



Is Our Medical Community Failing Women? The PTSD Epidemic among Women in the United States

PTSD has become fairly recognized within the United States Medical Community. Experts have begun to expand PTSD research beyond the confines of PTSD due to war and have begun looking at PTSD in the civilian populations. Due to this advancement in research, we now know that certain identities, like gender, can put someone at a higher risk for developing PTSD. In this essay I argue that even though we are aware that gender, and more specifically being a woman, can increase someone's chances of developing PTSD, we still see women being misdiagnosed and mistreated by medical professionals. I examine this perspective through an analysis of current PTSD literature regarding women and compare it to my own experience as a young woman who sought out PTSD diagnosis and treatment.

Introduction

Post-Traumatic Stress Disorder (PTSD) is a complex anxiety disorder often correlated with men and war, yet those most affected by PTSD in the United States are typically women who have never fought in or been victim to a war (Mayo Foundation for Medical Education and Research [MFMER], 2018). Experts have begun to expand PTSD research beyond the confines of PTSD due to war and have begun looking at PTSD in civilian populations. Due to this advancement in research, we now know that certain identities,

like gender, can put someone at a higher risk for developing PTSD. So, why is there still this myth of PTSD being a “veterans’ disease?” As the PTSD poster child, men seemingly have easier access to diagnosis and treatment, all while women seem to slip through the cracks of the system. In this essay I argue that even though we are aware that gender, and more specifically being a woman, can increase someone’s chances of developing PTSD, we still see women being misdiagnosed and mistreated by medical professionals. Not only are women’s PTSD symptoms being dismissed for “lesser” mental illnesses, but we see that women’s symptoms are sometimes ignored by their medical providers. In exploring the professionals’ failure to listen and properly diagnosis women, I look at how negative gender stereotypes about women are not only deeply embedded in our society, but also question if they are rooted in standard PTSD treatment. By invalidating women’s experiences, we are not only reinforcing gender stereotypes, we are creating a mental health epidemic among women. I examine this perspective through an analysis of current PTSD literature regarding women and compare it to my own experience as a young woman who sought out PTSD diagnosis and

treatment. Before continuing, I would like to take a moment to acknowledge the limits of my perspective. I am a queer, white, woman who was raised with access to health care. I experienced barriers when seeking out help, which is where my interest in this topic is rooted. The barriers that I faced are not and will never represent all of the barriers that women may face when seeking out PTSD treatment. My perspective may be limited due to how my identities affect my experiences in the world, but it is not meant to erase other women’s perspectives. My intent is to share my perspective as a woman to help encourage other women of various backgrounds to come forward about their own experiences.

What is PTSD

To truly understand the gendered differences in PTSD treatment we must first understand what exactly PTSD and gender stereotypes are, how someone may develop PTSD, and how gender stereotypes interact with this. Once known as combat fatigue, PTSD is described as “an anxiety disorder that can occur after an individual experiences a traumatic event such as a combat experience, a motor vehicle crash, physical assault, or sexual assault” (Coughlin, 2013, p. 1). Typically defined

by symptoms like intrusive thoughts, avoidance, memory problems, feelings of detachment, and changes in physical and emotional reactions, PTSD can become very debilitating for the person suffering from it. For a PTSD diagnosis to occur, you must be experiencing one or more of these symptoms not only for at least a month, but they must be considered severe or debilitating (MFMER, 2018). According to the American Psychiatric Association (APA), most people develop PTSD within three months of a traumatic event(s), but this incubation period is different for everyone, sometimes taking months to present itself. Experts at the Mayo Clinic recommend that you seek out treatment as soon as you notice a persistence in these symptoms to help prevent the potential worsening of these symptoms. The recommended treatment for PTSD varies depending on what you and your medical provider are comfortable with. Some of the most common treatments for PTSD are antidepressants and anti-anxiety medications and psychotherapies like cognitive therapy.

For the best possible outcome, the APA recommends that you not only seek out professional help but that you use a combination of medication and psychotherapy. On top of all of this,

there are also other health conditions and mental illnesses that can be associated or develop due to PTSD. Some of these conditions include but are not limited to: major depressive disorder, bipolar disorder, eating disorders, stomach ulcers, and suicidal ideations (MFMER, 2018). PTSD can not only trigger other illness in the short term, but there has been speculation that there could be some detrimental longer-term effects of having PTSD. Probably the most shocking and scariest correlation found between PTSD and illnesses as a result of it was in a study done by Sumner et al. (2017). Sumner et al. found that middle aged women who exhibit advanced and complex PTSD symptoms showed signs of lower cognitive abilities, having slower response times and presenting issues with information retention. Sumner et al. theorize that if PTSD, and trauma in general, can have an effect on your cognitive functions, then it may also play a role in the development of other diseases that attack your cognitive function like Alzheimer's. If you are middle aged and had been unknowingly dealing with lower cognitive functioning without treatment for a long period of time, it would make it much easier for something like Alzheimer's, which breaks down your brain and inhibits

cognitive abilities, to develop (Sumner et al., 2017).

Gender Issues and the Medical Community

Stereotypes are beliefs and images about certain communities that are then generalized and meant to represent that community as a whole. While they may seem harmless, stereotypes end up having a lot more power due to their negative connotations and value to society. Stereotypes can be used to hold back and police the very community that it affects. When talking about gender stereotypes, we are talking about the negative beliefs and implications about someone based on their gender identity. So, when looking at gender stereotypes in the medical community, what we are looking at is how these stereotypes in society may affect a woman's experience when seeking out medical treatment and more specifically, PTSD treatment.

Gendered stereotypes and bias have played a large role in medical research and in medical practices. This is very concerning, as not only can assumptions about one's identity lead to misdiagnosis, but it can be very dangerous for the patient depending on the circumstances (Munch, 2006). Up until about the 1970s, when the second wave of feminism in the United States was

beginning to peak, women did not really have a say in the treatment that they received from medical professionals. They were not able to advocate for themselves in a medical setting; they did not have access to their own medical records, and they were not included that often in medical research. Gender stereotypes and sexism were so deeply embedded in medical practices that there was actually a belief that women were biologically programmed to be feminine and, if they had reproductive issues or complained of them then they were rejecting their "inherent" femininity. This is one of many claims that were made about women in the medical community and like so many other medical myths, was believed to be true until being debunked after the feminist medical movement in the 70s and 80s. Medical beliefs like these are the very ones that can be very dangerous for women (Munch, 2006).

It was found in the 1980s that gender bias extended well beyond reproductive issues. Activists' focus began to shift. Munch (2006) found that women were often underrepresented or not represented at all by medical research. In a study about heart disease and aspirin, it was found that while the information gathered was applied generally, it did not actually work for women (Munch, 2006).

Experts found that aspirin was not as helpful in preventing heart disease in women as it was men. On top of this, doctors actually pursue less aggressive treatment for diseases, such as heart disease, in women despite the fact that there is not real medical proof that this is necessary (Munch 2006). While yes, different treatments work for everyone, how does this justify giving someone a less aggressive treatment due to their gender? Munch (2006) ends up drawing the same conclusion as many other scholars when examining gender and that is, medicine has come a long way, but we must remove gender stereotypes and gendered practices from medicine in order to ensure that everyone is getting proper treatment when they need it. This presumes that the woman seeking out treatment even has insurance coverage. Women have lower rates of access to healthcare, something that worsens as you begin to factor in race and class (Travis et al., 2012).

Gender and PTSD

Not only do women have to overcome the barriers of stigmas related to mental illnesses such as PTSD, but they also have to deal with negative gender stereotypes that may affect the treatment that women receive (Mizock & Kaschak, 2015). Gender stereotypes not only play

a role in the treatment of physical illnesses but also mental illnesses such as PTSD. This can make seeking out PTSD treatment much more complicated and even exhausting for the woman seeking it out. The literature on PTSD and its interactions with gender are somewhat limited, but we do know a few things. Even in female veterans there are issues obtaining proper PTSD treatment from the Veterans Affairs (VA) (Murdoch et al., 2003). Murdoch et al. found that in a comparison between combat veterans and civilian sexual assault survivors, the sexual assault survivors had higher rates of PTSD, yet combat veterans were more likely to receive PTSD treatment and referral. While gender did not play a role in referral rates, it still had a significant place in this study because while combat veterans are referred for PTSD treatment regardless of gender, those most likely to experience higher levels of combat in the military are men, and women have the highest sexual assault rates in the United States. Also, female veterans who have experienced sexual assault while serving in combat roles have the highest rates of PTSD. Though, interestingly enough, if they report this sexual assault and PTSD symptoms from this assault, they are still less likely to receive or be referred for PTSD treatment by the VA as their symptoms cannot as “easily” be linked back to trauma from

serving in the military (Murdoch et al.,

Regardless of military status, women who have PTSD not only are prone to develop physical and cognitive issues as a result of their PTSD, but we also see a development in social issues in these very same women. According to Sandberg et al. (2009), women suffering from PTSD are less likely to seek out interpersonal relationships, both romantic and platonic. They seem to develop antisocial behaviors due to severe anxiety behind this very relationship development. These women, who may have once flourished in a social setting like a college, now struggle to find a place and may not excel like their peers. Sandberg et al. (2009) conclude that a lot of this avoidance comes from the fear of experiencing new traumas, even if the woman does not notice it herself. There has been some more recent research exploring the possibilities of PTSD prevention because prevention is just as important as treatment. It has been found that there is an issue with getting women who face trauma the help they need at the time of the trauma (

If a woman is assaulted and goes to the hospital for medical services, she is given, or should be given, a full medical exam. This full medical exam covers

everything physically but fails to really address her mental health and where it may be in that moment and afterwards (Sullivan et al., 2018). It is believed that PTSD can be prevented or reduced if we provide adequate and timely mental health services as when a woman reports a trauma such as sexual assault (Scott et al., 2018). If we do not provide mental health services from the time a trauma like assault is reported, then how are we to guarantee that these people will be normal afterwards? Especially when we are so aware of not only PTSD and how to treat it but that in some cases it can be prevented. Sadly, due to these misinformed practices, a woman's PTSD diagnosis often comes much later in life after being diagnosed with another anxiety related disorder first, and that is if they even seek out a second opinion (Scott et al., 2018).

Reflection on My Experience Seeking Out PTSD Treatment

Since about the age of 12, I have been seeing therapists and doctors seeking out treatment for what my family and I believed to be anxiety and maybe some depression. These diagnoses and the treatments never seemed to do anything for what I was feeling. Instead they seemed to dismiss how I felt. An anxiety diagnosis, in some ways, made sense. I

experienced anxiety attacks and felt nervous or uncertain about the future. But it did not feel as if everything that I was experiencing could be addressed as general anxiety. My symptoms felt too intense for anxiety. I was constantly on edge, terrified of loud noises or sudden movements, struggled to speak to people who reminded me of my abusers, and to this day, struggle with nightmares. I spent years complaining of these very symptoms and chasing a diagnosis that felt right because “normal female anxiety” did not feel like a good fit. Looking back with the knowledge that I have now, I had very clear signs of PTSD, but my doctors always passed it off as me just being a “normal anxious girl.” Never once did they or any therapist think to look deeply into the anxiety that I was feeling and how it was truly manifesting itself. Instead, they took my nightmares and severe anxiety that was seemingly triggered by nothing and just boiled it down to me being a girl. It was always just, “this is what being a girl is like” or “women are naturally anxious, you will get over it one day.” How are nightmares multiple times a week, not being able to eat because my stomach constantly hurt, and feeling as if the walls are always closing in, just a part of being a girl? How is this normal?

It wasn't until I was a freshman in college when I began to find my voice and demand to see someone new, that I was able to get my diagnosis of PTSD. This diagnosis was life changing. In some ways it was so liberating, but in others, it was crushing. PTSD was not like anxiety; I could no longer reduce my feelings to being just a “girl,” which was something that I had heavily internalized and relied upon for comfort for many years. I instead had to come to terms with the fact that it was much more complex than that. It was terrifying. I could no longer use the excuse of this being something engrained in my genetics and completely out of my control. It was something that was caused by traumas that are embedded so deeply in my memories that I am still sorting through them today. But even as scary as this was, my diagnosis was so freeing because it was a diagnosis that made so much more sense in relation to what I was going through and allowed me to get proper treatment. I finally felt as if I had been listened to, that someone finally took how I was feeling into consideration when they diagnosed me. My doctor did not even consider my gender as an explanation, but rather, something that may change how I present and experience my symptoms.

I know my diagnosis was in some ways the result of me being aware of mental illness and the symptoms of things such as PTSD, and at times pushing back against what my doctors said. Self-advocacy, especially with medical professions, is so intimidating at times. Not everyone is capable of pushing back the way that I did. These collective experiences are what sparked my interest in PTSD advocacy. Because if it has taken me years to get a proper diagnosis even with access to health care and more specifically mental health services, how long was it taking other women to get the diagnosis that they deserve? I am grateful to now have doctors and therapists that want to listen and affirm what I am feeling, but I am aware that not everyone has this. This is why I believe that work like this is so important.

Conclusion

The information that I gathered during my time researching this topic not only validated my experiences but also shined an interesting light on how women are treated by medical professionals. I too had experienced inadequate services after trauma, and I sometimes wonder if I had been giving preventive services would I have ever developed PTSD? PTSD has forever changed the way I will

live my life. Every day is new. I am still learning how to do things and how to overcome my traumas. This is something that I will probably be doing for the rest of my life and I do not wish it upon anyone else.

The medical community is aware of gender issues and how they affect treatment for both physical and mental illnesses. The medical community is also aware of the fact that even though PTSD was once known as “combat fatigue,” civilians, specifically women, are more likely to develop PTSD. Yet, we have so much more research and information of PTSD due to war. I am not trying to claim that we should stop researching it, instead I argue, we should be spending more time talking about things such as childhood trauma, which was not mentioned in the conversation about gender and PTSD. I think if we started the conversation with something like that what we would find is that PTSD is far more common than what we think. Along with this, our medical community needs to address some discrepancies. One of the biggest discrepancies is that sexual assault causes some of the highest rates of PTSD in women. Yet, when women are assaulted, we fail to provide them with the resources necessary to help their mental health. This is also a realization that can be applied to mental

illness in general. Sometimes it feels like our medical community and systems rarely have their focus on mental illness in women. Resources for mental illness in general are very scarce and limited, and even those with access may still face barriers such as not being able to afford it. As, in my experience, many insurance companies still view mental health treatments as specialty services that they rarely cover in general. The medical community in the United States needs to address these PTSD related issues. It is clear that they have research to change the way PTSD treatment is practiced, and yet it does not often seem as if it is being utilized.

I believe there are a few things that need to be done in order to address the issues surrounding PTSD. First, there needs to be a better conversation about PTSD and civilian women that actually applies the knowledge that our medical community has. Meaning, we get rid of bias and stereotypes, specifically in medical practice as there is no place or room for bias in medicine. Second, we must create a space where women, regardless of their background, can safely and comfortably advocate for themselves. Women need to have their voices heard and respected. How can they advocate for their own health if they are not being taken seriously. It is a

doctor's job to thoroughly evaluate the information that we provide them with and give us a proper diagnosis based on those symptoms and only those symptoms. Gender, and identity in general, have no place in dictating the diagnosis that someone may receive from a doctor. Sex and biology may play a role in how illness and treatment may affect someone's physical body, but it does not change the illness that is affecting this person. Mizock and Kaschak (2015) make a great suggestion at the end of their research, arguing that a therapist should inquire about their patient's identity during severe mental health treatment. This can revolutionize and produce better outcomes during treatment. Medical research needs to be made more accessible. If someone is expected to be an advocate for themselves, then they must be able to access important information that will aid in this. While medical research has become more accessible in using Google searches, there is not much that goes deep into depth about PTSD and trauma. And while some scholarly information does require use of some terms that not everyone may be familiar with, medical research is filled with so much jargon exclusive to the medical community. If you're not someone who is already in this community, navigating

this information becomes difficult. Medical information is seemingly exclusive, and it should not be, as this is knowledge that we all could benefit from having.

There is so much more that could be said about our medical community and what could be done, but I would like to close this paper with one final observation. COVID-19 has forever changed society. It was something that the world was not prepared for in any way. This pandemic has had a strong negative impact on the mental state of everyone. Being confined to essential places like your home and work is only okay for so long. People will be feeling the repercussions of this for years to come, and we need to make sure that our medical community is prepared and doing everything within its power to help people. This means that we need to

change the way that mental health, especially things like PTSD, is viewed and treated. Bias must be removed from mainstream practice and people should have protections from discrimination and mistreatment due to bias in medical practice. Treatment needs to become accessible for all, not just rich white people. And while the medical community cannot change or take back its past actions, it can make a change for the future as we have already seen an increase in severe mental health issues.

It is never too late to try to make a difference as it could forever change someone's life. It is time that we start holding the medical community accountable and begin pushing for change because if we do not, then we will continue to fail the very people who uphold our society.

References

- COUGHLIN, S. (ED.) (2013). *Post-traumatic stress disorder and chronic health conditions*. American Public Health Association.
- MAYO FOUNDATION FOR MEDICAL EDUCATION AND RESEARCH (MFMER). (2018, July 6). *Post-traumatic stress disorder (PTSD)*. Mayo Clinic. <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967>.
- MIZOCK, L., & KASCHAK, E. (2015). Women with serious mental illness in therapy: Intersectional perspectives. *Women & Therapy*, 38(1-2), 6–13. <https://doi.org/10.1080/02703149.2014.978209>

- MUNCH, S. (2006). The women's health movement: Making policy, 1970-1995. *Social Work in Health Care*, 43(1), 17–32. https://doi.org/10.1300/j010v43n01_02
- MURDOCH, M., HODGES, J., HUNT, C., COWPER, D., KRESSIN, N., & O'BRIEN, N. (2003). Gender differences in service connection for PTSD. *Medical Care*, 41(8), 950-961. Retrieved May 5, 2021, from <http://www.jstor.org/stable/3768090>
- SANDBERG, D. A., SUESS, E. A., & HEATON, J. L. (2009). Attachment anxiety as a mediator of the relationship between interpersonal trauma and posttraumatic symptomatology among college women. *Journal of Interpersonal Violence*, 25(1), 33–49.
- SCOTT, K. M., KOENEN, K., KING, A., PETUKHOVA, M. V., ALONSO, J., BROMET, E. J., BRUFFAERTS, R., BUNTING, B., DE JONGE, P., HARO, J. M., KARAM, E. G., LEE, S., MEDINA-MORA, M. E., NAVARRO-MATEU, F., SAMPSON, N.A., SHAHLY, V., STEIN, D. J., TORRES, Y., ZASLAVSKY, A. M., & KESSLER, R. C. (2018). Post-traumatic stress disorder associated with sexual assault among women in the WHO World Mental Health Surveys. *Psychological Medicine*, 48(1), 155–167.
- SULLIVAN, J., WITKEMPER, K., MARKIEWITZ, N., COOK, J., SINGLA, A., D'ANZA, T., BELL, K., LECHNER, M., BUCHANAN, J., BLACK, J., REESE, R., HO, J., REED, G., RIVIELLO, R., DATNER, E., PLATT, M., ROSSI, C., NOUHAN, P., SOWARD, A., & MCLEAN, S. A. (2018). Most sexual assault survivors with significant posttraumatic stress do not receive mental health care in the initial weeks after assault. *Biological Psychiatry*, 83(9), 358–359.
- SUMNER, J. A., HAGAN, K., GRODSTEIN, F., ROBERTS, A. L., HAREL, B., & KOENEN, K. C. (2017). Posttraumatic stress disorder symptoms and cognitive function in a large cohort of middle-aged women. *Depression and Anxiety*, 34(4), 356–366. <https://doi.org/10.1002/da.22600>
- TRAVIS, C. B., HOWERTON, D. M., & SZYMANSKI, D. M. (2012). Risk, uncertainty, and gender stereotypes in health care decisions. *Women & Therapy*, 35(3-4), 207–220. <https://doi.org/10.1080/02703149.2012.684589>