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POSTTRAUMATIC STRESS DISORDER, BORDERLINE PERSONALITY
DISORDER, AND DISORDERS OF EXTREME STRESS,
NOT OTHERWISE SPECIFIED; A VIGNETTE STUDY
EXPLORING VA AND PRIVATE SECTOR
CLINICIANS' DIAGNOSTIC PERCEPTIONS

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ABSTRACT

Due to the role of trauma in the etiology of posttraumatic stress disorder (PTSD), borderline personality disorder (BPD), and disorders of extreme stress, not otherwise specified (DESNOS), and noted similar clinical pictures, it is important to explore differential diagnosis. There is evidence that gender influences the diagnosis of PTSD and BPD and of an “anchoring effect” in which disclosure of childhood trauma early versus late in a case vignette results in more diagnoses of PTSD or BPD, respectively. Additionally, as many veterans seek care within the private sector, it is important to understand possible diagnostic differences between VA and private sector clinicians. The present study explored gender bias, the anchoring effects of placement of childhood trauma in a case, and differences between VA and private sector clinicians in the diagnosis of PTSD and BPD.

A national sample of 62 VA psychologists and 87 private sector psychologists read one of four versions of a case vignette and assigned a diagnosis, diagnostic ratings, and symptom ratings. The vignettes included PTSD and BPD symptoms, and a history of childhood trauma and combat-related trauma, and the versions differed with regard to patient gender and the placement of a childhood trauma within the case. Overall, the cases tended to be seen as PTSD, with PTSD being the frequent diagnosis, followed by BPD. Gender played a role in BPD diagnoses, with the female version of the case receiving significantly more BPD diagnoses and higher BPD ratings than the male version, as hypothesized. However, gender did not influence the diagnosis of PTSD. There was little support for an anchoring effect of placement of the childhood trauma in the case. VA clinicians assigned significantly lower PTSD ratings, as

predicted, but also more diagnoses of BPD than private sector psychologists. Methodological limitations of the study and implications of the results are discussed.

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CHAPTER 1

INTRODUCTION

The spectrum of trauma disorders has become somewhat problematic, as research has indicated that long-term developmental trauma may produce symptoms that do not fit neatly into the current posttraumatic stress disorder (PTSD) symptom profile. The current conceptualization of PTSD captures only a small amount of posttraumatic psychopathology with a focus on re-experiencing, numbing, and hyperarousal. It does not address the effects of trauma on self-perception and interpersonal relationships (Van der Kolk & Courtois, 2005).

PTSD was first conceptualized as a disorder that primarily affected male, combat, veterans. Women and children were largely neglected in regards to the conceptualization of trauma-related symptomatology, and it was not until the 1970's that women and children began to be included in trauma research. Thus, the primary force behind trauma research for a significant amount of time was the constellation of symptoms reported by or observed in combat veterans. However, as subsequent research indicated that, not only were the responses of women and children to traumatic events important, but they often resulted in symptoms that were similar to those noted in combat veterans (e.g., nightmares, flashbacks). As a result, the diagnosis of PTSD was broadened to include trauma-related symptoms that resulted from a variety of traumatic events in women and children in addition to combat-related symptoms seen in men. However, the conceptualization and criteria for PTSD may not be sufficient to capture the range of symptoms seen with trauma-related disorders (Van der Kolk, Weisaeth, & Van der Hart, 1996).

Disorders of Extreme Stress not Otherwise Specified (DESNOS), or complex PTSD, was first conceptualized by Herman (1992) to better capture the deficits in affective and interpersonal functioning that can arise as a result of prolonged, multiple, or developmental traumas (Beall, 1997). DESNOS, the symptom constellation which is currently listed as an associated feature of PTSD, addresses alterations that may occur in the regulation of affect and impulses, attention and consciousness, self-perceptions, relationships, somatization, and individual meaning systems (Blaz-Kapusta, 2008). As noted by Lindner (2004), controversy has existed around the possible inclusion of DESNOS in the *Diagnostic Statistical Manual, 4th edition* (DSM-IV; American Psychiatric Association [APA], 1994) and the recently released DSM-5 (APA, 2013). The inclusion of DESNOS would have mitigated some of the concerns around the conceptualization of PTSD in that it would address the affective and interpersonal domains that can be affected following a traumatic event. Although a PTSD subcommittee voted 19-to-1 to include the diagnosis as a separate disorder, it ultimately was not accepted by the task force and was left out of the DSM-IV (Lindner, 2004).

Complicating the picture of trauma disorders further is borderline personality disorder (BPD), a personality disorder with a similar clinical picture to DESNOS. Although BPD and PTSD do not share much overlap in their diagnostic criteria, their clinical pictures may overlap (Cloitre, Koenen, Gratz, & Jakupcak, 2002). In addition, many individuals diagnosed with BPD report chronic abuse in their childhood which has been shown to have far-reaching effects in the areas of affective stability and interpersonal functioning (Lonie, 1993). Comorbid BPD and PTSD is common with 30-50% of individuals with BPD also meeting criteria for PTSD (Harned, Korslund, Foa, & Linehan, 2012). Like PTSD, BPD was formally added to the classification in the DSM-III (APA, 1980), but its symptom constellation was described in psychiatry much earlier.

Kernberg (1967) differentiated BPD (i.e., borderline personality organization) from other personality organizations (psychotic personality organization and neurotic personality organization) by an individual's weak identity formation, use of primitive defenses, and poor reality testing that worsened under stress. BPD is conceptualized in the DSM-IV (APA, 2000, p. 710) by "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that presents itself by early adulthood."

Gender complicates the pictures of both PTSD and BPD, as there has been some evidence of possible sex bias in the diagnoses of these two disorders (Becker & Lamb, 1994; Fish, 2004). Becker and Lamb (1994) found that case vignettes with a mixture of PTSD and BPD symptoms tended to be diagnosed as BPD when the case was presented as a woman, and PTSD when the same case was presented as a man. Fish (2004) noted that misdiagnosis of chronic, stigmatizing disorders such as BPD occurs more often with women than with men, while at the same time, there is an under diagnosis of PTSD. Although there is not much criteria overlap between the two disorders, the similar clinical picture and the prevalence of childhood trauma found in both disorders adds to the complexity of the clinicians' job of accurately diagnosing an individual.

Furthermore, Woodward et al. (2009) found some evidence of an anchoring effect in the diagnosis of PTSD and BPD. Research on anchoring effects suggests that information presented earlier appears to have a greater effect on judgment and diagnosis than information presented later (Friedlander & Stockman, 1983; Woodward et al., 2009). Woodward et al.'s research indicated that disclosure of childhood trauma early in a case vignette tended to result in more diagnoses of PTSD (despite balanced criteria for PTSD and BPD within the vignettes used), whereas disclosure of childhood trauma later in the vignette tended to result in more diagnoses of

BPD. This is an area that merits replication and further study as it has repercussions not only for diagnoses but for the resulting treatment mode used as well.

The issue of differential diagnosis of PTSD and BPD may be especially relevant for veterans, as high rates of childhood trauma (physical and/or sexual abuse) have been found in treatment-seeking veterans diagnosed with PTSD (Bremner, Southwick, Johnson, Yehuda, & Charney, 1993; Lapp et al., 2005). The Department of Veterans Affairs (VA) has long been a primary source of healthcare support for veterans dealing with physical and mental disorders following deployment. However, the high number of soldiers returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) has placed a significant amount of strain on VA resources (Klein & Kornblau, n.d.). As a result, some VA's have considered outsourcing certain services. In addition, a substantial number of soldiers may seek private sector care (through primary care, private practice, or community mental health) for a number of reasons including ineligibility for VA services, geographic barriers to seeking care at a VA, or stigma-related barriers. There are very few studies of differences in diagnosis and treatment between VA clinicians and non-VA clinicians. Leslie and Rosenheck (2003) compared VA and private sector pharmacotherapy for schizophrenia, but there are no known studies that have examined potential differences in the diagnosis of PTSD and its differential diagnosis from BPD.

The current study examined potential gender bias in the diagnosis of PTSD and BPD in a case vignette of an individual experiencing combat-related trauma by manipulating the gender of the individual in the case. In addition, the role of childhood trauma and the possible anchoring effect of where the report of the childhood trauma is presented in the case (early vs. late) was examined. Finally, differences between VA psychologists and private sector psychologists were explored.

CHAPTER 2

LITERATURE REVIEW

Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD), as it is conceptualized in the DSM-IV and DSM-IV text revision (DSM-IV-TR; APA, 2000), is an anxiety disorder that develops secondary to a traumatic event, with a specific focus on symptoms of numbing, re-experiencing, and hyperarousal (see Appendix A; Van der Kolk & Courtois, 2005).

Lifetime prevalence rates of PTSD are approximately 8% of the adult population in the United States (APA, 2000). However, this rate increases with groups exposed to traumatic events, particularly survivors of interpersonal violence and military combat. Magruder and Yaeger (2009) found a 1.5 to 3.5-fold increase in the risk of developing PTSD with military deployment. Wolfe and Kimerling (1997) noted that women are particularly at risk of developing PTSD as interpersonal violence is especially predictive of PTSD and occurs twice as often with women.

The history of the formulation of PTSD as a formal diagnosis is quite different from many of the other disorders found in the DSM-IV-TR, in that this disorder has been conceptualized as caused primarily by external events rather than by individual personality traits or characteristics. This initial conceptual basis of PTSD has been challenged recently, as research indicates that many people experience a traumatic event in their lifetime, yet only a few will develop PTSD afterwards (Brewin, Lanius, Novac, Schnyder, & Galea, 2009). Although the etiology of PTSD is now recognized to be multifaceted, there must be an identified “stressor” in order to diagnose the disorder (APA, 2000).

Although the symptoms of PTSD were recognized long before it was formally added into the DSM, the inclusion of it in the DSM-III (1980) legitimized it as a disorder. Prior to the introduction of PTSD as a diagnosis in the DSM-III, various terms such as “shell shock,” “war neurosis,” “traumatic neurosis,” “combat trauma,” and “combat fatigue” were all used to describe the symptoms that developed in response to trauma, particularly war-related trauma (Beall, 1997). In the DSM-I (APA, 1952) psychoneurotic disorders resulting from “intolerable stress” fell under the umbrella of “Gross Stress Reactions” (p.85). The DSM-II (APA, 1968) used the diagnosis of “Transient Situational Disturbance” to describe the symptoms that were observed in soldiers returning from war.

Kardiner (1941) was the first to define posttraumatic stress disorder in the United States. Kardiner used the term “physioneuroses” (Van der Kolk & Saporta, 1993, p. 26) to describe posttraumatic stress, noting that following a trauma, emotional constriction (i.e., a numbing or blunting of emotional expression) is common as is increased physiological reactivity (increased heart rate and blood pressure) to physical or emotional stimuli. Kardiner published his research in two books, *Traumatic Neuroses of War* (1941) and his second book, which he wrote with Spiegel (1947), *War Stress and Neurotic Illness* (1947), and promoted the idea that this disorder was primarily war-specific. As a result of this disorder being viewed primarily as a war-related disorder, the majority of the subsequent research on PTSD was focused on male veterans (Beall, 1997; Galovski, Mott, Young-Xu, & Resick, 2010).

PTSD, as a diagnosis, faced considerable controversy tied to its inclusion in the DSM-III. A number of questions were raised regarding its etiology as well as its classification (Becker, 2004; Van der Kolk, Weisaeth, & Van der Hart, 1996). In addition, there was a lack of consensus among DSM committee members with regard to the definition of PTSD. Lindner

(2004) noted that the disagreement regarding the criteria for PTSD was seen in clinical practice, with clinicians relaxing the diagnostic criteria based on their clinical experience. In regard to etiology, the diagnosis of PTSD is unique in that its diagnostic criteria specify the etiologic event that must occur (i.e., exposure to a traumatic stressor; Brewin, Lanius, Novac, Schnyder, & Galea, 2009; McNally, 2009). However, questions remain about preexisting vulnerabilities, biological versus psychological etiology, and the role of the event itself versus the interpretation of the event. Recent research suggests that the etiology of PTSD is multifaceted as a number of individuals who experience a traumatic event do not develop the disorder (APA, 2000). Brewin et al. (2009) proposed abolishing Criterion A due to the difficulties of defining a “traumatic event” in such a way that relevant cases are included without making the definition too broad. However, due to individual differences in genetic vulnerability, psychological vulnerability, and sensitization from prior exposure to trauma, identifying and defining all potential triggering events would be quite difficult.

A number of researchers have called for consideration and exploration of subtypes of PTSD, as different types of traumas may affect the presentation and clinical course of PTSD (Dyer et al., 2009; McFarlane & De Girolamo, 1996; Shea, Zlotnick, & Weisberg, 1999). Interpersonal traumas that occur early in life, particularly physical and sexual abuse, are typically more chronic in nature, are associated with subsequent re-victimization later in life, and are associated with personality changes and interpersonal difficulties. In contrast, traumas related to a single event may be more likely to lead to PTSD symptoms, including re-experiencing, numbing, and hyperarousal (Lilly & Valdez, 2011; Terr, 1991).

Kardiner (1941) allowed for variation in regard to different clinical types of PTSD, expression, and contextual factors in his definition of PTSD. However, the members of the

DSM-III Task Force focused on the commonalities among the known syndromes of PTSD rather than on the differences in expression. A group of mental health practitioners, along with members of a support group for Vietnam veterans, the Vietnam Veterans Working Group (VSWG), began to collect evidence and discuss “post-combat disorder” (Linder, 2004, p. 27). The VSWG helped push the focus of PTSD away from combat veterans specifically and towards survivors of catastrophic trauma in general, noting commonalities in the symptoms of veterans and Holocaust survivors. The Committee on Reactive Disorders (formed by Robert Spitzer to explore veterans’ issues) made the recommendation, based in large part on evidence collected by the VSWG, that Post-traumatic Stress Disorder be included in the DSM-III. The data used in the creation of the diagnosis of PTSD came primarily from one source and one trauma type (veterans and combat trauma); however, the diagnostic criteria were used in clinical practice to diagnose PTSD in victims of various types of trauma, including natural disasters and interpersonal trauma. Clinicians used the criteria to diagnose PTSD in women as well, despite the fact that VSWG data were based exclusively on men (Lindner, 2004).

The conceptualization of PTSD in the DSM-III subsumed a number of different syndromes that had been noted in research (e.g., Vietnam veterans syndrome, rape trauma syndrome, abused child syndrome). However, the literature noted a considerable amount of variation in the syndromes that was not included in the eventual definition of the DSM-III (Lindner, 2004). For example, the rape trauma syndrome included a number of subtypes of rape trauma such as “compounded reaction to rape trauma” (Burgess, 1983, p.107) in which victims of rape who have also experienced physical or sexual abuse in their past may express symptoms such as suicidal behavior, depression, psychotic behavior, psychosomatic symptoms, and acting

out with drugs and alcohol. Burgess noted that this particular type of trauma often resulted in poor or “guarded” prognosis.

Revisions to the definition and criteria of PTSD from the DSM-III to the DSM-III-R were substantial. Both the DSM-III and DSM-III-R required that the individual experienced a trauma that would cause significant distress in anyone. However, the DSM-III-R expanded the description to note that the trauma was “outside the range of usual human experience” and that it would be “markedly distressing to almost anyone” (DSM-III-R; APA, 1987, p. 250). The DSM-III required at least one of three re-experiencing symptoms, one of three symptoms of numbing of responsiveness, and two of a group of six additional symptoms (e.g., survivor guilt, sleep difficulties, avoidance). The DSM-III-R expanded the symptom criteria to require at least one of four re-experiencing symptoms, three of seven symptoms of numbing and avoidance, and two of six arousal symptoms. The DSM-III included acute and chronic subtypes based on onset and/or duration of less than or more than six months, but there was no minimum duration. DSM-III-R specified that symptoms must last a minimum duration of one month and included only a delayed onset specifier for onset of symptoms 6 months or more after the trauma.

Revisions to the definition and criteria of PTSD from the DSM-III-R to the DSM-IV were significant and controversial as well. First, questions of the classification of PTSD as an anxiety disorder were raised, as the International Classification of Diseases-Tenth Edition (ICD-10; World Health Organization, 1992) had removed PTSD from the category of Anxiety Disorders and placed it in a separate stress response category (Brett, 1996). The Anxiety Disorders Work Group (ADWG) disregarded the PTSD subcommittee’s proposal to create a new category of “Stress Disorders,” (Lindner, 2004, p. 35) for PTSD. Ultimately, PTSD remained in the Anxiety Disorders category for the DSM-IV (2000). The ADWG noted the central feature of

anxiety in PTSD, as well as the benefits seen from treatments used with other anxiety disorders, as reasons for this decision. However, internationally anxiety is seen as a common and nonspecific feature of many disorders, and thus PTSD is categorized in the ICD-10 based on other features (Lindner, 2004).

The criteria for PTSD in the DSM-IV and DSM-IV-TR maintained the structure established in the DSM-III-R. The trauma criterion was further elaborated to include a traumatic event that was experienced or witnessed, actual or threatened, and the requirement that the response of the person to the trauma was one of “intense fear, helplessness or horror” (p. 467). The criteria required a minimum of one of five re-experiencing symptoms, three of seven symptoms of avoidance and numbing, and two of five arousal symptoms. The minimum duration of one month was retained as was the delayed onset specifier. However, the DSM-IV also included acute and chronic specifiers for symptoms that last less than or more than three months. Moreover, a trauma related disorder of short duration, Acute Stress Disorder, was added for symptoms that last less than a month.

In the recently released DSM-5 (APA, 2013), the diagnosis of PTSD was once again under some scrutiny and underwent significant changes (see Appendix B). First, there was substantial reorganization of the diagnoses in the manual to reflect the symptom domains and common underlying vulnerabilities of disorders based on the purported relatedness of diagnoses to each other, and alignment with the upcoming ICD-11, expected in 2015 (Kupfer & Regier, 2011). A joint literature review by DSM-5 Anxiety, Obsessive Compulsive Spectrum, Post-Traumatic, and Dissociative Disorder work groups concluded that there was support for separation of PTSD and Acute Stress Disorder from the anxiety disorders (Stein et al., 2010). As a result, PTSD was placed in a new chapter, Trauma- and Stressor-Related Disorders, along with

Acute Stress Disorder and Adjustment Disorders, as had been previously recommended by the DSM-IV Task Force.

There were also significant changes to the criteria, including the trauma definition and the structure of the specific symptoms. The DSM-5 eliminated the requirement that an individual must experience fear, helplessness, or horror in response to the trauma, as the utility of this criterion has been called into question by numerous researchers who have noted that these reactions are weak predictors of PTSD (Brewin, Andrews, & Rose, 2000) and individuals may experience other emotions such as anger or shame (O'Donnell, Creamer, McFarlane, Silove, & Bryant, 2010; Rizvi, Kaysen, Gutner, Griffen, & Resick, 2008; Schnurr, Ford, Friedman, Green, Dain, Sengupta 2000). DSM-5 also provides further specification of qualifying traumatic events as well as the explicit exclusion of exposure to aversive details in electronic media, television, movies, or pictures, and specifies that exposure to aversive details of death applies to unnatural or traumatic death. Finally, the three symptom cluster structure used in the DSM-III-R and DSM-IV was replaced by a four-factor structure, consisting of intrusive symptoms, avoidance symptoms, negative alterations in cognitions and mood, and arousal/reactivity symptoms based on confirmatory factor analysis investigations exploring the latent structure of PTSD (Andrews, Joseph, Shevlin, & Troop, 2006; Asmundson, Frombach, McQuaid, Pedrilli, Lenox, & Stein, 2000; King, Leskin, King, & Weathers, 1998; McWilliams, Cox, & Asmundson, 2005). Although the Task Force considered DESNOS/Complex PTSD, a field trial determined that DESNOS was too rare an occurrence to yet be classified as a stand-alone diagnostic entity (Friedman, Resick, Bryant, & Brewin, 2011). However, the addition of the fourth cluster allowed for a broader range of symptoms, including negative emotions and perceptions of the self and others. It is important to note that the present study used the DSM-IV diagnoses and criteria as

the DSM-5 had not been published at the time this study was developed and data collection was initiated.

Gender and PTSD

Gender has been an issue of controversy and disagreement in regard to the PTSD diagnosis. Between the years of 1895 and 1974, women were virtually ignored as a potential research group for PTSD. Burgess and Holstrom (1974) first described “rape trauma syndrome” noting that the flashbacks and nightmares reported by rape victims were similar to symptoms that Kardiner (1941) noted in his research on combat veterans. However, it was believed that interpersonal traumas (such as incest and rape) were rare, and the lasting effects were believed to be questionable in regards to the psychological damage they inflicted. It was not until the mid 1980’s that the field of psychiatry recognized the breadth of interpersonal violence against women and the often damaging effects that this particular type of violence caused (Van der Kolk, Weisaeth, & Van der Hart, 1996).

Women are at greater risk for interpersonal violence, particularly sexual and physical abuse in childhood, than men (McGruder et al., 2000; Walker, Carey, Mohr, Stein, & Seedat, 2004), and this early victimization has been related to higher rates of re-victimization later in life (Lilly & Valdez, 2011). It is generally understood that victims of sexual abuse typically deal with a number of consequences in various domains (cognitive, affective, and behavioral). Somatic complaints, interpersonal difficulties, inappropriate sexual behavior, depression, self-destructive behavior, anxiety, and feelings of isolation have been associated with childhood sexual abuse (Bornovalova, Tull, Gratz, Levy, & Lejuez, 2011; Feerick & Snow, 2005; Gold, Ketchman, Zucker, Cott, & Sellers, 2008; Walker, Holman, & Busby, 2009).

Differential Diagnosis

In addition to being at greater risk of interpersonal violence, and for developing PTSD in response to trauma, women also face over-pathologization by clinicians. Research has indicated that women who may qualify for a PTSD diagnosis frequently receive multiple diagnoses instead of just PTSD, which complicates both therapeutic as well as pharmacological treatment (Elliot, 1995 [as cited in Cloitre, Koenen, Gratz, & Jakupcak, 2002]). This is particularly problematic with PTSD, as several efficacious treatment modes have been developed for rape victims with PTSD (Foa, Hembree, & Rothbaum, 2007; Shapiro, 2001) as well as more complex cases of PTSD with affective and interpersonal components (Cloitre, Koenen, Cohen, & Han, 2002; Krupnick, 2002).

In addition to receiving more comorbid mood and anxiety disorder diagnoses, women may also be at a greater risk of being assigned a personality disorder diagnosis, as those who have sustained chronic, interpersonal traumas have been shown to express some trait-like characteristics, such as affect dysregulation and interpersonal difficulties that may complicate the expression of PTSD (Cloitre, Koenen, Gratz, & Jakupcak, 2002). Among male and female PTSD samples, Hea et al. (1999) found that paranoid personality disorder was the most common personality disorder diagnosis in VA outpatient services, with borderline personality disorder being the second most common personality disorder diagnosis. Their results should be interpreted with some caution, however, as they used the Personality Disorders Questionnaire – Revised (PDQ-R) (Hyler & Rieder, 1987) which has been associated with overdiagnosis of personality disorders in both clinical as well as community samples (Miller & Lisak, 1999).

Research has shown that clinicians may have some difficulty differentiating PTSD from personality disorders, particularly borderline personality disorder (Landecker, 1992; Southwick,

Yehuda, & Giller, 1993; Woodward et al., 2009). However, this appears to be especially true for those with chronic PTSD resulting from traumas that were developmental, chronic, and/or interpersonal in nature. PTSD resulting from other types of trauma, such as sexual or physical assaults experienced as an adult or stand-alone combat trauma, does not show the same high rate of comorbidity with Axis II disorders (Cloitre, Koenen, Gratz, & Jakupcak, 2002).

Currently, there is a lack of consensus among both researchers and clinicians as to how to best conceptualize stress-response syndromes. The current PTSD diagnostic criteria do not address the effects of trauma on self-perception and interpersonal relationships (Van der Kolk & Courtois, 2005), and research has indicated that both of these areas may be affected, particularly in the case of developmental trauma (Ford, 1999; Herman, 1992; Van der Kolk, 1988). More research is needed in order to create a theoretical model that can integrate the many current conceptualizations of PTSD, including psychobiological models of disordered arousal (biological alterations that persist after the stressor has disappeared), phase/stage models and processes that form psychological factors that affect self-structure (Krystal, 1993). The recently published DSM-5 included several changes but notably none addressed the effects of trauma on self-perception and interpersonal relationships that have been noted by many investigators and clinicians (see Appendix C)

Disorders of Extreme Stress Not Otherwise Specified

The spectrum of trauma disorders has become somewhat problematic as research has indicated that long-term developmental trauma may produce symptoms that do not fit neatly into the current PTSD symptom profile (Van der Kolk & Courtois, 2005). A majority of individuals suffering from PTSD also deal with a comorbid disorder, and up to 44% of individuals with PTSD may be diagnosed with three or more additional diagnoses (Ivezic, Bagaric, Oruc,

Mimica, & Ljubin, 2000). This significant comorbidity suggests that the current diagnosis of PTSD may cover only a small portion of the symptoms that can occur as a result of trauma. Disorders of extreme stress not otherwise specified (DESNOS) or complex PTSD was first conceptualized by Herman in *Trauma and Recovery* (1992) as a diagnosis that better captures affective and interpersonal functioning deficits that have been shown to arise as the result of prolonged, multiple, or developmental traumas (see Appendix D for proposed diagnostic criteria for DESNOS; see Appendix E for diagnostic symptoms for DESNOS). Whereas PTSD is conceptualized as a stress reaction to a single acute trauma, DESNOS was put forth as an extension of the PTSD spectrum encompassing changes in the affective and interpersonal realms as well as meaning and belief systems (Herman, 1992). Because DESNOS was developed in order to address the symptoms not currently included in the criteria for PTSD, it does not include the hallmark symptoms of PTSD such as the re-experiencing, avoidance, or hyperarousal symptoms (Blaz-Kapusta, 2008).

Although DESNOS is not a formal diagnosis, it offers clinicians a framework for understanding and assessing the complex sequelae following extreme trauma. The syndrome was proposed as a potential alternative to personality disorder diagnoses when it can be demonstrated that traumatic events have compromised the individual's sense of self and interpersonal abilities (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). Despite the commonly used name, "complex PTSD" (Herman, 1992), Cloitre, Koenen, Gratz, and Jakupcak (2002) stated that DESNOS, with its focus on affective dysregulation and interpersonal disturbances, is perhaps a better term as it is more similar to a personality disorder, in particular borderline personality disorder, than to PTSD.

Kardiner (1941) recognized the often complex nature and presentation of PTSD, particularly when the traumatic stress was chronic, interpersonal in nature, or the symptoms were left untreated. Kardiner's model of PTSD was a two stage response model, with the immediate response being that of the current PTSD symptoms with a focus on hyperarousal, numbing, and re-experiencing. However, the second stage addressed the potential change in symptom presentation if the trauma was long-standing or developmental in nature. Stage two was identified as "PTSD with comorbidity," which is currently informally recognized by clinicians as DESNOS or complex PTSD (Pain, 2002).

Starting in the 1970's, the use of prospective disaster studies, along with more valid and reliable rating scales, have indicated that vulnerability plays a role in the development of PTSD as well as the adjustment to living with chronic PTSD. PTSD may have a multifaceted etiology, but the environment appears to play a significant role in the development of DESNOS later in life (Van der Kolk, Weisaeth, & Van der Hart, 1996). Research has shown that large numbers of psychiatric patients report trauma histories, and a number of psychiatric diagnoses, such as borderline personality disorder, antisocial personality disorder, and dissociative disorders, are associated with histories of developmental or chronic trauma (Daud, Klinteberg, & Rydelius, 2008; Diseth, 2005; Silk, Lee, Hill, & Lohr, 1995; Weine, Becker, Levy, Edell, & McGlahen, 1997). Research has indicated that, although trauma experienced as an adult tends to result in classic PTSD symptoms, trauma experienced as a child tends to result in a more complex clinical picture that does not fit the PTSD criteria as well (Pynoos, Steinberg, & Goenjian, 1996; Van der Kolk, 1996). Although the ICD-10 (World Health Organization [WHO], 1992) recognizes the potential personality changes that may occur following a traumatic event through inclusion of the diagnosis, "enduring personality change after catastrophic experience" (EPCACE) (see

Appendix F), the DSM-IV does not include a specific diagnosis for this. However, the DSM-IV does describe the symptom constellation of DEPNOS in the text under “Associated and Descriptive Features” of PTSD (see Appendix G). These features include “impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual’s previous personality characteristics” (APA, 2000, p. 465; Van der Kolk, Weisaeth, & Van der Hart, 1996).

During the development of the DSM-IV, the APA organized a field trial to, among other things, explore the DEPNOS syndrome. The conceptualization of DEPNOS included seven categories of symptoms: (a) alterations in ability to modulate emotions, (b) alterations of identity and sense of self, (c) alterations in ongoing consciousness and memory, (d) alterations in relations with the perpetrator, (e) alterations in relations with others, (f) alterations in physical and medical status, and (g) alterations in systems of meaning (Van der Kolk & Courtois, 2005). Despite the field trial finding support for the DEPNOS syndrome as a complex adaptation to chronic interpersonal trauma, the disorder was not included as a separate diagnosis but rather, was listed under the “Associated and Descriptive Features” of PTSD (APA, 1994, p. 425 [as cited in Van der Kolk & Courtois, 2005]; Roth, Pelcovitz, Van der Kolk, & Mandel, 1997). Lindner (2004) indicated that this was a controversial decision, as the PTSD subcommittee formed to evaluate DEPNOS supported its inclusion in its report to the Anxiety Disorders Work Group (ADWG). The PTSD subcommittee voted 19-to-1 to include DEPNOS as a stand-alone disorder in the *DSM-IV*, but the ADWG opposed the recommendation.

Beltran and Silove (1999) completed an exploratory survey of international experts' opinions of the disorder, "enduring personality change after catastrophic experience" (EPCACE), included in the ICD-10 (1992). Their results suggested there was a significant amount of support for the diagnosis among the experts, with the recognition of potential for personality change in individuals who have suffered particular types of trauma, specifically interpersonal or enduring traumas (e.g., childhood abuse, prisoner of war, concentration camp survivors). However, the criteria that are listed (i.e., *a hostile or mistrustful attitude towards the world; social withdrawal; feelings of emptiness or hopelessness; a chronic feeling of being "on-edge," as if constantly threatened; and estrangement*); ([ICD-10, 1992, F62]), have been criticized for their lack of specificity (Beltran & Silove, 1999).

Beltran, Llewellyn, and Silove (2008) completed a qualitative, exploratory study of clinicians' understanding of the ICD-10 EPCACE criteria. The ICD-10 has two sets of criteria for EPCACE, Diagnostic Criteria for Research (DCR) and Clinical Descriptions and Diagnostic Guidelines (CDDG). Their findings indicated that, although the clinicians endorsed the first criterion of EPCACE ("a hostile or mistrustful attitude" [ICD-10, 1992]), additional criteria including somatization, self-injurious/self-damaging behaviors, and sexual dysfunction would be helpful additions to the current symptom profile of EPCACE. Additionally, the study indicated that heterogeneity in the manifestation of particular criteria was not uncommon. For example, several clinicians noted that a "hostile attitude" may present as aggression, rage, anger, or hatred. Furthermore, although concerns have been voiced regarding the possible symptom complexity and multiplicity of DEPNOS (which includes the somatic complaints and self-injurious or self-destructive behaviors that the clinicians suggested including to the diagnostic criteria for EPCACE), the clinicians included in this study were able to identify core symptoms, as well as

identify and discuss specific characteristics of each symptom. Additionally, they were able to identify other symptoms that could indicate personality change (Beltran et al., 2008). Additional criticisms have been levied at the ICD-10 EPCACE disorder criteria, as the diagnosis can only be given after two years duration. In addition, it cannot be diagnosed with concurrent PTSD, as EPCACE is conceptualized as the outcome of chronic PTSD, rather than an entity separate from PTSD.

The diagnosis of DESNOS has faced similar criticisms. Research has been mixed on whether or not PTSD and DESNOS are separate entities (Ford, 1999; Ford & Kidd, 1998; Nemic-Moro et al., 2011; Van der Kolk, 1996). Using the Structured Interview for Disorder of Extreme Stress (SIDES; Luxenberg, Spinazzola, & Van der Kolk, 2001), Nemic-Moro et al. (2011) found comorbid DESNOS and PTSD in 43% of Croatian war veterans. Ford and Kidd (1998) found comorbid DESNOS and PTSD in 57% of veterans being treated at inpatient clinics for PTSD. Van der Kolk et al. (1996) found support for DESNOS as a better representation of the full effects of trauma, particularly chronic abuse. However, they did not find support for DESNOS as a distinct disorder separate from PTSD.

More recently, in response to a number of critiques and expressed dissatisfaction by clinicians and investigators regarding the absence of clinically significant problems not currently captured by the DSM-IV, the DSM-5 Work Group considered DESNOS/Complex PTSD (Sar, 2011). This was largely in response to clinical work and research (most often completed with non-Western patients) exploring clinically significant symptoms of behavioral difficulties, emotional difficulties, cognitive difficulties, interpersonal difficulties, and somatization noted in individuals exposed to severe and protracted traumatic exposure (e.g., childhood sexual abuse, adult torture, etc) (de Jong, Komproe, Spinazzola, van der Kolk, & Van Ommeren, 2005;

Sochting, Corrado, Cohen, Ley, & Brasfield, 2007; van der Kolk, et al., 2005). A field trial determined that DESNOS was too rare an occurrence to be classified as a stand-alone diagnostic entity, finding that approximately 8% of individuals with DESNOS did not also meet diagnostic criteria for PTSD. Therefore, complex trauma presentations may represent a subtype of PTSD rather than a distinct disorder (Friedman, Resick, Bryant, & Brewin, 2011). Although the DSM-5 did not include DESNOS as a diagnosis or subtype, the addition to the PTSD criteria of a fourth cluster of symptoms of negative alteration in cognitions and mood incorporates a couple of symptoms from DESNOS.

Ford (2010) reported that, although there is a substantial amount of overlap between DESNOS and PTSD, a number of features of DESNOS have been found to occur independently of a diagnosis of PTSD. The current diagnosis of PTSD does not include symptoms that have come to be characteristic of chronic, developmental abuse, such as an impaired view of self, destructive, impulsive, or suicidal behavior. In addition, DESNOS was found to be an independent risk factor requiring inpatient psychiatric treatment whereas PTSD was not (Ford, 2010). These results stand in contrast to the ICD-10 conceptualization of EPCACE, as well as to the DSM-IV's associated features of PTSD, and merit additional exploration in order to further refine the constructs.

Gender and DESNOS

Although research has indicated that men may have a greater risk of exposure to traumatic events, women are typically exposed to interpersonal violence at a much higher rate than men (Kessler, 1995) and are diagnosed with PTSD at a higher rate than men (Wolfe & Kimerling, 1997). Research has indicated that interpersonal violence carries one of the highest probabilities of developing subsequent PTSD (Breslau, Chilcoat, Kessler, Peterson, & Lucia,

1999; Hedtke, et al., 2008). Additionally, research has demonstrated that more girls than boys (13% versus 3%) report having suffered sexual assault (Kilpatrick & Saunders, 1999). Evidence in the trauma literature suggests that girls experience higher rates of familial sexual abuse than boys, and that the abuse tends to be more chronic or last for a longer duration than that of boys, who may experience a shorter duration of sexual abuse by a non-family member (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996). Ketring and Feinauer (1999) found that the severity of childhood sexual abuse was a strong predictor of the subsequent development of trauma symptoms. Additionally, they found that individuals who had been sexually abused by a family member reported higher trauma scores than individuals who were abused by an individual of no relation.

DESNOS and Combat Exposure

High rates of childhood trauma (physical and/or sexual abuse) have been found in treatment-seeking veterans diagnosed with PTSD (Bremner, et al., 1993; Lapp, et al., 2005). One study found that 50% of female soldiers and 15% of male soldiers reported some type of childhood sexual abuse, and 50% of both genders reported having experienced physical abuse (Rosen & Martin, 1996). Although women may suffer interpersonal abuse at a higher rate than men, both men and women may deal with chronic, developmental trauma, and these prolonged traumas in childhood may affect men and women in similar negative ways due to this being a period of significant brain development (Teicher, Anderson, Polcari, Anderson, Navalta, 2002). It is well known that combat exposure can have negative effects on the mental health of returning soldiers (Grieger et al., 2006; Hoge et al., 2004; Kardiner, 1941). Although research has examined the impact of multiple traumas (childhood and combat trauma), much of this research was done with veterans of wars prior to Operation Iraqi Freedom (OIF) and Operation Enduring

Freedom (OEF) (Fontana & Rosenheck, 1994; Lapp, Bosworth, Strauss, & Stechuchak, 2005). Fritch, Mishkind, Reger, and Gahm (2011) explored the impact of multiple traumas on OIF and OEF veterans. Their findings were consistent with prior research findings indicating a cumulative effect of multiple traumas (Bremner et al., 1993; Hoge et al., 2006).

The subsequent complexity that can arise in the clinical presentation of PTSD, due to the prevalence of interpersonal violence for women, as well as the high rates of a history of childhood trauma for veterans, presents a difficult job for clinicians working with women and veterans (Blaz-Kapusta, 2008; Ford, 1999). Owens et al. (2009) found that both combat exposure and childhood trauma were important variables in predicting PTSD severity. Their findings supported earlier research (Engel et al., 1993) that childhood trauma appears to have a strong influence on the later development of PTSD. Owens et al. noted that this appears to be the case particularly when the subsequent combat exposure is low. Ford (1999) found support for PTSD and DESNOS as separate syndromes among male combat veterans, noting that the preponderance of childhood physical abuse, but the lack of childhood sexual abuse, may have helped differentiate the two disorders, as studies that included women with childhood sexual abuse histories have tended to find more overlap between the syndromes (Van der Kolk et al., 1996). Ford noted that although DESNOS and PTSD may often be comorbid, results indicated that DESNOS occurred in half of the individuals who did not qualify for a diagnosis of PTSD. Additionally, Ford found that DESNOS was associated with the presence of a personality disorder more often than PTSD. Although DESNOS is not recognized as a formal disorder in the DSM-IV, research appears to support its existence as a disorder that may more accurately capture the full range of symptomatology that may be expressed following chronic or childhood abuse.

Borderline Personality Disorder

Borderline personality disorder (BPD) (see Appendix H) is another problematic disorder with regard to trauma and the diagnosis of PTSD. Individuals who suffer from long-term abuse in their childhood may develop character pathology, and research has demonstrated that these individuals may meet criteria for both PTSD as well as BPD (Lonie, 1993; Van der Kolk et al., 1996). The symptom constellation of BPD can be grouped into four trait dimensions with affective, impulsive, interpersonal, and cognitive symptoms (Paris, 2003). Although prevalence rates for BPD are varied (0.7 to 2.0%) the majority of findings place the prevalence of BPD at 2% (Lenzenweger, Lane, Loranger, & Kessler, 2007).

Kernberg (1967) was one of the first theoreticians to discuss BPD in terms that are similar to the current conceptualization of the disorder. Kernberg spoke of “borderline personality organization” (BPO), identifying it as “infantile” personality, and describing it as separate from psychotic personality organization due to adequate reality testing and separate from neurotic personality organization due to identity diffusion. Kernberg posited that individuals with BPO may have difficulty contenting themselves when left alone and may resort to dangerous sexual practices and substance abuse. BPO was later criticized for its heterogeneity. However, many of Kernberg’s ideas on the use of defense mechanisms, particularly splitting, have been retained (Stone, 2005).

Gunderson and Singer (1975) were the first to propose the term “borderline personality disorder.” Using Kernberg’s identity and reality testing criteria, Gunderson and Singer established criteria that could be easily measured. Their original criteria included lowered achievement, impulsivity, manipulative suicidal threats, brief psychotic episodes, good socialization, and interpersonal disturbances. In the DSM-III, BPD was put forth as a much

narrower concept than BPO. Impulsivity, identity disturbance, and acts of self-harm or self-mutilation were identified as being hallmark symptoms of the disorder (Stone, 2005). The DSM-III BPD criteria required five of eight symptoms which included impulsivity, unstable and intense relationships, inappropriate and intense anger, identity disturbance, affectivity instability, intolerance of being alone, physically self-damaging behaviors, and chronic feelings of emptiness or boredom. The BPD criteria were largely unchanged in the DSM-III-R, with revisions to two of the criteria and a change in the order of symptoms. The criterion, physically self-damaging behaviors was expanded to include “recurrent suicidal thoughts, gestures and behaviors” as well as self-mutilating behaviors, and intolerance of being alone was reworded as “frantic efforts to avoid real or imagined abandonment” (APA, 1987; p. 347).

There were few revisions to the BPD criteria in the DSM-IV (Dahl, 2008). A ninth criterion for transient paranoid or dissociative symptoms was added, although there was some controversy over whether the new symptom represented a core symptom of the disorder and reflected Kernberg’s original conceptualization or if it increased overlap with schizotypal personality disorder (Carlson, 2012; Dahl, 2008; Hopwood, Morey, Gunderson, Skodol, Shea, Grilo, & McGlashan, 2006). Despite the narrowing of criteria from the original concept of BPO to BPD, the diagnosis, as it is conceptualized in the DSM-IV, is still a heterogeneous diagnosis encompassing a broad range of symptoms (Cartwright, 2006). With the requirement of meeting five or more of the nine criteria, there are over 100 possible combinations of symptoms to receive a diagnosis of BPD, and two individuals with the diagnosis may share only one symptom. The BPD criteria in the DSM-5 are unchanged from the DSM-IV-TR. Although there were two drafts of proposals for a dimensional trait model of personality disorders, the DSM-IV

criteria were retained and the proposed trait model was put in section III of the DSM-5 for further study.

BPD and Trauma

In the 1970's and 1980's, research on BPD began pointing towards the frequency of trauma histories as a potential predisposing causative factor in the development of the disorder (Herman, Perry, van der Kolk, 1989; Landecker, 1992; Paris & Zweig-Frank, 1992; Zanarini, 1997). A number of studies were published revealing the high rates of childhood abuse (particularly sexual abuse) among individuals diagnosed with BPD (Landecker, 1992; Silk et al., 1995; Zanarini et al., 2002). However, although physical and sexual abuse appear to be significant predisposing factors, other traumatic childhood events are also associated with the BPD diagnosis. Early parental loss or separation, neglect, chaotic home environments, and inadequate parental involvement are also common in the histories of patients diagnosed with BPD (Frank & Paris, 1989; Joyce et al., 2003; Liu, Chen, Cai, Peng, & Zhou, 2011; Paris & Frank, 1989; Soloff & Millward, 1983).

Despite the high prevalence of trauma histories with BPD, viewing trauma as an etiological factor in the development of BPD simplifies the complex interplay between genetics and environment, as research has demonstrated the surprising resiliency in individuals (Rutter, 1987 [as cited in Cartwright, 2006]). A linear relationship between childhood trauma and BPD has not been supported in research (Paris, 1998). Rather, as suggested by Cartwright (2006), it may be most helpful to view childhood trauma through the lens of the diathesis-stress model, in which events in the environment interact with underlying personality traits and may highlight or magnify the expression of these pre-existing traits.

Gender and BPD

Although the true prevalence of BPD in each gender is unknown, epidemiological studies have found that women are given a diagnosis of BPD more frequently than men (Castaneda & Franco, 1985; Gilbertson, McGraw, & Brown, 1986; Strebel, Stacey, & Msomi, 1999).

Approximately 70-77% of individuals in clinical populations diagnosed with BPD are women (APA, 2000). Clinicians have noted a gender bias in the diagnosis but it is unclear as to what extent this may be due to bias in the criteria, biased sampling, or differences in the expression of personality pathology between men and women (Bjorklund, 2006; Swartz, Blazer, George, & Winfield, 1990; Sprague et al., 2011; Widiger & Weissman, 1991) as community samples have shown less of a gender difference in the diagnosis of BPD than clinical samples (Coid, 2003).

Skodol and Bender (2003) indicated that biased sampling may be the best explanation for gender differences in the diagnosis of BPD. However, they also noted that, as the true prevalence of BPD by gender is, as of yet unknown, there are several compelling biological and sociocultural hypotheses to explain the difference as well. To determine whether or not biased sampling is the most likely explanation for a gendered diagnosis, researchers need to examine samples from the general population. There is a paucity of representative population-based studies on BPD, and only one study (Torgersen, Kringlen, & Cramer, 2001) examined the prevalence of BPD in a representative population. However, the study was completed in Norway and, although a gender difference was not supported, more epidemiological research needs to be completed in other populations.

There are mixed research results regarding the possibility of criterion bias in the diagnosis of BPD. Sprock, Blashfield, and Smith (1990) examined gender weighting in the BPD criteria. Undergraduate students were asked to sort 142 DSM-III-R criteria for personality

disorders. Most of the BPD criteria were rated as being perceived as more characteristic of women. This finding raised the question of differential symptom presentation for BPD among men and women and the possibility of differential item functioning of the BPD criteria for men and women.

Jane et al. (2007) examined two large, nonclinical samples and found significant measurement bias with regard to gender for six specific criteria for personality pathology using the methods adopted from item response theory (IRT) and a self-report measure of the personality disorder criteria. The authors examined differential item functioning (DIF), which is when men and women with the same level of pathology do not show the same probability of endorsing the criterion item. The study indicated that the male and female participants with equal levels of pathology endorsed items at different rates. DIF was found for some of the criteria for paranoid and antisocial personality disorders, with men being more likely to endorse these criteria, and for schizoid personality disorder, with women being more likely to endorse these items. However, there was no evidence of DIF for BPD.

Boggs et al. (2009) examined sex bias in the diagnostic criteria for borderline, schizotypal, avoidant, and obsessive-compulsive personality disorders. The study had a large sample ($n=668$), utilizing data from the Collaborative Longitudinal Personality Disorders Study (CLPS). The study used three measures, the Diagnostic Interview for DSM-IV Axis II criteria (DIPD-IV; Zanarini, Frankenburg, Sikel, & Yong, 1996), the Social Adjustment Scale (SAS-SR; Weissman & Bothwell, 1976), and the Longitudinal Interval Follow-Up Evaluation (LIFE-PS; Keller et al., 1987), and results were analyzed to evaluate sex differences in diagnosis and measures of functioning. Using a regression model to identify bias, the authors found that although most diagnostic criteria do not appear to display sex bias, the borderline criteria showed

evidence of sex bias. Their results suggested that the diagnostic criteria for BPD may not be representative of the ways in which the disorder may manifest in men. Although Boggs et al. found evidence of a sex bias in the diagnostic criteria for BPD, others have not found evidence of criterion bias (Johnson, Shea, Yen, et al., 2003; Klonsky, Jane, & Turkheimer et al., 2002).

Additional research is needed to further illuminate the question of criterion bias.

Skodol and Bender (2003) cited additional research findings with regard to biased diagnostic thresholds as well as biased application of BPD criteria, noting that the results have been mixed. The authors concluded that sampling bias (i.e., differences in treatment seeking) has received the most consistent support as an explanation for the gender differences observed in the diagnosis of BPD. However, if representative epidemiological studies reveal a gender bias in BPD in community samples, biological and sociocultural hypotheses should be explored.

Differentiating BPD and PTSD

Although there is not much diagnostic overlap between PTSD and BPD, individuals may present a strikingly similar clinical picture, with alterations in self-image, inability or difficulty modulating emotions, increased reactivity to environmental or emotional stressors and difficulty tolerating extreme emotions (Herman & Van der Kolk, 1987; Woodward et al., 2009). However, despite their similar clinical presentation, clinicians regard the two disorders quite differently. Although recent research indicates that BPD has a relatively good prognosis as compared to other personality disorders, with symptoms remitting over a ten year time period (Paris, 2003), many clinicians consider it a chronic disorder and the stigma associated with it can have negative effects on the level of care a patient receives (Aviram, Brodsky, & Stanley, 2006; Gunderson & Ridolfi, 2001). This stands in contrast to the view of PTSD symptoms as situational in nature, which can have the effect of eliciting more empathy from the clinician (Woodward et al., 2009).

Additionally, the differences in diagnosis may lead to altering the nature of treatment provided; cognitive processing therapy (CPT), prolonged exposure (PE) therapy, or eye movement desensitization and reprocessing (EMDR) for PTSD (National Center for PTSD, 2007) versus psychodynamic psychotherapy (specifically Transference Focused Psychotherapy [TFP]) or dialectical behavior therapy (DBT) for BPD (Clarkin et al., 2001; van den Bosch, Koeter, Stijnen, Verheul, & van der Brink, 2005).

Research has also suggested that differential diagnosis may be complicated by the effects of gender. As noted above, gender differences have been found for PTSD and BPD. Results have been inconsistent regarding gender bias in the diagnosis of BPD versus PTSD (Becker & Lamb, 1994; Woodward et al., 2009). In the first study examining differential diagnosis of those disorders, Becker and Lamb (1994) found evidence for sex bias in the diagnosis of BPD and PTSD. In the study, clinicians received one of three vignettes that were balanced for BPD and PTSD criteria. The criteria were not sufficient for either diagnosis and the “hallmark” symptoms of BPD (overidealization and devaluation) and PTSD (dissociative episodes) were not included. The sex of the individual in the cases was manipulated by using male or female nouns and pronouns. Clinicians were asked to rate the degree to which a series of Axis I and II diagnoses were represented by the case. A significant main effect for sex of the client was found for the diagnosis of BPD, but not for the diagnosis of PTSD. However, female clinicians rated PTSD more highly than their male counterparts. Additionally, psychiatrists rated the presence of PTSD symptoms lower than social workers or psychologists. Younger psychologists and psychiatrists tended to rate BPD more highly than PTSD, whereas the opposite was true for social workers.

Becker and Lamb (1994) noted that considering the high frequency of traumatic abuse histories in women diagnosed with BPD, it may be more helpful for the client if clinicians

considered a diagnosis that more accurately reflects the possible traumatic etiology of the symptoms. In addition, PTSD is a diagnosis that is less stigmatizing than BPD (Kilpatrick & Saunders, 1999). The authors hypothesized that the higher PTSD ratings among female clinicians may be due to increased sensitivity regarding childhood sexual abuse, and possible underestimation by male clinicians of the effects of childhood sexual abuse.

In contrast to Becker and Lamb's (1994) findings, Woodward et al. (2009) did not find an effect of patient or clinician sex bias for the diagnosis of PTSD or BPD using one of Becker and Lamb's vignettes. However, they did find evidence of an anchoring effect of where the trauma history was presented in the case. Participants were 119 psychologists from New York who were asked to provide a primary diagnosis and a rule out diagnosis. The authors counterbalanced the disclosure of abuse history, with half of the participants receiving the vignette with the abuse history reported at the beginning and half receiving the vignette with the abuse history reported at the end. The vignettes met four of the nine criteria for BPD and five of the six necessary symptom clusters for PTSD, but fell short of the number needed to make a diagnosis. The authors suggested that the use of a categorical diagnoses rather than Likert scale diagnostic ratings, as used in Becker and Lamb (1994), may account for their lack of support for a gender bias. This change was made in response to a critique regarding the generalizability of diagnostic ratings collected in this manner (Garb, 1995). However, the authors found support for theoretical orientation influencing the diagnosis, with self-reported psychodynamic clinicians being more likely to diagnose BPD, whereas CBT clinicians were more likely to diagnose PTSD. Woodward et al. highlighted the importance of the anchoring effect finding, noting that previous research has found that clients may not mention their abuse histories unless clinicians ask (Briere

& Zaidi, 1989). This is a valid concern, as Pruitt and Kappius (1992) found that only 51% of therapists ask about childhood sexual abuse routinely.

The issue of differential diagnosis between PTSD and BPD may be especially relevant for veterans, as high rates of childhood trauma (physical and/or sexual abuse) have been found in treatment-seeking veterans diagnosed with PTSD (Bremner et al., 1993; Lapp et al., 2005). Complicating the picture further is the paucity of research on women veterans, yet they are a growing segment of the military (GAO reports, 1999). Gender differences in the prevalence and expression of BPD and PTSD symptoms are especially relevant for clinicians working with veterans in order to ensure proper diagnosis and subsequent treatment.

The VA and PTSD

The Department of Veterans Affairs (VA) is the largest provider of mental healthcare for returning veterans dealing with physical and mental health disorders. Of the 1.4 million troops deployed for Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), it is projected that upwards of 30% will seek mental health services following their deployment (Klein & Kornblau, n.d.). Research has shown that veterans returning from OIF/OEF are at a high risk for developing PTSD (Hoge, Auchterlonie, & Milliken, 2006; Seal, Bertenthal, Miner, Sen, & Marmar, 2007). Seal et al. (2007) noted that the rate of diagnosed PTSD among OEF/OIF veterans who utilized the VA had risen from 0.2% in 2001 to 21.8% in 2008. Within the VA, PTSD is the most common mental health diagnosis (Shiner, 2011).

Although the VA is a leader in recognizing the need for increased care for individuals diagnosed with PTSD, it may fall short both in recognizing the individuals for whom care is warranted, as well as being able to provide the breadth of services that those suffering with PTSD tend to need, including couples therapy, group therapy, and substance abuse treatment

(Defense Health Board Task Force, 2007). The VA typically uses two approaches to identify returning soldiers who may be at risk for developing PTSD: The combat stress control program and a post-deployment health assessment questionnaire (GAO, 2004). The two PTSD screeners, the Post-Deployment Health Assessment (PDHA; DD 2796) and the Post-Deployment Repeated Health Assessment (PDRHA), are used to screen for a number of medical conditions and mental health disorders including PTSD (Rona, Hyams, & Wessely, 2005). The assessment includes four questions related to identification of individuals at risk for developing PTSD: *Have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you (1) have had any nightmares about it or thought about it when you did not want to (2) tried hard not to think about it or went out of your way to avoid situations that remind you of it (3) were constantly on guard, watchful, or easily startled (4) felt numb or detached from others, activities, or your surroundings?* (DD 2796 [as cited in GAO, 2004). However, many combat soldiers experience a delay in the onset of PTSD symptoms, which has the result of limiting the successfulness of the aforementioned screening tools, as they are administered shortly upon returning home (Klein & Kornblau, n.d.). The combat stress control program entails traveling to various units in order to train service members to recognize signs of combat stress such as nightmares and relationships difficulties (GAO, 2004).

In addition to underestimates of PTSD resulting from the use of somewhat ineffective screening tools, there are additional barriers to receiving care from the VA and VA Vet Centers (Ouimette et al., 2011; Washington, Yano, Simon, & Sun, 2006). Although stigma-related barriers are some of the most salient for veterans, geographic barriers are also of particular concern. Increased distance from a VA center has been found to be associated with a greater risk of gaps in mental health services utilization (McCarthy et al., 2007; Ouimette et al., 2011). This

is especially problematic as rural areas have the highest concentration of veterans and the least access to specialized care, such as that offered by the VA (Veterans Health Administration, 2000 [as cited in Behrman, 2007]). In addition, research has demonstrated that less than 50% of veterans/soldiers who met screening criteria for a mental disorder expressed interest in receiving services through the military system (Hoge et al., 2006). Due to the pressures that the VA faces in delivering care to a growing number of veterans, strategies such as increasing mental health personnel and outsourcing certain services to the private sector have been considered by individual VA networks (Wakefield, Tripp-Reimer, Rosenbaum, & Rosenthal, 2007).

The VA commonly utilizes a compensation and pension (C&P) examination in order to identify veterans who may be eligible for VA disability benefits. Although this type of examination is one of the most common forensic mental health evaluations, there is little research on how the examinations are conducted (Worthen & Moering, 2011). This is particularly problematic as private providers may begin conducting these types of evaluations as outlined in the 2011 Disability Benefits Questionnaire system put in place by the VA. Although the VA currently allows for C&P evaluations to be completed by private practitioners, it does not provide payment for these exams. Providers are expected to collect payment from the veteran. These evaluations are complex and providers often face resistance from VA officials for assessing for malingering or symptom exaggeration as well as time restrictions allotted for the examinations. Furthermore, as C&P examinations are considered forensic exams (in that they are conducted to assist in evaluating for compensation due to functional impairments resulting from their work within the military), private providers need to be familiar with the principles of forensic psychology (Worthen & Moering, 2011).

Gender and the VA

The Veterans Health Care Act of 1992 provided gender-specific programs and services for women veterans. Prior to 1992, women were involved in the military but did not have the same access to VA benefits and services as their male counterparts. Approximately 25,000 women served in the Army Nurse Corps in World War I and that number rose to 319,000 in World War II. Following World War II, Congress passed the Veterans Preference Act of 1944, which included the first provision specifically for women, allowing them employment preference (VA History in Brief, n.d.). However, medical and mental health benefits were not offered to female veterans until 1988 (Fitzpatrick, 2010). Montrey (2000) estimated that women will comprise 10% of the military by 2010, and by 2005, women represented 7 percent of the military population, with their numbers expected to continue growing (VA History in Brief, n.d.). As one of the fastest growing segments, it is of utmost importance to explore this important group of the military, as women veterans may face different challenges during service and different barriers to treatment following service (Fitzpatrick, 2010; Washington et al., 2006)

Although institutional gains have been made within the VA system to address gaps in healthcare for women veterans, barriers appear to remain, as women veterans access care services less than their male counterparts (Skinner, Sullivan, Tripp, et al., 1999). Eight-seven percent of women veterans do not access health care services offered through the VA (Medical SAS Outpatient Dataset, 2003 [as cited in Washington et al., 2006]). In a study examining the factors that influence women veterans' use of VA healthcare in VA users and nonusers, Washington et al. (2006) found that VA users cited affordability, availability of a women's health clinic, quality of care, and convenience as reasons for use. Nonusers cited having insurance that covers health care outside the VA, convenience of non-VA care, lack of

knowledge regarding eligibility and benefits, and perceptions regarding higher quality of care outside of the VA as reasons for nonuse.

In addition to the aforementioned barriers to receiving treatment in the VA, some women may feel uncomfortable seeking treatment in a setting that tends to be dominated by male clients. This may be the case particularly if these women have dealt with military sexual trauma. In a study of Persian Gulf War veterans, 34% of women veterans reported a rape or attempted rape during active duty, with a majority reporting that this occurred more than once (Department of Defense Task Force on Domestic Violence, n.d. [as cited in Valente & Wight, 2007]). Although the problem of military sexual trauma is not confined to women, it is estimated that approximately 20-30 percent of female veterans experience military sexual abuse (Suris, Lind, Kashner, Borman, & Petty, 2004).

Military sexual trauma coupled with real and perceived barriers to VA care is such a pervasive problem that *Time* magazine published an article about it in 2010. In the article, it was noted that 22% of female veterans who have experienced a sexual trauma feel “unsafe” in the waiting rooms of VA’s. Fortunately, the VA has made some gains in regard to offering female veterans gender-specific services in clinics that are closed to male veterans. These gains are slow, however, with only one clinic offering treatment to women by women. The Center of Excellence for Women’s Health in California offers treatment to approximately 6,000 female veterans a year. In early 2010, the VA updated its guidelines for the care of female veterans, including new privacy requirements. Additionally, the VA has significantly increased its budget for gender-specific care (Fitzpatrick, 2010).

The unique experiences of women in the military may complicate the picture of diagnosis for clinicians. Fontana, Rosenheck, and Desai (2010) found that female veterans reported higher

levels of exposure to different types of trauma (i.e., military sexual trauma and noncombat, nonsexual trauma) and had fewer supports (both economic and interpersonal) than male veterans. Additionally, the authors reported that female veterans, in comparison to male veterans, received a diagnosis of PTSD less often, and anxiety and mood disorder diagnoses more often. The authors argued that, in light of these results, programs specifically tailored to the needs of female military personnel may be an area worthy of consideration for clinicians working with veterans.

Few studies have explored the potential effects of noncombat sexual trauma on female veterans. Himmelfarb, Yaeger, and Mintz (2006) found a rate of premilitary/postmilitary sexual assault of 35 percent. Furthermore the authors reported that both premilitary sexual trauma as well as military sexual trauma predicted postmilitary sexual trauma. Sadler, Booth, Cook, and Doebbeling (2003) reported that childhood sexual abuse and premilitary rape significantly predicted military rape. This was in contrast to Himmelfarb et al.'s results which did not indicate that premilitary sexual trauma increased the risk of military sexual trauma. The potential for multiple types and incidences of trauma for women in the military may complicate the clinical presentation of their symptoms (Bremner et al., 1993; Ford, 1999; Hoge et al., 2006)

Diagnosis in the VA and the Private Sector

Due to the number of barriers that veterans (particularly female veterans) may face in receiving care through the VA or an associated facility, they may turn to the private sector for their care (Hoff & Rosenheck, 1998). Klein and Kornblau (n.d.) reported that the VA's PTSD assessment tools and diagnostic procedures may differ from other service providers.

Additionally, Sharpless and Barber (2011) noted that civilian clinicians may not be as familiar with the presentation of combat trauma as they may be with other types of trauma (e.g., rape).

Not only do soldiers deal with traumatic events such as interpersonal violence and witnessing the

death of friends and others, they also likely deal with having taken action themselves that is traumatic, such as killing another person. Private sector clinicians also may not be as familiar with PTSD treatments as VA clinicians. Despite these potential differences, no known studies have examined potential differences between VA clinicians and private sector clinicians in assessment tools and procedures used to diagnose PTSD. Only three studies on the validity of VA primary care PTSD diagnoses have been conducted, and all three found variation in diagnostic validity (Magruder & Yeager, 2008; Magruder et al., 2005; Taubman-Ben-Ari, Rabinowitz, Friedman, & Vaturi, 2001).

Gravely et al. (2011) explored the validity of PTSD diagnoses in VA administrative data by comparing those diagnoses found in the data with PTSD Checklist (PCL) scores of participants diagnosed with PTSD. Their results supported earlier findings (Magruder & Yeager, 2008) indicating variation by clinic type (i.e., primary care clinic, non-PTSD mental health clinic, and PTSD clinic). However, whereas Magruder and Yeager indicated that PTSD diagnoses may be under-recognized in primary care, Gravely et al. found that PTSD may be over-diagnosed (when compared to PCL scores) in primary care settings. Magruder and Yeager also found suggestive, but not significant, results indicating that PTSD was under-diagnosed in female veterans as compared to male veterans (73.3% of women versus 54.2% of men).

Present Study

Due to the role of trauma in the etiology of PTSD, DESNOS, and BPD, as well as the similar clinical pictures that individuals with these disorders may present (Herman & Van der Kolk, 1987), it is important to examine differential diagnosis of these disorders and the factors that might influence diagnosis. Possible gender biases in diagnosis, as well as the anchoring effect of when trauma information is presented in a case, have been noted in the diagnosis of

PTSD and BPD (Becker & Lamb, 1994; Woodward et al., 2009). For veterans, it is critical to examine differences in diagnoses between VA clinicians and private sector clinicians, as veterans frequently seek treatment in the private sector rather than the VA and differences in diagnosis may affect treatment. Furthermore, it may be important to differentiate between VA clinicians within the Compensation and Pension (C&P) branch of the VA and other VA clinicians, as C&P clinicians operate as forensic psychologists since their diagnoses determine eligibility for benefits. Additionally, as more women are enlisting in the military than ever before (DHBTF, 2007) and many of these servicemen and women may have experienced noncombat traumas, the need for this research in addition to general research regarding the experiences of women in the military should be completed (Bremner et al., 1993; Lapp et al., 2005).

The present study examined potential gender bias in the diagnosis of PTSD and BPD in case vignettes in which the gender of the individual was manipulated. As previously noted, there is mixed evidence regarding the effect of client sex on diagnosis, particularly with regards to BPD and PTSD (Becker & Lamb, 1994; Woodward et al., 2009). This study aimed to add to the research that currently exists regarding a possible sex bias with the hypothesis that, given the same symptoms, women may be diagnosed with BPD more often than men who will be diagnosed with PTSD. In addition, the role of childhood trauma and the possible anchoring effect of placement of the childhood trauma in the case (early versus late) was explored. In particular, it was expected that early presentation of the trauma in the case would increase the likelihood of a diagnosis of PTSD whereas later presentation of the trauma in the case would increase the likelihood of a diagnosis of BPD. Finally, differences between VA psychologists and private sector psychologists were explored. Because of their familiarity with the diagnosis

and treatment of PTSD, it was expected that VA psychologists would be more likely to recognize the absence of PTSD cluster B symptoms in the vignette (i.e., re-experiencing) and therefore would be less likely to diagnose PTSD despite the addition of a combat trauma. However, it was hypothesized that they would be more likely to recognize the possibility of DESNOS in the cases than private sector psychologists due to their knowledge of trauma spectrum syndromes. This is an area of particular interest as many veterans and active-duty military members have reported seeking support within the private sector (Hoge et al., 2006) and no known studies have examined potential diagnostic differences.

The present study used a vignette methodology in which clinicians were presented with one of four versions of a vignette describing an individual with a history of childhood abuse and neglect as well as a combat trauma later in life. The clinicians were asked to assign diagnoses, diagnostic ratings, and to rate the symptoms that are present in the case. The gender of the client in the case and the placement of the childhood abuse history in the case (early versus late) was manipulated. Both VA and private sector psychologists were invited to participate in the study. As the DSM-5 was released while this study was in process, the study utilized DSM-IV-TR diagnoses and diagnostic criteria.

Hypotheses

1. It was hypothesized that gender of the individual in the vignette would have a significant effect on the diagnosis of BPD and PTSD. Specifically, it was hypothesized that:
 - a. The female version of the vignette would be seen as more representative of BPD than the male version:
 - 1) The BPD diagnosis would be assigned more often for the female version than for the male version.

2) The female version would receive higher BPD diagnostic ratings and BPD symptom ratings than the male version and more BPD symptoms would be endorsed

b. The male version of the vignette would be seen as more representative of PTSD than the female version:

1) The PTSD diagnosis would be assigned more often for the male version than for the female version.

2) The male version would receive higher PTSD diagnostic ratings and PTSD symptom ratings than the female version and more PTSD symptoms would be endorsed.

c. The female version of the vignette would tend to be seen as BPD rather than PTSD:

1) The BPD diagnosis would be assigned more often than the PTSD diagnosis for the female version

2) The female version would receive higher BPD than PTSD diagnostic ratings and symptom ratings and more BPD than PTSD symptoms would be endorsed

d. The male version of the vignette would tend to be seen as PTSD rather than BPD:

1) The PTSD diagnosis would be assigned more often than the BPD diagnosis for the male version

2) The male version would receive higher PTSD than BPD diagnostic and symptom ratings and more PTSD symptoms would be endorsed

2. It was hypothesized that the placement of childhood trauma in the case would have an anchoring effect on the diagnoses assigned to the cases. Specifically, it was hypothesized that:

a. When the childhood trauma is placed early, the vignette would be seen as more representative of PTSD than when the trauma is presented later:

1) The PTSD diagnosis would be assigned more often for the version in which the childhood trauma is presented earlier than for the version in which it is presented later.

2) The version in which the childhood trauma is presented earlier would receive higher PTSD diagnostic ratings and PTSD symptom ratings than the version in which it is presented later and more PTSD symptoms would be endorsed

b. When the childhood trauma is placed later, the vignette would be seen as more representative of BPD than when the trauma is presented earlier:

1) The BPD diagnosis would be assigned more often for the version in which the childhood trauma is presented later than for the version in which it is presented earlier.

2) The version in which the childhood trauma is presented later would receive higher BPD diagnostic ratings and BPD symptom ratings than the version in which it is presented earlier and more BPD symptoms would be endorsed

c. When the childhood trauma is placed earlier, the vignette would be seen as more representative of PTSD than BPD:

1) The PTSD diagnosis would be assigned more often than the BPD diagnosis for the version in which the childhood trauma is presented earlier

2) The version in which the childhood trauma is presented earlier would receive higher PTSD than BPD diagnostic ratings and symptom ratings, and more PTSD than BPD symptoms would be endorsed

d. When the childhood trauma is placed later, the vignette would be seen as more representative of BPD than PTSD:

- 1) The BPD diagnosis would be assigned more often than the PTSD diagnosis for the version in which the childhood trauma is presented later
- 2) The version in which the childhood trauma is presented later would receive higher BPD than PTSD diagnostic ratings and symptom ratings, and more BPD than PTSD symptoms would be endorsed

3. It was hypothesized that there would be differences in diagnoses and diagnostic ratings based on clinician work settings. Specifically, it was hypothesized that:

a. VA clinicians would see the vignette as less representative of PTSD than private sector psychologists:

- 1) The PTSD diagnosis would be assigned less often by VA than private sector psychologists.
- 2) VA psychologists would assign lower PTSD diagnostic ratings and PTSD symptom ratings than private sector psychologists and fewer PTSD symptoms would be endorsed

b. Private sector clinicians would see the vignette as more representative of PTSD than BPD:

- 1) The PTSD diagnosis would be assigned more often than BPD by private sector psychologists.
- 2) Private sector psychologists would assign higher PTSD than BPD diagnostic ratings and symptom ratings and more PTSD than BPD symptoms would be endorsed

c. VA clinicians would see the vignette as more representative of DESNOS than private sector clinicians:

1) VA psychologists would assign higher DESNOS symptom ratings than private sector psychologists and more DESNOS symptoms would be endorsed

d. VA clinicians within the Compensation and Pension branch of the VA would assign fewer PTSD diagnoses than other VA clinicians

CHAPTER 3

METHOD

Design

This study used a quasi-experimental design. VA and private sector psychologists read a case vignette that included a mixture of PTSD and BPD symptoms and were asked to assign a diagnosis and ratings for the case. Participants were randomly assigned to receive either a female or male client, with the childhood trauma presented either early or late in the vignette. The independent variables included the gender of the client presented in the vignette, the placement of the childhood trauma in the vignette (early versus late) and the work setting of the participant (VA psychologist versus private sector psychologist). All independent variables were between subjects. The dependent variables included the categorical diagnoses assigned by clinicians, diagnostic ratings for the disorders of interest (PTSD and BPD), ratings for symptoms of PTSD, BPD, and DESNOS, and the number of symptoms of each construct endorsed as being present in the vignette.

Power Analysis

Using the statistical power analysis program “Power and Precision” (Borenstein, Rothstein, & Cohen, 2001) to detect a medium effect size, for a factorial design with three independent variables each with two levels, with desired power of .80 and alpha of .05, it was determined that 136 participants were needed. A medium effect size was selected as no study has directly examined possible diagnostic differences between VA and private sector psychologists. This sample size is in line with Woodward et al. (2009) who explored sex bias as well as the effect of the placement of childhood trauma (early versus late) on diagnosis.

Participants

Given an anticipated response rate of 10-20% (i.e., Crosby & Sprock, 2004), 1500 psychologists were invited to participate. A randomly selected national sample of doctoral level, licensed, clinical or counseling psychologists who are members of the American Psychological Association (APA) were obtained from the APA on-line directory and were invited to participate. Additionally, the survey was distributed through several listservs for psychologists working within the VA. One listserv was specifically for those in the Compensation and Pension (C&P) branch of the VA as this group is primarily responsible for evaluating and assigning diagnoses that may result in some form of compensation (Liang & Boyd, 2011), whereas the others are more general listservs for VA clinicians.

The sample consisted of 149 participants, 62 VA psychologists and 87 psychologists employed in the private sector. Among the VA psychologists, 38 identified themselves as working in compensation and pension (C&P). One hundred and eighty psychologists agreed to participate; however, 31 individuals were eliminated from the database due to missing information. Generally, these participants began the study but discontinued, leaving a significant amount of the survey uncompleted. Demographic and professional information for the participants is presented in Table 1. Additional information is also presented in Appendix Q. It should be noted that a sizable minority did not report demographic or professional information. Overall, the sample was middle aged with an average of nearly 18 years of experience. More than half were women and the majority of the sample was Caucasian. Nearly all had a Ph.D. or Psy.D., and the most frequently identified theoretical orientation was Cognitive-Behavioral followed by eclectic or integrative. Overall, participants rated themselves as very familiar with

PTSD ($M = 4.67$, $SD = .67$) and BPD ($M = 4.34$, $SD = .87$), but not that familiar with DESNOS (2.12, $SD = 1.33$), using a 5 point Likert scale (1 = *not at all familiar* to 5 = *very familiar*).

Chi-square analyses and one-way analysis of variance tests were used to compare VA and private sector psychologists on gender, age, number of years of clinical experience, and ratings of familiarity with the diagnoses. There were no significant differences between VA and private sector psychologists for age, gender, or number of years of clinical experience. Both groups rated themselves as very familiar with PTSD and BPD and not familiar with DESNOS, but VA psychologists rated themselves more familiar with PTSD than private sector psychologists ($M = 4.92$, $SD = .28$ vs. $M = 4.46$, $SD = .82$), $F(1, 132) = 17.81$, $p < .001$.

Case Vignettes

The case vignette used for this study was taken from Woodward et al. (2009) and was one of Becker and Lamb's (1994) three cases that included a mixture of PTSD and BPD symptoms. The case described an individual who had significant childhood trauma (including sexual abuse and neglect), and who was experiencing significant difficulties psychologically as well as in interpersonal relationships. According to the authors, the vignette included four of the nine criteria for BPD (identity disturbance, impulsivity, chronic feelings of emptiness, and inappropriate rage). The vignette also included two of the three necessary PTSD symptom clusters, cluster C (avoidance and numbing including efforts to avoid thoughts, feelings, or conversations associated with the trauma, diminished interest in significant activities, sense of foreshortened future) and cluster D (arousal as indicated by outbursts of anger, hypervigilance, and insomnia). It also met criteria A (the experience of a traumatic event), E (duration more than 1 month) and F (causes significant distress or impairment). The case did not meet criteria for PTSD or BPD, or the proposed criteria for DESNOS. As indicated by Becker and Lamb (1994),

this ambiguity is helpful in uncovering diagnostic processes and biases in diagnosis. Like Woodward et al., there were four versions of the vignette (see Appendices H-K) that differed only in the gender of the client (male/female) and the placement of childhood abuse history in the case (early/late).

For the purpose of the present study, the case was modified by adding a history of combat trauma to make the vignette more representative of what clinicians may encounter when working with veterans (Bremner et al., 1993; Lapp et al., 2005). The history of combat trauma was presented in the middle of the case and described the client as a medic who experienced an IED blast. Due to the addition of a combat trauma, three VA clinicians (two of whom are currently working within the VA and one who has worked there in the past) were asked to read the vignette and give their initial impressions regarding the ambiguity of the cases to determine if the level of ambiguity desired to assess diagnostic bias was maintained. The psychologists indicated that the case was realistic and did not meet criteria for PTSD with the addition of the combat trauma.

Measures

Diagnostic Questionnaire. After reading the case vignette, participants completed the Diagnostic Questionnaire (see Appendix L). First, they were asked to rate the representativeness of a series of DSM-IV-TR Axis I and II diagnoses for each vignette, including BPD and PTSD, using a 5-point Likert scale (1 = *not at all* representative to 5 = *highly representative*). As noted earlier, the study was designed and data collection was initiated prior to the publication of the DSM-5. The participants were then asked to select one diagnosis as most representative of the case and to rate their confidence in their diagnosis on a 5-point Likert scale (1 = *not at all confident* to 5 = *very confident*). DESNOS was not included as a diagnostic choice as it is not a

diagnosis in the DSM-IV. Next, clinicians were asked to rate the descriptiveness of a series of symptoms for the case, including PTSD, BPD and DESNOS, using a 5-point Likert scale (1 = *not at all descriptive* to 5 = *highly descriptive*). Finally, participants were asked to rate the perceived severity of the client's overall psychopathology (1 = *very mild* to 5 = *very severe*), prognosis (1 = *very good* to 5 = *very poor*), and the likelihood of responding to treatment (1 = *not at all likely* to 5 = *very likely*).

Demographic Questionnaire. After completing ratings on diagnostic and symptom ratings of the vignette, participants were asked to provide demographic information and information regarding their professional training and clinical experience (see Appendix M). Participants were asked to report their age, sex, ethnicity, years of clinical experience, and theoretical orientation. They were also asked to report their primary and secondary work settings, internship setting, disorders they frequently encounter in their practice, and the percent of time working with various age groups. Finally, they were asked to rate their familiarity with PTSD, BPD and DESNOS on a 5-point Likert scale (1 = *not at all familiar* to 5 = *very familiar*).

Procedure

The Qualtrics web survey program was used to create an on-line survey. An email invitation was sent to psychologists who are members of the APA and have email addresses listed in the APA directory. Additionally, the on-line survey along with a letter of invitation was posted to a C&P listserv through the Louisville VA. In order to limit the sample to those certified to diagnose mental disorders, only licensed clinical or counseling psychologists were invited to participate. The invitation asked them to fill out the on-line survey (see Appendix N) and included a link to the web page. Once participants accessed the survey via the link, they were presented with the consent form explaining both the purpose and procedures of the present

study (see Appendix O). The consent form also noted that if they chose to participate, they may enter a raffle to win one of three \$100 gift cards as an incentive. The clinicians who clicked on the link indicating their willingness to participate were then taken to a page with the instructions along with the case vignette, followed by the Diagnostic Questionnaire. The Qualtrics survey program randomly assigned each participant to receive one of the four versions of the vignette. Of the total participants, 36 (24.0%) received vignette 1, 35 (23.3%) received vignette 2, 33 (22.0%) received vignette 3 and 45 (30.0%) received vignette 4.

After reading the case and completing the Diagnostic Questionnaire, the participants were asked to complete the Demographic Questionnaire. When participants selected the “submit” button, the data were automatically entered into a database. The participants were then directed to a separate page thanking them for their participation (see Appendix P). They then had the option of entering the raffle. The participants’ names as well as their email addresses were not linked to the questionnaires thereby ensuring anonymity. Three gift cards for \$100 each for Amazon, a large online retailer, were raffled off to three randomly chosen winners after data collection was completed.

CHAPTER 4

RESULTS

Data were collected by the Qualtrics on-line survey and saved in an SPSS database. SPSS version 22.0 was used to analyze the data. Results are presented for the categorical diagnoses, diagnostic ratings, and then the symptom ratings. Descriptive statistics and between-group analyses are presented for each set of dependent variables.

Diagnoses

Table 2 presents the most frequent categorical diagnoses assigned to the case. PTSD was most often assigned, followed by BPD, Major Depressive Disorder and Paranoid Personality Disorder. Note that due to a programming error, BPD was not one of the categorical choices in the drop-down menu, but participants could write in the diagnosis under “other.” Nevertheless, BPD was the second most frequent diagnosis assigned. Participants’ ratings of confidence in their diagnosis were generally moderate on the scale of 1 to 5, both for those who diagnosed PTSD ($M = 3.49$, $SD = 1.12$) and for those who diagnosed BPD ($M = 3.04$, $SD = 1.07$). Participants also rated the severity of the client’s overall psychopathology ($M = 3.60$, $SD = .63$), the prognosis ($M = 3.06$, $SD = .67$), and the likelihood of the individual of responding to treatment ($M = 3.17$, $SD = .74$) as moderate using 5-point scales.

Separate chi-square analyses were used to compare differences in the assignment of diagnoses of PTSD and diagnoses of BPD based on gender of the individual in the case, placement of the childhood trauma in the case (i.e., early versus late), and for VA versus private sector psychologists (see Table 3). The female version of the case received significantly more BPD diagnoses than the male version, but there was not a significant difference in PTSD

diagnoses between the male and female versions of the case. There were no significant differences in number of BPD diagnoses or number of PTSD diagnoses for presentation of the childhood trauma early in the case compared to presentation of the trauma late in the case. VA psychologists assigned significantly more diagnoses of BPD than private sector psychologists, and somewhat fewer PTSD diagnoses, although the difference in assignment of PTSD diagnoses was not significant.

Due to a programming error in which BPD was not offered as a diagnostic choice, comparisons between the number of BPD versus PTSD diagnoses assigned based on gender, placement of the childhood trauma in the case, or VA versus private sector psychologist were not conducted. For each case, the number of PTSD diagnoses exceeded the number of BPD diagnoses, which could be explained by BPD not being included in the dropdown list. Therefore, these hypotheses could not be examined.

Diagnostic Ratings

Like diagnoses, diagnostic ratings were also highest for PTSD followed by BPD (see Table 4). Separate 2 (patient gender) x 2 (placement of the childhood trauma in the case: early vs. late) x 2 (psychologist setting: VA vs. private sector psychologist) factorial analysis of variance (ANOVA) were conducted in order to examine the effects of the variables on the PTSD and BPD diagnostic ratings. For the BPD diagnostic ratings (see Table 5), the female version of the case was rated higher than the male version, and VA psychologists assigned higher BPD ratings than private sector psychologists. There were no significant differences in BPD diagnostic ratings based on placement of the childhood trauma in the case, nor any significant interactions.

For the PTSD diagnostic ratings, VA psychologists provided significantly lower PTSD ratings than private sector psychologists (see Table 6). There was also a significant 3-way interaction; VA psychologists provided lower PTSD ratings than private sector psychologists except for the female case with the childhood trauma presented late in the case, which was rated similarly to private sector psychologists. There were no significant differences in PTSD diagnostic ratings based on gender of the patient, placement of the childhood trauma in the case, or other significant interactions.

Separate paired t-tests were used to compare PTSD and BPD diagnostic ratings (see Table 7) to examine the hypotheses that the case would be seen as BPD or PTSD based on the independent variables. For the female case, there was not a significant difference between BPD and PTSD diagnostic ratings. For the male case, the mean diagnostic rating for PTSD was significantly higher than the BPD diagnostic ratings. When the childhood trauma was presented early in the case, the mean diagnostic rating for PTSD was slightly higher than the diagnostic rating for BPD but the difference was not significant. However, t-tests indicated that the cases were rated as more representative of PTSD than BPD when the childhood trauma was presented late in the case. Additional t-tests were also used to compare PTSD and BPD diagnostic ratings for VA psychologists and for private sector psychologists. For VA psychologists there was not a significant difference between BPD and PTSD diagnostic ratings. However, private sector psychologists rated the cases as being significantly more representative of PTSD than BPD.

Symptom Ratings

Table 8 presents the mean symptom ratings for PTSD, BPD and DESNOS. Although DESNOS is not an official diagnosis and therefore was not included in the diagnostic choices or diagnostic ratings, DESNOS symptoms were included in the symptom ratings because DESNOS

was proposed to provide a more comprehensive set of trauma-related symptoms than PTSD. Overall, the mean symptom ratings were highest for BPD symptoms, followed by PTSD, and then DESNOS.

Separate 2 (patient gender) x 2 (early vs. late presentation of the childhood trauma) x 2 (VA vs. private sector psychologist) ANOVAs were used to examine the effects of the independent variables on the BPD, PTSD and DESNOS symptom ratings. Mean BPD symptom ratings were significantly higher for the female than the male version of the case, and somewhat higher when the childhood trauma was presented late rather than early in the case, although the latter difference was not significant (see Table 9). There was not a significant effect of psychologist work setting on the BPD symptom ratings nor any significant interactions. For the PTSD symptom ratings, VA psychologists rated PTSD symptoms significantly lower than private sector psychologists, and there was also a significant 3-way interaction; VA psychologists assigned lower PTSD symptom ratings than private-sector psychologists, except for the male case with the childhood trauma presented late (see Table 10). Patient gender and placement of the childhood trauma in the case did not have a significant effect on PTSD symptom ratings. Mean DESNOS symptom ratings were significantly higher for the female than the male version of the case, but there was not an effect of trauma placement, VA versus private sector psychologist, or any significant interactions (see Table 11).

Paired t-tests were used to compare PTSD and BPD mean symptom ratings to examine whether the case was seen as primarily BPD or primarily PTSD based on the independent variables. Interestingly, although the diagnostic ratings were higher for PTSD than BPD, the mean BPD symptom ratings were higher than the mean PTSD symptom ratings regardless of the version of the case (see Table 12). BPD symptom ratings were significantly higher than PTSD

symptoms ratings for the female and male versions of the case, when the childhood trauma was presented early or late, and for VA and private sector psychologists.

Symptom Endorsement

Table 13 presents the mean number of PTSD, BPD and DESNOS symptoms endorsed (i.e., rating of 3 or higher on the 5 point scale). The highest number of symptoms endorsed was from DESNOS followed by PTSD. However, it is important to note that the total number of symptoms varies considerably between BPD (9), PTSD (17) and DESNOS (25). The highest percentage of symptoms endorsed was from BPD (91.3%), followed by DESNOS (84.0%) and then PTSD (81.3%), consistent with the higher mean symptom ratings for BPD than PTSD.

Separate 2 (patient gender) x 2 (early vs. late presentation of childhood trauma) x 2 (VA vs. private sector psychologist) ANOVAs were used to examine the effects of the independent variables on the number of BPD, PTSD and DESNOS symptoms endorsed. For number of BPD symptoms endorsed, there was a significant effect of gender, with significantly more BPD symptoms endorsed for the female version than the male version of the case, but there was not a significant effect of placement of the childhood trauma in the case or for VA versus private sector psychologists (see Table 14). There was a significant interaction between patient gender and psychologist work setting, with VA psychologists endorsing a similar number of BPD symptoms for male and female versions of the case and private sector psychologists endorsing more BPD symptoms for the female than the male version of the case. For number of PTSD symptoms endorsed, private sector psychologists endorsed significantly more PTSD symptoms than VA psychologists, and more PTSD symptoms were endorsed for the female version of the case, but the difference did not reach statistical significance (see Table 15). There was not a main effect of placement of the childhood trauma in the case or any significant interactions.

Significantly more DESNOS symptoms were endorsed for the female version than the male version of the case, but there were no significant effects of placement of the trauma in the case, VA versus private sector psychologists, or any significant interactions (see Table 16) .

Paired t-tests were used to compare the number of PTSD and BPD symptoms endorsed to examine whether the case was seen as BPD or PTSD based on the independent variables. Due to the large discrepancy in the total number of symptoms for BPD (9) and PTSD (17), the percentage of total symptoms endorsed was used in these analyses (see Table 17). Overall, the cases had a higher percentage of BPD than PTSD symptoms endorsed, with a significantly higher percentage of BPD symptoms endorsed regardless of patient gender or the placement of the childhood trauma in the case, and for VA psychologists.

VA Compensation and Pension (C&P) versus Other VA Psychologists

Analyses were also conducted to examine differences in diagnoses provided by VA psychologists specializing in C&P (compensation and pension) versus other VA psychologists. Presumably, VA C&P psychologists would be more familiar with diagnostic criteria and more likely to closely adhere to the criteria. Chi-square analyses demonstrated that there was not a significant difference in BPD or PTSD diagnoses assigned by VA C&P and non-C&P VA psychologists (see Table 18). A series of one-way ANOVA's (see Tables 19-21) was used to examine differences between C&P and non-C&P VA psychologists in their PTSD and BPD diagnostic ratings; PTSD, BPD, and DESNOS symptom ratings; and number of PTSD, BPD, and DESNOS symptoms endorsed as present. C&P clinicians assigned lower, although not significantly lower, BPD diagnostic ratings than other VA psychologists, and significantly higher PTSD diagnostic ratings than their VA non-C&P counterparts. There were no significant

differences between C&P and other VA psychologists in PTSD, BPD, or DESNOS symptom ratings or number of PTSD, BPD, or DESNOS symptoms endorsed.

Exploratory Analyses

Although not part of the hypotheses, exploratory analyses were conducted examining diagnostic differences based on psychologists' theoretical orientation. Woodward et al. found that clinicians who identified their orientation as CBT assigned more diagnoses of PTSD than psychodynamic clinicians, and those who ascribed to a psychodynamic orientation diagnosed BPD more frequently than psychologists with a CBT orientation, using the unmodified version of the case used in the present study. Separate chi-square analyses were conducted comparing differences in the rate of diagnosing BPD and PTSD based on clinician theoretical orientation. There were no significant differences based on theoretical orientation between CBT and psychodynamic clinicians, or when a third group of "other" orientation (eclectic, integrative, humanistic, existential, other orientation not listed) clinicians were included in the analyses.

Differences based on the gender of the psychologist were also explored. Results of chi-square analyses revealed no significant difference for the diagnosis of BPD, but female psychologists assigned significantly more diagnoses of PTSD than male psychologists, $\chi^2(136) = 4.04, p < .05$. There were no significant differences based on psychologist gender for BPD or PTSD diagnostic ratings, mean symptom ratings, or number of symptoms endorsed.

CHAPTER 5

DISCUSSION

Overview of Findings

The present study examined participants' diagnostic perceptions of one of four versions of a vignette (adapted from Woodward et al., 2009 and Becker & Lamb, 1994) that included PTSD and BPD symptoms, and differed with regard to patient gender and the placement of a childhood trauma within the case. The purpose of the study was to examine potential gender bias in the diagnosis of PTSD versus BPD, the anchoring effect on diagnosis of placement of the childhood trauma in the case, and also examine differences in PTSD and BPD diagnoses of VA versus private sector psychologists. This study also sought to explore the usefulness of the construct of DESNOS (Herman, 1997; Van der Kolk, 2005) in describing the symptoms in a case with early and multiple traumas as well as the influence of the independent variables on the assessment of DESNOS symptoms.

The first hypothesis, that gender of the individual in the vignette would have a significant effect on the diagnosis of BPD and PTSD, was partially supported. Gender influenced the diagnosis of BPD, with the female version of the case receiving more BPD diagnoses and higher BPD diagnostic ratings and symptom ratings than the male version of the case. However, there were no significant effects of gender on PTSD diagnoses or ratings. Moreover, the hypotheses that the case would tend to be seen as either BPD or PTSD based on the independent variables received little support. The case tended to be diagnosed as PTSD and to receive higher PTSD than BPD diagnostic ratings, but higher BPD than PTSD symptom ratings, regardless of the version of the case. The second hypothesis that the placement of the childhood trauma in the

case would have an anchoring effect on the diagnoses and ratings assigned received little support. The final hypotheses concerning differences in diagnoses and ratings between VA and private sector psychologists received partial support. VA psychologists saw the cases as less representative of PTSD than private sector psychologists but also more representative of BPD, which was not predicted. The following discussion addresses the findings for each of the hypotheses of the study, followed by a discussion of the limitations of the present study, implications of the findings, and directions for future research.

Effect of Gender on PTSD and BPD

There are mixed findings in the research literature regarding gender bias in the diagnosis of certain disorders, particularly BPD (Adler, Drake, & Teague, 1990; Becker & Lamb, 1994; Ford & Widiger, 1989). The present study sought to build on previous research (Adler, Drake, & Teague, 1990; Becker & Lamb, 1994; Ford & Widiger, 1989; Johnson, Shea, Yen, Battle, Zlotnick, et al., 2003) examining the effect of gender on the differential diagnosis of PTSD and BPD given the overlap in symptom presentation and frequent history of trauma in individuals diagnosed with BPD.

Overall, gender influenced the diagnosis of BPD, but not PTSD. The female version of the case was significantly more likely to receive a BPD diagnosis than the male version, although both were equally likely to receive a PTSD diagnosis. Additionally, the female version of the case received significantly higher BPD diagnostic ratings and BPD symptom ratings than the male case. These findings are consistent with previous work (Becker & Lamb, 1994) that found that gender influenced diagnostic ratings of BPD but not PTSD. However, Woodward et al. (2009) did not find an effect of patient gender on categorical diagnoses of BPD or PTSD.

The Woodward et al. (2009) study used only one of the three vignettes from the Becker and Lamb (1994) study, and the authors suggested that the use of categorical diagnoses may have been less sensitive than the diagnostic ratings used in the Becker and Lamb study. Also, the Woodward et al. research was conducted 15 years later, so that there may have been differences between the cohorts of clinicians, such as increased awareness of gender effects on diagnosis.

The present study used a modified version of the vignette from the Woodward et al. study and both categorical diagnoses and diagnostic ratings. However, the present study added a combat-related trauma to the case, which might have influenced the results. For example, the case overall was seen as more representative of PTSD than BPD, with PTSD the most frequent diagnosis assigned and higher PTSD diagnostic ratings than BPD diagnostic ratings. Thus, the hypothesis that the female case would receive more diagnoses of BPD than PTSD, and higher BPD than PTSD diagnostic ratings, was not supported. The failure to include BPD in the dropdown list of diagnostic choices likely accounted for the relatively low number of BPD diagnoses assigned and precluded meaningful comparisons between the number of BPD and PTSD diagnoses assigned. Contrary to the hypothesis, the female case received slightly higher PTSD than BPD diagnostic ratings, although the difference was not significant. Results supported the hypothesis that the male case would tend to be seen as PTSD rather than BPD, with PTSD the most frequent diagnosis assigned and significantly higher diagnostic ratings for PTSD than BPD. However, these findings may reflect the general finding that the case tended to be viewed as representative of PTSD.

In contrast to the diagnoses and diagnostic ratings, the case received significantly higher BPD than PTSD symptom ratings overall, and regardless of the gender of the patient. Although the higher mean BPD than PTSD symptom rating is consistent with the hypothesis for the female

version of the case, this reflects the general findings for the case overall. One explanation for these results is the larger proportion of BPD than PTSD symptoms rated as present in the case. The case was designed by the previous researchers to be balanced with respect to BPD and PTSD symptoms and to not meet criteria for either diagnosis. However, an examination of the symptom ratings indicated that 7 of the 9 BPD symptoms (78%) compared to 12 of the 19 PTSD symptoms (63%) were endorsed as present (i.e., rated 3 or higher on the 5 point scale) by at least half of the participants.

Anchoring Effect of Placement of Childhood Trauma

Research on clinical decision making has identified a number of potential biases, including primacy and recency effects, confirming and disconfirming biases, among others (Garb, 1994). Clinicians tend to make premature clinical judgments, reaching diagnostic decisions quickly and then focusing on confirming information while ignoring disconfirming information (Garb, 2005). Prior research has demonstrated an “anchoring effect” in which information presented earlier has a greater effect on judgment and diagnosis than information presented later (Friedlander & Stockman, 1983; Woodward et al., 2009). Woodward et al.’s research indicated that presentation of the childhood trauma early in the case vignette resulted in more diagnoses of PTSD, whereas presentation later in the vignette tended to result in more diagnoses of BPD.

In the present study, the hypothesis that the placement of the childhood trauma in the case would have an anchoring effect on the diagnoses and ratings was not supported. Placement of the childhood trauma (early versus late) within the case had no significant effect on the BPD or PTSD diagnoses, diagnostic ratings, symptom ratings, or number of symptoms endorsed. One possible reason for the difference between the present study and the Woodward et al. study may

have been the addition of the combat trauma to the case vignette. Although the case did not meet criteria for PTSD (or BPD), the addition of a combat trauma, presented at the midpoint in all versions of the case, may have masked any possible anchoring effect that would have otherwise been observed.

The one significant finding was that when the trauma was presented late in the case, the case received significantly higher diagnostic ratings for PTSD than BPD, which was opposite of the hypothesis. This result may relate to previous findings of a “recency effect” in which clinicians lessen personality attributes when later presented with situational information (Chapman, Bergus, & Elstein, 1996; Shenkel, Snyder, Batson, & Clark, 1979). However, there was also a trend toward higher PTSD than BPD diagnostic ratings when the trauma was presented early in the case, but the difference was not significant. Overall, these results may simply reflect the general findings for the case (i.e., higher PTSD diagnostic ratings and higher BPD symptom ratings) discussed earlier.

VA Versus Private Sector Psychologists

No known studies have directly compared diagnostic differences between VA and non-VA clinicians. However, a number of authors have discussed possible differences between VA and civilian clinicians, including the diagnostic and assessment tools utilized and familiarity with presentation of combat related trauma or complex trauma (Klein & Kornblau, n.d; Sharpless & Barber, 2011). Private sector clinicians have been found to be less familiar with PTSD and its treatment (Sharpless & Barber, 2011), and to under-recognize (Magruder & Yeager, 2008) or over-diagnose (Gravely et al., 2011) PTSD compared to results of a PTSD screening measure.

The hypothesis that VA and private sector psychologists would differ in their diagnoses and ratings was partially supported. VA psychologists saw the cases as less representative of

PTSD than non-VA psychologists, assigning lower PTSD diagnostic and symptom ratings than private sector psychologists, although not significantly fewer PTSD diagnoses. Surprisingly, VA psychologists also saw the cases as more representative of BPD than private sector psychologists, assigning more diagnoses of BPD and higher BPD diagnostic ratings than non-VA psychologists. Both VA and private sector clinicians assigned more diagnoses of PTSD than BPD, but private sector psychologists also assigned higher PTSD than BPD diagnostic ratings. Both groups of psychologists assigned higher BPD than PTSD symptom ratings and endorsed a higher percentage of BPD than PTSD symptoms, but the difference in symptom endorsement was significant only for VA psychologists. Overall, this pattern of results indicates that the VA psychologists saw the cases as less representative of PTSD and more representative of BPD, whereas private sector psychologists saw the cases as more representative of PTSD and less representative of BPD.

One possible explanation for these findings may be level of familiarity with the PTSD diagnostic criteria. It was expected that VA psychologists would be more familiar with the symptom clusters and individual symptoms for PTSD, and thus would be more likely to recognize the absence of significant symptoms in the case. As noted earlier, the case vignette did not include any symptoms from the re-experiencing cluster and at least one of these five symptoms is required for a diagnosis of PTSD. Consistent with previous research (Sharpless & Barber, 2011), the VA psychologists' ratings of their familiarity with PTSD was significantly higher than the ratings of the private sector psychologists, but there was no difference in ratings of familiarity with BPD between the two groups of psychologists.

In examining differences in diagnosis between VA and private sector psychologists, it is important to also explore possible diagnostic differences among VA clinicians depending upon

their work emphasis within the VA. The Compensation and Pension (C&P) branch of the VA falls under the umbrella of the Veterans Benefits Administration (VBA) rather than the Veterans Health Administration (VHA), and is responsible for VA disability compensation for veterans. Due to the more forensic nature of C&P work (i.e., assessing for disability related to their military service) in comparison to the therapeutic nature of other VHA work, it was hypothesized that there may be diagnostic differences between these two groups. Specifically, it was expected that the C&P psychologists would more closely adhere to the diagnostic criteria and assign fewer diagnoses of PTSD than other VA psychologists because the case did not meet criteria for PTSD.

This hypothesis was not supported; there were no significant differences between C&P and other VA psychologists with regard to number of PTSD or BPD diagnoses assigned. However, in contrast to the hypothesis, C&P clinicians assigned significantly higher PTSD diagnostic ratings than non-C&P clinicians and somewhat lower BPD diagnostic ratings, although the latter difference was not statistically significant. These findings may reflect a tendency on the part of C&P clinicians to err on the side of considering a diagnosis that might result in compensation and eligibility for benefits, rather than viewing the symptoms as an indication of personality disorder like BPD. Since PTSD was recognized as a diagnosis, there has been debate over the role of external factors (i.e., the traumatic event) versus internal factors (i.e., premorbid personality and psychopathology) in the etiology of the disorder (Brewin, Lanius, Novac, Schnyder, & Galea, 2009; McNally, 2009). Although current research indicates that both factors contribute to the development of PTSD, there is stigma associated with personality disorder diagnoses, particularly BPD (Aviram, Brodsky, & Stanley, 2006; Gunderson & Ridolfi, 2001), and attributing the symptoms to personality disorder may be paramount to “blaming the victim” (Kilpatrick & Saunders, 1999). Recent critical public and

media attention on the VA, C&P examinations, and the diagnosis of PTSD versus BPD (Dao, 2012; Philpott, 2010) may have also played a role in these results.

DESNOS

This study also sought to explore the usefulness of the construct of DESNOS (Herman, 1997; Van der Kolk, 2005) in describing the symptoms in a case with early and multiple traumas as well as the influence of the independent variables on the assessment of DESNOS symptoms. Although there was no hypothesis regarding the effect of gender on DESNOS symptoms ratings, it is interesting to note that the female version of the case received significantly higher DESNOS symptom ratings and more DESNOS symptoms were endorsed than the male version of the case. Given that the female case also received more BPD diagnoses than the male case, it is possible that DESNOS might serve as an alternative, less stigmatizing diagnosis than BPD for women with a history of early and multiple traumas. Despite past proposals and the recommendation of the DSM-IV PTSD subcommittee to add DESNOS or “complex PTSD” to the diagnostic system (Lindner, 2004; Van der Kolk & Courtois, 2005), DESNOS was not included in the DSM-IV-TR or in the recently released DSM-5. However, the addition of the cluster of symptoms of negative alterations in cognitions and mood to the PTSD criteria in the DSM-5 may capture some of the broader spectrum of symptoms included in DESNOS.

Limitations and Strengths

There are a number of limitations to the present study that need to be considered in the interpretation of the results. One limitation was the omission of BPD as a diagnostic choice due to a programming error. Although clinicians were given a space to write in a diagnosis that was not on the list of choices, the omission undoubtedly reduced the number of BPD diagnoses assigned. It is unclear whether those who diagnosed BPD would have chosen BPD as their

primary or secondary diagnosis, as the option of writing in other diagnoses was provided as an additional diagnosis. Additionally, the study utilized a vignette to represent a case of an individual with PTSD and BPD symptoms and a history of trauma, which may not be representative of actual clinical cases. In addition, the responses of clinicians to a case vignette might not generalize to the diagnostic practices of clinicians. With the use of a vignette methodology, clinicians are unable to gather additional data, such as behavioral observations or more in-depth information on current symptoms and history that may further inform their clinical impressions. Decision making errors, biases and heuristics (short cuts) are more likely to be observed when information is limited or ambiguous (Garb, 2005). Further, this study, like Woodward et al. (2009), used only one of three vignettes from the Becker and Lamb (1994) study. It is possible that different results may have been found using other vignettes with different presentations of BPD and PTSD symptoms. In spite of this limitation, there is a large body of literature supporting use of a vignette methodology (e.g., Becker & Lamb, 1994, Crosby & Sprock, 2004; Flanagan & Blashfield, 2005; Ford & Widiger, 1989; Woodward et al., 2009).

Another potential limitation was the addition of the combat trauma to the vignette to make it more representative of the type of client that would typically be seen through the VA. Prior to conducting the study, three VA clinicians were asked to read the vignette and give their initial impressions regarding the realism and diagnostic ambiguity of the cases. All three psychologists indicated that the case was realistic and did not meet criteria for PTSD with the addition of the combat trauma. However, the addition of the combat trauma may have slanted the case towards a diagnosis of PTSD. Also, it might have been helpful to solicit feedback from non-VA psychologists, particularly given the focus on diagnostic differences between VA and private sector psychologists.

An additional limitation of the study was that because DESNOS is not an official diagnosis, DESNOS was not included as a diagnostic choice or in the diagnostic ratings. In fact, both VA and private sector clinicians rated themselves as unfamiliar with the construct of DESNOS. Instead, symptom ratings were used as a proxy for the diagnosis of DESNOS, and some of these symptoms were likely unfamiliar to many of the clinicians.

A limitation to the generalizability of the results is that the PTSD criteria have been significantly revised in the DSM-5, which is now the official diagnostic system. The data for the present study were collected prior to the publication of the DSM-5 so that participants were likely basing their decisions on the DSM-IV-TR criteria. With the revisions to the criteria for PTSD, including a change to four symptom clusters and the addition of several symptoms, the conceptualization of PTSD may shift over time.

On the other hand, there were several strengths to the study, including the use of a case vignette that had been used in previous research (Beck & Lamb, 1994; Woodward et al., 2009) and a relatively large sample of VA and private sector psychologists. Modifying the case by adding the history of combat-related trauma allowed for examination of the diagnosis of PTSD versus BPD in an individual that experienced both childhood trauma and combat-related trauma. This is an important focus of research, as there is a high rate of childhood trauma in military personnel in general (Rosen & Martin, 1996), and particularly in those diagnosed with PTSD (Bremner et al., 1993; Lapp et al., 2005). There is also no known research examining gender and decision making biases in the differential diagnosis of BPD and PTSD for veterans, or comparisons between VA and private sector psychologists.

Implications and Directions for Future Research

The present study supported previous work suggesting gender bias in diagnosis, particularly for BPD. Despite including a second trauma in the case, combat trauma, the female case received more BPD diagnoses and higher BPD diagnostic ratings than the male case. Given the stigma associated with BPD (Bland et al., 2007; Deans & Meocevic, 2006; Markham, 2003; Westwood & Baker, 2010), as well as the mixed findings in the literature regarding a gender bias in the diagnosis of BPD (Bjorklund, 2006; Sansone & Sansone, 2011), it is important to continue exploring the influence of gender on differential diagnosis of BPD and PTSD. This topic is especially important with the increasing numbers of women in the military (National Center for Veterans Analysis and Statistics, 2011) and the greater vulnerability of women to developing PTSD in response to trauma (Halbreich, 2003). Women experience higher rates of interpersonal violence (McGruder et al., 2000; Walker et al., 2004), which may increase risk for subsequent re-victimization, as well as the development of PTSD in response to subsequent trauma (Lilly & Valdez, 2011; Mineka & Zinbarg, 2006). Women are also at higher risk than men for experiencing military sexual trauma (Suris et al., 2004), further increasing the risk of developing PTSD.

Women also demonstrate more affective dysregulation and interpersonal difficulties in response to trauma than men, and as a result, receive more personality disorder and comorbid diagnoses (Cloitre et al., 2002; Hea et al., 1999). The construct of DESNOS may capture these additional symptoms. In the present study, the DESNOS symptoms were rated higher for the female version than the male version of the case. Although the DSM-5 Work Group determined that there was not sufficient support for DESNOS as an independent diagnosis, as nearly all who met criteria for DESNOS also met criteria for PTSD, they also concluded that DESNOS may

represent a subtype of PTSD (Friedman et al., 2011). The revised criteria for PTSD in the DSM-5 added several symptoms described by DESNOS, but the majority of the DESNOS symptoms are included in the text on associated features. Further research on the relationship between DESNOS and PTSD, the new PTSD criteria in the DSM-5, as well the influence of gender is needed.

An anchoring effect was not demonstrated in this current study. In contrast with the hypotheses and previous research, the version of the case in which the childhood trauma was presented later resulted in higher diagnostic ratings for PTSD than BPD, although this may have reflected the overall findings that the case was viewed as more representative of PTSD than BPD. It may have been that clinicians were already primed for the possibility of PTSD by the presentation of the combat trauma in the middle of the case, and the subsequent presentation of the childhood trauma further established their diagnosis. Regardless, further research is needed to examine the effects of order of information on clinicians' diagnostic decisions. For example, research might investigate differences in diagnoses based on when information on abuse or trauma is elicited in clinical interviews, as well as various structured interviews.

The differences found between VA and private sector clinicians with regard to diagnosis point to another important area for continued research. There has been very little research in this area, and no known previous research studies examining differences in the diagnosis of PTSD. Given the high numbers of veterans receiving mental health care within the private sector (Gardner, 1996; Nelson, Starkebaum, & Reiber, 2007), understanding differences in the assessments and diagnoses of VA and private sector clinicians is of the utmost importance, as diagnostic differences will ultimately affect treatment. Research has found that private sector psychologists are not as familiar with combat trauma (Sharpness & Barker, 2011) and may

under-diagnose (Magruder & Yeager, 2008) or over-diagnose (Gravely et al., 2008) PTSD. In the present study, private sector psychologists also rated themselves as less familiar with PTSD compared to the VA psychologists. These results point to the need for increased continuing education and training on assessment and diagnosis of PTSD and combat-related trauma for private sector clinicians.

As the number of veterans engaging in mental health treatment continues to grow (Shiner, 2011), it will be important to understand how this population is assessed and diagnosed depending upon the work setting and emphasis of the treating clinician. The differences found between the C&P and other VA psychologists in the present study have implications for the services and benefits provided to veterans. The results highlight the possible role of nonscientific factors, such as the political and social climate, in the diagnosis of PTSD and other disorders and how eligibility for benefits is determined for veterans. Future research might examine differences between C&P and other VA psychologists in assessment methods and approaches (forensic versus clinical) and their influence on diagnosis and treatment.

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Table 1
Characteristics of Participants (N=149): Means and Standard Deviations; Frequencies and Percentages

Variable	<i>M (SD)</i>
Age	46.8 (12.33)
Years of Experience	17.6 (10.92)

Variable	Frequency (%)
Gender	
Female	83 (55.7%)
Male	53 (35.6%)
Not reported	13 (8.7%)
Race/Ethnicity	
White/Non-Hispanic	124 (83.2%)
Asian American/Pacific Islander	3 (2.0%)
Biracial/Multiracial	3 (2.0%)
African American/Black	2 (1.3%)
Hispanic	2 (1.3%)
Other	2 (1.3%)
Not reported	13 (8.7%)
Degree	
Ph.D.	89 (59.3%)
Psy.D.	45 (30.0%)
Ed.D.	1 (0.7%)
Not reported	14 (9.4%)
Theoretical Orientation	
Cognitive-Behavioral	64 (43.0%)
Eclectic/Integrative	35 (23.5%)
Psychodynamic	15 (10.1%)
Interpersonal	14 (9.4%)
Other	5 (3.4%)
Humanistic	2 (1.3%)
Not reported	14 (9.4%)

Table 2

Categorical Diagnoses Assigned to the Case

Diagnosis	#Assigned
Post-Traumatic Stress Disorder	92
Borderline Personality Disorder	24
Major Depressive Disorder	11
Paranoid Personality Disorder	11
Dysthymic Disorder	10
Dependent Personality Disorder	8
Histrionic Personality Disorder	6
Depressive Personality Disorder	3
Avoidant Personality Disorder	2
Dissociative Disorder NOS	2
Bipolar Disorder	1
Generalized Anxiety Disorder	1
Narcissistic Personality Disorder	1
Schizotypal Personality Disorder	1

*Note: Due to a programming error, BPD was not one of the categorical choices in the drop down menu but participants had the option of writing in diagnoses under “other diagnosis”

Table 3

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on PTSD and BPD Diagnoses Assigned to the Case: Results of Chi-Square Analyses

	<i>N</i>	χ^2	<i>df</i>	<i>p</i>
<u>Patient Gender:</u>				
BPD				
Female Case	28	5.49	1	.02*
Male Case	17			
PTSD				
Female Case	45	.154	1	.41
Male Case	47			
<u>Placement of Trauma:</u>				
BPD				
Trauma Early	19	.303	1	.36
Trauma Late	26			
PTSD				
Trauma Early	41	.111	1	.43
Trauma Late	51			
<u>Psychologist Work Setting:</u>				
BPD				
VA Psychologist	26	7.25	1	.01**
Private Sector	15			
PTSD				
VA Psychologist	36	1.58	1	.14
Private Sector	50			

* $p < .05$ ** $p < .01$

Table 4

PTSD and BPD Diagnostic Ratings by Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector): Means and Standard Deviations

	PTSD <i>M (SD)</i>	BPD <i>M (SD)</i>
<u>Patient Gender:</u>		
Female Case	3.88 (1.16)	3.69 (1.15)
Male Case	3.81 (1.12)	3.07 (1.30)
<u>Placement of Trauma:</u>		
Trauma Early	3.74 (1.19)	3.32 (1.26)
Trauma Late	3.93 (1.08)	3.37 (1.28)
<u>Psychologist Work Setting:</u>		
VA Psychologist	3.57 (1.15)	3.64 (1.17)
Private Sector	4.11 (1.03)	3.03 (1.29)
<u>Across All Cases</u>	3.84 (1.14)	3.36 (1.27)

Note: Diagnostic ratings were made on a scale of 1 (not at all representative) to 5 (highly representative).

Table 5

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on BPD Diagnostic Ratings: Results of ANOVA

	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
Patient Gender	1	8.11	.01**	.06
Trauma Placement	1	.53	.47	.004
Psychologist Work Setting	1	7.76	.01**	.06
Patient Gender x Trauma Placement	1	2.34	.13	.02
Patient Gender x Psychologist Setting	1	.07	.79	.001
Trauma Placement x Psychologist Setting	1	.89	.35	.01
Gender x Trauma x Psychologist	1	.28	.60	.002

$R^2 = .143$ (Adjusted $R^2 = .096$)

** $p < .01$

Table 6

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on PTSD Diagnostic Ratings: Results of ANOVA

	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
Patient Gender	1	.85	.36	.01
Trauma Placement	1	2.49	.12	.02
Psychologist Work Setting	1	6.48	.01**	.05
Patient Gender x Trauma Placement	1	1.39	.24	.01
Patient Gender x Psychologist Setting	1	.25	.62	.002
Trauma Placement x Psychologist Setting	1	.40	.53	.003
Gender x Trauma x Psychologist	1	4.21	.04*	.03

$R^2 = .116$ (Adjusted $R^2 = .066$)

* $p < .05$ ** $p < .01$

Table 7

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on PTSD versus BPD Diagnostic Ratings: Results of Paired T-Tests

	<i>M (SD)</i>	<i>t</i>	<i>p</i>	<i>d</i>
<u>Patient Gender:</u>				
Female Case				
PTSD	3.88 (1.16)	1.03	.31	0.18
BPD	3.67 (1.16)			
Male Case				
PTSD	3.81 (1.12)	3.37	.001***	0.61
BPD	3.07 (1.30)			
<u>Trauma Placement:</u>				
Trauma Early				
PTSD	3.74 (1.19)	-1.92	.06	0.35
BPD	3.32 (1.19)			
Trauma Late				
PTSD	3.93 (1.08)	-2.63	.01**	0.48
BPD	3.37 (1.28)			
<u>Psychologist Work Setting:</u>				
VA Psychologist				
PTSD	3.57 (1.15)	.31	.76	-0.06
BPD	3.64 (1.17)			
Private Sector				
PTSD	4.11 (1.03)	-5.20	.001***	0.93
BPD	3.03 (1.29)			

** $p < .01$ *** $p < .001$

Table 8

PTSD, BPD and DESNOS Symptom Ratings by Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector): Means and Standard Deviations

	PTSD <i>M (SD)</i>	BPD <i>M (SD)</i>	DESNOS <i>M (SD)</i>
<u>Patient Gender:</u>			
Female Case	3.08 (.73)	3.61 (.65)	2.92 (.56)
Male Case	2.92 (.70)	3.24 (.59)	2.69 (.57)
<u>Trauma Placement:</u>			
Trauma Early	2.93 (.70)	3.32 (.60)	2.74 (.58)
Trauma Late	3.05 (.74)	3.50 (.68)	2.86 (.57)
<u>Psychologist Work Setting:</u>			
VA Psychologist	2.82 (.65)	3.35 (.64)	2.69 (.50)
Private Sector	3.12 (.73)	3.47 (.66)	2.88 (.62)
<u>Across All Cases</u>	2.99 (.72)	3.42 (.65)	2.80 (.58)

Note: Symptom ratings were made on a scale of 1 (not at all descriptive) to 5 (highly descriptive).

Table 9

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on Mean BPD Symptom Ratings: Results of ANOVA

	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
Patient Gender	1	11.51	.001***	.09
Trauma Placement	1	3.41	.07	.03
Psychologist Work Setting	1	.56	.46	.01
Patient Gender x Trauma Placement	1	1.47	.29	.01
Patient Gender x Psychologist Setting	1	3.74	.06	.03
Trauma Placement x Psychologist Setting	1	1.28	.26	.01
Gender x Trauma x Psychologist	1	.51	.48	.004

$R^2 = .129$ (Adjusted $R^2 = .079$)

*** $p < .001$

Table 10

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on PTSD Mean Symptom Ratings: Results of ANOVAs

	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
Patient Gender	1	2.68	.10	.02
Trauma Placement	1	1.80	.18	.01
Psychologist Work Setting	1	4.71	.03*	.04
Patient Gender x Trauma Placement	1	.13	.72	.001
Patient Gender x Psychologist Setting	1	.28	.60	.002
Trauma Placement x Psychologist Setting	1	.04	.85	.001
Gender x Trauma x Psychologist	1	4.55	.04*	.04

$R^2 = .132$ (Adjusted $R^2 = .078$)

* $p < .05$

Table 11

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on Mean DESNOS Symptom Ratings: Results of ANOVA

	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
Patient Gender	1	7.00	.01**	.05
Trauma Placement	1	2.03	.16	.02
Psychologist Work Setting	1	3.12	.08	.03
Patient Gender x Trauma Placement	1	.23	.63	.002
Patient Gender x Psychologist Setting	1	2.91	.09	.02
Trauma Placement x Psychologist Setting	1	.39	.54	.003
Gender x Trauma x Psychologist	1	.83	.36	.01

$R^2 = .118$ (Adjusted $R^2 = .065$)

** $p < .01$

Table 12

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on PTSD versus BPD Symptom Ratings: Results of Paired T-Tests

	<i>M (SD)</i>	<i>t</i>	<i>p</i>	<i>d</i>
<u>Patient Gender:</u>				
Female Case				
PTSD	3.08 (.73)	-6.06	.001***	-0.77
BPD	3.61 (.65)			
Male Case				
PTSD	2.92 (.70)	-4.02	.001***	-0.50
BPD	3.24 (.59)			
<u>Trauma Placement:</u>				
Trauma Early				
PTSD	2.93 (.70)	-4.53	.001***	-0.60
BPD	3.32 (.60)			
Trauma Late				
PTSD	3.05 (.74)	-5.38	.001***	-0.63
BPD	3.50 (.68)			
<u>Psychologist Work Setting:</u>				
VA Psychologist				
PTSD	2.82 (.65)	-5.92	.001***	-0.82
BPD	3.35 (.64)			
Private Sector				
PTSD	3.12 (.73)	-4.44	.001***	-0.50
BPD	3.47 (.66)			

*** $p < .001$

Table 13

PTSD, BPD, and DESNOS Symptom Endorsement by Patient Gender, Placement of Trauma in the Case (Early vs. Late,) and Psychologist Work Setting (VA vs. Private Sector): Means and Standard Deviations

	PTSD <i>M (SD)</i>	BPD <i>M (SD)</i>	DESNOS <i>M (SD)</i>
<u>Patient Gender:</u>			
Female Case	11.25 (4.38)	6.92 (1.67)	14.14 (4.49)
Male Case	9.94 (4.31)	6.07 (1.77)	12.54 (4.33)
<u>Trauma Placement:</u>			
Trauma Early	10.36 (4.37)	6.25 (1.74)	13.05 (4.28)
Trauma Late	10.70 (4.41)	6.64 (1.79)	13.49 (4.63)
<u>Psychologist Work Setting:</u>			
VA Psychologist	9.51 (4.26)	6.35 (1.74)	12.60 (4.40)
Private Sector	11.32 (4.30)	6.58 (1.75)	13.74 (4.46)
<u>Across All Cases</u>	10.54 (4.38)	6.46 (1.77)	13.29 (4.46)

Note: Symptoms were considered endorsed if rated a 3 or higher on the 5 point scale (1 = Not at all descriptive to 5 = Highly descriptive).

Table 14

Effect of Patient Gender, Placement of Trauma in Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on BPD Symptom Endorsement: Results of ANOVA

	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
Patient Gender	1	7.17	.01**	.05
Trauma Placement	1	1.65	.20	.01
Psychologist Work Setting	1	.55	.46	.004
Patient Gender x Trauma Placement	1	.81	.37	.01
Patient Gender x Psychologist Setting	1	5.82	.02*	.04
Trauma Placement x Psychologist Setting	1	.72	.40	.01
Gender X Trauma X Psychologist	1	.17	.68	.001

$R^2 = .127$ (Adjusted $R^2 = .078$)

* $p < .05$ ** $p < .01$

Table 15

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on PTSD Symptom Endorsement: Results of ANOVA

	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
Patient Gender	1	3.50	.06	.03
Trauma Placement	1	.56	.46	.01
Psychologist Work Setting	1	4.12	.05*	.04
Patient Gender x Trauma Placement	1	.01	.93	.001
Patient Gender x Psychologist Setting	1	.45	.50	.004
Trauma Placement x Psychologist Setting	1	.002	.96	.001
Gender X Trauma X Psychologist	1	2.43	.12	.02

$R^2 = .095$ (Adjusted $R^2 = .039$)

* $p < .05$

Table 16

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on DESNOS Symptom Endorsement: Results of ANOVA

	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
Patient Gender	1	4.23	.04*	.04
Trauma Placement	1	.38	.54	.003
Psychologist Work Setting	1	1.74	.84	.02
Patient Gender x Trauma Placement	1	.02	.89	.001
Patient Gender x Psychologist Setting	1	2.16	.14	.02
Trauma Placement x Psychologist Setting	1	.60	.44	.01
Gender X Order X Setting	1	.04	.84	.001

$R^2 = .078$ (Adjusted $R^2 = .023$)

* $p < .05$

Table 17

Effect of Patient Gender, Placement of Trauma in the Case (Early vs. Late), and Psychologist Work Setting (VA vs. Private Sector) on percent of PTSD versus BPD Symptoms Endorsed: Results of Paired T-Tests

	<i>M (SD)</i>	<i>t</i>	<i>p</i>	<i>d</i>
<u>Gender of Patient:</u>				
Female Case				
PTSD	.65 (.25)	-3.82	.001***	-0.56
BPD	.77 (.18)			
Male Case				
PTSD	.59 (.26)	-2.44	.02*	-0.40
BPD	.68 (.19)			
<u>Trauma Placement:</u>				
Trauma Early				
PTSD	.63 (.25)	-2.37	.02*	-0.37
BPD	.71 (.18)			
Trauma Late				
PTSD	.60 (.27)	-3.59	.001***	-0.61
BPD	.74 (.19)			
<u>Psychologist Work Setting:</u>				
VA Psychologist				
PTSD	.55 (.25)	-4.90	.001***	-0.73
BPD	.71 (.19)			
Private Sector				
PTSD	.66 (.25)	-1.85	.07	-0.36
BPD	.74 (.19)			

* $p < .05$ *** $p < .001$

Table 18

Effect of Work Emphasis (VA C&P versus VA Non-C&P) on PTSD and BPD Diagnoses Assigned to the Case: Results of Chi-Square Analyses

	<i>N</i>	χ^2	<i>df</i>	<i>p</i>
BPD				
VA C&P	14	1.05	1	.22
VA Non-C&P	12			
PTSD				
VA C&P	23	.24	1	.41
VA Non-C&P	13			

Table 19

Differences between Compensation and Pension (C&P) VA Psychologists and Other VA Psychologists (Not C&P) on PTSD and BPD Diagnostic Ratings: Means, Standard Deviations and Results of One-Way ANOVAs

		<i>M (SD)</i>	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
BPD	VA C&P	3.47(1.22)	1	2.18	.15	.04
	VA Non-C&P	3.92(1.02)				
PTSD	VA C&P	3.81(1.08)	1	4.23	.04*	.07
	VA Non-C&P	3.21(1.18)				

* $p < .05$

Table 20

Differences between Compensation and Pension (C&P) VA Psychologists and Other VA Psychologists (Not C&P) on PTSD, BPD, and DESNOS Symptom Ratings: Means, Standard Deviations and Results of One-Way ANOVAs

		<i>M (SD)</i>	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
BPD	VA C&P	3.34 (.66)	1	.07	.79	.001
	VA Non-C&P	3.38 (.61)				
PTSD	VA C&P	2.90 (.67)	1	1.52	.22	.03
	VA Non-C&P	2.69 (.62)				
DESNOS	VA C&P	2.69 (.49)	1	.00	1.00	.00
	VA Non-C&P	2.69 (.52)				

Table 21

Differences between Compensation and Pension (C&P) VA Psychologists and Other VA Psychologists (Not C&P) on PTSD, BPD, and DESNOS Symptom Endorsement: Means, Standard Deviations and Results of One-Way ANOVAs

		<i>M (SD)</i>	<i>df</i>	<i>F</i>	<i>p</i>	<i>partial η²</i>
BPD	VA C&P	6.24 (1.78)	1	.45	.51	.01
	VA Non-C&P	6.54 (1.69)				
PTSD	VA C&P	9.91 (4.09)	1	.75	.39	.01
	VA Non-C&P	8.91 (4.54)				
DESNOS	VA C&P	12.22 (3.77)	1	.71	.40	.01
	VA Non-C&P	13.23 (5.32)				

Appendix A

DSM-IV-TR Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior
- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event. **Note:** In children, these may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participating in significant activities
 - (5) feeling of detachment or estrangement from others
 - (6) restricted range of affect (e.g., unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) Difficulty falling or staying asleep
 - (2) Irritability or outbursts of anger
 - (3) Difficulty concentrating
 - (4) Hypervigilance
 - (5) Exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

* American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. TR.). Washington, DC: Author. p. 467-468.

Appendix B

DSM-5 Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. 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(s) as it occurred to others.
- (3) Learning that the traumatic event(s) occurred to a close family member or close friend.
- (4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

- (1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

- (2) Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Note: In children, there may be frightening dreams without recognizable content.

- (3) Dissociative reactions (e.g., flashbacks in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings).

Note: In children, trauma-specific reenactment may occur in play.

- (4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- (5) Marked physiological reactions to internal or external cues that symbolize or resemble aspects of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

- (1) Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

- (2) Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
- (1) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
 - (2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
 - (3) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
 - (4) Persistent negative emotional state (e.g. fear, horror, anger, guilt, or shame).
 - (5) Markedly diminished interest or participation in significant activities.
 - (6) Feelings of detachment or estrangement from others.
 - (7) Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
- (1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
 - (2) Reckless or self-destructive behavior.
 - (3) Hypervigilance.
 - (4) Exaggerated startle response.
 - (5) Problems with concentration.
 - (6) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
- 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 (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual’s symptoms meet the criteria for post-traumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

* American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author. p. 271-274.

Appendix C

Proposed Diagnostic Criteria for Disorders of Extreme Stress Not Otherwise Specified

(DESNOS)

- (1) Alterations in regulation of affect and impulses
 - a. Extreme emotional reaction, inappropriate to the situation
 - b. Self-destructive behavior, such as: eating disorders, self injury
 - c. Suicidal preoccupation
 - d. Sexual impulses or extreme sexual inhibition
 - e. Problems in expressing or modulating anger

- (2) Disturbances in attention and concentration
 - a. Dissociative episodes and depersonalization
 - b. Amnesia or hyperamnesia due to traumatic experience

- (3) Disturbances in self-perception
 - a. Negative views of themselves
 - b. Feeling helpless, ineffectual
 - c. Shame, ignominy, feeling guilty, blaming themselves
 - d. Feeling dirty, disgraced, or marked with a stigma (stigmatization)

- (4) Disturbances in relationships
 - a. Lasting lack of trust
 - b. Revictimization
 - c. Victimization of others

- (5) Somatization
 - a. Persistent pain
 - b. Difficulties in digestive, circulatory and cardiopulmonary systems
 - c. Conversion symptoms
 - d. Sexual symptoms

- (6) Disturbances in meaning system
 - a. Loss of belief
 - b. Sense of helplessness and anguish

*Pelcovitz, D., Van der Kolk, B., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a Criteria Set and a Structured Interview for Disorders of Extreme Stress (SIDES). *Journal of Traumatic Stress, 10*, 3-16; Retrieved from *Medline*.

Appendix D

Symptom Categories for Disorders of Extreme Stress, Not
Otherwise Specified (DESNOS)

I. Alteration in Regulation of Affect and Impulses

(A and 1 of B–F required):

- A. Affect Regulation (2)
- B. Modulation of Anger (2)
- C. Self-Destructive
- D. Suicidal Preoccupation
- E. Difficulty Modulating Sexual Involvement
- F. Excessive Risk-taking

II. Alterations in Attention or Consciousness

(A or B required):

- A. Amnesia
- B. Transient Dissociative Episodes and Depersonalization

III. Alterations in Self-Perception

(Two of A–F required):

- A. Ineffectiveness
- B. Permanent Damage
- C. Guilt and Responsibility
- D. Shame
- E. Nobody Can Understand
- F. Minimizing

IV. Alterations in Relations With Others

(One of A–C required):

- A. Inability to Trust
- B. Revictimization
- C. Victimizing Others

V. Somatization

(Two of A–E required):

- A. Digestive System
- B. Chronic Pain
- C. Cardiopulmonary Symptoms
- D. Conversion Symptoms
- E. Sexual Symptoms

VI. Alterations in Systems of Meaning

(A or B required):

- A. Despair and Hopelessness
- B. Loss of Previously Sustaining Beliefs

Note. Numbers in parentheses indicate number of subscale items required for endorsement of subscale. Only one item required for endorsement of all other subscales.

*Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Appendix E
ICD-10 Criteria for enduring personality change after catastrophic experience
(EPCACE)

Enduring personality change, present for at least 2 years, following exposure to catastrophic stress. The stress must be so extreme that it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality. The disorder is characterized by a hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of being “on edge” as if constantly threatened, and estrangement. Post-traumatic stress disorder (F43.1) may precede this type of personality change.

Personality change after:

- A) Concentration camp experiences
- B) Disasters
- C) Prolonged:
 - a. Captivity with an imminent possibility of being killed
 - b. Exposure to life-threatening situations such as being a victim of terrorism
- D) Torture

Excludes: Post-traumatic stress disorder (F43.1)

* World Health Organization (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva. World Health Organization. p. 198-224.

Appendix F

PTSD: Associated Features and Disorders in DSM-IV-TR

*The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering):

- (1) Impaired affect modulation
- (2) Self-destructive and impulsive behavior
- (3) Dissociative symptoms
- (4) Somatic complaints
- (5) Feelings of ineffectiveness, shame, despair, or hopelessness
- (6) Feeling permanently damaged
- (7) A loss of previously sustained beliefs
- (8) Hostility
- (9) Social withdrawal
- (10) Feeling constantly threatened
- (11) Impaired relationships with others
- (12) A change from the individual's previous personality characteristics.

* Those associated features that are commonly found in individuals with DESNOS

* The format has been changed from the original text format to a list format.

* American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. TR.). Washington, DC: Author. p. 465

Appendix G

DSM-IV-TR Diagnostic Criteria for Borderline Personality Disorder (BPD)

A pervasive pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) frantic efforts to avoid real or imagined abandonment.
Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- (3) identity disturbance: markedly and persistently unstable self-image or sense of self
- (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- (6) affective instability due to a marked reactivity of mood (e.g., intense, episodic dysphoria, irritability, or anxiety usually lasting a few hours and rarely more than a few days)
- (7) chronic feelings of emptiness
- (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- (9) transient, stress-related paranoid ideation or severe dissociative symptoms

* American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. TR.). Washington, DC: Author. p. 706

Appendix H

Case Vignette 1

Female Client / Childhood Trauma Later

Presenting Problem

Kelly is a 33-year-old woman who entered therapy to explore a pattern of failed relationships.

Background Information

Kelly says she doesn't have much hope that she will stick with therapy and wonders if a person with problems such as hers is even capable of being helped. She called to make her first appointment shortly after her boyfriend of six months, John, left her. He told her that he could no longer take her jealous tantrums and that the only times Kelly looked animated had been when she was fighting with him. Kelly said that this was not the first time a relationship has ended "this way."

Kelly had met John through a friend and they hit it off right away. Soon Kelly was seeing him two or three nights a week and spending weekends at his apartment. About two months into the relationship, John failed to call her when he had promised to do so. When he called her the next evening, Kelly met him with accusations of betrayal and screamed and swore at him. The next day she called him at work to apologize, saying she didn't know what got into her at times. The arguments increased in frequency and intensified to the extent that during one of them Kelly pitched John's favorite high school trophy out the window.

After the relationship ended, Kelly reverted to her old pattern of drinking heavily and indiscriminately picking up men in bars. She called John several times- once waking from a nightmare in which she was brutally attacked, once to see if a woman answered, and occasionally when she was unable to sleep. During this time she not only experienced frequent insomnia and familiar feelings of worthlessness, shame, and disgust but became frightened of what might happen to her if her behavior continued in this fashion. It was this fear that led her to begin psychotherapy.

Kelly, an intelligent and articulate woman who was an outstanding student and athlete in high school, says she has felt adrift for years. Kelly enlisted as a medic in the military at the age of 20. She was stationed in Iraq for 14 months during which time, a vehicle that she and several of her fellow soldiers were in, drove over an IED. Kelly, and several others, sustained minor injuries and she noted that it was a "terrifying experience."

Kelly has quit three jobs in the past year – two because of embarrassment over angry outbursts directed at her supervisors and one because she was uncomfortable with sexual innuendos made by her co-workers. Currently she works for several temporary agencies on a per-diem basis. She finds the work tedious but her free-time is hardly more fulfilling. It has been several years since she got any pleasure from practicing the piano or playing softball – two activities to which she was once passionately committed. Kelly worries that she may never feel

sufficiently motivated to determine a career path for herself and feels that “I’ll probably die of AIDS by 40 so the issue is really irrelevant.”

Kelly noted that “my dad was gone, I never met him and my mom was never around. I raised myself for the most part.” When Kelly was ten, she was sexually abused by a next-door neighbor who was a friend of the family. The abuse stopped when the neighbor moved out of state a year later. Since that time she has always felt wary of her neighbors and whenever she moves she immediately has additional locks installed on the doors. Kelly states that she has never told anyone in the family about what has happened to her because she feels “too ashamed.”

Appendix I

Case Vignette 2

Male Client / Childhood Trauma Later

Presenting Problem

Kevin is a 33-year-old man who entered therapy to explore a pattern of failed relationships.

Background Information

Kevin says he doesn't have much hope that he will stick with therapy and wonders if a person with problems such as his is even capable of being helped. He called to make his first appointment shortly after his girlfriend of six months, Jane, left him. She told him that she could no longer take his jealous tantrums and that the only times Kevin looked animated had been when he was fighting with her. Kevin said that this was not the first time a relationship has ended "this way."

Kevin had met Jane through a friend and they hit it off right away. Soon Kevin was seeing her two or three nights a week and spending weekends at her apartment. About two months into the relationship, Jane failed to call him when she had promised to do so. When she called him the next evening, Kevin met her with accusations of betrayal and screamed and swore at her. The next day he called her at work to apologize, saying he didn't know what got into him at times. The arguments increased in frequency and intensified to the extent that during one of them Kevin pitched Jane's favorite high school trophy out the window.

After the relationship ended, Kevin reverted to his old pattern of drinking heavily and indiscriminately picking up women in bars. He called Jane several times- once waking from a nightmare in which he was brutally attacked, once to see if a man answered, and occasionally when he was unable to sleep. During this time he not only experienced frequent insomnia and familiar feelings of worthlessness, shame, and disgust but became frightened of what might happen to him if his behavior continued in this fashion. It was this fear that led him to begin psychotherapy.

Kevin, an intelligent and articulate man who was an outstanding student and athlete in high school, says he has felt adrift for years. Kevin enlisted as a medic in the military at the age of 20. He was stationed in Iraq for 14 months during which time, a vehicle that he and several of his fellow soldiers were in, drove over an IED. Kevin, and several others, sustained minor injuries and he noted that it was a "terrifying experience."

Kevin has quit three jobs in the past year – two because of embarrassment over angry outbursts directed at his supervisors and one because he was uncomfortable with sexual innuendos made by co-workers. Currently he works for several temporary agencies on a per-diem basis. He finds the work tedious but his free-time is hardly more fulfilling. It has been several years since he got any pleasure from practicing the piano or playing softball – two activities to which he was once passionately committed. Kevin worries that he may never feel

sufficiently motivated to determine a career path for himself and feels that “I’ll probably die of AIDS by 40 so the issue is really irrelevant.”

Kevin noted that “my dad was gone, I never met him and my mom was never around. I raised myself for the most part.” When Kevin was ten, he was sexually abused by a next-door neighbor who was a friend of the family. The abuse stopped when the neighbor moved out of state a year later. Since that time he has always felt wary of his neighbors and whenever he moves he immediately has additional locks installed on the doors. Kevin states that he has never told anyone in the family about what has happened to him because he feels “too ashamed.”

Appendix J

Case Vignette 3

Female Client / Childhood Trauma Early

Presenting Problem

Kelly is a 33-year-old woman who entered therapy to explore a pattern of failed relationships.

Background Information

Kelly noted that “my dad was gone, I never met him and my mom was never around. I raised myself for the most part.” When Kelly was ten, she was sexually abused by a next-door neighbor who was a friend of the family. The abuse stopped when the neighbor moved out of state a year later. Since that time she has always felt wary of her neighbors and whenever she moves she immediately has additional locks installed on the doors. Kelly states that she has never told anyone in the family about what has happened to her because she feels “too ashamed.”

Kelly says she doesn't have much hope that she will stick with therapy and wonders if a person with problems such as hers is even capable of being helped. She called to make her first appointment shortly after her boyfriend of six months, John, left her. He told her that he could no longer take her jealous tantrums and that the only times Kelly looked animated had been when she was fighting with him. Kelly said that this was not the first time a relationship has ended “this way.”

Kelly had met John through a friend and they hit it off right away. Soon Kelly was seeing him two or three nights a week and spending weekends at her apartment. About two months into the relationship, John failed to call he she had promised to do so. When he called her the next evening, Kelly met him with accusations of betrayal and screamed and swore at him. The next day she called him at work to apologize, saying she didn't know what got into her at times. The arguments increased in frequency and intensified to the extent that during one of them Kelly pitched John's favorite high school trophy out the window. Kelly noted that she often has “fits of anger” and gets mad over “the smallest things.”

After the relationship ended, Kelly reverted to her old pattern of drinking heavily and indiscriminately picking up men in bars. She called John several times- once waking from a nightmare in which she was brutally attacked, once to see if a woman answered, and occasionally when she was unable to sleep. During this time she not only experienced frequent insomnia and familiar feelings of worthlessness, shame, and disgust but became frightened of what might happen to her if her behavior continued in this fashion. It was this fear that led her to begin psychotherapy.

Kelly, an intelligent and articulate woman who was an outstanding student and athlete in high school, says she has felt adrift for years. Kelly enlisted as a medic in the military at the age of 20. She was stationed in Iraq for 14 months during which time, a vehicle that she and several

of her fellow soldiers were in, drove over an IED. Kelly, and several others, sustained minor injuries and she noted that it was a “terrifying experience.”

Kelly has quit three jobs in the past year – two because of embarrassment over angry outbursts directed at her supervisors and one because she was uncomfortable with sexual innuendos made by her co-workers. Currently she works for several temporary agencies on a per-diem basis. She finds the work tedious but her free-time is hardly more fulfilling. It has been several years since she got any pleasure from practicing the piano or playing softball – two activities to which she was once passionately committed. Kelly worries that she may never feel sufficiently motivated to determine a career path for herself and feels that “I’ll probably die of AIDS by 40 so the issue is really irrelevant.”

Appendix K

Case Vignette 4

Male Client / Childhood Trauma Early

Presenting Problem

Kevin is a 33-year-old man who entered therapy to explore a pattern of failed relationships.

Background Information

Kevin noted that “my dad was gone, I never met him and my mom was never around. I raised myself for the most part.” When Kevin was ten, he was sexually abused by a next-door neighbor who was a friend of the family. The abuse stopped when the neighbor moved out of state a year later. Since that time he has always felt wary of his neighbors and whenever he moves he immediately has additional locks installed on the doors. Kevin states that he has never told anyone in the family about what has happened to him because he feels “too ashamed.”

Kevin says he doesn’t have much hope that he will stick with therapy and wonders if a person with problems such as his is even capable of being helped. He called to make his first appointment shortly after his girlfriend of six months, Jane, left him. She told him that she could no longer take his jealous tantrums and that the only times Kevin looked animated had been when he was fighting with her. Kevin said that this was not the first time a relationship has ended “this way.”

Kevin had met Jane through a friend and they hit it off right away. Soon Kevin was seeing her two or three nights a week and spending weekends at her apartment. About two months into the relationship, Jane failed to call when he had promised to do so. When she called the next evening, Kevin met her with accusations of betrayal and screamed and swore at her. The next day he called her at work to apologize, saying he didn’t know what got into him at times. The arguments increased in frequency and intensified to the extent that during one of them Kevin pitched Jane’s favorite high school trophy out the window. Kevin noted that he often has “fits of anger” and gets mad over “the smallest things.”

After the relationship ended, Kevin reverted to his old pattern of drinking heavily and indiscriminately picking up women in bars. He called Jane several times- once waking from a nightmare in which he was brutally attacked, once to see if a man answered, and occasionally when he was unable to sleep. During this time he not only experienced frequent insomnia and familiar feelings of worthlessness, shame, and disgust but became frightened of what might happen to him if his behavior continued in this fashion. It was this fear that led him to begin psychotherapy.

Kevin, an intelligent and articulate man who was an outstanding student and athlete in high school, says he has felt adrift for years. Kevin enlisted as a medic in the military at the age of 20. He was stationed in Iraq for 14 months during which time, a vehicle that he and several of

his fellow soldiers were in, drove over an IED. Kevin, and several others, sustained minor injuries and he noted that it was a “terrifying experience.”

Kevin has quit three jobs in the past year – two because of embarrassment over angry outbursts directed at his supervisors and one because he was uncomfortable with sexual innuendos made by his co-workers. Currently he works for several temporary agencies on a per-diem basis. He finds the work tedious but his free-time is hardly more fulfilling. It has been several years since he got any pleasure from practicing the piano or playing softball – two activities to which he was once passionately committed. Kevin worries that he may never feel sufficiently motivated to determine a career path for himself and feels that “I’ll probably die of AIDS by 40 so the issue is really irrelevant.”

Appendix L

Diagnostic Questionnaire

Rate each of the following diagnoses in terms of how descriptive it is of the above case:

1 = Not at all descriptive 5 = Highly descriptive

Antisocial PD
Avoidant PD
Bipolar Disorder
*Borderline PD
Dependent PD
Depressive PD
Dissociative Identity Disorder
Dissociative Disorder NOS
Dysthymic Disorder
Generalized Anxiety Disorder
Histrionic PD
Major Depressive Disorder
Narcissistic PD
Obsessive-Compulsive PD
Panic Disorder
Paranoid PD
Posttraumatic Stress Disorder
Schizoid PD
Schizotypal PD
Social Phobia
Somatization Disorder

*Choose the one diagnosis most representative of the above case
(dropdown list of diagnoses, Borderline PD omitted)

How confident are you in your diagnosis of this client?

1 = Not at all confident 5 = Very confident

What is the overall severity in this case?

1 = Very mild 5 = Very severe

What prognosis would you give this client?

1 = Very poor 5 = Very good

Rate the likelihood of the client in this case responding to treatment:

1 = Not at all likely 5 = Very likely

Rate the following symptoms in terms of how representative it is of the above case:
1 = Not at all representative 5 = Highly representative

- _____ Profound loss of previously sustaining beliefs, leading to pervasive sense of despair
- _____ Diminished interest or participation in significant activities
- _____ Pervasive sense of hopelessness
- _____ Sense of a foreshortened future
- _____ Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
- _____ Exhibits hypervigilance
- _____ Exhibits heightened risk-taking behavior
- _____ Difficulty falling or staying asleep
- _____ Difficulty concentrating
- _____ Experiences somatic symptoms, such as digestive problems,
- _____ Experiences chronic pain
- _____ Experiences cardiopulmonary symptoms
- _____ Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- _____ Feeling of detachment or estrangement from others
- _____ Transient, stress-related paranoid ideation or severe dissociative symptoms
- _____ Efforts to avoid real or imagined abandonment
- _____ Exhibits a pervasive inability to trust others
- _____ Minimizes traumatic experiences, believes they have had little impact or are unrelated to present difficulties
- _____ Recurrent and intrusive recollections of a traumatic event, including thoughts, images or perceptions
- _____ Recurrent distressing dreams of a traumatic event
- _____ Feels guilty and responsible for own mistreatment
- _____ Feels excessive sense of shame
- _____ Feels unique, that nobody can understand their experience
- _____ Exhibits exaggerated startle response
- _____ Is sexually preoccupied or has difficulty modulating sexual impulses
- _____ Lacks ability to accurately read signs of danger, and expects mistreatment from others so is frequently revictimized
- _____ Acts out by victimizing others
- _____ Acting or feeling as if a traumatic event were recurring (includes sense of reliving the experience, illusions, hallucinations, dissociative episodes)
- _____ A pattern of intense and unstable interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- _____ Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- _____ Experiences amnesia, either for discrete episodes or for whole periods of personal history, or may be very forgetful on a regular basis
- _____ Identity disturbance: markedly and persistently unstable self-image or sense of self

- _____ Perceives self as ineffective or helpless
- _____ Perceives self as permanently damaged
- _____ Perceives self as undesirable to others
- _____ Chronic feelings of emptiness
- _____ Efforts to avoid activities, places or people that arouse recollections of the trauma
- _____ Inability to recall an important aspect of the trauma
- _____ Dissociates or withdraws when confronted with painful emotions or reminders of traumatic experiences, or may experience depersonalization
- _____ Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- _____ Recurrent suicidal behavior, threats or gestures, or self-mutilating behavior
- _____ Exhibits frequent suicidal or self-harm preoccupation
- _____ Uses self-destructive measures such as substance use, eating disorders to modulate affect
- _____ Restricted range of affect
- _____ Experiences sexual somatic symptoms, such as chronic pelvic pain
- _____ Manifests conversion symptoms
- _____ Inappropriate, intense anger or difficulty controlling anger
- _____ Overreacts to minor stresses, has extreme reactions to neutral or mild stimuli
- _____ Has great difficulty modulating or expressing anger
- _____ Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety lasting a few hours and only rarely more than a few days)
- _____ Irritability or outbursts of anger

*Due to a programming error, Borderline PD was omitted from the drop down list.

Appendix M

Demographic Questionnaire

Age _____

Sex M F

Ethnic background African American/Black _____ Asian/Pacific Islander _____
 Hispanic _____ Native American _____ White/Non-Hispanic _____
 Biracial/Multiracial _____ Other (specify) _____

Degrees (choose all that apply) _____ Ph.D. _____ Psy.D. _____ Ed.D.

Other (specify) _____

Years of clinical experience _____

Primary Theoretical Orientation Cognitive-Behavioral _____ Eclectic/Integrative _____

Humanistic _____ Psychodynamic _____ Interpersonal _____

Other(specify) _____

Primary setting in which you work?

1. Community Mental Health Center
2. VA Medical Center – Not C&P
3. VA Medical Center – C&P
4. University Medical School
5. Private Psychiatric Hospital
6. Correctional Facility
7. State Psychiatric Facility
8. University Psychology Department
9. General Medical Hospital
10. Private Practice
11. Other

Secondary setting in which you work?

1. Community Mental Health Center
2. VA Medical Center – Not C&P
3. VA Medical Center – C&P
4. University Medical School
5. Private Psychiatric Hospital
6. Correctional Facility

7. State Psychiatric Facility
8. University Psychology Department
9. General Medical Hospital
10. Private Practice
11. Other
12. Not Applicable

In which setting did you complete your internship

1. Community Mental Health Setting
2. VA Medical Center
3. University Medical School
4. Private Psychiatric Hospital
5. Correctional Facility
6. State Psychiatric Facility
7. University Psychology Department
8. General medical Hospital
9. Private Practice
10. Army
11. Air Force
12. Navy
13. Other

Type of disorders you typically encounter in your office? (Select as many as apply)

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
 Delirium, Dementia, and Amnesic and Other Cognitive Disorders
 Substance Related Disorders
 Schizophrenia and Other Psychotic Disorders
 Mood Disorders
 Anxiety Disorders
 Personality Disorders
 Dissociative Disorders
 Somatoform Disorders
 Adjustment Disorders
 Other _____

Percentage spent in each activity

_____ Clinical Work
 _____ Research
 _____ Administrative
 _____ Other

Percentage of clinical work with the following groups

_____ Children (12 and under)
_____ Adolescents (13-17)
_____ Young Adults (18-29)
_____ Adults (30-45)
_____ Middle Aged (46-64)
_____ Older Adults (65+)

Rate your familiarity with the following diagnoses

PTSD 1 = not at all familiar 5 = very familiar
BPD 1 = not at all familiar 5 = very familiar
DESNOS 1 = not at all familiar 5 = very familiar

Appendix N

Invitation to Participate

Dear Clinician, Date

I am a doctoral student in clinical psychology at Indiana State University and I am writing to request your participation in my doctoral dissertation exploring VA and private sector clinicians' diagnostic conceptualizations of clients. In order to make your participation as convenient as possible, the study data will be collected via a website. The study should take approximately 15 minutes to complete. Your participation would be most appreciated. I understand your time is likely limited, as well as valuable. In appreciation for your participation, I would also like to invite you to enter a raffle to win one of three \$100 gift cards for Amazon. This raffle may be entered upon completion of the survey.

If you agree to participate, please access the study webpage at the following web address: <http://XXXX> and use the verification code XXX. The verification code is merely to ensure that those clinicians invited to participate can access the study webpage; the code cannot be used to identify individual respondents. There will be no means of associating the data you submit with your email address. It is recommended that you cut and past the above address into your web browser to access the webpage; typing the link in may result in errors in accessing the page. Once you access the site, you will be asked to enter the verification code, read one brief vignette, answer some questions following the vignette, and provide demographic and professional information about yourself. You will then have an opportunity to enter the raffle, and also to request the results of the study once it is completed, should you choose.

If you have any questions regarding the study please contact me or the project director, June Sprock, Ph.D., through the Indiana State University Psychology Department at (812) 237-2445 by phone, or by email: slacy2@sycamores.indstate.edu or june.sprock@indstate.edu

Thank you for your time and effort and for your appreciation of the importance of supporting student research in psychology.

Sincerely,
Sara Lacy, M.S.
Doctoral Student, Clinical Psychology, Indiana State University

Appendix O

Informed Consent

Introduction:

This vignette study attempts to collect information about Veterans Affairs and private sector clinicians' diagnostic perceptions.

Procedures:

You will be shown a vignette and asked to complete a short questionnaire. The questionnaire consists of 19 questions and will take approximately 15 minutes or less to complete. Questions are designed to determine a primary diagnosis and ratings on the presence of particular symptoms in the vignette. This questionnaire will be conducted with an online Qualtrics-created survey.

Risks/Discomforts:

Risks are minimal for involvement in this study. However, you may feel emotionally uneasy when asked to make judgments based on the information provided. Although we do not expect any harm to come upon any participants due to electronic malfunction of the computer, it is possible though extremely rare and uncommon.

Benefits:

There are no direct benefits for the participants. However, it is hoped that through your participation, researchers will learn more about clinicians' diagnostic perceptions.

Confidentiality:

All data obtained from participants will be kept confidential and will only be reported in an aggregate format (by reporting only combined results and never reporting individual ones). All questionnaires will be concealed, and no one other than the primary investigator and assistant researchers will have access to them. The data collected will be stored in the HIPPA-compliant Qualtrics-secure database until it has been deleted by the primary investigator.

Compensation:

There is no direct compensation; however participants may choose to enter a raffle for a chance at obtaining one of three \$100 Amazon gift cards.

Participation:

Participation in this study is completely voluntary. You have the right to withdraw at anytime or refuse to participate entirely. If you desire to withdraw, please close down your internet browser

and notify the principal investigator at this email: slacy2@sycamores.indstate.edu.

Questions about the Research:

If you have any questions regarding this study, you may contact Sara Lacy, at 812-406-9347, slacy2@sycamores.indstate.edu

Questions about your Rights as Research Participants:

An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject (e.g., if you have questions about your rights as a participant in this research, or if you feel you've been placed at risk, you can contact the Institutional Review Board at Indiana State University (812) 237-8217 or irb@indstate.edu

Appendix P

Thank You/Debriefing

Thank you for your participation. My study is investigating VA and private sector clinicians' perceptions in diagnosing individuals who have experienced trauma. If you would like to receive information regarding the results of the study upon its completion, we will be glad to provide you with a summary of results. Additionally, you are invited to participate in a raffle in which 3 Amazon gift cards, valued at \$100 each, will be raffled off to participants in this study. Please enter your email address below if you would like to request results and/or enter the raffle. Your responses to the previous survey questions will not be linked to this information.

I would like to receive a summary of the results of this study. Please send to the following email address:

I would like to be entered in the raffle. Please notify me if I win at the following email address:

Appendix Q

Characteristics of Participants (N=149): Work Settings, Internship Setting, and Current Case Characteristics: Frequencies and Percentages

Variable	Frequency (%)
Primary Work Setting	
VA Medical Center	62 (41.3%)
VA Medical Center -C&P	38 (25.3%)
VA Medical Center-Not C&P	24 (16.0%)
Private Practice	42 (28.0%)
Other	12 (0.8%)
University Psychology Department	8 (5.3%)
Community Mental Health	5 (3.3%)
Correctional Facility	4 (2.7%)
University Medical School	1 (0.7%)
State/Private Psychiatric Facility	1 (0.7%)
Not Reported	14 (17.2%)
Secondary Work Setting	
Not Applicable	69 (46.0%)
Private Practice	21 (14.0%)
Other	12 (8.0%)
VA Medical Center	11 (7.3%)
VA Medical Center-Not C&P	6 (4.0%)
VA Medical Center -C&P	5 (3.3%)
University Psychology Department	5 (3.3%)
Community Mental Health	1 (0.7%)
State/Private Psychiatric Facility	1 (0.7%)
General Hospital	1 (0.7%)
Correctional Facility	1 (0.7%)
Not Reported	27 (18.6%)
Internship Setting	
VA Medical Center	36 (24.0%)
Community Mental Health Center	23 (15.3%)
Other	19 (12.7%)
State Psychiatric Facility	16 (10.7%)
University Medical School	14 (9.3%)

General Medical Hospital	8 (5.3%)
Correctional Facility	7 (4.7%)
Private Psychiatric Hospital	3 (2.0%)
University Psychology Department	3 (2.0%)
Army	3 (2.0%)
Air Force	2 (1.3%)
Private Practice	1 (0.7%)
Not Reported	14 (10%)