Letters

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-5\(^2\) 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 dyseu sia), 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, 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.”


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,” published online April 21, 2021, the phrase “the Black community” has been revised to “Black communities” throughout. This article was corrected online.