

PTSD: Updated

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Overview

- New Diagnostic Criteria
- Resources/Apps
- Timely Topic:
 - Anger, aggressiveness and PTSD
- Citation: National Center for PTSD





Updated Criteria

- Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters:
 - 1) Intrusion, 2) avoidance, 3) negative alterations in cognitions and mood, and 4) alterations in arousal and reactivity.
 - The sixth criterion concerns duration of symptoms
 - The seventh assesses functioning
 - The eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

New Specifications

- Two specifications are noted:
 - 1) Delayed expression
 - 2) Dissociative subtype of PTSD, which is new to DSM-5.
- In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted

Criterion A: stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: **(1 required)**

- Direct exposure.
- Witnessing, in person.
- Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
- Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.



Criterion B: intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): (1 required)



- Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
- Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
- Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
- Intense or prolonged distress after exposure to traumatic reminders.
- Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: **(1 required)**

- Trauma-related thoughts or feelings.
- Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).



Criterion D: negative alterations in cognitions and mood

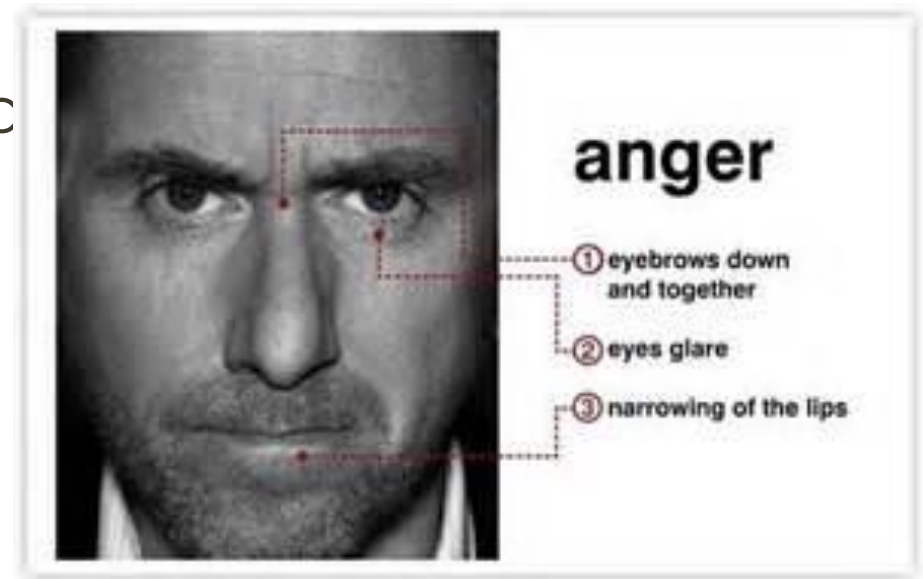
Negative alterations in cognitions and mood that began or worsened after the traumatic event: **(2 required)**



Criterion E: alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: **(2 required)**

- Irritable or aggressive behavior
- Self-destructive or reckless behavior
- Hypervigilance
- Exaggerated startle response
- Problems in concentration
- Sleep disturbance



• Criterion F: duration

- Persistence of symptoms (in Criteria B, C, D, and E) for more than one month



Criterion G: functional significance

- Significant symptom-related distress or functional impairment (e.g., social, occupational).



Criterion H: exclusion

- Disturbance is not due to medication, substance use, or other illness.



Specify if: With dissociative symptoms.

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

- **Depersonalization:** experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
- **Derealization:** experience of unreality, distance, or distortion (e.g., "things are not real").



Specify if: With delayed expression.

- Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

New Resources

- Apps
- Websites
- Videos
- Services



Mobile Applications



- PTSD is a serious mental health condition that often needs professional evaluation and treatment. These apps are not intended to replace needed professional care.
- Provide self-help, education and support
- Also have treatment companion apps to use with a health care provider
- These apps can be used on iOS and Android devices
- They are not intended to replace professional care.

Self-Help Apps

- PTSD Coach

This mobile app is to help you learn about and cope with the symptoms related to PTSD that commonly occur following trauma.

- Concussion Coach

This mobile app will help you manage symptoms of concussion, or mild to moderate traumatic brain injury.



Treatment Companion Apps



- [CBT-i Coach](#)

This mobile app will help you get the most out of Cognitive Behavioral Therapy for Insomnia so that you can develop good sleep habits and sleep better. CBT-i Coach is best used while in therapy with a provider.

- [PE & CPT Coach](#)

A mobile app to be used during Prolonged Exposure (PE) & CPT therapy with a mental health professional. Coach is not a self-help tool.

- [Stay Quit Coach](#)

A free mobile app that helps you stay quit after you stop smoking with tools to control cravings, reminder messages, and support links. This app is best used while in treatment with a therapist or after your treatment has ended

Website Information

- AboutFace videos
 - National Center for PTSD: [ptsd.va.gov](http://www.ptsd.va.gov)

<http://www.ptsd.va.gov/apps/AboutFace/>





Coaching into care

- VA has a program called [Coaching Into Care](#) to help family and friends of returning Veterans. A coach will help you figure out what to say to your Veteran and to help get him or her into care if needed
- Each family is different. Some people may need just one call, and others may find it helpful to have several calls with us over a few weeks. Coaching Into Care is free, and helps you make progress toward the goal of getting your Veteran to seek help by:

Coaching Into Care



- Answering questions about the type of services available at the VA
- Arranging for a specialist to speak with you on the phone about how to talk with your Service Member or Veteran
- Coaching Into Care takes the privacy of you and your Veteran very seriously. Coaches are aware of your concerns about the risk of getting your Veteran upset or into trouble. Every aspect of your care - from first call to services - are kept private, except in cases where we act to protect the lives of you, your Veteran, loved ones, or others.
- **Call Coaching Into Care: 1-888-823-7458**

Timely Topic

- Anger, Aggression, Violence



Anger and Trauma

Why is anger a common response to trauma?

- Anger is often a large part of a survivor's response to trauma.
- It is a core piece of the survival response in human beings.
- Anger helps us cope with life's stresses by giving us energy to keep going in the face of trouble or blocks.
- Yet anger can create major problems in the personal lives of those who have experienced trauma and who suffer from PTSD.



Survival Instinct

- One way of thinking is that high levels of anger are a natural survival instinct.
- When faced with extreme threat, people often respond with anger.
- Anger can help a person survive by shifting his or her focus. The person focuses all of his or her attention, thought, and action toward survival.



Injustice

- Anger is also a common response to events that seem unfair or in which you have been made a victim.
- Research shows that anger can be especially common if you have been betrayed by others. This may be most often seen in cases of trauma that involve exploitation or violence.



Coping

- The trauma and shock of early childhood abuse often affects how well the survivor learns to control his or her emotions. Problems in this area lead to frequent outbursts of extreme emotions, including an



How can anger after a trauma become a problem?

- In people with PTSD, their response to extreme threat can become "stuck."
- This may lead to responding to all stress in survival mode. If you have PTSD, you may be more likely to react to any stress with "full activation." You may react as if your life or self were threatened.
- This automatic response of irritability and anger in those with PTSD can create serious problems in the workplace and in family life. It can also affect your feelings about yourself and your role in society.

Posttraumatic Anger

- Researchers have broken down posttraumatic anger into three key aspects, discussed below. These three factors can lead someone with PTSD to react with anger, even in situations that do **not** involve extreme threat:

Arousal

- Anger is marked by certain reactions in the body. The systems most closely linked to emotion and survival — heart, circulation, glands, brain — are called into action.
- Anger is also marked by the muscles becoming tense. If you have PTSD, this higher level of tension and arousal can become your normal state. That means the emotional and physical feelings of anger are more intense.
- If you have PTSD, you may often feel on edge, keyed up, or irritable. You may be easily provoked. This high level of arousal may cause you to actually seek out situations that require you to stay alert and ward off danger.
- On the other hand, you may also be tempted to use alcohol or drugs to reduce the level of tension you're feeling.



Behavior



- Often the best response to extreme threat is to act aggressively to protect yourself.
- Many trauma survivors, especially those who went through trauma at a young age, never learn any other way of handling threat. They tend to become stuck in their ways of reacting when they feel threatened. They may be impulsive, acting before they think.
- Aggressive behaviors also include complaining, "backstabbing," being late or doing a poor job on purpose, self-blame, or even self-injury.
- Many people with PTSD only use aggressive responses to threat. They are not able to use other responses that could be more positive.

Thoughts and Beliefs

Everyone has thoughts or beliefs that help them understand and make sense of their surroundings.

After trauma, a person with PTSD may think or believe that threat is all around, even when this is not true. He or she may not be fully aware of these thoughts and beliefs.

For example, a combat Veteran may become angry when his wife, children, or coworkers don't "follow the rules." He doesn't realize that his strong belief is actually related to how important it was for him to follow rules during the war in order to prevent deaths.



Control



- If you have PTSD, you may not be aware of how your thoughts and beliefs have been affected by trauma.
- For instance, since the trauma you may feel a greater need to control your surroundings.
- This may lead you to act inflexibly toward others.
 - Your actions then provoke others into becoming hostile towards you.
 - Their hostile behavior then feeds into and reinforces your beliefs about others.

Some common thoughts of people with PTSD are:

- "You can't trust anyone."
- "If I got out of control, it would be horrible, life-threatening, or could not be tolerated."
- "After all I've been through, I deserve to be treated better than this."
- "Others are out to get me," or "They won't protect me."

How can you get help with anger?

- In anger management treatment, problems with arousal, behavior, and beliefs are all addressed in different ways. Cognitive-behavioral treatment (CBT), a commonly used therapy, uses many techniques to manage these three anger problem areas:

WHAT WE THINK, WE ARE..



You can't live a positive life with negative mind.

For increased arousal

- The goal of treatment is to help the person learn skills that will reduce overall arousal.
- He or she may learn how to relax, use self-hypnosis, and use physical exercises that release tension.

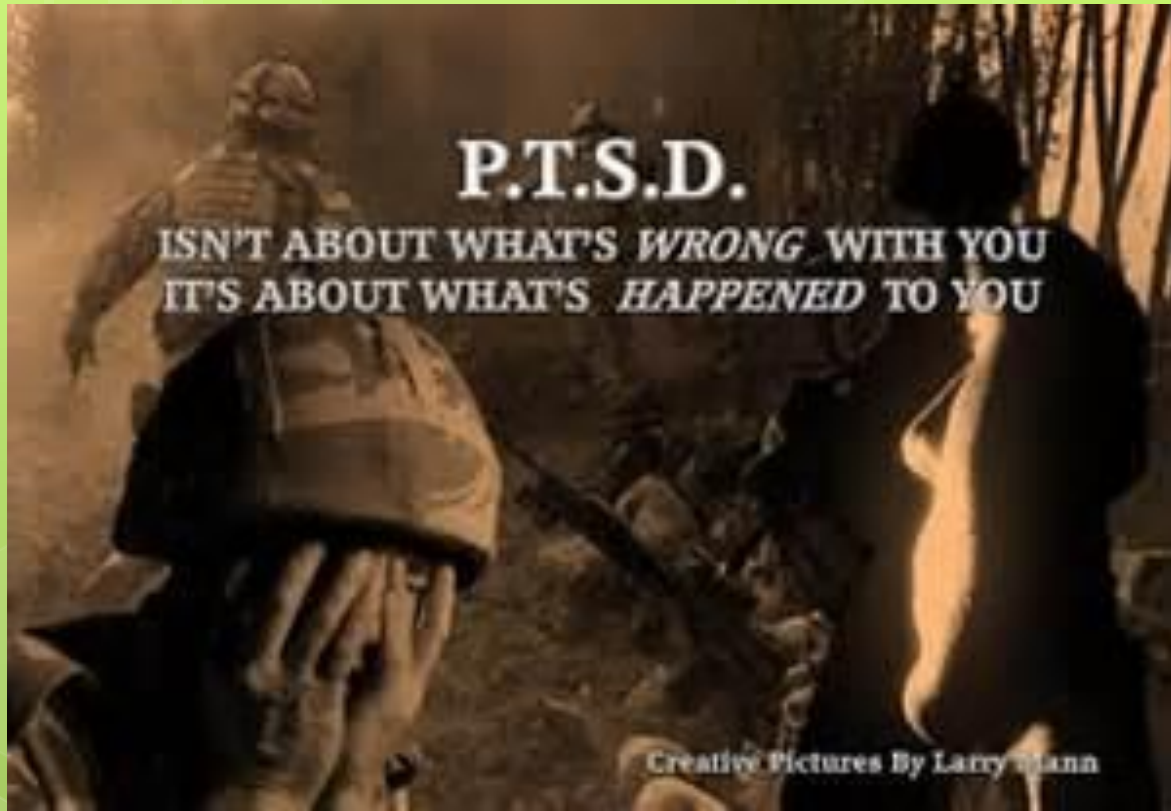


For behavior

- The goal is first to look at how a person usually behaves when he or she feels threat or stress. The next goal is to help him or her expand the range of possible responses. More adaptive responses include:
 - Taking a time out
 - Writing thoughts down when angry
 - Talking with someone instead of acting
 - Changing the pattern "act first, think later" to "think first, act later"

For thoughts and beliefs

- Clients are given help in becoming more aware of their own thoughts leading up to becoming angry.
- They are then asked to come up with more positive thoughts to replace their negative, angry thoughts.
 - For example, they may learn to say to themselves, "Even if I don't have control here, I won't be threatened in this situation."
 - Another example would be, "Others do not have to be perfect in order for me to survive or be comfortable."
- Role-play is often used so you can practice recognizing the thoughts that make you angry and applying more positive thoughts instead.



Questions?

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