1. Various attempts have been made to formally classify psychiatric disorders, the two major systems being:

    1.1. The **ICD-10 Classification of Mental and Behavioural Disorders** (World Health Organisation, Geneva) is part of the 10th edition of the International Classification of Disease. This appendix follows the common abbreviation of **ICD-10**. It is the international system used by the majority of clinical psychiatrists in Great Britain.

    1.2. The **Diagnostic and Statistical Manual of Mental Disorders (fourth edition)** (American Psychiatric Association Washington DC). References to it in this appendix follow the common abbreviation of **DSM-IV**. It is a system devised mainly by and for workers in the USA, however UK psychiatrists were consulted in its formulation.

2. The two systems above have been in existence for many years but only in their current editions have they been closely comparable.

3. This appendix discusses the clinical features and aetiology of post-traumatic stress disorder. It is generally based on the ICD-10 system with any major comparisons and distinctions with DSM-IV being discussed where relevant. The ICD-10 codes (numbers usually prefixed with F) are also provided.

## REACTIONS TO STRESSFUL EXPERIENCES: THE NORMAL RESPONSE

4. Most people react to a stressful experience with an emotional or somatic (physical) response. These are normal reactions and do not constitute mental disorders in themselves, although some people seek help from their doctor. What is interpreted as being stressful will vary from one individual to another and the ways in which they respond vary similarly. The response depends on personality variables, childhood experiences, family history and the resulting coping mechanisms developed as a result of these factors.

5. There are three components to the normal response:

    5.1. The emotional response to danger or threat is fear and anxiety. The response to loss is sadness or feeling "depressed".

    5.2. The somatic reactions to threat are those of autonomic arousal and include rapid pulse, dry mouth, increased muscle tension and gastrointestinal sensations. The physical response to loss is reduced energy and physical activity.

    5.3. The third part of the response comprises those psychological mechanisms which reduce the impact of the emotions engendered. Everyone unconsciously develops a variety of these "defence mechanisms" to differing degrees in order to help them deal with mental conflict. Some of the most commonly employed psychological processes are

5.3.1. **Regression** which is adopting behaviour from an earlier stage of development, eg passively being taken care of like a child.

5.3.2. **Denial** which is refusing to accept what someone would normally be expected to believe, for example someone is told they have terminal cancer but carries on as if unaware of the diagnosis.

5.3.3. **Displacement** where the emotion is shifted on to another less sensitive object, eg being angry with other people instead of the spouse.

5.3.4. **Repression** where uncomfortable memories or emotions are kept out of awareness.

5.3.5. **Identification** where the characteristics of another are incorporated in a person's own behaviour to reduce the sense of loss, eg carrying on a spouse's activities or hobbies following their death.

5.4. Other coping strategies include actual avoidance (so that the stressful situation is no longer encountered) and coming to terms with the situation. This latter involves working through the unpleasant idea and emotion by repeatedly recalling the event and finding a way of accepting it has happened. It is then possible to progress. Maladaptive strategies may be employed, including the excessive use of alcohol or drugs, aggressive behaviour and deliberate self-harm.

6. The adjustment reactions are differentiated from normal reactions to problems related to life experiences, these being observable normal behaviours or occurrences which may lead the individual into contact with health and related services. However, **they are not considered to be illnesses, mental disorders or personality disorders**. These reactions and behaviours are recorded in the ICD-10 under "Z" and "X" codes and the DSM-IV as "V codes". Only a small selection are listed here:

7. **Accentuation of personality traits** Z73.1

This refers to the more florid appearance of personality traits under certain circumstances. For example when a shy, restrained and timid person is required to speak in public for the first time, anxiety builds as the day approaches and the performance may be hampered by blushing and difficulty in speaking, their demeanour being even more timid than usual. This person is obviously not mentally ill, nor do they have a personality disorder. Other examples include the histrionic personality's increase in ostentatious weeping when their demands are thwarted, or the low mood of a depressive personality when faced with disappointments.

8. **Phase of life problem** Z60

Most people find difficulty in adjusting to various changes during life including problems associated with starting school, changing jobs, starting a new career, marriage, divorce and retirement. Individuals with certain personality traits may have more difficulty than others; for example those with high dependency may find returning to work after a long break threatening. Similarly those with a strong need for structure may find difficulties in adjusting to retirement or change of career.

9. **Employment difficulties** Z56

Some may encounter problems more specifically relating to employment, this including job satisfaction or dissatisfaction, "burn-out" and unemployment. Personality traits such as a lack of initiative may hamper efficient resolution of employment difficulties.

10. **Problems relating to lifestyle** Z72

These include the effect of inappropriate diet and eating habits, lack of exercise, tobacco, alcohol and drug use, high-risk sexual behaviour.

11. **Bereavement** Z63

The normal grief reaction can include disbelief, shock, numbness, waves of grief, pining, anger, guilt, hearing the dead person's voice, feelings of exhaustion, despair and powerlessness. The normal response to bereavement may cause severe disruption to the person's functioning, but only if it is exceptionally severe or prolonged is it considered to be a mental disorder.

12. **Intentional self-harm** X60-84

Of those people who harm themselves, for example by cutting or taking overdoses of various medications, few have a major psychiatric disorder. The motive behind some of these impulsive acts is obscure, although quarrels or threats of rejection by partners are common antecedents of many acts of deliberate self-harm. The reaction may represent a way of communicating in those people who have restricted internal resources, the behaviour being used to try and influence others. An isolated incident of this sort in the absence of other symptoms is a maladaptive response and does not constitute a mental disorder.

13. However if these acts are repeated or are accompanied by other symptoms, a mental disorder or personality disorder should be considered, the latter being diagnosed in one third of people who deliberately harm themselves.

## THE ABNORMAL RESPONSE TO STRESSORS

14. A wide variety of behaviour falls within the normal range and most neurotic disorders are on a continuum with the normal. If a stressor is sufficiently severe and/or the person is vulnerable (see below), various mental disorders may develop. The stage at which symptoms constitute a disorder or disease depends on several factors, including their severity and duration, whether treatment is required, and various other social and cultural factors. The disorders most commonly associated with exposure to a stressful event include acute stress reaction, post-traumatic stress disorder, the adjustment disorders and depressive reactions, phobic and other anxiety disorders, and acute and transient psychotic disorders.

## POST TRAUMATIC-STRESS DISORDER (PTSD) F43.1

## DEFINITION AND CLINICAL MANIFESTATIONS

15. This disorder may develop following exposure to an exceptionally stressful event. It usually develops some time after exposure to the event, once the initial danger has passed. It often follows a latency of a few weeks.

16. Those reactions which occur during and immediately after a severely traumatic event are more usually classified as either normal reactions or, if the psychopathology is appropriate, acute stress reactions. Very rarely there may be a delay of more than six months between the traumatic event and the onset of post-traumatic stress disorder; however the clinical manifestations **must** be typical and the possibility of another alternative diagnosis must have been excluded before the diagnosis is made.

17. The former labels of combat fatigue and shell shock may be now diagnosed as post-traumatic stress disorder; however if the condition lasted less than a month, the more appropriate diagnosis is acute stress reaction or acute stress disorder.

18. Post-traumatic stress disorder is characterised by:

    18.1. The spontaneous re-experiencing of the traumatic event without any triggering factors; this is a vivid and distressing experience in which the emotions experienced at the event recur with the original accompanying autonomic arousal ("flashback").

    18.2. Feelings of anxiety, irritability or inability to concentrate.

    18.3. The avoidance of all situations which remind the person of the event, including not reading newspapers, avoiding films and refusing to talk about it.

    18.4. The above symptoms are accompanied by a general emotional withdrawal, which includes a sense of emotional numbness, detachment from other people and lack of involvement.

18.5. The person's life is disrupted to the extent that occupational functioning, social and interpersonal relationships are affected.

19. The specific diagnostic criteria vary somewhat between DSM-IV and ICD-10, but both have the basic prime criterion that the condition **must** be precipitated by an event in which the person feels a sense of intense fear, helplessness or horror. These are specified below.

20. **DIAGNOSTIC CRITERIA ICD-10**

A. The patient **must** have been exposed to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature which would likely cause pervasive distress in almost anyone.

B. There must be persistent remembering or reliving of the stressor in intrusive flashbacks, vivid memories or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor.

D. Either of the following must be present:

1. Inability to recall either partially or completely some important aspect of the period of exposure to the stressor,

OR

2. persistent symptoms of increased psychological sensitivity and arousal shown by any two of the following:

difficulty falling or staying asleep,

irritability or outbursts of anger,

difficulty concentrating,

hypervigilance,

exaggerated startle response.

E. Criteria B, C and D must all arise within 6 months of the period of stress. The diagnostic guidelines show that the disorder should be diagnosed only after six months if the symptoms are typical and do not constitute one of the other psychiatric diagnoses such as phobic conditions, other anxiety disorders, depression.

**REACTION TO EXTREME STRESS UNSPECIFIED F43.9**

21. If not all of the criteria are met, the diagnosis of "reaction to extreme stress, unspecified" may be a more appropriate label. However the criterion of the presence of the extreme stressor must be fulfilled.

22. **DIAGNOSTIC CRITERIA DSM-IV**

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

The person experienced or witnessed an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

The response involved intense fear, helplessness or horror.

B. Re-experiencing of the trauma, as evidenced by at least one of the following:

recurrent and intrusive recollections of the event, including images thoughts or perceptions,

recurrent distressing dreams of the event,

suddenly acting or feeling as if the traumatic event were reoccurring because of an association with an environmental or ideational stimulus,

intense psychological distress at exposure to cues symbolising or representing the event,

reactivation of the physical responses on exposure to cues of the event.

C. Persistent avoidance of anything associated with the trauma, or numbing of responsiveness (not present before the trauma), or reduced involvement with the external world, beginning some time after the trauma, as shown by at least three of the following:

avoidance of thoughts, feelings or conversations associated with the trauma,

avoidance of activities, places and people that arouse recollections of the event,

inability to recall an important aspect of the trauma,

markedly diminished interest in one or more significant activities,

feeling of detachment or estrangement from others,

restricted affect (eg unable to feel loving feelings),

sense of a foreshortened future (eg does not expect to have a career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal that were not present before the trauma, as indicated by at least two of the following symptoms:

difficulty falling or staying asleep,

irritability or outbursts of anger,

difficulty concentrating,

hyper-alertness,

exaggerated startle response.

E. Duration of disturbance is more than a month.

F. There is clinically significant distress or impairment in social, occupational or other important areas of functioning.

**AETIOLOGY**

23. Several vulnerability factors have been identified (see below). However by definition the cause of the disorder is an extremely stressful event. The stressor is described differently in the two main classifications; however in the guidelines given, the common quality is that it must be severe, ie "exceptionally threatening or catastrophic" (ICD-10), or "extreme, ie life threatening" (DSM-IV).

24. Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (serious road traffic accidents with multiple or critical physical injury, aeroplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). However not all of those exposed to an extreme stressor go on to develop the disorder and it has been suggested that personal vulnerability plays a part in the condition.

25. Studies have suggested that genetic factors play a part in this susceptibility, recent work indicating that one third of the variance in susceptibility is genetic. Other factors predisposing to the condition are temperament and a history of psychiatric disorder. The condition is also more common in children and the elderly.

26. The most important external factors in determining whether PTSD will develop are proximity to the event, the severity of the event and the duration of exposure.

**ENDURING PERSONALITY CHANGE AFTER CATASTROPHIC EXPERIENCE**

27. Occasionally a profound change in personality may occur as a late consequence of exposure to extreme and prolonged stresses, which may manifest decades after the event. Examples of the types of stressor are the most extreme situations, such as torture, concentration camp experience, disasters, prolonged exposure to what is felt to be almost certain death, eg a prolonged hostage situation.

28. The personality change must be clearly obvious, of significant degree, and associated with maladaptive behaviour which was not present prior to the experience. These changes should be enduring, inflexible and maladaptive, cause long-standing problems in interpersonal, social or occupational functioning, and cause subjective distress. The change should be characterised by a hostile or mistrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, estrangement and a chronic feeling of being on edge as if constantly threatened.

29. The change must have been present for at least two years and should not be attributable to another psychiatric disorder, except post-traumatic stress disorder, and there should be no history of a pre-existing personality disorder or accentuation of personality traits.

## AETIOLOGY

30. Exposure to a prolonged intolerable situation, such as in concentration camps or where people have been held in prison and tortured, is easily understood as being such a severe stress that most people would not fail to be affected by it. The length of exposure to the situation and the degree of suffering have an influence on the development of the change in personality.

## CONCLUSION

31. **Post-Traumatic Stress Disorder** is a very specific disorder resulting from exposure to severe stresses which would generally be acknowledged to be outside the range of normal human experience. It may not be diagnosed less than 4 weeks after the stressful event, these short term reactions being more correctly considered under the diagnoses of **acute stress reaction**. However PTSD is not an inevitable consequence of exposure to a traumatic event, and the specific clinical manifestations above are required for the diagnosis to be made. "Harking back" to a stressful episode, presenting as a symptom of a psychiatric disorder, is not sufficient as this can occur in other psychiatric disorders. Similarly, mere emotional recollections of the event are insufficient to make a diagnosis as this falls within the range of normal behaviour.

32. Other conditions are more commonly diagnosed in the late aftermath of exposure to stressful events, and include phobic avoidance syndromes, depressive disorders and anxiety disorders. In very rare circumstances a permanent change in the personality may occur; however this again may only be diagnosed when a specific set of symptoms and criteria are met. This change in personality may follow post-traumatic stress disorder, but it may also arise without any apparent prior clinical symptoms.

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