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POST-TRAUMATIC STRESS DISORDER Factsheet

How is post-traumatic stress disorder diagnosed?

For a person to be diagnosed with PTSD, at least one stressor is required. Stressors, as determined by the DSM-5, include being exposed to threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Examples are direct exposure, witnessing a trauma, or learning that a relative or close friend was exposed to a trauma. At least one *"intrusion"* symptom is required for a diagnosis of PTSD. These symptoms include unwanted and upsetting memories, nightmares, flashbacks, and emotional distress and/or physical reactivity after exposure to reminders. At least one *"avoidance"* symptom is required. These include avoidance of trauma-related thoughts or feelings and/or avoidance of trauma-related external reminders. At least two *"negative alterations in cognitions and mood"* are required. These include negative thoughts or feelings that began or worsened after the trauma, an inability to recall key features of the trauma, overly negative thoughts and assumptions about oneself or the world, exaggerated blame of self or others for causing the trauma, negative affect, decreased interest in activities, feeling isolated, and difficulty experiencing positive affect. Finally, there needs to be at least two *"hyperarousal"* symptoms, such as irritability or aggression, risky or destructive behavior, hypervigilance, heightened startle reaction, difficulty concentrating, and difficulty sleeping. Symptoms must not be due to medication, substance use, or other illness. These symptoms must last for more than one month and cause significant distress or problems to the individual's daily functioning. The latest World Health Organization's International Classification of Diseases (ICD-11) also includes complex PTSD, which involves the core symptoms of PTSD plus disturbances in self organisation, affect dysregulation, negative self-concept, and disturbances in relationships.

A variety of tools have been developed to screen for, or diagnose, PTSD. The gold standards for diagnosis are the Clinician-Administered PTSD Scale (CAPS) and the Structured Clinical Interview for DSM-V (SCID-5), PTSD module. There are also a wide range of self-report PTSD measures, including the Primary Care PTSD Screen (PC-PTSD) and the PTSD Checklist (PCL), which are mostly used to monitor PTSD symptom severity, but can also be used for screening and diagnosing PTSD in people who have been exposed to trauma.

What is the evidence regarding diagnosis and detection of PTSD?

Moderate to high quality evidence finds a small increase in the severity of PTSD symptoms in people exposed to DSM-5 nominated stressors of actual or threatened death or serious injury or of threat to the physical integrity of self or others, compared to people exposed to other stressors such as divorce, financial stress, or minor car accidents.

Around 24.5% of people diagnosed with PTSD have a delayed onset (>6 months post trauma), with most of these people experiencing earlier subclinical symptoms. Delayed-onset PTSD is highest in professional groups and in those who experienced combat trauma (prevalence in both is around 40%).

There is reasonable sensitivity and good specificity of the PC-PTSD and the PCL for predicting a diagnosis of PTSD. There is good diagnostic validity and internal consistency, and reasonable test-retest and external (convergent) validity of the PCL. For children, the average T score on the Trauma Symptom Checklist for Children is around 50 in those exposed to traumatic events, which is 15 points less than the clinical cut-off for PTSD on this scale. Factors associated with increased scores on the Trauma Symptom Checklist for Children include international (vs. U.S.) samples, sexual abuse (vs. neglect, community violence, or complex trauma), female sex, and older age in sexual abuse samples.

Moderate to low quality evidence finds machine learning techniques (mostly support vector machine learning) using neuroimaging, neuropsychological, or audio data can reasonably predict PTSD in people previously diagnosed with PTSD using traditional means (mostly the CAPS or PCL).

For further information see the technical table

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