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COMMENT & RESPONSE

Improving the Assessment of COVID-19-Associated Posttraumatic Stress Disorder

To the Editor The recent meta-analysis from Cénat et al¹ revealed that the estimated pooled prevalence of COVID-19-associated posttraumatic stress disorder (PTSD) was almost 22%. However, prior to the study by Janiri and colleagues,² no study to our knowledge had confirmed PTSD diagnoses among patients using a structured clinician-administered diagnostic interview, such as the Clinician Administered PTSD Scale for *DSM-5* (CAPS-5).³ We commend Janiri et al² for applying rigorous diagnostic methods to better determine PTSD prevalence among COVID-19 survivors. Knowing which COVID-19 survivors are experiencing clinically significant PTSD and other psychiatric symptoms is important for allocating appropriate mental health resources.

We were surprised that the presence of delirium or agitation was the only acute COVID-19 characteristic associated with PTSD in the study by Janiri et al.² There were no significant differences in the percentage of patients with and without PTSD who required hospitalization, intensive care admission, or non-invasive or mechanical ventilation. Because a PTSD diagnosis requires an individual to be exposed to an event or events that involve death or threatened death, or actual or threatened serious injury,⁴ we expected to see PTSD significantly associated with more severe COVID-19 illness in general. Unfortunately, the authors provided no details regarding the PTSD criterion A stressor with which patients' PTSD symptoms were associated; thus, there is no way to know if the indicated stressors fulfilled PTSD criterion A. Patients for whom COVID-19-associated stressors did not include life-threatening, catastrophic medical events secondary to COVID-19 infection would not be eligible for the PTSD diagnosis. Counting these patients among those with a valid PTSD diagnosis would misrepresent the actual prevalence of the disorder.

We were also surprised that Janiri and colleagues² did not report mean total CAPS-5 scores for the PTSD group and non-PTSD group and did not test for between-group differences in symptom severity. This missing information is essential for the reader, as it is possible to meet PTSD diagnostic criteria with

relatively mild symptom severity (eg, a total CAPS-5 score of 12 out of 80). The presence of mild symptomatology may not require any intervention and may explain the limited COVID-19 characteristics associated with PTSD.

We recommend that clinician-administered interviews like the CAPS-5 be used in future research and that criterion A is specifically assessed and reported along with symptom severity scores. We also encourage longitudinal studies to ascertain the natural history of PTSD following COVID-19 and to identify factors associated with PTSD and protective measures that can promote better outcomes.

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In Reply We thank Marx and colleagues for their thoughtful comment on our recent article investigating the prevalence of posttraumatic stress disorder (PTSD) in postacute COVID-19 illness.¹ We fully agree with the authors on the importance of assessing COVID-19-associated PTSD through the criterion-standard Clinician Administered PTSD Scale for *DSM-5* (CAPS-5).² Based on the CAPS-5, we found a 30.2% prevalence of PTSD in patients after acute COVID-19. Our results partly match the pooled PTSD prevalence of 21.94% (95% CI, 9.37-43.31) found in the meta-analysis by Cénat et al,³ which Marx and colleagues cited. However, this meta-analysis³ pooled actual patients with individuals from the general population. Hence, the higher PTSD prevalence found in our study in patients who experienced acute COVID-19 illness is not surprising and in line with the rate of 32.2% (95% CI, 23.7-42.0) reported by Rogers et al⁴ in postacute patients after previous coronavirus epidemics. Because the field is rapidly expanding, it is likely that many studies will be added and used to meta-analyze and synthesize published evidence.

Regarding the methodological concerns raised by Marx and colleagues on criterion A, all patients in the study sought and received treatment at the emergency department, where their clinical conditions were considered severe. Consistently, 81% of participants were hospitalized. Medical events and injuries related to COVID-19 were assessed during the interview according to the CAPS-5² and the Life Events Checklist for DSM-5 (LEC-5).⁵ Patients were asked to describe their traumatic experience in their own words, then the interviewer asked for more details regarding the event. All participants with PTSD reported to have directly experienced life-threatening medical symptoms and/or personally witnessed the death of other patients at the emergency department or during hospitalization.

We understand Marx and colleagues' surprise that in our study the only acute COVID-19 characteristic associated with PTSD diagnosis was delirium or agitation. This result may be explained in light of the fact that COVID-19 is a life-threatening illness per se and was recently reported to be the leading cause of death in the US.⁶ Accordingly, our data may be related to the unpredictable severity of the illness, which can quickly escalate to serious and possibly life-threatening. In the PTSD group, we found more persistent medical symptoms specifically related to COVID-19 (ie, fatigue, dyspnea, ageusia, and dysgeusia), compared with the non-PTSD group. These results seem to suggest that the characteristics of both the acute phase and postacute phase of COVID-19 might contribute to patients re-experiencing trauma associated with the illness.

Regarding the severity of symptoms, the mean (SD) CAPS-5 score differed significantly for patients with PTSD (38.80 [10.32]) and those without PTSD (4.96 [5.11]) ($P < .001$). In patients reporting PTSD, mean symptom severity was within the moderate-severity range, which often requires therapeutic intervention. Nevertheless, the CAPS-5 total score in the PTSD group ranged from 14 to 57, covering a wide range of degrees of severity. Future studies could stratify patients according to PTSD symptom severity to better identify factors associated with PTSD, as well as protective measures, and to help design therapeutic and prevention strategies.

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CORRECTION

Errors in Text: In the Original Investigation titled "Accuracy Requirements for Cost-effective Suicide Risk Prediction Among Primary Care Patients in the US," published online March 17, 2021, in *JAMA Psychiatry*,¹ the word "variant" was changed to "variable" in 3 places in the Methods section in the Risk Assessment and Intervention subsection. In the third paragraph, the corrected sentence reads "For other variables (health care cost, societal cost, and uptake), no meta-analytic estimates were available; we instead derived estimates from single exemplar studies." In the fourth paragraph, the corrected sentence reads, "Other variables were derived from a randomized clinical trial of safety planning and telephone follow-up among military personnel with suicidal ideation or attempts." In the fifth paragraph, the corrected sentence reads, "Other variables were derived from a randomized clinical trial of brief CBT among military personnel with suicidal ideation or attempts."

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Error in Title and Text: In the Viewpoint by Akerele et al titled, "Healing Ethno-Racial Trauma in Black Communities: Cultural Humility as a Driver of Innovation,"¹ published online April 21, 2021, the phrase "the Black community" has been revised to "Black communities" throughout. This article was corrected online.

1. Akerele O, McCall M, Aragam G. Healing ethno-racial trauma in Black communities: cultural humility as a driver of innovation. *JAMA Psychiatry*. Published online April 21, 2021. doi:10.1001/jamapsychiatry.2021.0537