# June Medical Ethics Newsletter VOL. 40

Written and Edited By: Kaitlynn Esemaya, Alexis Thompson, Annique McLune, and Anamaria Ancheta

# POST-TRAUMATIC STRESS DISORDER IN WOMEN AND MINORITIES

Post-traumatic stress disorder (PTSD) disproportionately affects women and racial/ethnic minorities, with significant implications including increased prevalence, complicated clinical course, therapeutic access, and, finally, long-term health outcomes. PTSD is defined as a potentially chronic and disabling mental health condition that can develop after exposure to a traumatic event. According to published epidemiological data, sex and gender disparities exist in the prevalence of PTSD; it is nearly twice as high in women compared to men.

Overall, the lifetime prevalence was approximately 4.1% in men and 8.0% in women. Among racial/ethnic minorities in the United States, African Americans have the highest lifetime PTSD prevalence (~8.7%), followed by Whites and Hispanics (~7.0% and 7.4%), with Asians having the lowest rate (~4.0%). It is important to note that research has shown that experiences with chronicity in women experiencing PTSD are longer, with greater symptom burden and worse quality of life outcomes for women compared to men. Additionally, the clinical course remains poor for minorities; over five years of follow-ups, remission rates were only 0.35 for African Americans and 0.15 for Latinx adults with PTSD. Furthermore, fewer than half of racial/ethnic minorities with PTSD seek therapeutic intervention when compared to Caucasians.

Finally, the associated health consequences are significant; PTSD in women is associated with a 50–60% increased risk of incident cardiovascular disease, elevated stroke and dementia risk. Physicians should address PTSD disparities in women and minorities through a multi-level approach that involves universal proactive screening, culturally informed clinical practice, and evidence-based targeted treatment.

.

Women were underrepresented in initial research on PTSD, as many early studies included large samples of male military veterans. A concerning approach as women are twice as likely to develop PTSD following a traumatic event compared to men. While men are more likely to experience war-related, natural disaster, or accidental injury trauma, women face increased vulnerability to childhood sexual abuse and sexual assaults. It is critical for providers to recognize when patients have been exposed to trauma, identify their risk factors for developing PTSD, and continue to monitor them over the next few months, as their acute stress disorder may progress to PTSD. The need for increased monitoring is essential as women experience higher levels of physical stress when recalling or encountering reminders of the traumatic event within the one-month period following the event. This physical stress response, referred to as physiological reactivity, includes tachycardia, trembling, diaphoresis, nausea, muscle tension, and anxiety. Consistent reactivation and prolonged duration of this stress response contribute further to the development of chronic PTSD in women. Approaching each patient interaction with a trauma-informed lens helps to build trust between providers and their patients during these stressful periods. Trauma-informed care is deeply important, as women with PTSD often face barriers to treatment, from financial limitations to distrust of the healthcare system due to negative experiences with providers lacking trauma-informed training. Trauma-informed care serves to help patients not only with their PTSD diagnosis but also share their other health concerns, as PTSD in women is often associated with comorbidities such as depression, anxiety, and substance use disorder.

Racial and ethnic disparities for post-traumatic stress disorder within minority populations are shaped by socioeconomic and sociocultural factors, playing a major role in trauma exposure, access to treatment, and recovery. Few research studies report that among minority groups, the overall exposure to traumatic experiences is lower when compared to White Americans. This discrepancy can be caused by numerous factors, such as a lack of diversity in research studies and the types of trauma being studied. Both Latino and African American populations experience higher exposure to community violence, adverse childhood experiences, discrimination, and combat-related trauma. Racism and discrimination are both strongly associated with increased symptoms of PTSD, lower quality of life, slower recovery rates over time, and poorer psychosocial functioning.

Socioeconomic disparities such as unemployment, limited access to mental and physical healthcare, and financial stress intensify psychological distress for minorities, contributing to worse PTSD outcomes. Additionally, cultural factors influence PTSD recovery for minority populations. Immigration-related stress, language barriers, stigma surrounding mental illness, and emotional expression cultural differences complicate PTSD symptom management and treatment. Structural racism embedded within healthcare systems further exacerbates these disparities, affecting the detection of PTSD symptoms, management, and access to appropriate care. PTSD disparities are influenced by structural inequities and barriers to culturally competent care. To truly improve detection and management of PTSD symptoms within minorities, trauma-informed interventions are crucial to address both the social experiences and psychological symptoms affecting minority communities.

PTSD in women and minority populations challenges healthcare professionals to move beyond a one-size-fits-all approach to diagnosis and treatment. Physicians and other medical professionals must recognize that trauma often presents differently across patient populations, particularly among women and marginalized communities who may carry disproportionate burdens of interpersonal violence, discrimination, medical mistrust, and chronic stress. In many cases, PTSD may manifest through somatic symptoms such as chronic pain, fatigue, gastrointestinal concerns, or sleep disturbances rather than direct disclosures of emotional distress. As a result, clinicians must strengthen their ability to recognize subtle presentations and incorporate standardized screening tools, such as the VA PTSD Checklist for DSM 5, into routine practice. Equally important is the commitment to trauma-informed and identity-affirming care that acknowledges how race, ethnicity, gender, sexual orientation, and lived experiences shape a patient's healthcare journey. Implicit physician and healthcare provider bias and systemic inequities continue to contribute to underdiagnosis and undertreatment, particularly among minority populations who are less likely to be screened for mental health concerns or have their symptoms validated. Cultural differences in expressing distress may also influence diagnosis, emphasizing the need for humility, curiosity, and culturally responsive care. Ultimately, physicians and other healthcare professionals have an ethical responsibility not only to treat PTSD but also to create clinical environments where vulnerable patients feel safe, heard, and respected.

# Reflection Questions

- What are the ways in which healthcare professionals can aid in the early detection of PTSD symptoms in individuals who belong to minority and women's communities?
- What specific systemic changes within healthcare delivery could most effectively address the disparities in prevalence and treatment for minorities and women with PTSD?
- In what ways does the historical underrepresentation of women and minorities in PTSD research continue to influence the diagnosis and treatment of trauma-related disorders today?
- Why is early recognition and monitoring of acute stress disorder especially important in women following traumatic events?
- What changes in screening, communication, or cultural humility are needed to ensure equitable PTSD care for women and minority communities?

# Helpful Links

- Office on Women's Health | Post-traumatic stress disorder
- VA | PTSD Care for Women Veterans
- NAMI | Post-traumatic Stress Disorder
- Mental Health America | Racial Trauma Resources
- AFSP | Mental health resources for marginalized communities

# References


Am"A Woman Having a Therapy Session with a Psychologist." Pexels, photographed by SHVETS production, https://www.pexels.com/photo/a-woman-having-a-therapy-session-with-a-psychologist-5234573/. Accessed 20 May 2026.

"Crop Psychologist Encouraging Patient While Talking Indoors." Pexels, photographed by Alex Green, https://www.pexels.com/photo/crop-psychologist-encouraging-patient-while-talking-indoors-7176326/. Accessed 20 May 2026.

de Boer, Kathleen et al. "Barriers and facilitators to treatment seeking and engagement amongst women with complex trauma histories." Health & social care in the community vol. 30,6 (2022): e4303-e4310. doi:10.1111/hsc.13823

Flesaker, Michelle et al. "State of the Science: The epidemiology of posttraumatic stress disorder." Journal of traumatic stress, 10.1002/jts.70091. 6 May. 2026, doi:10.1002/jts.70091

Ford, Julian D. et al. "Social, cultural, and other diversity issues in the traumatic stress field." Posttraumatic Stress Disorder (2015): 503–546. doi:10.1016/B978-0-12-801288-8.00011-X

Goldstein, Risë B et al. "The epidemiology of DSM-5 posttraumatic stress disorder in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions-III." Social psychiatry and psychiatric epidemiology vol. 51,8 (2016): 1137-48. doi:10.1007/s00127-016-1208-5

Thurston RC, Jakubowski K, Chang Y, et al. Posttraumatic Stress Disorder Symptoms and Cardiovascular and Brain Health in Women. JAMA Netw Open. 2023;6(11):e2341388. doi:10.1001/jamanetworkopen.2023.41388

Roberts, A L et al. "Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States." Psychological medicine vol. 41,1 (2011): 71-83. doi:10.1017/S0033291710000401

Rønning, Line et al. "Gender differences in early posttraumatic stress disorder symptoms: a network analysis." European journal of psychotraumatology vol. 16,1 (2025): 2448385. doi:10.1080/20008066.2024.2448385

Sibrava, Nicholas J et al. "Posttraumatic stress disorder in African American and Latinx adults: Clinical course and the role of racial and ethnic discrimination." The American psychologist vol. 74,1 (2019): 101-116. doi:10.1037/amp0000339

Spoont, Michele, and Juliette McClendon. "Racial and Ethnic Disparities in PTSD." PTSD Research Quarterly, vol. 31, no. 4, 2020, U.S. Department of Veterans Affairs, National Center for PTSD, PTSD Research Quarterly PDF. Accessed 20 May 2026.

"Stressed Black Man with Dreadlocks in Psychological Office." Pexels, photographed by Alex Green, https://www.pexels.com/photo/stressed-black-man-with-dreadlocks-in-psychological-office-5699455/. Accessed 20 May 2026.

Vogt, Dawne, and Erin Mangan. "Research on Women, Trauma and PTSD - PTSD: National Center for PTSD." Va.gov, 2014, www.ptsd.va.gov/professional/treat/specific/ptsd_research_women.asp.

"Woman Sitting on a Sofa." Pexels, photographed by Alex Green, https://www.pexels.com/photo/woman-sitting-on-a-sofa-6753164/. Accessed 20 May 2026.

"Women Talking in Room and Crying." Pexels, photographed by Alex Green, https://www.pexels.com/photo/women-talking-in-room-and-crying-6255874/. Accessed 20 May 2026.