

Trauma Redefined in the *DSM-5*: Rationale and Implications for Counseling Practice



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Trauma survivors are a unique population of clients that represent nearly 80% of clients at mental health clinics and require specialized knowledge on behalf of counselors. Researchers and trauma theorists agree that, with the exception of dissociative identity disorder, no other diagnostic condition in the history of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* has created more controversy with respect to the boundaries of the condition, diagnostic criteria, central assumptions and clinical utility than post-traumatic stress disorder. However, this mutable conceptualization of trauma and its aftermath have considerable implications for counseling practice. With the recently released fifth edition of the *DSM (DSM-5)*, the definition of trauma and the diagnostic criteria for post-traumatic stress disorder have changed considerably. This article highlights the changing conceptualization of trauma and how the *DSM-5* definition impacts effective practices for assessing, conceptualizing and treating traumatized clients.

Keywords: trauma, post-traumatic stress disorder, PTSD, *DSM-5*, diagnostic, clinical utility

Nearly 80% of clients seen in community mental health clinics have experienced at least one incident of trauma during their lifetime, representing roughly five out of every six clients (Breslau & Kessler, 2001). Over the past 15 years, between increases in school and community violence in the United States and unrelenting wars overseas, overt exposure to traumatic events has become an epidemic. Such events affect individuals across the life span and precipitate numerous diagnoses within the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, most notably post-traumatic stress disorder (PTSD; Breslau & Kessler, 2001).

Survivors of trauma are a unique population of clients who require specialized knowledge and multifaceted considerations on behalf of counselors (Briere & Scott, 2006). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) reiterates across both master's and doctoral training levels the importance of understanding the implications of trauma theory, research and practice in counselor preparation and ultimately practice. CACREP (2009) standards incorporate trauma training within all eight core curricular areas of demonstrated knowledge and within each core counseling track. Section II, *Professional Identity*, says that counselors should understand the "effects of ... trauma-causing events on persons of all ages" (CACREP, 2009, p. 10). However, even with the notable rates of trauma exposure, the deleterious outcomes faced by survivors and the call for counselor training in this area, counselors report feeling unprepared to work with survivors (Parker & Henfield, 2012). Over 60% of practicing therapists reported wanting additional support and education in their trauma work (Cook, Dinnen, Rehman, Bufka, & Courtois, 2011).

Trauma theorists agree that, with the exception of dissociative identity disorder, no other diagnostic condition in the history of the *DSM* has created more controversy about boundaries of the condition, symptomatological profile, central assumptions, clinical utility and prevalence than PTSD (Brewin, Lanius, Novac, Schnyder, &

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Galea, 2009). Changing definitions and the rationale for such shifts have significant implications for counselors. The fifth edition of the *DSM (DSM-5)*, released in May 2013 (American Psychiatric Association [APA], 2013a), contains substantial changes, including the reorganization of “Trauma- and Stressor-Related Disorders” (TSRDs) into a new category and chapter distinct from “Anxiety Disorders,” the restructuring of factors, the modification of symptoms and specifiers, and the addition of a new subtype of PTSD in children.

The highly debated and variable definition of trauma and the diagnostic criteria for psychological responses to traumatic events may contribute to low counselor efficacy in trauma practice. Without a clear understanding of the latest views and requirements for trauma diagnosis using *DSM-5*, counselors may feel tentative about assessing for trauma and selecting efficacious interventions. This manuscript explores the changing definitions of trauma over time, implications of such changes on counseling practice and areas of needed growth and research. While this article’s core focus is on PTSD, we also briefly describe other TSRDs. By outlining *DSM-5* changes, reviewing recent research substantiating such modifications and providing practical suggestions for practitioners, we hope to mitigate confusion and enhance efficacy in counselors working with trauma clients during this crucial diagnostic transition.

History of Trauma

Derived from the Greek word for “wound,” tales of trauma and the its profound consequences thereof date back to writings in antiquity. Only in the late 19th century did Pierre Janet and Sigmund Freud provide the first writings on the characterizations and clinical implications of traumatic events. In the mid-1890s, both practitioners developed similar theories of the etiology of hysteria, namely experiences of psychological trauma, particularly sexual trauma (Herman, 1992a). The theories presented in Freud’s *The Aetiology of Hysteria* (1962), however, were met with vehement contention, and such censoring stifled potential ramifications of his discoveries. Consequently, contemporary theories and definitions of trauma became largely fashioned from studies of male soldiers’ reactions to the horrors of war. Investigations of traumatic stress and apposite interventions for survivors emerged following World War I, purportedly as a means of rehabilitating soldiers for redeployment (van der Kolk, 2007). This attention waned during times of peace, but took command of the mental health research and literature during the Vietnam War. Concurrently, marked attention again became drawn to the consequences of sexual and domestic violence against women and children owing to the Women’s Movement (Herman, 1992a).

The examination of traumatic responses on both fronts (i.e., combat and interpersonal violence) led to the inclusion of a distinct PTSD diagnosis in the third edition of the *DSM (DSM-III; APA, 1980)*. Previous iterations of the *DSM* recognized reactions to stressful experiences as a “transient situational disturbance,” suggesting that without an underlying psychological condition, the individual’s psychological experiences would wane as the stressor subsided (Yehuda & Bierer, 2009). However, the *DSM-III* classified trauma as an event existing “outside the range of usual human experience” (APA, 1980, p. 236) and provided legitimization for the potential pervasive and deleterious effects of exposure. As research continues, however, both the definitions of what constitutes a traumatic experience and what characterizes the symptoms of PTSD have rapidly transformed.

The publications of the *DSM-IV* and *DSM-IV-TR* brought a considerably more inclusive definition of trauma (APA, 1994, 2000). Varied events as a car accident, a natural disaster, learning about a death of a loved one, and even a particularly difficult divorce were considered variations of traumatic experience. This expanded definition engendered a 59% increase in trauma diagnoses (Breslau & Kessler, 2001). Modern trauma theory conceptualizes trauma and traumatic responses as occurring along a continuum (Breslau & Kessler, 2001), with researchers elucidating the importance of differentiating between traumatic experiences when investigating the

etiology, physiological responses, course and efficacious therapeutic interventions for the range of potential traumatic responses (Breslau & Kessler, 2001; Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009). The unique consequences of these diverse populations may be obscured if survivors of disparate populations are combined in research or excluded from trauma definitions altogether.

Primary Challenges to the *DSM-IV-TR*

The 13 years between the *DSM-IV-TR* (2000) and the *DSM-5* (2013a) engendered considerable debate regarding how trauma was defined and the core criteria of PTSD. In the *DSM-IV-TR*, the presence of at least six symptoms (out of 17) distributed among three core symptom clusters served as a basis for diagnosing PTSD. This three-factor model stipulated that following a traumatic event, which induced fear, helplessness or horror, a survivor must experience at least one symptom of persistent re-experiencing (criterion B), three symptoms of avoidance or emotional numbing (criterion C), and two indicators of increased arousal (criterion D), all of which must persist for at least 1 month. Further, a clinician could specify whether the condition was *acute*, *chronic* and/or *with delayed onset*. An examination of the challenges surrounding this diagnosis follows.

Is Trauma an Anxiety Disorder?

PTSD was historically characterized as an anxiety disorder within the *DSM*. Authors supporting this view reference the pronounced fear and classical conditioning believed central among survivor experiences and treatment approaches that aim to extinguish such fear-based responses (i.e., exposure therapies; Zoellner, Rothbaum, & Feeny, 2011). Zoellner et al. (2011) branded PTSD a “quintessential anxiety disorder” (p. 853), arguing that the co-occurrence of PTSD with other anxiety disorders suggests common core constructs. These authors warned that reclassifying PTSD would suggest incorrectly to clinicians and researchers that “fear and anxiety are not critical in understanding PTSD” (p. 855). However, other researchers promoted making trauma-related disorders a new diagnostic category, suggesting that the traumatic event and not the symptoms demarcate such disorders (Nemeroff et al., 2013). Nemeroff et al. (2013) suggested that using the traumatic event as the foundation for the diagnosis respects the intensely heterogeneous nature and symptomatic presentation of the disorder.

Precipitating Events and Subjective Response

Also termed the *stressor criterion*, PTSD criterion A stipulated two requirements. An individual must first experience a traumatic episode (A1), defined as:

A direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about an unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA, 2000, p. 463).

The second prerequisite (A2) required that the survivor must have experienced “intense fear, helplessness, or horror” (p. 467) following the event. Clinicians and researchers have criticized both requirements (Breslau & Kessler, 2001; Friedman, Resick, Bryant, & Brewin, 2011).

The debate over what constitutes a traumatic event emerged with the first inclusion of the diagnosis into the *DSM-III*, and has persisted. Some researchers argued that the *DSM-IV*’s broad definition of trauma led to “bracket creep” (McNally, 2009, p. 598) and overdiagnosis of PTSD resulting from less threatening events. McNally (2009) questioned the ramifications of having equivalent diagnoses for a traumatized individual

who watched the World Trade Center collapse from thousands of miles away and a survivor who escaped the building directly. Some postulated that weakening the A1 criteria had detrimental outcomes in client care and in forensic and disability settings and supported a narrower definition of trauma (Rosen & Lilienfeld, 2008). Others starkly disagreed, suggesting that what may be traumatic for one individual may not be for another, and that an attempt to include all possible traumatic events within the context of a diagnosis was futile (Brewin et al., 2009). Numerous researchers and clinicians have remarked that for no other diagnosis in the *DSM* is a specific precursory event stipulated, and they have argued for the removal of the A1 event altogether (Brewin et al., 2009), questioning the compulsory relationship between a traumatic event and PTSD (i.e., other disorders may result from such an event) and asserting that minor events, repeated over time, can likewise lead to PTSD.

More prominent was dispute over the latter stressor requirement (A2). Friedman et al. (2011) emphasized that the presence of a subjective response did not predict that an individual would go on to develop PTSD. Although these subjective responses are characteristic trauma reactions, limiting the range of psychological responses may discount subpopulations, most notably survivors of sexual and partner violence, military and first responders (Friedman et al., 2011). The predominant post-traumatic reactions of interpersonal violence survivors include anger, guilt and shame; the military and first responders often report not having an immediate emotional reaction to traumatic exposure as a result of their training. In a sample of adult sexual assault survivors, over 75% endorsed shame as a leading psychological response (Vidal & Petrak, 2007). Over 20% of survivors were misdiagnosed due to not meeting the A2 criteria (Creamer, McFarlane, & Burgess, 2005).

Three-factor Model: The Avoidance and Numbing Debate

The third criterion for a PTSD diagnosis in *DSM-IV-TR* included experiencing at least three symptoms related to *either* behavioral avoidance *or* affective numbing (APA, 2000). Having a double-barreled criterion engendered considerable disagreement in trauma research and clinical practice. Although these two constructs were initially considered synonymous, with emotional numbing serving as a volitional form of emotional avoidance, research has elucidated differences in their bases, functions and neurophysiological underpinnings (Asmundson, Stapleton, & Taylor, 2004). Foa, Riggs, and Gershuny (1995) further determined that emotional numbing, over and above avoidance or another symptomatic feature of PTSD, best distinguishes PTSD from other diagnostic categories. Conceptually, authors (Foa, Zinbarg, & Rothbaum, 1992; Ullman & Long, 2008) frequently distinguished avoidance and numbing by examining the intentionality behind the event: whereas avoidance represents conscious attempts to escape trauma-related stimuli or responses, numbing is an unconscious and automatic physiological response to trauma exposure. Confirmatory factor analyses substantiated such claims and repeatedly demarcated a four-factor rather than a three-factor model of PTSD that differentiates avoidance and numbing (Friedman et al., 2011).

The integrated conceptualization of numbing and avoidance had marked significance on clinical practice. It was often difficult to confirm three of the seven conditions (Schützwohl & Maercker, 1999), leading to subthreshold diagnoses or underdiagnosis. Further, the severity of numbing precipitated a category of trauma survivors marked by the most chronic and pervasive disturbances following trauma and most pronounced disruptions in daily life (Breslau, Reboussin, Anthony, & Storr, 2005). In addition, Asmundson et al. (2004) determined that symptoms of avoidance and numbing are differentially influenced by treatment approaches, reinforcing the notion that avoidance and numbing should be considered and clinically addressed as distinct symptomatic concerns. Further, using the *DSM-IV*, a clinician treating an unconscious response (i.e., numbing) as an intentional action (i.e., avoidance) could unintentionally lead to treatment that was ineffective, blaming, disempowering or even re-traumatizing to clients.

Subthreshold Diagnoses

Several of the aforementioned considerations denote concern around subthreshold or subsyndromal survivors, namely individuals whose trauma did not match the A1 or A2 events or whose symptoms did not fulfill the restrictive criterion C. These survivors, potentially facing grossly impaired functioning, did not fulfill PTSD criteria and thus may have been prohibited from receiving any services, appropriate services or related validation of their experiences (Cukor, Wyka, Jayasinghe, & Difede, 2010; Schützwohl & Maercker, 1999). Problems with subthreshold diagnoses and misdiagnoses under the *DSM-IV* guidelines were particularly notable among children (Pynoos et al., 2009; Scheeringa, Zeanah, & Cohen, 2011). Using *DSM-IV* criteria, over 30% of children with pervasive symptoms and severe functional impairment did not meet criteria (Scheeringa, Myers, Putnam, & Zeanah, 2012). Although notes regarding symptom presentation in children were presented, the *DSM-IV* did not identify a separate diagnosis for preschool post-traumatic reactions. Researchers argued that the *DSM-IV* criteria were not attentive to developmental considerations, owing largely to the linguistic and introspective differences of young children, and provided unrepresentative criteria for this population (Pynoos et al., 2009; Scheeringa et al., 2011). Consequently, researchers highlighted the need for child-specific PTSD criteria. Underdiagnosis in children and adults is particularly troubling given that these populations of survivors have long been misdiagnosed and stigmatized by the *DSM* (Fish, 2004; Rojas & Lee, 2004). Drawing on both behavioral and neurological research, these challenges to the *DSM-IV* PTSD diagnosis touched at the core of trauma theory and resulted in many shifting perspectives in the fifth edition. Given the historical complications in trauma theory and recent reformulations of trauma, it is important that counselors receive guidance on trauma-informed practice using the *DSM-5* (APA, 2013a).

Shifting Perspectives and New *DSM-5* Diagnostic Criteria

In the *DSM-5*, PTSD now serves as the cornerstone of a new category of diagnoses, TSRD. Within the new category, the definition of trauma is more explicit, and the symptomatic profile was expanded from a three- to four-factor structure. Subjective responses following a traumatic event are no longer required, and a separate preschool diagnosis for children 6 years old and younger is now available. The modifications to the PTSD diagnosis in the *DSM-5* are delineated in Table 1.

Exemption from Anxiety Disorders

The foremost change in the *DSM-5* diagnosis of PTSD is its assignment to an innovative diagnostic category, TSRDs. Throughout the review period, members of the Trauma and Stressor-Related and Dissociative Disorders (TSRDD) Sub-Work Group of the *DSM-5* (Friedman, 2013) determined that PTSD did not “fit neatly into the anxiety disorder niche to which it had been assigned since *DSM-III*” (p. 549). This redefining of PTSD marks a significant shift from its former conceptualization and highlights the central importance of the predisposing stressor. Exposure to a traumatic or aversive event is now recognized as a vital cause of an entire class of conditions affecting mental well-being. Before the *DSM-5*, trauma exposure was an accepted catalyst of Acute Stress Disorder and PTSD, yet the explicit influence of such aversive events on numerous other disorders went largely unacknowledged.

Restructuring the Stressor Criterion

Emphasis on the precipitating traumatic event called for reconsideration of the definition of trauma. Despite the argument by Brewin et al. (2009) that what is or is not considered a traumatic event should be defined by the individual rather than a committee, the *DSM-5* retained criterion A1, with modifications to the breadth of the definition. Trauma is now defined as exposure to actual or threatened death, serious injury or sexual violence in one or more of four ways: (a) directly experiencing the event; (b) witnessing, in person, the event occurring to others; (c) learning that such an event happened to a close family member or friend; and (d) experiencing

repeated or extreme exposure to aversive details of such events, such as with first responders. Actual or threatened death must have occurred in a violent or accidental manner; and experiencing cannot include exposure through electronic media, television, movies or pictures, unless it is work-related.

Table 1

Key Modifications to PTSD in DSM-5

PTSD Modifications	
Location	New category: “Trauma- and Stressor-Related Disorders” No longer a subcategory of “Anxiety Disorders”
Criteria	
A. Exposure	Included sexual violence as a traumatic event Exposure refined to include: <ul style="list-style-type: none"> • Learning the event(s) occurred to close family or friend^a, • Repeated or extreme exposure to details of the event(s)^b, i.e., vicarious trauma. Removed A2, subjective response (i.e., fear, helplessness, horror)
B. Intrusion (1 of 5)	No major changes
C. Avoidance (1 of 2)	New separate criterion (factor) for avoidance symptoms No major changes to symptoms
D. Negative Alterations in Mood/cognition (2 of 7)	New criterion (factor) for numbing symptoms Two new symptoms: <ul style="list-style-type: none"> • Persistent negative emotional states • Persistent blame
E. Arousal and Reactivity (2 of 6)	One new symptom: <ul style="list-style-type: none"> • Reckless or self-destructive behavior
F. Duration	No change: Still 1 month since stressor
G. Significance	No change
H. Not substance or medical	Added criterion
Specifiers	Two types available: <ul style="list-style-type: none"> • With dissociative sx, i.e., depersonalization or derealization • With delayed expression of 6 or more months
Subtype	For children 6 years or younger (Preschool subtype) Separate criteria

Note. sx = symptoms. Adapted from *DSM-5* (APA, 2013a, p. 272).

^aActual or threatened death must have been violent or accidental.

^bSuch exposure through media, television, movies or pictures does not qualify unless for work.

Several changes in the *DSM-5* definition stand out immediately, such as the inclusion of sexual violence within the core premise of trauma. Experiencing sexual violence may precipitate PTSD, as can witnessing it, learning about it and experiencing repeated exposure to stories of such acts. Furthermore, loss of a loved one to natural causes is no longer considered a causal factor. For example, now a client whose partner unexpectedly died of a heart attack no longer fits PTSD criteria. Lastly, a new subset of possible exposure has been established, namely vicarious trauma. This is the first time that *DSM* criteria have included deleterious effects of repeatedly witnessing or hearing stories regarding the aftermath of trauma. This inclusion may not be surprising to trauma counselors, as nearly 15–20 % develop PTSD symptoms from hearing and sharing in the stories of survivors; this inclusion may help to legitimize the gravity of counselors' reactions (Arvay & Uhlemann, 1996; Meldrum, King, & Spooner, 2002). The inclusion also may serve to de-stigmatize the reactions of first responders and reinforce the need for wellness training and post-exposure care (Royle, Keenan, & Farrell, 2009). However, the *DSM-5* clearly states that vicarious trauma cannot be the result of repeated exposure via electronic or print media. This precludes, for example, McNally's (2009) case example of an individual with trauma symptoms who repeatedly witnessed the attacks on the World Trade Center by way of television monitors.

Removal of Subjective Response

Along with changes to the definition of trauma, the *DSM-5* now excludes the A2 subjective response. The PTSD diagnosis now represents survivors who experience reactions other than fear, helplessness or horror, or who exhibit no pronounced emotional response. For example, a client who witnessed a fatal car accident and predominantly feels pervasive guilt for not offering support could be diagnosable. This change has great significance for numerous populations and may lead to more survivors gaining access to efficacious mental health care.

A Four-Factor Approach

In accordance with evidence supporting a four-factor model of PTSD, the APA (2013a) split the previous criterion C into two distinct categories within the *DSM-5*: (a) avoidance and (b) negative reactivity and related numbing. The new criterion C (i.e., persistent avoidance) requires only one of the two original avoidance symptoms. The new criterion D in *DSM-5*, “negative alterations in cognitions and mood” (p. 271, APA, 2013a), underscores the notion that trauma leads to unconscious numbing of positive emotions and increased negative affect overall (Frewen et al., 2010). Persistent negative emotionality and persistent blame are additions to the original symptom profile, the latter of which predicts PTSD severity and chronicity (Moser, Hajcak, Simons, & Foa, 2007). Two of seven symptoms must be endorsed in the new criterion D.

Criterion B (i.e., presence of intrusive symptoms) remains unchanged from the *DSM-IV*, and requires only one of five symptoms. The new criterion E, persistent alterations in arousal, reflects the previous criterion D and includes one additional symptom, reckless or self-destructive behaviors. Self-destructive behaviors comprise anything from hazardous driving to suicidal behavior (Friedman, 2013). Two of the now six symptoms of altered arousal are required. Despite refinements to criteria, considerable overlap remains across and within PTSD symptoms, such as between intrusion and the dissociative-depersonalization specifier.

Dissociative Specifier

In addition to delayed expression, the *DSM-5* includes specifiers for dissociative symptoms in PTSD, with either depersonalization or derealization constituting the primary presentation. Dissociation often predicts significantly greater severity, chronicity and impairment in survivors, as well as decreased responsiveness to common treatment approaches (Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012). The inclusion of this subtype acknowledges differences in neurological and physiological functioning among this population (Felmingham et al., 2008) and relevant needs and clinical considerations (Lanius et al., 2012).

Post-traumatic Stress Disorder in Children

In recognizing the gross oversights in previous iterations of the *DSM* regarding developmental considerations in PTSD, the *DSM-5* explicitly provides a preschool subtype for children 6 years and younger. This new diagnosis honors the unique trauma experiences and responses of children, with symptoms that are behaviorally based and thus not reliant upon the cognitive or linguistic complexity absent in young survivors. For example, symptoms include restless sleep, temper tantrums or decreased participation in play. Children may express symptoms through behavior or play reenactment, which may or may not appear related to the traumatic event. The preschool subtype retains the three-factor model that combines avoidance and negative alterations of mood and cognition. To circumvent concerns related to children not meeting criterion C requirements, only one of six symptoms is necessary. These changes have pronounced implications for counseling adult and child survivors of trauma.

Implications for Counseling Practice

Understanding these changes and the rationale behind them is essential to thorough client conceptualization and efficacious counseling. Otherwise, counselors may feel tentative about key areas of care, such as assessing for trauma exposure, making accurate diagnoses, selecting efficacious interventions and filing reimbursement claims. A consideration of specific ways the new that the *DSM-5* PTSD diagnosis impacts counselors, clients and clinical practice follows.

Multifarious Symptom Structure and Trauma Prevalence

The expanded PTSD symptom set in the *DSM-5* set leads to extensive variations in possible trauma responses. The increase in symptoms from 17 in the *DSM-IV-TR* to 20 in the *DSM-5* now yields over 600,000 possible symptom combinations (Galatzer-Levy & Bryant, 2013). Consider this number in comparison to the potential 70,000 combinations possible in the *DSM-IV-TR* (2000), a number already criticized for its expansiveness, and the meager 256 possible for depression (Zoellner et al., 2011). This marked increase in symptom patterns calls into question prevalence rates for trauma under the new *DSM*. A recent study established similar prevalence rates using *DSM-5* and *DSM-IV-TR* criteria, 39.8% and 37.5%, respectively, and an overall 87% consistency between the two versions (Carmassi et al., 2013). Carmassi et al. (2013) determined that the discrepancy was due primarily to individuals not fulfilling criterion C within the *DSM-IV-TR*. This finding illustrates the impact of modifications related to the bifurcation of avoidance and numbing. Kilpatrick et al. (2013), however, found marginally decreased prevalence with the *DSM-5*, citing constraints on the A1 definition of trauma. However, both studies found significantly increased prevalence among females than males using *DSM-5* (Carmassi et al., 2013; Kilpatrick et al., 2013).

Although heterogeneity may provide a more thorough scope and representation of traumatic responses, the considerable variation in behavioral presentation may lead to confusion among both counselors and clients (Friedman, 2013). Two clients may present in drastically different manners, but receive the same diagnosis. One client with PTSD may be distrustful, experience violent nightmares and behave aggressively, while another with a PTSD diagnosis is more withdrawn and self-blaming, with internally directed negative emotionality. Conversely, a counselor could have two clients who present analogously; and yet, due to the nature of the traumatic event, one could be diagnosable and the other not. This may cause complications for counselors in providing psychoeducation or in determining appropriate clinical interventions.

Counselors will encounter many questions with the changing and heterogeneous face of PTSD. For instance, would a counselor work differently with the client with a PTSD diagnosis than with a client having an analogous presentation, but no PTSD diagnosis? Do neurological ramifications differ dramatically now given

the shifting labels, and thus call for varied interventions? How does a counselor explain to a client who had PTSD under the *DSM-IV* that she or he no longer meets criteria nor qualifies for reimbursement with the new diagnosis of adjustment disorder? Or will adjustment disorder, re-categorized as a TSRD in *DSM-5*, now be recognized by third-party payment systems as a reimbursable disorder? Although some answers are beginning to unfold, an increased awareness and adaptation of trauma assessment, treatment and administration can help counselors navigate such questions and effectively work with clients.

Client Assessment

Changes precipitated by the *DSM-5* require counselors be acutely aware of the modified PTSD diagnostic criteria for careful assessment of survivors. Thorough assessment includes applying both informal and formal approaches, using multiple sources of information, and conducting initial and ongoing screenings. During the present transition, informal assessment becomes especially important as efforts to revise and validate formal assessment tools continue.

Informal assessment. Given the central importance of trauma exposure in client care, counselors may continue to struggle to sensitively solicit needed information early in the counseling process. Honed skills for developing and continually fostering the therapeutic alliance are essential to client disclosure and in conscientiously deciphering such information. Some clients may be more reticent to share information, while others may reveal very detailed accounts of their story. In either case, counselors need to remain cognizant of the risk for re-traumatization during this process and pace sessions accordingly. Friedman (2013) also recognized that the current conceptualization of trauma in the *DSM-5* insinuates the trauma has already happened, and that the individual is now “in a context of relative safety” (p. 763). This assumption may complicate assessment of individuals in enduring traumatic environments (e.g., partner violence).

During informal assessment with adults, counselors should practice acute observation skills for nonverbal clues that may signal present intrusive, numbing, arousal and dissociative symptomatology. Reported experiences of feeling detached from body or mind and reports of the world seeming dreamlike or unreal are primary indicators of dissociative experiences. Objective cues of dissociative responses also may be present, such as the client appearing to *space out* (Briere & Scott, 2013). Further, behavioral responses such as reckless and self-destructive behavior must also be recognized as potential trauma responses. The two new criterion D symptoms related to client cognitions, however, require counselors to determine a survivor’s cognitive perception of the event, self and world, and how perceptions of the latter two may have shifted post-trauma. Moreover, given the current distinction between numbing and avoidance symptoms, counselors may need to discern conscious from unconscious motivations behind client behaviors.

In children, informal assessment of traumatic responses, although now facilitated by developmentally appropriate criteria, may be particularly challenging. This requires keen observation of behavior, interpersonal interactions, sleep patterns and play. Cohen et al. (2010) suggested that child assessments must account for the onset of symptoms and changing patterns therein to avoid potential misdiagnoses. Recognizing how trauma responses manifest in children will help counselors correctly identify child survivors and help children get the mental health care needed to avert potentially protracted concerns across the life span.

Formal assessment. Formal assessment methods consistent with the revised diagnostic criteria are an essential adjunct to a counselor’s informal assessment. A notable addition to the *DSM-5* is the provision of diagnostic assessments. Many are still considered “emerging,” as the APA continues to gather feedback from clinicians (APA, 2014). Counselors can familiarize themselves with these measures and stay updated on their availability and validation through the *DSM-5* website (www.psych.org/practice/dsm/dsm5).

Relevant formal measures of PTSD for the *DSM-5* include the following: Level 1 Cross-Cutting Symptom Measures for brief assessment, Level 2 measures for in-depth domain-specific assessment, disorder-specific Severity Measures, and potentially Early Development and Home Background Forms (APA, 2014). *Level 1* surveys include questions related to avoidance, sleep quality, repetitive unpleasant thoughts and other symptoms found in *DSM-5* PTSD criteria. This level provides a measure for adults, a self-rated measure for children ages 11 to 17, and a guardian-rated measure for children ages 6 to 17. *Level 2* Cross-Cutting Symptom Measures allow for more in-depth explorations of symptoms. Disorder-Specific Severity Measures contain the National Stressful Events Survey PTSD Short Scales for adults and for children ages 11-17. Although guardian measures are available, the applicable age range is limited from 6 to 17 years. Thus these measures are not appropriate for assessing symptoms in preschool children, despite the addition of distinct diagnostic criteria for this population.

In addition to the *DSM-5* measures provided by the APA, the National Center for PTSD updated three measures to include *DSM-5* criteria: the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5), the PTSD Checklist for *DSM-5* (PCL-5), and the Life Events Checklist for *DSM-5* (LEC-5). Counselors wanting to access these measures can submit requests on the National Center for PTSD's website (www.ptsd.va.gov/).

Differential diagnosis: A resource with limitations. Another component of assessment is differential diagnosis. The use of updated measures for formal assessment may not always resolve confusion engendered by facets of *DSM-5* diagnosis such as overlapping criteria. Selecting among the Level 2 cross-cutting measures may be challenging, as many currently focus on anxiety, anger and inattention, which may not be applicable or adequate in assessing PTSD. Differential diagnosis may help counselors gain needed clarity and is often considered integral to every initial clinical encounter and the basis for treatment planning (First, 2014).

Decision trees allow for diagnostic determination based on the entirety of a client's presenting symptoms and assist in identifying diagnostic options by using lists of symptoms relevant to PTSD, including distractibility, mood concerns, suicidal behavior, anxiety, avoidance and insomnia. Out of the 29 available decision trees in the *DSM-5* Handbook of Differential Diagnosis (First, 2014), nine include decisions that may result in an accurate diagnosis of PTSD or another TSRD, not including lists with adjustment disorder as the sole TSRD.

However, some decision trees, which include symptoms reflective of PTSD criteria, do not include the disorder as a possible conclusion. For instance, criterion D covers "negative alterations in cognitions and mood," though none of the three decision trees associated with mood include PTSD. The new symptom in criterion E is "self-destructive or reckless behavior," yet the Decision Tree for Suicidal Ideation or Behavior does not include PTSD as a possible diagnosis, nor does its counterpart for self-injury or self-mutilation. Thus, in the initial absence of information about a precipitating event, well-developed informal assessment skills for PTSD may be the best tool a counselor can use to form initial hypotheses for client conceptualization and associated treatment planning.

Treatment

New changes to the *DSM* also engender implications for PTSD treatment. As noted, the four-factor model of PTSD discriminates between avoidance and negative emotionality/numbing. This transition emphasizes the need to address these two constructs as unique symptom sets in survivors and highlights the influence of neuroscience research on best practices in trauma care. For instance, positive emotional numbing is considered a neurologically based symptom outside the conscious control of survivors, as opposed to the conscious or conditioned behavioral-based responses of effortful avoidance used to decrease arousal (Asmundson et al., 2004). The degree of emotional numbing versus avoidance in clients (or vice versa) suggests differential subpopulations of survivors and thus treatment approaches. For example, exposure therapy has proven

particularly beneficial for avoidance symptoms (Asmundson et al., 2004). However, given the longstanding conceptual overlap in avoidance and numbing symptoms, optimal measures to assess treatment responses to emotional numbing have been limited (Orsillo, Theodore-Oklot, Luterek, & Plumb, 2007). Such findings suggest that effective treatment for trauma clients may become increasingly multidimensional and multidisciplinary.

The addition of new symptoms within criterion E and subtypes of PTSD calls for modified treatment approaches and goals for survivors who fulfill such criteria. For example, the inclusion of reckless or self-destructive behaviors as a feature of hyperarousal in criterion E now encompasses suicidal behavior (Friedman, 2013). Researchers have long denoted strong correlations between PTSD and suicide risk (Krysinka & Lester, 2010). The inclusion of self-destructive behavior as a symptom finally gives credence to this relationship. Counselors should practice vigilance and responsiveness to warning signs of suicidality. Regarding treatment, distress tolerance was shown to moderate PTSD and suicidal behavior (Anestis, Tull, Bagge, & Gratz, 2012), although perceived social support may buffer the impact of trauma symptoms on such behavior (Panagioti, Gooding, Taylor, & Tarrier, 2014). Similarly, the addition of dissociative subtypes highlights the severity and uniqueness of this subpopulation and the need for appropriate treatment considerations. Cloitre et al. (2012) endorsed a staged treatment emphasizing affective and interpersonal regulation as one option for treating dissociation in PTSD.

The addition of a preschool PTSD diagnosis increases the discernible importance of trauma-informed counseling with children and families. Research on best practices with children 6 years old and younger supports the use of cognitive-behavioral therapy (CBT), individually or in groups, most notably Trauma-Focused CBT; as well as child-parent relational psychotherapy; EMDR; and play therapy (Scheeringa, 2014). Scheeringa stressed that the key to working with this age group is engaging the child in developmentally appropriate methods that respect linguistic and introspective abilities (2014). Although some treatment implications stemming from the *DSM-5* are presently discernible, additional research on best practices for addressing novel symptoms and symptom patterns of PTSD in children and adults will further inform practice.

Reimbursement and Legal Ramifications

Additional implications of *DSM-5* modifications, such as healthcare consequences, remain largely unknown. General healthcare implications are explored in a file provided on the *DSM-5* website (APA, 2013b), with the major foci including International Classification of Diseases (ICD) coding and assessment of disability and functioning. The APA (2013b) assured “periodic updates of agreements with federal agencies, private insurance companies, and medical examination boards as they become available” (p. 4). It can be expected that insurance companies will continue to reimburse for PTSD. However, a parallel expectation or hope is for companies to begin reimbursing more consistently for subthreshold PTSD, adjustment disorder and related diagnoses.

Conclusion

Although the changes to PTSD in the *DSM-5* were empirically based and arose after considerable analysis and debate, several areas of concern and oversight still stand. Research remains mixed about overall prevalence rates of vicarious trauma (VT) in mental health practitioners (Kadambi & Ennis, 2004). Given the inclusion of VT in trauma definitions, the expected increase of PTSD diagnoses in clients, and the related potential for reimbursement and access to care for a broader range of traumatized clients, the prevalence of VT in clinicians may increase as well. Further research is needed on prevalence, risk and protective factors, and effective help for counselors experiencing VT. The addition of VT in the *DSM-5* provides a diagnostic construct, yet future research will yield notable contributions to conceptualization and inform counseling practices for individuals experiencing VT.

Furthermore, a growing body of evidence suggests that a traditional diagnosis of PTSD is not sufficient to describe the range and intensity of symptomatology experienced in survivors of unremitting and recurrent abuse, notably abuse during early stages of development. Research has determined that such iterative and early trauma engenders symptomatic sequelae divergent from adult onset or isolated acts of violence (Herman, 1992b; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Herman (1992b) and van der Kolk et al. (2005) proposed a diagnostic formulation distinct from PTSD: complex PTSD or disorders of extreme stress not otherwise specified (DESNOS). The profoundly disruptive nature of DESNOS led researchers to characterize complex PTSD as an experience of “mental death” (p. 617; Ebert & Dyck, 2004). In field trials on the addition of complex PTSD in forthcoming editions of *DSM*, 68% of children who experienced sexual abuse were found to have complex PTSD over and above an expression of PTSD alone (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). In a follow-up to earlier field trial studies, van der Kolk et al. (2005) found early interpersonal trauma gives rise to more complex pathology than later interpersonal victimization, and that the younger the age of onset of the trauma, the more likely the individual is to suffer from C-PTSD. However, at the time of the *DSM-5*'s publication, the TSRDD Sub-Work Group of the *DSM-5* determined that there was not currently enough information on the distinctiveness and pervasiveness of the disorder to warrant a formal diagnosis (Friedman, 2013). However, the group incorporated certain proposed DESNOS symptoms (e.g., self-destructive behavior, dissociative subtype) into the reformulated diagnosis (Friedman et al., 2011). Given evidence of uniquely deleterious consequences of early and repeated trauma, ongoing conceptualization and validation of DESNOS will be essential.

Although the *DSM-5* provides improvements to PTSD diagnoses, it also presents notable challenges and engenders numerous unanswered questions for counselors and other mental health professionals. Counselor experiences in the field will inform practice, and continued research will provide more coherent understanding of criteria such as negative emotionality and numbing, accurate assessment of TSRDs, and ramifications in legal, health care and forensic settings. To continue to work ethically within their scope of practice (American Counseling Association, 2014), counselors must ensure that they are trained in the area of trauma and continue to seek professional education and guidance on the ongoing developments in this topic.

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