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Prevalence and Burden of PTSD in Women: Focus on Factors That Affect Patient Presentation, Such as Race, Risk Factors, Stigma, and Other Drivers

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. McIntyre:
This is CME on ReachMD. I'm Dr. Roger McIntyre. Here with me today is a very good friend and colleague, Dr. Joseph Goldberg. Welcome, Joe.

Dr. Goldberg:
Thank you, Roger. Good to be here.

Dr. McIntyre:
We're going to be discussing, Joe, the prevalence and the burden of PTSD in women and what are the factors, such as confounding symptom presentation, stigma, and race, that may affect obtaining a timely diagnosis and subsequent treatment.

Joe, could you please address some of these issues for our learners?

Dr. Goldberg:
Yeah. So don't ask, don't tell. If you fail to screen for PTSD, if you fail to ask about a history of trauma, if you fail to then follow up with the impact on thinking and mood and behavior, you're missing a lot. 3% to 4% of the population in the United States has post-traumatic stress disorder. It's about twice as likely in women as in men. Overall, about 8% versus 4% with some degree of variation and part influenced by things like, well, what was your trauma exposure? People that have been in high-risk situations, combat veterans, for example, or people that have been victims of things like domestic violence, interpersonal violence, or have a history of physical, emotional, or sexual abuse, especially in early developmental years are particularly at high risk for PTSD. So we want to ask patients if they've ever endured any kind of a traumatic experience and, if so, what that was. And then ask about the kinds of questions that then lead to a diagnosis of PTSD.

There can be confounding presentations and some things you just want to keep an ear open for. So this is a kind of a wide list. It could be anger, mood dysregulation, depression, physical complaints like chronic pain, self-harm, thoughts about suicide, sleep dysregulation, a sense of overwhelming grief. There can be a lot of overlap among symptoms. So this is not a quick kind of diagnosis to make when you think of differentiating is this PTSD? Is this a mood disorder? Is this a behavior or personality disorder? Are there substances in the picture? So we screen for PTSD with standard kinds of measures, but once we've identified a history of severe threatening trauma with these core domains of intrusive thoughts, hyperarousal, mood and cognitive symptoms, and avoidant behaviors, that sort of then moves us along the track of further elucidating the diagnosis once it's there.

Other things that can impact making a timely diagnosis of PTSD are self-stigma, attitudes about PTSD, a sense of I should just shake this off, or it's not really PTSD; everybody has trauma. That's true. A lot of people do endure trauma, but it's thought that PTSD is a maladaptive or abnormal response to a traumatic event, so you wouldn't just say, well who wouldn't have PTSD? It's actually speaking to a biological susceptibility or vulnerability, and we really want to educate that it's not about stigma. It's about saying if someone has the predisposition biologically for PTSD and the right environmental factor comes along to trigger it, we make the diagnosis and then we treat it.

Now, part of the challenge, too, is we don't have a lot of wonderful data on treatment. We also have not a lot of data that help us stratify different subgroups of patients and how they fare. So, for instance, higher risks in African American patients than white patients, somewhat greater risk of poor outcome in women than men. There haven't been a lot of studies that have looked at the human diversity factors that can play out in the case of PTSD, and so some groups that may be either marginalized or not recognized as being at high risk, we want to pay special attention to.

We want to think about the impact of PTSD symptoms on quality of life, daily social functioning, interpersonal functioning, work functioning, the ways in which the aftereffects of trauma in someone with a biological vulnerability PTSD may actually present with problems that linger around psychosocial functioning, taking care of their family and others. So it's a complex area. We want to screen for it, we want to ask about it, we want to destigmatize it, and we want to render help.

Dr. McIntyre:
Joe. Amazing, comprehensive, so concise, so clinically meaningful what you covered. And what really stuck out among other things that you said, Joe, was that aspect about self-stigma. I've been really struck in my clinical practice at how often there's a shame, there's a tremendous guilt associated with prior trauma, especially certain contexts of trauma, like family sexual abuse, things of that nature. And the other part were social determinants of health. Certainly, there's no question that there are inequities with respect to access and availability of care and affordability of care, and no question that's been another factor that has absolutely influenced course and outcome for PTSD. So something we all need to be cognizant of as clinicians.

Joe, thank you so much. We hope that this discussion that Joe and I have had will be helpful in your clinical practice. Thank you so much for listening.

Announcer:
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