FIGHT to remember PTSD

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Certain clinical features of posttraumatic stress disorder (PTSD) appear in other psychiatric diagnoses and therefore can confound accurate diagnosis and treatment. PTSD is frequently comorbid with other classes of psychiatric disorders, including mood, personality, substance use, and psychotic disorders, which can further complicate diagnostic clarity. Comorbidity in PTSD is important to recognize because it has been associated with worse treatment outcomes.[1]

In DSM-5, the updated criteria for PTSD included Criterion D: "Negative alterations in cognitions and mood associated with the traumatic event(s) …."[2] In addition to inability to remember an important aspect of the traumatic event, this criterion may be met by developing persistent and exaggerated negative beliefs or expectations about oneself, blaming oneself or others for the event, and developing a persistent negative emotional state and decreased interest.[2] These characteristics overlap with DSM-5 criteria for major depressive disorder (MDD), including low self-worth, guilt, depression, and anhedonia. It is easy to imagine how one could diagnose MDD based on these features if a full history has not been obtained. Similarly, many of the elements in Criterion D overlap with the criteria for anxiety disorders, including irritable behavior, problems with concentration, and sleep disturbance. Re-experiencing symptoms can exist on a continuum with primary psychotic symptoms, and comorbid substance use disorders can add additional diagnostic complexity.

We created the mnemonic **FIGHT** to help remember the updated DSM-5 criteria for PTSD when considering the differential diagnosis.

Flight. Avoidant symptoms, including efforts to avoid distressing memories, thoughts, or feelings about the traumatic event, as well as avoidance of external reminders.

Intrusive symptoms, such as distressing dreams, intrusive memories, and physiological distress when exposed to cues.

Gloomy cognitions. Negative cognitions and mood associated with the traumatic event.

Hypervigilance. Alterations in arousal, such as irritability, angry outbursts, reckless behavior, and exaggerated startle response.

Trauma. Exposure to actual or threatened death, serious injury, or sexual violence.

A diagnosis of PTSD requires ≥1 month of symptoms that cause significant distress or impairment and are not attributable to the physiological effects of a substance or medical condition. Specifiers in DSM-5 include with *depersonalization* or *derealization*, as well as *delayed expression*.[2]

Vigilance in the assessment and treatment of PTSD will aid the clinician and patient in producing better care outcomes.

References

1. Angstman KB, Marcelin A, Gonzalez CA, et al. The impact of posttraumatic stress disorder on the 6-month outcomes in collaborative care management for depression. J Prim Care Community Health. 2016;7(3):159-164.
2. Diagnostic and statistical manual of mental disorders, 5th ed. Washington, DC: American Psychiatric Publishing; 2013.

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Disclosures
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