Are Women More Likely to Exhibit Psychogenesis…Or Just More Likely to Be Diagnosed That Way?

ALYSON J. McGREGOR, MD, MA, FACEP

After reading Dr. Friedman's commentary, "What To Do When Bad News Isn't Understood?" which appeared in the November 2018 issue of this journal, I was inspired to add to the conversation a point which was not addressed directly in the article.

Dr. Friedman's observations had the effect of highlighting a subject which is central to my research, and which is being recognized as an area of profound imbalance in all branches of medicine. This subject, of course, is sex – in particular, the role sex differences play in patients' diagnoses, treatments, and outcomes.

The patient he described in his article did not present with "typical" symptoms of Parkinson's disease; in particular, he noted the absence of tremor as a cause to examine other potential diagnoses. He ordered the appropriate dopamine transporter (DaT) scan and was able to give her a conclusive diagnosis – to which she reacted in an unexpected way.

My question for Dr. Friedman – and to all of us who interact with patients on a daily basis – is: If your patient had been a man, with the same symptom profile and exam findings, would a psychogenic diagnosis have been considered? This is a question we all need to be asking ourselves in our respective practices every day – particularly with regard to one of the most prevalent psychogenic diagnosis, anxiety.

In nearly every area of medicine, research is revealing that women do, in fact, experience disease differently than men on a physiological level. However, there currently exist few protocols which take these differences into account. From cardiovascular disease and stroke to chronic pain conditions and physical trauma, women's outcomes are poorer than men's.[1,2,3] They are more likely to be misdiagnosed, more likely to receive inadequate or inappropriate treatment, and more likely to suffer mortality than their male counterparts.

For example, chest pain is the most common presentation of acute coronary syndromes; however, women are more likely to experience nonspecific symptoms, including no chest pain at all, than men.[4,5] The American Heart Association reports women who experience heart attacks have worse outcomes – more likely to die within one year of a heart attack, more likely to have another heart attack within six years, and more likely to be disabled because of heart failure than men.[6] It's not difficult to assume that differences in clinical presentation in women can lead to under-recognition, less aggressive treatments and lower representation in clinical trials.

Women often present with nontraditional symptoms of stroke, which causes delays in recognition and diagnosis. When they arrive at the hospital, they are less likely to receive rapid brain imaging within the 20-minute maximum time suggested by the American Stroke Association. They are also less likely to receive treatment with tPA (tissue plasminogen activator) even though overall women and men have similar rates of eligibility.[7]

Out of ten prescription drugs withdrawn from the market from 1997-2001, eight were found to pose "greater health risks for women."[8]

Drug-induced Torsade's de Pointes is more common in women than men, because women lack the testosterone-protective effect which prevents QT elongation. The majority (66 percent) of drug-related Long QT Syndrome patients are female confirmed according to World Health Organization (WHO) criteria.[9]

In one study of patients with similar symptoms of irritable bowel syndrome (IBS), researchers found that men were more likely to be referred for X-rays, while women were offered anti-anxiety medication and lifestyle advice.[10]

These examples are just the tip of the iceberg, so to speak. Our current medical model does not account for any of the above disparities. There are few to no guidelines in place for assessing and treating female-pattern disease. And in many cases where such guidelines are lacking, data show that our solution is to resort to the diagnosis of exclusion – which, for women, is often psychogenic. While psychological symptoms may, in fact, be present, there's a vast difference between anxiety as a symptom of an underlying physical disease and anxiety

as causation for those disease symptoms.[11] We need to be aware of when and how we are treading that line.

As physicians, we must routinely and thoroughly examine and reconsider our implicit biases, assumptions, and "textbook" knowledge. More specifically, we must discover where and how we may have allowed our ideas and biases about women – who women are, what they do, and what they need – to influence our professional judgment. Only then can we apply appropriate and objective criteria to every patient, every diagnosis, and every prescription.

Finally, as we evolve in our understanding of how sex and gender influence both disease patterning and treatment pathways, we should also consider our tendency to dismiss patients' research and self-knowledge. When a patient references Dr. Google, or FDA drug trial snapshots, the possibility exists that he or she may have actually discovered something relevant about their drug or disease – something we may have not yet encountered in our own research. In this information age, we are no longer the sole disseminators of medical knowledge. Moreover, on a human level, it does more good than harm to treat our patients' research, responses, and knowledge of their own bodies – regardless of their sex, gender, age, or ethnicity – as relevant until proven otherwise. ❖

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Response to Point of View on the Question of Bias

JOSEPH H. FRIEDMAN, MD

I appreciate the response of Dr. McGregor to my commentary in the November 2018 issue of RIMJ, "What to do when bad news isn't understood?"

(http://www.rimed.org/rimedicaljournal/2018/11/2018-11-07-commentary.pdf)

Her observations of the different ways in which men and women are viewed and treated by physicians and other health professionals are well known. There are racial, cultural and age biases as well. In the area of psychogenic disorders, which is an area of great interest to all neurologists, particularly epilepsy and movement disorders specialists, we are keenly aware of the potential for bias. After all, the disorders we currently label as "conversion" disorders were once considered "hysterical," etymologically based on ancient theories of causality being related to the wandering uterus.

About 2–5% of new cases seen at movement disorder centers are thought to be of psychogenic origin. These are not rare. As with any diagnosis, the consideration of a psychogenic etiology is based on the history and examination. When signs and symptoms appear to be non-physiological, we generally go out of our way to look for organic causes. We don't want to punish our patients by "blaming" them for their disorder. In the movement disorders field, we generally order very few tests. The appropriate work-up for someone with Parkinson's disease, for example, is a clinical examination and nothing more. I order tests only when I'm unsure, as in the case described. In my practice, it is only *after* I find signs that I believe are non-physiological, that I delve into more details of the psychiatric history. As Dr. McGregor knows, there is a strong correlation between childhood sexual abuse and conversion disorders, and that childhood sexual abuse is more common among girls than boys, probably explaining some of the gender disparity in psychogenic diagnoses. Some diagnoses, undoubtedly, are due to physician bias, although long-term, follow-up studies have shown a remarkably low rate of error. I suspect that I diagnose about the same ratio of males to females with conversion disorders as my female and male colleagues in my field.

What Dr. McGregor may fail to appreciate is that under-diagnosis of psychogenic disorders can lead to extreme doctor shopping, multiple unwarranted tests and useless treatments while not addressing the real problems affecting the patient.

The point of my article was the lack of a response that I thought was appropriate to bad news. One might, perhaps, think that I was biased in my response to her lack of a response, and that if the patient was male I would have applauded his sangfroid. I don't think my consideration of a psychogenic etiology was gender-based, but as Scottish poet Robert Burns noted,

O wad some power the giftie gie us
To see oursels as ithers see us!

Author

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