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Exploring Racial Disparity in Posttraumatic Stress Disorder Diagnosis: Implications for Care of African American Women

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Objective: To explore factors contributing to disparities in posttraumatic stress disorder (PTSD) diagnosis between African Americans and White Americans, while controlling for gender and class by using a data set limited to poor women.

Design: A cross-sectional epidemiological secondary analysis.

Setting: Michigan Medicaid fee-for-service claims data from 1994 through 1997.

Sample: A total of 20,298 African American and White American adolescents and adult women, including 2,996 with PTSD diagnosis.

Main outcome measures: Victimization, PTSD diagnosis, psychiatric and somatic comorbidities, and PTSD treatment.

Results: African American women were underrepresented in the group diagnosed with PTSD (12% versus 31% in the comparison group), despite having equal rates of hospitalization for rape and battering. They were less likely to be diagnosed with comorbidities associated with complex PTSD, such as dissociative disorder (OR = 0.259, $p < .001$) or borderline personality disorder (OR = 0.178, $p < .001$), but were equally likely to be diagnosed with conduct disorder, schizophrenia, or substance abuse. African American women were 40% less likely to have continuous insurance coverage.

Conclusions: Patient, provider, and system factors appear to interact to create disparities in PTSD diagnosis and treatment. Attention to case finding and provider or system bias may help reduce disparities. *JOGNN*, 34, 521-530; 2005. DOI: 10.1177/0884217505278296

Keywords: Health disparities—African American women—mental health—posttraumatic stress disorder (PTSD)

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Posttraumatic stress disorder (PTSD) is a significant U.S. and global health problem, for which female gender and socioeconomic disadvantage are recognized as major risk factors (Breslau et al. 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Less is known about race or ethnicity as a risk factor for PTSD or as a factor in treatment service use or outcomes. In other U.S. surveys, after controlling for poverty and urban environment, African Americans did not differ in their rate of symptoms meeting PTSD diagnostic criteria (Breslau et al., 1998). However, when we analyzed female Medicaid recipients' health service claims data from Michigan, African American women were half as likely as White American women to have a PTSD diagnosis, although we controlled for poverty by their Medicaid eligibility.

In the analysis described in this article, we used an ecosocial perspective (Krieger, Chen, Waterman, Rehkopf, & Subramain, 2003) to seek out alternative factors that could have accounted for this lower rate of PTSD diagnosis. Our discussion evaluates the support for these potential explanations and points

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to areas for further research on African American women's responses to traumatic stress, their experiences with treatment, and their desires for posttraumatic stress-related services. Individual clinicians can take a number of actions to provide appropriate assessment, diagnosis, and treatment to help close the current gap.

Race, Class, Gender, and Mental Health

Policy makers, researchers, and clinicians are increasingly aware of the intersecting effects of race, class, and gender on health (Krieger, Rowley, Avery, Phillips, & Herman, 1993). A growing number of studies document disparities in mental health treatment among minority racial or ethnic groups.

According to the Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services [USDHHS], 1999), almost two thirds of people identified in community surveys as having a diagnosable mental disorder do not receive any treatment. The disparity between need and treatment is greater among ethnic minorities. For example, the National Comorbidity Survey showed that only 13% of African Americans received services from a mental health specialist, and less than one third had seen any kind of health care provider (USDHHS, 2001a; Kessler et al., 1995). Recent data suggest that race and ethnic disparities in unmet need persist (Wells, Klap, Koike, & Sherbourne, 2001).

Because PTSD is relatively common (Breslau et al., 1998; Resnick et al., 1993), often appears early in the lifespan (Breslau, Davis, Peterson, & Schultz, 1997), and becomes chronic in a majority of affected women (Breslau et al., 1997; Kessler et al., 1995), it has important effects on women's mental and physical health. This disorder entails high levels of impairment and distress (Stein, McQuaid, Pedrelli, Lenox, & McCahill, 2000; Hidalgo & Davidson, 2000) and high medical service utilization (Kimerling, Clum, & Wolfe, 2000; Greenberg et al., 1999) but low mental health service utilization (Kimerling & Calhoun, 1994; Golding, Stein, Siegel, Burnam, & Sorenson, 1988).

In addition, PTSD is comorbid or has overlapping symptom profiles with numerous other mental and physical disorders (Kessler et al., 1995), but it is underdiagnosed (Seng et al., 2001; Stein et al., 2000), even though there are effective psychotherapeutic and pharmacological treatments (Foa, Keane, & Friedman, 2000).

Factors That May Explain Disparities in PTSD Diagnosis

Using a general framework for studying health disparities (LaVeist, 2002), we identified three categories of factors that may explain racial disparities in PTSD diagnoses: biopsychosocial differences in susceptibility or

resilience among racial or ethnic groups (i.e., patient group factors) that could impact the likelihood of either illness or diagnosis; disparities in clinician practices or health services (i.e., provider or system factors), such as provider bias or unequal access; and interactions among these factors, such as when mistrust affects care seeking, disclosure, or presentation. Structuring the analysis using LaVeist's framework, we tested a series of potential explanatory factors in the order below.

Patient group factors:

1. African American women could have lower rates of victimization trauma.
2. African American women, like other cultural groups, might express distress from trauma in somatic rather than psychological symptoms, which would be seen in higher rates of chronic medical conditions.
3. African American women might use the health care system less for all types of health care.

Provider or system factors:

4. African American women's access to care may be more limited because of their having less insurance (Medicaid) coverage.
5. Clinician bias or patient acuity may affect history taking and differential diagnosis, resulting in higher rates of severe mental illness diagnoses.

Interaction factors:

6. African American women might not disclose their trauma history, resulting in higher rates of other diagnoses.

Methods

Design

This study was a cross-sectional, comparative secondary analysis of service use data extracted for a larger study of PTSD and women's health. The purpose of the main study was to systematically elucidate patterns of physical comorbidity with PTSD among females across the lifespan. Data were from the Michigan Medicaid Eligibility and Paid Claims database from the years 1994 through 1997, including inpatient, practitioner, and pharmacy records. The University of Michigan Institutional Review Board approved this analysis. Data were made available under a data use agreement with Health Management Associates of Lansing, Michigan.

Sample

Female recipients with the *International Classification of Diseases, Ninth Revision* diagnostic code for PTSD ($n = 4,894$) were extracted from all female recipients.

TABLE 1**Comparison of Posttraumatic Stress Disorder Characteristics in African American and White American Women**

	<i>African Americans</i>	<i>White Americans</i>	<i>Test Statistic^a</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>
Proportion in comparison group	28.2%	71.8%				
Proportion in PTSD group	14.9%	85.1%	$\chi^2 = 306.3, df = 1$	0.399	0.359, 0.444	<.001
Within PTSD Group (<i>n</i> = 2,996)						
Duration of PTSD coding, mean (<i>SD</i>)	200 days (237)	252 days (307)	$t = 3.3, df = 447.6$.001
Rate of psychotherapy use	18.3%	81.7%	$\chi^2 = 16.618, df = 1$	1.523	1.243, 1.865	<.001
Rate of SSRI use	12.8%	87.2%	$\chi^2 = 17.495, df = 1$.649	0.529, 0.796	<.001
PTSD without depression	15.3%	84.7%	$\chi^2 = 374.213, df = 4^b$.001
PTSD with depression	17.0%	83.0%				
“Complex PTSD” ^b	7.1%	92.9%				

Note. PTSD = posttraumatic stress disorder; SSRI = selective serotonin reuptake inhibitor.

^aTest statistic reported is chi-square or *t* test with degrees of freedom.

^bChi-square for categorical variable: PTSD diagnosis only, PTSD with depression, and PTSD with either a dissociative disorder or borderline personality. Some in the “complex PTSD” category also have depression comorbidity.

Then, comparison cases were extracted in a 10:1 ratio from all remaining female records. We eliminated records that included months of insurance coverage under capitated programs because detailed claims coding was not performed under capitation. For this secondary analysis, we also eliminated the much smaller groups of women from Native American (0.6%), Asian (1.2%), Hispanic (4.1%), and unknown (2.5%) racial or ethnic minority groups. Because so little is known about PTSD among young children, we described the rates of PTSD and victimization in the child group, but the main analyses were conducted using records of 20,298 African American and White American adolescents and adult women, a sample size more than adequate for this secondary analysis.

Variable Preparation

Variables for the original study were constructed from the Medicaid database’s eligibility and paid claims tables. Demographic variables available were age, race, and number of months of coverage in fee-for-service programs. Most of the variables were dichotomous indicators of the existence of a diagnostic, visit, explanation, procedure, or pharmacy code. Some additional details were gleaned in relation to the PTSD variable. Duration of this coding in the record, a proxy for duration of treatment, was calculated by subtracting the first date from the last date. Type of treatment (psychotherapy, selective serotonin reuptake inhibitor) was derived from the procedure coding. A proxy for severity of PTSD was created, based on whether that diagnosis occurred with comorbid

diagnosis of depression or dissociative or borderline personality disorder.

Data Analysis

During the analysis conducted for the main study, a pattern of decreased PTSD diagnosis across the lifespan was noted for African American females. This secondary analysis was conducted with the following aims: (a) describing the pattern of difference, (b) verifying that racial group membership remained a main effect predictor of PTSD after controlling for effects of victimization, age, and continuous Medicaid coverage, and (c) testing potential alternative explanations organized according to LaVeist’s framework. Bivariate analyses included *t* tests and chi-square tests with bivariate odds ratios.

The multivariate model was tested using logistic regression.

Results

Racial Differences in PTSD Diagnosis

African American females were underrepresented among those diagnosed with PTSD (Table 1). Overall, they comprised 31.1% of the randomly selected non-PTSD comparison group but only 17% of the PTSD-diagnosed group overall ($\chi^2 = 303, df = 1, OR = 0.45, p < .001$). Looking across the lifespan, African American girls were not underrepresented in the PTSD group (27.0% versus 32.4%), but by adulthood, African Amer-

TABLE 2

Logistic Regression Model of Association of Racial or Ethnic Identity With Posttraumatic Stress Disorder Diagnosis, Controlling for Age, Continuous Insurance Coverage, and Known Victimization

	<i>Beta</i>	<i>SE</i>	<i>Wald</i>	<i>Adjusted Odds Ratio</i>	<i>95% CI</i>	<i>p</i>
Age, per year	-0.032	0.001	499.206	.968	0.965-0.971	<.001
Continuous coverage	0.952	0.054	308.448	2.592	2.331-2.883	<.001
Victimization	2.034	0.098	429.016	7.645	6.306-9.267	<.001
African American race	-0.959	0.056	293.261	.383	0.343-0.428	<.001

Note. Model is significant at $p < .001$; Nagelkerke R square = 0.141; percent predicted correctly = 85.9%.

ican women were only 12.5% of those diagnosed with PTSD (versus 29.5% of the control group). Among the African American adolescents and adults, the duration of the PTSD code, a proxy for duration of PTSD treatment, was shorter, and rates of both psychotherapy and selective serotonin reuptake inhibitor use were lower. African American women were less likely to have PTSD comorbid with depression, or the more severe or complex form of PTSD that is complicated by either borderline personality disorder or a dissociative disorder.

Independent Effect of African American Race

A multiple variable model was then constructed to determine the extent to which African American race remained associated with lower likelihood of having the PTSD diagnosis, while controlling for other predictive factors. We controlled for age, because PTSD is more prevalent in the late adolescent and early adult periods, and in this sample the mean age of African American adults was slightly younger. We also controlled for disparity in Medicaid coverage and for the effect of having a known assaultive trauma exposure.

African American women were underrepresented among those receiving some diagnoses and diagnostic services.

As can be seen in Table 2, all predictors were significantly associated with the PTSD diagnosis. Taking the differences in age and coverage into account, however, did not affect the reduced likelihood that an African American woman would have the PTSD diagnosis. Comparing Tables 1 and 2, the multivariate odds ratio for PTSD diagnosis (OR = 0.383; 95% CI, 0.343-0.428) when age and insurance coverage were taken into account (Table 2) was

very similar to the bivariate odds ratio (OR = 0.399; 95% CI, 0.359-0.444) for the effect of race alone (Table 1).

Patient Group Factors as Explanations for Racial Difference

Based on data from emergency department and counseling visits related to sexual and physical assaults and abuse, the possibility that African American females might have lower rates of victimization trauma was not supported. Although African American females were evaluated in the emergency department after an assault at slightly decreasing rates into adulthood, their rates of victimization were not statistically different from the rates among White American females (OR = 0.893; 95% CI, 0.731-1.091; $p = .268$).

The second explanation, that African American women, like other cultural groups, might express distress from traumatic stress via somatic rather than psychological symptoms (Marsella, Friedman, Gerrity, & Scurfield, 1996) was assessed by comparing rates of coding for four chronic medical conditions associated with both sexual trauma and PTSD in previous studies (Barrett et al., 2002; Heim, Ehler, Hanker & Hellhammer, 1998), with the significance level set at $p < .001$ level after Bonferroni correction for multiple comparisons (Pedhazur & Schmelkin, 1991). This explanation was not supported; African American women were, in fact, significantly less likely to have a diagnosis for chronic fatigue (OR = 0.462; 95% CI, 0.405-0.526), irritable bowel (OR = 0.460; 95% CI, 0.353-0.599), or chronic pelvic pain (OR = 0.655; 95% CI, 0.581-0.740). They were slightly less likely to have a menstrual pain diagnosis, but this difference was not statistically significant.

The third explanation, that African American women might use the health care system less in general, was evaluated by comparing rates of codes for all *International Classification of Diseases, Ninth Revision* disease categories (and pregnancy) and rates of use of the preventive services of Papanicolaou (Pap) tests and screening mammograms. This possibility was only partially supported. African American women had similar or greater rates of

TABLE 3*Comparisons of System and Interactive Factors in African American and White American Women*

	<i>African Americans (28.2% overall)</i>	<i>White Americans (71.8% overall)</i>	<i>Test Statistic^a</i>	<i>Odds Ratio</i>	<i>95% CI</i>	<i>p</i>
Access to health care						
Mean number of months of coverage	24.4%	25.4%	4.3			<.001
Proportion with continuous coverage	20.6%	79.4%	97.4, 1	0.662	0.566-0.684	<.001
Comorbid disorders						
Drug or alcohol psychosis	26.9%	73.1%	0.056	0.937	0.545-1.609	.813
Schizophrenia	28.5%	71.5%	0.061	1.019	0.880-1.180	.805
Conduct disorder	29.6%	70.4%	2.631	1.083	0.984-1.192	.104
Bipolar disorder	14.8%	85.2%	63.525	0.432	0.349-0.534	<.001

^aTest statistic reported is chi-square or *t* test with degrees of freedom.

pregnancy and infectious, blood, circulatory, genitourinary, neoplastic, endocrine, and cutaneous diseases but had lower rates of mental, nervous system, respiratory, digestive, musculoskeletal, and ill-defined conditions. African American women also had slightly lower rates of use of Pap test and mammogram services.

Provider or System Factors as Explanations for Disparity

To test the fourth explanation, the amount of insurance coverage was a proxy for access to care, because lack of coverage is one barrier to access. This explanation was supported; African American females were 40% less likely to have continuous coverage, declining from 26.6% with continuous coverage in childhood to 19.9% among adults (see Table 3).

Clinician bias is a provider factor that may explain differences in rates of diagnosis between White and minority groups. The level of acuity of the patient's disorder could also affect differential diagnosis, if PTSD-affected women seek care at more severe levels of impairment (Read, Agar, Argyle, & Aderhold, 2003; Hamner et al., 2000). Thus, the fifth alternative explanation explored the possibility that clinician bias or more acute presentation resulted in diagnosis of other acute, severe mental illness. This explanation was partially supported. African American women were diagnosed with alcohol or drug psychosis, schizophrenia, and conduct disorders at similar frequencies to White American women but were diagnosed less often with bipolar disorder (see Table 3).

Interaction Factors as an Explanation for Disparity

Unlike other mental health disorders for which diagnosis is based on symptom profile alone, PTSD requires

disclosure of a traumatic life event. Because of the stigmatized, sensitive nature of some traumas, especially sexual and intrafamilial traumas (Read et al., 2003), and because of potentially lower levels of trust, minority women may not disclose trauma history and providers might not ask about it. Nondisclosure of trauma could preclude assignment of the PTSD diagnosis, even when PTSD symptoms are present, and another diagnosis with an overlapping symptom profile might be assigned instead. If African American women were seeking treatment for traumatic stress symptoms in mental health settings as often as White women but disclosing trauma history less, then a pattern of higher rates of other trauma-associated diagnoses might be evident, including comorbid or associated features, such as anxiety, depression, dissociative, borderline personality, self-harm and suicidality, or substance abuse diagnoses (American Psychiatric Association, 1994). Thus, the sixth alternative explanation explored was that African American women would be overrepresented among these patient groups.

This possibility was not supported, except for substance abuse disorders, for which the proportion of African American women did not differ from the proportion in the sample overall. They were less likely than White women to receive other mental health diagnoses.

Discussion

Although recent national and community surveys controlling for socioeconomic status and inner-city residence showed no race differences in PTSD rates (USDHHS, 2001b; Breslau et al., 1998), in our sample, a difference in PTSD rates persisted, although the entire sample met criteria for federally defined poverty status. Using LaVeist's (2002) framework for understanding race-based health

disparities, we found support for some of the alternative explanations we explored, but not for all of them.

We did not find support for the possibility that African American women had fewer assaultive trauma exposures or sought care for somatic trauma-associated conditions instead. African American women were underrepresented among those receiving some diagnoses and diagnostic services. However, disparities were not apparent for several other conditions. In fact, African American women were proportionally or slightly overrepresented in rates of some conditions, similar to previous research showing that Medicaid coverage is associated with significantly increased use of ambulatory mental health services among minorities (Taube & Rupp, 1986), increased odds of treatment in the public sector for African Americans (Swartz, Wagner, & Swanson, 1998), and minimal differences between White and African American women in overall treatment expenditures for behavioral health care (Jerrell, Wieduwilt & Macey, 2002).

The system factor we explored, that African American women experienced less access to health care, was supported based on racial differences in the amount of insurance coverage. Minority persons disproportionately lack private health insurance, and this gap is not eliminated by public sources of coverage (USDHHS, 2001a). Several previous studies indicated that lack of insurance coverage was a major barrier to health care, particularly for ethnic minorities (USDHHS, 2001b).

In exploring interactions between patient and system issues, we did not find convincing support for the possibility that African American women were overrepresented among other trauma-associated diagnoses, except for substance abuse disorders. In a previous study, greater likelihood of substance use disorders and substance abuse treatment were found for African American women in comparison with White American women using behavioral health services in the public sector (Jerrell et al., 2002). In our data, substance abuse, substance-related psychosis, conduct disorder, and schizophrenia were diagnosed more frequently for African American women than for White American women, suggesting that either there are race-related differences in the prevalence and presentation of symptoms or that there was clinician bias.

Thought disorder symptoms and substance abuse often coexist with PTSD, but clinicians who observed these conditions may have neglected to probe further for trauma exposure. Clinicians treating poor African Americans may have been more likely to diagnose substance abuse rather than PTSD because of racial bias; however, this hypothesis would need investigation beyond what is possible with these data.

Two broad potential explanations emerged for our findings. The first is the possibility that African American women, as a cultural group, are generally more resilient

and have less trauma-related physical and mental health “morbidity,” even though epidemiological surveys suggest that they do not have fewer PTSD “symptoms.” Our finding that African American women had lower rates of other trauma-associated mental and physical diagnoses while having the same rate of victimization-related hospital encounters support the plausibility of this explanation, which can be seen as a patient group factor.

Although there is little direct support for this explanation in the literature, there is some evidence. For example, African Americans have been described as being more tolerant of moderate depressive symptoms (Sussman, Robins, & Earls, 1987) and better at bearing burden, including emotional stress, in comparison with White Americans (Hines-Martin, 1992; Hughes, Giobbie-Hurder, Weaver, 1999; Cox & Monk, 1996; Williams, Spencer, & Jackson, 1999). Unfortunately, researchers have not sought to identify health-enhancing or resilient factors among minorities and instead have focused on pathology and deficits (Williams et al., 1999).

The second potential explanation is the possibility that African American women, as a disadvantaged minority group, turn to the health system less often for treatment of posttraumatic distress (whether mental or physical). Having less coverage could explain a proportion of this difference, but not all of it, because the odds ratio for having the PTSD diagnosis was unchanged when access to insurance was taken into account. Our finding of equal rates of diseases such as cancer, addiction diagnoses, and psychotic disorders but lower rates of conditions such as chronic fatigue, depression, and “signs, symptoms, and ill-defined conditions” suggested that selective care seeking was a major potential explanation. Specifically, African American women may differ in the threshold at which they perceive something as an illness, define it as an appropriate problem for the health care system, or choose to seek care.

In keeping with the second explanation, previous research suggests that African Americans have different patterns of care, possibly related to care choices or preferences for alternative sources of care. Racial differences in patterns of care may be attributed to doubt regarding the efficacy of treatment for particular problems (Hall & Tucker, 1985; Cooper-Patrick, Ford, & Mead, 1997), preferences for delaying or deferring treatment to allow symptoms spontaneously to remit (Cooper-Patrick et al., 1997), the utilization of spiritual practices (Broman, 1996; Snowden & Cheung, 1990; Snowden, 2002), or coping via self or family reliance (Snowden, 2003). However, other studies have not found evidence that disparities in mental health treatment can be explained by minority groups’ reliance on traditional healers, spiritual or religious advisers, extended family members, or social support network members (Barrera, 1978; Griffith &

Baker, 1993; Neighbors et al., 1992; Neighbors, Musick, & Williams, 1998; Snowden, 1998).

In this study, the pattern of equal or greater use of services for “objective” conditions “curable” by Western medicine (e.g., infectious, blood, circulatory, and neoplastic diseases) but lesser use of services for “subjective” conditions that may only be somewhat alleviated (e.g., mental, respiratory, gastrointestinal, musculoskeletal, and ill-defined conditions) cannot discount the possibility that alternative therapies or no treatment are the treatments of choice. Further research is warranted for PTSD, a disorder that falls into the “subjective” category.

Limitations and Research Implications

This descriptive epidemiological analysis of service use data can only elucidate the different *pattern* of encounters. Understanding the *reasons* the patterns occur will require different research strategies. Qualitative research could focus on cultural factors, such as resilience and non-health system healing strategies, and learning about experiences in which mistrust, different criteria for care seeking, lack of disclosure, and dissatisfaction with treatment may have played a role in decision making. Participatory research could also help with development of desired interventions. Sophisticated research designs could help uncover evidence of different presentations or clinician bias, or both, as in the recent study indicating physician racial and gender bias in treatment and diagnosis of cardiac distress (Rathore et al., 2000). Quantitative determinations of the threshold levels of symptoms that result in care seeking would also be valuable. To increase our ability to accurately assess and treat PTSD for all women, it is important to understand all these research programs and decrease disparities based on race.

Routine screening is critical for PTSD because patients, regardless of racial or ethnic group, may not recognize the symptoms as a treatable syndrome.

Clinical Implications

Our data indicated that patient and provider or system factors may interact to create barriers to understanding or detecting the effects of trauma on poor African American women. Based on these findings, we offer several suggestions for health care system providers. First, it would be advisable for health care workers to self-monitor for stereotypes or misperceptions based on race. Snowden

(2003) described three types of bias in mental health care settings. Individual bias occurs at the level of beliefs and actions of clinicians. Bias can also occur when unsubstantiated assumptions become normative beliefs and affect practice styles shared by members of treatment organizations. Another form of bias exists when authorities or members of majority communities differentially apply norms of acceptable behavior to minorities. Previous research has found strong evidence for bias in diagnosis of mental disorders in African Americans (López, 1989), including overdiagnosis of schizophrenia and underdiagnosis of mood disorders (see Snowden, 2003, and Baker & Bell, 1999, for review). Therefore, it is critical that health care providers be aware of this evidence for bias and consciously avoid repeating this pattern in their interactions with African American patients.

Second, if our results were caused by undetected cases of PTSD among poor African American women, routine screening for trauma exposure or PTSD-related symptoms could increase case finding and reduce racial disparities. There is evidence that when a PTSD diagnosis is missed at an initial visit in a mental health setting, as many as four other diagnoses may be used to cover the presenting symptoms (Cloitre, 1998). Previous research has found that self-recognition of depression is particularly low among African American and Latina women receiving care at a public urban hospital (Alvidrez, 1999). Therefore, relying on African American women to recognize and report symptoms characteristic of PTSD, without screening, may result in missed cases. Routine screening may be particularly critical for PTSD because patients, regardless of racial or ethnic group, may not recognize the symptoms as a treatable syndrome.

Furthermore, PTSD is a complicated disorder and often occurs with substance abuse or dependence. Evidence of other psychiatric disorders does not preclude diagnosis of PTSD. Therefore, clinicians should systematically follow up on indicators of PTSD, even in the presence of symptoms of thought disorders or substance abuse, particularly in African American women. When comorbid PTSD is not identified and addressed, treatment plans can be ineffective and unsatisfying. If poor African American women are less likely to be diagnosed appropriately, this factor may contribute to their dissatisfaction with treatment received in the health care system and the lower likelihood of return visits or perception of the health care system as an appropriate source of care. In fact, previous studies suggest that ethnic minorities are more likely to distrust (Sue & Zane, 1987; Vega & Lopez, 2001) or be dissatisfied with (Diala, Muntaner, Walrath, Nickerson, & LaVeist, 2000) the mental health care system. African Americans with moderate depression were less likely than Whites to seek treatment, citing fear of treatment and hospitalization (Sussman et al., 1987).

TABLE 4**Resources for Learning About Posttraumatic Stress Disorder**

- Foa, E.B., Keane, T. M., & Friedman, M. J. (Eds.) (2000). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford, 2000.
- Friedman, M., Charney, D., & Deutch, A. (Eds.) (1995). *Neurobiological and clinical consequences of stress: From normal adaptation to posttraumatic stress disorder*. Philadelphia: Lippencott-Raven.
- Marsella, A. J., Friedman, M. J., Gerrity, E. T., & Scurfield, R. M. (Eds) (1996). *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications*. Washington (DC): American Psychological Association.
- Schiraldi G. (2000). *The posttraumatic stress disorder sourcebook: Resources for healing, recovery, and growth*. Los Angeles: Lowell House.
- International Society for Traumatic Stress Studies (ISTSS) via www.istss.org
- National Center for PTSD via www.ncptsd.org
- PILOTS database via www.dartmouth.edu/dms/ptsd/PILOTS.html
- The Sidran Foundation via www.Sidran.org
- Information for clinicians and links to screening tools are available at <http://www.ncptsd.va.gov/topics/assessment.html>

African American women with PTSD symptoms may be less inclined than other women to discuss trauma exposure or subsequent symptoms. Sensitive topics, such as history of abuse and assault, may be particularly uncomfortable to discuss across the barrier of racial difference. Discomfort can lead to ignoring or prematurely ending discussion of the problem. African American women in this study may have found that once they were involved in the health care system, they were not satisfied with treatment and therefore were less likely to be involved in services that would lead to PTSD diagnosis. Diala et al. (2000) found that before receiving mental health treatment, African Americans had more favorable attitudes in comparison with Whites, but among those who had received treatment, African Americans reported less favorable attitudes. African Americans and other ethnic minorities are more likely than White Americans to leave mental health treatment prematurely (Sue, Zane & Young, 1994). Clinicians should learn to tolerate some discomfort so that care can occur to improve both outcomes and satisfaction.

Treatment of PTSD commonly includes pharmacotherapy, often with selective serotonin reuptake inhibitors, such as sertraline, paroxetine, or fluoxetine. Psychotherapy, which may include exposure therapy, is also a com-

mon treatment modality. Table 4 provides links to screening tools and resources for learning more about PTSD.

Women's health nurses are in an excellent position to provide information about supportive or treatment services and to help women locate psychotherapists who work effectively with trauma survivors and are experienced in treatment of PTSD. Nurses also are in the very important position of being able to follow up with women—especially African American women—to learn whether they sought treatment and whether the mental health clinician provided appropriate, satisfying, and effective care.

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