# ICD-11 DIAGNOSTIC GUIDELINES

## Disorders Specifically Associated with Stress

*Note:* This document contains a pre-publication version of the ICD-11 diagnostic guidelines for Disorders Specifically Associated with Stress. There may be further edits to these guidelines prior to their publication.

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# DISORDERS SPECIFICALLY ASSOCIATED WITH STRESS

*Disorders Specifically Associated with Stress* are directly related to exposure to a stressful or traumatic event, or a series of such events or adverse experiences. For each of the disorders in this grouping, an identifiable stressor is a necessary, though not sufficient, causal factor. Most people who experience stressors do not develop a disorder. Stressful events for some disorders in this grouping are within the normal range of life experiences (e.g., divorce, socio-economic problems, bereavement). Other disorders require exposure to a stressor that is extremely threatening or horrific in nature (i.e., potentially traumatic events). With all disorders in this grouping, it is the nature, pattern, and duration of the symptoms that arise in response to the stressful events—together with associated functional impairment—that distinguishes the disorders.

*Disorders Specifically Associated with Stress* include the following:

6B40 Post-Traumatic Stress Disorder
6B41 Complex Post-Traumatic Stress Disorder
6B42 Prolonged Grief Disorder
6B43 Adjustment Disorder
6B44 Reactive Attachment Disorder
6B45 Disinhibited Social Engagement Disorder
6B4Y Other Specified Disorders Specifically Associated with Stress

The categories in the grouping of Disorders Specifically Associated with Stress should not be used to classify normal responses to recent stressful or traumatic events.

To assist in differential diagnosis, also listed here is:

QF74 Acute Stress Reaction

Normal responses to recent traumatic events may be classifiable under Acute Stress Reaction. Acute Stress Reaction is not considered to be a mental disorder, but rather appears in the section of the ICD-11 that lists reasons for clinical encounters that are not diseases or disorders.

*General Cultural Considerations in Disorders Specifically Associated with Stress:*

- Culturally sanctioned and recognized concepts and means of expressing distress, such as local idioms of distress, explanations, and syndromes, may be a prominent part of the trauma response. Examples of these cultural concepts include possession states in many cultural groups, *susto* or *espanto* (fright) among Latin American populations, *ohkumlang* (tiredness) and bodily pain among tortured Bhutanese refugees, *ihahamuka* (lungs without breath) among Rwandan genocide survivors, and *kit chraen* (thinking too much) in Cambodia, among others. The symptoms of Disorders Specifically Associated with Stress may be described in terms of emotional, cognitive, behavioural and somatic elements of these cultural concepts. Idioms of distress may also influence the symptomatology and co-occurrence of other mental disorders.

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- Individuals from collectivistic cultures may focus their concern on family and community relationships rather than personal reactions to trauma. The clinical presentation may include guilt or shame about perceived failures to assist others or fulfil culturally important social roles. For example, survivors of sexual violence may be preoccupied with the shame their family may incur because of the event.
- Across cultures, traumatic events may be attributed to a variety of spiritual or supernatural causes, such as karma, fate, envy, witchcraft/sorcery, or vengeful spirits. These attributions influence the personal and social impact of stressors and the nature of the individual's response.
- Knowledge of cultural norms is necessary to assess the severity of the trauma response, in particular, whether psychotic symptoms should be considered consistent with certain cultural expressions of the disorder, a manifestation of another mental disorder (e.g., a psychotic disorder), or consistent with normal functioning within that cultural context.
- The traumatic impact of certain exposures may be strongly influenced by cultural interpretations. For example, for some cultural groups, exposure to the destruction of religious and holy sites or sacred artifacts may be more stressful than personal trauma. It is the characteristic syndromic response that determines whether a diagnosis of a particular disorder is appropriate.
- Migrant populations may experience higher levels of distress related to traumatic exposure as a function of concomitant social factors, including poverty, discrimination by the receiving community, and acculturative stressors.

## 6B40 Post-Traumatic Stress Disorder

*Essential Features:*

- Exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature. 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, consisting of all three core elements:
    - Re-experiencing the traumatic event in the present, in which the event(s) 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(s). 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(s) and

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remembering the feelings that one experienced at that time are not sufficient to meet the re-experiencing requirement.
    - Deliberate avoidance of reminders likely to produce re-experiencing of the traumatic event(s). This may take the form either of active internal avoidance of thoughts and memories related to the event(s), or external avoidance of people, conversations, activities, or situations reminiscent of the event(s). In extreme cases the person may change his or her environment (e.g., move to a different city or change jobs) to avoid reminders.
    - Persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. Hypervigilant persons 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 ones' back to the door, repeated 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 life span following exposure to a traumatic event.
- Onset of Post-Traumatic Stress Disorder symptoms typically occurs within three 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 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

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events. Some individuals diagnosed with Post-Traumatic Stress Disorder can experience persistent symptoms for months or years without reprieve.
- Nearly one 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—manifest differently depending on age and developmental stage.
- Emerging cognitive capacities and limited verbal abilities for self-report in young children (e.g., less than 6 years of age) makes 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 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 reenactments 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 pre-school 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-age 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 reenactments or overt avoidance may be necessary.
- Children or adolescents may deny feelings of distress or horror associated with re-experiencing but 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

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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(s) as well as hypervigilance typically persist. Older persons 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 the person him/herself; 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, due to their connection with specific catastrophic cognitions, and may precipitate panic attacks in the context of Post-Traumatic Stress Disorder. These catastrophic interpretations may impact the trajectory of the disorder and 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 pathognomonic.

*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.

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*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:*** Similar to 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, where the individual re-experiences the event or situation associated with the death, 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 removal from the threatening situation, or 1 month in the case of ongoing stressors). If clinical intervention is warranted in these situations, a diagnosis of Acute Stress Reaction from the chapter 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(s) 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’ qualifier (MB23.H) may be applied. However, if unexpected panic attacks (i.e., those that come on ‘out of the blue’)

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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(s), 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 of 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 other 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 or 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 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. 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 all three core elements of Post-Traumatic Stress Disorder, lasting for at least several weeks:
    - Re-experiencing the traumatic event after the traumatic event has occurred, in which the event(s) 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(s). 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

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  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(s) and remembering the feelings that one experienced at that time are not sufficient to meet the re-experiencing requirement.
  - Deliberate avoidance of reminders likely to produce re-experiencing of the traumatic event(s). This may take the form either of active internal avoidance of relevant thoughts and memories related to the event(s), or external avoidance of people, conversations, activities, or situations reminiscent of the event(s). In extreme cases the person may change his or her environment (e.g., move house or change jobs) to avoid reminders.
  - Persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. Hypervigilant persons 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 (not sitting with ones' back to the door, repeated checking in vehicles' rear-view mirror). In Complex Post-Traumatic Stress Disorder, unlike in Post-Traumatic Stress Disorder, the startle reaction may in some cases be diminished rather than enhanced.
- 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, 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. The person may consistently avoid, deride or have little interest in relationships and social engagement more generally. Alternatively, there may be occasional intense relationships, but the person 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.

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*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 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 both 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 or participation in drug trafficking or as child soldiers. Many children and adolescents exposed to trauma have been exposed to multiple traumas, which increases the risk for 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 regressive, reckless, or aggressive behaviours towards self or others, and in difficulties relating to peers. Furthermore, problems of affect regulation may manifest as dissociation, suppression of emotional experience and expression, as well as 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 less than 5 years old, 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

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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 persons as well as physiological symptoms of anxiety (e.g., enhanced startle reaction, autonomic hyperreactivity). 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.

*Gender-Related Features:*

- Females are at greater risk for developing Complex Post-Traumatic Stress Disorder than males.
- Females with Complex Post-Traumatic Stress Disorder are more likely to exhibit a greater level of psychological distress and functional impairment in comparison to males.

*Boundaries with Other Disorders and Conditions (Differential Diagnosis):*

- ***Boundary with Personality Disorder:*** Personality Disorder is a pervasive disturbance in how an individual experiences and thinks about the self, others, and the world, manifested in maladaptive patterns of cognition, emotional experience, emotional expression, and behaviour. The maladaptive patterns are relatively inflexible and are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships and are manifest across a range of personal and social situations (i.e., are not limited to specific relationships or situations), relatively stable over time, and of long duration. Given this broad definition and the requirement of persistent symptoms related to affect dysregulation, distorted view of the self, and difficulty maintaining relationships in Complex Post-Traumatic Stress Disorder, many individuals with Complex Post-Traumatic Stress Disorder may also meet the diagnostic

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requirements for Personality Disorder. The utility of assigning an additional diagnosis of Personality Disorder in such cases depends on the specific clinical situation.
- ***Boundary with other Mental and Behavioural Disorders:*** Because the diagnostic requirements for Complex Post-Traumatic Stress Disorder include all Essential Features of Post-Traumatic Stress Disorder, guidance provided in the section on 'Boundary with Normality' and 'Boundaries with Other Disorders and Conditions' for Post-Traumatic Stress Disorder also applies to Complex Post-Traumatic Stress Disorder.

## 6B42 Prolonged Grief Disorder

*Essential Features:*

- History of bereavement following the death of a partner, parent, child, or other person close to the bereaved.
- A persistent and pervasive grief response characterized by longing for the deceased or persistent preoccupation with the deceased accompanied by intense emotional pain. This may be manifested by experiences such as sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to experience positive mood, emotional numbness, and difficulty in engaging with social or other activities.
- The pervasive grief response has persisted for an atypically long period of time following the loss, markedly exceeding expected social, cultural or religious norms for the individual's culture and context. Grief responses lasting for less than 6 months, and for longer periods in some cultural contexts, should not be regarded as meeting this requirement.
- 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:*

- Persistent preoccupation may focus on the circumstances of the death or manifest as behaviours such as the preservation of all of the deceased person's belongings exactly as they were before their death. The individual may alternate between excessive preoccupation and avoidance of reminders of the deceased.
- Other features of Prolonged Grief Disorder may include problems coping without the loved one, difficulties in recalling positive memories of the deceased, difficulty trusting others, social withdrawal, and the feeling that life is meaningless.
- Increased tobacco, alcohol, and other substance use, as well as increased suicidal ideation and behaviour may be present.

*Boundary with Normality (Threshold):*

- An individual experiencing a grief reaction that is within a normative period given their cultural and religious context is considered to be experiencing normal bereavement and should not be assigned a diagnosis of Prolonged Grief Disorder. It is often important to consider whether other people who share the bereaved person's cultural or religious

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perspective (e.g., family, friends, community) regard the response to the loss or duration of the reaction as abnormal.
- Children and adolescents may respond to the loss of a primary attachment figure (e.g., a parent or caregiver) with an intense and sustained grief response (e.g., greater in intensity, symptomatology, duration) because of the role these individuals play in the child's life. Pre-school age children commonly have difficulty accepting the loss. Aspects of the grief response may be retriggered at various points during the individual's development, for example as new needs arise that would normally be supplied by the parent or caregiver. Generally, these reactions should be regarded as normal and the diagnosis of Prolonged Grief Disorder should be assigned with caution to children and adolescents in this situation.

*Developmental Presentations:*

- Prolonged Grief Disorder can occur at all ages, but the grief response can differ depending on the age and developmental stage and thus on age-specific concepts of death.
- Children often do not explicitly describe the experience of longing for the deceased or persistent preoccupation with the death of a loved one. These symptoms may be more likely to manifest behaviourally such as in play or in other behaviours involving themes of separation or death. Other behavioural expressions of longing can include waiting for the deceased person to return or returning to places where they last saw the deceased. Some children may develop a fearful preoccupation that others may die, magical thinking, as well as separation anxiety centering on worries about their caregivers' welfare and safety.
- In younger children, intense sadness or emotional pain may emerge intermittently with seemingly appropriate moods. Anger related to the loss may be exhibited in children and adolescents as irritability, protest behaviour, tantrums, oppositional behaviour or conduct problems.
- Various contextual factors can influence symptoms related to the death of a loved one in children. For example, delayed onset or worsening of symptoms may occur in response to a change to a child or adolescent's social environment, degree of coping of parents or caregivers with the loss, and family communication.
- In older adults, Prolonged Grief Disorder may manifest as enduring depression with the feeling one has lost a part of one's self and accentuated feelings of emptiness. Feelings of being stunned and dazed over the loss are common. A preoccupation with somatic complaints is often found to be the primary sign of distress at this developmental stage.

*Culture-Related Features:*

- Cultural practices vary with regard to appropriate emotional expressions of bereavement, rituals and practices for managing the grieving process, modes of commemorating the deceased, concepts of an afterlife, stigma associated with certain types of death (e.g., suicide), or situations that may be especially traumatic (e.g., death of a child). This variation may contribute to the likelihood of experiencing prolonged grief reactions, and the range of symptoms and clinical presentations.
- Cultural groups vary regarding the normative duration of grief reactions. Among some groups, prescribed grief reactions may last for one year or even be postponed until the

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first anniversary. Among others, rituals or ceremonies are expected to prompt negative emotions related to loss, and formal grieving periods are relatively short. It is often important to consider whether other people who share the bereaved person's cultural or religious perspective (e.g., family, friends, community) regard the response to the loss or duration of the reaction as abnormal.

- In some cultural or religious traditions, death is not seen as the cessation of life, but as an important transition to another form of existence. Such cultural beliefs may focus on karma, rebirth, heaven/hell, purgatory, or other transitions into the afterlife. Prolonged grief may be caused by concern about the status of the deceased in the afterlife. Culturally specific rituals and yearly celebrations may aim to assure the auspicious spiritual status of the deceased. Prolonged grief may be associated with concern about the status of the deceased in the afterlife.
- Encounters with the deceased may vary greatly across cultures. For example, in some societies, any waking encounter with the deceased is considered abnormal. By contrast, it is common in many Southern European and Latin American societies to receive visitations from deceased relatives soon after their death, which may be comforting to the bereaved. Other groups (e.g., some American Indians) may encounter the deceased in dreams, with a variety of interpretations. Among Cambodians, for example, having dreams of the deceased may be highly upsetting, indicating that rebirth has not occurred.

*Gender-Related Features:*

- Prolonged Grief Disorder is more prevalent in females.

*Boundaries with Other Disorders and Conditions (Differential Diagnosis):*

- ***Boundary with Post-Traumatic Stress Disorder:*** Similar to 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 Prolonged Grief Disorder the person may be preoccupied with memories of the circumstances surrounding the death but unlike Post-Traumatic Stress Disorder does not re-experience them as occurring again in the here and now.
- ***Boundary with Depressive Episode:*** Some common symptoms of Prolonged Grief Disorder are similar to those observed in a Depressive Episode (e.g., sadness, loss of interest in activities, social withdrawal, feelings of guilt, suicidal ideation). However, Prolonged Grief Disorder is differentiated from Depressive Episode because symptoms are specifically focused on the loss of the loved one, whereas depressive thoughts and emotional reactions typically encompass multiple areas of life. Further, other common symptoms of Prolonged Grief Disorder (e.g., difficulty accepting the loss, feeling angry about the loss, feeling as though a part of the individual has died) are not characteristic of a Depressive Episode. The timing of the onset of the symptoms in relation to the loss and whether there is a prior history of Depressive or Bipolar Disorder are important to consider in making this distinction. However, Prolonged Grief Disorder and Mood Disorders can co-occur, and both should be diagnosed if the full diagnostic requirements for each are met.

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**6B43 Adjustment Disorder**

*Essential Features:*

- A maladaptive reaction to an identifiable psychosocial stressor or multiple stressors (e.g., single stressful event, ongoing psychosocial difficulty or a combination of stressful life situations) that usually emerges within a month of the stressor. Examples include divorce or loss of a relationship, loss of a job, diagnosis of an illness, recent onset of a disability, and conflicts at home or work.
- The reaction to the stressor is characterized by preoccupation with the stressor or its consequences, including excessive worry, recurrent and distressing thoughts about the stressor, or constant rumination about its implications.
- The symptoms are not better accounted for by another mental disorder (e.g., a Mood Disorder, another Disorder Specifically Associated with Stress).
- Once the stressor and its consequences have ended, the symptoms resolve within 6 months.
- Failure to adapt to the stressor 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:*

- Symptoms of preoccupation may worsen with reminders of the stressor(s), resulting in avoidance of stimuli, thoughts, feelings or discussions associated with the stressor(s) to prevent preoccupation or distress.
- Additional psychological symptoms of Adjustment Disorder may include depressive or anxiety symptoms as well as impulsive ‘externalizing’ symptoms, particularly increased tobacco, alcohol, or other substance use.
- Symptoms of Adjustment Disorders usually abate when the stressor is removed, when sufficient support is provided, or when the affected person develops additional coping mechanisms or strategies.

*Boundary with Normality (Threshold):*

- Adjustment Disorder represents a maladaptive reaction and failure to adapt to a stressor that is associated with significant preoccupation and results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Emotional reactions to negative life events that do not meet these requirements should not be diagnosed as Adjustment Disorder.
- Symptoms that occur as transient responses and resolve within a few days do not typically warrant a diagnosis of Adjustment Disorder.
- In cases in which responses to traumatic events are considered normal given the severity of the stressor, Acute Stress Reaction may be assigned.

*Course Features:*

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- Onset of Adjustment Disorder usually occurs within a month after exposure to a stressful life event (i.e., illness, marital distress). However, onset can occur after a longer delay (e.g., 3 months after exposure).
- Acute and intense stressful life events (e.g., sudden job loss) typically result in a correspondingly precipitous onset of symptoms that tend to have a shorter duration, whereas more persistent stressful life events (e.g., ongoing marital distress) typically result in delayed onset of symptoms and a longer duration.
- The intensity and duration of Adjustment Disorder varies widely.

*Developmental Presentations:*

- In children, the characteristic symptoms of preoccupation with a stressor or its consequences or constant rumination about the stressor are often not expressed directly but rather are manifested in somatic symptoms (e.g., stomach aches or headaches), disruptive or oppositional behaviour, hyperactivity, tantrums, concentration problems, irritability, and increased clinginess. Other reactions to stressors including regression, bedwetting, and sleep disturbances may be a manifestation of Adjustment Disorder if they are persistent (e.g., have been present for approximately 1 month).
- In adolescents, behavioural manifestations of Adjustment Disorder can include substance use and various forms of acting out or risk-taking.
- Because children and adolescents may not explicitly verbalize a connection between stressful events and their own symptoms and behaviours, in making the diagnosis it is important to consider the temporal relationship between the stressor and the onset of symptoms and the extent to which they constitute a change from prior functioning.
- Among older adults, preoccupation with somatic complaints is a common sign of distress related to stressors. Older adults who suffer from Adjustment Disorder tend to express greater anxiety about their health, report significant demoralization, and often display persistent somatization of psychological symptoms.

*Culture-Related Features:*

- Adjustment Disorder may be exacerbated in the context of limited family or community support, particularly in collectivistic or sociocentric cultures. In these societies, the focus of the preoccupation may extend to stressors affecting close relatives or friends.
- Symptoms of Adjustment Disorder may be influenced by local idioms (e.g., *susto* or *espanto* [fright] in Central America) that are associated with fear or subsequent preoccupation with a stressor with strong cultural connotations (e.g., experiencing intense fear when crossing an unpopulated area alone at night).

*Boundaries with Other Disorders and Conditions (Differential Diagnosis):*

- ***Boundary with Post-Traumatic Stress 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 should be diagnosed as Adjustment Disorder. Moreover, many people who have experienced an extremely threatening or horrific event develop Adjustment Disorder and not Post-Traumatic Stress Disorder in its aftermath. The distinction should be made based on whether the full

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diagnostic requirements for either disorder are met, not solely based on the type of stressor.

- ***Boundary with other mental disorders:*** It is common for mental disorders to be triggered or exacerbated by stressful life experiences. Moreover, many mental disorders can involve symptoms including maladaptive reactions to stressors, preoccupation with stressors and excessive worry or rumination, and failure to adapt. In the presence of another mental disorder that can account for these symptoms (e.g., a Primary Psychotic Disorder, a Mood Disorder, another Disorder Specifically Associated with Stress, a Personality Disorder, an Obsessive-Compulsive or Related Disorder, Generalized Anxiety Disorder, Separation Anxiety Disorder, Autism Spectrum Disorder), a separate diagnosis of Adjustment Disorder should generally not be assigned, even if stressful life events or changing circumstances have led to an exacerbation of the symptoms. However, a diagnosis of Adjustment Disorder may be assigned in the presence of other mental disorders with substantially non-overlapping symptomatology (e.g., Specific Phobia, Panic Disorder, Bodily Distress Disorder) that do not fully account for the Adjustment Disorder symptoms, provided that the course of the two disorders is distinguishable and the full diagnostic requirements are met for each. If symptoms persist for longer than 6 months after a stressor has ended, it is generally appropriate to change the diagnosis to another relevant mental disorder.

## 6B44 Reactive Attachment Disorder

*Essential (Required) Features:*

- A history of grossly insufficient care that may include:
  - Persistent disregard for the child's basic emotional needs for comfort, stimulation, and affection.
  - Persistent disregard for the child's basic physical needs.
  - Repeated changes of primary caregivers (e.g., frequent changes in foster care providers).
  - Rearing in unusual settings (e.g., institutions) that prevent formation of stable selective attachments.
  - Maltreatment.
- Markedly abnormal attachment behaviours towards adult caregivers in a child, characterized by a persistent and pervasive pattern of inhibited, emotionally withdrawn behaviour including both of the following:
  - Minimal seeking of comfort when distressed.
  - Rare or minimal response to comfort when it is offered.
- The grossly insufficient care is presumed to be responsible for the persistent and pervasive pattern of inhibited, emotionally withdrawn behaviour.
- The symptoms are evident before the age of 5.
- The child has reached a developmental level by which the capacity to form selective attachments with caregivers normally develops, which typically occurs at a chronological age of 1 year or a developmental age of at least 9 months.
- The abnormal attachment behaviours are not better accounted for by Autism Spectrum Disorder.
- The abnormal attachment behaviours are not confined to a specific dyadic relationship.

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*Additional Clinical Features:*

- Persistent disregard for the child's basic needs may meet the definition for neglect: Egregious acts or omissions by a caregiver that deprive a child of needed age-appropriate care and that result, or have reasonable potential to result, in physical or psychological harm. Reactive Attachment Disorder is associated with persistent neglect rather than isolated incidents.
- Maltreatment is characterized by one or more of the following: 1) non-accidental acts of physical force that result, or have reasonable potential to result, in physical harm or that evoke significant fear; 2) sexual acts involving a child that are intended to provide sexual gratification to an adult; or 3) non-accidental verbal or symbolic acts that results in significant psychological harm. Reactive Attachment Disorder is typically associated with persistent maltreatment rather than isolated incidents.
- Children with Reactive Attachment Disorder related to repetitive maltreatment (e.g., chronic physical or sexual abuse) are at risk for developing co-occurring Post-Traumatic Stress Disorder or Complex Post-Traumatic Stress Disorder.
- Children with Reactive Attachment Disorder often exhibit more generalized persistent social and emotional disturbances including a relative lack of social and emotional responsiveness to others and limited positive affect. There may be episodes of unexplained irritability, sadness, or fearfulness that are evident during non-threatening interactions with adult caregivers.
- Children with a history of grossly insufficient care but who have nonetheless formed selective attachments do not appear to develop Reactive Attachment Disorder but may still be at risk of developing Disinhibited Social Engagement Disorder.

*Boundary with Normality (Threshold):*

- Many children without a diagnosis of Reactive Attachment Disorder show transient reductions of attachment behaviours towards a parent or caregiver as a normal part of development. In contrast, children with Reactive Attachment Disorder exhibit markedly atypical social responses toward caregivers that persist over time, extend across all social situations, and are not confined to a dyadic relationship with a particular caregiver.

*Course Features:*

- With the provision of adequate care, children with Reactive Attachment Disorder often experience a near or complete remission of symptoms. If appropriate caregiving is not provided, the disorder can persist for several years.
- Children with Reactive Attachment Disorder are at higher risk for developing Depressive Disorders and other internalizing disorders during adolescence and adulthood. They may also experience problems in developing and maintaining healthy interpersonal relationships.
- There is limited information about the course features of Reactive Attachment Disorder beyond the childhood years.
- Some adults with a history of Reactive Attachment Disorder may experience difficulty in developing interpersonal relationships.

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*Developmental Presentations:*

- Caregiver neglect during the first 9 months of life is often an associated precursor to the onset of the disorder.
- The features of this disorder become noticeable in a similar fashion up to 5 years of age.
- It is currently unknown whether clinical features of the disorder vary among children older than 5 years of age.

*Boundaries with Other Disorders and Conditions (Differential Diagnosis):*

- ***Boundary with Autism Spectrum Disorder:*** In contrast to individuals with Autism Spectrum Disorder, children with Reactive Attachment Disorder have the capacity for initiating and sustaining social communication and reciprocal social interactions. Although some children with Reactive Attachment Disorder may show delays in language development due to a history of social neglect, they do not exhibit social communication deficits or the persistently restrictive, repetitive, and stereotyped patterns of behaviour, interests and activities characteristics of Autism Spectrum Disorder. Some individuals reared under conditions of severe deprivation in institutional settings exhibit autistic-like features including difficulties in social reciprocity and restricted, repetitive, and inflexible patterns of behaviour, interests, or activities. Also referred to as 'quasi-autism', affected individuals are differentiated from those with Autism Spectrum Disorder based on significant improvement of autism-like features when the child is moved to a more nurturing environment.
- ***Boundary with Disorders of Intellectual Development:*** Children with Disorders of Intellectual Development are able to form selective attachments to caregivers. Attachment usually develops consistent with the child's general developmental level, and are typically evident by the time the child has reached a developmental age of at least 9 months. Reactive Attachment Disorder should only be diagnosed if it is clear that the characteristic problems in the formation of selective attachments are not a result of limitations in intellectual functioning.
- ***Boundary with Social Anxiety Disorder:*** Social Anxiety Disorder in children may include emotionally withdrawn behaviours in social situations or in anticipation of social encounters due to marked and excessive fear or anxiety. Unlike in Reactive Attachment Disorder, children with Social Anxiety Disorder exhibit appropriate attachment behaviours with parents or caregivers and seek comfort from them when distressed but are typically fearful of unfamiliar individuals. Children with Reactive Attachment Disorder exhibit emotionally withdrawn behaviours across all social contexts.
- ***Boundary with Depressive Disorders:*** Like Reactive Attachment Disorders, children with Depressive Disorders may exhibit emotionally withdrawn behaviour as well as associated features of lack of social and emotional responsiveness to others, limited positive affect, and/or episodes of unexplained irritability, sadness, or fearfulness. However, unlike Reactive Attachment Disorders, children with Depressive Disorders exhibit appropriate attachment behaviours with parents or caregivers and seek comfort from them when distressed.

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## 6B45 Disinhibited Social Engagement Disorder

*Essential (Required) Features:*

- A history of grossly insufficient care of a child that may include:
    - Persistent disregard for the child's basic emotional needs for comfort, stimulation, and affection.
    - Persistent disregard for the child's basic physical needs.
    - Repeated changes of primary caregivers (e.g., frequent changes in foster care providers).
    - Rearing in unusual settings (e.g., institutions) that prevent formation of stable selective attachments.
    - Maltreatment.
- A persistent and pervasive pattern of markedly abnormal social behaviours in a child, in which the child displays reduced or absent reticence in approaching and interacting with unfamiliar adults, including one or more of the following:
    - Overly familiar behaviour with unfamiliar adults, including verbal or physical violation of socially appropriate physical and verbal boundaries (e.g., seeking comfort from unfamiliar adults, asking age-inappropriate questions to unfamiliar adults).
    - Diminished or absent checking back with an adult caregiver after venturing away even in unfamiliar settings.
    - A willingness to go off with an unfamiliar adult with minimal or no hesitation.
- The symptoms are evident before the age of 5.
- The child has reached a developmental level by which the capacity to form selective attachments with caregivers normally develops, which typically occurs at a chronological age of 1 year or a developmental age of at least 9 months.
- The disinhibited social engagement behaviour is not better accounted for by another mental disorder (e.g., Attention Deficit Hyperactivity Disorder).

*Additional Clinical Features:*

- Persistent disregard for the child's basic needs may meet the definition for neglect: Egregious acts or omissions by a caregiver that deprive a child of needed age-appropriate care and that result, or have reasonable potential to result, in physical or psychological harm. Disinhibited Social Engagement Disorder is associated with persistent neglect rather than isolated incidents.
- Maltreatment is characterized by one or more of the following: 1) non-accidental acts of physical force that result, or have reasonable potential to result, in physical harm or that evoke significant fear; 2) sexual acts involving a child that are intended to provide sexual gratification to an adult; or 3) non-accidental verbal or symbolic acts that results in significant psychological harm. Disinhibited Social Engagement Disorder is typically associated with persistent maltreatment rather than isolated incidents.
- Children with a history of grossly insufficient care are at increased risk for developing Disinhibited Social Engagement Disorder, particularly when it occurs very early (e.g., prior to the age of 2). However, Disinhibited Social Engagement Disorder is rare, and most children with such a history do not develop the disorder.

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- In contrast to Reactive Attachment Disorder, symptoms of Disinhibited Social Engagement Disorder tend to be more persistent following the provision of appropriate care, even with the development of selective attachments.
- Children with Disinhibited Social Engagement Disorder related to repetitive maltreatment (e.g., chronic physical or sexual abuse) are at risk for developing co-occurring Post-Traumatic Stress Disorder or Complex Post-Traumatic Stress Disorder.
- General impulsivity is commonly associated with Disinhibited Social Engagement Disorder, particularly among older children, and there is a high rate of co-occurrence with Attention Deficit Hyperactivity Disorder.

*Boundary with Normality (Threshold):*

- Children vary greatly in their temperamental features, and Disinhibited Social Engagement Disorder should be distinguished from the ebullience associated with an outgoing temperamental style. Distinguishing features of the Disinhibited Social Engagement Disorder are the dysfunctional nature of the behaviour and its association with a history of grossly insufficient care.

*Course Features:*

- Disinhibited Social Engagement Disorder is moderately stable and symptoms may persist throughout childhood and adolescence. Overly friendly behaviour appears to be relatively resistant to change.
- Individuals with Disinhibited Social Engagement Disorder who lived in institutions for an extended period of time appear to be at greatest risk for persistent symptoms, even after adoption. Early removal from an adverse environment decreases the likelihood that indiscriminate social behaviours will persist.
- In adolescence, individuals with a history of Disinhibited Social Engagement Disorder demonstrate superficial peer relationships (e.g., identification of acquaintances as close friends) and other deficits in social functioning (e.g., increased conflict with peers).
- Evidence-based treatment for maltreated children and adolescents and for enhancing secure attachment is recommended for children and adolescents diagnosed with Disinhibited Social Engagement Disorder. However, only some individuals with Disinhibited Social Engagement Disorder appear to respond to interventions targeting enhancement of caregiving.
- During childhood, Disinhibited Social Engagement Disorder often manifests in violation of socially appropriate physical (e.g., seeking comfort from unfamiliar adults) and verbal boundaries (e.g., asking inappropriate questions to unfamiliar adults).

*Developmental Presentations:*

- Children and adolescents are at greater risk for Disinhibited Social Engagement Disorder if they have experienced seriously neglectful caregiving and adverse environments, such as institutions, particularly if this occurred prior to the age of 2. However, Disinhibited Social Engagement Disorder is relatively rare and not all children or adolescents with a history of experiencing such environments go on to develop Disinhibited Social Engagement Disorder.

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- Individuals with Disinhibited Social Engagement Disorder may or may not have developed selective attachment to caregivers.

*Boundaries with Other Disorders and Conditions (Differential Diagnosis):*

- ***Boundary with Attention Deficit Hyperactivity Disorder:*** Similar to Disinhibited Social Engagement Disorder, children with Attention Deficit Hyperactivity Disorder may display socially disinhibited behaviour. Disinhibited Social Engagement Disorder is distinguished by specific behaviours with unfamiliar adults and its association with a history of grossly insufficient care. However, children with Disinhibited Social Engagement Disorder do often exhibit inattention, general impulsivity, and hyperactivity. Rates of Attention Deficit Hyperactivity Disorder are elevated among children with Disinhibited Social Engagement Disorder, and both disorders may be diagnosed if all diagnostic requirements for each are met.
- ***Boundary with Disorders of Intellectual Development:*** Children with a Disorder of Intellectual Development may exhibit atypical social behaviours. However, these are usually consistent with the child's general developmental level. Children with Disorders of Intellectual Development are able to form selective attachments to caregivers by the time the child has reached a developmental age of at least 9 months. Disinhibited Social Engagement Disorder should only be diagnosed if it is clear that the characteristic problems in social behaviour are not a result of limitations in intellectual functioning.
- ***Boundary with Diseases of the Nervous System, Developmental Anomalies and other conditions originating in the perinatal period:*** Indiscriminate social engagement may be a result of brain damage or a feature of neurological syndromes such as Williams syndrome or foetal alcohol syndrome. These conditions are differentiated from Disinhibited Social Engagement Disorder by confirmatory clinical features and laboratory investigations and typically by the absence of a history of grossly insufficient care.

## 6B4Y Other Specified Disorders Specifically Associated with Stress

*Essential (Required) Features:*

- The presentation is characterized by stress-related symptoms that share primary clinical features with other Disorders Specifically Associated with Stress (e.g., occurring in specific association with an identifiable stressor).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the grouping of Disorders Specifically Associated with Stress or for Acute Stress Reaction.
- The symptoms are not better accounted for by another mental disorder (e.g., a Mood Disorder or an Anxiety or Fear-Related Disorder).
- The symptoms are not a manifestation of another medical condition and are not due to the effect of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or 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.

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## QE84 Acute Stress Reaction

***Note:*** Acute Stress Reaction is not considered to be a mental disorder, but rather appears in the section of the ICD-11 that lists reasons for clinical encounters that are not diseases or disorders. It is listed here to assist in differential diagnosis.

*Essential Features:*

- Exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature. Such events include, but are not limited to, directly experiencing natural or human-made disasters, combat, serious accidents, torture, sexual violence, terrorism; assault, 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.
- The development of a response to the stressor that is considered to be normal given the severity of the stressor. The response to the stressor may include transient emotional, somatic, cognitive, or behavioural symptoms, such as being in a daze, confusion, sadness, anxiety, anger, despair, overactivity, inactivity, social withdrawal, amnesia, depersonalization, derealisation, or stupor. Autonomic signs of anxiety (e.g., tachycardia, sweating, flushing) are common and may be the presenting feature.
- Symptoms typically appear within hours to days following the stressful event, and usually begin to subside within a few days after the event or following removal from the threatening situation, when this is possible. In cases where the stressor is ongoing or removal is not possible, symptoms may persist but are usually greatly reduced within approximately 1 month as the person adapts to the changed situation.

*Additional Clinical Features:*

- Acute Stress Reaction in help-seeking individuals is usually, but not necessarily, accompanied by substantial subjective distress and/or interference with personal functioning.

*Developmental Presentations:*

- In children, responses to stressful events can include somatic symptoms (e.g., stomachaches or headaches), disruptive, regressive, or oppositional behaviour, hyperactivity, tantrums, concentration problems, irritability, withdrawal, excessive daydreaming, increased clinginess, bedwetting, and sleep disturbances. In adolescents, responses can include substance use and various forms of acting out or risk-taking.

*Boundaries with Other Disorders and Conditions (Differential Diagnosis):*

- ***Boundary with Adjustment Disorder and Post-Traumatic Stress Disorder:*** If symptoms have not begun to diminish within about 1 week of the stressor ceasing (or within about 1 month in the case of continuing stressors), a diagnosis such as Adjustment Disorder or Post-Traumatic Stress Disorder should be considered, depending on the nature of the symptoms.

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- ***Boundary with Acute and Transient Psychotic Disorder:*** Acute and Transient Psychotic Disorder, like Acute Stress Reaction, has an acute onset and may occur in response to a traumatic experience. Acute Stress Reaction does not typically include psychotic symptoms such as hallucinations or delusions that are characteristic of Acute and Transient Psychotic Disorder.
- ***Boundary with other mental disorders:*** The symptoms do not meet the diagnostic requirements for another mental disorder, such as Acute and Transient Psychotic Disorder, a Depressive Disorder, an Anxiety or Fear-Related Disorder, or a Dissociative Disorder.

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