WHAT DOES PTSD LOOK LIKE

DSM-5 Criteria for PTSD

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (1). The diagnostic criteria are specified below.

You Can Also

- Read more about the [DSM-5 Revisions for PTSD](#)

Note that DSM-5 introduced a preschool subtype of PTSD for children ages six years and younger. The criteria below are specific to adults, adolescents, and children older than six years.

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: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of 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: (one required)

1. Direct exposure.
2. Witnessing, in person.

3. 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.

4. 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): (one required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.

2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).

3. 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.

4. Intense or prolonged distress after exposure to traumatic reminders.

5. Marked physiologic reactivity after exposure to trauma-related stimuli.

**Criterion C: avoidance**

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

1. Trauma-related thoughts or feelings.

2. 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: (two required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).

2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").

3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.

4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

**Criterion E: alterations in arousal and reactivity**

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

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. 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:

1. 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).
2. 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.
Military with PTSD

PTSD Changes Thinking

It’s very frustrating for us living with PTSD. PTSD involves rocketing into extreme states of stress re-activity (in the form of terror, rage, and uncontrollable impulses) and plunging into equally extreme states of being shut-down (exhaustion, emotional numbing, despair, and dissociation).

From this vantage point, PTSD clearly is about much more than fear and anxiety, involving the full range of emotions and undermining our body’s health, our ability to think clearly, to set and achieve goals, and to fully participate in and benefit from relationships.

All we know is we are safe, we are alive. It becomes all about the loss of self-regulation that occurs when survival dominates how we think, feel, and behave in every area of our life.

PTSD replaces the “me” who was still growing, learning, and becoming a unique person before the trauma(s), leaving only a desperate survivor who may have no clear sense of identity and who may even hate or loathe herself or himself.

But because our thinking kept us safe kept us alive, we honestly do not think we have a problem. To us we aren’t acting nuts, we are acting exactly how we trained. We are military, it’s who we are. Our training, the military way kept us alive. We have to be able to respond to threat with minimal time pondering choices and we don’t use kid gloves. No we go on full attack. So how can our thinking and actions be wrong now?

In our mind we don’t have the problem, the problem is the spouse who cries, who pushes, who nags, who says we need help (which in military world that translates to we are weak). We really think you as the spouse are our problem and the cause for pushing us till our anger explodes. But hey we are military, that is a perfectly acceptable emotion and reaction to have.

I’ve made a list of things I’ve learned over the years or realized from my experience. Many veterans I speak to have expressed to me this list is pretty well right on although it may not be everyone’s experience.

1. We use video games to escape and feel in control of something, that is normal. Don’t fight us on this it will only make things worse. We don’t need a mom telling what to do or trying to punish us by taking it away. Instead try playing a game with us. The point is find something, anything, to get involved with us, and get some communication going. Spending time together even over a video game helps rebuild trust.

2. Lack of intimacy normal due to being numb. Do you have any idea what it’s like to look at your family and not be able to feel anything? It is not about you, it is about us and trying to figure out what the hell is going on. It also could probably be contributed to the next point.

3. Anger, yelling, cussing, and reacting before thinking (i.e overreacting or doing stupid things on impulse) The trauma we endure caused physical changes in our brain. The amygdala which
controls flight or fight is now always on. We can go from 0-60 in a nanosecond. It is what kept us alive. Every situation is an emergency. We just came back from a place that everyone wanted to kill us and our brothers and sisters are dying right in front of us. Our amygdala can’t tell the difference between Iraq and home. We will not fight with kid gloves on. We are now playing by a different set of rules. (We have to relearn to control it which takes time.)

4. Spending money. Again most of us have this problem. Due to lack of impulse control because of changes in our brain, and well, what’s the point of saving for a future that may never come. Death is in us, we saw our buddies laughing and joking one minute and dead the next.

5. As far as us getting a job. I don’t know many of us with PTSD that can hold down jobs. It freaks us out to be in public. Civilian world is not even in the same universe as military world. An example, I got fired from a job with in the first week. We were moving office furniture and the guys who I was working with were just throwing this furniture on top of each other without putting the protective covering in between the furniture to protect it from damage. So I called them out on it and went to the supervisor to let him know that policy and procedure were not being followed and the potential problems that could cause. In my mind first of all not following rules and regs is completely unacceptable. In the military it’s your ass if something goes wrong and you didn’t follow procedure. That is how people die! But I found out they were not as worried about policy and procedure being followed as they were about the work getting done as fast as possible when they fired me citing I was difficult to work with. And this wasn’t the only job this happened at. Each of them saying, I was difficult to work with.

6. Startle response and having to be in a position to see everything. Most of us with PTSD have a quick reaction to sudden movement and noises and almost always stay on guard and where we can see an entire room. The way I explained it to my wife why she couldn’t sneak up behind me or touch me unexpectedly was like this, hopefully you will be able to understand this way too. I was a MP so I was always armed! On the ship or anywhere we always had to be where we could see everything like in a corner or some place we weren’t exposed. If someone was able to get behind us and we didn’t know about it they could disarm us. So to stay in control we always had to be on guard and make sure no one got close enough to take our weapon. With that if someone (buddy) would come up next us, tap us on the shoulder or on the back and we weren’t expecting it we immediately would go into protect mode and reach for our gun. It was something trained into us and it kept us safe. It is not something you can just turn off.

Just a little insight to our thinking. It has taken me 10 years to start to see a little bit of the work I have put in to retrain my thinking. -Justin Gourley

To read what it feels like to live with PTSD click here. If you would like to know more about PTSD and the Brain click here.