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Psychotherapists' Experiences Utilizing the New Posttraumatic Stress Disorder Diagnostic Criteria in DSM-5

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MS, California State University Fullerton, 2003

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Dissertation Submitted in Partial Fulfillment

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Abstract

The fifth and most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), has presented revised diagnostic criteria for posttraumatic stress disorder (PTSD). The impact of the new diagnostic criteria upon the day-to-day experiences of mental health professionals, including diagnosis, treatment, and insurance billing has remained unclear. Using the adaptive information processing model as a theoretical framework, this multiple case study explored how licensed clinicians experienced utilization of the revised diagnostic criteria for PTSD. Fifteen mental health practitioners who had experience in the treatment of clients presenting PTSD symptoms were interviewed. Data from participant interviews were analyzed and themes developed. Participants agreed with the removal of Criterion A2 (in which the individual must experience intense fear, helplessness, or horror at the time of the event), the addition of a dissociative subtype, and separate criteria for PTSD in children. However, clinicians strongly disagreed with the changes to Criterion A, which defines trauma as directly experiencing the event, witness the event as it happens to others, or learning about the event happening to close friends or family. In the case of the event happening to close friends or family, the event must be violent or accidental. Additionally, an individual may experience repeated extreme or repeated exposure to aversive details of the event (for example, first responders). Results of this study uncovered gaps between the *DSM-5* criteria and the experiences of clinicians in the diagnosis of PTSD. This contributes to the ongoing debate about the appropriate definition of trauma in the *DSM-5* and supports the need for continuing research.

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Chapter 1: Introduction

The *DSM* has been described as a living document, in which the diagnostic criteria for various mental disorders are subject to change as new research is published (Friedman, 2013). Therefore, although the changes to the diagnostic criteria for PTSD are based on the conclusions of solid research, additional research may uncover new information that may require augmentation of the PTSD diagnostic criteria for future editions. Kilpatrick et al. (2013) stated that the prevalence of PTSD in the United States is over 10% of the total population, and that untreated PTSD may lead to physical, psychological, behavioral, and relational issues for those who have the disorder. Therefore, identifying the most accurate diagnostic criteria may assist in effectively treating individuals who experience the potentially devastating effects of PTSD.

In this chapter, I provide information on the background of the study and describe the problem I sought to address. I also discuss the purpose and significance of this study and describe the theoretical framework. Finally, I discuss the interview questions, the terms that I used in the study, and the scope and limitations of this study.

Background of the Study

In the United States, the *DSM* is a central diagnostic tool for mental health professionals, and is the most commonly utilized diagnostic tool in mental health facilities (Bowen, 2013; Rogler, 1997). Additionally, the *DSM* plays a significant role in court proceedings, in the distribution of funds for government hospital and mental health facilities, and in third-party payment for mental health fees (Bowen, 2013; Rogler, 1997). The development of the *DSM* was an attempt to create a common language in mental

health classification, as previously, several nomenclatures existed (Clegg, 2012). The first *DSM*, or *DSM-I*, was developed in 1952, and revised editions have been distributed regularly over the past 64 years (APA, 1952). Each new edition attempts to refine previous concepts about mental health diagnoses, making changes to diagnostic criteria based upon the current research regarding the most efficacious terminology to define mental disorders (Rogler, 1997). Each new edition typically creates heated discourse within the mental health community, as old diagnostic criteria may be altered or completely discarded from the nomenclature (Friedman, 2013; McNally, 2003). The most current edition, the *DSM-5*, has followed in the footsteps of its predecessors, causing heated debates among mental health professionals about the latest constructs in the diagnosis of mental disorders (Friedman, 2013).

In 1980, the APA released the *DSM-III*, and added the diagnosis of PTSD. The addition of the diagnosis of PTSD in the *DSM-III* was significant, as it was the first diagnosis that stressed the importance of the etiology of the disorder and emphasized that the magnitude of the event, rather than a weakness in the individual, created the disorder (National Center for PTSD, n.d.). The diagnostic category has been altered as the *DSM* has been revised, with the *DSM-IV* including three symptom clusters (APA, 1994). These three symptom clusters include intrusive recollections, avoidant or numbing symptoms, and hyperarousal symptoms (National Center for PTSD, n.d.). In order to meet the criteria for PTSD in the *DSM-IV*, an individual must have experienced a traumatizing event, as well as experience symptoms from each of the three categories listed above for

at least 1 month, and these symptoms must cause significant impairment in social, occupational or other important areas of functioning (APA, 1994).

The most recent revision of the *DSM* was released in 2013, and includes revised diagnostic criteria for PTSD (APA, 2013). The most recent diagnostic criteria for PTSD removes the disorder from its previous classification as an anxiety disorder and creates a new category titled *trauma and stressor-related disorders* (APA, 2013). This change may assist in altering the perception that the diagnosis of PTSD reflects a spontaneous development of the disorder in the individual, as it emphasizes the role that a traumatic event plays in the etiology of the disorder (Kilpatrick et al., 2013). The diagnosis places an emphasis upon the magnitude of the triggering event, which is described as something that occurs outside of typical human experience (Kilpatrick et al., 2013).

The revised diagnosis includes the exclusion of events that were previously considered traumatic in the *DSM-IV* (for example, sudden natural death is no longer considered a traumatic event). Additionally, the diagnosis no longer requires that the individual experience fear, helplessness, or horror; the diagnostic criteria includes four symptom clusters rather than the three presented in the *DSM-IV*; and new symptoms are introduced. Moreover, the new diagnosis requires at least one active avoidance symptom for a diagnosis of PTSD and subdivides the PTSD diagnosis into two separate categories: *Composite Event PTSD* and *Same Event PTSD* (Kilpatrick et al., 2013).

Problem Statement

The new diagnostic criteria for PTSD in the *DSM-5* have created a great deal of disagreement among mental health professionals as to whether the changes effectively

characterize PTSD (Calhoun et al., 2012). The most current research has shown that the prevalence of the disorder has somewhat declined with the new diagnostic criteria, but the impact of the new diagnostic criteria upon the day-to-day experiences of mental health professionals, including diagnosis, treatment, and insurance billing has remained unclear (Calhoun et al., 2012).

The *DSM-5* was released in April 2013; however, many insurance companies had not required clinicians to use the new diagnostic criteria until October 2015. Therefore, the full effect of the diagnostic changes may not have been present until after October 2015. Many have theorized that the changes would result in an increase in the number of diagnoses of PTSD, as the new diagnostic criteria no longer require that the individual exhibit fear symptomology (Miller, Wolf, & Keane, 2014). However, other researchers have theorized that the exclusion of an individual witnessing a natural death as qualifying an individual for a PTSD diagnosis may reduce the number of diagnoses of this disorder (Miller et al., 2014). Other researchers have stated that the *DSM-5* requirement of at least one active avoidance symptom as necessary for a diagnosis may also reduce the number of diagnoses for PTSD (Kilpatrick et al., 2013).

Research into the actual experiences of clinicians provided valuable information as to the impact of the new diagnostic criteria on the diagnosis of PTSD. Research has shown that individuals with PTSD may reduce their vulnerability to potential long-term mental, behavioral, and physical ailments by undergoing successful treatment (Polak et al., 2012). Successful treatment for PTSD is expected to alleviate an individual's suffering, potential for compounded mental and behavioral problems, and possibility of

physical ailments (Polak et al., 2012). Successful treatment, however, is dependent upon accurate diagnosis. In this qualitative study, I sought to explore how psychotherapists experienced utilization of the new diagnostic criteria with their clients who presented with the potential for a PTSD diagnosis. My research resulted in valuable insights into the effects of the changes in the PTSD diagnosis in the *DSM-5* on psychotherapists.

Purpose

The purpose of this multiple case study was to discover the experiences of licensed clinicians as they assess and provide treatment to individuals presenting with symptoms of PTSD. This research uncovered important information regarding how behavioral health professionals experienced the *DSM-5* diagnostic criteria for PTSD as they utilized it in their practice.

Significance

The impact of PTSD is significant, both for the individuals diagnosed with the condition and for society as a whole (Kilpatrick et al., 2013). Research into the prevalence of trauma has shown that approximately 60% of American men and 51% of American women experience a traumatic event at some point in their lives (National Center for PTSD, n.d.). According to recent research into the prevalence of PTSD, the disorder affects 10.5% of the U.S. population when considering composite event PTSD (due to exposure to combination of event types), and 9.3% of the of the U.S. population when considering single event PTSD (due to exposure to the same event type) (Kilpatrick et al., 2013).

PTSD causes difficulties for millions of Americans, impacting their personal, social, educational, and occupational functioning (Kilpatrick et al., 2013). For those who experience a traumatic event, roughly 10% will develop PTSD under the *DSM-IV* diagnostic criteria (Kilpatrick et al., 2013). The potential risks for PTSD that most often remain untreated include personal distress, interpersonal relationship problems, job loss, drug abuse, alcoholism, conflict with law enforcement, suicide attempts, and other psychiatric disorders (National Center for PTSD, n.d.). Research into the potential effects of PTSD on the physical health of those with the disorder suggests that individuals with untreated PTSD may be at greater risk of developing heart disease than those who have been successfully treated for PTSD (Sutherland & Tulkin, 2012).

Furthermore, untreated PTSD may increase an individual's susceptibility to diabetes, stroke, and other stress-related physical ailments (Sutherland & Tulkin, 2012). Research has shown, however, that individuals with PTSD may reduce their vulnerability to potential long-term mental, behavioral, and physical ailments by undergoing successful treatment (Polak et al., 2012). This research on the effects of untreated PTSD indicate the importance of successful treatment to alleviate individual suffering as well as the potential for other social, occupational and physical ailments; however, successful treatment is dependent upon accurate diagnosis. The intention for this qualitative study was therefore to explore how psychotherapists have experienced utilization of the new diagnostic criteria with their clients who present with the potential for a PTSD diagnosis. The findings of the study provide valuable insights into the effects of the changes in the PTSD diagnosis in the *DSM-5*.

Framework

I used the adaptive information processing (AIP) model (F. Shapiro, 2007) to guide my research into how psychotherapists experienced utilizing the *DSM-5* PTSD diagnostic criteria. The AIP model is commonly used to describe the development of psychological pathology as a result of the brain failing to incorporate information, or an experience, in an adaptive fashion (F. Shapiro & Laliotis, 2011). As F. Shapiro (2007) explained, "in a healthy individual, as new experiences are processed, they are 'metabolized' or 'digested' and what is useful is learned, stored with appropriate emotions, and made available to guide the person in the future" (p. 70). In the case of traumatic events, however, rather than processing information or an experience by integrating it with previous knowledge in an adaptive, healthy manner, the information or experience is stored, unprocessed, within the brain. All of the original thoughts, sensations, and images present at the time of the incident remain "stored in their own neural network, unable to link up naturally with anything more adaptive" (p. 70).

F. Shapiro and Laliotis (2011) pointed out that researchers and clinicians use the AIP model to understand how pathology develops, predict the prognosis of psychological pathology, assist practitioners in the development of treatment plans, and implement treatment for their clients. The authors posited that an individual who experiences a traumatic event may later develop symptomatology for PTSD due to the brain failing to process the overload of stimulation that occurs, including the sounds related to the trauma, the sensations related to the trauma, the thoughts related to the trauma, and their thoughts regarding the trauma. F. Shapiro and Laliotis advised that the AIP model can be

utilized to understand how mental health professionals experience and conceptualize individual pathology. They noted that individuals diagnosed with PTSD hold thoughts, feelings, sensations, and images about the event, and clinicians may utilize these individual factors to help the brain reprocess the event with a more positive, adaptive result. The AIP model therefore provided an excellent theoretical framework for this research study.

Research Questions

The research questions for this study were the following:

1. What are psychotherapists' impressions of the new PTSD diagnostic criteria in the *DSM-5*?
2. How does the new PTSD diagnostic criteria affect psychotherapists' use of diagnostic tools?
3. How does the new PTSD diagnostic criteria affect psychotherapists' use of interventions?
4. How does the new PTSD diagnostic criteria affect psychotherapists' use of insurance claims (i.e., filing claims, collecting on claims, coding claims, etc.)?

Interview Questions

I formulated the interview questions to explore how psychotherapists experienced the new diagnostic criteria for PTSD in the *DSM-5*, including their use of tools, interventions, and insurance claims. Please see Appendix A for the specific interview questions used for this study.

Nature of the Study

The nature of the study was qualitative. Qualitative research methods are the best fit for investigating experiences of individuals (Creswell, 2009). For this study, through the multiple case study approach to research, I sought to explore the experiences of psychotherapists who utilize the new PTSD diagnostic criteria in the *DSM-5*. The multiple case study approach may be the best fit for researchers when they seek to explore a complex phenomenon through in-depth interviews with those who actually live with the phenomenon in question (Yin, 2012).

In an exploratory multiple case study, the research questions may be broad, in order to explore a topic that lacks research (Yin, 2012). In this current study, the experiences of the participants are explored through interviews with psychotherapists who use the new PTSD diagnostic criteria in the *DSM-5* when they provide counseling services to clients. Additionally, participants completed a demographics questionnaire, and I took notes on observations made while interviewing the participant.

I used criterion sampling as the sampling method for this study. Criterion sampling is useful when participants must be experiential experts in a specific area (Patton, 2002; Rudestam & Newton, 2015). The criterion for inclusion in this research was for each participant to be a licensed mental health professional, with experience working with clients presenting with symptoms of PTSD. One source of participants was the Eye Movement Desensitization and Reprocessing International Association (EMDRIA). Members of EMDRIA (2017c) who hold licensure to practice psychotherapy have completed training in Eye Movement Desensitization and Reprocessing (EMDR)

through the EMDR Institute. EMDR has been shown to be a leading treatment modality for individuals experiencing trauma related symptoms commonly found in those with PTSD (Buydens, Wilensky, & Hensley, 2014). Additionally, I recruited potential participants through a state-funded behavioral health organization. This state-funded behavioral health organization provided clinical mental health services, employed therapists committed to trauma-informed care, and advocated for social change. For this multiple case study approach, I sought 15 psychotherapists who were using the new PTSD diagnostic criteria from the *DSM-5* to participate in in-depth interviews and complete a demographics questionnaire.

Possible Types and Sources of Data

For this research, I sought to explore the experiences of psychotherapists utilizing the new PTSD diagnostic criteria in the *DSM-5* when working with clients. Multiple case study approaches to research allow the researcher, first, to explore the experiences of the participants, then to compare and contrast the case studies. Using this multiple case study approach, I sought participants through an online announcement and then utilized criterion sampling to select 15 participants. The 15 participants, each a licensed mental health professional, participated in in-depth interviews regarding their experiences with applying the new PTSD diagnostic criteria in the *DSM-5* as they worked with clients. Additionally, the participants completed a demographics questionnaire, and I recorded my insights gleaned during the interview process in a journal.

Data analysis included interview analysis as well as cross-interview analysis (Yin, 2012). As suggested by Yin (2012), the analysis of the interviews included searching for

themes that emerged from the data, member checking to ensure the accuracy of the data collected, and soliciting feedback on the themes that emerged from the data. I used HyperRESEARCH software (Version 3.7.2; Researchware, 2015) to organize and analyze the relationships within and between data collected. The researcher plays a key role in case study research, and for this study, I conducted all interviews and analyzed data using coding, a role that Glaser and Strauss (1967) mentioned as a central feature of multiple case study analysis.

Definition of Terms

Diagnostic and Statistical Manual, Fifth Edition (DSM-5): In the United States, the *Diagnostic and Statistical Manual of Mental Disorders*, published by the APA, is a central diagnostic tool for mental health professionals and is the most commonly utilized diagnostic tool in mental health facilities (Bowen, 2013; Rogler, 1997). The fifth edition, *DSM-5*, was released in 2013, and provides the diagnostic criteria for mental disorders (APA, 2015).

Diagnostic and Statistical Manual, Fourth Edition (DSM-IV): The fourth edition of the *DSM* (*DSM-IV*) was released by the APA in 1994 (APA, 2015). The fourth edition of the *DSM* was replaced by the *DSM-5* in 2013 (APA, 2015). The diagnostic criteria for posttraumatic stress disorder were changed between the *DSM-IV* and the *DSM-5* (APA, 2015).

Posttraumatic Stress Disorder: Posttraumatic stress disorder may be described as a group of symptoms that develop as a result of exposure to one, or to multiple, traumatic events (APA, 2013). Although the diagnostic criteria changed between the *DSM-IV* and

the *DSM-5*, the focus on the precipitating trauma as the stimulus for the development of symptoms has remained constant (APA, 2013).

Posttraumatic stress disorder diagnostic criteria: Posttraumatic stress disorder diagnostic criteria include the list of potential symptoms that may develop in an individual after exposure to one or more traumatic events (APA, 2013). Although the clinical presentation for each individual may vary, the diagnostic criteria requires that that the individual experience the trauma directly, experience repeated exposure to the negative details of the traumatic event, or if the trauma occurred to a close friend or family member, the traumatic event must be violent or accidental (APA, 2013).

Mental health professionals, clinicians, and psychotherapists: Mental health professionals, clinicians, and psychotherapists may be defined as licensed professionals, credentialed to provide diagnosis and treatment services to individuals who present with mental and/ or behavioral issues (EMDRIA, 2017a). Mental health professionals, clinicians, and psychotherapists may work in private practice, hospitals, for-profit clinical settings, or nonprofit clinical settings. As employed in this dissertation, the terms *mental health professional, clinician, and psychotherapist* are interchangeable.

Assumptions

In seeking to explore the experiences of clinicians as they utilize the diagnostic criteria for PTSD in the *DSM-5* in their clinical practice, my assumption was that participants would be truthful in their responses. I assumed that participants agreed to take part in the study due to a sincere desire to contribute to the research in question and neither sought outside favor due to positive reactions nor feared retribution if they were

to reveal a negative reaction to the new diagnostic criteria. Following Wargo's (2015) suggestions for identifying assumptions for one's dissertation, I also assumed that no unknown factors or conditions existed in the working or living environment of participants that may have biased their responses and that the inclusion criteria for participation in the sample were appropriate. Finally, I assumed that the respondents had utilized the diagnostic criteria for PTSD in the *DSM-5* for a sufficient amount of time, which allowed them to experience utilization of the diagnostic criteria sufficiently to reach conclusions. Since October 2015, many insurance companies have required that clinicians use the revised diagnostic criteria for PTSD. I assumed that clinicians had enough experience with the new diagnostic criteria to enable them to contribute significant information regarding their experiences.

Scope and Delimitations

The purpose of this study was to explore the experiences of clinicians as they utilize the diagnostic criteria for PTSD in the *DSM-5*. I therefore limited the scope of this research to clinicians' use of the *DSM-5* diagnostic criteria for PTSD, not for other diagnoses. The *DSM-5* presents changes to many diagnostic criteria, and the participants may assess and treat clients who present with a variety of diagnoses; however, I limited this research to the diagnosis and treatment of PTSD. Additionally, due to the qualitative nature of this case study research, the results reflect the experiences of each individual. I therefore did not assume causality or generalize the results to the general population; however, valuable insight was gained into the experiences that clinicians may have when

utilizing the diagnostic criteria for PTSD in the *DSM-5*, which may assist in assessing the utility of the diagnostic changes.

Limitations

Mental health clinicians assess, and provide treatment for, a wide variety of mental health disorders. For this study, however, I sought participants who specifically conducted assessments and provided clinical services for individuals who presented for treatment after experiencing a traumatic event, which could lead to a PTSD diagnosis. According to Solomon and F. Shapiro (2008), one of the most efficacious treatment methods for PTSD is EMDR. Mental health clinicians who are trained to provide EMDR therapy for their clients through the EMDR Institute and are members of EMDRIA are listed on the official EMDRIA website as certified, licensed therapists who may provide EMDR to individuals experiencing the troubling repercussions of trauma (EMDRIA, 2017c). The members of EMDRIA, certified and trained to administer EMDR to clients diagnosed with PTSD, provided a logical base for criterion sampling. Mental health practitioners working through a state-funded mental health clinic also provided a logical base for criterion sampling, as they are licensed clinicians trained to work with a variety of mental health disorders, including PTSD. Criterion sampling is the best fit when participants must be experiential experts in a specific area (Rudestam & Newton, 2015). However, the choice to utilize criterion sampling for this research may have presented a limitation to the study, as the results may apply only to those who are trained to provide EMDR for their clients who have experienced a traumatic event, or to those who worked at the state-funded mental health clinic. Therefore, it is possible that clinicians who are

not trained in EMDR or those who do not practice within the state-funded mental health clinic may report a different experience as they utilized the PTSD diagnostic criteria in the *DSM-5*.

Summary

As outlined above, individuals who suffer with untreated PTSD may develop chronic mental, emotional, behavioral, and relational problems (Kilpatrick et al., 2013). These chronic problems influence not only the life of the individual suffering with the disorder but also his or her family, friends, and society as a whole (Kilpatrick et al., 2013). Effective treatment is dependent upon the diagnostic criteria upon which mental health professionals assess individuals (Kilpatrick et al., 2013), and the experiences of clinicians as they utilize the revised diagnostic criteria for PTSD in the *DSM-5* had yet to be explored.

The *DSM-5* includes revised diagnostic criteria for PTSD. Although research to date has provided information regarding the prevalence of PTSD when clinicians utilize the new diagnostic criteria, research regarding the experiences of clinicians as they utilize the new PTSD diagnostic criteria in the *DSM-5* is scarce. Utilizing the AIP model as a theoretical framework, I designed this research to explore the experiences of clinicians as they utilized the new PTSD diagnostic criteria in the *DSM-5* in their clinical practice. In this chapter, the research problem, the purpose of this research, and the research questions were detailed, and the assumptions, scope, and limitations were presented. The following chapter provides background literature regarding the *DSM*, PTSD, and the AIP model.

Chapter 2: Literature Review

Introduction

The changes in the diagnostic criteria for PTSD in the *DSM-5* are significant (APA, 2015). Changes include the development of a new category of disorders titled trauma and stress or related disorders, which removes the diagnosis of PTSD from the anxiety disorder category (APA, 2015). This change was instituted to ensure that there is an emphasis on the precipitating traumatic event to the development of symptoms rather than spontaneous development of client symptoms (APA, 2015). The traumatic event must be exposure to actual or threatened death, serious injury, or sexual violation, and the individual must directly experience the event, witness the event in person, learn that the event occurred to a close family member or very close friend (and the actual or threatened death must be violent or accidental), or experience first-hand, repeated exposure to the event (APA, 2015).

A second significant change in the diagnostic criteria for PTSD in the *DSM-5* was the elimination of language specifying that the individual must have an immediate aversive reaction to the traumatic event (for example, horror, fear, or helplessness), as it has been shown that this type of reaction is not predictive of the development of PTSD in the future (APA, 2015). Additionally, the *DSM-5* increases the number of symptom clusters from three to four, including reexperiencing, avoidance, negative cognitions and mood, and arousal (APA, 2015). The latest diagnostic criteria eliminate the distinction between acute and chronic PTSD, but include the addition of two PTSD subtypes: a PTSD *Preschool Subtype*, for children under age six, and a PTSD *Dissociative Subtype*,

for those that experience feeling detached from their own body or mind or feel as though they are detached from the world (some describe this as a "dream-like" state; APA, 2015). My review of the literature revealed that although much research into the *DSM-5* suggests that the overall reliability of this newer edition is similar to that of the *DSM-IV*, research into the experiences of clinicians as they utilize the *DSM-5* diagnostic criteria for PTSD had not been conducted (Chmielewski, Clark, Bagby, & Watson, 2015). This current research fills the void in exploring how practitioners experience the new diagnostic criteria as they assess for PTSD.

Literature Search Strategy

In my search for relevant scholarly research articles, I searched the Walden University electronic library. Most frequently, I used the Elton B. Stephens Company (EBSCO) system, as it allows for the inclusion of a variety of databases. Through the PsychINFO and PsychARTICLES databases, I found many articles, as research into the *DSM*, posttraumatic stress disorder, and the AIP model are psychology-oriented topics.

In the search for relevant peer-reviewed journal articles for inclusion in this literature review, I used various search terms as well as keywords. These search terms included words, phrases, and combinations of the two, including *DSM-5, DSM-IV, DSM-IV-TR, Diagnostic and Statistical Manual-V, Diagnostic and Statistical Manual-IV,* and *Diagnostic and Statistical Manual IV-TR*. Additional search terms included *posttraumatic stress disorder, PTSD, and Post-traumatic Stress Disorder.* Other search terms included *Adaptive Information Processing model, AIP model, PTSD Assessment, PTSD Treatment, PTSD Diagnostic Criteria, clinicians, therapists, and practitioners.* The EBSCO system

searches multiple databases simultaneously, and multiple search terms may have been used by the researcher in a variety of combinations. Variations in the input of search terms resulted in a wide variety of results, providing exhaustive results on each search term and each combination of search terms.

It is common for a single author to provide multiple research articles on a particular topic. Therefore, in addition to the utilization of search terms to uncover related research, the names of specific authors were utilized to seek associated research. For example, my search on the name *Francine Shapiro* provided a vast amount of research into the AIP model, trauma, and PTSD (F. Shapiro, 2013). Additionally, specific research-oriented websites provided the most current research on a specific subject, which was key to finding the most recent studies after the release of the *DSM-5*. EMDRIA (2017b), for example, provided many recently released studies regarding the most current research into the diagnosis and treatment of PTSD, and utilization of this website provided relevant, peer-reviewed research.

In this chapter, background literature related to the *DSM-5*, PTSD, and the AIP model is examined to provide the groundwork for the research questions. This literature review includes information on the AIP model, which I used as the theoretical framework for the study, and research regarding this model. Additionally, the chapter presents relevant research on the *DSM-5* and PTSD in subcategories.

Theoretical Framework

The AIP model was described by F. Shapiro (2007) as the brain's method of processing new information as it incorporates new information with previous

information. When subjected to a traumatic experience, the brain has the ability to link the new information (the traumatic experience) effectively with a positive thought process; for example, the brain may shift a traumatic experience from a negative thought process to a positive thought process, determining that the experience "was not my fault" and "sometimes bad things happen, but I did everything I could" (p. #19). Conversely, the brain may "freeze" and be unable to link the traumatic information with positive memory networks (p. #). If this occurs, PTSD symptoms for the individual may be the result (p. #). F. Shapiro claimed that the AIP model may be helpful in diagnosing client presentations, predicting the effectiveness of treatment, and provide assistance to clinicians as they provide clinical services to clients suffering with the effects of PTSD, as detailed below.

The AIP model describes the development of psychological pathology as a result of the brain failing to incorporate information or an experience in an adaptive fashion (F. Shapiro & Laliotis, 2011). Rather than processing information or an experience by integrating it with previous knowledge in an adaptive, healthy manner, the information or experience is stored within the brain unprocessed (F. Shapiro, 2007). Solomon and F. Shapiro (2008) described the manner in which the brain processes an experience in terms of an information processing system, which processes new information by seeking to assimilate that information or experience with similar experiences. The authors noted that in situations in which trauma is experienced, the brain may not be able to associate the new information or experience with a previous experience or information, and the experience or information is then stored, frozen, in its own category. They explained that

because the traumatic experience or information is stored with all of the original images, thoughts, cognitions, and emotions in its own category, new experiences that contain similar content may then be associated with the traumatic experience. This process sets the stage for posttraumatic stress disorder, triggering panic attacks, nightmares, flashbacks, and dissociative episodes.

Adaptive information processing may become blocked when an individual is subjected to trauma, and the brain's repetitive cycle of continuing to link incoming data to memories of the traumatic experience prevent the individual from processing the incident in an adaptive fashion (E. Shapiro & Laub, 2008). E. Shapiro and Laub (2008) indicated that as the brain continues to attempt to process a traumatic incident in an adaptive fashion, and fails to do so, the more likely the incident will be linked to incoming data in a negative fashion. They stated that, therefore, the earlier an individual receives assistance in successfully processing the traumatic material in an adaptive fashion, the less likely it may be that the individual develops symptoms of PTSD.

F. Shapiro (2002) discussed how the AIP model provides not only a theory on the manner in which PTSD may develop in an individual who has experienced a traumatic event but also a theory as to how clinicians may treat clients presenting with PTSD in clinical practice. F. Shapiro stated that clinicians seeking to treat clients with PTSD may view treatment planning through the lens of the AIP model, and seek to stimulate the client's information processing in a more adaptive manner. The goal of treatment, she said, is to stimulate the information processing system to transform the negatively stored memories into more adaptive thought processes. For example, an individual who

experiences a traumatic automobile accident, and consequently develops PTSD, may develop a thought process regarding the event that states he or she is flawed, stupid, careless, or worthless as a result of the automobile accident. The therapist may seek to assist the individual to change his or her thought process to accommodate more adaptive thoughts, perhaps transforming the thought process to embrace the belief that accidents happen to the best of people, and that the automobile accident does not reflect negatively on the individual's worth. F. Shapiro stated that the AIP model provides a theoretical lens to understand how PTSD may develop in those who experience a traumatic episode, as well as a theoretical guide to develop treatment plans and estimate the prognosis of treatment.

For this research, I used the AIP model as a theoretical lens to view the experiences of clinicians as they utilize the revised diagnostic criteria for PTSD in the *DSM-5*. For example, the new diagnostic criteria now require that if symptoms develop in response to the death of a close friend or family member, the death must be violent or accidental to warrant a diagnosis of PTSD (APA, 2013). The development of PTSD in response to a traumatic event may be described as subjective to each individual (F. Shapiro, 2002). The AIP model details how PTSD may develop in those who experience trauma, as detailed above. In my proposed study, exploring clinicians' experiences with the new diagnostic criteria for PTSD using the AIP model as a theoretical lens, valuable data may emerge to assist in future revisions of the PTSD diagnostic criteria.

In her research detailing the case study of an individual who had experienced not only a chronically traumatic childhood home but also rape by a teacher in middle school,

F. Shapiro (2013) explored how the AIP model explains the development of PTSD. The individual in question reported suffering from chronic traumatic experiences, and the AIP model proposes that these experiences may result in the development of negative, maladaptive responses to these experiences. The individual may develop physical responses, emotional responses, and negative thought processes that may include thoughts such as "I am flawed," "I am dirty," "I do not deserve to be treated with respect" (p. 19).

Schubert and Lee (2009) compared and contrasted the AIP model with other information processing models. The authors found that the AIP model was similar to emotional processing theory and the dual-representation theory, in that each assumes the existence of an information processing system that works to integrate new information into the existing information. Additionally, they noted that each of these theories states that these memory networks are the foundation of individual perception, attitudes, and behavior and that the path to recovery from PTSD may be instigated by stimulating the process of the traumatic memory, integrating it into adaptive memory networks.

Differences between the AIP model and the dual representation theory include the fact that the dual representation theory states that each individual has two separate memory systems, rather than the single memory system in the AIP model (Schubert & Lee, 2009). The first memory system is composed of verbally accessible memories (VAMs), which may be verbally retrieved when desired; the second memory system is composed of unconscious situationally accessible memories, which may be stimulated by reminders of the traumatic experience (SAMs) (Schubert & Lee, 2009).

In order to treat PTSD successfully, the dual representation theory therefore states that both memory systems must be processed separately, whereas the AIP model states that only a single memory system must be stimulated (Schubert & Lee, 2009). A second difference between the two is that the AIP model states that healing PTSD may require that traumatic memories be integrated into the memory system in an adaptive manner, whereas the dual representation theory states that new, positive memories must be created that essentially override the previous negative memories (Schubert & Lee, 2009).

Differences between the AIP model and emotional processing theory include the fact that the emotional processing theory states the individual must relive, or reexperience, the traumatic event so that the individual becomes habituated to the arousal created (Schubert & Lee, 2009). The AIP model states that change (a reduction in PTSD symptoms) occurs through the association of the traumatic material to adaptive material (Schubert & Lee, 2009).

One manifestation of a traumatic experience may be in the form of false memories. Dasse, Juback, Morissette, Dolan, and Weaver (2015) conducted research into false memories in individuals who meet the diagnostic criteria for PTSD, asking participants to complete the Beck Depression Scale (Beck, Steer, & Brown, 1996), the Anxiety and Stress subscales of the Depression Anxiety Subscales (Lovibond & Lovibond, 1995), the Dissociative Experiences Scales (Carlson & Putnam, 1993), and the Tellegen Absorption Scale (Tellegen & Atkinson, 1974). Results showed that veterans diagnosed with PTSD were more likely to suffer with memory impairment on all items, with the exception of items that were trauma-related cues; on those items, the veterans

displayed false-memory tendencies (Dasse et al., 2015). This result may provide support for the AIP theory, which states that trauma inhibits the manner in which the brain processes information, providing clues as to the best practices for treating PTSD (Dasse et al., 2015).

According to F. Shapiro (2002), the AIP model provides a theoretical foundation for the manner in which PTSD may develop in individuals who have experienced a single, or multiple, traumatic event. She noted that the theory describes how the brain fails to process the information in an adaptive fashion, and the memory is stored by the brain, unprocessed, with all of the original cognitions, sensations, images, and emotions of the original trauma. F. Shapiro added that the model also provides a theory as to the manner in which the brain may be assisted to assimilate the traumatic memories in a more adaptive fashion. With the research questions for this study, I inquired into how therapists experienced the diagnostic criteria for PTSD in the *DSM-5*, including diagnosis and treatment of PTSD. The AIP model describes how individual experiences may be maladaptively processed by the brain, possibly resulting in the development of PTSD; therefore, the AIP model provided an excellent theoretical foundation for research into how clinicians experience their use of the PTSD diagnostic criteria in the *DSM-5*.

Literature Review: Diagnostic and Statistical Manual-5

The APA's (2013) development of the *DSM-5* diagnostic criteria was based upon research into the etiology, course, and prognosis of the disorder. Many members of the committee responsible for the development of the new diagnostic criteria conducted research into the disorder, which is summarized below.

Research Discussing Proposed Changes to Diagnostic Criteria

McNally (2009) explored the potential effects of changes to the PTSD diagnosis in the *DSM-5*, including the restriction of reimbursement to individuals who suffer with PTSD symptoms but have not experienced a trauma as described in the new diagnostic criteria. Under the then-proposed *DSM-5* criteria, individuals who present with symptoms of PTSD but had not experienced the trauma directly would not qualify for a diagnosis of PTSD; rather, they might receive a diagnosis of an anxiety disorder, depending upon their specific symptoms (APA, 2015). McNally (2009) recommended that the new diagnostic criteria require that the individual experience the trauma directly, requiring that the individual be physically present. Additionally, he stated that the *DSM-5* should eliminate the symptom of inability to recall an important aspect of the trauma, as this symptom is ambiguous. Finally, McNally insisted that the new diagnosis state that the symptoms cause significant impairment in social, occupational, or other areas of functioning but not state that the symptoms cause clinically significant distress. He believed this statement was redundant to other criteria stating that the symptoms cause clinically significant distress and was not necessary.

The *DSM-5* contains specific diagnostic criteria for PTSD in children, separating children from adults in diagnosis. Prior to the development of the *DSM-5*, Pynoos et al. (2009) recommended that the *DSM-5* address age-specific manifestations and the manner in which modifications should be made for PTSD among children and adolescents. The authors point to specific research into the concept of danger and the tendency for children and adolescents to turn to adult caregivers for assurance. They argued that because

children look to others to protect them, developmental considerations should be taken into account in the diagnosis of PTSD for children and adolescents. The authors suggested that specific modifications be made in the diagnosis of PTSD in children and adolescents, creating two separate diagnoses for adults and children/adolescents.

As a precursor to making recommendations for the diagnostic categories for PTSD in the *DSM-5,* Friedman, Resnick, Bryant, and Brewin (2011) reviewed literature regarding the *DSM-IV* diagnostic criteria for PTSD. Most of the research that Freidman et al. reviewed focused upon two components of the stressor criterion, considering whether the stressor is etiologically or temporally related to the symptoms that emerge in PTSD, and whether it is possible to distinguish traumatic from nontraumatic stressors. Additionally, the authors stated that there is little support for preserving the criterion that the individual respond with intense fear, helplessness, or horror and observed that the structure of PTSD appears to support four distinct symptom clusters rather than the current three-symptom cluster. Friedman et al. found that the current research revealed that in addition to the fear-based symptoms listed in the *DSM-IV*, there appear to be dysphoric symptoms, aggressive symptoms, guilt and shame, dissociation, and negative perceptions of self and the world. The authors recommended that (a) the *DSM-5* refine the definition of trauma, (b) the criteria that the individual react to the trauma with fear, helplessness or horror be eliminated; (c) the diagnosis include a group of four symptom clusters rather than three symptom clusters; and (d) revisions of criteria B through E go beyond fear-based criteria. The authors also discussed the creation of subcategories for PTSD.

Friedman (2013) described the process that took place in the construction of the diagnostic criteria for PTSD in the *DSM-5*. Friedman was part of the work group that investigated the evidence and proposed the newly refined criteria. He described the process as rigorous and based upon empirical evidence. He stated that the most important changes in the PTSD diagnosis between the *DSM-IV* and the *DSM-5* are the change in the definition of trauma, the shift in categorization of PTSD from the anxiety disorder category to a new category of trauma and stressor-related disorders, the distinction between anhedonic/dysphoric PTSD and dissociative PTSD, and the addition of a preschool subtype.

Large and Nielssen (2010) explored the reliability of PTSD diagnosis based on the analysis of diagnoses made through structured interviews compared to diagnoses made through the use of unstructured interviews. The researchers stated that the use of unstructured interviews to diagnose PTSD has not been reliable; however, the use of structured interviews has shown some reliability in a clinical setting. They observed that the criteria for PTSD in the *DSM-IV* state that the individual experience a traumatic experience (Criterion 1A), and that the individual experience fear, horror, and helplessness (Criterion 1B). Large and Nielssen argued that the inclusion of these two criteria may falsely link client symptoms to the traumatic experience and that although each statement may be true, the fact that each is present does not prove causality. The researchers thus suggested that the PTSD diagnostic criteria in the *DSM-5* eliminate Criterion A1, thereby eliminating the conclusion that the traumatic event caused the client's symptoms. They claimed that with this change, when expert witnesses testify in

court regarding an individual diagnosed with PTSD, the court would have the ability to determine causality rather than the diagnosis assuming causality.

Research After Changes Made to PTSD Diagnostic Criteria in the *DSM-5*

The APA (2013) provided a synopsis of the changes to the PTSD diagnostic changes in the *DSM-5*:

> *DSM-5* criteria for posttraumatic stress disorder differ significantly from those in *DSM-IV*. As described previously for acute stress disorder, the stressor criterion (Criterion A) is more explicit with regard to how an individual experienced "traumatic" events. Also, Criterion A2 (subjective reaction) has been eliminated. Whereas there were three major symptom clusters in *DSM-IV*, including re-experiencing, avoidance/numbing, and arousal, there are now four symptom clusters in *DSM-5*, because the avoidance/numbing cluster is divided into two distinct clusters: (a) avoidance and persistent negative alterations in cognitions and (b) mood. This latter category, which retains most of the *DSM-IV* numbing symptoms, also includes new or re-conceptualized symptoms, such as persistent negative emotional states. The final cluster, which includes alterations in arousal and reactivity, retains most of the *DSM-IV* arousal symptoms. It also includes irritable or aggressive behavior, and reckless or self-destructive behavior. PTSD is now developmentally sensitive in that the diagnostic thresholds have been lowered for children and adolescents. Furthermore, separate criteria have been added for children age 6 years or younger with this disorder. (p. 9)

Table 1 provides a comparison between the diagnostic criteria for PTSD in the *DSM-IV*, and the diagnostic criteria for PTSD in the *DSM-5*.

Table 1

Comparison of PTSD Criteria in DSM-IV vs. DSM-5

DSM-IV	*DSM-5*
A1 The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury or threat to physical integrity to self or others.	A1 Exposure to actual or threatened death, serious injury, or sexual violence, in one or more of the following ways: 1. Directly experiencing the traumatic event(s) 2. Witnessing in person the event as it occurred to others. 3. Learning that the traumatic event occurred to a close family member or friend. In cases of actual or threatened death of a family member or friend, the event must be violent or accidental. 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s), (ex: First responders) NOTE: Criterion A4 does not apply to exposure through electronic media, television, movies, or photos, unless it is work related.
A2 The person's response involved intense fear, helplessness, or horror.	A2 No longer included
B The traumatic event is persistently reexperienced in one or more of the following ways:	B Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s) beginning after the traumatic event occurred
B1 Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.	B1 Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)
B2 Recurrent distressing dreams of the event	B2 Recurrent distress and/or affect of related to traumatic event

(table continues)

DSM-IV	*DSM-5*
B3 Acting or feeling as though the event were recurring, including a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes including those that occur when wakening or when intoxicated	B3 Dissociative reactions (ex: flashbacks) in which the individuals feels or acts as though the event were recurring
B4 Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	B4 Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
B5 Physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	B5 Marked physiological reactions to internal and external cues that symbolize or resemble an aspect of the traumatic event
C Persistent avoidance of stimuli associated with the trauma ad numbing of general responsiveness as indicated by three or more of the following:	C Persistent avoidance of stimuli associated with the traumatic event(s) as evidenced by one or both of the following:
C1 Efforts to avoid thoughts, feelings, or conversations associated with the trauma	C1 Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event
C2 Efforts to avoid activities, places, or people that arouse recollections of the trauma	C2 Avoidance of or efforts to avoid external reminders that arouse distressing memories, thoughts, feelings, or feelings about or closely associated with the traumatic events
C3 Inability to recall an important aspect of the trauma	
C4 Sense of shortened future or a normal lifespan	
C5 Markedly diminished interest or participation in significant activities	
C6 Feeling detached or estranged from others	
C7 Restricted range of affect	
D Persistent symptoms of increased arousal as indicated by two or more of the following:	D Negative alterations in cognitions and mood that are associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:
D1 Difficulty falling or staying asleep	D1 Inability to remember an important aspect of the event (s) due to dissociative amnesia, not due to alcohol or drugs

(table continues)

DSM-IV	*DSM-5*
D2 Irritability or outbursts of anger	D2 Persistent and exaggerated negative beliefs or expectations about self, others, or the world
D3 Difficulty concentrating	D3 Persistent distorted cognitions about the cause of consequence of the traumatic event that lead the individual to blame themselves or others
D4 Hyper vigilance	D4 Persistent negative emotional state (ex: fear, horror, etc.)
D5 Exaggerated startle response	D5 Markedly diminished interest or participation I significant activities
	D6 Feeling of detachment or estrangement from others
	D7 Persistent inability to experience positive emotions
E Duration of the disturbance is at least one month • Acute when the duration is less than one month • Chronic when symptoms last three months or more	E Marked alterations in arousal and reactivity associated with the traumatic events, beginning or worsening after the traumatic event, and evidenced by two or more of the following
	E1 Irritable behavior and angry outbursts with little or no provocation, typically expressed as verbal or physical aggression toward people or objects
	E2 Reckless or self-destructive behavior
	E3 Hypervigilance
	E4 Exaggerated startle response
	E5 Problems with concentration
	E6 Sleep disturbances
F Requires significant distress or functional impairment Specifiers include *with delayed onset*, if onset of symptoms is at least six months of the stressor	F Duration of the disturbance in criteria B, C, D and E is longer than one month

(table continues)

DSM-IV	*DSM-5*
	G The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning H The disturbance is not attributable to the physiological effects of a substance or other medical condition • With dissociative symptoms (depersonalization or derealization) • With delayed expression: If the full diagnostic criteria is not met until at least 6 months after the event, although some symptoms may be immediate

Note: Adapted from the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), copyright 1994 by the American Psychological Association; and the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), copyright 2013 by the American Psychological Association.

Research After Changes in Support of New Diagnostic Criteria

Spiegel (2012) discussed the potential changes that were considered for the *DSM-5*, including revision of Dissociative Disorders and the addition of the Posttraumatic Stress Disorder dissociative subtype. Spiegel stated that evidence supports the dissociative subtype, as successful treatment planning for PTSD with dissociative symptoms may look very different from successful treatment planning for PTSD without dissociative symptoms. He further noted that the differences between the two types of PTSD are clinically significant, therefore warranting differential diagnosis in the *DSM-5*. Additionally, Calhoun et al. (2012) conducted research to examine the impact of the *DSM-5* criteria on PTSD prevalence. Clinical interviews with participants compared results from the *DSM-IV* diagnostic criteria against the *DSM-5* diagnostic criteria, as applied to the participants. Results showed that 95% of participants experienced an event that met the criteria to be identified as a trauma in the *DSM-IV*, but only 89% experienced

an event that met the criteria to qualify as a trauma in the *DSM-5*. The authors concluded that in spite of the significant changes in the diagnostic criteria for PTSD in the *DSM-5*, changes in classification rules maintained consistency with the *DSM-IV*.

Many researchers have been interested in examining the effect of changes in symptom criteria for PTSD in the *DSM-5*. Koffel, Polusny, Arbisi, and Erbes (2012) conducted research analyzing the revised symptom criteria in the *DSM-5* to examine their relationship with PTSD. Questionnaires and interviews conducted by the researchers with 213 National Guard Brigade Combat Team members revealed that the *DSM-5* symptom of anger showed the greatest increase from predeployment to postdeployment in participants diagnosed with PSTD. However, the researchers found that negative expectations and aggressive behaviors showed equivalent correlations with PTSD, substance abuse, and depression. Schnurr (2013) summarized the changes to PTSD diagnostic criteria in the *DSM-5* and provided brief overviews of current research as to the prevalence of PTSD when diagnosed using the new *DSM-5* diagnostic criteria. The latest research that Schnurr reviewed showed that the prevalence of PTSD using the *DSM-5* diagnostic criteria is slightly lower than the prevalence found using the *DSM-IV* criteria. Schnurr also stated that the separation between avoidance and numbing symptoms is an important distinction, as research has shown that the two are significantly different presentations of the disorder.

Keane et al. (2014) conducted research to examine the stability of the *DSM-5* factors as measured by the PTSD Checklist for the *DSM-5*. Participants included 507 combat-exposed war veterans enrolled in an online intervention program for problem

drinking and combat related stress. The research supported the *DSM-5* model of PTSD symptoms, and the study was the first on the temporal stability of the PTSD Checklist-5 (Weathers et al., 2010) over time.

Research into the creation of a new category of disorders provided support for the diagnostic changes to the PTSD diagnostic criteria in the *DSM-5*. Kilpatrick (2013) stated that the placement of PTSD in the *DSM-5* category of Trauma and Stressor-Related Disorders is a significant action toward underscoring the magnitude and impact that the precipitating event has on an individual's reaction rather than a weakness in the individual. Additionally, Kilpatrick observed that the new diagnosis criteria accurately encompasses the symptomology present in PTSD and that the creators of the *DSM-5* utilized surveys to gather the data needed to make determinations regarding diagnosis construction. Researchers were curious as to how the new diagnostic criteria may influence the prevalence of individuals diagnosed with a PTSD diagnosis. Kilpatrick et al. (2013) researched the prevalence of PTSD as defined by both the *DSM-IV* and the *DSM-5* and compared the two the samples. Using online participants, the researchers assessed exposure to traumatic events, PTSD symptoms, and impairment in participants. The results showed that all six *DSM-5* prevalence estimates were slightly lower than those in *DSM-IV*; PTSD was higher among women than men, and the prevalence increased with increased trauma exposure. Additionally, Miller et al. (2013) conducted two internet-based surveys to seek information regarding the impact the proposed changes to the PTSD diagnostic criteria in the *DSM-5* may have on PTSD prevalence. Using a newly developed instrument to assess event exposure and the *DSM-5* PTSD

symptoms from a sample of American adults and U.S. Military veterans, Miller et al. found considerably lower PTSD prevalence rates than with the *DSM-IV* PTSD diagnostic criteria.

Research Critical of the Changes in the PTSD Diagnostic Criteria in the DSM-5

Although many researchers and clinicians have welcomed the changes to the PTSD diagnostic criteria in the *DSM-5*, others have been critical of the changes. According to the APA (2015), members of the United States military objected to the term *posttraumatic stress disorder*, as they felt that the word *disorder* places a stigma on those who may seek help for their symptoms. The APA added that many military members would prefer the term *posttraumatic stress injury*, which they believed would reduce the possibility that those seeking treatment may feel stigmatized. Pilgrim (2014) summarized the criticisms of the *DSM-5*, including excessive pathologization (for example, mourning is now a mental disorder). Additionally, Pilgrim stated that diagnoses are not based upon research but instead on what is deemed to be normal behavior in Western culture. He stated that diagnoses should be based on research that displays empirical validity, construct validity, predictive validity, inter-rater reliability, test-retest reliability, etiology and pathogenesis, treatment specificity, and acceptability. Pilgrim discussed the impact of third-party payers in the diagnostic process and the influence of drug companies, which may play a role in maintaining the current diagnostic process. He revealed the roles that many individuals and entities, including practitioners and insurance companies, have played in the development of diagnostic criteria for *DSM* diagnoses. It is therefore important to carefully review revised diagnostic criterion as it is released.

Posttraumatic Stress Disorder

For the purpose of this study, relevant research into posttraumatic stress disorder (PTSD) is separated into three categories: assessment, trauma and PTSD, and PTSD treatment. This review of studies provides background for a deeper understanding of the experiences of mental health professionals when dealing with the diagnosis and treatment of PTSD as presented in the *DSM-5*.

PTSD Assessment

Due to the fact that the new *DSM-5* contains changes to Criterion A, which defines events that may be identified as traumatic, many researchers are interested in exploring the best way to define trauma. May and Wisco (2015) reviewed the differences between direct exposure to trauma versus indirect exposure to trauma and the likelihood that each type of exposure may lead to the development of PTSD. The researchers were interested in whether indirect exposure could cause the development of PTSD and how the physical proximity of the traumatic event effects the development of PTSD. May and Wisco reviewed previous research regarding the changes in Criterion A in PTSD, different types of traumatic exposure and the proximity of the trauma to the individual when symptoms develop. The result of their review included their conclusion that the proximity of the trauma influenced the likelihood of the individual developing symptoms of PTSD, with the increased level of closeness to the trauma increasing the likelihood of PTSD developing. Additionally, the researchers found that individuals who experience indirect exposure to trauma may develop PTSD, although the likelihood is much greater for those who experience the trauma directly.

Marx and Gutner (2015) discussed a variety of tools to assess for PTSD in individuals who have experienced trauma. The researchers recommended instruments to obtain client data, which may provide therapists with valuable information as they make clinical decisions and begin client treatment. They noted that although individual interviews with clients may provide the most quality information, individual interviews are time consuming and may require that the clinician be specially trained. Therefore, self-report measures may be the best fit, and the researchers recommended that regardless of whether the clinician utilizes an interview format or a self-report measure to gather information, multiple tools should be utilized to triangulate information. Marx and Gutner concluded that the best, most comprehensive approach may be to utilize the individual interview, self-report measures, and behavioral observations to take advantage of each method's strengths and overcome any limitations.

Elhai and Naifeh (2012) discussed the importance of utilizing a method to assess for PTSD that focuses upon the client's worst trauma to diagnose the disorder effectively. The researchers stated that the majority of research supports the use of *worst-case* methods of assessment, as the majority of PTSD cases are described as linked to a single trauma. Additionally, the authors stated that PTSD that is not linked to a single trauma lacks focus, not only for diagnostic purposes but for treatment as well. Most of the self-administered PTSD assessment tools do not focus on single-event trauma; however, the Posttraumatic Stress Diagnostic Scale (PDS) (Foa et al., 1997) was described by Elhai and Naifeh (2012) as the best self-administered questionnaire, with the most stringent methodological standards. The authors stated that the clinician-facilitated diagnostic

interview is the most valid and reliable diagnostic tool; however, due to the limited amount of time and resources available in a crisis situation, the PDS may be a good fit.

Lancaster, Melka, and Rodriguez (2011) were interested in examining the specific emotional responses that may lead to PTSD, as they suspected that horror, fear, and helplessness are not the only emotions that may predict the development of PTSD in those who suffer a traumatic experience. The researchers recruited 771 undergraduate students to participate in their study and requested that the participants submit a demographics form and complete the Brief Trauma Questionnaire (Schnurr, Vielhauer, Weathers, & Findler, 1999) and the PTSD Checklist-Specific (Weathers, Litz, Herman, Huska, & Keane, 2010). Lancaster et al.'s (2011) analysis of the results led them to conclude that horror, fear, and helplessness did not predict the onset of PTSD and that the presence of anger, guilt, sadness, and disgust more accurately predicted such an onset. Additionally, Lancaster et al. found that the level of anger was correlated with the level of PTSD symptoms in both male and female participants; however, they found that guilt was a unique predictor for the male participants, whereas disgust and sadness were unique predictors for female participants. As a final point regarding emotional determinants of the development of PTSD, the researchers found that whereas European-American participants presented with guilt, helplessness, disgust and anger, African-American participants presented only with anger. Although Lancaster et al. theorized that perhaps these differences in precipitating emotions between gender groups and between racial groups might be due to different types of traumatic events experienced by

participants, they suggested additional research in this area to determine the cause of these differences.

The change in the *DSM-5* to separate adult PTSD diagnostic criteria from child PTSD criteria provided the stimulus for Gigengack, van Meijel, Alisic, and Lindauer (2015) to compare three different diagnostic algorithms of PTSD in young children who had survived traumatic episodes: the DSM-5 algorithm for PTSD in children 6 years and younger, Scheeringa's alternative PTSD algorithm (PTSD-AA), and the DSM-IV PTSD algorithm. They assessed child posttraumatic stress symptoms by means of phone interview with the parents of 98 children involved in an accident between 2006 and 2012, using the Anxiety Disorders Interview Schedule for the *DSM-IV* Child Version (Silverman & Albano, 1996) as well as items from the Diagnostic Infant and Preschool Assessment (Sieblink & Treffers, 2001). To compare the three PTSD diagnostic algorithms, Gigengack et al. (2015) used descriptive statistics based on the specific characteristics of the children, the specifics of the traumatic incident, and the children's PTSD symptoms as described by their parents. The researchers concluded that the *DSM-5* subtype for children and Scheeringa's alternative PTSD algorithm are a better fit than the *DSM-IV* algorithm, providing support for the new *DSM-5* diagnostic criteria for children.

The latest revision of the *DSM*, the *DSM-5*, has eliminated the previous diagnostic criterion in the *DSM-IV* that required the individual to react to an event with fear, helplessness, or horror to be considered for a PTSD diagnosis (APA, 2013). Kubany, Ralston, and Hill (2010) conducted research to examine whether an immediate intensely negative emotional response had a causal relationship with PTSD. The researchers

recruited 205 military personnel, military retirees, and military family members from four treatment programs at an army medical center, 43% of whom reported experiencing helplessness, fear, and horror, and met the diagnostic criteria in the *DSM-IV* for PTSD. Alternatively, only 9% of the participants who reported fewer than three of the symptoms (fear, helplessness, or horror) met the diagnostic criteria in the *DSM-IV* for PTSD. Kubany et al. stated that the results might suggest that the most effective method to identify individuals who may need follow-up care after experiencing a trauma may be best identified by asking three specific questions: "(a) 'Did you experience intense fear during the event?' (b) 'Did you feel helpless or powerless during the event?' and (c) 'Did you experience horror during the event?'" (p. 81). Additionally, the researchers stated that the results might suggest that the *DSM-IV* diagnostic criteria may be too broad, thus supporting the revisions made in the *DSM-5*.

Without effective assessment tools, it may be difficult to detect PTSD in those who suffer with the disorder. One of the most commonly used assessment tools is the PTSD Checklist, a self-report measurement tool utilized to assess for PTSD symptoms (Legarreta et al., 2015). Using the Quality Assessment of Diagnostic Accuracy Studies (Whiting et al., 2011) assessment tool, McDonald, Brown, Benesek, and Calhoun (2015) assessed the quality of 22 diagnostic accuracy studies of the English version of the PTSD Checklist (Weathers et al., 2010). McDonald et al. (2015) used the Quality Assessment of Diagnostic Accuracy Studies (QUADAS; Whiting et al., 2011) assessment tool to examine the quality of the diagnostic accuracy studies of the PTSD Checklist as well as to assess whether there had been an improvement in quality since 2003, when the

Standards for the Reporting of Diagnostic Accuracy Studies (STARD) initiative was implemented to standardize diagnostic reporting accuracy. For McDonald et al.'s (2015) research, three independent raters applied the QUADAS assessment tool to each study. Results of the study included the finding that most studies met standards in several quality areas; however, McDonald et al. found a need for improvements in the areas representativeness, descriptions of clinical and demographic characteristics, and detailed descriptions of test and reference standard execution. They stated that the results reveal that the quality of research reporting has not improved significantly since 2003, when the STARD initiative was implemented.

In another study, Carper et al. (2015), seeking markers that might predict PTSD, assessed 120 women who had been sexually assaulted. The researchers pointed out that recent PTSD development models separate symptoms into specific subclusters that, when presented by a client in the early weeks after a traumatic episode, may predict the onset and/or course of PTSD. They targeted four specific subclusters, including reexperiencing, strategic avoidance, emotional numbing, and hyper arousal, and assessed participants at both 1 month and 4 months after they were assaulted. Results of their research included the discovery that both reexperiencing and emotional numbing at the 1-month evaluation were predictive of the presence of PTSD at the four-month evaluation. Additionally, the findings showed that negative thoughts about the self were linked to the development of both reexperiencing and emotional numbing, which were, in turn, linked to the development of PTSD. Carper et al. concluded that these findings might provide clues to

not only the course of PTSD development but also how to provide early, effective treatment.

Bauer et al. (2013) were interested in assessing the construct validity of an instrument that might be utilized to assess the psychophysiological reactivity that may be present in those with PTSD. The researchers recruited 46 individuals who had experienced a traumatic event as described by the *DSM-IV*; 36 completed the study, which consisted of self-report measures, structured clinical interviews, and the Clinician Administered PTSD Scale (National Center for PTSD, 2010). Bauer et al. (2013) initially measured participants' reactivity to script-driven imagery (SDI) and repeated this measure an average of 6.6 months later. A psychophysiological posterior probability score (PPPS) was compiled for each participant based upon their scores on the reactivity to script-driven imagery, and associations both between and within each factor were computed. Bauer et al. concluded that the use of SDI was a valid and reliable tool to assess for PTSD in individuals who had experienced trauma, particularly due to the fact that physiological reactivity is more difficult to falsify than verbal expressions. The researchers recommend that the SDI be considered as an adjunct to currently used tools to measure the presence and severity of PTSD effectively.

Regarding the prevalence, course, and risk factors for posttraumatic stress disorder, Marmar et al. (2015) presented findings from the National Vietnam Veterans Longitudinal Study based upon survey results and clinical diagnostic measures from a cohort of Vietnam veterans. They presented findings regarding the course of PTSD in those who served in combat during the Vietnam War (frequently with comorbid

disorders) and the risk factors for PTSD. The results as of the date of the study included the prevalence of PTSD for combat veterans at 11.2% and the finding that 14.5% met the criteria for either full or subthreshold PTSD. Furthermore, according to clinical interviews of a smaller sample of Vietnam combat veterans, the lifetime PTSD rate was 17%, with the combination rate of both full and subthreshold PTSD rate at 26.2%. Notably, for those who served in combat in Vietnam, the self-reported symptoms of PTSD increased significantly from the level reported 25 years earlier, with the percentage of those whose condition worsened being three times larger than the percentage of those who improved. Additionally, the results suggested that those with Black or Hispanic ethnicity as well as suffering from combat injury were more likely to experience PTSD symptoms. Based on these findings, Marmar et al. (2015) suggested that when clinicians assess for PTSD in clients, it may be important to explore the individual's trauma history thoroughly, including participation in the Vietnam War, as the effects may worsen over time.

Although many researchers sought to examine PTSD's prevalence and how the disorder impacted the lives of those who suffer from it, other researchers were interested in the prevalence and impact of subthreshold PTSD. Using the three most commonly used subthreshold definitions, Brancu et al. (2015) conducted a meta-analysis of PTSD subthreshold rates and found that across all three definitions the average subthreshold rate was 14.7%. The researchers stated that the a wide variety of definitions, methods of measurement, and populations studied led to a wide range of rates, from 13.7% for the most rigorous studies to 16.4% for the more lenient research. Through additional

qualitative research evaluation, the researchers concluded that psychological and behavioral health was lower for those with subthreshold PTSD compared to those who did not exhibit PTSD symptoms, but the subthreshold PTSD group did not exhibit lower psychological and behavioral health than the full PTSD group. Individuals suffering with both PTSD and sub-threshold PTSD were found to be more likely to experience lowered behavioral health as well as psychological health and an increased need for health care. Brancu et al. recommended the development of an evaluation method to diagnosis subthreshold PTSD effectively in order to ensure that those who suffer with subthreshold PTSD receive the treatment necessary to alleviate their symptoms

Whereas Brancu et al. (2015) explored the prevalence of subthreshold PTSD, other researchers were interested in exploring the possibility that the symptoms exhibited by individuals who had suffered with childhood institutional abuse warrant a separate diagnostic category. Knefel, Garvert, Cloitre, and Lueger-Schuster (2015) analyzed the profiles of 229 individuals who had suffered childhood institutional abuse and had been diagnosed with complex PTSD in order to assess whether the diagnosis of complex posttraumatic stress disorder (CPTSD) per the World Health Organization's (WHO) International Classification of Diseases (ICD-11) was appropriate. After conducting a latent profile analysis, Knefel et al. found that participants fell into one of four classifications: individuals who experienced elevated symptoms of CPTSD, which includes elevated symptoms of PTSD and lower levels of self-organization; individuals who displayed elevated levels of PTSD symptoms but higher levels of self-organization; individuals who display lowered levels of self-self-organization as well as some

symptoms of PTSD; and individuals who experienced a low level of symptoms. The researchers concluded that the results of the analysis supported the changes in ICD-11 regarding the addition of a separate category of complex PTSD (CPTSD). They also claimed that the category of CPTSD is particularly applicable to both male and female victims of childhood institutional abuse.

Trauma and PTSD

Müller, Moeller, Hilger, and Sperling (2015) were interested in whether individuals diagnosed with PTSD who were victims of trauma as well as witnesses of the trauma of others would differ from victims of trauma who had not witnessed others' trauma. In assessing a group of victims diagnosed with PTSD who were both victims and witnesses of the Holocaust and a group of PTSD patients who had not witnessed the traumatization of others, the researchers compared the participants' symptoms; educational level; working capacity; and ability to function socially, occupationally, and educationally. The results showed that although the victims/witnesses of the Holocaust showed more PTSD symptoms, they were better able to function socially, occupationally, and educationally than were the PTSD patients. The severity and intensity of the PTSD symptoms did not appear to affect their functioning in these areas. Muller et al. suggested that more research into the role of educational level in the prognosis of those diagnosed with PTSD be conducted. They proposed that higher education levels might perhaps provide a protective barrier, resulting in a better prognosis than those with a lower educational level.

Muller et al's (2015) findings appear to be supported by research conducted by Ng, Ahishakiye, Miller, and Meyerowitz (2015). In 2002, 61 representatives of the Rwanda Orphaned Heads of Households Organization, who had lost both their mother and father in the Rwandan genocide, were interviewed by Ng et al. The organization provides services and support to those who have lost both parents in the Rwanda genocide. The participants were interviewed again in 2008 to collect mental health data and risk factors for those who had been identified as needing assistance in 2002. Ng et al. found that participants reported low social support, poverty, PTSD symptoms, and distress. In addition, they found that participants who had trauma personally and had also witnessed the trauma or death of family members reported more distress than those who had experienced trauma personally but had not witnessed it. Ng et al.'s research also concluded that educational level was a protective factor after the genocide, possibly due to the hope for a brighter future that may be present when an individual has access to a better life. It appears that higher education, whether secured prior to the trauma or after the trauma, is a positive, protective factor for those who are subjected to a traumatic experience.

Kulkarni, Graham-Bermann, Rauch, and Seng (2011) explored whether there was a relationship between two types of childhood violence and the development of PTSD, while controlling for other traumatic experiences. The researchers studied a sample of pregnant women who fell into one of four categories: witnesses of intimate partner violence as children, individuals who directly experienced child abuse, individuals who not only were abused as children but also witnessed intimate partner abuse, and a control

group that had not experienced either type of childhood violence. Participants completed the Life Stressor Checklist-Revised (Wolf, Kimerling, Brown, Chrestman, & Levin, 1996), the Abuse Assessment Screen (McFarlane et al., 2001), the National Women's Study PTSD Module (Kilpatrick, Resnick, Saunders, & Best, 1989), and the Pregnancy Risk Assessment Monitoring System (Shulman, Gilbert, & Lansky, 2006). The total number of participants was 1,581 pregnant women from Southeast Michigan, with a mean age of 26 years. Results showed that childhood violence was associated with both childhood and current PTSD, with women who experienced both witnessing and experiencing violence having the highest rates of childhood and lifetime PTSD. Kulkarni et al. also found that direct victimization was predictive of the development of PTSD, but only witnessing violence was not. The researchers posited that perhaps once an individual is subjected to direct violence as a child, additional traumatic experiences have an additive effect in the development of PTSD. They therefore suggest that it may be helpful for clinicians with clients who have had a traumatic experience to assess them for childhood trauma as well, as this may increase the potential for the development of PTSD.

Marchand, Nadeau, Beaulieu-Prévost, Boyer, and Martin (2015) were interested in exploring potential protective factors as well as risk factors for the development of PTSD in police officers after a work-related traumatic event. Eighty-three police officers were interviewed to assess the most recent work-related traumatic event and to diagnose acute stress disorder, PTSD, or no diagnosis. Police officers were questioned at between 5 and 15 days after the incident, after 1 month, at 3 months, and again at 12 months after

the incident in question. In addition, participants were asked to complete self-report questionnaires to assess for potential predictors for and protectors from PTSD. Marchand et al. found that at the first assessment, 9% of participants met the criteria for acute stress disorder, with 3% meeting the criteria for PTSD at the second assessment (1 month later). The results included the discovery that the more an officer relied on emotional strategies to cope with the stress of the trauma, and the more children he or she had, the greater the likelihood that he or she would develop PTSD. Notably, the researchers found that the severity of the reaction at the time of the trauma was a predictor of increased PTSD symptoms; however, it was the severity of the reaction at the time of the trauma, as measured only at the 1-month mark, that was a predictor of increased PTSD symptoms, not at any other point of measurement. It is interesting to note that the diagnosis of acute stress disorder transitions into PTSD when the symptoms have lasted over thirty days, and perhaps plays a role in Marchand et al.'s finding.

Treatment of PTSD

In order to provide effective treatment for individuals who develop PTSD, it is important to understand the manner in which their PTSD symptoms manifest in trauma survivors' daily living. Brockman et al. (2015) conducted research to uncover the relationship between military veterans' PTSD symptoms and experiential avoidance. The researchers explored whether military veterans' PTSD symptoms were related to their social interactions or social avoidance, reactivity-coercion, and distress avoidance during interactions with their families. The researchers recruited 184 male military veterans of Middle East deployment, and requested that they complete self-report questionnaires

regarding deployment-related trauma, PTSD symptoms, and experiential avoidance. All participants had a partner, and had at least one child between 4 and 13 years of age. Video samples of partner and child-parent interactions, problem solving, and deployment-related discussions were collected for each participant. Analyses of the video samples by trained observers included an assessment of the veterans' positive social engagement, social withdrawal, reactivity-coercion, and distress avoidance. Brockman et al. defined distress avoidance as veterans' inability to tolerate thoughts, feelings, sensations, or an environment that is reminiscent of the traumatic experience of the veteran, and therefore, they avoid these reminders. They found that veterans' avoidance was positively related to less positive engagement with family members, and increased the likelihood of withdrawal and distress avoidance. The researchers stated that perhaps integrating parenting skills, including coaching veterans to resist distress avoidance when interacting with their families, might provide veterans diagnosed with PTSD with the tools to increase their distress tolerance, increasing psychological health.

EMDR has been shown to be an effective method to treat PTSD in soldiers returning from combat (F. Shapiro & Laliotis, 2011). Zimmermann, Biesold, Barre, and Lanczik (2007) were interested in investigating whether the effects of EMDR on combat veterans could be replicated on soldiers diagnosed with PTSD who had not seen combat. Additionally, the researchers were seeking to identify the factors in the traumatic experience that influenced the course and development of PTSD in German soldiers. Treatment results were retroactively evaluated for 89 German soldiers who had undergone treatment for PTSD at a German hospital, and had completed a series of tests

to assist in their diagnosis. The tests included the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979) the Post-Traumatic Stress Scale (Falsetti, Resnick, Resick, & Kilpatrick, 1993), the Beck Depression Inventory (Beck et al., 1996), and the Giessen Test (Beckmann, Brahler, & Richter, 1991). In Zimmermann et al.'s (2007) sample, EMDR had been provided to 40 of the individuals, while the other 49 had received other treatments, including relaxation training and other trauma therapy. Patients were not randomly assigned a therapeutic condition, but the X^2 test revealed that were no significant differences between groups in age, trauma level prior to treatment, rank, or location of participant deployment. Questionnaires were sent out to the 89 patients after treatment; also included were the Impact of Events Scale (Horowitz et al., 1979) the Post-Traumatic Stress Scale (Falsetti et al., 1993), The Beck Depression Inventory (Beck et al., 1996) and the Giessen test (Beckmann et al., 1991).

Results of Zimmermann et al.'s (2007) study revealed that individuals who had received treatment in the EMDR group reported lower scores on the Impact of Events Scale (Horowitz et al., 1979), with a mean score of 25.8 (mild trauma), compared to a mean score of 36.1 (moderate trauma) at pre-treatment (Zimmermann et al., 2007). Additionally, Zimmerman et al. (2007) reported that individuals showed a decrease on the Post-Traumatic Stress Scale (Falsetti et al., 1993) with the average reduction of stress at 35.1% (p= 0.028). Results for the group that did not receive EMDR revealed a decrease on the Post-Traumatic Stress Scale (Falsetti et al., 1993) of 12.9%, and an increase on the Impact of Events Scale (Horowitz et al., 1979) of 14.8%. The Beck

Depression Inventory (Beck et al., 1996) and the Giessen test (Beckmann et al., 1991) results for the two treatment groups were not significantly different.

Cook and Dinnen (2015) discussed the applicability of exposure therapy for older trauma survivors diagnosed with PTSD. Additionally, the authors reviewed the role that culture, disability, and cognitive impairment may play in the treatment of PTSD in older adults. They reported that cognitive behavioral therapy (CBT) has been shown to be one of the most successful treatment methods for PTSD, with Prolonged Exposure (PE) as the most researched and validated form of CBT. Cook and Dinnen explained that PE is constructed upon the theory that the fear present in PTSD is based on three individual sources, including the fear stimulus, the physiological responses as a result of the fear, and the individual's constructed meaning about the fear response. If one develops PTSD after a traumatic car accident, for example, the fear stimulus may be riding in a car; the physiological response may be quick heart rate and shallow breathing; and the constructed meaning may be "I will crash and die if I get into the car" (p. 7). Although many fear that the physiological responses that may occur during PE may be hazardous to an older adult, Cook and Dinnen stated that PE may be the best choice, particularly if the treating clinician works in concert with a medical professional to monitor specific physical abreactions that may occur with older clients. Additionally, the authors stressed the importance of a thorough, ongoing discussion with clients to assist in providing culturally-sensitive counseling services, seeking to understand each client's own unique cultural background, specific disabilities, and individual concerns. Cook and Dinnen warned that although there may be lists of commonly-held cultural differences between

racial and cultural groups, it is important to view each client as an individual and not attempt to apply general concepts to specific individuals.

Conclusion

For this study, research into the *DSM-5* included literature by authors discussing proposed changes prior to the final development of the *DSM-5* and research discussing the final development of the PTSD diagnostic criteria in the *DSM-5*, including both supportive and critical assessments of the diagnostic changes. Research into PTSD included literature on the assessment of PTSD, trauma and the development of PTSD, and treatment of PTSD. The AIP model, which provided an excellent theoretical framework for this research, was researched to provide the origin of the theory, the major hypotheses of the theory, and how the model relates to the present study.

The diagnostic validity and reliability of the *DSM* has increased since the publication of the *DSM-III*, as researchers have refined the diagnostic criteria for each disorder (Chmielewski et al., 2015). Although there are sources that suggest that the overall reliability of the *DSM-5* is similar to the reliability of the *DSM-IV*, research into the experiences of clinicians as they utilize the *DSM-5* diagnostic criteria for PTSD had not been conducted (Chmielewski et al., 2015). This current research fills the void in assessing how practitioners experience the new diagnostic criteria as they assess for PTSD. Interviews with licensed mental health clinicians exploring how they experience utilizing the new PTSD diagnostic criteria in the *DSM-5* uncovered valuable insights into how the new criteria affects diagnosis, treatment, prognosis, and insurance reimbursement for individuals who present with symptoms after experiencing a traumatic

event. Additionally, as the interviewer of participants in this study, my insights into the type of practice in which the participant practices, the environment in which the participant works, and other insights not included in a transcript of the interview provide further information. Finally, a demographics questionnaire completed by the participant regarding their personal background, type of license under which they provide psychotherapy, level of education, and practice information support the information gleaned from the interview and my insights. These sources of information assist in providing new insights into how clinicians are experiencing utilization of the PTSD diagnostic criteria in the *DSM-5*.

Chapter 3: Research Method

Introduction

The new diagnostic criteria for PTSD in the *DSM-5* have created a great deal of disagreement among mental health professionals as to whether the changes effectively characterize the disorder (Calhoun et al., 2012). The most current research has shown that the prevalence of the disorder has somewhat declined with the new diagnostic criteria, but the impact of the new diagnostic criteria upon the day-to-day experiences of mental health professionals, including diagnosis, treatment, and insurance billing remained unclear (Calhoun et al., 2012).

The *DSM-5* was released in April 2013; however, many insurance companies did not require clinicians use the new diagnostic criteria until October 2015; therefore, the full effect of the diagnostic changes may not have been present until after October 2015. Research into the actual experiences of clinicians provided valuable information as to the impact of the new diagnostic criteria on the diagnosis of PTSD. Therefore, this qualitative study regarding how psychotherapists were experiencing utilization of the new diagnostic criteria with their clients who present with the potential for a PTSD diagnosis, provides valuable insights into the effects of the changes in the PTSD diagnosis in the *DSM-5*.

The purpose of this study was to explore the experiences of clinicians as they use the PTSD diagnostic criteria in the *DSM-5*. As shown in the previous chapter, the research regarding the *DSM-5* had been primarily quantitative in nature. Quantitative

methodology is a good fit for researchers who seek to test a theory; I, however, sought to explore individual clinicians' experiences as they use the diagnostic criteria.

A comprehensive examination that revealed the unique perspective of participants required the use of a research method that allowed complex, individual perceptions and personal experiences to emerge. Interviews conducted in the qualitative case study tradition provided the data for this study. In this chapter, I describe the research design and the methodology that I utilized in the study. The chapter also includes the research questions and descriptions of the method utilized to recruit participants, the sample, and the researcher's role. Finally, I discuss data collection procedures, the methods to ensure quality, and the methods used to analyze the data collected.

Research Design and Rationale

The qualitative approach was the best fit for this research as it allowed participants to bring to light their own experiences with the phenomenon in question. Qualitative research is intended to uncover the "essence of experience of . . . [a] phenomenon for the people" (Patton, 2002, p. 104). In other words, the researcher employed qualitative research to capture the individual subjective experiences of participants in their own words, as they experience the world, utilizing the five senses. Using the qualitative approach allowed me to explore the experiences of clinicians as they use the PTSD diagnostic criteria in the *DSM-5*, pursue unique perceptions, and capture information beyond what has been previously researched in regard to this subject.

The case study method of research was also an excellent fit for this research. Willig (2008) stated that the case study approach to research does not emphasize the

methods used to explore a phenomenon but focuses on each individual case to allow for an in-depth understanding of the subject of research. Additionally, the case study approach does not begin with a theory *a priori*, or prior to, the commencement of research (Gillham, 2010). The case study approach to research is appropriate for research into a topic on which there is little information, as the collection of data may be of use to develop theories in the future (Gillham, 2010).

Specifically, the exploratory case study approach is a good choice for research into an area that lacks the information for researchers to identify a hypothesis to test (Streb, 2010). Streb (2010) stated that the exploratory case study

> is often applied to a research context that is not clearly specified and still requires data for the formulation of valid hypotheses, their broad concept provides the researcher with a high degree of flexibility and independence with regard to the research design as well as with data collection. (p. 139)

For this study, I utilized the multiple exploratory case study (or collective explorative case study) approach, which entails the study of multiple entities within their real-life context (Yin, 2012). This approach increases the analytic benefits of the single case study approach, as the independently developing data from multiple case studies are much more significant than the data that may emerge from a single case study (Yin, 2012).

Research Questions

Interviews utilizing open-ended questions that allowed participants to discuss their experiences with the phenomenon in question that they deem important provided the

qualitative data. The participants completed a demographics questionnaire, I took notes after the interview with each participant, and I recorded observations during interactions with each participant. Specifically, I conducted this multiple case study in order to understand psychotherapists' experiences with utilizing the new PTSD diagnostic criteria in the *DSM-5* through detailed descriptions of clinician's impressions of the *DSM-5* and how the new PTSD diagnostic criteria affected their use of diagnostic tools, interventions, and insurance claims. The research questions were as follows:

1. What are psychotherapists' impressions of the new PTSD diagnostic criteria in the *DSM-5*?
2. How do the new PTSD diagnostic criteria inform psychotherapists' use of diagnostic tools?
3. How do the new PTSD diagnostic criteria inform psychotherapists' use of interventions?
4. Insurance companies' start dates for clinicians to begin using the new diagnostic criteria were not flexible. The major insurance companies required use of the revised diagnostic criteria on October 1, 2015. How did the new PTSD diagnostic criteria affect psychotherapists' use of insurance claims (i.e. filing claims, collecting on claims, coding claims, etc.)?

In my interviews with the participants, I utilized a list of questions as a guideline to solicit responses (see Appendix A). All questions were phrased in an open-ended questioning manner, which elicited responses formulated by the participant, rather than

forcing participants to respond to a limited number of choices when they answered questions posed to them.

Role of the Researcher

My role as the researcher for this study was to design the qualitative case study, gain IRB approval, locate and screen participants, gather data, analyze the findings of the study, and report the results. The research paradigm was such that the participants were viewed as "the experts" from whom I was gathering data. I did not criticize, support, encourage, or pass judgment upon the participants' disclosures. I maintained a professional, yet conversational, demeanor throughout the interview, minimizing input to ensure that the participants provided information regarding their experiences without guidance from me. Participants were instructed that I did not have any relationship with the *DSM-5* or the APA committee that developed the *DSM-5*, other than that of fellow therapist and researcher on this topic. Any preconceived ideas regarding the *DSM-5* and the PTSD diagnostic criteria that I may have had were bracketed to minimize their impact (per Fischer, 2009), and the participants were encouraged to express themselves freely without fear of negative consequences. Their responses were completely confidential, and their names were altered via utilization of a coding system to protect their identity.

Methodology

The research design of this study was a qualitative, multiple case study approach (per Yin, 2012). The recruiting method I utilized for this research into clinicians' experiences utilizing the PTSD diagnostic criteria in the *DSM-5* was the purposeful sampling approach. This approach is commonly utilized when researchers seek data-rich

participants for identification and recruitment and the most effective method to utilize limited resources (Patton, 2002). Purposeful sampling is the best fit for research that requires participants who have specific knowledge or experience with the phenomenon of interest, which, in this case, is clinicians utilizing the new PTSD diagnostic criteria in the *DSM-5*. Bernard (2002) stated that purposeful sampling requires participants to have specific knowledge and be willing and able to participate. In addition, the researcher must be able to have access to them, and the participants must be able to articulate their thoughts and opinions clearly to the researcher. Specifically, criterion sampling is utilized to access participants with the specific knowledge and experience necessary to provide the information that is being explored (Yin, 2012). Criterion sampling entails the use of participants who meet a predetermined list of qualifications (Patton, 2002).

I utilized the purposeful, criterion sampling method for recruiting participants from EMDRIA (2017c), an organization that consists of licensed mental health professionals who pledge to maintain the highest quality procedures and ethical standards in their utilization of EMDR therapy. Additionally, I sought to recruit participants from a state-funded mental health organization that employs mental health professionals trained to work with a variety of mental health issues. EMDR is a clinical therapy utilized by mental health professionals to treat various disorders; however, EMDR is most commonly used for the treatment of disorders related to client trauma, including PTSD (F. Shapiro, 2009).

Members of EMDRIA (2017c) must be state licensed, EMDR-trained individuals, and must maintain current knowledge on the treatment of trauma. EMDRIA members

work in a variety of clinical settings, and reside in various locations around the United States as well as worldwide. Therefore, the use of the members of EMDRIA as a basis for purposeful, criterion sampling was a good fit for this research. Additionally, due to the fact that I needed participants who had experience with working with both the *DSM-IV* and the *DSM-5* diagnostic criteria, I sought the participation of clinicians with a minimum of 5 years of experience working with clients. This additional criterion ensured that those chosen to participate would have experience with the previous PTSD diagnostic criteria as well as with the current *DSM-5* diagnostic criteria.

Sample

On the List Serve on the EMDRIA (2017d) website, I placed a bulletin seeking the assistance of participants for this research to explore the experiences of clinicians as they utilized the new PTSD diagnostic criteria in the *DSM-5* (see Appendix B). This area of the website exists for the sole purpose of providing information, guidance, and feedback on current research in mental health. This service, available to members only on the EMDRIA website, does not require that the EMDRIA member gain permission prior to placement of their advertisement, as the service is provided to members who agree to follow the stated protocol when posting. EMDRIA provides a disclaimer on their website that states the following:

> EMDRIA disclaims all warranties with regard to information posted on this site, whether posted by EMDRIA or any third party. In no event shall EMDRIA be liable for any special, indirect, or consequential damages or any damages

whatsoever resulting from loss of use, data, or profits, arising out of or in connection with the use or performance of any information posted on this site.

EMDRIA (2017d) members are allowed access to utilize the list serve and are informed that EMDRIA is not responsible for the content of the information on the list serve. Any issues with the content of the list serve are between the individual who posted the advertisement and the individual who responded to it.

A second source of participants was a state-funded mental health organization that consisted of a nonprofit psychiatric hospital as well as three individual mental healthcare clinics across the state. In addition to providing treatment to the citizens of the state, this mental health organization is dedicated to psychiatric research and therefore agreed to allow me to post a recruitment advertisement to assist in recruiting licensed mental health professionals for possible participation in this study.

The recruitment advertisement (Appendix B) was placed at the mental health organization sites and on the EMDRIA listserve with the intention of securing the participation of licensed professionals in order to explore their experiences and impressions of the PTSD diagnostic criteria. The stated goals of EMDRIA (2017c) include creating and maintaining high standards for clinical practice, training, EMDR certification, and research. Members are expected to provide information, education, and advocacy and, as clinicians, to meet their responsibilities to the community. The high standards of the organization created an atmosphere of highly skilled, socially responsible clinicians dedicated to providing high quality consultation, diagnosis, and treatment for those suffering from the after effects of trauma and other mental health ailments. This

group of clinicians was thus a good fit for this research. Additionally, clinicians at this mental health care institution professed a willingness to contribute to research in areas that may potentially bring more effective treatment for those suffering with mental illness. Their ability and willingness to participate in this research made them an excellent group from which to draw my sample.

In the bulletin I distributed, I provided an email address created solely for the purpose of this research so that potential participants could contact me regarding their willingness to participate. As stated above, participants were currently licensed mental health providers utilizing the *DSM-5* diagnostic criteria for PTSD as they worked with their clients. Additionally, the participants must have had a minimum of 5 years experience working with clients to qualify to participate. Interviews were scheduled as qualified participants responded to the recruitment advertisement, and informed consent was signed by the participant and returned to me. When the clinicians individually notified me of their willingness to participate, I sent each one a packet including a consent form (Appendix C) and a demographics questionnaire (Appendix D). Upon receipt of the completed packet, I contacted each participant and set up a time and place for the individual interview.

The number of participants for this research was 15. Using the multiple exploratory case study approach allowed me to provide in-depth information about each case and a detailed description of each case, including a cross-case comparison of each (Creswell, 2009). This cross-comparison allowed me to identify potential themes that emerged from the data (Creswell, 2009). The number of case studies explored was

limited to 15 to allow me to explore the participant's experiences thoroughly as well as to maintain a manageable number of participants for practicality purposes.

Instrumentation

Yin (2012) stated that the most effective method of utilizing the multiple case study approach to research is to collect data from a variety of sources. Sources of data for this multiple case study research included the one-on-one interview with the participant, the demographic sheet completed by the participant, and the use of member checking at two distinct points in the research process. Member checking is described as soliciting feedback from participants regarding the data collected in order to increase the likelihood of validity and accuracy of the results (Doyle, 2007). For data analysis purposes, I recorded and subsequently transcribed the interviews. The transcribed interviews, responses gathered through the demographics questionnaire, and any additional data gathered in the member checking process were utilized for coding and categorization purposes.

Data Collection

A demographics questionnaire was sent to the participants through email, to be completed prior to the interview. The demographics questionnaire included questions about age, race, gender, education, licensure, experience, number of years in practice, stated theoretical orientation, and general information about the types of clients the participants see in their practice (see Appendix D).

Interviews were set up by mutual agreement between the participant and me. We met for an interview in person, via Skype or V-See videoconferencing services, or by

phone, if meeting in person or videoconferencing service was not feasible. If meeting in person was possible, the participant and I met in a public place such as a library or university.

Data collection occurred via a single interview, with each interview lasting approximately one hour. If the participant needed additional time for sufficient disclosure of his or her impressions of the utilization of the PTSD diagnostic criteria in the *DSM-5*, extra time was granted. Additionally, participants were allowed to contact me if they had additional impressions they wished to disclose in the future. To ensure that I had captured the intended message of the participant accurately, I conducted member checking through email at two specific points in the data collection process: (a) after the transcription and data analysis of each interview and (b) after the data analysis of all 15 participant interviews, to gain additional data from participants regarding the overall findings. Each participant's transcribed interview was emailed to him or her, and I requested that the participants review the transcript for accuracy and return the transcribed interview to me, noting any inaccuracies. If a participant noted inaccuracies, I revised the transcript to reflect his or her statements accurately.

All in-person interviews as well as all Skype, V-See videoconferencing, and phone interviews were recorded via audiotape. Written permission to videotape or audiotape interviews was secured prior to commencement of the interview.

The recorded interview, along with the transcribed interview, demographic questionnaire, and data from the member checking process were secured in a locked cabinet and on a password-protected computer. I transcribed each interview and

requested that each participant review the transcript for accuracy. Once an accurate transcript was obtained, I analyzed each interview for the themes and categories that emerged. After all 15 interviews were conducted, transcribed, and member checked, I analyzed the data from the totality of interviews to elicit themes from the data collected.

Debriefing Procedures

Once demographic questionnaires were completed and collected, interviews conducted, and member checking completed, I thanked the participants for their participation and provided them with information regarding how to contact me if they wished to provide additional insights, ask questions, make comments, or express concerns. I provided participants with a $20.00 gift card as a symbol of my gratitude for their participation. Additionally, I provided information regarding how they could access the final research report once I had completed it. Finally, participants were instructed that they might withdraw their participation at any time, up until the date of final approval of the dissertation by my dissertation committee.

Data Analysis Plan

For research exploring the experiences of mental health professionals as they utilize the *DSM-5* diagnostic criteria for PTSD, I interacted with the data to uncover themes, patterns, and/ or categories (Yin, 2012). Data analysis for the multiple case study approach to research was described by Merriam (2009) as occurring in two stages: (a) a single case analysis, whereby each individual case is viewed separately in this stage of analysis, and (b) multiple case analyses, when the data from the total number of case studies is compared and contrasted in a cross-case analysis.

Following the above plan for data analysis, in the first stage, I coded the interviews individually for each individual case. Data analysis at this stage included the categorization and coding of the data from each source (Yin, 2012). Initially, I used open coding, which allowed the findings to emerge from the data (Yin, 2012). Interviews were evaluated line-by-line, as I was looking to label or categorize information as it occurred. A list of codes from each interview was created. Member checking was launched at this stage to assist in increasing accuracy, validity, and credibility. Member checking refers to the process of allowing the participants to check the content of the transcribed interview; however, the additional process of allowing the participant to provide feedback on the themes or codes that I derived from the data was also engaged to ensure that I was accurately capturing the message the participant was seeking to convey.

The second stage of data analysis entailed the multiple case analyses (Merriam, 2009). In this stage, I compared the data from each case study to identify common codes, or themes, that emerged (Yin, 2012). to organize and analyze the relationships within and between data collected, I used HyperRESEARCH software (Version 3.7.2; Researchware, 2015). I played a key role in case study research, as I conducted all interviews, transcribed all interviews, and analyzed data using coding to protect the confidentiality of participants. Once I had identified the themes that emerged, I listed them in the order of the frequency in which they occurred in the data, with the most frequently occurring themes listed first, followed by themes that occurred less frequently.

Once I had determined the themes derived from the totality of interviews, I again engaged in member checking. At this time, I presented each participant with the list of

themes derived from the totality of interview data, listed in order of frequency and solicited his or her feedback regarding these themes. I gathered any additional feedback provided by participants, including potential explanations for differences in participant experiences. Regarding participants' confidentiality, I substituted pseudonyms for their names. Additionally, I was the only individual with access to the data, which was stored on a password-protected computer and in a locked cabinet. I will destroy this data 5 years after completion of the dissertation.

Saturation

Saturation in qualitative analysis was described by Mason (2010) as a time in which additional participants do not add enough additional information to justify the time, energy, and money required to secure additional participant data. In qualitative research, said Mason, it is common to utilize fewer participants than in quantitative research, as the data that the researcher seeks to uncover may require a much more in-depth exploration than quantitative research may require. Typically, multiple case study designs utilize between four and 15 participants, as fewer than four may not provide enough data, and more than 15 participants may provide more information than the researcher may be able to process adequately (Stake, 2006). Additionally, saturation may occur early in the research process. Guest, Bunce, and Johnson (2006) found that in their research on health care for 60 African women, saturation had taken place very early in their research. Data analysis included the creation of a total of 36 codes after analysis of all 60 interviews; however, they found that 34 of those codes had been created after data analysis of only six interviews. Guest et al. stated that this result may have been due to

the significant similarities within the population researched. For research exploring the experiences of clinicians as they utilize the PTSD diagnostic criteria in the *DSM-5*, the clinician participants exhibited considerable similarities, creating saturation at a fast pace. Therefore, the sample size of 15 cases reflects the assertion by Stake (2006) that the maximum number of case studies should be 15, as that number offers manageability of data yet also provides enough data to increase the likelihood of saturation.

Negative Case Analysis

As discussed by Stake (2006), the term *negative case analysis* refers to cases in which the participants report experiences that are atypical from the main body of cases. Stake claimed that negative cases can provide valuable information that assists in either strengthening of weakening the themes common within the other cases. For the analysis of data, I set aside the negative cases, as recommended by Stake, to explore the possible explanations for their departure from the experiences of the main body of cases. As Stake proposed, information from these cases provided a logical explanation for deviation from the other cases and thus supported the developed themes; conversely, negative cases for which alternative explanations were not developed may require additional research. See the results section of this dissertation for my identification and explanation of negative cases along with my suggestion that additional research may assist in exploring those issues.

Trustworthiness

For this qualitative research including case study design, I heightened the trustworthiness through the use of multiple case studies versus a single case study, the

use of member checking to ensure accuracy, and the use of cross-case data analysis in addition to within-case data analysis, as recommended by Eisenhardt (1989). My identification of negative cases also assisted in assuring trustworthiness as well, as the use of negative cases in the data analysis stage provided support for the findings. Additionally, the use of negative cases also helped identify areas in which further research might be warranted.

Internal Validity

My use of triangulation in qualitative research increased internal validity, as it strengthened the grounding of theory, and the use of cross-case data analysis allowed me to look past the initial impressions presented by the data and examine the data through various lenses (Eisenhardt, 1989). My use of multiple member checks enhanced construct validity (Yin, 2012). For example, in this research, I first used member checking for each case, to ensure that the participant concurred with the individual data collected from the interview. I again conducted member checking after the data from all 15 cases had been analyzed. In this phase of member checking, I presented participants with the data analysis from the totality of cases, including the themes that emerged from the data and collected and processed their feedback.

External Validity

External validity refers to whether or not the results of research demonstrate transferability (Yin, 2012). Transferability is viewed as the transfer of knowledge gleaned from a study to a specific case (Yin, 2012). For this research, I enhanced reliability through the use of multiple case studies rather than a single case study; however, my

effort to uncover the experiences of clinicians as they utilized the PTSD diagnostic criteria in the *DSM-5* may result in development of theory at a later time. I was not seeking to test a theory and provide statistical generalizations regarding the population (Yin, 2012), but the use of a variety of clinicians who work in various clinical settings along with thorough descriptions in each case study assisted in increasing the external validity for this multiple case study research.

Dependability

In multiple case study research, *dependability* refers to the reliability of the data gathered (Yin, 2012). I utilized member checking to ensure the accuracy of each interview. Additionally, I maintained a clear audit trail to ensure that those who review the research data can clearly delineate the source of information as well as how it was processed and presented.

Confirmability

Confirmability refers to the objectivity in research (Yin, 2012). Yin (2012) stated that one way to assist in promoting confirmability in multiple case study research is for the researcher to maintain a journal throughout the research process. In this study, per Yin's suggestion, I used a journal to note personal reactions and interpretations as they occurred.

Ethical Procedures

Ethical Standards

To ensure the protection the human subjects used as participants in this study, I complied with the ethical standards set and required by state agencies, federal agencies,

independent agencies, and individual universities (U.S. Department of Health and Human Services, 2016). Additionally, I obtained the approval of the Walden University Institutional Review Board (IRB # 06-28-16-0316164) for the use of human participants.

Participants

Once I received an email from participants expressing an interest in participating, I contacted them directly. I assured them that their participation in the research would be confidential. Their agreement to participate in the study was facilitated through the completion of a consent form, which detailed the rights and responsibilities of both the researcher and the participant (see Appendix C). A statement within the consent form expressed my willingness to meet the participant at his or her choice of location. Conducting the interview within the participant's clinical setting provides the interviewer the opportunity to get a glimpse of the participant in his or her work environment, the type of practice the participant maintains, and the types of clients the participant sees. However, I encouraged participants to meet me in a neutral location, such as a library or university. Information regarding the participant's work environment and the typical client population with whom the participant works were revealed through the demographics questionnaire (see Appendix D).

Ethics in Data Analysis

As stated previously, in the data analysis, I included cases that deviated from the others; however, negative cases were investigated further through member checking to gather additional information from the participant that might explain their deviance. Stake (2006) detailed the manner in which negative cases can provide valuable

information that either supports the mainstream cases or indicates areas in which additional research should be conducted. In this research, negative cases provided valuable data and were included in data analysis and reporting.

Informed Consent

In the consent form, I provided details regarding the purpose of research and stated that the participation of the clinician was voluntary (see Appendix C). I also assured the participants that I would not disclose participant identities, would remove all identifying details from the final report, and securely store the data at all times. Additionally, I acknowledged all potential psychological, relationship, legal, professional, and other risks to the participants. Participants were licensed mental health clinicians, knowledgeable regarding where to seek assistance if they experienced distress as a result of participating in this research. Nevertheless, in the consent form, I offered assistance through referrals, but this was not necessary. Participants were not coerced nor provided with any incentive to participate; however, a $20 gift card was offered to participants as a symbol of gratitude.

I wrote the consent form in plain language, with the inclusion standards clearly enumerated, so that participants were able to understand why they had been chosen and the rights and responsibilities of both parties. Additionally, I clearly stated the time commitment, outlined the data collection methods, and summarized the potential benefits of the research (see Appendix C).

Interview Protocol

To assist the participants in feeling comfortable in revealing his or her experiences to me, I strove to develop rapport with each one. I encouraged them to ask questions or to seek clarification on any concern they may have had and assured them that they could withdraw from participating at any time. I conducted the interviews using open-ended questions, which allowed the participants to express themselves freely. I elicited additional information with statements such as "Would you like to say more about that?" I gave participants my phone number and email address and instructed them to contact me if they wished to contribute more impressions and/or information, had questions or concerns, or were experiencing any issues after their participation in this research.

Summary

The case study approach to research is a good fit for research into an area in which little research has been conducted (Yin, 2012); however, in order for case study research to be conducted in an effective, ethical manner, the researcher must prepare a solidly constructed research plan. This chapter presented the research design and methodology for research seeking to explore the experiences of psychotherapists as they utilize the PTSD diagnostic criteria in the *DSM-5*. Additionally, this chapter included an outline of the data analysis plan and provided discussion of issues of trustworthiness and ethical considerations when conducting this research. The results of this research yielded important data regarding how the changes in the *DSM-5* may influence therapists as they work with their clients. The data gathered and the summary of the results provided

valuable information not only to therapists but also to those who develop the *DSM*, researchers, and the general public.

Chapter 4: Results

The purpose of this multiple case study was to explore clinicians' experiences in using the revised PTSD diagnostic criteria as described in the *DSM-5* (APA, 2013). The following research questions guided the research:

1. What are psychotherapists' impressions of the new PTSD diagnostic criteria in the *DSM-5*?
2. How do the new PTSD diagnostic criteria affect psychotherapists' use of diagnostic tools?
3. How do the new PTSD diagnostic criteria affect psychotherapists' use of interventions?
4. How do the new PTSD diagnostic criteria affect psychotherapists' use of insurance claims (i.e., filing claims, collecting on claims, coding claims, etc.)?

This chapter presents the results of this multiple case study. Results are organized by research question. The participants were 15 licensed mental health clinicians who volunteered to participate by contacting me via email or telephone. I conducted interviews with the participants in person, via Skype, or over the telephone. I audiorecorded the interviews and sent and collected participant questionnaires through email. In the data analysis, I examined data from each of the 15 participants, including discrepant cases. I used open coding in analyzing the data for themes and successfully employed the strategies described in Chapter 3 to increase credibility, transferability, dependability, confirmability. Table 3 documents the results regarding each diagnostic

criterion, and in my narrative, I discuss research findings related to the research questions.

Results

Results for Research Question 1

Research Question 1 was as follows: What are psychotherapists' impressions of the new PTSD diagnostic criteria in the *DSM-5*? I organized results for this research question by diagnostic criterion and by specific themes. To specifically report participants' thoughts and ideas about the changes, I created a table with details of participants' impressions and vignettes on each criterion (see Table 2).

Table 2 shows that participants displayed a high level of agreement regarding the diagnostic changes to the PTSD diagnostic criteria in the *DSM-5* (APA, 2013). Participants agreed with criteria that remained unchanged between the *DSM-IV* and the *DSM-5*, including the criterion requiring a precipitating event, intrusion symptoms, and psychological and physiological distress at reminders of the event, avoidance, and hyper-vigilance.

Participants agreed with the changes regarding the removal of Criterion A2, which requires the individual to respond with fear, hopelessness, or horror. Similarly, participants stated that they agreed with the addition of feelings of detachment, persistent inability to experience positive emotions, and marked alterations in arousal and reactivity. Participants were particularly pleased with the addition of the dissociative subtype and separate diagnostic criteria for children.

Table 2

Participant Impressions of Specific Diagnostic Criterion

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette (direct quotes from participants)
A1 Exposure to actual or threatened death, serious injury, or sexual violence, in one or more of the following ways:	A precipitating event is necessary for a PTSD diagnosis. Participants agree with this concept.	Agreement	"The precipitating event has to be there. That is the same. The same kind of symptoms."
1. Directly experiencing the traumatic event(s)	Most participants felt that this is not appropriate. Most participants believe that individuals can be traumatized by an event even if they are not physically present.	Disagreement	"A client that comes in, all the kind of extraneous symptoms are there, and there's a lack of direct experience with trauma. . . . We had a 10- or 11-year-old, and mom had a trauma, but a lot of the symptoms were there for the child, even if it was not a direct trauma for the child. The fit was there. That has been part of the frustration. It's more difficult. Clearly there, but doesn't quite fit with the *DSM* now."
2. Witnessing in person the event as it occurred to others.	Similarly, although most participants believe that including witnessing the trauma as it occurs to others is appropriate, they believe that vicarious trauma may also precipitate PTSD.	Disagreement	"It is harder to give a diagnosis to patients who weren't there, who heard about it or saw it on TV. Like 9/11, people weren't there but felt threatened at that time. Not just in New York but all over America no one knew what was next, you see. I would still give a diagnosis to someone who wasn't there because the threat was omnipresent, you see?"

(table continues)

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette
3. Learning that the traumatic event occurred to a close family member or friend. In cases of actual or threatened death of a family member or friend, the event must be violent or accidental.	Most participants believe that PTSD can also develop in cases in which the victim was a stranger. Additionally, most participants believe that PTSD can develop even if the trauma was not violent or accidental (i.e. natural sudden death).	Disagreement	"They need to re-do it again. The body, physiologically, does not know if it is violent or accidental."
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s), (ex: First responders) NOTE: Criterion A4 does not apply to exposure through electronic media, television, movies, or photos, unless it is work related.	Although most participants believe that including first responders in the diagnostic criteria is a positive addition, most participants believe that individuals may experience trauma through repeated exposure through electronic media, television, movies or photos even if they are not first responders.	*Agreement* with first responder inclusion. *Disagreemen*t with excluding exposure through media for non-first responders.	"Social workers are not directly experiencing the trauma but there is a lot to be said about the impact of secondary traumatic stress. I am not familiar with the conversion rates of social workers or first responders but for me, I look on an individual basis and look for symptoms that are more reflective of that."
A2 No longer included in criteria. A2 stated that the person's response involved intense fear, helplessness, or horror	The majority of respondents stated that this was a positive change. Professionals trained to work within traumatic situations may not experience or display a fear response at the time of the trauma due to their training.	Agreement	"This is the one that makes a difference for my patients. Military trained patients are trained, conditioned, trained to compensate, to ignore their fear. They go into the fire, not run from it. The *DSM-IV* did not look at this fact, did not recognize this fact from military. This makes, this gives us, a wider criteria pool for our patients. This gives us the ability to give more PTSD diagnoses to patients."
B Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s) beginning after the traumatic event occurred	Intrusion symptoms for PTSD are unchanged between *DSM-IV* and *DSM-5*.	Intrusion symptoms are unchanged between *DSM-IV* and *DSM-5*; therefore participants did not comment.	Not Applicable

(table continues)

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette
B1 Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)	The intrusive memory symptom for PTSD is unchanged between *DSM-IV* and *DSM-5*.	The intrusive memory symptom is unchanged between *DSM-IV* and *DSM-5*; therefore, participants did not mention it directly.	Not Applicable
B2 Recurrent distress and/or affect related to traumatic event	Most respondents believe that the criteria in B2 are appropriate for the diagnostic criteria for PTSD.	Agreement	"I think that's something that I think that we all just knew about trauma, that that was an outcome of trauma that I just thought about before. But again, this kind of put it in writing and validated it."
B3 Dissociative reactions (ex: flashbacks) in which the individual feels or acts as though the event were recurring	Majority of respondents felt that dissociative reactions were a positive addition to the diagnostic criteria for PTSD.	Agreement	"I think that for those of us who see a lot of trauma, we know that dissociation can be an outcome of trauma, and so it is nice to have it specified here. But it is something that has always been a part of my thinking about PTSD before, so I don't think it really changed anything for me in practice."
B4 Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	The criterion of intense or prolonged psychological distress at exposure to cues is unchanged between *DSM-IV* and *DSM-5*.	The criterion of intense or prolonged psychological distress at exposure to cues is unchanged between *DSM-IV* and *DSM-5*; therefore, participants did not mention it directly.	Not Applicable
B5 Marked physiological reactions to internal and external cues that symbolize or resemble an aspect of the traumatic event	Physiological reactions to internal and external cues are unchanged between *DSM-IV* and *DSM-5*.	Physiological reactions to internal and external cues is unchanged between *DSM-IV* and *DSM-5*; therefore, participants did not comment on it.	Not Applicable
C Persistent avoidance of stimuli associated with the traumatic event(s) as evidenced by one or both of the following: C1 and/or C2	Avoidance symptoms were part of the diagnostic criteria in *DSM-IV* as well as the *DSM-5*.	Avoidance symptoms were part of the diagnostic criteria in *DSM-IV* as well as *DSM-5*. Therefore, most participants did not comment on this.	Not Applicable

(table continues)

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette (direct quotes from participants)
C1 Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event	Participants feel this is a common presentation of PTSD.	Agreement	"Some of the things that we have labeled as something different, like conduct disorder or some other pathology, was really was just avoidance. Or maybe looking at some other behavior, like substance abuse is more like avoidance."
C2 Avoidance of or efforts to avoid external reminders that arouse distressing memories, thoughts, feelings, or feelings about or closely associated with the traumatic events	Participants feel this is a common presentation of PTSD.	Agreement	"When I work with a child I may now label avoidance as a form of dissociation. I really look at that differently, with my notes and how we formulate treatment plans. With dissociative kids, we do a lot more grounding, a lot more breathing work, to kind of help them to get grounded, and we are really labeling those kids differently. Looking at resistance differently in a session. How to address that, and even labeling it differently for kids. For example, what I might see as a behavioral issue, I may now see as dissociation. I may not see it as dissociation rather than negatively labeling it, which is easy to do when they are mouthy and yelling at you. You're like stop being a brat when it is actually a more complex process."

(table continues)

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette (direct quotes from participants)
D Negative alterations in cognitions and mood that are associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following	Participants overwhelmingly believed that negative alterations in cognitions and mood were a positive addition. Participants reported that this symptom is extremely common in individuals who experience PTSD, and that previously they had to include a secondary diagnosis of depression.	Agreement	"You know what is really interesting about that, is clients in the past when I was a newer clinician, would have negative self talk or negative cognitions, I might have diagnosed that as depression, I might have put that under anxiety. I would have put that under another diagnostic category. I was trained in EMDR, and what's fascinating about EMDR is, I don't know if you're familiar with EMDR but there's a whole portion on negative cognitions and trauma, so I kind of feel validated that, of course, when people have something traumatic happen of course that's going to change their world view. Even more so than somebody who is depressed. So that also supports what I have been learning and what I experience with my clients."
D1 Inability to remember an important aspect of the event (s) due to dissociative amnesia, not due to alcohol or drugs	Participants felt dissociative amnesia is a logical inclusion in the PTSD diagnostic criteria, as individuals who experience PTSD frequently display this symptom.	Agreement	"Patients dissociate and are able to do what they need to do, what they are trained to do. A civilian may avoid anything, doing anything, thoughts, whatever, that has to do with, that is related to the trauma, the trauma they experienced. Military are trained to walk through fear, to go, to function, on automatic. It is dissociation. So a patient may not make a clean diagnostic pattern for some criteria but with the dissociative features it all comes together in the end. This is how the criteria allow more diagnoses. Makes it allowable. The dissociation."

(table continues)

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette (direct quotes from participants)
D2 Persistent and exaggerated negative beliefs or expectations about self, others, or the world	This was described as a positive addition to the PTSD diagnostic criteria by most participants.	Agreement	"Posttraumatic stress disorder sometimes presents like depression and it is time for depression to be seen as a symptom. Patients see the world through a fear-tinged filter and look at the world as scary and bad even when they are far away from where the trauma took place, and see self as bad and broken even though they did nothing to cause the trauma. Soldiers do their jobs and follow orders then blame their self when they see trauma. They generalize everything to be bad forever. It looks like depression but it is posttraumatic stress disorder."
D3 Persistent distorted cognitions about the cause or consequence of the traumatic event that lead the individual to blame themselves or others	This criterion was found to be a positive addition.	Agreement	"This is common for so many people who have trauma. Big trauma or little trauma. People try to blame someone, something, themselves. It is a defense thing. If you can figure out whom to blame you get some control. The *DSM* recognizes it now. But it doesn't change what people have after trauma. But this is a good addition."

(table continues)

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette (direct quotes from participants)
D4 Persistent negative emotional state (ex: fear, horror, etc.)	Participants approve of this criterion.	Agreement	"The patients that I see, some are depressed. It looks like depression but it is really posttraumatic stress disorder. A patient feels sad, guilty, for killing innocent bystanders and blames himself or herself for it. Not their fault. They think so. They think it is their fault. They should have done something different. It looks like depression but it is really Posttraumatic Stress. The change in D shows that it can look like depression."
D5 Markedly diminished interest or participation in significant activities	Diminished interest in significant activities is unchanged between *DSM-IV* and *DSM-5*.	Diminished interest in significant activities is unchanged from the *DSM-IV*; therefore, participants did not comment on it	Not Applicable
D6 Feeling of detachment or estrangement from others	Participants stated that individuals experiencing PTSD may present with a variety of feelings.	Agreement	"Depression and other emotions can be a sign for posttraumatic stress disorder, not just anxious emotions."
D7 Persistent inability to experience positive emotions	Participants stated that this addition is appropriate.	Agreement	"I think now they also have something regarding Negative Mood in the symptoms. Like depression symptoms. Not just anger or rage but sadness and no energy. That's good."
E Marked alterations in arousal and reactivity associated with the traumatic events, beginning or worsening after the traumatic event, and evidenced by two or more of the following.	Participants stated that arousal and reactivity beginning after the traumatic event is a typical response.	Agreement	"Typically, what I see is people who are having a lot of re-experiencing someone's death, or any photos that they have seen, maybe a vehicle fire or whatever."

(table continues)

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette (direct quotes from participants)
E1 Irritable behavior and angry outbursts with little or no provocation, typically expressed as verbal or physical aggression toward people or objects	Participants stated that aggressive behavior is a common reaction to a traumatic event.	Agreement	"I've been doing this for many years, and sadly I think a long time ago when I started out, we would look at a kid and label them negatively, like with conduct disorder or oppositional defiant, and I think we really missed the boat. So I think with this clarification, there has been a real focus on informing the courts, the judges, counselors about trauma, and that shift helps all of us to look at a child's behavior differently. So we are moving away from conduct disorder and depression and anxiety disorders to look more at specifics."
E2 Reckless or self-destructive behavior	Participants stated that this is a valid addition to the diagnostic criteria.	Agreement	"People who have dissociated may not have any reaction other than irritability, depression, or a number of other reactions."
E3 Hyper-vigilance	The criterion of hyper-vigilance is unchanged between *DSM-IV* and *DSM-5*.	The criterion of hyper-vigilance is unchanged between *DSM-IV* and *DSM-5*. Therefore, participants did not comment on it	Not Applicable
E4 Exaggerated startle response	Participants stated that this is an appropriate symptom for the PTSD diagnostic criteria.	Agreement	"It is a common reaction. A lot of somatic symptoms. That is a common reaction. A good change."
E5 Problems with concentration	Participants agreed with this symptom as a criterion for PTSD.	Agreement	"My patients show a range of symptoms and the new diagnosis include these, you see. A good change."

(table continues)

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette (direct quotes from participants)
F Duration of the disturbance in criteria B, C, D and E is longer than one month	Duration requirements in the *DSM-5* remain unchanged from the *DSM-IV*. Participants did not disagree with the decision to maintain duration requirements for an individual to qualify for a PTSD diagnosis.	Agreement	"Duration of symptoms determines diagnosis. Clients with symptom duration less than 30 days receive a lesser diagnosis; however if symptoms persist over 30 days diagnosis changes to PTSD."
G The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning	This criterion is common in many diagnoses, and is unchanged in the PTSD diagnostic criteria between *DSM-IV* and *DSM-5*.	This criterion is common in many diagnoses, and is unchanged between *DSM-IV* and *DSM-5*. Therefore, participants did not comment on it.	Not Applicable

(table continues)

DSM-5	Summary of participant impressions	General agreement/ disagreement with changes	Representative vignette (direct quotes from participants)
H The disturbance is not attributable to the physiological effects of a substance or other medical condition With dissociative symptoms (depersonalization or derealization)	This criterion is unchanged between the *DSM-IV* and the *DSM-5*.	This criterion is unchanged between the *DSM-IV* and the *DSM-5*; therefore, participants did not comment on it Agreement	Not Applicable
With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event, although some symptoms may be immediate. Addition of specific criteria for diagnosing PTSD in children under the age of 6.	Participants overwhelmingly approved of the addition of the Dissociative Subtype, as dissociation is a common reaction to trauma. Additionally, participants believe that the inclusion of a dissociative subtype encourages clinicians to actively assess for dissociative symptoms, which are common in this population.	This criterion was unchanged from the *DSM-IV*; therefore participants did not specifically comment on it.	"A good change. Many patients with PTSD disassociate to avoid facing the trauma they went through. Then they still disassociate after the trauma to cope with painful thoughts and feelings."
Addition of the Dissociative Subtype	This criterion is unchanged between the DSM-IV and the DSM-5. The delayed expression subtype is not new to the PTSD diagnostic criteria.	Agreement	Not Applicable
Separate Diagnostic Criteria for Children	Participants believe that having a specifier for children is a positive addition.		"It is so nice that they've included children, because I feel like that was a huge stretch before, applying this to children, whereas we all knew intuitively that it fit, but that made a big difference for those of us who work with children to have them included in this category. So that was probably the most important change in my mind."

Participants strongly disagreed with the requirement that the individual experience the trauma directly as well as with the criterion stating that if the trauma occurred to someone else, that person must be a close friend or family member, and the traumatic event must be violent or accidental. Similarly, the participants disagreed with the criterion that excludes individuals traumatized through exposure via media.

Themes Related to Research Question 1

This section includes three themes related to the research question as well as tables summarizing the definition of the identified themes (see Table 3), the number of times the theme is mentioned, and the number of participants that discussed a specific theme (see Table 4). As reflected in Table 3, the primary themes include "therapists made no changes to diagnoses," "It is easier to make a diagnosis due to greater clarity [regarding symptoms]," and "New criteria have a negative impact upon diagnosis." Table 4 shows the number of times the themes appeared across interviews and across the data.

Table 3

Themes and Definitions for Research Question 1

Theme	Definition
Therapists made no changes to diagnoses.	Therapists rely on their clinical skills to make diagnosis.
It is easier to make a diagnosis due to greater clarity.	It is easier to make a diagnosis due to the removal of Criterion A2. A2 is the requirement of fear, helplessness, or horror in reaction to a traumatic event; addition of Criterion D, which is the presence of negative mood and cognitions; the addition of separate, specific diagnostic criteria for children; and the addition of the dissociative subtype. Clinician indicates if individual qualifies for dissociative subtype when making diagnosis, and specifies this subtype on diagnosis form.
New criteria have a negative impact upon diagnosis.	The new PTSD diagnostic criteria in the *DSM-5* made diagnoses more complicated due to criteria being more complex, the requirement that individuals experience the trauma directly, the fact that patients that met old criteria do not meet new criteria, and symptoms do not match real-life experiences.

Table 4

Frequency of Themes for Research Question 1

Theme	Number of interviewees mentioning this theme	Total exemplar quotes
Therapists made no changes to diagnoses.	14	43
It is easier to make a diagnosis due to greater clarity.	13	46
New criteria have a negative impact upon diagnosis.	8	17

Therapists made no changes to diagnoses. The most frequently occurring theme for Research Question 1 was "Therapists made no changes to diagnoses." This theme refers to the perception that therapists made no changes to diagnoses when using the new PTSD diagnostic criteria in the *DSM-5* (APA, 2013) compared to using *DSM-IV* diagnostic criteria. The majority of participants agreed that their years in practice gave them highly developed clinical judgment into psychological diagnoses, relying less on structured diagnostic criteria like the *DSM*. Participants reported that they felt that their education and experience had provided them with a keen intuition into client presentations.

Debra shared that she had not changed her diagnostic process due to the diagnostic changes to Criterion A1 based on the fact that she assessed each patient on an individual basis, looking at their subjective experiences/symptoms:

> Well, in regard to the need to experience a trauma directly, I do not agree with that. I work with a lot of social workers and there is a lot of secondary traumatic stress. And the social workers are not directly experiencing the trauma but there is a lot to be said about the impact of secondary traumatic stress. I am not familiar with the conversion rates of social workers or first responders, but for me, I look on an individual basis and look for symptoms that are more reflective of that.

When asked what participants had noticed in their experiences with the changes in the diagnostic criteria for PTSD in the *DSM-5*, Kristin said, "I really haven't noticed much change. It hasn't felt like a huge change for me." Similarly, when asked what changes she had experienced in working with clients since the addition of a dissociative

subtype to the diagnostic criteria, Brittany stated that the addition of the dissociative subtype had not changed her diagnostic process, as she did not view the *DSM* as a rule book; rather, she considered the diagnostic criteria as a general guideline for potential symptoms:

> Um, I don't notice any difference. That it is pretty standard fare. The fact that they made it part of the criteria. . . . I don't know. The diagnostic criteria are a guideline. It isn't perfect. It's generalities. You know when you see it. I am not really OCD about it. If it walks like a duck, quacks like a duck, it's a damn duck.

The majority of respondents reported that in spite of the changes in the PTSD diagnostic criteria and individual criticisms of the criteria, their diagnostic process had not changed since the *DSM-5* was published. Some participants reported that their education and experience had provided them with a keen perspective into clinical presentations.

It is easier to make a diagnosis due to greater clarity. This theme refers to the perception that the new PTSD diagnostic criteria in the *DSM-5* makes it easier to make a diagnosis due to greater clarity regarding symptoms. Lauren shared,

> I don't think the changes change the likelihood that I would diagnose someone with PTSD. I honestly think the change made it easier to diagnose someone with PTSD because the wording is less confusing and less vague.

Criterion A2. Rose stated that the removal of Criterion A2, in which the person's immediate response to the trauma had to involve intense fear, helplessness or horror, was a positive change for her client population:

> I work at a military mental health clinic, and I have contact with soldiers who have seen combat, soldiers who are stateside. Also, their families. I notice that a posttraumatic stress disorder diagnosis is easier because the patient doesn't have to have Criterion A2 anymore to qualify for the posttraumatic stress disorder diagnosis in the new *DSM*. I used to, it used to be harder to make that diagnosis because the patient had to experience the extreme fear, the panic, at the time of the trauma, and soldiers are trained to focus on the job in front of them. They are trained to carry on, to rise above their emotions. Sometimes they do not even realize what they have been through until long, long after it occurred. So the removal of the A2 criterion works in favor of the majority of our patients, to get a diagnosis of PTSD.

Criterion D. Debra stated the addition of self-blame and negative cognitions provided clarity to the PTSD diagnosis. She stated,

> You know what is really interesting about that, is clients in the past, when I was a newer clinician, would have negative self-talk or negative cognitions, I might have diagnosed that as depression, I might have put that under anxiety. I would have put that under another diagnostic category. I was trained in EMDR, and what's fascinating about EMDR is, I don't know if you're familiar with EMDR but there's a whole portion on negative cognitions and trauma, so I kind of feel validated that, of course, when people have something traumatic happen of course that's going to change their world view. Even more so than somebody who is

> depressed. So that also supports what I have been learning and what I experience with my clients.

Brittany reported that the addition of self-blame and negative cognitions "clarifies things more." Sarah explained that the addition of self-blame and negative cognitions in Criterion D added clarity to the diagnosis. Sarah stated,

> This was a good addition. It is something we have recognized for a long time. People look for a reason, a place to, well, blame for the trauma. So they blame other people, sometimes people who had nothing to do with it or blame themselves when they had no power over it. I think because when you blame yourself you take some of the fear away. You feel powerful when you feel you could have done something different, you know? It is a common reaction.

Dissociative subtype. Helen felt that the addition of a dissociation specifier with either depersonalization or derealization was helpful in clarifying symptoms as well. She stated, "That is a good addition. It is important to address whether one has dissociated or not, as they may not experience symptoms because they have dissociated." Finally, Charlene also appreciated the dissociative subtype addition to the PTSD criteria:

> I think it really added a reality to what was already there. I mean EMDR; it really places a strong emphasis on, or identified, dissociative symptoms all along, so that was encouraging to see. I mean, if I really step back and look at the diagnostic criteria, I mean in talking with other clinicians, it wasn't really a focus. So now, I mean this feels like it really fits with what I see. Justifies something that was already there.

Many participants mentioned the addition of the dissociative subtype as a positive change to the PTSD diagnostic criteria in the *DSM-5*. Participants stated that the addition of the dissociative subtype provided validation to trauma survivors who react to a traumatic event with an absence of, rather than the presence of, an emotional reaction. For example, Corrine stated,

> Ridiculous. People go into shock. Shock. Sometimes do not feel anything for a long, long time. This is ridiculous. I don't pay any attention. I do file claims for reimbursement, but not for anything else. It doesn't matter. The insurance company has to pay. I don't pay any attention.

Miller et al. (2014) supported the addition of the dissociative subtype by stating,

> The inclusion of the dissociative subtype in *DSM-5* helps to define a more homogenous subgroup from the vast heterogeneity associated with PTSD. This should help in the evaluation of the correlates, course, and treatment of the disorder. It also provides a uniform definition of dissociation in PTSD that may allow for greater reliability in the conceptualization of dissociation across PTSD studies. The inclusion of the subtype should also alert clinicians to assess for this type of comorbidity and consider its role in case conceptualization and treatment planning. (p. 7)

Although some researchers have argued that a dissociative subtype is a positive addition to the diagnostic criteria for PTSD, because it recognizes the possibility for an individual to dissociate in reaction to trauma, they believe that the addition of a "subtype" of dissociation implies that some individuals diagnosed with PTSD have dissociative

symptoms, whereas others do not. Dorahy and van der Hart (2015) posited that all individuals with PTSD suffer from some type of dissociation and that dissociation should play a larger role in the diagnostic criteria for PTSD in the *DSM-5*. The participants' reactions in this current research reflect their own experience with the addition of the dissociative subtype and appear to support the important role dissociation plays in the diagnosis of PTSD.

Specific criteria for children age 6 and under. The new PTSD diagnostic criteria in the *DSM-5* differentiate between groups like children and adults. Practitioners who worked with children were appreciative of the addition of specific criteria for children, as PTSD may have a different clinical presentation than that of adults. Debra, for example, shared,

> I do, um, appreciate the differences, the way they describe the differences between adults and children, in the new diagnostic criteria. Because I do work with children. And I do think that a lot of, that there is a big difference between adults with PTSD and children with PTSD. . . . What I appreciate about the change is the focus on children and on how children are different from adults. I appreciate the research that went into that.

In the final example for this theme, Lauren said,

> Although I have not had any clients under age 7 diagnosed with PTSD, I appreciate the inclusion in the *DSM-5*. I think this is important, as kids may show their symptoms much differently than adults. I like this part. And I overall think the changes are good.

Participants saw the creation of a specific set of diagnostic criteria for children as a positive addition to the PTSD criteria. As reported regarding this theme, most participants believed that the new diagnostic criteria added clarity to symptoms. Some participants stated that the removal of Criterion A2, in which the individual must experience fear or horror at the time of the event, enables the clinician to render a PTSD diagnosis to first responders and others who are trained to work in a potentially traumatic environment. Other participants stated that the addition of the dissociative subtype has provided clarity regarding an absence of symptoms in clients who have experienced a traumatic event, which makes diagnosis easier for clients who may not have met the previous criteria. Additionally, most participants approved of the addition of negative mood and cognitions as a symptom of PTSD, as it was consistent with what they had witnessed in their clinical practice. Finally, participants approved of the addition of separate diagnostic criteria for children age 6 and under. Although most participants stated that the new criteria provide greater clarity, they also disagreed with some diagnostic criteria. The discussion of the following theme includes these criteria.

New criteria have a negative impact upon diagnosis. Some participants who reported that the new PTSD diagnostic criteria have not affected their diagnostic process also reported that they disagreed with some of the changes, or that changes may have created frustrations in other aspects of their practice.

Criterion A. Lori explained her disagreement with Criterion A, whereby the patient must experience the trauma directly, or if the trauma happens to a close friend or family member, it must be violent or accidental:

> It reminds me of a client that I had, from a very chaotic family. Her family did not do a great job of protecting her from the details of the things going on in the family, like a friend of her step-mom was murdered and they just kept talking about it in front of her, and I started thinking about it as PTSD when she was with me. This new criteria doesn't encompass that.

Corrine also disagreed that an individual must experience the trauma directly:

> The body, the mind, doesn't know the difference, if it's in person or not. I worked with many, many people, many people in 9-11, people in [retracted location], far from the actual, you know, New York. And they had the same things, the same symptoms as anyone. I led some groups with people from New York, and the symptoms are the same. It doesn't matter if, where you are, when you see people suffering, dying, you, jumping, fire, screaming, running. It's all the same. It's ridiculous. It's because the insurance companies do not want to pay, they have to make it harder to qualify. And pharma companies. The *DSM* is set up to work in favor of pharma and insurance, not the public.

John's statement seemed to imply that the requirement of experiencing the traumatic event directly excludes many people who clearly need assistance to process their experience. He said,

> I know friends who are counselors who have patients in the military, from the military. And police officers, firemen. They say that patients who used to meet the symptoms in the *DSM-IV* do not make the symptom list in the *DSM-5*. So what do you do with those patients?

Sue also indicated that Criterion A excludes individuals who did not experience the traumatic event directly and that these patients once qualified for a PTSD diagnosis under the previous diagnostic criteria:

> I have noticed that the percentage of patients that present, that get, a PTSD diagnosis is equal to the percentage of patients before the *DSM-5*. But the patients that, some of the patients that got the diagnosis in the *DSM-IV* do not get a diagnosis in the *DSM-5*. Some patients that would not get, not qualify, not get a PTSD diagnosis in the *DSM-IV* would now get a diagnosis in the *DSM-5*. See what I'm saying? Before the new version was produced, before we had to use it, everyone was saying that it would be easier to make the diagnosis, that it was wider. That isn't true. It got wider in some areas, but got more stringent in other areas. Now the patient doesn't have to have the fear response, but at the same time patients traumatized by something that wasn't violent or accidental don't qualify.

The majority of participants stated that, due to their reliance on their clinical intuition, the changes have not affected their diagnostic process. Nevertheless, they reported that they disagree with some diagnostic criteria and that feeling the changes in the PTSD diagnostic criteria has created difficulties for them in their practice.

In regard to Criterion A.3, whereby the traumatic experience must be violent or accidental, Brittany stated,

> I don't know of a practitioner alive who would disagree with what I just said. Maybe they don't experience the event itself, but they experience the effects of

> that event. Then you start getting into semantics. As experienced clinicians, we know what we see. But for more unseasoned clinicians, it may be more of a difficult line to walk, especially when you are trying to do an ethical practice. It is very challenging.

Similarly, Corrine said,

> Ridiculous. The body doesn't know the difference. The soma, the soma, what is the word? Somatic. The somatic symptoms, the physical symptoms that people have after such a tragedy, trauma. Trauma is trauma. The body doesn't know if it is violent or accidental. It's awful. It creates symptoms. It creates disease. Dis-ease.

When asked about how they have experienced the changes in A1.1 and A1.2, which now require an individual to experience a trauma directly, or if a close family or friend experiences the trauma it must be violent or accidental, Judy said,

> I think that is really stupid. We know there is such thing as vicarious trauma. We also know about multigenerational transmission of trauma. And we know, like with holocaust survivors, some of their children actually had PTSD even though they hadn't been in the actual concentration camps with their parents. Even though they hadn't gone through trauma, per se, it appears to be passed down through genetics. That's stupid.

As shown above, most therapists reported that they have not made significant changes to their diagnostic process due to their reliance on their own intuition when rendering diagnoses. Additionally, most participants appreciated the removal of Criterion

A2, as most of them agreed that vicarious, or secondary, trauma is possible. Participants also appreciated the addition of a dissociative subtype, negative mood and cognitions, and specific diagnostic criteria for children, as children and adults may display symptoms in very different presentations. Clinicians also reported, however, that the requirement that individuals experience the trauma directly, or if the traumatic event happens to a close friend or family member, it be violent or accidental, have made diagnoses more complicated. Therefore, although there is a high level of agreement among participants regarding their overall impressions of the new PTSD diagnostic criteria in the *DSM-5*, their specific feedback varies depending on the population with whom they work, whether or not they accept second-party reimbursement, and if they work in private practice or for an organization.

Themes Related to Research Question 2

Research Question 2 was as follows: How do the new PTSD diagnostic criteria inform psychotherapist's use of diagnostic tools? The three primary themes related to this research question are summarized in this section. As reflected in Table 5, the primary themes were "No changes in use of diagnostic tools," "Use of tools is difficult or misaligned," and "Therapists use different tools." Table 6 shows the frequency with which the themes appeared across interviews and across the data.

Table 5

Themes and Definitions for Research Question 2

Theme	Definition
No changes in use of diagnostic tools.	Participants reported no changes in their use of diagnostic tools due to relying on interviews or diagnostic tests that had continued validity after the release of the new diagnostic criteria.
Use of tools is difficult or misaligned.	The new PTSD diagnostic criteria led to difficulty and misalignment in use of diagnostic tools.
Therapists use different tools.	The new PTSD diagnostic criteria led psychotherapists to change or use different diagnostic tools.

Table 6

Frequency of Themes for Research Question 2

Theme	Number of interviewees mentioning this theme	Total exemplar quotes
No changes in use of diagnostic tools.	10	10
Use of tools is difficult or misaligned.	3	3
Therapists use different tools.	2	2

No changes in use of diagnostic tools. The most frequently occurring theme for Research Question 2 was "No changes in use of diagnostic tools." This theme was derived from data indicating that the new PTSD diagnostic criteria did not change or affect psychotherapists' use of diagnostic tools. Overall, those who reported no changes in their use of diagnostic tools stated that there was no change for them due to their use of a diagnostic interview rather than formal tools to diagnose or that the tools they had used

prior to the changes in the PTSD diagnostic criteria were still valid. The theme "No changes in the use of diagnostic tools" appeared 10 times in 10 interviews.

When I asked Rose, for example, "What changes have you experienced when using diagnostic tools, for example, tests, to assist in diagnosing PTSD in clients since the changes in the diagnostic criteria for PTSD?" she stated, "I use the same methods to assess and diagnose patients that I used for the *DSM-IV*. That changed, I mean did not change, the way I diagnose patients. That's the same." Debra indicated, "We were already using the ICTC [Illinois Childhood Trauma Coalition] Trauma Intake, and the UCLA [University of California Los Angeles] PTSD Intake. We were using it before the book (*DSM-5*) came out; we still use them now." Kristin also indicated no change in use of tools: "The AOD [Alcohol and Other Drugs] questionnaire, a tool, a very short questionnaire about trauma, alcohol, substance abuse. That's what I use. It has been revised but I have always used it. So, no change." John stated, "I use the same tests now as before." Corrine also stated there was no change:

> No change. It's the same. I don't use tests. I assess directly. That hasn't changed. I have friends who use scales, scales like the Beck, but I don't. Why the formal?
>
> Why the formal manner? I just ask directly. Let the person tell me how they feel.

Similarly, Judy indicated not using diagnostic tools before and after the changes: "I don't really use diagnostic tools. I have been trained to use them, but I don't. I would rather just assess the individual by talking with them. I didn't before and I don't now." In the final example for this theme, Frank explained, "No changes. I know that some new diagnostic

tests are out now, but I don't use tests here. Not here. I use a structured interview, not tests. So nothing is changed for diagnostic tools."

Use of tools is difficult or misaligned. The next theme for Research Question 2 was "Use of tools is difficult or misaligned." This theme was derived from data indicating that the new PTSD diagnostic criteria led to difficulty and misalignment in use of diagnostic tools. The theme of tools being difficult or misaligned was mentioned three times in three interviews. Sarah felt there was a misalignment between the revised diagnostic criteria for PTSD and the diagnostic tools:

> As I said, this has been the biggest issue for me. They put out new diagnostic criteria before they put out assessment tools that are in alignment with the new diagnostic criteria. Hello? So we were using outdated assessment tools, then having to write lengthy summaries explaining why the results of the assessment tools are disqualifying and why we feel that the client is presenting with symptoms that resemble the current diagnostic criteria. Ridiculous, and a tremendous waste of time and money.

When asked whether she was using the same diagnostic tools that she always had, Erin said,

> I am now. It's interesting that that's another frustrating piece, when the *DSM-5* rolled out, it was like everyone will now be using this to diagnose. I mean they quickly got on board with the ICD-10 [International Statistical Classification of Diseases and Related Health Problems, 10th edition]. I mean, it still took another year, but the PCL [Posttraumatic Checklist] and the CAPS-5 [Clinician

> Administered Posttraumatic Scales, 5th edition] took forever to come out, so we were using *DSM-5* diagnostic criteria like we were supposed to, but all the screening measures were still *DSM-IV*. We would have to indicate this may or may not be a limitation, etc.

Some participants reported that the new PTSD diagnostic criteria are more complicated due to delays in updating diagnostic tools. For example, Sarah stated,

> They need to put out the new diagnostic criteria and the assessment tools at the same time. This has been incredibly frustrating and time-consuming for everyone. The assessment tools were not out for over a year after the new *DSM*. Ridiculous.

The lack of synchronicity between the new PTSD diagnostic criteria and the creation of diagnostic tools that have been shown to measure accurately whether or not an individual shows signs of the disorder based upon the new criteria has been frustrating for some clinicians. Additionally, clinicians reported frustration due to delays in updating claims requirements in practice. Some clinicians reported that although current PTSD assessment tools had been developed, their specific employer or workplace had not yet implemented those tools in their practice. Erin, for example, stated,

> When I transitioned from one department of the government to another department in May, we weren't able to start using any of the *DSM-5*-related material until July. It wasn't even available for us yet. So that was a huge problem. And it still isn't in the electronic system, so I have to do paper copies of the 5.

In the final example for this theme, Sue explained,

> Ok, this one, this part, I have an issue with. They change the criteria. They change the criteria we have to use to diagnose the disorder. But then they don't have tests that are validated relative to the new criteria. So we are using tools that aren't validated yet. And we have to write it up that we are rendering diagnoses that aren't validated. We are using outdated tests and tools.

Participants who reported that use of tools is difficult or misaligned since the change to the PTSD diagnostic criteria in the *DSM-5* worked in clinical settings such as nonprofit organizations or government health facilities. Conversely, those who reported no changes in their use of diagnostic tools were in private practice and had more flexibility in their diagnostic processes.

Overall, those who reported no changes in their use of diagnostic tools stated that this was due to the use of a diagnostic interview (which allows them flexibility), rather than relying on standardized diagnostic tests, or that the tools they use were not outdated with the release of the new diagnostic criteria. Clinicians who use different tools reported doing so due to the addition of the dissociative subtype. These clinicians appear to do so to ensure that they thoroughly assess for dissociative symptoms in clients who have experienced a traumatic event.

Therapists use different tools. The final theme for Research Question 2 was "Therapists use different tools." This theme refers to the new PTSD diagnostic criteria leading psychotherapists to change or use different diagnostic tools. Therapists adjusted diagnostic tools to incorporate assessment for dissociative subtype. One participant had begun using a dissociation assessment tool more frequently, whereas another reported

adjusting her clinical interview to inquire about dissociation more in depth than she did prior to the release of the *DSM-5* diagnostic criteria for PTSD.

Therapists use different tools was mentioned two times in two interviews. In the first example of this theme occurring, Lauren explained her use of different tools since the addition of the dissociative subtype to the PTSD diagnostic criteria in the *DSM-5*:

> I have found that the results for dissociation in the trauma symptom checklist for children would easier coincide with the dissociation specifier. I am more aware of dissociation, and more likely to use tools to assess for it since the changes.

Charlene stated that she uses a diagnostic interview and explained that she changed her probing questions to ensure that she assesses for dissociative symptoms:

> I have had to change some of the probing questions that I use to really bring to surface some of the new criteria that we've talked about. To kind of highlight things that I didn't focus on in the past. So in the past I wouldn't really focus on dissociation because it really wasn't focused on in the diagnostic process. So now I have adjusted my questions so that it really matches the diagnostic criteria.

Themes Related to Research Question 3

Research Question 3 was as follows: How do the new PTSD diagnostic criteria inform psychotherapists' use of interventions? The two primary themes related to this research question are summarized in this section. As reflected in Table 7, the primary themes were "There were no effects on therapists' treatment planning for clients" and "New criteria led to changes in treatment approaches or interventions." Table 8 shows the frequency with which the themes appeared across interviews and across the data.

Table 7

Themes and Definitions for Research Question 3

Theme	Definition
There were no effects on therapists' treatment planning for clients.	The new PTSD diagnostic criteria did not change or affect psychotherapists' treatment planning process for clients.
New criteria led to changes in treatment approaches or interventions.	The new PTSD diagnostic criteria led to changes in treatment approaches or interventions due to the addition of a dissociative subtype in the PTSD diagnostic criteria, and/or because of their training in EMDR.

Table 8

Frequency of Themes for Research Question 3

Theme	Number of interviewees mentioning this theme	Total exemplar quotes
There were no effects on therapists' treatment planning for clients.	15	48
New criteria led to changes in treatment approaches or interventions.	11	8

There were no effects on therapists' treatment planning for clients. The most frequently occurring theme for Research Question 3 was "There were no effects on therapists' treatment planning for clients." This theme refers to the perception that the new PTSD diagnostic criteria did not change or affect psychotherapists' treatment planning process when working with clients. The theme "There were no effects on therapists' treatment planning for clients" appeared 48 times in 15 interviews. Rose stated, for example, that there were "no changes to the manner that patients are treated,

the treatment planning is the same." When I asked, "Any changes in your treatment planning process?" Debra stated "No." Kristin also said she had not made any changes to her treatment planning. John explained his continuing use of the same treatment planning process:

> I use cognitive behavioral treatments because they are shown to work best, you see. I give my support and help patients to understand that they are safe; they survived; they are a survivor. Not the victim. Cognitive changes the mind, the thoughts, and then the feelings. You have to begin with thoughts to change feelings.

Sue explained her continued use of the same treatment planning for PTSD as follows:

> We are trained to pair treatment with symptoms, so that hasn't changed at all. We are trained to list symptoms, list symptoms on the left, with the intervention on the right. So I list the patient's symptoms here and the treatment here.

Frank said, "No changes in treatment planning. No change, no." In the final example, Charlene indicated,

> For me, I am learning EMDR. It is changing the way I look at interventions. And yeah, treatment. But EMDR has changed the way I work, but not the *DSM*. The individuals haven't changed, the diagnostic criteria changed. So it's the same. Make sense?

As stated, all participants reported that there were no effects on their treatment planning since the changes to the PTSD diagnostic criteria in the *DSM-5*. Any changes

reported were in relation to other factors, such as the introduction of EMDR into the clinician's practice.

New criteria led to changes in treatment approaches or interventions. The next theme for Research Question 3 was "New criteria led to changes in treatment approaches or interventions." This theme refers to the perception that the new PTSD diagnostic criteria led to changes in psychotherapists' approach to treatment and choice of client interventions. Most participants who reported changes to their interventions stated that this was due to the addition of a dissociative subtype in the PTSD diagnostic criteria and/or because of their training in EMDR. These participants asserted that the shift in focus toward the possibility of dissociation in clients who present with the potential for a PTSD diagnosis has prompted them to add treatment approaches or interventions that assess for dissociative symptoms.

New criteria that led to changes in their treatment approaches or interventions was mentioned 11 times in eight interviews. Some participants who work with children reported that the shift from viewing defiant behavior in children as conduct disorder to viewing it as possibly PTSD has changed their use of interventions. Debra explained,

> When we look at a kid, I've been doing this for many years, and sadly I think a long time ago when I started out, we would look at a kid and label them negatively, like with conduct disorder or oppositional defiant, and I think we really missed the boat. So I think with this clarification, there has been a real focus on informing the courts, the judges, counselors about trauma, and that shift helps all of us to look at a child's behavior differently. So we are moving away

> from conduct disorder and depression and anxiety disorders to look more at specifics.

Brittany indicated how her treatment approach had changed. “Now I’m adding in ego state work, instead of straight DBT [dialectical behavioral therapy], like I used to do. Which, by the way, is incredibly effective. And more attachment theory stuff, you know what I mean?” Sarah stated, “I do find that I am using more grounding work, adding more grounding techniques to my interventions. Because I am more aware of the dissociative symptoms in the new diagnostic criteria.”

Helen explained that her treatment changes were due to her training in EMDR rather than the changes in diagnostic criteria:

> What has really changed the way I diagnose PTSD isn’t the changes in diagnostic criteria but in changing my perspective on diagnosis and treatment with EMDR. Previously, I would have gone strictly off of the *DSM* diagnostic criteria for diagnosis of PTSD, but now that I use EMDR, I see trauma differently. So, while not everyone I work with has PTSD, EMDR has expanded how I see trauma in someone, how I see PTSD in someone.
>
> And . . . one of the luxuries that I have in working only with cash pay is that I don’t have to worry if they meet full criteria for PTSD in the *DSM*, that I can focus on whether my intuition tells me that the client has experienced trauma rather than worrying about whether or not I can check boxes.

Similarly, Sue mentioned the use of EMDR:

> I am learning EMDR, and I am using it more frequently. I would like to use it much more frequently. It is approved so I can use it. I do use it, but I want to use it more. What was, what did you ask me? Oh, about dissociation. Well, EMDR therapy is a good fit for dissociative symptoms but you have to have experience. I have experience with dissociation and I am getting more experienced with it, in my work with EMDR.

Brittany explained that there were changes in her use of treatment approaches and interventions due to her training in EMDR as well: "I use new interventions because I am always looking for interventions that are effective, so I am always evolving. That's why I am using EMDR. It is a powerful tool for working with clients." Sarah indicated that she had changed her choice of interventions due to the dissociative addition to the PTSD diagnostic criteria in the *DSM-5*:

> I use more grounding techniques, more safe place and ego state work. Transactional analysis work, helping people to transition from child states to their adult states to feel safe. The dissociative additions to the diagnostic criteria really stimulated my use of transactional analysis again. Great techniques to help clients to ground themselves. Get grounded, calmed down, feel safe.

Themes Related to Research Question 4

Research Question 4 was as follows: How does the new PTSD diagnostic criteria affect psychotherapists' use of insurance claims (i.e., filing claims, collecting on claims, coding claims, etc.)? The three primary themes related to this research question are summarized in this section. As reflected in Table 9, the primary themes were "No

changes or effects to billing or insurance claims," "Changes made insurance claims more difficult," and "Therapists do not handle or know about insurance." Table 10 shows the frequency with which the themes appeared across interviews and across the data.

Table 9

Themes and Definitions for Research Question 4

Theme	Definition
No changes or effects to billing or insurance claims	The new PTSD diagnostic criteria had no effect and did not lead to any changes in billing or psychotherapists' use of insurance claims for clinicians who operate on a cash-only basis, or due to parity laws for mental health.
Changes made insurance claims more difficult	The new PTSD diagnostic criteria made billing and filing/ collecting on insurance claims more difficult for clinicians working in a nonprofit or government setting, as new current procedural terminology (CPT) codes were not released at the same time as the *DSM-5*.
Therapists do not handle or know about insurance	The new PTSD diagnostic criteria had no effect because therapists do not participate in billing or only accept cash payment for services.

Table 10

Frequency of Themes for Research Question 4

Theme	Number of interviewees mentioning this theme	Total exemplar quotes
No changes or effects to billing or insurance claims	6	8
Changes made insurance claims more difficult	5	7
Therapists do not participate in billing or only accept cash payment for services	4	5

No changes or effects. The most frequently occurring theme for Research Question 4 was "No changes or effects to billing or insurance claims." This theme refers to the perception that the new PTSD diagnostic criteria had no effect and did not lead to any changes in psychotherapists' billing procedures, use of insurance claims, or bill collection. No changes or effects to billing or insurance claims was mentioned eight times in six interviews. For example, Debra mentioned,

> Where I work, we use evidence-based practices. So we document everything that we are doing; we use specific trauma scales and include them in our notes. And I haven't noticed, well, I shouldn't say, because I actually don't work directly with submitting claims, but I think that most of our claim returns are just because of basic mistakes like forgetting dates or no signatures. So I haven't heard about anything.

Corrine said there were no changes in completing, submitting, or receiving reimbursement for insurance claims since the changes in the PTSD diagnostic criteria in the *DSM-5*. When asked what changes she had experienced since these changes were

made, Corrine shared that because she lived in a state that requires insurance companies to recognize mental health disorders in the same manner as a physical illness or disorder, she had not experienced any changes. She said,

> No change. Our state requires payment. For so long, mental health was not important but now mental health is getting attention, getting payment. The insurance companies have to pay for mental health treatment in this state. I don't know if that is everywhere but it is here.

Many states have parity laws that require health insurance companies to provide mental health treatment coverage that is equal to physical health treatment coverage. These parity laws have helped ensure that individuals diagnosed with PTSD or other mental health disorders are able to receive the treatment that they need.

Changes made insurance claims more difficult. The next theme for Research Question 4 was "Changes made insurance claims more difficult." This theme refers to the perception that the new PTSD diagnostic criteria made billing and insurance claims more difficult. Participants who reported frustrations with billing and filing insurance claims stated that the fact that the *DSM-5* was released prior to the new CPT codes' release created problems in deciphering the correct codes to use when filing claims. Additionally, participants stated that at nonprofit and government clinics, the computer screens used for intake and billing were not updated to reflect the new diagnostic criteria. This created confusion and required the clinician to take extra steps in clarifying diagnoses. Finally, other participants reported difficulties with filing insurance claims and stated that the

changes created confusion for them, as they were not sure how to file claims reflective of the new diagnostic criteria for PTSD.

Participants referred to changes making insurance claims more difficult seven times in five interviews. Brittany explained the difficulty with insurance claims and billing resulting from the *DSM* changes as problematic, due to the fact that the *DSM-5* and the *CPT* codes were not released simultaneously:

> I just think there are some odd things that have happened with it. There's a difference for me, as a practitioner, because I do my own billing. And I think that is really important to talk about. Because the *DSM* came out, and it was widely panned. I mean people were really upset with it. And a year later, the new *CPT* codes come out, 'cause we switch over to ICD-10 [International Classification of Diseases, 10th edition], right? So the billing codes are different from the *DSM* codes. So in the billing codes, we still have chronic, acute designations. So as a practitioner, using the *DSM* for a billion years, it's like you people are high, right? They had to be high; I have no idea what they were doing. There is a difference between people who are chronically experiencing symptoms and people who aren't as bad. The intermittent people who clearly have PTSD from an event but they function well, they don't have the consistent symptoms but when they get triggered, holy smokes! Sometimes I feel like the criteria in the *DSM* don't match up with real life. It's not what I see in my office. And with the *CPT* codes, here is what I am going to say: When you do your own billing—which I think is what most people do now because it is so much easier now because of online and its

> cheaper—when you do your own billing codes, it is a lot easier to use the criteria that you have used for years, rather than use the criteria that is in the latest rendition of the *DSM*. I think that's an important distinction to make.

Sarah indicated a negative reaction:

> Nightmare! The *ICD* codes still have acute or chronic. And clients are still acute or chronic. So this has been a nightmare for all of us. A big source of kickback for billing. Admin gets so frustrated with the insurance companies and with us up here. I hope that in the future they get all, everything lined up before they change something, you know? Too much time wasted on paperwork anyway but this has made it even worse, you know? I don't submit claims, personally. But I hear about it when they come back and the admin department has really had problems with getting the codes right.

In the final example of this theme, Charlene said,

> Yeah, it's [billing] gotten a little trickier. I find myself on the phone a lot with insurance companies, kind of consulting and, in regard to questions that they may have. Like, well, you know, this person doesn't look like they were directly impacted by the traumatic event, you know, like loss of a loved one due to terminal illness. Everyone says, like, well, they saw it coming, but they still experience the symptoms of PTSD. I talked to an insurance company rep about this—it was not unforeseen circumstances—and I was finding a way to justify that so the insurance company will not see it as a diagnostic limitation. I mean, fortunately, I haven't had a complete shut down in receiving reimbursement, but it

has been frustrating at times to, you know, to figure out how to present it in a way that the insurance company wants it.

As indicated by the participants' responses, the changes in the PTSD diagnostic criteria in the *DSM-5* have made billing and filing claims more difficult for some clinicians in practice. Participant responses varied due to whether or not they accept second party reimbursement and dependent upon whether they work in private practice or for an organization.

Therapists do not handle or know about insurance. The next theme for Research Question 4 was "Therapists do not handle or know about insurance." This theme refers to the perception that the new PTSD diagnostic criteria had no effect because therapists do not participate in billing or only accept cash payment for services. Not knowing about insurance or how to handle it was mentioned five times in four interviews. When I asked participants about changes in completing, submitting, and receiving reimbursement for insurance claims, for example, Rose stated, "You would have to talk to admin staff about that. I don't know." Lauren stated, "I do not complete claims. We have administration staff that specifically takes care of billing. Therefore, I do not know if there have been any changes experienced." Helen also did not conduct her own billing, file health insurance claims, or collect insurance payments. Sue stated, "I used to take insurance when I was in private practice, but I closed my private practice about six, six and a half years ago. I wanted to do therapy, not paperwork."

The data showed that the participants that work for government or nonprofit agencies, or therapists that work on a cash only basis, do not file claims with insurance

companies. They therefore do not have insight into changes in submitting claims to insurance companies.

Summary

This chapter described recruiting methods, participants' characteristics, and the coding and data analysis procedures used to generate the findings and emerging themes presented in this case study. The data analysis generated eleven themes. The most relevant issues that emerged from the data analysis indicated that rather than follow strict diagnostic criteria; many participants rely on their clinical judgment and intuition when rendering diagnoses. Therefore, despite any criticism that they have for the new diagnostic criteria in the *DSM-5* for PTSD, the new diagnostic criteria did not affect diagnoses in their practice.

Further issues revealed by participants pertain to the addition of a dissociative subtype to the PTSD diagnostic criteria and the criterion that an individual may experience negative beliefs and expectations. Most participants considered the addition of a dissociative subtype, specific diagnostic criteria for children age 6 and under, and the criterion regarding negative beliefs and expectations about oneself was a positive change and that these changes reflect what they have always experienced in their practice. A fourth issue that participants addressed was the lack of attention to the possibility of secondary traumatization as a stimulus for the development of PTSD symptoms.

This chapter included discussion of the issue of trustworthiness and how both internal and external validity was increased in this study. Also addressed in this chapter were issues regarding dependability, confirmability and the adherence to ethical

standards. A discussion of the ethics in data analysis included a review of the specific steps taken in data analysis. In this study, I took two different approaches to data analysis, and this chapter provided an explanation of the relevance of each to the research questions explained. Additionally, this chapter included a summary of the data analysis approaches, tables displaying the demographics results, tables summarizing the identified themes, and references to the number of participants that responded within each of the themes. Finally, the report regarding themes stated the number of interviewees who mentioned a specific theme and examples of the themes. Chapter 5 provides a discussion of the results.

Chapter 5: Discussion of Findings

Introduction

The APA publishes the *DSM*, which lists the diagnostic criteria for the assessment of mental disorders. With each new edition of the *DSM*, the APA provides revised diagnostic criteria for particular psychological ailments. In 2013, the APA released the *DSM-5*, providing revised diagnostic criteria for PTSD.

The *DSM* is the central diagnostic tool for mental disorders in the United States, and each revision of the manual is typically met with heated debate among mental health professionals as to whether it provides appropriate representations of various mental disorders. The *DSM-5* was no exception, as the revised diagnostic criteria for PTSD has created controversy among both researchers and clinicians.

The purpose of this study was to explore the experiences of licensed clinicians as they assess, provide treatment, and bill insurance companies for individuals presenting with the symptoms of PTSD. Quantitative research into the revised diagnostic criteria for PTSD in the *DSM-5* had previously been conducted to assess whether the new diagnostic criteria has impacted the prevalence of a PTSD diagnosis.

In this study, however, I explored clinicians' experiences as they utilize the new diagnostic criteria for PTSD in practice with their clients to uncover how they perceive its use and applicability. The nature of the study was a qualitative, multiple case study approach. The benefit of this type of research design includes the ability of the researcher to elicit accounts of real-world experiences from those who actually work with the diagnostic criteria in their work place. The research questions were the following:

1. What are psychotherapists' impressions of the new PTSD diagnostic criteria in the *DSM-5*?
2. How do the new PTSD diagnostic criteria affect psychotherapists' use of diagnostic tools?
3. How do the new PTSD diagnostic criteria affect psychotherapists' use of interventions?
4. How do the new PTSD diagnostic criteria affect psychotherapists' use of insurance claims (i.e., filing claims, collecting on claims, coding claims, etc.)?

I attempted to provide answers to these questions by collecting information through semistructured interviews and a demographics questionnaire completed by each participant. This chapter presents key findings of the study, my interpretation of the results, and my recommendations for possible future research as well as discussion of the limitations of the study and the implications it has for social change.

Key Findings

Findings Regarding Specific Criteria

Research into clinicians' experiences with the new PTSD diagnostic criteria in the *DSM-5* revealed key results regarding disagreement with Criterion A, which defines a traumatic event and an individual's proximity to it and disagreement with Criterion A3, which states that if the traumatic event happened to a close friend or family member, it must be violent or accidental. Participants overwhelmingly agreed with the removal of Criterion A2, which previously required an individual to experience helplessness or horror at the time of the trauma, and agreed with diagnostic criteria that remained

unchanged between the *DSM-IV* and the *DSM-5*, including the requirement of a precipitating event and Criterion B.

Additionally, participants agreed with Criterion C, whereby individuals must display at least one avoidance-type symptom, and with Criterion D, which includes negative alterations in cognitions and mood. Participants also welcomed the addition of a dissociative subtype and separate diagnostic criteria for children. Lastly, most participants believed that the diagnostic criteria failed to address the role of secondary traumatization in the development of PTSD in individuals who have experienced trauma vicariously through media, family history, or nonviolent trauma to family members or close friends.

Significant Findings Based Upon Research Questions

In addition to providing feedback regarding specific diagnostic criteria, participants also responded to questions regarding their diagnostic process, assessment tools, clinical interventions, and billing/insurance claims. Participants overwhelmingly reported that they rely on their clinical judgment when making diagnoses. One participant stated that she has added specific assessment tools to target symptoms of dissociation due to the addition of the dissociative subtype. However, most participants stated that they use a clinical interview and their clinical judgment to include questions encompassing the new PTSD diagnostic criteria. Furthermore, although some participants reported that the addition of the dissociative subtype and the addition of separate diagnostic criteria for children had influenced their choice of interventions, most participants reported no change in their clinical interventions. Finally, whereas most participants reported no

changes to their billing process or insurance claims, several participants reported that billing/insurance claims have become more difficult because of the changes in PTSD diagnostic criteria. A few participants did not provide feedback because they only accept cash in their practice or work for an organization that assigns the billing/insurance claims process to a separate department.

Interpretation of the Findings

My interpretation of the results of study's findings is presented here, organized by research question. My discussion of the first question includes interpretations of the findings based on the participants' responses regarding each change in the criteria for diagnosis of PTSD as presented in the *DSM-5*.

Research Question 1: Impressions of the New Diagnostic Criteria for PTSD

The first research question explored psychotherapists' impressions of the new diagnostic criteria in the *DSM-V*. The majority of participants (13 out of 15) reported no changes in their diagnosis of PTSD as they utilized the new diagnostic criteria in the *DSM-5*. Moreover, many participants reported that after years in practice, they know what PTSD looks like in a client and that symptoms are subjective. The subjective nature of PTSD was a common theme in this research, as most participants believe that PTSD may manifest in a variety of ways, depending upon the individual's psychosocial history and genetic background. In fact, some participants reported that the diagnostic criteria are not a "one size fits all" set of symptoms but instead represent generalized symptoms that may or may not be present. Participants reported that when the client showed significant

signs of suffering from PTSD, they worked toward uncovering specific symptoms to justify a PTSD diagnosis.

Participants reported that they felt that their education and experience had provided them with a keen intuition into client presentations. This experience has been reflected and validated in clinical research. Brammer (2002), for example, concluded that clinical experience is a strong predictor of diagnostic accuracy versus simply following diagnostic criteria. The majority of participants agreed that their years in practice have given them highly developed clinical instincts into psychological diagnoses, resulting in relying less on structured diagnostic criteria like the *DSM*. The majority of participants in this study believed that their intuition regarding client symptoms, brought forth through the diagnostic interview process, is the key component in assessment for PTSD**.** The diagnostic interview "explores the presenting complaint(s) (i.e. referral question), informs understanding of the case history, aids in the development of hypotheses to be examined in the assessment process, and assists in determination of methods to address the hypotheses through formal testing" (National Center for Biotechnical Information, 2015, para. 4). This conclusion contradicts the beliefs of some researchers, who have stated that clinicians who rely on clinical interviews to assess clients are not addressing the critical constructs of the diagnostic criteria (North, Suris, Smith, & King, 2016). However, it is important to keep in mind that objective tests such as the Clinician-Administered PTSD Scale for *DSM-5* Clinician Training and the Life Events Checklist for *DSM-5*, which are commonly used tools to assess for PTSD, are self-report measures that do not assess client behavior, affect, tone of voice, or body language, among other factors. As such,

these tools may miss critical aspects of a client's presentation. The clinical interview and its results therefore provide the clinician with the information necessary to determine which additional assessment tools are the best fit for each client presentation (National Center for Biotechnical Information, 2015). Ultimately, the role of clinician intuition in guiding the diagnostic process cannot be overstated, and it figured into the participants' responses regarding the changes in the criteria for a diagnosis of PTSD in the *DSM-5*.

Criterion A (precipitating event and proximity to it). Most participants agreed with the PTSD diagnostic criteria that were unchanged between the *DSM-IV* and the *DSM-5*. All participants agreed with the requirement that there be a precipitating event prior to the development of symptoms. Furthermore, most believed that the development of symptoms may occur due to an individual experiencing a single traumatic event or due to the individual experiencing multiple traumatic events. Research into the role of a traumatic precipitating event appears to support the participants' experiences. Yehuda et al. (2015) found that posttraumatic symptom development may vary, based on an individual's genetic and psychosocial makeup as well as the magnitude of the precipitating event. Participants in this research also emphasized that trauma is subjective and that, in similar circumstances, an event may adversely affect one individual and not another.

Most participants stated that they disagreed with Criteria A1, A2, and A3, in which the individual must directly experience the traumatic event in person, or if the traumatic event occurred to a close friend or family member it must be violent or accidental. The majority of participants emphasized their belief that an individual can be

traumatized by an event even if he or she is not physically present. They stated that individuals may be affected by trauma experienced through a variety of ways, including seeing it on television, hearing about it from loved ones, and even through a shared heritage (for example, Jewish people may experience symptoms due to the horrific trauma experienced by Jews in World War II).

McNally (2009) stated that one reason the *DSM-5* Work Group revised Criterion A was the overuse of the PTSD diagnosis after the attacks on September 11, 2001. The diagnostic criteria for PTSD in the *DSM-IV* classified those who qualified for the PTSD diagnosis into one of three categories: (a) those who were personally in danger; (b) those who witnessed others in danger; and (c) those who were exposed to a traumatic event through other means, including through the media (television, Internet, etc.) (Schlenger et al, 2002).

Those in favor of limiting the diagnostic criteria for PTSD to exclude those who witness trauma through secondary sources (such as through the media) argued that to place those who directly suffered trauma in the same category as those who simply witnessed it through the media minimizes the importance of the PTSD diagnosis (Andreason, 2004; Friedman et al., 2011; McNally, 2009). Additionally, the work group charged with revising the PTSD diagnostic criteria in the *DSM-5* reportedly considered the elimination of Criteria A1 altogether, as they "understood that whereas exposure to an A1 event is a necessary condition for the development of PTSD, it is clearly not a sufficient condition, because most A1-exposed individuals do not develop the disorder" (Friedman, 2013a, p. 550). Ultimately, the *DSM-5* Work Group decided to keep Criterion

A1 but attempted to prevent misuse of the diagnosis by removing individuals who are exposed to trauma through the media (APA, 2013).

Notably, participant reports regarding the impact of secondary trauma are supported by research. Freyberg (1980), in his research on Holocaust survivors, found that it was not the actual retelling of the holocaust survivor's trauma that negatively affected others, but that the survivor's subjective emotional response to the trauma created symptoms in those around them. Therefore, although the diagnostic criteria may include a limited group of trauma survivors, it may ultimately be the subjective response of the individual that experienced the trauma, rather than a specific set of traumatic event criteria, that may lead to the development of PTSD.

Similarly, most participants disagreed with Criterion A3, which states that if the traumatic event happened to a close friend or family member, it must be violent or accidental. Participants assert that trauma is subjective and that what may be characterized as a traumatic experience for one individual may not be traumatic for another. This conclusion is supported by research. Dörfel, Rabe, and Karl (2008) found that factors such as personality type and an individual's general coping style may impact whether an individual develops PTSD, rather than the specifics of the trauma itself. Creamer, McFarlane, and Burgess (2005) found that the subjective experience of the individual experiencing the trauma and his or her emotional response to the traumatic event were associated with whether or not that individual developed full-blown PTSD. Anders, Frazier, & Frankfurt (2011) found that stressful life events such as serious financial problems or serious relationship issues may be as likely to cause PTSD

symptoms as a life-threatening event might. These findings appear to be supported by the participants in this research as well.

Contrary to the majority of participants in this research and to the research cited above, other researchers have found that the presence of a violent traumatic event, versus a nonviolent traumatic event, to be predictive of the development of PTSD symptoms and depression (Kaltman & Bonanno, 2003). Kaltman and Bonanno (2003) found that individuals whose spouses died a violent death were more likely to experience PTSD symptoms and depression over those whose spouses died a nonviolent death. Other researchers stated that the inclusion of diagnostic criteria that includes indirect traumatic experiences to close friends or relatives is inconsistent with the definition of trauma for the diagnosis of PTSD (North et al., 2016). These researchers stated that the definition of trauma continues to be ambiguous in the *DSM-5* and that the current definition is too inclusive, rather than exclusive, as most participants in this research believe (North et al., 2016). The *DSM-5* defines *violent and/or accidental* experiences as "violent personal assault, suicide, serious accident, and serious injury" (APA, 2013, p. 274). Natural death does not qualify; therefore, if a couple is walking down the street and one of them suddenly collapses and dies from an undiagnosed brain aneurysm, that event would not qualify as a precipitating event under the current Criteria A in the PTSD diagnostic criteria (APA, 2013).

Individuals who do not meet the *DSM-5* criteria for PTSD may qualify for a diagnosis of adjustment disorder (AD), which includes the development of emotional or behavioral symptoms in response to a stressor, arises within 3 months of the stressor, and

"lasts no longer than 6 months after the stressor or its consequences cease" (APA, 2013, p. 287). The emotional or behavioral symptoms must be deemed "out of proportion to the severity or intensity of the stressor" (APA, 2013, p. 286). Strain and Friedman (2014) state that the diagnosis of AD in the *DSM-5* is unique in the newest edition of the *DSM* because, "the very nonspecificity of the AD diagnosis provides great clinical utility because it provides a placement for significant clinical states that do not conform to another *DSM-5* diagnosis, but are of sufficient severity to qualify as a psychiatric disorder" (p. 519). Additionally, Strain and Friedman stated that due to the fact that there are no specific designated assessment tools or itemized symptoms for AD, the onus for diagnosis is dependent upon the subjective assessment of the clinician. As the debate about the most useful definition of trauma continues, it appears as though further research into the topic might be beneficial in addressing this issue.

Participants overwhelmingly agreed that the removal of Criterion A2, the requirement that the individual express an emotional reaction at the time of the trauma, is a positive change to the diagnostic criteria. As Friedman et al. (2011) noted, first responders, members of the military, and others who are trained to work within a traumatic environment may not express fear at the time of the trauma, yet they may go on to display symptoms of PTSD at a later date. The authors explained that military personnel and first responders are highly trained to set their personal feelings aside when assisting in an emergency and may not express the fear, horror, or helplessness that may be more common for other trauma survivors. The participants in this current study stated that the removal of the requirement for an individual to experience fear, helplessness, or

horror at the time of the trauma and the recognition that dissociation might restrict an individual's emotional response (Rizvi, Kaysen, Gutner, Griffen, & Resick, 2008) have broadened the diagnostic criteria.

The removal of the DSM's criterion that individuals experience fear, helplessness or horror at the time of the traumatic event to qualify for a diagnosis of PTSD has been supported by research (Brewin et al., 2000). Breslau and Kessler (2001) found that the predictive value of an individual experiencing an intense emotional response at the time a traumatic event occurs appears to be minimal in predicting the occurrence of PTSD. The results of their research included the finding that those who exhibited helplessness or horror at the time of the trauma were not significantly more likely to develop full PTSD symptomology over those who did not exhibit these strong emotions at the time of the traumatic event. Individuals must no longer experience these strong emotions when the trauma occurs in order to qualify for a PTSD diagnosis, and the participants in this study stated that this change in criteria reflects what they see in their own practice.

In summary, the participants in this research expressed the most criticism for Criterion A over any other change to the PTSD diagnostic criteria. This criticism is shared by researchers, who have found that the diagnostic changes regarding Criterion A resulted in a 60% decrease in the number of individuals that qualified for a PTSD diagnosis due to the *DSM-5* requirement that for those who witness death, the death must be violent or accidental (Kilpatrick et al., 2013). Some individuals may attempt to abuse a PTSD diagnosis to avoid criminal punishment or for financial gain through civil court procedures (Young, 2017); therefore, the *DSM-5* work group attempted to narrow the

definition of a traumatic experience (Pai, Suris, & North, 2017). However, participants in this research were passionate in their insistence that trauma is subjective and that the restrictions presented in Criterion A were not appropriate.

Criterion B (intrusion symptoms). Participants agreed with many of the diagnostic criteria that remain unchanged between the *DSM-IV* and the *DSM-5*. For example, Criterion B (intrusion symptoms), which has continued unchanged, has been a common symptom found in those presenting with PTSD (Weiss, Tull, Anestis, & Gratz, 2013). Additionally, the dissociative reactions described in Criterion B.3 were reported by the clinicians as a common presentation in their practice for those who suffer from PTSD. Criterion B.4 and Criterion B.5, whereby an individual may express psychological or physiological distress in reaction to internal or external cues that resemble an aspect of the traumatic event, were also unchanged between the *DSM-IV* and the *DSM-5*; therefore, participants did not comment on those criteria. Given that Criterion B was unchanged between the *DSM-IV* and the *DSM-5*, I did not ask participants specific questions about it. Additionally, participants did not comment upon Criterion B in their individual interviews or provide additional comments this criterion during the member checking process. This result led the researcher to conclude that the participants do not object to the decision to leave Criterion B unchanged in the *DSM-IV* and the *DSM-5*.

Criterion C (avoidance symptoms). Many participants in this research supported Criterion C, whereby individuals must display at least one avoidance-type symptom. Participants overwhelmingly agreed that avoidance and dissociative symptoms are quite common in those experiencing PTSD. Research into the use of avoidance as a defense

mechanism after a traumatic experience has revealed that individuals who utilize avoidance to cope with traumatic memories are likely to develop more severe PTSD symptoms overall than those who use defense mechanisms other than avoidance to cope (Leiner, Kearns, Jackson, Astin, & Rothbaum, 2012). The identification of avoidance as a coping mechanism after a traumatic experience therefore appears to be an important part of identifying and providing treatment for individuals presenting with PTSD.

Criterion D (negative alterations in cognitions and mood). Participants in this study also appreciated the changes to Criterion D. Criterion D (negative alterations in cognitions and mood) includes an inability to remember important aspects of the event, persistent negative beliefs about self or the world, distorted cognitions about the cause or consequence of the traumatic event, and a persistent negative emotional state. Additionally, Criterion D includes diminished interest in significant activities, feeling detached from others, and a persistent inability to experience positive emotions. Participants stated that they agreed with this addition and that symptoms listed are commonly found in those presenting with PTSD in their practice. This finding is supported by other research as well (Contractor et al., 2015). Morina et al. (2013) found a statistically significant association between major depressive disorder (MDD) symptoms and PTSD symptoms in individuals who experienced at least one war-related traumatic event that may be regarded as qualifying for the stressor required to meet Criterion A1 in the *DSM-IV*. Their research found that individuals that met the criteria for PTSD also met the criteria for MDD.

Participants expressed their approval of the addition of Criterion D, stating that these are common reactions to a traumatic event and may be indicative of PTSD rather than depression. The *DSM-5* Anxiety and Dissociative Disorders Work Group developed Criterion D to include changes in mood or perception that began after the traumatic event (Friedman, 2013). Participants stated that the new diagnostic criteria for PTSD encompasses the negative mood that frequently accompanies other symptoms of PTSD, and therefore, clinicians may not feel compelled to address negative mood symptomology with a depression diagnosis secondary to PTSD. The results of the research conducted by Morina et al. (2013) as well as the results of this research appear to support the addition of depression-type symptoms to the *DSM-5* diagnostic criteria for PTSD.

Dissociative subtype. Participants stated that the addition of the dissociative subtype for PTSD was a necessary change to the PTSD criteria. The participants believed that most of the individuals they have seen presenting with PTSD symptomology in their clinical practice show signs of dissociation. Research into dissociation related to PTSD has supported the importance of a distinction between individuals who have dissociated versus those who have not (Armour, Karstoft, & Richardson, 2014). In their research with Canadian military veterans, Armour et al. (2014) found that the majority reported symptoms that met the threshold for dissociation in addition to meeting the criteria for PTSD. Additionally, Felmingham et al. (2008) showed that individuals with the dissociative subtype of PTSD experience overactive activation of the prefrontal cortex when completing fear-related tasks, in contrast to individuals without the dissociative subtype of PTSD. Distinct differences appear to exist between individuals who present

with symptoms of dissociation and those who do not, which may require a different treatment approach. Research conducted by Hansen, Ross, and Armour (2017) supports this conclusion as well. In a systematic review of literature on the dissociative construct for the new PTSD diagnostic criteria, 10 of the 11 samples supported the use of a dissociative subtype. The distinction between those who present with the dissociative subtype and those who do not present with this subtype appears to be an important addition to the *DSM-5* diagnostic criteria for PTSD, particularly when developing treatment plans for patients.

Dorahy and van der Hart (2015) discussed research into the prevalence of dissociation for those presenting with PTSD. After carefully reviewing research regarding trauma, dissociation, and PTSD, the authors stated that dissociation is far more prevalent in those who suffer from PTSD than the diagnostic criteria suggests. They posited that all individuals with PTSD suffer from some type of dissociation and that dissociation should play a larger role in the diagnostic criteria for PTSD in the *DSM-5*. Some participants in the current study reported that the addition of the dissociative subtype gave them greater latitude in making a PTSD diagnosis, as a lack of symptomology in a client may be due to the client's dissociation at the time of the trauma, blunting his or her affect. Additionally, the addition of the dissociative subtype has influenced the manner in which these clinicians conduct assessments for PTSD, as they now actively seek symptoms of dissociation in clients who present with the potential for a PTSD diagnosis.

Diagnostic criteria for children. Participants who work with children stated that the distinction between children and adults is a valuable addition to the PTSD diagnostic criteria in the *DSM-5*. Pynoos et al. (2009) advocated for this developmental supplement to the PTSD diagnostic criteria, as an individual's level of physical, mental and psychosocial development may play a key role in the development of psychopathology. For example, considerable variability may be found in the perception of a traumatic experience based solely on the individuals' ages, as an adult may have greater ability than a child does for understanding the wider repercussions of a traumatic event. Additionally, adults may be better able to communicate their thoughts and feelings more effectively than children can (Pynoos et al., 2009). These developmental factors may be significant, thus warranting the separate diagnostic criteria included in the PTSD diagnostic criteria in the *DSM-5*.

Many participants appreciated the addition of separate criteria for children age 6 and younger, and clinicians who typically work with children stated that children might express symptomology in a manner very different than adults. For example, participants reported that prior to the revised diagnostic criteria, a child who displayed irritability or angry outbursts might have been given a diagnosis of a mood or behavioral disorder, when the symptomology was actually an expression of PTSD. Clinicians who work with children reported experiencing the addition of diagnostic criteria for children as providing greater clarity for them in their clinical practice.

Although many researchers have advocated the inclusion of a separate set of PTSD diagnostic criteria for children, some believe that the diagnostic criteria changes do

not go far enough in addressing developmental differences. Scheeringa, Zeana, and Cohen (2011) revealed that their research led them to the conclusion that the *DSM-5* diagnostic criteria for PTSD should not only distinguish children from adults but also distinguish preschool-aged children from school-aged children. Specifically, the researchers found that the Cluster C (avoidance/numbing symptoms) threshold should be lowered for all children, especially for preschool-aged children. They observed that children might not express avoidance or numbing symptoms to the same degree as adults; the diagnostic criteria now reflect this. Perhaps, as researchers become more aware of the developmental differences that may influence the development of PTSD, future editions of the *DSM* will break down the diagnostic criteria further by separating preschool-aged children from school-aged children.

Research Question 2: Diagnostic Tools

The second research question explored how the new diagnostic criteria affected the participants' use of diagnostic tools. The majority of participants reported that they had not made changes in their use of diagnostic tools since the change to the PTSD diagnostic criteria. This response was common among clinicians who use an interview process to conduct assessments rather than using formal diagnostic tools. Alternatively, those who reported using diagnostic tools in their diagnostic process stated that they now might use a dissociation checklist if they believe that the client presents with symptoms of dissociation. Because many participants were trained in EMDR, they were already using the Dissociative Experiences Scale (DES) (Bernstein and Putnam, 1986), which screens clients for dissociative disorders, prior to the changes to the PTSD diagnostic

criteria in the *DSM-5*. Participants not trained in EMDR reported that the addition of the dissociative subtype had made them more aware of the possibility that clients may have symptoms of dissociation and that they might not deviate from their previous methods of assessment unless they felt it necessary to conduct a formal assessment for dissociative symptoms. However, those trained in EMDR were already capable of assessing for dissociation in clients who have experienced a traumatic experience, a skill they employ prior to the commencement of EMDR therapy, as EMDR therapy may destabilize a dissociative client (F. Shapiro, 2001). Participants who utilize EMDR therapy reported that the addition of the dissociative subtype only validated their assessment protocol.

A source of frustration for several participants, however, was the experience that diagnostic tools were not in alignment with the new diagnostic criteria until at least a year after the *DSM-5* was released. Participants in structured mental health facilities such as veterans' hospitals and community mental health centers expressed that it was difficult to justify and document diagnoses due to a delay in updating diagnostic tools.

Research Question 3: Treatment Interventions

The third research question explored how the new diagnostic criteria affect psychotherapists' use of interventions. Most participants stated that there was no change in their treatment planning since the changes to the PTSD diagnostic criteria in the *DSM-5*. Participants reported that they continued to use the same treatment planning methods as they had prior to the diagnostic changes. Several participants, however, stated that due to their training in (EMDR), they were more likely to include EMDR therapy in their treatment planning. EMDR placed an emphasis upon the potential for dissociation prior

to the diagnostic changes for PTSD in the *DSM-5* (F. Shapiro, 2001), and several participants stated that the addition of the dissociative subtype to the diagnostic criteria further emphasized their belief that EMDR therapy is an appropriate fit for treatment for PTSD.

Participants who reported changes in treatment planning reported changes in interventions. The addition of the dissociative subtype has increased the likelihood that a clinician may include clinical interventions such as grounding techniques to address dissociative symptoms. EMDR therapy was also mentioned by the participants multiple times as the therapy of choice for individuals presenting with PTSD. The successful use of EMDR to treat symptoms of PTSD has been supported through extensive research. Power et al. (2002) found that EMDR was more successful at treating the depression symptoms that accompany PTSD than cognitive restructuring and that fewer treatment sessions were required. Similarly, Ironson, Freund, Strauss, and Williams (2002) found that in a community-based study of two treatments for symptoms developed after traumatic stress, 70% of EMDR participants reported positive outcomes after three treatment sessions, whereas only 29% of participants reported positive outcomes after three treatment sessions. Studies have shown that EMDR has consistently provided successful treatment for symptoms developed after individuals experience a traumatic event, and the participants of this research report the same results in their own practices.

Research Question 4: Billing/Insurance Claims

The fourth research question explored how the new diagnostic criteria affected psychotherapists' billings or use of insurance claims. The majority of participants

reported that they had not experienced changes in their use of insurance claims (filing claims, collecting on claims, coding claims, etc.). Many participants reported that they do not accept insurance or that they are not responsible for filing insurance claims and therefore could not provide information on that particular question. Other participants stated that due to parity laws in their state, which require that insurance companies provide coverage for mental health issues in the same manner in which they would cover physical health issues, they did not experience changes in reimbursement by insurance companies. However, some participants stated that completing insurance claims has become more difficult, as the delay of the release of ICD-10 created a discrepancy between the *DSM-5* codes and the ICD-10 codes, which made billing confusing. Participants also reported spending additional time on the phone consulting with insurance companies regarding how to file claims that include the new PTSD diagnostic criteria, as they wanted to help a client receive the coverage needed for the required treatment. Only one participant reported that insurance billing was easier, as he or she appreciated that she no longer had to provide a rationale to the insurance company explaining the client's lack of fear, horror, and other reactions at the time of the trauma.

Limitations of the Study

Every research study presents with limitations, and this study was no exception. I identified six limitations in this study. The first limitation is related to whether or not participants were forthcoming in their responses. Two participants expressed concern that the APA may be able to identify them and therefore become aware of any criticism that the participant may have about the new diagnostic criteria. Although the clinicians were

assured that their participation was confidential, the fact that some were fearful of any repercussions due to any potentially critical responses regarding the new diagnostic criteria may have influenced their responses. Some participants may have been hesitant to provide critical feedback regarding their experiences with the new diagnostic criteria for PTSD and therefore withheld their true feelings.

A second limitation is the fact that many participants in this research were proficient in EMDR therapy. Although EMDR is a very effective and commonly utilized treatment for PTSD, the fact that the majority of participants utilize EMDR therapy in their treatment plans may have had an impact on their individual experiences with the new diagnostic criteria. Perhaps participants who are not proficient in EMDR therapy would have a different experience.

A third limitation is the fact that the majority of participants were Caucasian, middle-aged females. I accepted qualified participants as they contacted me, regardless of their demographic background, and it is possible that clinicians from varying backgrounds would have reported different results.

A fourth limitation is that participants represented four groups of licensed mental health professionals: Licensed Marriage and Family Therapists, Licensed Clinical Professional Counselors, Licensed Psychologists, and Licensed Clinical Social Workers. I was not contacted by potential participants with other types of mental health licensure, such as psychiatrists. It is possible that professionals with different types of licensure other than those who volunteered for participation would have a different experience than the participants, thus yielding different results.

A fifth limitation is my lack of experience in interviewing participants. As I reviewed data, I realized that I might have been overly conservative in adhering to the script I had developed. I was concerned that I might inadvertently influence participant responses and therefore stuck to the script. In retrospect, I believe that I may have been better able to gather information had I allowed myself to ask more follow-up questions during the participant interviews. With more follow-up questions during interactions with participants, I may have been able to increase the depth of my interview. It is unclear whether my determination to follow the script acted as a limitation in this research, but it may have influenced my ability to elicit more specific information.

A sixth limitation may be the fact that two interviews were conducted by phone rather than in person. Although the interviews were conducted in a manner consistent with other participant interviews, the fact that I did not have the ability to witness these participants' facial expressions or body language may be considered a limitation. It is possible that the participants expressed confusion, provided facial expressions or body language that punctuated their speech, or expressed other behaviors that may have affected the interview and the data collection process. In-person interviews were preferred; however, due to the national sample of participants, this option was not always feasible.

Although the above limitations were present in the research study, significant patterns were discovered. Based on these findings, important recommendations for future changes to diagnostic criteria in the *DSM* may be made, providing valuable insight.

Recommendations

Based upon the experiences of the participants in this research study, several recommendations are suggested. First, the participants overwhelmingly endorsed the concept that trauma is subjective and that an event may be traumatizing to one person yet not to another. Specifically, the majority of participants expressed disagreement with Criterion A, in which the definition for a traumatic event has been narrowed significantly. In addition to the requirement that an individual experience a specific type of trauma, the criterion also requires that the individual must have had a qualifying exposure to the trauma (North et al., 2016). Future research might focus on a quantitative survey regarding Criteria A1-A4, utilizing a larger group of clinicians. Based upon the results with this limited group of clinicians, the appropriate definition of a qualifying trauma, and the type of exposure one has to that trauma, responses may differ wildly between researchers and clinicians. A quantitative study on this topic with a larger group of clinicians could provide valuable insight to researchers working to develop the next version of the *DSM*.

Secondly, consistent throughout participants' responses was the concept that experienced clinicians know PTSD when they see it. Many participants reported that their intuition tells them whether a client is experiencing PTSD and that they tailor their assessment to uncover the symptoms. The importance of a set of criteria to assess for specific mental disorders is apparent: Without a specific set of criteria, clinicians may not have consistent and reliable diagnoses on which to focus (APA, 2017). Additionally, without clear guidelines for diagnosis, clinicians may not have the common language

necessary to communicate regarding specific diagnoses. Research into clinician intuition regarding appropriate diagnoses for clients versus the sole use of diagnostic tools to diagnose clients may provide additional insight into the value of clinician intuition in relation to diagnosis.

Thirdly, participants reported experiencing issues with the timing of the release of the new *DSM-5* diagnostic criteria in relation to the release of the ICD codes and diagnostic tools. Participants reported that the diagnostic tools and ICD codes were not updated to reflect the new diagnostic criteria at the time the *DSM-5* was released, thus complicating the diagnostic process. I recommend that for future revisions of the *DSM*, the release of the manual be in sync with the release of updated diagnostic tools and a current edition of the ICD. Consistency between the *DSM*, the ICD codes, and diagnostic tools may reduce the frustration reported by participants when diagnostic criteria for a mental disorder changes.

Finally, participants stated that they appreciated the development of specific criteria for children under age 6. Participants who work with children had found that children express PTSD symptoms quite differently from adults and believed that the creation of separate diagnostic criteria for them was a positive addition. Based upon the success of this addition, one cannot help but wonder what other groups may benefit from specific diagnostic criteria. Perhaps gender, ethnicity, or other age groups, for example, could benefit from specific criteria for PTSD tailored specifically to their unique expression of the disorder. It may be helpful to conduct future research into other groups that might benefit from diagnostic criteria tailored to their specific needs.

Significance and Implications of the Study for Social Change

The impact of PTSD on society is significant. The issues related to untreated PTSD include the development of other psychiatric disorders, substance abuse, suicide ideation, relationship problems, job loss, and conflict with law enforcement, in addition to the personal distress of the individual subjected to the trauma (Alvarez et al., 2011). Significant health problems have also been associated with individuals experiencing the symptoms of PTSD. These risks may be minimized with successful treatment for the disorder; however, successful treatment is dependent upon accurate diagnosis and treatment. Ultimately, accurate diagnosis is dependent upon the most efficacious definition of trauma in the *DSM*. The insights garnered from this study as well as the recommended future research may provide valuable information to aid in the development of future diagnostic criteria for PTSD in the *DSM*.

Conclusion

The release of the revised diagnostic criteria for PTSD in the *DSM-5* has created controversy among mental health clinicians in the United States (Friedman, 2013; Horesh, 2016). The most recent diagnostic criteria for PTSD removes the disorder from its previous classification as an anxiety disorder and creates a new category titled *trauma and stressor-related disorders* (APA, 2013). Additionally, the new PTSD diagnostic criteria include the exclusion of events that were previously considered traumatic in the *DSM-IV*. With the removal of Criterion A2, the diagnosis no longer requires that the individual experience fear, helplessness, or horror at the time of the traumatic incident, and a dissociative subtype and diagnostic criteria for children have been added (APA,

2013). Results of this study include overall participant appreciation of the removal of Criterion A2, overwhelming agreement with the addition of the dissociative subtype, and the endorsement of the addition of diagnostic criteria for children by clinicians that work with children. However, the most significant results of this research may be the participants' opinions regarding the changes to the definition of trauma, specifically regarding the type of exposure required for a PTSD diagnosis (Criterion A). Based on the qualitative results from this research, it may be beneficial to conduct future research into the definition of trauma, addressing the discrepancy between clinician experiences with clients and the definition of trauma in the *DSM*.

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Appendix A: Interview Questions

1. Tell me how you experience the changes in the *DSM-5* diagnostic criteria for PTSD:

1a. What have you noticed?

1b. What has been similar between the diagnostic criteria from *DSM-IV* and *DSM-V*?

1c. What changes have you observed in the diagnosis of PTSD?

2. How have the changes in criteria changed the likelihood that you would diagnosis someone with PTSD?

3. As you know, the change in 1.1 and A1.2 now requires an individual to experience a traumatic event directly. How have you experienced this change in working with clients?

4. What changes have you experienced in working with clients since the change in Criterion A1.3, in which individuals who learn of close family or friends who experienced actual or threatened death, it must be violent or accidental?

5. How has the change to Criterion A2, in which the individual no longer must respond with intense fear, helplessness, or horror, affected your assessment process, treatment planning, or insurance billing?

6. What changes have you experienced in working with clients since the addition to Criterion D, "distorted blame of self or others for causing the traumatic event"?

7. As you know, the new diagnostic criteria include the addition to Criterion D, the "persistent (and often distorted) negative beliefs and expectations about oneself or the world." What changes have you experienced in working with clients since this addition?

8. What changes have you experienced when using diagnostic tools (for example, tests) to assist in diagnosing PTSD in clients since the changes in diagnostic criteria for PTSD?

9. How have the changes in the diagnostic criteria for PTSD in *DSM-5* changed your treatment planning process?

10. How have the changes in the diagnostic criteria for PTSD in *DSM-5* changed your use of interventions?

11. As you know, the new diagnostic criteria for PTSD has removed the specifiers of "acute" or chronic" in the diagnostic criteria. What changes have you experienced in the diagnosis or treatment of PTSD related this change?

12. As you know, the new diagnostic criteria for PTSD include the addition of a dissociative subtype. What changes have you experienced in the diagnosis of PTSD since this addition to the diagnostic criteria in *DSM-5*?

13. What changes have you experienced in the treatment of PTSD since the addition of the dissociative subtype to the diagnostic criteria in *DSM-5*?

14. What changes have you experienced with completing, submitting and receiving reimbursement on insurance claims since the changes to the PTSD diagnostic criteria in *DSM-5*?

15. Overall, how have the changes to the PTSD diagnostic criteria in *DSM-5* changed your diagnostic process, use of diagnostic tools, treatment planning and use of insurance for reimbursement?

16. Do you have additional comments? Do you have any questions?

Appendix B: Participant Solicitation Flyer

VOLUNTEERS WANTED FOR A RESEARCH STUDY

HOW DO CLINICIANS EXPERIENCE UTILIZING THE DIAGNOSTIC CRITERIA FOR PTSD IN *DSM-5*?

Are you a licensed mental health provider currently utilizing the revised diagnostic criteria for PTSD in *DSM-5*? I am conducting a research study about how clinicians are experiencing the new PTSD diagnostic criteria, and I am looking for your input! This research is part of a doctoral dissertation, and participants must be licensed mental health practitioners. Research has obtained Institutional Review Approval from Walden University, my educational institution. Your participation includes completion of a short demographics survey and a phone or face-to-face interview, which should take approximately 1 hour.

Participation is confidential, and your input may assist in understanding the impact of the revised PTSD diagnostic criteria in the *DSM-5*.

Research is conducted by Linda Jacobus, LMFT, LPCC.

To be a part of this research, please send your name, phone number, and email address to Linda Jacobus at xxxxxxxxxxxx.

Appendix D: Demographics Questionnaire

1) Ethnic Self-Identification?

2) Gender

3) Years in Practice

4) Category of License: Please Indicate by Underlining License Type

Marriage and Family Therapy (MFT) Licensed Clinical Social Worker (LCSW)

Licensed Educational Psychologist (LEP) Licensed Psychologist (LP)

Other

5) Primary Practice setting: Please Indicate by Underlining Type

Private Practice State/Federal Agency County/Municipal Agency

Nonprofit/Charitable

Licensed Health Care Facility College or University School (education setting)

Other

6) Specialty Certifications (Please List)

7) Do you accept insurance? Which companies?

8) Primary Theoretical Orientation: Please Indicate by Underlining

Systems Cognitive Cognitive/ Behavioral Behavioral

Humanistic Psychodynamic Solution Focused

Please send to xxxxxxxxxxxx **when the form has been completed.**

Thank you for your assistance in this important research!