Table 17-5 Criteria for Diagnosis of Posttraumatic Stress Disorder

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. Note: In children, this may be expressed instead by disorganized or agitated behavior.
B. The traumatic event is persistently reexperienced in one or more of the following ways:
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including flashbacks that occur on awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
C. Persistent 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 a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
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 >1 month
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
Specify the following:
• Acute: if duration of symptoms is <3 months
• Chronic: if duration of symptoms is ≥3 months
• With delayed onset: if onset of symptoms is at least 6 mo after the stressor

within 3 months of the trauma, although delay in symptom expression can occur. Rates of suicide attempts are threefold higher than unaffected controls.

Acute stress disorder is characterized by the same signs and symptoms as PTSD but occurs immediately after a traumatic event. If impaired function persists after 1 month, the diagnosis is PTSD.

Anxiety disorder not otherwise specified is a common condition in clinical practice. This diagnosis is used when there is impairing anxiety or phobic symptoms that do not meet full criteria for another anxiety disorder.

Separation anxiety disorder (SAD) is seen in children and adolescents who express vague somatic symptoms (e.g., headaches, abdominal pain, fatigue) to avoid or refuse to go to school. Patients may have a valid or an irrational concern about a parent or have had an unpleasant experience in school. They often have been seen by numerous specialists and have undergone elaborate medical evaluations. Their absence from school often is mistakenly seen as a consequence of their symptoms. The prospect of returning to school provokes extreme anxiety and escalating symptoms. True phobia related to schoolwork is rare. SAD is a strong (78%) risk factor for developing problems in adulthood, such as panic disorder, agoraphobia, and depression. School phobia that first presents during adolescence may be an expression of a severe underlying psychopathologic condition. Psychiatric consultation is needed.

Specific phobias are marked persistent fears of things or situations, which often lead to avoidance behaviors (Table 17-6). The associated anxiety is almost always felt immediately when the person is confronted with the feared object or situation. The greater the proximity or the more difficult it is to escape, the higher the anxiety. Many patients have had actual fearful experiences with the object or situation (traumatic event). The response to the fear can range from limited symptoms of anxiety to full panic attacks. Children may not recognize that their fears are out of proportion to the circumstances, unlike adolescents and adults, and express their anxiety as crying, tantrums, freezing, or clinging.

School phobia is one of a range of reasons for school nonattendance. In severely worried children, defensive aggression may be used to prevent attendance. Otherwise these patients do not have antisocial tendencies. Boys and girls are equally affected and there is no association with social class, intelligence, or academic ability. The youngest in a family of several children is more likely to be affected as well as children of older parents. Truancy is generally associated with older adolescents with lower levels of fear. Unlike anxious school refusers, truants hide their school nonattendance from their parents.

Social phobia is a common (3% to 13% prevalence; girls predominate over boys) type of phobia characterized by a marked and persistent fear of social or performance situations in which embarrassment might occur (Table 17-7).

There is a wariness of strangers and social apprehension or anxiety when encountering new, strange, or socially threatening situations. Children appear to have a lower rate of negative cognitions (e.g., embarrassment, overconcern, self-consciousness) than adults. Children with simple avoidant disorders are younger than those with more socialized phobic conditions. Left untreated or poorly treated, phobias can become immobilizing and result in significant morbidity and restriction of their lives.