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Setting the Stage: Unmet Needs in the Treatment of Women With PTSD

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

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Goldberg:
Hello, everyone. This is CME on ReachMD. I'm Dr. Joe Goldberg. I'm joined today by my good friend and colleague, Dr. Roger McIntyre.

Welcome, Roger.

Dr. McIntyre:
Joe, good to be with you.

Dr. Goldberg:
Likewise. So we're going to be talking to you about the unmet needs of women that are impacted by PTSD.

Rog, what can you tell us?

Dr. McIntyre:
Joe, happy to address this issue. We know that women are more likely to be victims of trauma, and they're also more likely to have PTSD in the general population. In fact, up to half of women are exposed to at least one trauma. One in five women have been victims of trauma, especially of a sexual or violation nature. So these are common experiences. I think it begins with recognition, not just of the commonality of trauma and the follow-up of trauma, that being in some cases, PTSD, but recognizing for too many patients that there's a long delay from the declaration of PTSD clinically from when it's actually being detected and diagnosed.

I think there's been a low index of suspicion for a long time in many circles, Joe. I think people don't systematically and routinely ask about trauma, and then the follow-up questions, I think in part because they may be a little less familiar with the PTSD criteria. It's hard to keep all this in our head on a day-to-day basis. And that's why it's important, I think, to probe for trauma, consider screening tools for PTSD, like the PCL-5 or the PC-PTSD scale, and then empathically probe patients about some of the symptoms that are commonly manifesting in PTSD, like intrusion, avoidance, arousal, subtype symptoms, along with disturbance and mood and cognition. So I think it begins with moving from precontemplation to contemplation of PTSD, recognizing its common occurrence, probing empathically about symptoms, and in some cases, even screening for PTSD in practice.

Dr. Goldberg:
You can sure see a diversity of symptoms, right? I mean, seldom will the patient come in and say, "Well, Dr. McIntyre, I'm having hyperarousal and nightmares." But rather you might hear patients say, "I'm so moody. I'm so irritable and fly off the handle. I don't know why." And that opens a wide differential diagnosis. So I think a first question – maybe not the first question, but certainly a pertinent question is, if I may, as we try to understand what you're describing, may I ask was there a traumatic event or some terrible thing that

happened to you, because that's the gateway question, right?

Dr. McIntyre:
Absolutely. It truly is. And again, it's empathic. I know a lot of colleagues may have a little of their own discomfort talking about that with their patients, but it's certainly empathic. And then finding a time that's appropriate for your patient to have a more deeper discussion as to the circumstances and the symptoms that may have been a consequence of this traumatic event, I think, is imperative in clinical practice.

Dr. Goldberg:
Indeed. Empathy is the word.

All right. Well, we're out of time. But this is a great sound bite in understanding some of the important factors that go into evaluating and understanding PTSD in women and opens the door to our thinking about imparting a sense of optimism about treatment.

So, Roger, thank you so much for joining us today. Thank you all out there for joining us, and we hope this is helpful. We hope to see you again soon.

Dr. McIntyre:
Thanks, everybody.

Announcer:
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