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Proactively Uncovering Potential Traumatic Experiences Linked to Patient Psychiatric Symptoms in Women

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, and I'm Dr. Roger McIntyre here with my very good friend and colleague, Dr. Joe Goldberg.

Joe, welcome.

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

Dr. McIntyre:
We're going to be discussing today, Joe, how primary care and obstetrics and gynecology physicians can help uncover potential traumatic experiences in their female patients that could be linked to suspected psychiatric symptoms.

Joe, over to you.

Dr. Goldberg:
So I think one of the most fundamental themes we want to touch on here today is not so strictly about screening tools or even the content of questions as much as the delicacy of the relationship. So trauma and PTSD can evoke a lot of awkward feelings on both the part of the clinician and the patient, as well as stigmatizing feelings. And one of the things about trauma is people sometimes have the idea that they may have caused it to happen and that they're to blame and that there's a great sense of disavowal about what happened. So I think one of the overarching messages, when a healthcare provider asks questions about was there ever a time when you experienced any kind of trauma in your life, what was that, it's with a very open stance. It's in a very nonjudgmental way. It's phrased in the positive, not like, you haven't had any trauma, have you? And even to speak about how trauma does happen. The risk of PTSD in women is about twice as high as in men. If someone is known to have been the victim of, say, domestic violence, interpersonal violence, childhood trauma, it is altogether appropriate to flag that and say, now, I know you've endured experiences that are very difficult for you in the past. Would it be okay if I ask you some questions about that? Ask permission. You're on their side. You're not there to be in any way judgmental. You're there, in fact, to try to uncover something. And just as you would be, well, delicately probing a wound or a very sensitive area or a burn, this is an emotional burn. It's an emotional wound, so I think you could approach it with the very same sort of mindset that one might do in those instances and ask permission. And is it okay if I say a little bit more about this? And if you're not comfortable talking about it, what can we try to do to make you more comfortable with it? Would it make a difference if you were talking to a man versus a woman, or someone older? Have you talked to anyone else about this?

And you've opened a door. Right? So sometimes people might say this is not an area I want to talk about. We may come back to it at

some other point if it's on my radar, I've noticed it. If I'm treating you for, say, depression or anxiety and my alarm has gone off in my head that I'm concerned about trauma or possible PTSD, I might ask just questions like do you get bad dreams? Instances where you'll avoid certain situations because they make you very uncomfortable and uneasy? Do you find that you replace certain things in your mind over and over again and it feels sort of inescapable like Groundhog Day in your head? So just that stance of making these phenomena, these symptoms of PTSD sort of very understandable and approachable to the extent that a patient, particularly a woman with a higher risk, might be more open to say, well, now that you mentioned it, there was something that happened. And then, your whole stance is, this could very well be PTSD. And there may well be a sense of relief in being able to name something. When you can name it, usually that means I can do something about it, right? And so we can talk about the various approaches. Those approaches are not just limited to pharmacology. Behavioral interventions for PTSD are among the most evidence based.

So I think the overriding message, again, is a delicate approach, asking for permission to talk about something that you recognize may be very sensitive and to offer a sense of hope and optimism that I'm here to help.

Dr. McIntyre:
Joe, so wonderfully put, and I agree with your comment. I think it's being delicate. That is certainly a great word. I've had so many occasions, Joe, where a patient will say, yeah, I've had a trauma history, but I don't really feel comfortable talking about it. But as you were so correct in pointing out, that doesn't mean you cannot probe empathically and delicately around some of the symptoms of PTSD. And I often will acknowledge that the patient's wish to maybe not discuss it, at least in that moment, is registered. But would they be okay if I ask about some of the symptoms? And I usually get an affirmative. And so I think it's a great way to sort of keep the discussion going, and I think it's also very empathic to the patient's experience.

Thanks for that, Joe. Really appreciate it. And I do hope this information has been useful for all of our colleagues in their clinical practice. We're out of time. Thanks for listening.

Dr. Goldberg:
Thanks, everyone.

Announcer:
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