

A COMPARISON OF MALE AND FEMALE EXPERIENCES OF POST TRAUMATIC  
STRESS DISORDER

A Seminar Paper

Presented to

The Graduate Faculty

University of Wisconsin-Platteville

In Partial Fulfillment of the

Requirement for the Degree

Master of Science

In

Education

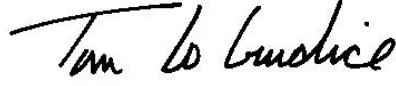
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Spring 2010

A Comparison of Male and Female Experiences of Post Traumatic Stress Disorder

Approved

A handwritten signature in black ink that reads "Tom Lo Giudice". The signature is written in a cursive style with a long horizontal stroke at the beginning.

Date August 30,2010

## Abstract

Although first recognized and studied in male war veterans, research shows that women are more vulnerable to and effected differently by Post Traumatic Stress Disorder (PTSD). A review of the literature concerning types of trauma and the risk to trauma victims of developing PTSD is summarized. A comparison of male and female experiences with trauma, symptoms of PTSD, and comorbidity of PTSD was analyzed by gender differences. Symptoms of PTSD have been around as long as there have been traumatic events to cause them. Looking back at American History one can see many instances of combat related trauma having a negative effect on soldiers. Although PTSD was originally developed to describe the reactions of war veterans attempting to reintegrate into society, similar symptoms were noticed in civilian populations. The type of traumatic events plays a crucial role in the development of PTSD. Several studies on PTSD show gender differences in violence exposure and the development of PTSD (e.g., Breslau & Anthony, 2007; Breslau et al., 1998; Breslau, Peterson, Poisson, Schultz & Lucia, 2004; Kessler, 1995; Kessler, Sonnega, Bromet, & Hughs, 1995; Stein & Gelberg, 1997; as cited in Hanson et al., 2008). There is statistical evidence of gender disparity in specific types of trauma exposure. The types of trauma that show the greatest gender difference are: combat related trauma, nonsexual physical violence, sexual violence, and child abuse. Sexual violence is the most gender dependent form of trauma in the general population (Cortina & Pimlott-Kubiak, 2006). There appears to be gender differences in the types of symptoms reported after exposure to violence. It is possible that there are underlying gender differences in the type of response to trauma (Hanson et al., 2008). Women may be more likely to report and manifest internalizing symptoms (depression, anxiety, and hyperarousal, suicidal ideation) (Hanson et al, 2008; Walker, 2004). Men more often report and display externalizing symptoms (oppositional behavior, aggression, impulsivity, substance abuse, and conduct problems) (Hanson et al, 2008; Kendall-Tackett et al., 1993 as cited by Walker et al., 2004). Women are significantly (2.5 times) more likely to have comorbid PTSD and Major Depressive Episode (MDE) than men (Hanson et al., 2008). The prevalence of comorbid PTSD and substance use disorders is higher in men than women (Hapke et al, 2006). Analysis showed that the higher risk for PTSD in women than men is mainly due to the higher risk of being a victim of sexually motivated violence and the higher prevalence of pre-existing psychiatric disorders (Hapke et al, 2006). Many women experience multiple forms of violence during their lives, and this victimization increases a woman's risk of developing PTSD (Cortina & Pimlott-Kubiak, 2006). More study needs to be done on female combat veterans and male sexual abuse survivors, however it does not appear that women are inherently prone to PTSD, only that being female carries more risk for developing PTSD.

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## CHAPTER ONE: INTRODUCTION

Although first recognized and studied in male war veterans, research shows that women are more vulnerable to and effected differently by Post Traumatic Stress Disorder (PTSD). Post Traumatic Stress Disorder is characterized by a cluster of symptoms that include re-experiencing the trauma (e.g. flashbacks, night mares), avoidance of reminders of the trauma (e.g. not walking down street where rape occurred, not watching war movies), numbing of general responsiveness and increased arousal (e.g. hypervigilence, exaggerated startle response). Other symptoms that may occur are depression, dissociation, feelings of guilt, searching for reason, and disruption of developmental issues (Goldman, 2005).

This paper reports on attitudes toward PTSD symptoms starting in male war veterans from early American history to the present in order to understand the evolution of this disorder. A review of the literature concerning types of trauma and the risk to trauma victims of developing PTSD is summarized. A comparison of male and female experiences with trauma, symptoms of PTSD, comorbidity of PTSD, and treatment outcomes was analyzed by gender differences.

## **Statement of the Problem**

Post Traumatic Stress Disorder is a terrible affliction suffered by people who have survived traumatic experiences. There is much stigma surrounding PTSD. Since the disorder was first recognized, people have thought that the sufferers were in some way deficient, because they could not “get over” or cope with the memories of their experiences. Since the first recognized cases of PTSD, people have wondered how survivors of trauma develop PTSD. Why do some people develop PTSD and some do not? What difference does gender make in the development and symptoms of PTSD? Can PTSD be successfully treated?

## **Delimitations of the Research**

The research was conducted through the Hedberg Library (Janesville, WI) and Karmann libraries (University of Wisconsin-Platteville) over a period of Sixty-four (64) days. Primary searches were conducted via Internet through EBSCO Host with Academic Search Elite. Key search topics will include “Post Traumatic Stress Disorder,” “Trauma,” and “gender differences in PTSD.”

## **Method of Approach**

A review of literature related to research, studies, and anecdotal evidence of the experiences of people with PTSD, and the impact that gender has on PTSD experiences in areas of PTSD development and symptoms, was conducted. The findings are summarized and recommendations made.

## CHAPTER TWO: REVIEW OF LITERATURE

### History of Post Traumatic Stress Disorder

Symptoms of PTSD have been around as long as there have been traumatic events to cause them. Looking back at American History one can see many instances of combat related trauma having a negative effect on soldiers. Some examples follow.

During the American Revolution, George Washington's Continental Army was filled with mental health disorders that are recognized today as PTSD symptoms. Revolutionary veterans suffered fear, paralysis and flashbacks. "The newly formed United States Army applied labels of melancholia and insanity to the most severe cases and dishonorably discharged soldiers who had these symptoms as defective"(Coleman, 2006). Melancholia and insanity were highly stigmatized disorders at this time.

PTSD symptoms again surfaced during the American Civil War. Physician Dr. Jacob Mendes DaCosta is credited with conducting the first scientific study of combat-related stress during the Civil War. During the Civil war soldiers who witnessed death in battle had higher rates of post war illness (Paulson & Krippner, 2007). DaCosta found that soldiers complained of experiencing an aching in the left side of the chest and having the feelings of a weak heartbeat, or they suffered withdrawal and lethargy. DaCosta called the assortment of trauma related symptoms he identified as "the irritable heart of a soldier." Nostalgia was another popular diagnosis for these symptoms at the beginning of the war, because it was believed the symptoms were a sign of a pathological fear of being far from home. This was stigmatizing because the name nostalgia or homesickness given to symptoms of trauma implied a weakness of character in the soldier (Coleman, 2006). The horrific illnesses and injuries suffered by Civil war soldiers led to the

recognition for better training in medicine. American doctors of this time had little training or education compared to their European counterparts.

The study of psychiatry was fashionable in Europe during the late nineteenth century. “In the nineteenth century in Europe, the causal relationship between traumatic experience and psychiatric disabilities was known as “Swiss disease” because adverse reactions to combat were noted among Swiss soldiers” (Carr, 2002 cited by Paulson & Krippner, 2007). Jean Martin Charcot studied hysteria in patients during the 1870’s and 1880’s who exhibited many of the same symptoms as DaCosta’s traumatized American Civil War veterans. Charcot was interested in identifying and categorizing the symptoms exhibited by hysteria patients rather than finding the cause of their distress. Pierre Janet and Sigmund Freud two of Charcot’s students began to study the cause of hysteria. It was concluded by both Janet and Freud that trauma was at the root of all hysterical symptoms. Janet was convinced that a trauma event was the cause of the symptoms; however Freud insisted that a premature sexual encounter was always to blame. They agreed that negative symptoms masked unbearable memories and if the traumatic memories could be accessed then symptoms would ease. Janet and Freud also agreed that talking was the way to access the memories (Coleman, 2006). The popularity of psychiatry and Freud in particular led to more research being done in the area of psychiatry. As Americans became more involved on the worlds stage, American scholars and scientists had more exposure to the ideas of psychiatry in Europe.

The World Wars I and II led to an abundance of medical and scientific research. During World War I, physician Dr. Charles Myers studied veterans and wounded soldiers with PTSD like symptoms. He hypothesized that the constant and random concussion of bursting shells caused lesions on the brain. Myers called the condition Shell Shock and the name stuck although

the idea of brain lesions was discredited. British and American soldiers who commonly exhibited Shell Shock symptoms including: nervous tics, grotesque body movements, and even paralysis, continued to be labeled cowards or malingerers. As a result of this stigma, they could be dishonorably discharged or executed (Coleman, 2006). In 1942, World War II United States psychiatric casualties were more than five times those of the previous war. The number of psychiatric discharges in 1943 exceeded the number of new enlistees (Coleman, 2006).

After WWII, there was a time of peace and prosperity that fostered scientific studies and advancement. The American Psychological Association (APA) published the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in 1952 and this edition included a diagnosis of “Gross Stress Reaction” that covered victims of stress, including combat stress (Paulson & Krippner, 2007).

In 1968 at the height of the Vietnam War, the APA published the DSM-II and dropped the diagnosis of Gross Stress Reaction. A majority of the studies on PTSD after this war used Vietnam veterans as their study populations. However, without a diagnosed mental disorder many Vietnam veterans, who suffered from PTSD symptoms that could have been helped by a diagnosis, were not eligible for Veteran (VA) benefits until 1980 when Post Traumatic Stress Disorder was included in the DSM-III (Coleman, 2006). In fiscal year 2007, ~393,000 (7.7%) of the ~5,100,000 veterans who received VA services had a diagnoses of PTSD. (Schnurr & Lunney, 2008)

Although PTSD was originally developed to describe the reactions of war veterans attempting to reintegrate into society, similar symptoms were noticed in civilian populations. Many of the same symptoms were observed among rape survivors, people exposed to natural

disasters and a range of human caused trauma. Studies reveal that rape survivors may make up one of the largest groups of PTSD sufferers (Davis & Breslau, as cited in Basile, 2006).

### **Types of Trauma and Gender Differences**

Today (2010), the DSM-IV criteria for Posttraumatic Stress Disorder states that a person must have been exposed to a trauma event to develop PTSD. The trauma can be experienced or witnessed so that the person is threatened with real or perceived death or serious injury, or a threat to others and the person's response involved intense fear, helplessness, or horror (American Psychiatric Association, 2000). Many kinds of traumatic events can cause PTSD.

Most researchers look at trauma of combat, natural disasters, acts of terrorism, or acts of physical assault (robbery, rape, sexual assault, child abuse, beatings, etc.). A traumatic event can be a one-time occurrence such as an automobile accident or a natural disaster like an earthquake. Traumatic events can also occur over time and be repeated such as child abuse and domestic violence.

The type of traumatic events plays a crucial role in the development of PTSD. Several studies on PTSD show gender differences in violence exposure and the development of PTSD (e.g., Breslau & Anthony, 2007; Breslau et al., 1998; Breslau, Peterson, Poisson, Schultz & Lucia, 2004; Kessler, 1995; Kessler, Sonnega, Bromet, & Hughs, 1995; Stein & Gelberg, 1997; as cited in Hanson et al., 2008). Males report more exposure to trauma than females: 51.3% versus 44.1% (Hanson et al., 2008). Kessler et al., found that although in the general population women were less likely than men to experience a trauma; the lifetime rate of PTSD was 10% for women versus 5% for men (1995). There is statistical evidence of gender disparity in specific types of trauma exposure. The types of trauma that show the greatest gender difference are: combat related trauma, nonsexual physical violence, sexual violence, and child abuse.

Studies of war veterans show that males face far more combat related trauma than females (Schnurr & Lunney, 2008; Turner et al., 2007). Historically women have not been in combat situations, they have been in the periphery during past wars. Researchers have had a hard time in comparing male and female veterans of war due to irreconcilable differences of wartime experience (Paulson & Krippner, 2007). Much of the research involving PTSD has been generated by the US Department of Defense, the US Military and the US Department of Veteran Affairs and has primarily studied the experiences of veterans exposed to combat. Although US Department of Veterans Affairs is the home of the National Center for PTSD, there is an abundance of civilian research on the topic of PTSD.

In civilian populations, nonsexual physical violence has a gender bias. Men were more likely to report physical assault (Norris et al, 2003). Males have higher rates of exposure to physical assault and witnessing violence in the community (Hanson et al, 2008). In a study in Germany, men were found to be more likely to be physically threatened, attacked, injured or tortured, and were more often exposed to serious accidents than women. This study's findings are similar to studies in America and other countries in Europe (Hapke et al., 2006). While men have more exposure to physical violence, more women (39%) than men (24%) feared serious injury or death during at least one of their victimizing experiences. Women also sustained greater physical injury during this violence than men (38% vs.25%) (Cortina & Pimlott-Kubiak, 2006).

Research shows that sexual trauma history is by far the largest risk factor for lifetime PTSD. Rape survivors are more likely to develop PTSD than are victims of theft, physical violence, serious accidents, combat and natural disasters (Kessler et al., 1995; Norris et al., 2003). Several other studies have similarly found that rape, sexual abuse and other personal assaults were associated with a higher risk of PTSD compared to less personally traumatic events

such as automobile accidents (Breslau et al., 2002, 2002, 1999, 1991, 1997 as cited by Hapke). Female victims of sexual violence were 2.5 times more likely to report PTSD symptoms compared to those who experienced physical violence. Women who reported intimate partner or family violence were three times more likely to have PTSD symptoms than women who experienced violence by friends, acquaintances, or strangers (Baker et al, 2005).

Sexual violence is the most gender dependent form of trauma in the general population (Cortina & Pimlott-Kubiak, 2006). Nearly every study done on PTSD and gender indicate that women face significantly more sexual assault and rape in their lives than men do (e.g. Kessler et al., 1995; Norris et al, 2003; Cortina & Pimlott-Kubiak, 2006; Hapke et al., 2006; Hanson et al, 2008). Recent US Department of Veteran Affairs studies show that among male and female veterans, female soldiers experience higher rates of PTSD and that may be a result of sexual abuse. “A study of 60,000 soldiers with PTSD found that 22 percent of the women suffered from MST, military sexual trauma, which includes sexual assault and harassment” (Newhouse, 2008). Women are also significantly more likely than men to report intimate partner violence (Baker et al., 2005).

Women are not alone in experiencing sexual violence; however men are less likely to disclose this abuse or report it to the authorities (Hanson et al., 2008). Men feel greater stigma about sexual violence probably due to traditional ideals of masculinity. This may account for underreporting of sexual assault by men. Statistically, the majority of perpetrators of sexual violence are male. This may be another reason male victims are reluctant to report these crimes (Baker et al., 2005). Age can also play a role in determining PTSD development due to trauma exposure.

Younger age is associated with increased risk for the development of PTSD following exposure to violent acts (Turner, 200). Adolescents are twice as likely as other age groups to be victims of violent crime and they are also at high risk for witnessing violence against others. 48% of surveyed adolescents reported exposure to some type of violence in their lifetimes. Of young people who experience a trauma, it's estimated from 3% to 15% of girls and 1% to 6% of boys develop PTSD. 36% of sexually abused children and 39% of physically abused children meet criteria for PTSD. Lifetime rates of PTSD are elevated in people with a history of child abuse (Foa & Wasmer Andrews, 2006).

Childhood abuse may be the most common cause of PTSD in American women. Girls and women are more vulnerable than men to developing PTSD as a result of childhood abuse. About 16% of American women are sexually abused before they reach their 18<sup>th</sup> birthday (Bremer, 2000). Kessler et al., found that lifetime rates of PTSD were higher for women (48%) than for men (22%) who had experienced childhood physical abuse and also higher for women (26%) than men (12%) who had experienced molestation (1995).

Childhood sexual abuse is a major cause of PTSD. Adolescents with a sexual abuse (SA) history are at greater risk from PTSD compared with those who have not experienced SA (Hanson et al, 2008). Boys are 5.64 times as likely to meet criteria for PTSD when reporting a history of SA, whereas girls with a SA history are 2.14 times more likely to meet PTSD criteria than those with no SA history (Hanson et al, 2008). Suicidality was reported 4.8 times more often by sexually abused girls than by non-abused girls, 10.8 times more often by sexually abused boys than nonabused boys (Garnefski and Diekstra, 1997 as cited by Walker, 2004).

The tragedy of child abuse is that children are abused by people who are close to them. Females are more likely to report intimate partner, and family violence, while males most often

report violence perpetrated by friends, acquaintances, or strangers (Baker et al, 2005).

Conservatively about 80% of cases that are reported to child protection agencies involve one or more of the child's parents as the alleged perpetrator (Foa & Wasmer-Andrews, 2006). The initial trauma is magnified by the strain on familial relationships.

The impact of violence is generally more severe in cases of sexual violence, childhood violence and recurrent violence. Childhood and sexual abuse are more statistically likely to reoccur (Kessler et al., 1995). Recurrent, sexual, childhood, intimate partner, and family violence are associated with higher probabilities of lifetime PTSD (Baker et al, 2005). Research on repeated victimization indicates that the more traumatic events a person experiences, the more serious psychological damage is done (Cortina & Pimlott-Kubiak, 2006). For women in the military, repeat victimization is all too common. A 2003 study by the US Department of Veteran Affairs found that nearly a third of female soldiers seeking health care in a national sampling, reported that they experienced rape during their time in service. 37 % said they were raped multiple times, and 14 % reported gang rape. The perpetrators of these rapes were primarily fellow soldiers. Women make up approximately 15% of all military personnel serving in Iraq and evidence suggests that these women are at risk for trauma from both combat exposure and sexual assault (Vogt, et al, 2005).

### **Symptoms of PTSD and Gender Differences**

PTSD manifests itself with symptoms falling into three domains: avoidance, numbing, and hyperarousal. These symptoms must persist for more than 1 month and cause clinically significant impairment in at least one major life domain (American Psychiatric Association, 2000). There appears to be gender differences in the types of symptoms reported after exposure

to violence. Women report more severe symptoms of PTSD than those reported by men (Cortina & Pimlott-Kubiak, 2006). It is possible that there are underlying gender differences in the type of response to trauma (Hanson et al., 2008).

Women may be more likely to report and manifest internalizing symptoms (depression, anxiety, and hyperarousal, suicidal ideation) (Hanson et al, 2008; Walker, 2004). Women appear to be more likely to report symptoms of distress after experiencing violent incidents (Horowitz, Weine, and Jekel, 1995 as cited in Hanson). Women experience higher levels of intrusive thoughts and hyperarousal symptoms compared to boys. In a study conducted by Sonne et al., women demonstrated greater rate of occurrence and intensity of avoidance of thoughts, feelings, or conversations associated with the trauma (2003). Women were more likely than men to report trying to avoid such thoughts and feelings daily or almost always. Women were also more likely than men to report that PTSD severely impacted their social functioning (Sonne et al, 2003). Brain scans done of adults show women with PTSD have deficits in hippocampal-based declarative verbal memory and smaller hippocampal volume than men with PTSD (Bremner et al., 2003 as cited by Walker et al., 2004). This would cause memory problems in women with PTSD.

Men more often report and display externalizing symptoms (oppositional behavior, aggression, impulsivity, substance abuse, and conduct problems) (Hanson et al, 2008; Kendall-Tackett et al., 1993 as cited by Walker et al., 2004). Men with PTSD are more likely to feel angry and to have more trouble controlling their anger than women. Sexually abused boys had considerably more emotional and behavioral problems including suicidality than their female counterparts (Garnefski and Diekstra, 1997 as cited by Walker et al., 2004). Abused males with PTSD demonstrated greater evidence of adverse brain development (greater corpus callosum and

enlarged lateral ventricular volume) than abused females, suggesting that males may be more vulnerable to the effects of severe trauma on brain development than females (Bremner et al., 2003 as cited by Walker et al., 2004).

### **Comorbidity in PTSD and Gender Differences**

The risk factors that lead to development of PTSD also lead to range of psychological outcomes (low self-esteem, guilt, self-blame, shame, delinquency, substance abuse, and impaired sexual functioning) and increase the risk of comorbid psychiatric disorders (Walker et al., 2004). PTSD is associated with increased rates of depression, substance abuse, dissociation and borderline personality disorder (Bremner, 2002). Anxiety disorder, somatoform disorder and depressive disorder are significantly associated with increased odds of PTSD. Adults with at least one pre-existing psychiatric disorder had a threefold higher risk of developing PTSD after trauma (Hapke et al, 2006).

The prevalence of anxiety disorders, somatoform disorders, and depressive disorders are generally higher in women (Hapke et al, 2006). Pre-existing anxiety disorders were also associated with an increased risk of PTSD. These disorders are more prevalent in women than in men (Hapke et al, 2006). Women are significantly (2.5 times) more likely to have comorbid PTSD and Major Depressive Episode (MDE) than men (Hanson et al., 2008).

The prevalence of comorbid PTSD and substance use disorders is higher in men than women (Hapke et al, 2006). Men are twice as likely to be diagnosed with substance abuse or dependence as women. The presence of comorbid PTSD has been shown to be associated with poorer treatment outcome and high relapse rates (Kilpatrick et al., 2003 as cited in Hanson et al., 2008).

## **Treatment Outcomes and Gender Differences**

The conventional treatments for PTSD include group therapy, cognitive behavioral therapy, and exposure therapy. Alternate Treatments specific to PTSD are Eye-Movement Desensitization and Reprocessing (EMDR) and Emotional Freedom Techniques (EFT). The most widely used treatments for PTSD are pharmaceutical including the use of selective serotonin reuptake inhibitors (SSRIs) and other antidepressants (Newhouse, 2008).

There are a number of differences in the treatment outcomes of PTSD for women and men. Research involving Veterans returning from Iraq show that women are slightly more likely to report mental health concerns (e.g., PTSD, depression, suicidal thoughts) compared with men (24% compared to 19%) (Hoge et al, 2006). This willingness to discuss mental health may be related to women's greater comfort in expressing a wider range of emotions. Women are traditionally more likely than men to talk about their struggles and feelings.

Several studies suggest that women are more likely than men to seek treatment after exposure to a traumatic event (Foa et al, 2000 as cited by Vogt, 2007). Reasons for this may vary but could be that because women are more likely to experience recurrent trauma, they more quickly recognize symptoms that they have experienced before. Based on the findings of a larger percent of men having comorbid PTSD and substance abuse problems, one can assume that men may be self-medicating with drugs and alcohol.

“While research on gender differences in treatment efficacy is in its infancy, at least one study found that women respond as well or better to treatment than men,” (Vogt, 2007). It has been suggested that women may respond better to treatment due to greater experience with

interpersonal intimacy, and greater likelihood to draw from a range of coping strategies (Foa et al, 2000 as cited by Vogt, 2007).

### **CHAPTER THREE: CONCLUSIONS AND RECOMMENDATIONS**

In this comparison of male and female experiences with trauma, symptoms of PTSD, and comorbidity of PTSD, it is apparent that Posttraumatic stress disorder can develop in people exposed to trauma who meet certain risk factors. Specific types of trauma, stressful events preceding and following the index trauma, and pre-existing anxiety disorders and somatoform disorders increase the risk and can amplify symptoms of PTSD. Several studies have concluded that PTSD is more directly attributed to type of exposure to sexually violent, injurious, life-threatening situations across the life span rather than gender (Kessler et al., 1995; Cortina & Pimlott-Kubiak, 2006; Hapke et al, 2006). Female gender was not revealed to be an independent risk factor for PTSD. Analysis showed that the higher risk for PTSD in women than men is mainly due to the higher risk of being a victim of sexually motivated violence and the higher prevalence of pre-existing psychiatric disorders (Hapke et al, 2006). Many women experience multiple forms of violence during their lives, and this victimization increases a woman's risk of developing PTSD (Cortina & Pimlott-Kubiak, 2006).

Since PTSD was first recognized, people have thought that the sufferers were in some way deficient, because they could not "get over" or cope with the memories of their experiences. This is not true, although it is still not known exactly why some people develop PTSD and some do not, it is known that there are risk factors that are more likely to determine how PTSD will develop in trauma survivors. More study needs to be done on female combat veterans and male sexual abuse survivors, however it does not appear that women are inherently prone to PTSD, only that being female carries more risk for developing PTSD. Current conflicts in Iraq and

Afghanistan with female soldiers in combat situations will provide researchers the opportunity to better study gender differences.

There is more to the differences between male and female experiences of PTSD than psychological and physiological reactions to traumatic events. Historical research on PTSD has been limited due to the fact that trauma events that trigger PTSD have been different for men and women, but are these risks being studied in societal and cultural context? In the past it was socially expected that men would go off to fight wars and women would wait for them or tend to them when they returned broken from battle. American culture has changed as have expectations associated with the societal and cultural aspects of being a man or a woman. More research needs to be done in areas of social psychology and cultural studies on the experiences of PTSD across cultures and gender. “A victim processes a traumatic event as a function of what it means. This meaning is drawn from their society and culture and this shapes how they seek help and their expectations of recovery,” (Watters, 2010). The question has been raised that PTSD is the psychosis ‘du jour’ and that the prevalence of PTSD is partly due to societal expectations. This argument may have political foundation given the overwhelming costs associated with treatment and disability claims discussed on the nightly news. Regardless of politics, it is important for professionals in the field of psychology to be good stewards of mental health research.

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