptions of the disorder, and may therefore be missed by clinicians unfamiliar with those cultural expressions. For example, somatic symptoms such as headaches (often with visual aura), dizziness, bodily heat, shortness of breath, gastrointestinal distress, trembling and orthostatic hypotension may be prominent.
- Cultural variation may affect post-traumatic stress disorder onset and the meaning of traumatic stressors. For example, some cultural groups attribute greater risk of post-traumatic stress disorder to traumatic events affecting family members than those affecting the person themselves; other societies may find it particularly traumatic to observe the desecration or destruction of religious symbols or to be denied the ability to perform funeral rites for deceased relatives.
- Certain trauma-related symptoms may be associated with intense fear in particular cultural contexts owing to their connection with specific catastrophic cognitions, and may precipitate panic attacks in the context of post-traumatic stress disorder. These catastrophic interpretations may affect the trajectory of the disorder, and may be associated with greater severity, chronicity or poorer response to treatment. For example, some Latin American patients may consider trauma-related trembling to be the precursor of a lifelong condition of severe *nervios* (nerves), and some Cambodians may interpret palpitations as signs of a "weak heart".
- Some post-traumatic stress disorder symptoms may not be viewed as pathological in some cultural groups. For example, intrusive thoughts may be considered normal rather than a symptom indicating illness. It is important to evaluate the presence of all required diagnostic elements, including functional impairment, rather than treating any one symptom as pathognomic.

Sex- and/or gender-related features

- Post-traumatic stress disorder is more common among females.
- Females diagnosed with post-traumatic stress disorder are more likely to experience a longer duration of impairment and higher levels of negative emotionality and somatic symptoms as a part of their clinical presentation.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with complex post-traumatic stress disorder

Whereas the diagnostic requirements for complex post-traumatic stress disorder include all essential features of post-traumatic stress disorder, the diagnosis of complex post-traumatic stress disorder also requires the additional essential features of severe problems in affect regulation, persistent negative beliefs about oneself, and persistent difficulties in sustaining relationships.

Boundary with prolonged grief disorder

As with post-traumatic stress disorder, prolonged grief disorder may occur in individuals who experience bereavement as a result of the death of a loved one occurring in traumatic circumstances. In post-traumatic stress disorder the individual re-experiences the event or situation associated with the death, while in prolonged grief disorder the person may be preoccupied with memories of the circumstances surrounding the death but, unlike in post-traumatic stress disorder, does not re-experience them as occurring again in the here and now.

Boundary with adjustment disorder

In adjustment disorder, the stressor can be of any severity or any type, and is not necessarily of an extremely threatening or horrific nature. A response to a less serious event or situation that otherwise meets the symptom requirements for post-traumatic stress disorder but that is beyond the duration appropriate for acute stress reaction should be diagnosed as adjustment disorder. Moreover, many people who experience an extremely threatening or horrific event develop symptoms that do not meet the full diagnostic requirements for post-traumatic stress disorder; these reactions are generally better diagnosed as adjustment disorder.

Boundary with acute stress reaction

Normal acute reactions to traumatic events can include all the symptoms of post-traumatic stress disorder, including re-experiencing, but these begin to subside fairly quickly (e.g. within 1 week after the event terminates or after removal from the threatening situation, or within 1 month in the case of ongoing stressors). If clinical intervention is warranted in these situations, a diagnosis of acute stress reaction from Chapter 24 on factors influencing health status or contact with health services (i.e. a non-disorder category) is generally most appropriate.

Boundary with schizophrenia and other primary psychotic disorders

Some individuals with post-traumatic stress disorder re-experience traumatic events in the form of severe flashbacks that may have a hallucinatory quality, or are hypervigilant to threat to the extent that they may appear to be paranoid. Auditory pseudo-hallucinations, recognized as being the person's own thoughts and of internal origin, can occur in post-traumatic stress disorder. Such symptoms should not be considered evidence of a psychotic disorder.

Boundary with depressive episode

In a depressive episode, intrusive memories are not experienced as occurring again in the present, but as belonging to the past, and they are often accompanied by rumination. However, depressive episodes commonly co-occur with post-traumatic stress disorder, and an additional mood disorder diagnosis should be assigned if warranted.

Boundary with panic disorder

In post-traumatic stress disorder, panic attacks can be triggered by reminders of the traumatic event or in the context of re-experiencing. Panic attacks that occur entirely in these contexts do not warrant an additional, separate diagnosis of panic disorder. Instead, the *with panic attacks* specifier (MB23.H) may be applied together with the post-traumatic stress disorder diagnosis. However, if unexpected panic attacks (i.e. those that come on "out of the blue") are also present and the other diagnostic requirements are met, an additional diagnosis of panic disorder is appropriate.

Boundary with specific phobia

In some cases, a situational or conditioned specific phobia can arise after exposure to a traumatic event (e.g. being attacked by a dog). Specific phobia can generally be differentiated from post-traumatic stress disorder by the absence of re-experiencing of the event in the present. Although phobic responses may include powerful memories of the event, in response to which the individual experiences anxiety, the memories are experienced as belonging to the past.

Boundary with dissociative disorders

Following an experience of a traumatic event, a variety of dissociative symptoms can occur, including somatic symptoms, memory disturbances, flashbacks or other trance-like states, alterations in identity and sense of agency, and experiences of depersonalization, especially during the episodes of re-experiencing. If the dissociative symptoms are confined to episodes of re-experiencing in an individual with post-traumatic stress disorder or complex post-traumatic stress disorder, an additional diagnosis of a dissociative disorder should not be assigned. If significant dissociative symptoms are present outside episodes of re-experiencing, and the full diagnostic requirements are met, an additional dissociative disorder diagnosis may be assigned.

Boundary with other mental disorders

It is common for mental disorders other than or in addition to post-traumatic stress disorder to develop in the aftermath of an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature. Thus, a history of exposure to a potentially traumatic event does not in itself indicate the presence of post-traumatic stress disorder. Depressive disorders, anxiety and fear-related disorders, disorders due to substance use, and dissociative disorders can all occur in the aftermath of potentially traumatic experiences, often in the absence of post-traumatic stress disorder.

6B41 Complex post-traumatic stress disorder

Essential (required) features

- Exposure to an event or series of events of an extremely threatening or horrific nature – most commonly prolonged or repetitive events from which escape is difficult or impossible – is required for diagnosis. Such events include, but are not limited to, torture, concentration camps, slavery, genocide campaigns and other forms of organized violence, prolonged domestic violence, and repeated childhood sexual or physical abuse.

- Following the traumatic event, the development of a characteristic syndrome lasting for at least several weeks consists of all three of the following core elements of post-traumatic stress disorder.
  - The traumatic event is re-experienced in the present: it is not just remembered but is experienced as occurring again in the here and now. This typically occurs in the form of vivid intrusive memories or images; flashbacks, which can vary from mild (there is a transient sense of the event occurring again in the present) to severe (there is a complete loss of awareness of present surroundings); or repetitive dreams or nightmares that are thematically related to the traumatic event. Re-experiencing is typically accompanied by strong or overwhelming emotions, such as fear or horror, and strong physical sensations. Re-experiencing in the present can also involve feelings of being overwhelmed or immersed in the same intense emotions that were experienced during the traumatic event, without a prominent cognitive aspect, and may occur in response to reminders of the event. Reflecting on or ruminating about the event and remembering the feelings experienced at that time are not sufficient to meet the re-experiencing requirement.
  - Reminders likely to produce re-experiencing of the traumatic event are deliberately avoided. Deliberate avoidance may take the form either of active internal avoidance of thoughts and memories related to the event, or external avoidance of people, conversations, activities or situations reminiscent of the event. In extreme cases, the person may change their environment (e.g. move house or change jobs) to avoid reminders.
  - There are persistent perceptions of heightened current threat – for example, as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. Hypervigilant people constantly guard themselves against danger, and feel themselves or others close to them to be under immediate threat either in specific situations or more generally. They may adopt new behaviours designed to ensure safety (e.g. not sitting with their back to the door, repeatedly checking in vehicles' rear-view mirrors). In complex post-traumatic stress disorder, unlike in post-traumatic stress disorder, the startle reaction may in some cases be diminished rather than enhanced.

- The presentation is characterized by severe and pervasive problems in affect regulation. Examples include heightened emotional reactivity to minor stressors, violent outbursts, reckless or self-destructive behaviour, dissociative symptoms when under stress, and emotional numbing – particularly the inability to experience pleasure or positive emotions.
- Persistent beliefs about oneself as diminished, defeated or worthless are accompanied by deep and pervasive feelings of shame, guilt or failure related to the stressor. For example, the individual may feel guilty about not having escaped from or succumbing to the adverse circumstance, or not having been able to prevent the suffering of others.
- Persistent difficulties in sustaining relationships and in feeling close to others are present. The individual may consistently avoid, deride or have little interest in relationships and social engagement more generally. Alternatively, there may be occasional intense relationships, but the individual has difficulty sustaining them.
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Suicidal ideation and behaviour, substance abuse, depressive symptoms, psychotic symptoms and somatic complaints may be present.

Boundary with normality (threshold)

- A history of exposure to a stressor of extreme and prolonged or repetitive nature, from which escape is difficult or impossible, does not in itself indicate the presence of complex post-traumatic stress disorder. Many people experience such stressors without developing any disorder. Rather, the presentation must meet all diagnostic requirements for the disorder.

Course features

- The onset of complex post-traumatic stress disorder symptoms can occur across the lifespan – typically after exposure to chronic, repeated traumatic events and/or victimization that have continued for a period of months or years at a time.
- Symptoms of complex post-traumatic stress disorder are generally more severe and persistent in comparison to those of post-traumatic stress disorder.
- Exposure to repeated traumas, especially in early development, is associated with a greater risk of developing complex post-traumatic stress disorder rather than post-traumatic stress disorder.

Developmental presentations

- Complex post-traumatic stress disorder can occur at all ages, but responses to a traumatic event – that is, the core elements of the characteristic syndrome – can manifest differently depending on age and developmental stage. Because complex post-traumatic stress disorder and post-traumatic stress disorder share these same core elements, information provided in the *developmental presentations* section for post-traumatic stress disorder also applies to children and adolescents affected by complex post-traumatic stress disorder.
- Children and adolescents are more vulnerable than adults to developing complex post-traumatic stress disorder when exposed to severe, prolonged trauma such as chronic child abuse, participation in drug trafficking or being used as child soldiers. Many children and adolescents exposed to trauma have been exposed to multiple traumas, which increases the risk of developing complex post-traumatic stress disorder.

- Children and adolescents with complex post-traumatic stress disorder are more likely than their peers to demonstrate cognitive difficulties (e.g. problems with attention, planning, organizing) that may in turn interfere with academic and occupational functioning.
- In children, pervasive problems of affect regulation and persistent difficulties in sustaining relationships may manifest as regression, reckless behaviour or aggressive behaviours towards themselves or others, and in difficulties relating to peers. Furthermore, problems of affect regulation may manifest as dissociation, suppression of emotional experience and expression, and avoidance of situations or experiences that may elicit emotions, including positive emotions.
- In adolescence, substance use, risk-taking behaviours (e.g. unsafe sex, unsafe driving, non-suicidal self-harm) and aggressive behaviours may be particularly evident as expressions of problems of affect dysregulation and interpersonal difficulties.
- When parents or caregivers are the source of the trauma (e.g. sexual abuse), children and adolescents often develop a disorganized attachment style that can manifest as unpredictable behaviours towards these individuals (e.g. alternating between neediness, rejection and aggression). In children under 5 years of age, attachment disturbances related to maltreatment may also include reactive attachment disorder or disinhibited social engagement disorder, which can co-occur with complex post-traumatic stress disorder.
- Children and adolescents with complex post-traumatic stress disorder often report symptoms consistent with depressive disorders, eating and feeding disorders, sleep-wake disorders, attention deficit hyperactivity disorder, oppositional defiant disorder, conduct-dissocial disorder and separation anxiety disorder. The relationship of traumatic experiences to the onset of symptoms can be useful in establishing a differential diagnosis. At the same time, other mental disorders can also develop following extremely stressful or traumatic experiences. Additional co-occurring diagnoses should only be made if the symptoms are not fully accounted for by complex post-traumatic stress disorder, and all diagnostic requirements for each disorder are met.
- In older adults, complex post-traumatic stress disorder may be dominated by anxious avoidance of thoughts, feelings, memories and people, as well as physiological symptoms of anxiety (e.g. enhanced startle reaction, autonomic hyper-reactivity). Affected individuals may experience intense regret related to the impact of traumatic experiences on their lives.

Culture-related features

- Cultural variation exists in the expression of symptoms of complex post-traumatic stress disorder. For example, somatic or dissociative symptoms may be more prominent in certain groups, attributable to cultural interpretations of the psychological, physiological and spiritual etiology of these symptoms and of high levels of arousal.
- Given the severe, prolonged or recurrent nature of the traumatic events that precipitate complex post-traumatic stress disorder, collective suffering and the destruction of social bonds, networks and communities may present as a focal concern or as important related features of the disorder.
- For migrant communities – especially refugees or asylum seekers – complex post-traumatic stress disorder may be exacerbated by acculturative stressors and the social environment in the host country.

Sex- and/or gender-related features

- Females are at greater risk of developing complex post-traumatic stress disorder.
- Females with complex post-traumatic stress disorder are more likely to exhibit a greater level of psychological distress and functional impairment.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with personality disorder

Many individuals with personality disorder have a history of traumatic events, particularly in childhood, and affective dysregulation can be a feature of both complex PTSD and personality disorder, particularly personality disorder with borderline pattern. However, there are several ways in which the specific symptom profiles of the two disorders differ. Avoidance of trauma-related reminders and a heightened sense of current threat are not diagnostic features of personality disorders. Intimate and interpersonal relationships in complex PTSD are less likely to be characterized by fear of abandonment and relationship instability, but rather by avoidance and a general sense of disconnection. Individuals with complex PTSD tend to manifest a stable but persistently negative self-view, in contrast to personality disorder in which an unstable sense of self is more common. Whereas personality disorder is more likely to be characterized by frequent impulsive behaviors, including impulsive suicidality, suicidality among individuals with complex PTSD tends to be less frequent, less impulsive, and of higher lethality. If the diagnostic requirements for both disorders are met, the utility of assigning an additional diagnosis of personality disorder depends on the specific clinical situation.

Boundary with other mental, behavioural and neurodevelopmental disorders

Because the diagnostic requirements for complex post-traumatic stress disorder include all essential features of post-traumatic stress disorder, guidance provided in the sections on boundary with normality (threshold) and boundaries with other disorders and conditions (differential diagnosis) for post-traumatic stress disorder also applies to complex post-traumatic stress disorder.

6B42 Prolonged grief disorder

Essential (required) features

- A history of bereavement following the death of a partner, parent, child or other person close to the bereaved is required for diagnosis.