

# **ADJUSTMENT DISORDERS AND PTSD**

# 1. Introduction

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Acute Stress Reaction, Post-Traumatic Stress Disorder (PTSD) and Adjustment Disorders arise as a consequence of acute severe stress or continued psychological trauma. They are unique among mental and behavioural disorders in that they are defined not only by their symptoms, but also by a specific aetiological factor, namely:

- An exceptionally stressful life event or
- A significant life change leading to continued unpleasant circumstances.

Acute Stress Reaction by definition has a short-lived natural history and so does not normally feature in disability assessment, however, it is included in this protocol as it frequently follows stressful events and may precede the development of PTSD and Adjustment Disorders.

The concept and nomenclature of psychological stress has caused confusion in the past, as 'Stress' has been used both to describe the **events acting on** a person, and also the **psychobiological response** to these events. The current convention is to describe stressful events and situations as **stressors**, and the adverse or unpleasant effects as **stress reactions**. There is great individual variation as to what constitutes a stressor. Some individuals may find certain situations such as riding a roller coaster pleasurable, whereas others might find the experience extremely unpleasant.

After suffering a stressor, people experience physiological and psychological responses.

Psychological protection from, and adaptation to, the effects of the stressor is achieved by using:

- **Coping strategies** (using activities that are mainly conscious) and
- **Mechanisms of defence** (using activities that are mainly unconscious).<sup>1</sup>

An **adaptive** coping strategy is an activity to mitigate the effects by -- expressing grief, working through problems and coming to terms with situations and learning. Avoidance of stressful situations may be adaptive. If avoidance is carried to extremes the strategy may become **maladaptive**. Other **maladaptive** coping strategies include the excessive use of tranquillising drugs or alcohol, aggression, continued expression of grief and histrionic behaviour, and self-harm.

## Medical Services

**Mechanisms of defence** were originally described by Freud and are hypothetical unconscious psychological mechanisms. These are still useful descriptions of the types of behaviours observed in individuals after a stressful event.

- **Repression** or denial (exclusion from consciousness of memories and emotions that would cause recurrence of stress);
- **Regression** (adopting behaviours of an earlier stage of development);
- **Displacement** (transferring emotional linkage from a situation or person originally associated with the stressor to another which causes less distress; and
- **Projection** (attributing to another person thoughts and feelings similar to one's own, thereby rendering one's own feelings more acceptable).

It can be seen that Adjustment Disorder and PTSD result from the failure, or overloading, of the individual's coping strategies and mechanisms of defence.

The diagnostic criteria for the conditions are given under the individual conditions.

The essential criteria are that:

1. There should have been a traumatic event causing the condition.
2. In the case of Adjustment Disorder, there should be functionally significant distress and emotional disturbance affecting mood, anxiety and/or conduct.
3. In the case of PTSD there should be:
  - i. Symptoms of re-experiencing the event,
  - ii. Avoidance behaviour and numbing of responsiveness, and
  - iii. Persistent symptoms of increased arousal.

The timescale of the various disorders is summarised below:

<b>Diagnostic Conditions</b>	<b>Duration of Symptoms</b>
Acute Stress Reaction (ICD-10)	A few hours to 2 or 3 days
Acute Stress Disorder ("Short lived PTSD")	2 days to 4 weeks
Acute PTSD	Less than 3 months
Chronic PTSD	More than 3 months
Delayed onset PTSD	At least 6 months between the traumatic event and the onset of symptoms
Adjustment Disorder	From 1 month (ICD-10) or 3 months (DSM-IV) to 6 months (may remain chronic)

## Medical Services

There are minor differences in the definitions of all these conditions between the ICD -10<sup>2</sup> and DSM – IV.<sup>3</sup> and there is a spectrum of symptoms overlapping between the conditions.

The most notable difference, that has medico-legal implications, is in the definition of PTSD. The DSM - IV definition is detailed in Appendix A. The DSM-IV definition does not fully qualify the severity of the traumatic event except in so far as it causes “fear, helplessness, or horror in the person witnessing or experiencing it”. Both definitions imply that the stressor should be severe. However, the ICD-10 definition clearly states that the stressful event must be of “...an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone...”.

## 2. Acute Stress Reaction

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This is the *transient reaction to severe physical and/or mental stress* which occurs in a normal individual who does not have an apparent mental disorder. This definition therefore excludes those people who have a pre-existing anxiety disorder.

The stressor may involve a serious threat to the security or physical integrity of the individual or that of a loved person(s), (e.g. natural catastrophe, accident, battle, criminal assault, rape). It may be an unusually sudden and threatening change in the social position and/or network of the individual, such as multiple bereavements or a domestic fire.

Characteristically Acute Stress Reaction has two components: - physiological, and psychological.

- Physiologically, autonomic lability causes tachycardia, flushing, and sweating followed by pallor, piloerection, and perhaps involuntary urination, diarrhoea, vomiting and even syncope. Hyperventilation may occur.
- Psychologically, the individual may become disorientated and dazed, with an acute reduction in the ability to complete tasks. Subsequently they may become further withdrawn – even stuporose, or they may become agitated, vociferous, and over-active.

The condition subsides within hours, or two or three days at the most.

### 3. Adjustment Disorder

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Adjustment Disorders (AD) are *states of subjective distress and emotional disturbance that interfere with social or occupational functioning*; and which arise during a period of adaptation to an adverse life change or life event. An Adjustment Disorder is a more prolonged disturbance than an Acute Stress Reaction and, by definition, the response is quantitatively more severe than would normally be expected given the nature of the stressor. The stressor may be an adverse event that has affected the individual's group or community as well as the individual themselves.

Adjustment Disorders lie on the threshold between normal behaviour and major psychiatric morbidity. They present diagnostic dilemmas in that they are poorly defined, overlap with other diagnostic groupings and have indefinite symptomatology.

This vagueness of diagnosis is also seen as one of its strengths, allowing Adjustment Disorder to serve as a 'temporary' diagnosis before the definitive psychiatric morbidity becomes more apparent. For the disability analyst this means that Adjustment Disorder can be a 'melting pot' of transient psychiatric morbidity, combined with early stage affective disorders.

Seven types of Adjustment Disorder are listed in ICD-10<sup>2</sup>, and 6 types are listed in DSM-IV<sup>3</sup>. Both classifications divide AD according to symptomatology (Appendix A).

In order to diagnose an Adjustment Disorder, the onset of symptoms should be within:

- One month in the ICD-10
- or
- Three months in DSM-IV

- of the stressful event or change in circumstances.

Once the stressful circumstances causing the disorder are ended, the symptoms do not persist for more than another 6 months.

DSM-IV subdivides Adjustment Disorder into Acute (less than 6 months duration) and Chronic (more than 6 months duration).

Adjustment Disorder may remain chronic if the adverse life circumstances continue.

#### 3.1 Epidemiology

There are no reliable statistics regarding the epidemiology of Adjustment Disorders in the United Kingdom.

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### 3.2 Aetiology

Little is written about the aetiology of Adjustment Disorders, however individual vulnerability is thought to play an important role.

### 3.3 Diagnosis

Adjustment Disorders lie on the threshold between normal behaviour and major psychiatric morbidity. They present diagnostic dilemmas in that they are poorly defined, overlap with other diagnostic groupings and have indefinite symptomatology.

Symptoms may include:

- Depressed Mood.
- Anxiety.
- Mixed Anxiety and Depression.
- Occasionally individuals may be liable to dramatic behaviour or violent outbursts.
- Conduct disorders (aggressive or anti-social behaviour) may be a feature.

Conduct disorders are more common in children and adolescents, whereas adults have more depressive symptomatology. Anxiety symptoms are frequent at all ages.<sup>4</sup>

Adjustment Disorder, especially if chronic, can cause diagnostic difficulty as the condition may be interpreted as depression, anxiety, or a behavioural disorder, without taking into account the initial and ongoing stressor(s).

### 3.4 Co-morbidity

Substance abuse is common in those with a diagnosis of Adjustment Disorder.<sup>4</sup>

### 3.5 Treatment

The treatment of Adjustment Disorders focuses on psychotherapeutic and counselling interventions to:

- Expose the concerns and conflicts that the patient is experiencing,
- Identify means of reducing the stressor,
- Clarify the patient's perspective on the adversity,
- Enhance the patient's coping skills, especially if a stressor cannot be reduced or removed,
- Enable a system of supportive relationships.

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Counselling, psychotherapy, crisis intervention, family therapy and group treatment are utilised to encourage the verbalisation of fears, anxiety, rage, helplessness and hopelessness to the stressors imposed on the patient.<sup>4</sup>

If these psychosocial treatments do not work, then symptoms of anxiety and depression can be managed pharmacologically (see relevant protocols).



### 4. PTSD

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Although Post Traumatic Stress Disorder (PTSD) was only included in DSM-III in 1980, descriptions of the behaviour of survivors of stressful historical events indicate that the condition was known previously.

Kraepelin described the condition of *Schreckneurosis* – a nervous disorder that occurred after shocks or accidents (German, *schreck* = terror).

Rescuers of survivors of ship explosions in Toulon in 1907 and 1911 exhibited “recapitulation of the scene, terrifying dreams, diffuse anxiety, fatigue, and various minor phobias”. Second World War soldiers were noted to have “Irritability, fatigue, difficulties falling asleep, startle reaction, ...nightmares and battle dreams, phobias, personality changes, and increased alcoholism”.

“Stragglers”, who had ceased to function as soldiers in the American Civil War, were described as “trembling, staring into the middle distance and jumping at any loud noise”.<sup>5</sup>

PTSD is an anxiety-type disorder defined by the coexistence of three symptom clusters:

1. **Re-experiencing:** symptoms of fear, panic and autonomic disturbance and a sense of reliving the traumatic event.
2. **Avoidance:** both of stimuli associated with the trauma and other stimuli (even those previously considered pleasurable).
3. **Hyperarousal:** may manifest itself as insomnia, poor concentration, anger, hypervigilance and an exaggerated startle response.

Dissociation is also characteristic of PTSD, especially in acute cases. During a dissociative episode, the person may behave as though he or she is experiencing the event and the patient may report amnesia or flashbacks.

The DSM-IV definition of the condition is given in Appendix A.

DSM-IV also has a definition of an additional disorder called Acute Stress Disorder. This condition has some of the characteristics of PTSD but lasts for a minimum of 2 days and a maximum of 4 weeks. It occurs within 4 weeks of the traumatic event. The traumatic event has to be of the same intensity as PTSD. The condition has the added symptoms of “numbing”, dissociative amnesia, depersonalisation, and reduction in awareness of surroundings.

# Medical Services

## 4.1 Prevalence of PTSD

Surveys of the general population indicate that PTSD affects about 1 in 12 adults at some time in their life, equivalent to 15-24% of those exposed to traumatic events.<sup>6</sup> Although exposure to trauma is reported as being lower in females, the female to male lifetime prevalence of PTSD is often reported as 2:1.<sup>6</sup>

### 4.1.1 Incidence of stressful events

Studies on general populations have shown a lifetime likelihood of exposure to a severely stressful event of between 51% and 97% of the population, depending on the type of population sample. The lifetime likelihood of any individual being subjected to at least one severely stressful event is therefore high. It is especially high in certain occupations such as fire, police, ambulance, and military personnel.

### 4.1.2 Incidence of PTSD symptoms following stressful events

PTSD symptoms are moderately common following road traffic accidents (11% of RTA cases at 3 months post-accident, in a study of road accidents in Oxford).<sup>7</sup>

PTSD-type symptoms are very common following severely stressful incidents such as rape. Normally there is a rapid reduction in symptom severity over a few months.<sup>8</sup> At two weeks, 94% of victims fulfil the symptom criteria for PTSD, (but not the duration criterion and so would be now be classified as Acute Stress Disorder), but this figure falls to 65% at four weeks, (by which time the duration criterion for PTSD is reached), 40% at 12 months and 15% long-term.

The lifetime prevalence of PTSD in Western countries appears to be about 8%. The US National Co-morbidity Survey estimates around 10% for women, and 5% for men. In some populations, (concentration camp survivors, refugee victims of civil wars, etc), the prevalence is much higher.

PTSD can occur at any age and may affect children who have been exposed to traumatic events.

The most common cause of PTSD is road traffic accidents.

## 4.2 Aetiology of PTSD

The development of PTSD is thought to be facilitated by an atypical biological response to trauma which in turn leads to a maladaptive psychological state<sup>9</sup>. This is supported by the following observations:

### 4.2.1 Neurophysiological impairment

Abnormalities of psychophysiological responses have been shown in PTSD. Traumatized patients show increased autonomic reactions to specific stimuli related to the original stressor. They also show failure of habituation to an acoustic startle response and have elevated urinary catecholamines.

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Cortisol levels in normal subjects rise after a stressful event. In subjects who subsequently develop PTSD, the cortisol response is significantly lower than in those who develop major depression and those who do not develop any psychiatric disorder post-trauma. The rise in cortisol levels is also lower after stressor events in people who have had previous trauma.<sup>10</sup>

Infant rats, if chronically stressed by maternal deprivation, show marked endocrine changes in adulthood with increased physiological and behavioural responsiveness to stressors.

### 4.2.2 Neuroanatomical impairment

Recent developments of brain imaging techniques have shown that there are abnormalities affecting the hippocampus, medial prefrontal cortex, and visual association cortex in patients with PTSD. It is not known whether these changes predate the development of PTSD or not.

### 4.2.3 Individual risk factors

A past history of mental illness and previous traumatic experiences are risk factors that appear to sensitise individuals to the development of PTSD.

In adults exposed to trauma, risk factors include:

- Childhood abuse
- Family psychiatric history
- Low intelligence
- Lack of social support
- "Life stress".<sup>11</sup>

### 4.2.4 Risk factors related to the type of stressor

The types of stressors commonly causing PTSD are:

- Natural disasters: earthquakes, volcanic eruptions, floods, forest fires etc.
- Transport accidents: rail crashes, ship sinkings, road traffic accidents, aircraft crashes etc.
- Armed conflict: combat, bombing, imprisonment, torture and mutilation, rape etc.
- Domestic: physical and sexual abuse, victims of violent crimes etc.

Some stressors are more likely to result in PTSD than others. Proximity to the stressor, and whether the stressor is of natural or man-made origin alter the likelihood of the development of PTSD.

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Rape, disfiguring injury and torture, and similar stressors are more likely to cause PTSD than natural disasters. Helplessness and lack of situational control appear to increase the likelihood of the development of the condition. Women suffering an incident of interpersonal violence, (physical or sexual assault, witnessed homicide of a close friend or relative), are about 3 times more likely to develop PTSD than women reporting other types of severe stressors. In men, combat exposure, and witnessing someone being injured or killed are common stressors related to PTSD.

Rape, sexual assault, and childhood physical abuse are common PTSD-inducing stressors in women.

### 4.3 Diagnosis

Diagnosis of PTSD is sometimes difficult, as the sufferer may be reticent in describing their symptoms to avoid recalling the traumatic event. This may be due to avoidance behaviour, “survivor guilt”, shame, and loss of trust. Direct closed questioning about symptoms may be needed.

Physiological reactivity in response to trauma cues is a diagnostic criterion for PTSD. Psychophysiological assessments that measure heart rate, blood pressure and skin conductance in response to trauma cues have been used to aid diagnosis. Although an effective aid to diagnosis, they are not used routinely in clinical practice.

Rating scales, (such as the 8-item treatment outcome post-traumatic stress disorder scale (TOP-8) and the Davidson trauma scale), may also facilitate the diagnosis of PTSD and monitor the response to treatment.<sup>12</sup>

### 4.4 Co-morbidity

Co-morbidity with other psychiatric illness is very common in PTSD. Clinical and epidemiological studies have shown figures of about 80% of persons with PTSD having a previous or concurrent psychiatric disorder. Common conditions (in a study of Israeli soldiers)<sup>13</sup> are:

- Major depressive disorders (30-50% of PTSD sufferers have concurrent depression)
- Alcohol related disorders
- Substance misuse disorders (the incidence of alcohol and substance misuse is double that of the general population)
- Generalised Anxiety Disorder
- Phobias
- Somatization Disorder
- Obsessive Compulsive Disorder
- Mania.

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Epidemiological studies show that the PTSD is most likely to be the primary disorder with the co-morbid disorders developing later. However the interplay between conditions is complex, with data showing that a history of a pre-existing depressive disorder may increase the severity of post-traumatic morbidity.<sup>9</sup>

Sufferers with PTSD tend to have more somatic symptoms and present more frequently to emergency departments and physicians.

This complex of co-morbidity in post-traumatic disorders is so common that some psychiatrists have argued for a so-called “trauma spectrum” of disorders.

Disability assessors sometimes use the term “post-traumatic psychological dysfunction” to encompass all the effects of psychological trauma without attaching a specific diagnostic label to the condition.

### 4.5 Traumatic Grief

Traumatic Grief (TG) is a term used to describe complicated pathological bereavement reactions that have many similarities with PTSD. For a significant minority (20%) of bereaved individuals, the impact of the loss appears to overwhelm their coping capacity, and persistent phenomena of “numbness”, re-experiencing, and irritability occur to such an extent that they chronically interfere with social and occupational functioning.

Although the precipitating stressor cannot be regarded as severe as the PTSD definition stressor, TG has many symptomatic similarities to PTSD and can be thought to fall within the category of trauma spectrum disorders.

### 4.6 Treatment of PTSD

#### ***Prevention, training and pre-selection of individuals likely to be exposed to severe stressors***

By analysing individual risk factors, (see **4.3.3 Aetiology**), and protecting susceptible individuals from severe stressors, there is a possibility of reducing the likelihood of the development of PTSD.

#### ***Immediate treatment***

It is believed that counselling following a severely stressful event (“debriefing”) may be beneficial and therefore pro-active treatment of this type has been recommended.

However, research shows that this is ineffective in preventing PTSD or other post-traumatic psychopathology. There is a possibility that debriefing may cause further harm.<sup>14,15</sup>

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It was thought that early intervention with psychoactive drugs following a severely stressful incident reduces the likelihood of onset of PTSD or other post-traumatic psychopathology. In the past alcohol, barbiturates and benzodiazepines have been given during Acute Stress Reactions. A controlled trial has failed to show any benefit from treatment with benzodiazepines. The study showed that administration of benzodiazepines may even have a deleterious effect.<sup>16</sup>

### ***Psychosocial treatments***

Reports on the efficacy of psychodynamic interventions are equivocal. The majority of studies are not well controlled.

There are a variety of treatments available:

1. Hypnotherapy: may offer some help for post-trauma suffering. Studies lack methodological rigour.
2. Psychodynamic psychotherapy: there are some reports that trauma victims may worsen during treatment. Results are equivocal.
3. Cognitive-behavioural therapy (CBT): this involves prolonged repeated imaginary exposure to the stressful event combined with cognitive therapy to alter thinking patterns. This therapy appears to have the most evidence of efficacy, especially if combined with selective serotonin reuptake inhibitor (SSRI) drug therapy.<sup>17</sup>
4. Systematic desensitisation, including Eye Movement Desensitisation and Reprocessing (EMDR): these techniques involve exposing the individual to the memory or simulation of the stressful event, combined with relaxation and/or distraction techniques. In EMDR, the patient imagines the trauma at the same time as eye-tracking moving fingers or lights. Results are varied and may represent differences in victim groups and therapy technique.

Overall there appears to be evidence that CBT is the most effective psychosocial therapy for PTSD.

### ***Drug treatments for PTSD***

The neurophysiological impairments found in PTSD indicate that there is a theoretical basis for drug treatment of PTSD. However, the common prevalence of co-morbid psychiatric disorders and pre-existing risk factors in the aetiology of the condition complicate the interpretation of efficacy of various drug treatments.

1. Selective Serotonin Reuptake Inhibitors (SSRIs): several trials have demonstrated that SSRIs improve symptoms in patients with PTSD, particularly hyperarousal symptoms. Studies with paroxetine show slow improvement in symptoms, although pre-existing childhood trauma significantly reduces improvement.<sup>19</sup> Benefits have also been shown with fluoxetine. Patients with co-existing depression may be particularly responsive to antidepressant therapy.<sup>12</sup>

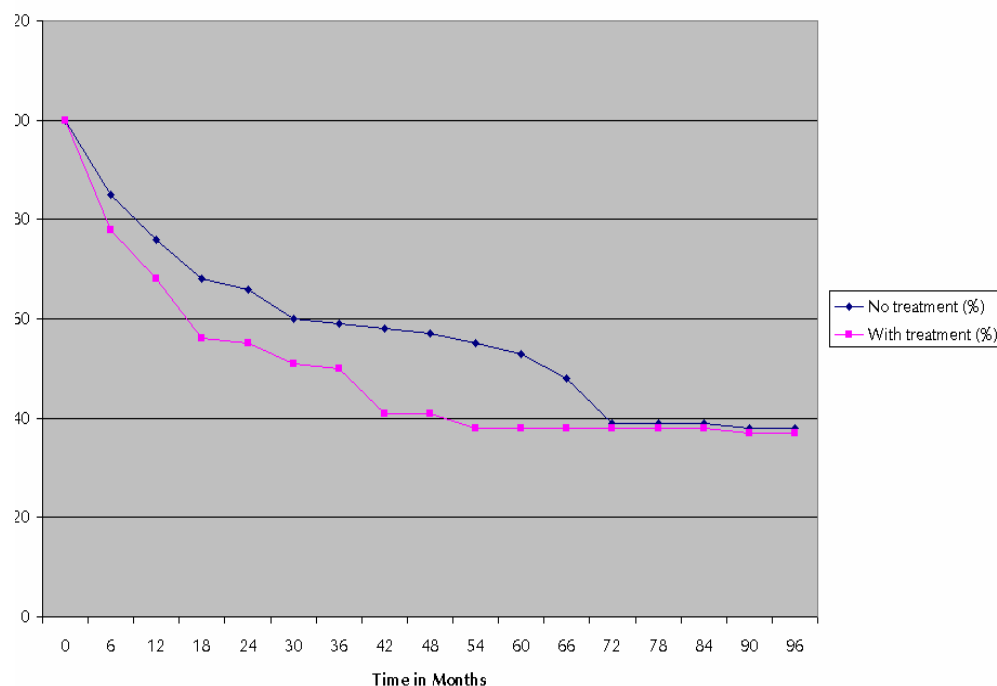
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2. Other agents: tricyclic antidepressants (TCADs), monoamine oxidase inhibitors (MAOIs), and a variety of agents such as propranolol and clonidine have been shown to improve symptoms of sleep disturbance and hyperarousal.

Overall, a combination of drug and CBT treatment seems to reduce the duration of symptoms in a majority of patients, although the number that remain significantly symptomatic in the long term is not reduced.

### 4.7 Prognosis

Graph of PTSD symptoms over time (derived from ref. 5).



As can be seen from the graph above, PTSD has a slow natural recovery time over a period of about six years, after which time the condition is likely to remain chronic in about 40% of cases. Treatment appears to accelerate recovery time although the long-term chronicity remains about 40% with or without treatment.

The slow recovery times show that, for purposes of disability assessment, two-year reassessments, up to a 6-year maximum, are indicated.

Disability assessments performed at intervals of less than 2 years are unlikely to show much change, and after a 6-year interval, those chronically disabled are likely to remain so.

## 5. Disabling Effects of Adjustment Disorders & PTSD

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The disabling effects of these conditions are very varied because of:

- The common prevalence of co-morbid psychiatric conditions in PTSD, and
- The polysymptomatic presentation of Adjustment Disorder.

Impairment of work performance due to problems with concentration, memory and increased irritability has been recorded in soldiers suffering from PTSD.<sup>13</sup>

There is a widely held belief that PTSD is inherently more disabling than other post-traumatic psychopathological conditions such as chronic Adjustment Disorder with phobic anxiety and mood disorder. Civil compensation for cases with a PTSD diagnosis is likely to be higher than for post-traumatic cases with another psychiatric diagnosis.<sup>20</sup> There is no logical evidence that PTSD per se leads to more disability than other post-traumatic psychiatric conditions.

Each case should be assessed individually for disablement.

### 5.1 Assessing the Claimant

Documentary evidence is frequently unhelpful in the functional assessment of post-traumatic states, and the Typical Day History, together with a Mental State Examination give the evidence required to advise the Decision Maker. Informal observations during the Mental State Examination showing irritability, hypervigilant behaviour, poor concentration, and an exaggerated startle response may be helpful in corroborating the history of functional limitation from the Typical Day.

A careful and empathic interview will reveal the extent of variability and functional limitation.

The common co-morbid disorders are:

- Major depressive disorders
- Alcohol related disorders
- Substance misuse disorders
- Generalised Anxiety Disorder
- Phobias.

The co-morbid conditions associated with PTSD may contribute more to disability than the PTSD itself.

Cases of Adjustment Disorder presenting for disability assessment are likely to be chronic cases. The primary diagnosis given in the documentary evidence may be Depression, Anxiety or a Personality/Behavioural disorder. Careful history taking may reveal the existence of Adjustment Disorder with an initial stressor in a relatively normal pre-morbid functional state.



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### 5.2 IB-PCA Considerations

In the IB-PCA, PTSD and its associated co-morbid conditions can affect all four psychological functional areas in the Mental Health Assessment.

These four areas are Completion of Tasks (CT), Daily Living (DL), Coping with Pressure (CP) and Interaction with Other People (OP).

PTSD alone rarely fulfils the criteria for exemption. However, any associated co-morbid disorders can increase disability to the required extent: "...*the presence of a mental disease which severely and adversely affects a person's mood or behaviour, and which severely restricts his social functioning, or his awareness of his immediate environment*".

This will normally be if the associated co-morbid disorders are of such severity that the claimant would be likely to be exempted by severe restriction in social functioning.

PTSD symptoms of re-experiencing the traumatic event may vary from frequent horrific daily flashbacks causing panic and anxiety symptoms (CP effect); to rarely experienced distress, and anxiety induced only in circumstances similar to the original stressor. Sleep disturbance may affect daytime wakefulness (DL), but this is rare due to increased arousal and hypervigilance.

"Numbing" and avoidance may affect enjoyment of previously enjoyed activities (DL effect). Avoiding people can affect OP, as can the arousal effect of increased irritability and anger outbursts.

CT can be affected by reduced concentration. Hypervigilance can paradoxically affect concentration on normal tasks.

The assessment of Adjustment Disorder is as for any other psychiatric condition. The polymorphic symptomatology can affect any or all functional areas. Predominantly depressive symptoms affect DL and CT, anxiety symptoms affect CP, and irritability with conduct disorder affects OP, although mixed pictures of symptoms are common.

## **Appendix A - DSM – IV Diagnostic Criteria for PTSD**

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**A. The person has been exposed to a traumatic event in which both of the following were present:**

- (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- (2) The person's response involved intense fear, helplessness, or horror.

**B. The traumatic event is persistently re-experienced in one (or more) of the following ways:**

- (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions.
- (2) Recurrent distressing dreams of the event.
- (3) Acting or feeling as if the traumatic event were recurring.
- (4) Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
- (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

**C. Avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:**

- (1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
- (2) Efforts to avoid activities, places, or people that arouse recollections of the trauma.
- (3) Inability to recall an important aspect of the trauma.
- (4) Markedly diminished interest or participation in significant activities.
- (5) Feeling of detachment or estrangement from others.
- (6) Restricted range of affect (e.g. unable to have loving feelings).
- (7) Sense of foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).

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**D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:**

- (1) Difficulty falling or staying asleep.
- (2) Irritability or outbursts of anger.
- (3) Difficulty concentrating.
- (4) Hypervigilance.
- (5) Exaggerated startle response.

**E. Duration of the disturbance (symptoms in criteria B, C and D) is more than 1 month.**

**F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.**

**Adjustment Disorders in DSM-IV**

**Six Subtypes:**

With Depressed Mood

With Anxiety

With Mixed Anxiety and Depressed Mood

With Disturbance of Conduct

With Mixed Disturbance of Emotions and Conduct

Unspecified

**Adjustment Disorders in ICD-10**

**Seven Subtypes:**

Brief depressive reaction (not exceeding 1 month)

Prolonged depressive reaction (up to 2 years)

Mixed anxiety and depressive reaction

With predominant disturbance of other emotions

With predominant disturbance of conduct

With mixed disturbance of emotions and conduct

With other specified predominant symptoms

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