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EDITORIAL

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Does COVID-19 count?: Defining Criterion A trauma for diagnosing PTSD during a global crisis

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Abstract

Introduction: The ongoing coronavirus disease 2019 (COVID-19) pandemic is a globally significant crisis with a rapid spread worldwide, high rates of illness and mortality, a high degree of uncertainty, and a disruption of daily life across the sociodemographic spectrum. The clinically relevant psychological consequences of this catastrophe will be long-lasting and far-reaching. There is an emerging body of empirical literature related to the mental health aspects of this pandemic and this body will likely expand exponentially. The COVID-19 pandemic is an example of a historic catastrophe from which we can learn much and from which the field will need to archive, interpret, and synthesize a multitude of clinical and research observations.

Methods: In this commentary, we discuss situations and contexts in which a diagnosis of posttraumatic stress disorder (PTSD) may or may not apply within the context of diagnostic and statistical manual of mental disorders, fifth edition (DSM-5) criteria.

Results: Our consensus is that a COVID-related event cannot be considered traumatic unless key aspects of DSM-5's PTSD Criterion A have been established for a specific type of COVID-19 event (e.g., acute, life-threatening, and catastrophic).

Conclusion: The application of a more liberal interpretation of Criterion A will dilute the PTSD diagnosis, increase heterogeneity, confound case–control research, and create an overall sample pool with varying degrees of risk and vulnerability factors.

KEYWORDS

anxiety, diagnosis, DSM, etiology, peritraumatic reactions, PTSD phenomenology

The ongoing coronavirus disease 2019 (COVID-19) pandemic is a global crisis with a rapid spread worldwide, high rates of illness and mortality, a high degree of uncertainty, and disruption of daily life across the sociodemographic spectrum exposing racial and economic disparities. Reports on the pandemic in the empirical literature began emerging in early 2020. We expect that this body of work will continue to expand exponentially from the approximately 3000 articles available as of this writing (Feingold et al., 2021; Jiang et al., 2020; Maalouf et al., 2021; Zhu et al., 2021). Critically, there has been a renewed call to expand the definition of a qualifying Criterion A trauma and consider the pandemic, in general, to be a Criterion A stressor (Wathelet et al., 2021).

From a strictly clinical perspective, none of us would disagree that persistent fears of infection, upheaval of life routines, isolation,

illness, and death could precipitate a host of adverse psychological outcomes and require therapeutic intervention. Diagnostically speaking, however, these may be better accounted for as presentations of adjustment disorders, major depression, prolonged grief disorder, generalized anxiety disorder (GAD), or more simply, chronic stress reactions (i.e., "other specific trauma and stressor-related disorders" [Van Overmeire, 2020]). Taylor and colleagues (2020) have suggested a distinct conceptualization of "COVID Stress Syndrome" to capture the clinical features of COVID-related distress that is not traumatic; however, this conceptualization poses a nosological problem of creating new mental disorders linked to specific types of events.

PTSD requires exposure to a traumatic event (i.e., Criterion A), so the presence of symptoms, alone, without traumatic exposure, is insufficient for the diagnosis. Unfortunately, trauma is difficult to define unambiguously; there is no crisp demarcation between traumatic and nontraumatic stressors. Nevertheless, to protect the integrity of the diagnosis, it is essential to thoroughly explicate a conceptual definition of trauma and apply it carefully to distinguish traumatic stress from other stressors. From a measurement perspective, a significant concern is that many categories of stressful events encompass a range of specific events with widely varying magnitudes, compounding the ambiguity of assessing traumatic exposure (Dohrenwend, 2010). We and others suggest that "COVID-19 pandemic" is one such category, and therefore cannot be considered traumatic unless key aspects of diagnostic and statistical manual of mental disorders, fifth edition's (DSM-5's) PTSD Criterion A have been established for a specific type of COVID-19 event (Asmundson & Taylor, 2021).

A question that continues to arise:

Does the COVID-19 pandemic qualify as a Criterion A trauma? If so, under what conditions?

The definition of a trauma in Criterion A has been debated vigorously and has undergone considerable revision since its original conceptualization in DSM-III (Weathers & Keane, 2007). In response to sharp criticism that the definition of trauma had become too broad, an effort was made to tighten the definition for DSM-5 (American Psychiatric Association A. P, 2013). As part of that effort, a primary point of emphasis for DSM-5 was that not all life-threatening events—whether medical, vehicular, or weather-related, as examples—are Criterion A events. Furthermore, in the upcoming DSM-5 text revision (DSM-5-TR) for PTSD, greater emphasis has been given to descriptors such as "emergency," "catastrophic," and "acute" in an effort to distinguish the extreme nature of Criterion A events from lower magnitude stressors that occur as part of daily human experience. Similarly, the international classification of diseases 11th revision (ICD-11) specifies that the event should be "exceptionally threatening" or "horrific" and likely to "cause pervasive distress in almost anyone."

A strict, conservative approach to conferring a PTSD diagnosis, in which the identification of a "true" Criterion A trauma serves as a gateway element, requires that some aspect of the traumatic exposure was "sudden" and "catastrophic." Under these restrictions, a chronic threat of potential virus exposure, actual infection, active COVID symptoms, or even death would not be sufficient to merit Criterion A status and thus would preclude a diagnosis of PTSD. Indeed, for any medical event to meet PTSD's Criterion A, as highlighted in the supporting DSM-5 text, it must occur under traumatic circumstances (e.g., acute myocardial infarction, anaphylactic shock, and severe respiratory distress).

We must also emphasize that we are not suggesting that COVID-related Criterion A traumas be minimized or that this clinical manifestation of PTSD does not exist. Numerous reports, anecdotal and empirical, from the early literature present examples that undoubtedly satisfy Criterion A (Rodriguez et al., 2021). These include events in which there was a sufficiently high probability of harm or death with clear, direct exposure to the threat, such as patients with severe respiratory distress who were admitted to intensive care units and either experienced themselves or witnessed near-death encounters with devastating features and robust psychological effects (de Graaf et al., 2021). Having a family member or friend who is a frontline worker could begin to be considered as a Criterion A event *if* the frontline worker was exposed to graphic details of death and dying then subsequently and repeatedly relayed these details to the vicariously traumatized individual.

Representative, but not exclusive, examples of COVID-related experiences meeting Criterion A are as follows:

1. Extreme anxiety/panic and fear of death during severe respiratory distress.
2. Being overwhelmed by the magnitude of exposure to/witnessing severely ill and dying COVID patients as a health-care worker or exposure as a health-care worker without adequate personal protective equipment.
3. Being a family member or close personal friend of a child, parent or partner, and then subsequently learning about that individual's experience (e.g., indirect exposure) with extreme anxiety/panic and fear of death during severe respiratory distress.

Where does that leave us as clinician scientists?

As the field moves through empirical and phenomenological examinations of the COVID-19 era, it is important that standards of classification be established and that this global stressor and its psychobiological effects are appropriately and soundly archived and interpreted. This sets a high bar for PTSD diagnosis and places innumerable cases under the umbrella of more broad diagnoses such as adjustment and "other specified trauma- and stress-related" disorders (Van Overmeire, 2020). Our group recommends the use of structured, clinician-administered interview as the basis for determining Criterion A exposure in addition to the widely used, established self-rated measures. If self-rated measures are used (e.g., PTSD Checklist for DSM-5; PTSD checklist for DSM-5 [PCL-5]; Bovin et al., 2016), we would strongly encourage using a version *with* a Criterion A assessment to allow a clearer determination whether a reported event meets Criterion A (Weathers et al., 2013).

Many of the neuropsychosocial manifestations observed with COVID-19 and its associated fears overlap with acute stress disorder

and mimic prodromal or subthreshold PTSD. This is not surprising given that PTSD as a clinical disorder lies at the extreme end of a spectrum of severity/impairment broadly defined as "stress reactions" and there are common neuro- and psycho-biological consequences, and shared underlying neural mechanisms, with both stress and traumatic exposures. As a recent example, Na and colleagues (2021) reveal overlap between posttraumatic distress symptoms in individuals who experienced loss whether "violent" or "non-violent." However, it is important to note that placement at this extreme end of a putative stress reaction spectrum *requires* the presence of a defined Criterion A trauma *and* severe symptoms.

With these considerations in mind, we are concerned that, instead of adhering to strict DSM-5 criteria for PTSD, as we have proposed, some clinicians and investigators will utilize more liberal conceptualizations of post-COVID distress and bypass a careful Criterion A assessment, altogether. For example, Shevlin and colleagues (2020) suggest that "living through the most deadly infectious respiratory disease pandemic since 1918" meets the guideline for an ICD-11, but not DSM-5-defined, traumatic event and, as such, serves as an appropriate anchor point from which to launch COVID-related mental health outcomes through a PTSD "lens." We disagree with the use this broad application of the definition of trauma.

If the threshold for Criterion A trauma and PTSD diagnosis were lowered, there is the risk of labeling a significant percentage of the population with PTSD when it is better accounted for as another diagnosis or, even, healthy, appropriately vigilant anxiety or chronic stress. Wathelet and colleagues (p. 1, 2021) state that application of a strict Criterion A definition "could leave a number of patients without the appropriate care." We would argue that identifying the presence of symptoms that overlap with PTSD, without an index trauma or full PTSD diagnosis, does not preclude access to and implementation of evidence-based interventions after exposure to COVID-related stressors. Moreover, we believe that a more accurate diagnostic determination should lead to better treatment selection and outcomes.

In conclusion, we are simply recommending that clinicians and investigators adhere to the letter and spirit of DSM-5's Criterion A. Applying a more liberal interpretation of Criterion A will dilute the PTSD diagnosis, increase heterogeneity, muddle case–control research, and create an overall sample pool with varying degrees of risk/vulnerability factors (Asmundson & Taylor, 2021). As with other historical catastrophes, we have a lot to learn from this pandemic. But the traumatic stress field can only optimize this opportunity if we approach COVID-19 exposure with the accuracy and rigor needed to advance our scientific understanding.

CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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