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Navigating PTSD: Expert Insights on Diagnosis and Challenges

Announcer:
Welcome to ReachMD.

This medical industry feature, titled “Navigating PTSD: Expert Insights on Diagnosis and Challenges,” is sponsored by Otsuka.

Here’s your host, Dr. Charles Turck.

Dr. Turck:
This is ReachMD, and I’m Dr. Charles Turck. Today, my guests and I will be discussing post-traumatic stress disorder, also known as PTSD, and we’ll review its screening and diagnosis, as well as address some important diagnostic challenges.

Joining me in this discussion is Dr. John Krystal and Dr. Lori Davis. Dr. Krystal is the Chair of Psychiatry at the Yale School of Medicine in New Haven, Connecticut. Dr. Krystal, welcome to the program.

Dr. Krystal:
Thanks for having me.

Dr. Turck:
Also with us is Dr. Lori Davis, who is a Clinical Professor of Psychiatry at the University of Alabama at Birmingham. Dr. Davis, thank you for joining us today.

Dr. Davis:
It’s great to be here.

Dr. Turck:
Let's begin by discussing PTSD diagnosis. Starting with you, Dr. Krystal, could you explain how the different types of trauma are intertwined with the development of this condition?

Dr. Krystal:
I’d be happy to. PTSD is a serious mental health disorder that’s diagnosed using criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, also known as the DSM-5.[1,2] About 83 percent of patients are diagnosed by a mental health provider as compared to a primary care or other provider, which is about 17 percent, respectively.[3] The diagnosis requires exposure to one or more traumatic events, defined as the index trauma, which serves as the basis for the assessment of PTSD severity.[4]

And after this exposure, the average risk of developing PTSD is four percent and up to 30 percent, varying by trauma type.[5-8]

The World Health Organization, or WHO, World Mental Health Survey performed an analysis of the prevalence and distribution of trauma exposure over 51,000 traumatic events.[8] The highest proportion of PTSD cases were associated with the unexpected death of a loved one at about 31 percent, and then direct exposure to death or injury at about 24 percent.[8]

Several other trauma types can be considered key drivers of PTSD, including: rape, physical abuse by a partner, being kidnapped, sexual assault, witnessing war-related atrocities, childhood physical abuse, combat exposure, and natural disasters.[5-8]

Dr. Turck:

Now let's delve into the specifics. Turning to you now, Dr. Davis, can you break down the DSM-5 diagnostic criteria for PTSD for us?

Dr. Davis:
Of course. First, we should be aware of the four core symptom clusters of PTSD, which are intrusion or re-experiencing symptoms, avoidance, negative cognition and mood, and alterations in arousal and reactivity.[2]The DSM-5 requires patients to meet certain diagnostic criteria covering the four symptom clusters, beginning with the identification of the index trauma.[1,2] Let's go through the rest of the criteria here.

After identification of the traumatic event or events, Criterion B is the presence of at least one or more intrusion symptoms, which are the re-experiencing of the traumatic event. These can include:[1,2]

- Recurrent, involuntary, and distressing memories that are intrusive
- Recurrent and distressing dreams
- Dissociative reactions, such as flashbacks
- Intense or prolonged psychological distress to external or internal cues that symbolize or resemble an aspect of the traumatic event
- And marked physiologic arousal to external or internal cues

Criterion C is the persistent avoidance of stimuli, which present as either or both of the following: [1,2]

- This could be avoidance of, or efforts to avoid, distressing memories, thoughts, or feelings
- And avoidance of, or efforts to avoid, external reminders that arouse distressing memories, thoughts, or feelings such as avoidance of people, places, conversations, or situations

In terms of affective symptoms, Criterion D of the DSM-5 diagnosis requires the presence of at least two of the following negative alterations of cognition and mood, such as: [1,2]

- inability to remember important facets of the trauma
- Persistent or exaggerated bad feelings about oneself, others, or the world
- Persistent, distorted cognitions about the cause or consequences of the trauma, leading to self-blame
- Persistent negative emotional states, such as anger, fear, guilt, or shame
- Marked diminished interest or participation in significant activities
- Feelings of detachment or estrangement from others
- And the persistent inability to experience positive emotions such as happiness or satisfaction

Another important aspect of PTSD includes marked arousal and reactivity in Criterion E, as evidenced by the presence of at least two of the following symptoms, which include:[1,2]

- Irritable behavior or angry outbursts, which is typically expressed as verbal or physical aggression towards people or objects
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- And sleep disturbances

Finally, DSM-5 Criteria F, G and H for PTSD require that those symptoms are ongoing for more than one month, cause clinically significant distress or functional impairment, and aren't attributable to a substance or another medical condition.[1,2]

Dr. Turck:
Thanks for taking us through the diagnosis, Dr. Davis. Turning to you now to follow-up, Dr. Krystal, could you shed light on any other diagnostic considerations that healthcare professionals should be aware of in their practice?

Dr. Krystal:
That's an important question as the clinical presentation of PTSD can vary amongst individuals. PTSD symptoms may occur soon after the index trauma or may be delayed.[9]

Delayed-onset PTSD affects an estimated 25 percent of individuals with PTSD who don't fully meet diagnostic criteria until at least six months after the index event.[1,10]PTSD is a chronic disorder, and data show that by one year after symptom onset, about one-third of patients with PTSD recover; however, another approximate one-third remain symptomatic *ten years* after the index trauma.[11] In these patients, symptom recurrence and intensification may occur in response to reminders of the original trauma, ongoing life stressors, or newly experienced traumatic events.[1]

In addition to varying duration, PTSD symptoms—as well as their relative predominance—may fluctuate over time.[1]

Dr. Turck:
And coming back to you, Dr. Davis, how can clinicians appropriately screen and assess PTSD in their clinical practice?

Dr. Davis:
There are a number of assessment tools for screening, diagnosing, and monitoring PTSD symptoms in the patient. Let's start with the Clinician-Administered PTSD Scale, or CAPS-5 for short. This structured 30-question diagnostic interview is primarily used in clinical research and is a thorough assessment of all the PTSD criteria, as well as symptom severity.[12]Two other assessment tools that are based on patient self-report and can be used for screening for PTSD including the PTSD Checklist for DSM-5, also known as the PCL-5, and the Primary Care PTSD screen for DSM-5, known as the PC-PTSD-5.[13-15]

The PCL-5 has four different versions and consists of a 20-item checklist. This tool also can be used to monitor patients on treatment for clinically significant change, defined as a decrease in the PCL-5 score to 28 or below.[13-16]

The PC-PTSD-5, in comparison, is a shorter tool with six yes or no items. It can be used to screen for trauma exposure and PTSD symptoms in a time-limited setting, such as primary care clinics.[13]

Other assessments are useful for monitoring symptoms and progress during clinical management.[17-20] The Patient-reported Brief Inventory of Psychosocial Functioning, known as the B-IPF, is a seven-item self-reported questionnaire to assess psychosocial functional impairment related to PTSD.[17] And the Clinical Global Impression-Severity, or CGI-S, is a seven-point scale for clinicians to rate the patient's current severity of illness during clinical assessment.[18]

Dr. Turck:
For those just tuning in, you're listening to ReachMD.

I'm Dr. Charles Turck, and today I'm speaking with Dr. John Krystal and Dr. Lori Davis about PTSD and important diagnostic considerations.

So now that we've reviewed the clinical diagnostic criteria, Dr. Krystal, what are some of the challenges clinicians should be aware of when navigating the diagnosis of PTSD?

Dr. Krystal:
Well, unfortunately, in practice, misdiagnosis and underdiagnosis of PTSD is a common issue, which can lead to significant delays in patient management.[21-23] We should be aware that the average time from index trauma to symptom presentation is 2.2 years, and to PTSD diagnosis is 8.7 years.[24] The median time from onset of PTSD symptoms to treatment is 12 years.[22,23,25]

Many factors lead to misdiagnosis of PTSD as another mental health disorder. For one, individuals with PTSD are 80 percent more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental health disorder.[1] So what we see in the primary care setting is that, of individuals meeting diagnostic criteria for PTSD, 50 percent were diagnosed with depression, 23 percent were diagnosed with anxiety or panic attacks, and only 11 percent received a diagnosis of PTSD.[26]

And as we know, underdiagnosis is just as much of an issue. Due to both misdiagnosis and underdiagnosis, studies show that less than 50 percent of patients who meet criteria for PTSD are being correctly diagnosed in primary and secondary care settings.[21,27,28]

Timely and appropriate diagnosis of PTSD can be challenging due to multiple factors, including variation in symptom onset, heterogeneity in clinical presentation, psychiatric comorbidities, and stigma.[11,29-32] Misdiagnosis and underdiagnosis can also in part be due to under-utilization of guideline-recommended diagnostic tools.[33]

As a result, misdiagnosis of PTSD is associated with ineffective management of this disorder, which can lead to a negative impact on treatment response, treatment adherence, and patient satisfaction.[34]

Dr. Turck:
And, Dr. Davis, can you provide insight into any other complexities clinicians may encounter in their clinical practice when considering PTSD?

Dr. Davis:
Yes, I'd like to point out that individuals with PTSD also face many barriers that may impact seeking or receiving an appropriate diagnosis.

Studies estimate that only about 50 percent of patients with PTSD seek treatment.[22,23,25] And many individuals with PTSD who may seek care for physical symptoms don't mention any psychiatric symptoms or trauma histories, not realizing that the trauma exposure can be related to their symptoms.[21]

Other potential barriers to care include limited resources, fear of negative social consequences, lack of knowledge or treatment-related doubts, low mental health literacy, and, unfortunately, stigma.[35] Stigma is of major concern in PTSD underdiagnosis, as some traumas are likely to be systematically under-reported if a patient considers them embarrassing or culturally sensitive.[8] What's more, misconceptions about mental health symptoms and PTSD can actually lead to stigma within the family and community.[36] For example, although PTSD is often associated with the military and veteran populations,[36] the prevalence is actually greater in the general population.[37-39]

There's also the concern for self-stigma, which is the internalization of prejudices of mental illnesses from others.29 Self-stigma is common in individuals with PTSD, perhaps in part due to negative thoughts of oneself.29 Not only is self-stigma potentially a significant barrier to seeking and engaging with treatment, but it's also associated with greater symptom burden.[29-31]

Dr. Turck:
Now we're just about out of time for today, but before we close, I'd like to hear final thoughts from each of you. Dr. Davis, starting with you, what key takeaways would you like to leave with our audience?

Dr. Davis:
I think it's important to be aware that PTSD has a complex and heterogenous presentation in terms of symptoms, and as we discussed, the patient journey is remarkably protracted. So it's crucial to keep the diagnosis in mind for patients with a history of trauma exposure. Also keep in mind the potential clinical barriers, including stigma, which can significantly impact how an individual may present with symptoms, and seek or engage with treatment.

Dr. Turck:
Thank you for sharing, Dr. Davis. And Dr. Krystal, you get the final word.

Dr. Krystal:
I'd like to emphasize that we can't begin to help individuals with PTSD without asking—if we don't ask, we can't diagnose, and then appropriate care can get delayed. So I hope my colleagues take away from this program that early and appropriate diagnosis and intervention by clinicians, with consideration to all four PTSD symptom clusters, are important to optimizing patient outcomes.

And becoming familiar with trauma types and PTSD risk, the core symptom clusters and the DSM-5 diagnostic criteria, as well as using appropriate screening tools at the office visit, is how we can help address the diagnostic challenges of this very common and serious mental health disorder.

Dr. Turck:
Thank you both, these are great takeaways from our discussion. And with those final thoughts in mind, I want to thank my guests, Dr. John Krystal and Dr. Lori Davis, for sharing their perspectives on screening, diagnosis, and navigating the diagnostic challenges of PTSD.

Dr. Krystal, Dr. Davis, it was great speaking with you both today.

Dr. Krystal:
Thank you for having me.

Dr. Davis:
Thank you. It was a pleasure being here.

Announcer:
This program was sponsored by Otsuka. If you missed any part of this discussion, visit Medical Industry Features on ReachMD.com, where you can Be Part of the Knowledge.

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