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A

Everyday sexism and post-traumatic stress disorder in women: A correlational study

by

Susan H. Berg

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, the City University of New York

2001

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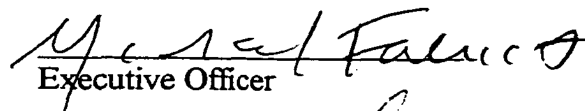
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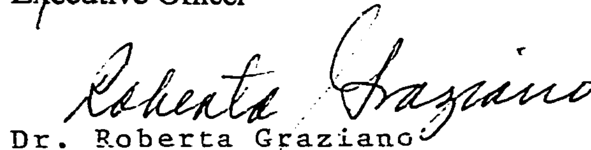
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Abstract

Everyday sexism and post-traumatic stress disorder in women: A correlational study

by

Susan H. Berg

Advisor: Professor Mimi Abramovitz

This study examined the effects of everyday sexism upon the development of trauma symptoms in women. Everyday sexism includes acts of disrespect, discrimination, and unfairness due to gender, as well as structural inequities. Female respondents (n=382) completed a survey that included a subjective measurement of the experience of sexism (Schedule of Sexist Events [SSE; Klonoff & Landrine, 1995]); a checklist of gender-based stressors, including acts of violence (Gender-related Stressors [GRS]); a measurement of post-traumatic stress disorder (Trauma Symptom Inventory [TSI; Briere, 1995]); and a demographic questionnaire, which included a question on feminist identity.

The SSE assessed the experience of sexism within four domains—close relationships, distant relationships, workplace and society (sexist degradation and its consequences)—along two dimensions: lifetime and recent (i.e., within the previous

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year). The GRS included instances of gender role burdens and gender-based abuse throughout one's life. The TSI measured PTSD symptoms as outlined in the DSM-IV.

Scores on the SSE were significantly positively correlated with TSI scores, indicating a moderately strong relationship between the experience of daily nonviolent sexism and PTSD. Lifetime Sexism scores accounted for 11% of the variance in TSI scores; Recent Sexism accounted for 18% of that variance. GRS scores were positively correlated with TSI at a much weaker level, accounting for 6% of the variance on TSI scores. Moreover, within this questionnaire, the only category of gender-related stressors that achieved a significant correlation with TSI was that of violence and abuse. A stepwise multiple regression revealed when all variables (test scores, subscale scores, and demographic characteristics) were entered, the most predictive variable for TSI scores was Recent Sexist Degradation and Its Consequences, accounting for 20% of the variance in TSI scores.

This finding expands the definition of traumatagenic events to include nonviolent everyday sexist acts toward women.

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Chapter I – Introduction

The focus of this study is women and mental health; it investigates the conundrum of why women's rates of mental illness far exceed those of men. In 1977-1989, the National Institute of Mental Health Epidemiological Catchment Area Study (ECA), a survey of 20,000 patients and nonpatients, found that more women than men in the United States experience a wide range of mental disorders. These include depression, anxiety and panic disorders, simple phobia, agoraphobia, eating disorders, obsessive-compulsive disorders, schizophrenia, somatization disorders, and dissociative disorders, as well as borderline, histrionic, avoidant, and dependent personality disorders (National Institute of Mental Health [NIMH], 1990). (Men were overrepresented in diagnoses of alcohol and substance abuse and within the category of anti-social personality disorder.) As the largest and most scientific survey of psychiatric disorders ever undertaken, the ECA is a highly respected study commonly used as a basis for understanding patterns of mental health in the U.S. population (Lefley & Bestman, 1995).

The 1990-2 National Comorbidity Study (NCS) substantiated the ECA findings. Based on structured interviews with 8,098 Americans, it sought to determine mental health diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders – 3rd edition, Revised (DSM-III-R; 1987), the official diagnostic guide published by the American Psychiatric Association. The authors concluded that, "The NCS data are

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consistent with those of previous epidemiological studies in finding that women have higher prevalences than men of affective disorders (with the exception of mania, for which there was no gender difference), anxiety disorders, and nonaffective psychosis, and that men have higher rates of substance abuse disorders and anti-social personality disorder" (Kessler, et al. 1994, p.12).

Numerous theories have evolved to explain the high incidence of psychiatric disorders among women. They include feminist analyses which tend to fall into two categories: those that indict the mental health field for misconstruing and mislabeling women's behaviors according to sexist interpretation, and those that focus on the impact of societal and interpersonal sexism on women's mental health. Within the first category, critics have accused psychiatry of bias in creating and attributing diagnostic categories according to sexist views and for encouraging socially approved behaviors that are then diagnosed as illnesses, such as passivity and self-starvation (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Caplan, 1995; Chesler, 1972; Ford & Widiger, 1989; Kaplan, 1983; Loring & Powell, 1988; Miller, 1976; Mirowsky & Ross, 1989; Sprock, Blashfield, & Smith, 1990; Sherman, 1980; Stoppard, 1991; Warner, 1978; Weisstein, 1971). In this schema, psychiatry both promotes and punishes stereotypical feminine behavior.

Critics in the second category emphasize the role of structural and interpersonal sexism in creating conditions that lead to mental distress in women (Bernard, 1971;

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Brown & Harris, 1978; Busfield, 1989; Cloward & Piven, 1979; Eichenbaum & Orbach, 1983; Friedan, 1963; Gove, 1978; Jaggar, 1983; Kahn & Jean, 1983; Pierce, 1995). They contend that the actual circumstances of women's lives "drive them crazy," i. e., provoke responses in them that cause psychic pain, confusion and disability. This idea was popularized by Friedan in The Feminine Mystique (1963), and steadily gained acceptance within the psychology profession. In 1978, the President's Commission on Mental Health Subpanel on Women recognized the "failure of mental health practitioners to recognize, understand, and empathize with the feelings of powerlessness, alienation, and frustration expressed by many women" (PCMH; 1978, p. 7). By 1987, NIMH had developed a women's mental health agenda that emphasized the stressful effects of violence, poverty and multiple roles in women's lives (Belle, 1990).

While these two approaches to understanding female mental illness are not incompatible, it is the latter that has gained ascendancy in both psychiatric and feminist circles. There now exists a growing body of literature that attests to the psychological consequences of gender inequality as a major public health issue (Belle, 1990; Carmen, 1995; Carmen, Reiker, & Mills, 1984; Faludi, 1991; Kaplan, Klein, & Gleason, 1991; Koss et al., 1984; Surrey, 1991; Kreiger et al., 1993; Landrine & Klonoff, 1997; Lerner, 1988; Rieker & Jankowski,1995; Russo, 1995).

The focus on women's mental illness as a social product, rather than a social construct, has been aided by emerging theories of the role of trauma in the etiology of

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women's psychological disorders. These theories hold that the traumatic victimization of women in our culture is a primary and pre-eminent causative factor in the development of female mental disorder (Courtois, 1988; Freyd, 1997; Hamilton & Jensvold, 1992; Herman, 1992; Koss et al., 1994; McGrath, 1990; Root, 1992; Russo, 1995; Waites, 1993; Walker, 1989). This victimization ranges from blatant interpersonal abuse—such as incest, rape and battering—to subtle societal abuse, including exploitation, discrimination, and harassment. Extensive documentation of the negative psychological sequelae of interpersonal violence against women exists (Boudewyn & Liem, 1995; Briere, 1988; Goldman, D'Angelo, DeMaso, & Mezzacappa, 1992; Jacobs, 1994; Herman, Russell, & Trocki, 1986; Kiser, Heston, Millsap, & Pruitt, 1991; McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988; Murray, 1993; National Victims Center, 1992; Pribor & Dinwiddie, 1992; van der Kolk, Perry, & Herman, 1991). However, studies on the detrimental psychological impact of everyday nonviolent sexist events are rare (Landrine & Klonoff, 1997).

Nonetheless, a growing number of theorists now believe that the overt gender-based violence that traumatizes women may not be exceptional. Instead it may be an endpoint on a continuum of sexist oppression that pervades society (Jaggar, 1983; Kirkwood, 1993; Koss et al., 1994; Kravetz, 1986). In this regard, scholars have suggested that many aspects of contemporary culture have become potentially pathogenic for women and should be examined as ongoing sources of mental distress (Belle, 1990;

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Bloom, 1997; Koss et al., 1994; Herman, 1992; Pierce, 1995; Walker, 1989; Vivero & Jenkins, 1999). Psychiatrist Judith Herman (1992) has suggested that those "who have endured prolonged exposure to exploitation" manifest chronic post-traumatic stress symptoms that are protean in nature, and often mimic a variety of other diagnoses (p. 120). In concordance with this view, Pierce (1995) has written:

> For many decades persons who have endured duress have developed symptoms given such labels as "post-traumatic stress disorder"...Some persons who endure racism and sexism—like those who have suffered terrorism, torture and disaster—also must develop these symptoms...We must classify and understand which...victims...develop continuing and perhaps cumulative symptoms. (p. 292)

The current study aims to further the exploration and understanding of the psychological trauma that results from women's experience of sexism. In order to do this, I investigated the impact of daily occurrences of sexism on the development of post-traumatic stress disorder within a selected sample of women. The basic assumption underlying this study is that the experience of everyday sexism can and does result in PTSD symptoms. These, in turn, are characterized as varied psychiatric disorders (Brady, 1997; Friedman, 1997; Keane & Wolfe, 1990; Kessler, et al., 1995; Southwick, Yehuda, & Giller, 1993). The information gained in this study will assist in our understanding of the etiology of widespread psychiatric disorders among women in our culture.

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Chapter II – Historical Background

Trauma and Women's Mental Health

For over one hundred years physicians and theoreticians have discussed the psychology of women, seeking to determine reasons for the apparent emotional frailty that was often synonymous with womanhood. Rarely did they consider the social factors that provoked or encouraged behaviors associated with their mental conditions. Instead, scientists developed far-ranging biological theories to explain the preponderance of mental dysfunction among women. These include the infamous Psychology of the Ovary theory of the mid-nineteenth century, which posited that, "the ovaries give to woman all her characteristics of body and mind" (Ehrenreich & English, 1973, p. 30). The recommended cure for mental disorders therefore involved removal of the afflicted woman's ovaries. This was extended to the clitoris if additional evidence indicated that the patient indulged in masturbation, believed to be a primary symptom of mental illness. In his treatise, On the Curability of Certain Forms of Insanity, Epilepsy, Catalespsy, and Hysteria in Females (1858), the gynecologist Isaac Baker Brown, who was later to become the president of the Medical Society of London, wrote that female masturbation led inevitably to hysteria, epileptic fits, mania, and finally, death (Coventry, 2000).

Physicians advised ovarectomies not only for depression and "vapors," but also for "hysteria," the malady that appeared among large numbers of women during the last

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century both in the U.S. and Europe. Named for the Greek goddess of the hearth and eponym of the uterus, Hyster, this strange disorder manifested in myriad forms, including blindness, stomach disorders, fainting, and uncontrollable screaming. Similar to today, nineteenth century physicians often debated whether hysteria had its roots in women's bodies or in their psyches. Some continued to designate the uterus as the original site of the condition; others, influenced by the new science of neurology, saw it as a malfunction of the cerebral cortex, or the "metabolic or nutritional changes in the cellular elements of the central nervous system" (Smith-Rosenberg, 1972, p. 666). Finally, encountering failure in their attempts at permanent cure, many physicians decided (somewhat inconsistently) that hysteria stemmed from the "indolent, vapid, and unconstructive life of the fashionable middle- and upper-class women, or by the ignorant, exhausting and sensual life of the lower or working class women" (Smith-Rosenberg, 1972, p. 667).

During the same period in France, Jean-Martin Charcot began to investigate the social conditions of the lives of the wretched inmates in Salpetriere asylum—the poor, the insane, and the prostitutes—who exhibited flamboyant hysterical symptoms. He concluded that rather than being deranged or delusional, the Salpetriere women had suffered from a life of unremitting violence, exploitation and rape (Herman, 1992). He termed hysteria the Great Neurosis and began to teach his theories at his famous Tuesday lectures, attended by prominent physicians of the time, such as Janet and Freud. Both men would come to believe that the underlying causation of hysterical neurosis was

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sexual assault, which then became dissociated in the psyche and later emerged as symptoms of the disorder. (In addition, they discovered that talking with these women about their lives reduced their symptoms and brought relief to their condition, thus introducing the world to psychoanalysis.) In 1896, Freud wrote, "I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience...I believe that is an important finding - the discovery of a *caput Nili* in neuropathy" (Herman, 1992, p.13).

However, within a year Freud reversed himself and returned to a belief in the internal causation of neurosis. He established his theory that women's remembrances of sexual trauma reflected Oedipal fantasies that represented wishes of their union with the paternal phallus. He wrote of this reversal: "This etiology broke down under its own improbability and under contradiction in definitely ascertainable circumstances" (Freud, 1914/1972, p. 51). Freud also found the sheer number of reports of sexual abuse "inherently implausible" in "its uncompromising sweep" (Joyce, 1995, p. 201). From then until the late twentieth century, the study of trauma as a precursor to women's mental illness stood still.

The Impact of Second Wave Feminism

The re-emergence of the women's movement in the mid-twentieth century brought renewed interest in crimes against women. In consciousness-raising groups

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women began to reveal their experiences of encountering abuse and violence throughout their lifetimes. Feminist researchers, teachers, and therapists revised long-standing theories on female development to include this compelling and disturbing information. In 1969 the Women's Caucus of the American Psychological Association declared the family to be a locus of violence, abuse and domination, and the primary contributor to women's mental illness (Kahn & Yoder, 1989). In 1983, Dworkin wrote: "Incest is the first assault...It is terrifically important in understanding the conditions of women." Of the child victim of incest, she wrote: "Her whole system of reality, her whole capacity to form attachments, her whole capacity to understand the meaning of self-respect are now destroyed" (cited in Armstrong, 1994, p. 105). Finally, a segment of society began to understand and accept that the trauma of sexual assault strongly influenced women's subjective experience and psychological development.

Widespread revelation of female sexual victimization spurred new their exploration of women's psychopathology. Feminist researchers of the 1970s eschewed positivist methods, and instead chose to conduct lengthy interviews of the women entering the mental health system. These narratives revealed a powerful portrait of symptoms which, when not screened by prevailing diagnostic taxonomies, resembled those of veterans ravaged by war. These women suffered sleep disturbance and nightmares, intrusive memories, hyperarousal, acoustic startle response, dissociation, poor affect modulation, numbing interspersed with outbursts of hostility (often directed at

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themselves), loss of meaning in life, anhedonia and problems in relationships and work.

Extended research within clinical populations revealed patient self-reports not only of childhood sexual abuse, but also of rape and battering (Briere, 1988; Russell, 1984; Walker, 1979). Upon learning the conditions of patients' lives, feminist researchers reframed their symptoms as the after-effects of trauma. They re-named these conditions “post-sexual abuse accommodations syndrome” (Briere, 1984), “rape trauma syndrome” (Burgess & Holmstrom, 1974), and “battered woman syndrome” (Walker, 1979) as a way of acknowledging the reality suffered by these women.

During this time, feminist investigators began to examine the daily life of women as another source of female psychological distress. They reasoned that male-to-female violence was the most visible aspect of a societal oppression that was also expressed through everyday acts and mundane circumstances. Brown and Harris (1978) diverged from traditional psychiatric theory by proposing that depression in women was closely linked to the social conditions in which they lived. Their study of poor women in England, entitled The Social Origins of Depression, noted the circumstances of poverty, hardship and family dissolution that might predict chronic depressive episodes within this population. In the U. S., Jessie Bernard critiqued traditional marriage and the role of “housewife” as a source of mental distress (Bernard, 1972). Her colleague, sociologist, Pauline Bart examined how traditional roles of motherhood created the phenomenon of “involutional psychosis,” or menopausal depression, in an article facetiously subtitled

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Portnoy's Mother's Complaint (Bart, 1971). Additional studies explored female sex role conflict as a precursor to phobic syndromes, (Fodor, 1974); female "learned helplessness" as a determinant of depression (Seligman, 1975); family demands as a forerunner of agoraphobia (Chambliss & Goldstein, 1980); female objectification as a contributor to eating disorders (Orbach, 1986); and maternal stress as the rationale for post-partum depression (Magnus, 1980). The concept of everyday sexism as an etiological factor in women's mental health was becoming established as an important concept for research, theory development and treatment strategies.

Veterans and Post-traumatic Stress Disorder

Throughout the twentieth century, study of the psychological maladies produced by combat followed a similar pattern of recognition and discovery as that of future feminist researchers in psychology. Charles Samuel Myers was a British military psychiatrist and the first to use the term "shell shock" to describe the emotional ravages of war as witnessed in World War I veterans. He rejected the common explanation of "molecular commotion in the brain," in favor of an "emotional disturbance" as a natural response to war, and noted the close resemblance of shell shock to hysteria (van der Kolk, Weisaeth, & van der Hart, 1996, p. 48-49). But it was not until 1922, when a young psychoanalyst named Abram Kardiner began to work for the Veterans' Bureau, that a systematic exploration of the war neurosis yielded vital information regarding the brain's

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processing of traumatic material. In 1941 Kardiner's clinical and theoretical study, The Traumatic Neuroses of War, detailed the outlines of the traumatic syndrome as it is understood today. He and his colleagues concluded from their investigations that combat leaves a lasting impression on men's minds, changing them radically (Herman, 1992, p. 24-26). Unfortunately, few experts used this information to advocate against the promotion of war; rather, they limited their efforts to addressing the psychological effects of war so that soldiers could return to battle.

In the 1970s the anti-war protest group, Vietnam Veterans Against the War, helped focus public attention on the psychological condition exhibited by many Vietnam war veterans. This syndrome included nightmares, flashbacks, depression, addiction, disrupted relationships, isolation, withdrawal, raging outbursts, and other debilitating symptoms. Veterans demanded, and received, attention from the Veterans' Administration (VA), culminating in a five-volume study delineating the syndrome of Post-traumatic Stress Disorder and its unquestionable relationship to war. The VA concluded that normal, healthy men could succumb to some form of psychiatric disorder after exposure to war (van der Kolk, Weisaeth, & van der Hart, 1996). After overcoming years of disagreement with authorities who wished to frame the disorder as a form of malingering, veterans began to receive recognition of the validity of their complaints. This enabled veterans to receive psychological treatment and, in some cases, qualify for disability payments. In 1980, Post-Traumatic Stress Disorder (PTSD) appeared in the

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DSM-III, gaining formal recognition as a legitimate psychiatric diagnosis with detailed symptoms.

The inclusion of PTSD in the DSM was historic not only for veterans, but for mental health clinicians who had advocated for the recognition of external causation for many of the conditions observed within the patient population. PTSD became the first diagnosis in the DSM to cite exogenous etiology (termed Criterion A) for a mental disorder. The DSM-III (1980) stated that "an event that is outside the range of usual human experience and that would evoke significant symptoms of distress in almost anyone" must be present for a patient to receive the PTSD diagnosis. The remainder of the DSM definition of PTSD condenses the most common aspects of the disorder into three categories: (1) Criterion B: re-experiencing of the trauma (flashbacks, nightmares, intrusive thoughts or feelings, reactivity) (2) Criterion C: attempts at numbing of responsiveness to the world (dissociation, alexithymia, amnesia, depression) and (3) Criterion D: persistent increased arousal (irritability, hypervigilance, sleep disturbance, exaggerated startle response (Brett, Spitzer, & Williams, 1988; APA,1980, 1994).

Trauma and Women's Mental Health

When advocates seeking redress for psychologically-impaired combat veterans succeeded in legitimizing the concept of PTSD as a psychiatric diagnosis in the DSM-III (APA, 1980), those working with mentally disturbed women recognized the syndrome as

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similar to that found in many of their patients. The psychological phenomena reported by survivors of incest, rape, and domestic battery clearly paralleled those found in war veterans. Acknowledging this similarity, Judith Herman wrote: "Hysteria is the combat neurosis of the sex war" (1992, p. 28). The pattern of symptoms among abused women in clinical care mirrored the PTSD symptoms of combat veterans, as well as survivors of natural disasters, prisoners of war, and victims of torture.

Generally, the pattern consisted of flashbacks/nightmares, efforts to avoid thoughts and feelings associated with trauma, psychogenic amnesia, diminished interest in significant activities, feeling detached from others, restricted affect, anger, present-centeredness, hypervigilance, and difficulty concentrating or learning (Keane, Wolfe, & Taylor, 1987). When viewed through the lens of standard psychiatric diagnoses, these traits become labeled as dissociation, obsessive-compulsive disorder, depression, borderline personality disorder, schizotypal personality, impulsive personality disorder, anxiety/panic disorder and learning disability.

Feminists sought to persuade the psychiatric community to recognize these symptoms as a possible PTSD response to traumatic life events, rather than signs of inborn mental deficiency.

The PTSD Diagnosis

It had taken the psychiatric community over one hundred years to begin

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investigating the thesis put forth by Janet regarding the physical underpinnings of hysterical symptoms. He posited that these symptomatic reactions were a response to "vehement emotions" that are stimulated by disturbing events and then are biologically encoded in the individual (Van der Kolk & van der Hart, 1989, p. 1536). His theory was eclipsed by that of his contemporary, Sigmund Freud. Freud had abandoned his "seduction theory" of neurosis, and instead presented a complex explanation of psychiatric disorder as a response to the inner conflict of libidinal drives and societal restriction, mediated by ego functioning. Certainly Freud's contention that all psychoneurosis emanated from individual disturbance synchronized with the prevailing views of the age, which extolled personal responsibility and denied social culpability for individual distress and unhappiness. These tenets received strong support from prevailing social institutions, including the medical and psychological community. As Bessel van der Kolk has stated, "...(P)sychiatry as a profession has had a very troubled relationship with the idea that reality can profoundly and permanently alter people's psychology and biology" (van der Kolk, Weisaeth, & van der Hart, 1996, p. 47). Nevertheless, the plethora of evidence emerging from studies on trauma after the Vietnam War has gained the attention of the psychiatric community and its practitioners, and may permanently alter the ways clinicians view and treat psychological dysfunction.

Many feminist mental health practitioners embrace the introduction of data on PTSD, believing that it will enable psychiatry to amend its position regarding women's

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demonstrations of pathology, and become less sexist in its treatment of patients (Bloom 1997; Brown, 1992; Herman, 1992; Root, 1992). Ultimately, many hope it will lessen the profession's dependence on Freudian theory. The PTSD diagnosis moves the focus of psychiatric intervention from the woman's inherent biological or psychological "defect" to her reaction to an injurious external event. It elevates her symptoms to the status of survival skills and life-saving behaviors (Bloom, 1997; Brown, 1992; Foa, 1997; Herman, 1992; Waites, 1993; Walker, 1994). In contrast to prevailing diagnoses, PTSD offers a non-pejorative description of responses to events. Rather than a stigmatization process, it values the subjective experience of the victim/patient. It validates her claims of violation and pain and helps devise a treatment plan that addresses the issue of abuse and encourages the development of resources, both internal and external, which aid in personal growth (Bloom, 1997; Herman, 1992; Nes & Iadicola, 1989; Marmar, Foy, Kagan, & Pynoos, 1994; Shapiro, 1989; Stiver, 1991).

Feminist clinicians hope to educate professionals to view the standard diagnostic categories in which women are typically overrepresented—depression, anxiety, phobias, dissociative disorder and personality disorders—as secondary and compensatory reactions to trauma. In this regard, Lenore Walker has written that "coping strategies against the psychological consequences of living through horrendous trauma situations" often become diagnosed as personality disorders (Walker, 1991, p. 136). Brown concurred that "certain normative post-traumatic responses to violence" have been treated

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as "indicative of a serious, deeply rooted characterological flaw" (Brown, 1990, p. 142). She continued, "Syndromes that might constitute a normative, if not frankly normal response to abnormal events in the social and interpersonal environment, continue to be construed as forms of psychopathology" (1992, p. 213). Harvard psychologist Gina O'Connell Higgins has suggested that some version of PTSD may in fact be the "overarching rubric under which most other disorders are subordinated" (Higgins, 1994, p. 13). In a similar vein, Herman has argued that most of the existing diagnostic taxonomy can be conflated into one syndrome, namely Complex Post-traumatic Stress Disorder, which can then categorize most psychological symptoms as behavioral, cognitive, and affective artifacts of trauma and abuse (Herman, 1992).

PTSD researchers can now demonstrate concretely that trauma causes neurological and psychobiological changes which may result in some of the persistent pathological symptoms seen in female clients. Positron Emission Tomography (PET) and Magnetic Resonance Imaging (MRI) scans, hormone and enzyme level tests, and central nervous system response measurements, reveal evidence of brain and body changes which appear after serious trauma (Friedman, 1997; van der Kolk, 1994, 1997). For a woman in our culture, this trauma often takes the form of assault perpetrated upon her body—sexual assault, rape, and battering.

In less dramatic, but equally important ways, accruing evidence attests to the traumatic sequelae of the daily occurrences of sexism in our culture (Benokraitis &

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Feagin, 1995; Landrine & Klonoff, 1997; Ronai, Zsembik, & Feagin, 1997). Several researchers have theorized that "subtle" sexism can be highly damaging to victims in hidden ways (Benokraitis & Feagin, 1995; Brown, 1992; Rowe, 1990; Haslett & Lipman, 1997; Pierce, 1995; Vivero & Jenkins, 1999). Rowe writes of the "micro-inequities," or "tiny, damaging characteristics of the environment," that exclude targeted people and render them less confident and productive (1990, p. 189). Benokraitis (1997) posits that isolated instances of hostile humor, subtle sexual innuendo, and exclusion via chivalry, in the aggregate, create a climate of widespread oppression toward women that can contribute to individual distress. Psychologists Vivero and Jenkins (1999) believe that suffering discrimination and oppression affects individuals' self-esteem and ability to trust. Thus, as feminist psychologist Laura Brown urges, the PTSD diagnostic paradigm can—and should—be expanded to include the daily occurrences of sexism, and by extension, racism, ageism, heterosexism and other biases as well (Brown, 1992).

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Chapter III – Review of the Literature

It is the contention of many feminist theorists and clinicians that the widespread abuse of women in our society, and its noxious sequelae, contributes to the inordinately high rates of female mental illness. Of course the question arises whether the coincidence of abuse and psychiatric symptoms provides sufficient proof of causality, or whether they are co-determined by other, unseen, forces. Researchers have sought possible ways causality might be demonstrated, seeking material substantiation for the evolving theory of traumatology, i.e., the study of the "victim-to-patient" process by which a hurt person becomes a psychiatric client (Carmen, Rieker, & Mills, 1984, p. 378). Recently, neurobiological and psychopharmacological studies have provided concrete evidence linking the events of trauma, brain dysfunction, and psychological symptoms, thus creating a basis for understanding their relatedness. This new information has also guided recent efforts to re-define the concepts of psychiatric illness, diagnosis, and treatment.

A small but growing body of literature points to a relationship between PTSD, women's mental health, and everyday sexism. A review of this literature will be presented below.

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Post-traumatic Stress Disorder

The addition of PTSD to the psychiatric diagnostic nosology helped provide a material basis for the discussion of the mental health aspects of trauma in women's lives. Prior to its inclusion, researchers and theorists were likely to blame gender-based violence—battering, rape, harassment—on the mental defects of the woman who was being abused. The victim was often characterized as being masochistic, unassertive, passive, traditionally feminine, or having a personality disorder (Koss et al., 1994). (Self-defeating Personality Disorder narrowly missed being included in the DSM-IV, only after a vigorous fight mounted by feminist psychologists [Caplan, 1995]). In other words, a woman's mental disorder was likely to cause her trauma, rather than vice versa.

However, emerging data from PTSD studies contradicted the prevailing view that early childhood development was the sole determinant of mental health or illness. These studies indicated that exposure to war, natural disaster, crime and abuse could create profound disruption in brain activity that would lead to mental disorder and a variety of psychiatric symptoms (Van der Kolk, 1997a). The existence of a concrete pattern of post-abuse symptomatology thus offers an explanation not only for the high rates of mental disorder among veterans, but also among women, who are chronically abused and oppressed. A summary of this pattern, and the controversy that continues regarding this new diagnostic category, follows.

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The biology of PTSD. Increasingly, physiological studies have presented evidence that demonstrates how traumatized persons develop neuropsychiatric symptoms (van der Kolk, 1994; Bremner et al., 1995; Rausch et al., 1996; Yehuda, Giller, Southwick, Lowy, & Mason, 1991). Van der Kolk summarized the scientific findings in the PTSD field within the past two decades and reports that "the dysregulation of PTSD can be measured on physiologic, neurohormonal, immunologic, and functional neuroanatomical levels" (1997, p. 16). He cited findings that indicate that "there are profound and persistent alterations in physiologic reactivity and stress hormone secretion in people with PTSD," as well as anatomical abnormalities, endocrine disruption, and memory disturbances (p.16-19). Scientists have hypothesized that trauma creates disturbances in the limbic system, which regulates attachment and affect; the hippocampus, which engages in memory retrieval; and the cortex, responsible for abstract cognition. These abnormalities result in responses often codified as psychiatric symptoms, including depression, anxiety, compulsivity, aggressive-impulsivity, dissociative disorder, somatization and distorted self-concept (van der Kolk, 1994, p. 20).

The growing field of research on PTSD specifically demonstrates its effects on the human brain. Child psychiatrist Bruce Perry has written, "Ultimately, it is the human brain that processes the internalized traumatic...experiences. It is the brain that mediates all emotional, cognitive, behavioral, social and psychological functioning. Understanding...brain-mediated responses to threat are the keys to understanding

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[trauma]" (Perry, Pollard, Blakley, Baker, & Vigilante, 1996, p. 3). Current understanding of the brain suggests that the processing of trauma alters the intracellular constituents, which in turn alter the microenvironment of the cell nucleus, which affects the neuronal structures of the brain. The result is a malorganization of the brain parts affecting reasoning, humor, empathy, and affect, which may lead to psychiatric disorders, anti-social behaviors, criminality and substance abuse. To emphasize the importance of environmental factors in affecting these results, Perry et al. (1996) have written, "The single most distinguishing feature of all nervous tissue, including neurons, is that they are designed to change in response to external signals" (p. 3).

Modern technology has provided physiological markers of PTSD and a clearer understanding of how trauma produces the symptoms, both obvious and diffuse, associated with the syndrome. The information gathered via PET and MRI scans of the brain, neurohormonal level measurements, and central nervous system response tests, offers evidence of the physical impact of trauma and its effects on brain development and functioning.

Early studies utilizing PET scans demonstrated that traumatized patients, when read scripts pertaining to their trauma, produced increased blood flow to the right hemisphere of the brain, in a pattern different from that of memory activation in normal and depressed subjects. This suggested an overstimulation of the right-sided components of the limbic and paralimbic system, as well as the visual cortex, which play an important

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role in the mediation of intense emotion and emotional memory. In particular, right temporal activation can produce simple phobias, panic disorder and disturbances in the emotional memory schema, such as amnesia or flashbacks (Rausch et al., 1996). Brain scans also demonstrated decreased activation of Broca's area during exposure to trauma scripts. Since this area is responsible for labeling emotions, impairment makes it difficult for traumatized individuals to understand or communicate the kinesthetic arousal and emotional responses they are experiencing, resulting in the clinical condition of alexithymia (van der Kolk, 1997).

Van der Kolk used MRI measurements to demonstrate differences in hippocampal size and amygdala irregularities in victims of various types of trauma, including women who were survivors of childhood incest. He believes that the dissociative and depressive disorders of these subjects can be traced to the overuse of the brain stem during trauma. The result is an increase in epinephrine and stress steroids, rises in dopamine, overstimulated mesolimbic and mesocorticoal systems, and concomitant changes in affect, behavior, and cognition (van der Kolk, 1994).

In 1996, Murray Stein of the University of California reported that MRIs detected hippocampal volumes in 22 women who cited repeated childhood sexual abuse smaller by 5 percent than those of 20 women who had no sexual abuse and no psychiatric disorders (Bower, 1996). Hippocampal volume was smallest in those reporting the most severe symptoms of dissociation. Similarly, Bremner et al. found that patients with PTSD

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examined via MRI had a statistically significantly smaller hippocampal volume than non-traumatized subjects, with all other factors being similar. The authors explained that "extreme stress results in increased glucocorticoids, excitatory amino acids, serotonin, and other neurotransmitters and neuropeptides that could be associated with damage to the hippocampus" (1995, p. 999).

Since the hippocampus mediates verbal and visual memory, its impairment seriously affects memory recall and learning ability. In discussing the findings of decreased left hippocampal and amygdal volume among survivors of childhood emotional or sexual abuse, researchers have hypothesized that a traumatic insult early in development may arrest or delay normal brain development. They believe excessive opioids released during trauma, and in its aftermath, blunt emotional responses and prevent learning from experience. These opioids continue to be released decades after the original events when the subject is exposed to similar cues. The combination of overstimulation and blunted emotions may create a bi-modal response to stimuli which appears as varying states of hyperarousal (hypervigilance) and numbing (dissociation) (Perry, 1995).

A NIMH study indicated that sexually abused girls develop neuroendocrine disturbances, particularly in their corticosteroid and thyroid functions, with related problems with attention, memory, and concentration (McFarlane, 1997). Neuroendocrine studies of veterans with PTSD revealed chronically increased sympathetic nervous

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system activity, with elevated norepinephrine and epinephrine secretions. Both veterans and rape victims had lowered cortisol excretions, inversely proportional with their PTSD symptoms. It was concluded that excessive amounts of cortisol—a neurohormone produced during stress—remain in the brain after trauma, creating abnormalities such as reduced hippocampal size. These results led researchers to hypothesize that the overstimulated brain of a trauma victim produces an undifferentiated flight or fight response which prevents coping and adaptation, leading to impulsivity, aggression, hyperactivity, hyperexcitability, and/or obsessive thinking (van der Kolk, 1994).

Several researchers have found variations in responses to trauma within age and sex categories. Children traumatized at a younger age, and females of all ages, tend to develop symptoms of dissociation, which often appear as passivity, avoidance, restricted affect, daydreaming, poor attention span and compliance, while older children and males often become hyperaroused, exhibiting hyperactivity, sleep problems, and aggressiveness. Each case involves a distinct differentiation of neurobiology associated with the response; hyperarousal involves catecholamines originating in the brainstem, while dissociation involves a similar brainstem-mediated central nervous system activation, but also vagal tone increases, causing decreased blood pressure and heart rate (which may result in fainting) despite increased epinephrine. In addition, in dissociative states there is an increase in the dopaminergic systems and endogenous opioids which alter perceptions of time, place, reality and pain (Perry et al., 1996). Scientists have

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formulated various explanations for these differences. These include anthropological theories regarding the roles of the sexes in assuring survival of the species (males had to fight; women and children had to surrender when attacked), biological theories regarding male and female brain structures, and sociological theories regarding the conditioned roles of males and females responding to danger.

In addition to the biological model of PTSD, there are adjunctive theories regarding the development of the syndrome. Concurrent with the physiological consequences, intrapsychic, relational, and social factors contribute to the maladjustment of trauma victims. Friedman (1997) and Foa (1997) have suggested that exposure to uncontrollable and unpredictable stressors distorts the normal appraisal process, rendering victims unable to discriminate "safety cues" or respond appropriately to "danger cues," thus causing them to respond inappropriately to their environments (Friedman, 1997, p. 34). Learning theory has been utilized to explain both the arousal symptoms (e. g., startle response, hypervigilance) and avoidance symptoms (e. g., denial, dissociation) that distinguish the disorder. This theory holds that the victim is conditioned to respond fearfully to all cues related to the trauma, both internal and external, and is therefore either continually overstimulated or avoidant (Freedy & Donkervoet, 1995).

In general, both adults and children respond to traumatic events with generalized hyperarousal, attentional difficulties, problems in stimulus discrimination, inability to self-regulate and dissociative processes. But research indicates that interpersonal traumas

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are likely to have a more profound impact than impersonal ones, such as accidents or natural disasters (De Zulueta, 1993). Janoff-Bulman (1992) has theorized that assumptions regarding the safety of one's world and the goodness of one's self are shattered by human-induced traumatic events, altering one's sense of security, faith, or willingness to love. Walker (1984) extended Seligman's theory of learned helplessness (as a precursor to depression) to provide a rationale for symptoms found in those suffering "battered wife syndrome." Several other scholars have delineated the cognitive and emotional deficits that result from the impairment of trust that follows abuse (Freyd, 1997; Herman, 1992; Terr, 1990). As PTSD is a relatively new and evolving diagnosis, with multiple mental and behavioral symptoms, many explanatory theories regarding its etiology and course are being proposed.

PTSD and comorbidity. Oftentimes PTSD is misdiagnosed, due to its multifaceted presentation and the concurrence of comorbid, or co-occurring, symptoms (Brady, 1997; Fierman, et al., 1993; Keane & Wolfe, 1990; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Southwick, Yehuda, & Giller, 1993). Kilpatrick, Saunders, Veronen, Best and Von (1987) found that among the PTSD-positive cases in their sample of crime victims, the most frequent collateral problems were sexual dysfunction, major depression, obsessive-compulsive disorder, social phobia and agoraphobia. Subsequent surveys revealed PTSD as likely to be associated with affective disorders, anxiety disorders,

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somatization, substance abuse and dissociative disorders (Brady, 1997). Breslau et al. (1991) reported that close to 80% of respondents in their sample with PTSD had experienced other psychiatric disorder, compared with about 44% of those without PTSD.

PTSD is not only associated with additional psychiatric disorders, it is also often concomitant with self-destructive or anti-social behavioral patterns. Researchers in the field of adolescent health found that among 90 female teenagers seen for routine healthcare at an inner-city primary care clinic, 92% had experienced at least one form of trauma and 13% had developed PTSD. Compared with girls without PTSD or with partial PTSD, those with the disorder were significantly more depressed. They were also more likely to exhibit behavior disorder, to smoke marijuana and cigarettes, to have failed a class or grade, to have been suspended from school, or to have been arrested (Lipschitz, 2000).

Matthew J. Friedman, Executive Director of the National Center for PTSD, has written that if an individual meets diagnostic criteria for PTSD, it is likely that he or she will meet DSM-IV criteria for more additional diagnoses, including personality disorders (1998). Southwick et al. concluded as a result of their study that "war-related PTSD in treatment-seeking Vietnam veterans is often accompanied by diffuse, debilitating, and enduring impairments in character," evidenced by high rates of borderline, obsessive-compulsive, avoidant and paranoid personality disorders among that population (1993, p.

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1020). Kolb remarked on the "heterogeneity" of PTSD, which "is to psychiatry as syphilis was to medicine...[It] may appear to mimic every personality disorder" (1989, pp. 811-812).

Because of the considerable overlap between symptoms of borderline personality disorder (BPD) and PTSD, some researchers have proposed that the BPD diagnosis is often a misinterpretation of a trauma response (Brown, 1992; Courtois, 1988; Herman, Russell, & Trocki, 1986). BPD, which is also grossly overrepresented by women (Becker, 1997), is a serious malady marked by a pattern of unstable interpersonal relationships, identity disturbance, potentially self-damaging impulsivity, suicidal behavior, extreme reactivity of mood, inappropriate anger and/or dissociative symptoms (DSM-IV; APA, 1994). Herman, Russell and Trocki (1986) have stated that BPD is a "posttraumatic stress disorder which has become chronic and integrated into the victim's personality structure" (p. 1293). Hamilton and Jensvold agreed that "it may be more parsimonious and helpful to diagnose PTSD, rather than BPD, when there is a history of victimization" (1992, p. 129). In fact, Hamilton and Jensvold (1992) have asserted that both female depression and personality disorders often co-occur because of the intervening factor of PTSD, which is the primary disorder.

In their 1990 review of the literature pertaining to PTSD cormorbididty, Keane and Wolfe concluded that while considerable support for PTSD as a unique diagnostic entity has evolved, "it seems clear that PTSD is associated with the presence of other

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psychological disorders...regardless of the factors such as the interview used...the training of the interviewers...patient/nonpatient status and veteran/nonveteran status" (p. 1782). They countered arguments of patients' overreporting symptoms by noting the systematic endorsement of symptoms and the consistency of the symptom profile presented in the studies they reviewed.

Boudreaux, Kilpatrick, Resick, Best, & Suanders (1998) recently addressed the issue of primacy of diagnoses within a PTSD-afflicted population. Their survey of community women explored the relationship among victimization, PTSD and comorbid psychopathology. Boudreaux et al. administered the Incident Classification Interview to determine types of criminal victimization, and the Diagnostic Interview Schedule to assess different types of mental disorders, based on DSM-III classifications. Their findings indicated that participants who currently had PTSD were significantly more likely to have a concurrent Axis I disorder, major depressive disorder, panic disorder, agoraphobia, obsessive-compulsive disorder and social phobia. The authors noted, "Consistent with expectations based on previous research, we found women suffering from PTSD at marked elevated risk of having another Axis I disorder" (p. 674).

By means of hierarchical multivariate logistic regression, Boudreaux et al. were able to determine that other variables within this studied population (demographics, victimization status, crime factors, etc.) decrease in significance once PTSD is factored in, suggesting a mediating role for PTSD in the development of character disorders,

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major depression, agoraphobia, obsessive-compulsive disorder, simple phobia and panic disorder, but not social phobia (1998, p. 675). (They also determined that different types of criminal victimization were related to different mental disorders, with completed rape resulting in the most severe pathology.) As these authors noted, questions regarding primacy of disorders had been addressed by Davidson et al., who found that PTSD among World War II and Vietnam veterans was most likely to precede the development of comorbid disorders, including depression, anxiety disorder and panic disorders, but that substance abuse preceded the development of PTSD (Davidson, Kudler, Saunders, & Smith, 1990). Similarly, Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) stated in the National Comorbidity Study that PTSD was primary more often than not with respect to affective disorders and substance disorders and, among women, to conduct disorders (p. 1055).

Studies in the field of PTSD may be providing clues regarding the continuing disproportionate rates of mental illness among women as compared to men. The two to one female-to-male ratio that prevails in PTSD rates may be associated with the two to one female-to-male ratio in most categories of mental distress within the general population. This suggests that unrecognized but pervasive traumata in women's lives underlie the imbalance in mental disorder between the sexes. It is possible that the traumatic impact of everyday sexism is an underlying determinant of a disorder that either manifests as, or contributes to, the expression of mental distress in women.

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Prevalence rates of PTSD. General population studies vary in their reports regarding the prevalence of PTSD, probably due to the variety of screening instruments used in the surveys. The ECA study, using the DSM-III (1980) criteria, discovered lifetime prevalences of 1-2% in the general population (Helzer, Robins, & McEvoy, 1987). But Resnick and associates, using DSM-III-R (1987) criteria, found an average 12.3% prevalence rate among women (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993).

Kessler et al. made several screening modifications for the National Comorbidity Survey (NCS) of 1990-92, which surveyed more than 8,000 people for PTSD symptoms (Kessler et al.,1995). This national study was a stratified multistage area probability sample of persons aged 15 to 54 years, who were interviewed using a modified version of the Composite International Diagnostic Interview (CIDI), a research interview designed to reveal DSM-III-R diagnoses. The authors of the NCS used the same interview schedule as previous researchers, and also limited the response to the selection of one traumatic event. However, they added 12 questions, one for each of 12 types of trauma to focus memory searches, plus an open-ended question regarding "any other terrible experience that most people never go through" (p. 1049). The results yielded a 7.8% lifetime prevalence of PTSD in the general population, with female rates being twice that of male rates.

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Authors of the NCS acknowledge the limitations of their study and the probability of underdiagnosing PTSD from this sample. As they stated, "Many of the traumas identified as likely to cause PTSD are common, and so the stipulation in Criterion A of DSM-III-R that the trauma must be outside the range of usual human experience is difficult to defend" (Kessler et al., 1995, p.1051). Nevertheless, they determined that although a greater percentage of men than women reported traumatic events in their lives, twice as many women as men were likely to have lifetime PTSD (10.4% vs. 5.0%). Even when traumatic experiences were identical, twice as many women as men developed PTSD as sequela (20.4% vs. 8.2%). Also, within the 15-24 age subset, in which fewer women than men reported ever having a traumatic event, vulnerability for PTSD was still higher for females. The authors state that these younger women were significantly more vulnerable than men even when the researchers controlled for sex differences in the types of trauma. They added, "This sex difference might be explained by detailed aspects of trauma exposure, such as age at exposure, and/or previous trauma history" (p. 1054).

In a more focused epidemiological study, a random sample of 1007 young adults within an urban population was tested and researchers discovered an average 9.2% lifetime rate for PTSD, with women at greater risk than men for both symptoms and chronicity (Breslau & Davis, 1992).

Gender differences in PTSD rates. There is a striking parallel in the gender

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differences in both general mental health rates and PTSD rates within the general population. As stated previously, females are overrepresented in most categories of mental illness roughly two to one. Similarly, PTSD rates are generally twice as high among women than among men (Wolfe & Kimerling, 1997). Breslau, Davis, Andreskie, Peterson, & Schultz (1997) reported that although several epidemiological studies have documented a higher rate of PTSD among women than men, the finding has received little attention. Males and females often report equal numbers of traumatic events in their lives, with men experiencing more occurrences of physical violence and accidents, and women reporting more domestic and sex-related violence. Yet, even when exposure to trauma is equal, females outnumber males twofold in PTSD symptoms (Norris, 1992; Breslau et al., 1997). This discrepancy was theorized as related to the types of events that are traumatizing for women, since they are usually of a sexual nature and therefore possibly more damaging. However, Breslau et al. reported that "(a)cross major event types, females had higher rates of PTSD than did males," although the authors could not find an explanatory rationale for the difference (1997, p. 1048).

Authors of previous studies have suggested a gender-based susceptibility to PTSD due to underlying conditions prevalent among women, but Breslau et al.'s study did not find that pre-existing anxiety disorder or major depressive disorder "differentially increased women's vulnerability to PTSD" (Breslau et al.,1997, p. 1048). The researchers in the NCS reached a similar conclusion (Kessler et al., 1995). After noting the greater

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vulnerability of women to PTSD in their sample, Kessler et al. assessed age of onset of PTSD and the comorbid symptoms. They concluded that in both sexes PTSD was primary more often than not with respect to affective disorders, substance abuse disorders and, among women only, with respect to conduct disorders (1995, p.1055). (PTSD was less likely to be primary with respect to comorbid anxiety disorders and, among men, conduct disorder, although even in these cases the percentage of cases in which PTSD was primary was substantial.)

Sarah Halligan and Rachel Yehuda recently completed a review of the risk factors for PTSD and concluded that "(g)ender is an extremely salient risk factor, even controlling for differences in the type of events that are experienced by men compared to women." Although female rates are consistently twice that of males, they add, " To date, there are no firm explanations for this finding" (2000, p. 1).

In an attempt to understand the gender difference in PTSD, Breslau and her associates conducted telephone interviews using computerized random digit dialing to contact more than two thousand community residents (Breslau, Chilcoat, Kessler, Peterson, & Lucia, 1999). Using a list of 19 items that conform to Criterion A characteristics (e. g., assault, violence, injury, accident, disaster, sudden death of a loved one, etc.), she again found females having PTSD rates twice those of males, with duration among females of 48 months and among males of 12 months. These rates were maintained even when holding the type of event constant. She noted that the heaviest

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burden of PTSD is likely to be borne by young women in late adolescence and early adulthood (between the ages of 16 and 25), when they are at peak vulnerability for exposure to male assault. She suggested that previous assaults continue to affect women's vulnerability to develop PTSD in response to future traumatic events.

In their examination of these assaults upon women, Breslau et al. (1999) discovered that when rape and "domestic violence" were eliminated from their statistical analysis, the difference in PTSD rates between the sexes was still high, leading to their assertion that "other assaultive violence" may be contributing to this disparity. At the International Society for Traumatic Stress Studies Conference (Miami, FL, November, 1999), Breslau cautioned future researchers that the common list of Criterion A events, and even additional questions about the "worst event" that ever occurred, do not represent all qualifying events and may in fact restrict the selection of qualifying events for PTSD.

At the same conference, Fran Norris reported on a study she and her colleagues conducted to examine the possible underlying causes of the gender differential in PTSD rates. She surmised that sociocultural factors played a part in this difference and developed the following hypothesis: If cultural differences underlie sex differences in responses to trauma, then differences between male and female outcomes should be greater in a society that fosters traditional gender roles than in a less traditional society. In other words, a culture "high in masculinity" would create greater differences [in PTSD responses] between the sexes (Norris, Perilla, Murphy, & Ibanez, 1999).

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Norris et al. (1999) surveyed 200 Mexican men and women who survived a devastating hurricane, and 400 non-Hispanic U.S. residents following a similar storm, assuming that the Mexican culture was more traditional and would promote greater distinction between the sexes. Using the Civilian Mississippi PTSD Scale (Revised) with both populations, she found that women scored higher than men in both settings, but that the sex difference was much greater among the Mexicans. Although the Arousal subscale showed the same difference in both populations, the Intrusion, Avoidance and Remorse subscales revealed sex differences that were greater for the Mexicans than Americans.

In her discussion of the results, Norris stated that feminist psychology would argue that a more traditional society promotes more violence within women's primary relationships and therefore they would be predisposed to the development of PTSD in subsequent disasters or accidents. She cites Wolfe and Kimerling (1997), who wrote that routine stressors of oppression may produce in women a general heightened perception of threat which may explain their greater propensity to develop PTSD symptoms following traumatic events.

In their review of the literature pertaining to women and PTSD, Wolfe and Kimerling (1997) observed that most studies report higher rates of both exposure to traumatic events and severity of symptoms for women than for men. Even when numbers of events reported are equal, women will generally report more PTSD symptoms (at a general rate of two to one) and suffer greater intensity and chronicity of distress than

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men. (Breslau et al., 1991, reported women as being four times as likely as men to develop chronic PTSD symptoms following similar events.) However, Wolfe and Kimerling noted that there are few studies that might explicate why females appear more susceptible to the disorder than males. They suggested that gender-based differences in PTSD rates indicate "significant gaps…in current conceptualizations of this disorder" (p. 192). Rather than continuing to base prevalency rates on the most obvious traumatic life events, the authors encouraged researchers to pay attention to "distinctive stressor experiences" across genders to determine role-related factors in PTSD etiology (p. 218). They advised researchers interested in establishing gender correlates for PTSD to emulate the studies on women and depression by focusing on the "daily, negative events" which impact on women, e. g., competition between social and vocational roles, job discrimination, lack of economic and social advantage, domestic and caretaking roles (p. 219).

In her discussion of the sex differential in PTSD rates, Kimerling (1999) suggested three avenues of future research: (1) biological vulnerability of females to PTSD symptoms, (2) under- or over-pathologizing of female responses due to diagnostic constructs that are less valid for women, and (3) other variables that are associated with gender that can account for the differences, such as social roles in our culture, social context, or other demographic characteristics that covary with gender. She asks that researchers in the PTSD field consider gender as a multidimensional societal construct

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that impacts widely on research.

Definitions of trauma. Since its inclusion in the DSM in 1980, the diagnosis of PTSD has undergone several important reconfigurations. The first DSM-III definition of PTSD stated that the causative factor for the trauma (Criterion A) must be "an event that is outside the range of usual human experience" (APA, 1980). The specific mention of this etiological factor was a noticeable exception to the symptom-based DSM taxonomy, but its usefulness as a criterion was limited by its restrictive nature. The revised edition of DSM-III (1987) enlarged Criterion A by listing generic characteristics of traumatic stressors, and examples, such as serious threat or actual injury to oneself or a loved one, sudden destruction of one's home or community, and witnessing mutilation or violent death (Brett, Spitzer & Williams, 1988).

Accumulating evidence of the ubiquity of trauma-provoking violence in American society led to a further amendment in the DSM-IV. The current Criterion A for the diagnosis of PTSD reads:

> The person has been exposed to a traumatic event in which both of the following were present:
>
> 1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

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2. the person's response involved intense fear, helplessness, or horror (APA, 1994, p. 427-428).

This expanded definition not only widened the parameters for inclusion of more traumatic events, but emphasized the subjective response of the victim as a critical factor in the diagnosis. However, critics of the DSM-IV definition of PTSD fault the authors for continuing to be too restrictive in their description of Criterion A events.

Because the initial DSM definition of PTSD remained dependent on the existence of an event "outside the range of usual human experience" (APA, 1980), researchers approached the determination of trauma as though there were a limited number of "spaces" for what constitutes valid trauma (Horowitz, Weiss, & Marmar, 1987). Therefore the ECA survey revealed a 2% rate of PTSD within the American population, whereas subsequent studies using the later DSM-III-R (1987) criteria (Kessler, et al., 1995) produced a 7.8% rate, with higher rates for women. However, events which qualified under this criteria were still confined to "terrible experience(s) that most people never go through" (Kessler et al., 1995, p.1051). The authors concluded, "It would be useful for subsequent research to conduct a more broad-based investigation of this sort to determine which types of nonqualifying life events are most likely to provoke…symptoms" (p. 1057).

Epidemiological studies that do not select traumatic events a priori are rare, and therefore understanding of the range of events contributing to PTSD is limited (Amir &

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Sol, 1999). In their survey of a healthy college population, Vrana and Lauterbach (1994) did not limit the events selected and found that 84% of the respondents reported at least one event of sufficient intensity to produce PTSD, as opposed to previous national averages of 69% in the ECA and 75% in the NCS. The authors noted that "diagnostic cutpoints for PTSD are arbitrary and conceal much distress that would become evident if diagnostic criteria were relaxed" (p. 302).

In their community survey of 2,181 persons in the Detroit area, Breslau and associates assessed the lifetime history of traumatic events and PTSD in order to estimate the relative importance of specific types of trauma (Breslau et al., 1998). The researchers found that the highest risk of PTSD was associated with assaultive violence (20.9%), but the trauma most often reported as the precipitating event among persons with PTSD (31% of all PTSD cases) was "sudden unexpected death of a loved one." They wrote: "Although recent research has focused on combat, rape, and other assaultive violence as causes of PTSD, sudden unexpected death of a loved one is a far more important cause of PTSD in the community" (Breslau et al., 1998, p. 631).

In her article on the epidemiology of trauma (1992), Norris defined traumatic events objectively as "violent encounters with nature, technology, or humankind," omitting references to the subjective states induced by the event. She then surveyed 1,000 people, equally divided into groups of males, females, Whites and African Americans, to determine the incidence of traumatic events and PTSD within each population. Her study

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yielded high rates of exposure to traumatic events within the entire population: 69% experienced at least one such event, with events maintaining the same rank order of frequency across the groups, with the exception of combat, which only older males experienced. (More than 5% of the total sample satisfied all criteria for full PTSD). There were distinct demographic differences in PTSD rates. For any event, women showed a current rate about 40% higher than men; in the case of crime, women showed a rate of PTSD more than twice that exhibited by men. Younger people had higher rates of the disorder and Blacks highest rates of all groups. (These results differed from those of Breslau et al., 1997, who found in their epidemiological study that neither race nor education was associated significantly with PTSD).

PTSD researchers have offered support for the expansion of Criterion A events by demonstrating that either common or chronic events may produce PTSD symptoms (Shalev, 1996). Examples include witnessing violence in an inner city setting (Ozer & Weinstein, 1998), surviving a heart attack (Shalev, Schreiber, Galai & Melmed, 1993), developing breast cancer (Andrykowski, Cordova, Studs & Miller 1998) and being in a traffic accident (Blanchard, Hickling & Taylor, 1991). Recently, Lauterbach & Vrana (1999) completed a study exploring the impact of everyday racism on PTSD among a minority population in the South (D. Lauterbach, personal communication, 1/29/99).

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Acute vs. chronic traumatic stressors. In 1988, NIMH convened a conference to help illuminate the various definitions and components of traumatic stress as they were being debated within the field. At that gathering, the definition of the traumatic stressor (Criterion A) received much attention, since it had been altered in succeeding versions of the DSM, and because its components remained unclear. Some maintained the stressor needed to be discrete, horrific, and outside the normal range of human experience, while others suggested a more fluid (and some would say tautological) definition of the stressor as an event that causes extreme stress (Solomon & Maser, 1990).

In their review of that conference, Solomon and Maser cited an early researcher in the field, A. H. Barton, who defined disaster as a "subset of 'collective stress situations' that occur when a social system fails to provide many of its members with the expected conditions of life" (1990, p.1624). Kasl (1990) also promoted the idea that trauma stressors are continuous with "familiar stressful life events," (p. 1658) and advocated an integration of research on traumatic stress with that of more common life events. He wrote, "In the case of the dialogue surrounding PTSD, it is not clear why we need such a tight conceptual and measurement linkage to the unique notion of a traumatic stressor, the presumed primary risk factor" (p. 1659-1660). Instead, he proposed that the study of traumatic stressors and disasters not be separated from studies of stressful life events and chronic stressors, stating that the "merger of the two areas can only be beneficial for both" (p. 1662).

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The traditional concept of stress, as outlined by Hans Selye, suggested that stress is a biological response to "increased demand," and that all demands, whether pleasant or unpleasant, created a similar response, based on their intensity (Breslau & Davis, 1987). Thus, the causal factor in a stressor was its magnitude, a concept challenged by subsequent researchers who maintained this to be a reductionist, biological conception of stress. In contrast, they proposed that the subjective response of the individual—one's emotional and cognitive response to the event—plays a large part in determining the psychological outcome.

In fact, some theorists are challenging the concept of PTSD as a stress disorder, claiming that attempts to articulate theoretical links between stress and traumatic stress have been problematic. Shalev (1996) has noted that the core of Selye's stress theory consists of a homeostatic model of self-conservation and resource allocation in response to adversity that assumes a period of fatigue or recovery following a stressful event or series of events, and a return to normality. It does not address the long-term consequences of exposure, or the psychological response to the stress. Shalev argued, "Stress, however, becomes traumatic precisely [in this period] when psychological damage...occurs—that is, damage to a hypothetical stimulus barrier to the 'self,' to one's cognitive assumptions, to one's affect, to neuronal mechanisms governing habituation and learning, to one's memory network, or to emotional learning pathways" (1996, p. 93).

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Yehuda and McFarlane (1995) also argue that the disorder of PTSD is distinct from the normal stress response. They report that biological tests indicate that the physical substrates of PTSD differ from the normative stress response. Whereas patients with chronic stress symptoms develop attenuated biological systems, PTSD sufferers develop physiological patterns that result in a generalized hyperresponsiveness to external stimuli. Yehuda and McFarlane question the presumed nature of the relationship between trauma and PTSD, noting that (a) not all victims develop the disorder and (b) PTSD is not the only possible psychological consequence of trauma. Halligan and Yehuda (2000) have called for PTSD to be recast in a stress-diathesis model, with trauma characteristics—such as severity of incident—interacting with individual risk factors to determine vulnerability. They urge researchers to consider environmental and demographic factors, personality and psychiatric history, cognitive and biological systems, and familial risk as possible contributors to the development of PTSD.

In their efforts to clarify the disagreements regarding traumatic stress, Baum, O'Keefe, & Davidson (1990) created a paradigm that classifies stress as either acute or chronic, and also supplies differentiation along that continuum. They proposed three dimensions for consideration: duration of the event, appraisal of the threat or demand associated with the event, and duration of the response to the event. In this model, the unifying concept of stress is that of stress as a "bundle of acute events" (p. 1649). They wrote:

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> It is unlikely that stressors are always "conscious" when chronic. Stress occurs periodically—often enough to make the stress chronic but not continuous. It is also likely that when faced with events that give rise to persistent threat appraisal, awareness of the threat is not conscious but episodic....daily hassles, small, irritating, episodic events such as commuting or having to deal with a bureaucracy, individually pose little threat but together can place considerable adaptive demand on an individual. (p. 1650)

Monroe and Johnson (1990) advanced Baum et al.'s model of acute vs. chronic stress to suggest that different types of stress produce disorders related to that specific type. In particular, they highlighted the Brown and Harris 1986 study of 164 community women which concluded that life events that signaled danger ("the degree of unpleasantness of a specific future crisis which might occur as a result of the event") were more likely to induce anxiety disorders, and that life events related to loss ("deaths or separations of important others, as well as losses of physical health, jobs, careers, material objects, and cherished ideas") were more likely to induce depression (pp.1688-1689). Brown and Harris proposed that "the traumas of disasters and war may operate in a manner similar to the traumas of more ordinary life circumstances" and call for research to provide a "more differentiated conceptualization and measurement of the characteristics that constitute life stress" (p. 1690).

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For his concept analysis of PTSD, Symes (1995) reviewed 113 articles that contributed to the evolving definition of the disorder, and concluded that it is a complex, varying psychological and biological response to an acute stressor experienced directly or indirectly, or to chronic stress. In fact, he emphasized that the literature demonstrates that those who had prolonged exposure to a stressor had more severe symptoms than those whose exposure was of shorter duration.

In 1997, Lepore, Miles, and Levy tested the hypothesis that exposure to chronic stressors, which reflect persistent negative life situations, would have greater physiological, psychological, and physical health costs than exposure to episodic or intermediate length stressors, which reflect relatively transient negative life situations. Of 150 tested college students, subjects with many chronic life stressors had exaggerated cardiovascular responses to acute challenges, delayed recovery to resting levels of cardiovascular functioning after the acute challenges, elevated psychological distress levels, and they reported more illnesses, than those with few stressors. The researchers stated that tests results suggest that ongoing stressors that are static are more detrimental to health and well-being than are episodic or change-related stressors. In relation to this, Fields et al. (1998) have authored studies which demonstrate the stress of everyday discrimination is more detrimental to the mental and physical health of Black women than major, blatant incidents.

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In a similar study, Pike, Smith, Hauger, and Nicassio (1997) examined the effects of antecedent chronic life stress on psychological and physiological responsivity after acute challenge with a psychological stressor, in this case, a mathematics exam. Subjects undergoing chronic stress showed greater subjective distress, higher peak levels of epinephrine, lower peak levels of beta-endorphin and of natural killer (NK) cells lysis, and a more pronounced redistribution of NK cells than controls during acute stress. (The acute stressor induced a protracted decline in NK lysis per NK cell in the chronic stress subjects but had no effect in the controls.)

In her 1992 epidemiological survey, Norris emphasized that persons with previous traumatic experiences tended to have higher levels of perceived stress than those without that history. In discussing this finding, Norris emphasized that the traumatic events examined in her study appear to be only one of many sources of stress in people's lives. She wrote, "Interpersonal relations, financial problems and the like entail little drama but much stress...It is not particularly helpful to force an either-or choice about whether acute or chronic demands contribute the most to perceptions of stress. All sources matter, undoubtedly in complex and interconnected ways" (p. 416). This was reinforced by the finding that Blacks within her study, especially Black males, had higher rates of stress levels, although Whites reported more instances of trauma. Norris suggested that economic and social conditions increase Blacks' vulnerability, and that minorities may "confront hostility, prejudice and neglect which serve to heighten the

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effect of stress" (p. 417), an insight that may be applicable to women as well.

Stressful life experiences as trauma. In their discussion of the Criterion A debate, Solomon and Canino (1990) questioned whether the psychiatric sequelae resulting from exposure to traumatic events " 'outside the range of usual human experience' do in fact differ from the sequelae resulting from exposure to more common yet stressful life experiences (e. g., money problems, family illness...bereavement, separation)" (p. 228). Using data from studies of disaster victims (including flooding, dioxin release, andmudslides), the authors concluded that many common events reported by the victims related more closely to PTSD symptoms than the disaster itself. These included experiencing a move, money difficulties, household illness and "other upsetting events" (p. 230). In their companion study, the disaster produced increased PTSD symptoms, but events such as breaking up with a best friend, having to take someone into one's home, and "other upsetting events" also related "much more strongly to PTSD" (p. 231). The authors suggested that the stressor criterion be removed from the diagnosis of PTSD and reserved for Axis IV (psychosocial stressors) assessment, a dimension given little attention by most clinicians. (DSM assessment includes Axis I – Clinical Disorder, Axis II – Personality Disorder, Axis III – General Medical Conditions, Axis IV – Psychosocial and Environmental Problems, Axis V – Global Assessment of Functioning.) They wrote:

Were this change in the diagnosis adopted, it would of course require that

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> clinicians take Axis IV seriously, and routinely incorporate information regarding experience with traumatic stress as part of any diagnostic workup. This kind of attention to Axis IV considerations would appear to be clinically advisable in any case, since trauma has been found to be associated with a range of outcomes besides PTSD (e.g., anxiety, depression, substance abuse, antisocial personality). (p. 235)

As McFarlane and DeGirolamo pointed out, "The utility of PTSD as a psychopathological construct has created pressure to widen the definition of the stresses that qualify for the diagnosis" (1996, p. 138). To assess the impact of non-Criterion A events which might explain differential rates of PTSD rates between sexes, Frazier & Hurliman (Frazier, 1998) conducted a random survey of 894 women, revealing a 21% lifetime rate of PTSD symptoms. Twenty-three percent of those women selected a non-Criterion A event as the worst occurrence in their lives, with "serious relationship problems" as the most common choice (Frazier,1998). Similarly, when asked to write about the "most stressful event they had ever undergone" in a study on the use of expressive writing to alleviate both asthma and rheumatoid arthritis, most patients wrote about the death of a loved one, problems in a close relationship or disturbing events in childhood (Goode, 1999).

Scott and Stradling (1994) reported evidence of "full (PTSD) symptomatology in the absence of a single, acute, dramatic trauma" and concluded that this is "not a

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necessary condition" for the development of the disorder" (p. 73). In reviewing several of their own cases and those reported in previous studies, the authors stated that either acute stressors or "enduring circumstances" may lead to PTSD, including "a series of unremitting, though individually (relatively) less intense circumstances" (p. 73). They re-named this type of disorder Post Duress Stress Disorder to distinguish it from trauma resulting from a single, acute dramatic episode and asked future researchers to consider: Is the syndrome of intrusion, avoidance and disordered arousal reactions triggered by the product of intensity by duration of distress, and how are these subjective experiences to be metricated? (p. 74).

At the November 1999 conference of the International Society of Traumatic Stress Studies in Miami, FL, Michele Murburg, Rachel Yehuda and Harold Kudler presented a workshop entitled "Criterion A: Can a Wider Range of Traumas Cause PTSD?" In that setting, panelists and attendees discussed proposed modifications to this portion of the PTSD diagnosis. Yehuda reported that patients at her trauma clinic who suffered distinct PTSD symptoms often presented non-Criterion A events for treatment, including "marital breakup" and "relationship problems." Workshop attendees offered anecdotal evidence of PTSD patients whose disorder seemed to be linked to experiences that encompassed being children of Holocaust survivors, HIV-infected mothers, and victims of racial and sexual harassment. In their workshop precis, the panelists asserted that stressors not deemed extreme by DSM-IV standards may also cause behavioral and

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biological changes consistent with PTSD. They included stressors such as sexual or racial harassment, school and work harassment, and other traumatic social situations which compromise threats to the integrity of the selfhood, identity, or social functioning of the victims. Kudler suggested that some forms of harassment and discrimination create a threat to psychic integrity which may be perceived as "life-threatening" and therefore traumatagenic (Murburg,1999).

Oppression as trauma. In his discussion of prejudice and exclusion as "social traumata," Paul L. Adams (1990) designated women, the poor, children, the elderly, Jews and other minorities as vulnerable to the kinds of psychosocial stressors that interfere with mental and social adaptation and adjustment. Although traumatic episodes can be added up to determine the total stress in a person's life, Adams maintained that research has shown that, "hassles," i. e., the minor annoyances and burdens that beset daily life, can lead to even greater strain and disability when they are numerous. He posited that for oppressed groups, these hassles encompass being disparaged, belittled, labeled, stereotyped, dehumanized, ignored, excluded, and denied opportunity due to some characteristic (pp. 375-376).

Maria Root (1992) has added her voice to those calling for an expansion of the DSM diagnosis of PTSD. She encouraged theorists to broaden the scope of experiences that are considered traumatic so that we can "delve deeper into understanding trauma

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and...construct a more inclusive general theory of trauma" (p. 230). As long as trauma theory remains a theory of individual distress, Root cautioned, the breadth of traumata and their impact relevant to women and minority groups will receive minimal consideration. She outlined what she terms a "feminist" reconstruction of the impact of trauma on personality. She wrote:

> Central to this [feminist] conceptualization is the tenet that trauma is a very personal experience, the upheaval, stress, and pain of which can only be judged subjectively...As such, what is deemed traumatic is determined by the traumatized person rather than the observer. This feminist conceptualization of trauma broadens the experiences that are considered traumatic and subsequently is more inclusive of experiences subsumed by gender, race, class, sexual orientation and ability—variables about people who those with relatively more status have often transformed into objects of hatred and oppression...Broadening the scope of experiences that are traumatic allows us to delve deeper into understanding trauma and to construct a more inclusive general theory of trauma. (p. 230)

Root maintained that the PTSD schema is limited by the narrowness of experiences that have been considered traumatic by professionals. This problem is sustained, she posited, because PTSD definitions evolved from a decidedly male environment of war studies, and remain steeped in a culture that envisions problems as

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individually-bound. As such, problems that are the result of social conditions, such as discrimination, are overlooked. She exhorted researchers to attend to the effects of living in "daily traumatic environment (e. g., poverty, threat to life, persistent denial or abrogation of human rights, etc.) or the effects of cumulative trauma" (1992, p. 236). She has offered her own conceptualization of trauma, which rests on three categories of traumatic impact: direct, indirect, and insidious.

Direct traumas include "maliciously perpetrated violence, war experiences, industrial accidents and natural disaster," as well as physical illness and destruction of cultural communities. Indirect trauma, largely neglected in research, includes the "trauma sustained by another with whom one identifies (e. g.,..another woman…), witnessing trauma, receiving information about devastation or violence." Insidious trauma, which Root stated has been totally ignored, is "associated with the social status of individuals being devalued because a characteristic intrinsic to their identity is different from what is valued by those in power, for example, gender, color, sexual orientation, physical ability" (1992, pp. 239-240). As a rule, these traumas present throughout a lifetime, and are therefore frequent and cumulative. For victims, the result may be a construction of reality in which one is chronically insecure or frightened, with attendant responses of hypervigilance, paranoia, sensitivity to stimuli and hostility. She stated that the effects of insidious trauma, which are cumulative and generally directed to a community of people, may create symptoms of "anxiety, depression, paranoia, and substance abuse" (p. 240).

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Root mentioned that the most common of these insidious traumata are ageism, homophobia, racism and sexism.

Psychologist Laura Brown argued that inattention to traumatic life events in women's lives calls into question many diagnostic categories in the DSM, and called for an alternative framework that acknowledges "the very wide and diverse range of conflicts that can result from being powerless, oppressed, and discriminated against in a repetitive and ongoing manner" (Brown, 1992, p. 209). She wrote, "Extrapolating this conceptual framework beyond the experience of direct abuse and victimization, a feminist analysis of severe psychological distress would take into account the lifetime learning experiences of living in a sexist, racist, homophobic, ageist, and otherwise oppressive cultural context" (p. 220). She contended that it is the accommodations made by members of oppressed groups that are diagnosed as mental illness, and offered a diagnostic category designed to address these symptoms, named Abuse/Oppression Artifact Disorders. This category would recognize the behavioral, affective and cognitive problems that would arise as the result of exposure to stressors that are often embedded in the culture in "subtle and difficult to identify" ways (p. 223).

Several researchers in the field of PTSD have suggested the formulation of a wide spectrum of post-traumatic disorders that encompasses many of the current psychopathologies (Brown & Fromm, 1986; Davidson, 1994; Herman, 1992; Horowitz, 1986; Kolb,1989). As Herman has written, the current PTSD formulation "fails to capture

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the protean sequelae of prolonged, repeated trauma" (p. 377) or the hidden characterological changes which occur as a result of chronic subordination or exploitation. She proposed the diagnosis of Complex PTSD, which reflects the psychological damage incurred as a result of "repeated victimization" and which is characterized by a "pleomorphic symptom picture, enduring personality changes and high risk for repeated harm" (p. 389). In a similar vein, Horowitz (1986) has suggested the concept of a "post-traumatic character disorder," Brown and Fromm (1986) speak of "complicated PTSD," and Davidson writes of post-traumatic stress disorders (plural) in his argument for an expanded category of psychological disorders related to trauma (1994).

Their viewpoint is compatible with social work clinical practice, which has been instrumental in directing mental health care away from psychoanalytic, and toward ecological, models of human behavior (Zastrow, 1996). This approach views human beings as adapting and developing through transactions with all elements of their environment. In this vein, social work educators Mailick and Vigilante encouraged clinicians to attend to "social pathologies" when assessing individuals and families who present for treatment. They posited that clients are affected, either directly or indirectly, by negative social conditions, including "racism, economic deprivation, sexism, homophobia, heterosexism, ageism and other forms of social pathology," and that both presenting problems and treatment modalities are informed by these social forces (1997,

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p. 364).

Social work educator Mary Swigonski has recommended that the PTSD diagnostic category be re-named Persistent (or Pernicious) Oppression Stress Disorder in order to encompass the distress of many groups suffering under adverse societal conditions (Swigonski, personal communication, 10/31/1998). Others have called for an expanded Criterion A list that would include occurrences of "totalitarian systems in sexual and domestic life," (Herman, 1992), "racial discrimination," (Root, 1992) and "cultural oppression" (Brown, 1992). In addition, several scholars have supported the possibility of measuring the extent to which sexism, both interpersonal and institutional, operates as a distal predictor of PTSD in the female population (Bloom, 1997; Pierce, 1995; Root, 1992).

Trauma and Women's Mental Health

The mental health of women is known to be adversely affected by a number of traumatic events, including sexual abuse, physical abuse, verbal/emotional abuse and sexual harassment at work and at school. Recent literature also shows a link between everyday sexism and women's mental health. Everyday sexism includes both the impact of gender roles and also those interpersonal interactions in the home, workplace and society that are deemed hurtful to women.

This section will review the extant literature related to the first category: gendered

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interpersonal abuse and its effect on women's mental health. That will be followed by a review of the literature pertaining to the impact of everyday sexism, a topic which informs the research questions of this study.

Sexual abuse and women's mental health. Women in consciousness-raising groups of the 1970s revealed widespread accounts of sexual abuse histories. These revelations prompted large-scale speak-outs on incest and rape held throughout the country (Armstrong, 1994). The testimony of women at these meetings, as well as the large attendance, challenged the official prevalence rates of sexual abuse as reported by government sources. This outpouring encouraged researchers to conduct independent studies to determine the scope and psychological impact of female victimization. The results of these studies argued for changes in the prevailing theories of women's mental illness.

Russell's 1982 survey of 935 women in the San Francisco area, a well-documented and methodologically rigorous study, became the benchmark for future research in the area of women and gender-based violence. On the topic of childhood sexual abuse, Russell found that 16% of respondents reported at least one experience of intrafamilial sexual abuse before the age of 18 years and 12% reported at least one such experience before the age of 14. Thirty-one percent reported at least one experience of extrafamilial sexual abuse before the age of 18, and 20% reported at least one such

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experience before the age of 14. In sum, 38% reported at least one experience before the age of 18 and 28% reported at least one experience before the age of 14. (Of these total cases, only 8% were reported to the police.) The majority of the victims interviewed by Russell reported emotional and psychological distress due to the assault (Russell, 1982a).

In 1986, Herman, Russell, & Trocki reported that childhood sexual abuse was widespread and fostered long-term malignant effects. (Victimization rates in this study were 1 in 10 for males and 1 in 3 for females, when the perpetrator was not a family member. Intra-familial abuse rates were approximately 18% for girls under age 18.) The authors state, "The resultant impairments of ego functioning and social relatedness increase the likelihood that victims of childhood sexual abuse will present at some point in their lives as psychiatric patients" (p.1293).

Subsequent studies continued to validate the widespread occurrence of childhood sexual abuse and its consequent psychological effects (Briere, 1988; Gelinas, 1983; Harney, 1992; Higgins, 1994; Murray, 1993). Browne and Finkelhor's 1986 review of the research concluded that the most psychologically damaging experiences involved father figures, genital contact, and physical force. Boudewyn and Liem's 1995 study indicated a sexual abuse rate (including unwanted fondling) in the general population of 16% for males and 24% for females, with resultant depression, chronic self-destruction, acts of self-harm, and suicide attempts among the victims. The authors noted that the more frequent and severe the abuse and the longer its duration (as is often the case with girls),

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the greater the effects of depression and self-destructiveness in adulthood.

Russell's study also revealed higher rates for adult sexual assault than had been reported by government sources (1983). Within her studied population, 44% of the women had experienced at least one attempted rape, although only 8% of the total rapes and attempted rapes were reported (1983). Russell (1982) reported that 14% of ever-married women had been raped by a husband or ex-husband, more than twice as many as were sexually assaulted by acquaintances or strangers. This figure is considered a significant underestimate, since interviewers did not ask about forced oral, anal, or digital sex unless the women mentioned this type of rape themselves. When Kilpatrick, Saunder, Best, & Von (1987) used behaviorally specific language, as was utilized in the present study, they found an overall rate of sexual assault among adult women of approximately 50% and a rate of approximately 20% for completed rape.

Among younger women, rates of sexual assault are consistently high. Research conducted in 1987 found that over 27% of college women had been victims of rape or attempted rape; 53.7% (including rape victims) had experienced some form of unwanted sexual contact or sexually assaultive behavior (Donat & D'Emilio, 1997).

Since then, various independent surveys have estimated the prevalence of completed rape to be approximately 20% among adult women (Koss, et al., 1994). In addition, Rozee (1993) has discussed "normative rape," that is, "genital contacts that the female does not choose, but that are supported by social norms," such as acquaintance

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and date rape. She notes that these are unlikely to be treated the same as rapes perpetrated by total strangers, even where the law makes no such distinction (p. 503). Cumulative data from the ECA studies reveal evidence of continuing psychological problems among rape victims, even many years after the event. These include depression, generalized anxiety, obsessive-compulsive disorder and substance abuse (NIMH, 1990).

In order to corroborate the relationship between victimization and psychiatric symptoms, researchers also conducted studies among psychiatric populations. By reviewing clinic data, hospital records, and patient self-reports, they discovered high rates of abuse within the patient population. Forty-three percent of psychiatric inpatients in a 1984 study had experienced physical or sexual abuse, with women having more than twice the rate of abuse as men (Carmen, Reiker & Mills, 1984). The abused patients in this study had longer hospital stays and exhibited higher rates of self-destructive behavior than non-abused patients. In their study of psychotic women. Beck and van der Kolk (1987) found that nearly 50% of intractable psychiatric patients reported incest histories, although until that time not one study had reported a specific relationship between incest and psychosis. The abused patients in their study showed greater agitation, hyperarousal, disorganized thinking and threatening behavior than non-abused patients.

In their 1992 survey, Pribor and Dinwiddie noted that nearly every psychiatric category dominated by women highly correlated with the existence of incest in their background. (Patients with multiple personality disorder—now termed dissociative

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identity disorder—had incest rates of 90%). They concluded that "...incest victims had markedly higher lifetime prevalence of most major psychiatric disorders" (p. 54). A similar study in 1991 compared abuse histories among psychiatric patients with various diagnoses: borderline personality disorder, borderline traits, bipolar disorder, antisocial personality disorder and schizotypal personality disorder (van der Kolk, Perry, and Herman, 1991). These researchers found that borderline personality disordered patients revealed the highest rates of abuse (81%), with women reporting more physical and sexual abuse in childhood, and more sexual abuse in adulthood, than men (p. 491). The authors wrote:

> Childhood trauma has been implicated as an etiological factor in such diverse psychiatric conditions as somatoform disorder, panic disorder, and multiple personality disorder (MPD). Thus, it might be possible to conceptualize a range of adaptations to childhood trauma, or trauma spectrum disorders, with MPD representing an extreme adaptation to severe chronic abuse, borderline personality disorder representing an intermediate form of adaptation to chronic abuse, and some forms of somatoform, panic and anxiety disorders representing dissociated somatic re-experiencing of more circumscribed traumatic events. (p. 494)

Physical abuse and women's mental health. The women's movement of the 70s

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also encouraged women to reveal the many instances of physical violence that occurred in marriages and intimate relationships. Women disclosed that in addition to suffering the effects of sexual abuse and rape, many were also victims of physical abuse. Russell's 1983 survey substantiated these reports by finding that 21% of the married women she interviewed experienced at least one occasion of violence within their marriage. Similar studies attested to the prevalence of spouse abuse in American households. For example, Strauss and his associates (1980) reported that 28% of couples had experienced violence in their marriage, 16% of those within the survey year. In a follow-up study a decade later involving 8,000 households, 12% of the women reported an assault the previous year, with 3% suffering severe injury (Strauss & Gelles, 1990). Briere (1995) discovered that 43.6% of a stratified random sample of over 400 women had experienced "interpersonal victimization." Some studies suggested that dating or cohabiting couples may have even higher prevalences of physical assault than those who are married (Koss et al., 1994). In a nationwide study of courtship violence, 32% of the women had experienced physical aggression from a date or other intimate partner (White & Koss, 1991).

Like sexual assault, most physical assault of women is perpetrated by male intimates (The National Victims Center, 1992). This may include family members, acquaintances, boyfriends, partners or spouses, as well as trusted friends. Current figures indicate that between three and four million women each year are battered by husbands, partners, and boyfriends; half of them are beaten severely and one third are attacked with

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weapons (Davis, 1999). Patricia Abbate of the Long Island Women's Agenda reports that one quarter of American women say they have been abused by a husband or boyfriend at some time in their lives, and that employee assistance experts estimate that as many as 50% of job performance problems are the result of family violence (Abbate, 2000).

Research studies have found that women who are victims of chronic partner abuse suffer profound psychological distress, including anxiety, panic disorder, depression, and hostility (Hilberman, 1980; Janoff-Bulman, 1992; Russell, 1983; Symonds, 1979; Walker, 1984, 1991). Not surprisingly, these studies indicated that combined physical and sexual abuse in relationships places women at risk for more severe psychological distress, and that symptoms increase with the severity of abuse (Walker, 1984).

Hilberman (1980) found severe levels of stress in a sample of 120 women referred to a rural clinic for psychiatric evaluation. Of this sample, half were victims of repeated violence by their partners. The victimized women suffered from feelings of incompetence, unworthiness, guilt, shame, fear of being controlled, and depression. Similar reviews of clinical samples of abused women reveal a high prevalence of depressive symptoms, as well as suicidal ideation (McGrath, Keita, Strickland, & Russo, 1990; Stark & Flitcraft, 1988).

Verbal/emotional abuse and women's mental health. Many women also suffer damaging verbal and emotional abuse within their relationships. Since it is difficult to

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quantify this type of abuse, feminists have struggled to define its parameters. Researcher Ginny NiCarthy (1986) attempted to delineate emotional abuse from ordinary irritability and occasional name-calling in which many couples engage. She wrote, "In fact, much of that behaviour is abusive, but it may not be permanently damaging until it reaches the level of a campaign to reduce the partner's sense of self-worth and to maintain control" (1986, p.285).

In 1993, Catherine Kirkwood conducted in-depth interviews with 30 formerly abused women and reported that in these women, emotional abuse seemed to be a "deeper and more central form of abuse [than physical assault]" (p. 44). In fact, Kirkwood stated that women who had suffered purely from emotional abuse described healing processes that were nearly indistinguishable from those of women who had suffered physical abuse. Drawing on the reports of her interviewees, and using NiCarthy's work in this area, Kirkwood isolated six major components of women's subjective experience of emotional abuse. These were: degradation, fear, objectification, deprivation, overburden of responsibility, and distortion of subjective reality. These behaviors, which often occur in concert, create an atmosphere in which women feel demeaned, confused, powerless, depressed and hopeless. Kirkwood concluded: "Abuse, whether it was physical violence, sexual coercion or verbal attacks, had an impact at an emotional level which women described as deeply injurious" (p. 46). For this reason, it is important to consider verbal assault as a potentially traumatic occurrence and to

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investigate the development of PTSD as a response to emotionai, as well as physical, abuse.

Often, emotional abuse is reflected in the overburdened and unequal workload of many married women. Hochschild and Machung addressed this problem a decade ago in their book, The Second Shift: Working Parents and the Revolution at Home (1989). In this volume the authors reported on an in-depth study of 52 couples in which both spouses were employed and found that the women worked roughly 15 more hours each week than the men in housework and childcare. They wrote:

> More women than men kept track of doctor's appointments and arranged for kids' playmates to come over. More mothers than fathers worried about a child's Halloween costume or a birthday present for a school friend. They were more likely to think about their children while at work and to check in by phone with the baby sitter. (p. 24)

Married employed women with children routinely work "double days" by completing household and childcare duties after (and often before) work. They also usually have the onerous responsibility for the family's social engagements, holiday observations, extended family obligations and children's school activities. In fact, divorce often decreases, rather than increases, women's domestic responsibilities once they no longer have to attend to their husbands' and in-laws' needs. Benokraitis and Feagin (1995) reported that among the women they interviewed those who were divorced

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reported having considerably more time to pursue their own interests and spend more time with friends (p. 176).

Sexual harassment and women's mental health. In the workplace and at school, the phenomenon of sexual harassment has drawn the attention of researchers seeking evidence of harassment as a risk to women's mental health. According to Equal Employment Opportunity Commission Sex Discrimination Guidelines (1980, 1993), sexual harassment generally consists of sexual suggestions or jokes, constant leering or ogling, touching the body inappropriately, or propositions backed up with threats of loss of employment. It also includes creating an environment hostile to women, which may involve unwelcome sexual advances, making gestures or taunts, displaying obscene material, or threatening and intimidating women. Sexist treatment at school or the workplace is conceptualized as sexual harassment, even when there is no overt threat of loss of job or lowering of grades. The discomfort and intimidation a woman feels as the result of maltreatment that is based on gender falls within the legal definition of sexual harassment (Koss et al., 1994).

Unfortunately, sexual harassment at work or school is often ignored or dismissed as normal heterosexual flirting and seduction. Like other manifestations of sexism, it is so pervasive that it often remains invisible. Bernice Lott has written:

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> Sexual harassment is part of living in a sexist culture...in which women expect to be the targets of sexual jokes and innuendo as well as the receivers of positive sexual attention. Sexual harassment is deeply enmeshed in the relationships between women and men which we have been taught are natural. (1996, p. 231)

Nevertheless, women respond to this type of harassment with severe and long-lasting symptoms. Results of the U.S. Merit Systems 1981 and 1987 surveys of more than 23,000 federally employed women disclosed that thousands of female employees experienced a deterioration of their emotional or physical condition as a result of harassment. Several investigators report that women who experience sexual harassment exhibit symptoms which include nervousness, depression, headaches, lessened self-confidence, lowered self-esteem, fear, anger, anxiety, irritability, helplessness, vulnerability and poor sexual functioning (Crull, 1982; Gutek & Koss, 1993). Victims of sexual harassment suffer a pattern of psychological aftereffects that prompted researchers Gutek and Koss (1993) to argue for the utility of the general PTSD model as a framework for understanding the consequences of this form of abuse. Koss (1994) writes that workplace victims can exhibit a "postabuse syndrome" characterized by shock, emotional numbing, constriction of affect, flashbacks and signs of anxiety and depression (p. 141).

In 1992, the National Victims Center presented the first formal data concerning the relationship between harassment and both PTSD and depression. In their sample of

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3,020 women surveyed through a telephone interview, they found that women suffering from PTSD and depression were more likely to have been sexually harassed than those without these disorders. Respondents diagnosed as having PTSD or depression were more likely to report each of seven types of harassing behaviors than non-PTSD diagnosed working women (National Victims Center, 1992). Incidents of verbal assault, intimidation, humiliation, and exploitation were shown to produce PTSD symptoms similar to those experienced by victims of battering.

In 1997, a study of a sample of victims of workplace sexual harassment found that lifetime rates of PTSD were positively related to the harassment, and that sexual harassment remained a significant predictor of current PTSD when controlling for other sexual or physical assault (Dansky & Kilpatrick, 1997). A similar study, conducted on academic harassment, reported that the severity of sexually harassing behaviors experienced by female students was positively correlated with PTSD symptoms (McDermut, Haaga, & Kirk, 2000). Clearly, although most harassment is not physically abusive, these behaviors are a form of violence against women, differing from other forms mainly in venue rather than in essence.

Everyday Sexism

Extrapolating information from the foregoing material inevitably leads to the consideration of everyday acts of harassment, rudeness, exploitation and discrimination

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as potentially traumatic events for women. Benokraitis and Feagin (1995) have offered a succinct definition of sexism that emphasizes its pervasiveness in women's daily lives:

> Sex discrimination refers to the unequal and harmful treatment of people because of their sex (i.e., biological differences between males and females)... Broadly viewed, it is the socially organized set of attitudes and practices that deny women the opportunities, freedoms, and rewards that this society makes available to men. Modern sexism involves both anti-female prejudices and stereotypes and the power men have to implement them in the everyday practices of discrimination. (p. 39)

Until recently, sexism has been omitted as a topic of examination within the annals of studies on prejudice. In his bibliographic survey, John Duckitt (1992) reviewed the major American and British social scientific studies on prejudice and theories on its causes, development, and dynamics. However, although this treatise attempts to be inclusive in its sweep, the only prejudice being studied within these major tracts is racial prejudice. Prejudice against women has been largely ignored by those who study the phenomenon of prejudice, except by feminists committed to its exploration, and those writers and researchers are seldom included within mainstream studies. In her book, The Anatomy of Prejudices, Elisabeth Young-Bruehl writes, "Sexism helped rule sexism out of social scientific consideration" (1996, p. 111).

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For the past half-century, the standard for the study of prejudice was Gordon Allport's, The Nature of Prejudice (1954). This major work by an outstanding social psychologist and personality theorist examined the nature of prejudice—mainly the prejudice of White Protestants toward other ethnic and religious groups—as an outgrowth of man's irrational mind. (Discrimination toward women is mentioned once, when Allport explains that some "antifeminist" men consider females to be an "outgroup" [pp. 33-34].) Allport's thesis is that prejudice is a singular phenomenon with several manifestations, peculiar to certain personality types and supported by socio-cultural factors. Young-Bruehl refutes the idea that all prejudices are the same, and maintains that neither feminist studies of sexism nor queer studies of homophobia have been seriously discussed within official social science texts as the unique psychosocial disturbances that they represent. She advances the theory that they are qualitatively distinct from other forms of prejudice, more difficult to recognize, and therefore more persistent and debilitating (1996).

Young-Bruehl cites several reasons for the omission of sexism from social scientific study. For one, there has been a lack of research instrumentation for the study of discrimination toward women. She writes: "Asking about prejudice against women immediately raises the question—whom shall we ask? Just men? Men and women?...Shall we question people of different ethnic groups, racial groups,

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socioeconomic statuses? Gender distinction, that is, cuts across all the other in-group and out-groups distinctions" (1996, p. 115).

Also, consideration of sexism alters the prevailing thought that "all prejudice is one," and challenges the existing paradigm. Sexism is unique precisely because is crosses all ethnic, racial, religious, and even socioeconomic, groups. These intersections create new and complicated conflicts with other prejudices, alliances, and beliefs that cannot be explained by the traditional concepts of scapegoating, projection, or learning theory put forth by Allport in his explication. Women do not constitute a minority in society, are not generally members of an outgroup, and are often privileged. Few other victims of prejudice are chosen by their antagonists as wives, given economic support, treated as objects of desire, or used as symbols of the highest human aspirations. The difficulties inherent in conceptualizing and researching the subject of sexism, along with the tendency of a male-dominated scientific community to dismiss such study, has resulted in a dearth of material on the topic and a reluctance to enter into critical debate on its widespread effects.

The lack of the awareness of sexism within scientific study is a reflection of its absence from the general consciousness. Often, the maltreatment of women by men is perceived as a natural part of the human condition and unequal relations between men and women seen as a naturally occurring social condition. This attitude is encouraged not only by the universality of sexist behavior, but by the scientific community that promotes

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ideas of a sociobiological basis for the inequality of the sexes. (A recent publication of a study in the field of sociobiology purports that rape is a necessary activity in the evolutionary scheme [Thornhill & Palmer, 2000].). Bernice Lott suggests that the ideology of gender difference, as promoted in scientific and lay media, informs and encourages the social and interpersonal behavior of individuals in daily life (1997). This ideology supposes a dichotomy between the two sexes, each with an inherent set of characteristics determined by biological and cultural factors that govern their structure, cognition, affect and behavior. That these characteristics are presented as functionally unequal is often obscured by the overarching assumption that this presumed template is useful for the development and continuance of the human species.

The promotion of the idea that there are essential differences between males and females (the theory of essentialism) not only justifies the unequal, and often aggressive, treatment of women, but precludes any attempt to examine this treatment as wrongful. Lott (1997) proposes that this constant cataloging of gender differences, and ignoring of gender sameness, serves a "primarily political, not scientific, purpose as it rationalizes and perpetuates differences in power" (p. 282). Cynthia Fuchs Epstein also argues that although it is typical for men and women to be regarded as manifesting mutually exclusive behaviors and characteristics, these differences should be viewed as the result of biases and their consequences, rather than as an explanation for their maintenance (1997). She writes:

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> Women are certainly positioned differently than men in most societies, and may even exhibit patterned behavior that is associated with their gender, but it is questionable whether their nature accounts for such differences, or rather...they come from formal and informal social controls ranging from micro-interactions to formal policies. (1997, p. 261)

Regardless of the obstacles, it remains imperative for social scientists to direct research toward exposing and critiquing these social controls and the manner in which they affect the emotional and psychological, as well as economical, life of so many women.

Nancy Felipe Russo has designed a research agenda for the twenty-first century designed to combat the epidemic of mental illness experienced by women in our culture. She wrote, "Existing scientific knowledge is inadequate for understanding gender differences in the etiology, diagnosis, treatment, and prevention of mental disorder" (1995, p. 374). In addition to the study of the physical and sexual abuse of women, she has suggested that factors of everyday sexism must be considered when engaging in research in this arena. These factors include women's multiple roles, lower social status, poverty, stresses of womanhood, as well as sexual harassment.

Gender roles as everyday sexism. In her discussion of research on women's mental health, Vivian Makosky (1980) alluded to the underlying sexist structures that

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produce increased stress for women. She included abortion, rape, physical assault, changes in childcare arrangements, as well as incidents of sex discrimination, as items related to female stress. She added, "Separation, divorce, widowhood, and childbearing (among others), are more stressful events for women than men, because women are likely to suffer greater financial loss, are less likely to remarry, and are more likely to have care of the children, regardless of marital status" (p. 119). Rieker and Jankowski (1995) have discussed how "routine aspects of daily life sexism intersect with racial and cultural differences to shape women's experience, identity and psychological well-being" (p. 27). They asserted that to have an adequate understanding of female psychiatric patients, clinicians must obtain information about the "subtle alienation and stresses that women experience, but may not always recognize as they enact their roles as wives and parents" (p. 40).

Cheryl Rowe, a psychiatrist at the University of Toronto, also cited exposure to abuse, poverty, and powerlessness as factors that make more women than men vulnerable to stress-related mental disorders such as anxiety and panic (High Anxiety, 1994). Women are more likely to experience sexual harassment, sexual abuse, financial loss in divorce settlements, and lower income than men, psychologist Michael Yapko reported. These conditions leave women exposed to sources of stress that men do not face and thereby increase their mental health risks (Colino, 1999).

Studies on the linkages between women's roles and their mental health status

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indicate that role-related stressors, including multiple role strain, role overload, and role conflict, erode women's mental and physical health (D'Elio, Ness, Matthews, & Kuller, 1997; Gregory, 1999; Reifman, Biernat, & Land, 1991; Verbrugge, 1986; Waldron & Jacobs, 1989). Although more women are entering the workforce than ever before in American history, women's household and childcare duties have not decreased substantially (Benokraitis & Feagin, 1995; Faludi, 1991). The stress inherent in being a parent, a lower-paid employee, and homemaker can be psychologically injurious. Landrine & Klonoff (1997) comment that "(s)uch multiple roles can be overwhelming, requiring more time than anyone has, and the behavioral demands in one of these roles can and often do contradict those in another; problems with multiple roles occur for women rather than for men" (p. 68).

Studies in the field of women's mental health consistently report higher rates of depressive disorder for married rather than unmarried women (Weissman, 1987), Similarly, parents, rather than nonparents, suffer more depression; number of children is negatively related to female depression when other demographic characteristics are controlled (Russo & Zierk, 1992). For many women, family caretaking, including care of elderly parents, creates a constant sate of "planning and apprehension" (Rieker & Jankowski, 1995) that increases risk of psychological disorder as well (De Vault, 1991).

Women's experiences of reproductive experiences such as pregnancy, birth, perinatal loss, and menopause entail substantial stress as well. McGrath et al. (1990) state

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that since these life events are also used to justify women's disadvantaged social, economic and political status, they affect the lives of all women even those not directly experiencing the event. Women's subsequent reduced income and low socioeconomic status are major contributors to their mental health problems (Belle, 1990). In addition to the strains of poverty, poor women must cope with ill health, inadequate housing, crime, and unresponsive bureaucratic systems, resulting in chronic fear, frustration and powerlessness. In fact, one author suggests that interaction with social services departments may itself induce PTSD among welfare recipients (Gerdes, 1997).

Nancy Tomes has provided an analysis of the psychic costs of restrictive gender roles (1992). Her in-depth review of psychiatric care of women throughout the past two centuries led her to conclude that a fundamental link exists between women's experience of powerlessness and their emotional distress. Rieker and Jankowsi (1995) support the contention of Tomes, and others (Belle, 1990; Mirowsky & Ross, 1989a; Russo, 1995), that "it is not just gender or race per se but the demonstrable objective lack of power and resources and the consequences that follow from that condition which produce stress" (p. 37). Russo (1995) asserted that all women face issues of in inequality at home and pay inequity, occupational segregation, job discrimination, and sexual harassment at work, with women of color having additional burdens. Russo therefore has proposed adoption of a new perspective on women's mental health that includes recognition of stressful conditions that contribute to their psychological disorders. She welcomes the advent of

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stress theory as a conceptual framework, but cautions:

> ...its potential will not be fulfilled until the multiple realities of women's lives are fully investigated and reflected in research protocols and instruments. In particular, the impact of the pervasive physical and sexual abuse of women, effects of poverty, and problems associated with multiple roles must be more fully taken into account in research on the etiology, diagnosis, and treatment of mental disorder. (1995, p. 380)

Interpersonal sexism. Rieker and Jankowski (1995) defined sexism as the prejudicial evaluation of a person based on sex, and noted that it is most often used to describe the process of discrimination against women. They stated, "Sexism has institutional, cultural, interpersonal, and emotional dimensions and can be manifest in every form of behavior from subtle gestures and language to covert exploitation" (p. 27). They cite Burstow, who emphasizes that "what is especially insidious and psychologically destructive about sexism is its closeness" and the disguised ways it enters the personal sphere (p. 27).

Chester M. Pierce (1995) has observed that the most grievous offensive acts toward victims of both racism and sexism are what he terms "micro-aggressions," the subtle, daily wounds that accumulate within the minds and bodies of women and minorities. As he has written,

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> "These...innocuous... unconscious degradations, and putdowns, often kinetic but capable of being verbal and/or kinetic...may seem harmless, but the cumulative burden of a lifetime of micro-aggressions can theoretically contribute to decreased mortality, augmented morbidity, and flattened confidence" (p. 281).

For those coping with unrelenting oppression and discrimination, the development of adaptive techniques is necessary for survival. Yet, these very techniques—psychological, emotional, and behavioral—frequently become mental health symptoms that eventually necessitate treatment.

Pierce (1995) drew an analogy between racism/sexism and terrorism/torture, positing that both types of domination exist on one continuum and must be considered as closely related. He stated that in both situations, there are forces compelling people to do what they might not otherwise do. These forces may involve threats of physical harm as a response to noncompliance, thus the victim/survivor is challenged, often beyond available resources, to maintain "hope, options, self-esteem and group esteem" (p. 279). By controlling their victims' space, time, energy and motion, the oppressive agent diminishes the capacities of their subjects and removes feelings of support. This condition creates classic stress-related trauma in those affected. Pierce includes prisoners of war, homeless inner city men, and upper-middle-class mothers of newborns in his examples of tyrannized victims. In discussing the public health "menace" of both sexism

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and racism, Pierce stressed the importance of studying the relationships among these types of discrimination, oppression, trauma, stress, PTSD, and mental health symptoms.

In a study of racist, sexist and social class influences on health, Kreiger and her associates defined sexism as "an oppressive system of gender relations, justified by ideology, premised on the subordination of women by men" (1993, p. 89). Like racism, the beliefs and actions inherent in sexism are expressed and implemented in both overt and subtle forms, by institutions and individuals, rendering harm to its victims that largely goes undetected. They noted that the everyday expression of sexism in women's lives is pervasive, stating, "Women are routinely treated as sex objects, and face the daily harassment of street remarks, the fear of rape, and, for some, the threat or memories of sexual abuse and domestic violence" (Krieger et al., p. 90). And, they added, like racism, sexism in its daily form is rarely studied as a determinant of women's well-being.

However, several theorists and researchers now recognize the detrimental effects of everyday sexism and have begun to create conceptual and empirical bases for understanding its impact on women. Melissa Monson (1997) has investigated women's "everyday experience" of sexual harassment that is not brought to the attention of authorities, but which causes discomfort and unhappiness at the workplace (p. 138). Robinson interviewed interracial Lesbian couples to explore the impact of heterosexism in their "everyday life" (1997, p. 47), and St. Jean and Feagin researched black women's experiences with "subtle racism" and "subtle sexism" that impact on a daily basis (1997,

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p. 185). Similar studies have been done on "the gender gap" in the court system (Schafran, 1997), the "chilly climate" for women in academe (Hall & Sandler, 1982), "male domination" on the Internet (Cook & Stambaugh, 1997, p. 67) and "unintentional discrimination" against Latinas (Bento, 1997, p. 95). Collectively, these studies examined common occasions of sex discrimination that are usually legal, and often invisible, but which effectively serve to reinforce women's secondary status and create roles that limit and distort their life experiences.

Although the psychological effects of discrimination may vary according to social and economic factors, Lott and Rocchio write that "(h)igh status in income, education, or employment appears not to protect a women from being the target of either subtle or obvious sexist behavior" (1997, p. 149). A study of female professors found that one third reported sexist comments from male students (Grauerholz, 1989), and a study of female attorneys found that two thirds reported being inappropriately addressed, or on the receiving end of sexual remarks, by other attorneys, clients or judges (Rosenberg, Perlstadt, & Phillips, 1993). Lee, Marks, and Byrd (1994) found that boys dominated class discussions in private schools, often at the bequest of their teachers, and fraternity "little sister" in five universities received consistent treatment requiring them to be subservient and dependent (Stombler & Martin, 1994). Studies of female police officers, firefighters, and postal workers revealed that generally "women face a hostile working environment filled with sexual propositions, pornographic material, and cursing" (Martin,

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1994; Yoder & Aniakudo, 1995).

At the 15th annual meeting of the International Society for Traumatic Stress Studies (Miami, FL, November, 1999) Vivero and Jenkins presented a paper in which they suggested that suffering discrimination and oppression due to one's minority status in any identity dimension (race, ethnicity, sexual orientation, or gender) affects individuals' self-esteem and ability to trust. They argued that although racism, sexism and homophobia are seldom studied from a traumatic model perspective, they may be traumatic because they violate interpersonal relationships, interrupt individuals' attachment to their reference group, and create feelings of powerlessness and betrayal that can cause psychological injury similar to other traumatic events. They asserted that having a disadvantaged status in several self-identity dimensions may increase vulnerability to traumatic stress response due to cumulative experiences of discrimination.

Nijole Benokraitis (1997) offered a tripartite typology of sex discrimination that is useful for researchers. She defined sex discrimination as the unequal and harmful treatment of people because of their sex, i.e., their biological differences. Although she acknowledged that men also face discrimination, she presented data to support the belief that sex discrimination in the United States is overwhelmingly a "woman's problem" (p. 6). The typology she designed presents sex discrimination as varying events along a continuum in terms of visibility, intent and remedies. Blatant sex discrimination refers to

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harmful treatment of women that is intentional, visible and easily documented. This category includes physical and sexual violence, sexual harassment, jokes and language. Subtle sex discrimination is often not noticed because most people have internalized it as the norm, and is therefore difficult to document. This may include exclusion, chivalrous behavior, exploitation, objectification, and humor. Covert sex discrimination refers to treatment of women that is hidden, purposeful and often maliciously motivated; some of the most common forms are tokenism, manipulation and sabotage (pp. 7-13).

When Benokraitis' formulation is compared with Root's (1992) paradigm of trauma, a new construction can be created in which sexist events become a continuum that can be matched to the trauma continuum:

Blatant Sexism	—	Direct Trauma
Subtle Sexism	—	Indirect Trauma
Covert Sexism	—	Insidious Trauma

Of course, it is difficult to separate direct, indirect and insidious traumata; they intersect and overlap in multiple ways in society and in interpersonal interactions. For example, wife battering is both a direct assault and an indirect threat to those who witness the assault, potentially creating both direct and indirect traumas. In addition, those who treat or study wife battering may suffer the insidious trauma of vicarious assault, and all women suffer the insidious effects of identification with female victims. Similarly, it is difficult to separate brutal sexism from everyday sexism, since acts of violence,

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threatening behavior, veiled hostility, and the indirect traumatization which occurs by being a member of an oppressed group are hard to differentiate. As Koss (1994) stated, "Acts of violence are everyday events in women's lives, touching even the existence of women who do not experience violence directly" (p. 231).

Landrine and Klonoff attempted to create similar distinctions in the introduction to their study of discrimination against women (1997). They differentiated institutional discrimination—such as pay inequity, unfair hiring practices, inequity in health services, and social devaluation—from personal experiences of discrimination. Within the latter category, they differentiated further between the more "blatant" sexist acts against women, such as battering, rape and sexual harassment, and the "subtle" acts, i.e., "the daily ongoing petty acts of discrimination—being ignored, treated as if they are stupid, excluded, ridiculed, called names, and treated in an unfair way by their families, lovers, employers, and coworkers alike" (p.17).

Landrine and Klonoff contended that although there are numerous studies that indicate that brutal sexist acts such as sexual abuse and battering harm an individual's psyche, it is nonviolent sexism that most women will experience over a lifetime. These daily incidents therefore should be recognized as having the potential of creating widespread impact within a large segment of the female population. In Discrimination Against Women (1997), they wrote that two general types of gender-specific stressful life events have been investigated and have been clearly demonstrated to erode women's

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physical and mental health: role-related stressors and brutal, physical gender-specific stressors (p. 68). However, they believe that attempts to understand stress-related symptoms among women without acknowledging the impact of ongoing sexism are limited and inadequate. For this reason, their research on the impact of sexism on women's physical and mental health focused on the "more global sexist discrimination" which inform women's lives (Klonoff & Landrine, 1995, p. 445).

Landrine and Klonoff's work is important in several ways. Critically, their study was the first, and to date the only, examination of the physical or mental health impact of everyday sexism. By conceptualizing discrimination against women as a gender-specific type of stressful event, they brought the issue of sexism into the mainstream of scientific research that examines the impact of stress on people's physical and mental health. They accomplished an important task for researchers when they formulated the Schedule of Sexist Events (SSE; Klonoff & Landrine, 1995), a quantitative measurement of women's subjective experience of sexism. The questions posed on the SSE were based on commentary from 120 women polled by the authors in 1995. They asked the women to report "the worst thing that has ever happened to or been done to you because you are a woman" (1997, p. 12). The responses included instances of being beaten, harassed, molested or raped. But the majority of the answers were subtle acts of discrimination common to most women: being treated as if they were stupid, being treated with a lack of respect, being ignored, ridiculed, discredited, being ripped-off by people in service jobs,

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being discriminated against in public places (banks, restaurants), and being called sexist names like "bitch," "cunt," "whore" (1997, p. 15). The SSE was designed to identify these pernicious instances of abuse that are often undetected, as well as more the obvious assaults against women.

In the construction of the SSE, Klonoff and Landrine defined sexism in terms of "sexist events," and operationalized that term by measuring actions in the home, workplace and society that were deemed hurtful to women. These included listening to sexist jokes, being called sexist names, being sexually harassed, being treated disrespectfully, being discriminated against by strangers, colleagues and family, and being picked on, hit, shoved or threatened because one is a woman. Also, they demarcated events as being frequent or infrequent, recent or past, thereby creating a useful design for concrete measurement of a subjective construct.

Using the Schedule of Sexist Events, Landrine and Klonoff (and their associates) effectively demonstrated that daily sexist events in a woman's life have a negative impact on several physical and mental health symptoms, above and beyond that caused by non-gendered stressful events (Landrine, Klonoff, Gibbs, Manning, & Lund, 1995). It had long been demonstrated that stressful life events and cumulative life stress can cause a variety of psychological symptoms (Belle, 1990; Henry, 1990; Kanner et al., 1981; Russo & Green, 1993). Landrine and Klonoff (1997) hypothesized that sexist stress would be an even stronger determinant of psychological distress than generic stress, due to its highly

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personal nature. They suggested that sexist stress is inherently demeaning, degrading, and offensive because it is directed at something essential about the self that cannot be changed—gender. In addition, women have less control over sexist events, as opposed to other stressful life events such as moving or finding a job, and this lack of control might contribute to psychological distress (p. 27).

Landrine et al. (1995) tested this hypothesis and found positive results with a sample of 631 women. Participants were given two scales measuring generic stressors, both major and minor: the PERI-Life Events Scale (Dohrenwend, Krasnoff, Askenasy, & Dohrenwend, 1978) and the Hassles Frequency Scale (Kanner, Coyne, Schaffer, & Lazarus (1981), along with the SSE. They were also administered three measurements of psychiatric symptoms: the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961), the Hopkins Symptom Checklist (HSC; Derogatis, Lipman, Rickles, Uhlenhuth, & Covi, 1974) and the Speilberger State-Trait Anxiety Inventory (STAI; Speilberger, Gorsuch, & Lushene, 1970). By running several stepwise multiple regressions on women's psychiatric symptom measures, they found that:

> Experiences with sexist discrimination [lifetime and recent] were the single best predictor of women's total...psychiatric symptoms, somatic symptoms, obsessive-compulsive symptoms, interpersonal sensitivity symptoms...and they were the best predictor of women's depressive symptoms and anxiety symptoms as well, depending on how the latter two

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> were measured. Scores on the SSE scales were better predictors of women's symptoms than were scores on generic stress scales for the majority (7 out of 10) of the types and measures of symptoms. Sexist stress thus appears to be a more powerful variable contributing to women's symptoms than generic stress. (p. 73-74)

With a second sample of 652 women, Landrine and Klonoff (1997) administered the SSE along with the BDI, the HSCL, and the Center for Epidemiological Studies Depression scale (CES-D; Radloff, 1977). Within this sample, the frequency of sexist events, rather than participants' appraisal of the events, best predicted women's psychiatric symptoms. These results imply that the amount of sexist discrimination in a woman's life significantly increases the ability to predict and explain her psychological symptoms. The authors concluded that all women living in a sexist culture are at greater risk than males for having this additional damage to their health and emotional well-being.

Summary

The preceding review reveals several lacunae in the literature related to women's mental health. Although there is much evidence regarding the traumatic impact of gender-related assault upon women, few studies examine the impact of nonviolent sexist events on women's mental health. Trauma is rarely presented as a dimensional construct

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extending beyond abusive or assaultive behavior. Therefore, the Criterion A events selected as qualifying events for the development of PTSD limit the investigation of trauma which results from structural violence, systemic abuses, and everyday discrimination.

The accumulated research revealed that PTSD is associated with a range of mental disorders common to women, including both Axis I and Axis II diagnoses. In order to effectively examine the differential rates of mental disorder between men and women, it is necessary to investigate the multiple ways that trauma is impacting on women's lives. The recognition of sexism as traumatagenic allows researchers and theoreticians to investigate oppression as an exogenous contributor to a variety of mental illnesses.

The current research regarding the disparity of PTSD rates between men and women continues to ignore the influence of the daily living experience of women and the potentially traumatic impact of subtle and covert sexism. Several theoretical explanations for the gender difference in PTSD diagnoses failed to be substantiated in the research; studies failed to show either pre-existing conditions among women, or higher incidence of trauma in their lives. The search for traumatagenic forces that impact on women needs to be extended to the everyday interactions that create widespread distress.

Several researchers have called for expansion of the criteria for the diagnosis of PTSD. Often, patients exhibit a full range of symptoms without meeting Criterion A

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(experiencing or witnessing an event outside the range of usual human experience, with concomitant feelings of intense fear, helplessness or horror). The addition of nonviolent sexism as a Criterion A event would expand the PTSD definition toward inclusion of chronic and static stressors. This would encourage greater flexibility in researching similar chronic oppressions as traumatic experiences for additional populations.

The one study on the role of everyday sexism on the mental health of women, conducted by Klonoff and Landrine (1995) was limited by the use of traditional psychiatric testing instruments rather than trauma measurements. This choice eliminated the application of trauma theory, which can provide a cohesive framework for understanding and evaluating the physiological, affective, cognitive and behavioral responses that result from exposure to oppressive situations.

The present study attempts to address the gender imbalance in the distribution of mental illness in general, and PTSD in particular, by examining the traumatic influence of sexist events in women's lives. These events range from single, acute occurrences to pervasive, chronic stressors that may impact negatively on women in subtle but profound ways. This study extends Klonoff and Landrine's concepts to include trauma theory and instrumentation in order to appropriately assess the presence and frequency of traumatic events that occur in women's everyday lives.

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Chapter IV - Goals and Rationale

Research Premises

PTSD has been shown to manifest as a psychological disorder with varied symptoms, including intrusive experiences, angry outbursts, anxiety, hypervigilance, dissociation, somatization, emotional numbing, and depression. In addition, PTSD is often comorbid with associated disorders such as panic disorder, phobias, obsessive-compulsive disorder and substance-related disorders (APA, 1994; Friedman, 1997; Kessler et al., 1995; Lipschitz, 2000). The underlying premise of the present study is that PTSD, which occurs in women at rates twice those of men, is a contributory factor to the high rates of female mental illness.

As noted earlier, researchers have failed to determine a rationale for the disproportionate of female-to-male PTSD rates that prevail under all circumstances. It is, therefore, important to consider what aspects of gender may be responsible for this disproportion. Following the suggestion of Kimerling (1999), this study examined those variables that are associated with female gender that may account for differences in trauma rates, such as the social context in which women live. Resick also has suggested that researchers examine whether the sex differential in PTSD is determined by biological, cognitive, historical, or cultural aspects of women's lives (Kimerling, 1999). Since a major aspect of social culture is the sexist treatment of women, the present study

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explored the role of everyday sexism as a contributor to PTSD rates in women.

It is a formidable task to evaluate the extent to which oppressive forces affect the mental health problems of women. It is equally difficult to establish direct linkages between social conditions and the symptoms presented for treatment, or to conceptualize how oppression "gets into the body," especially via the more commonplace and diffuse expressions of discrimination (Kreiger et al., 1993, p. 100). In fact, the present literature search produced only one study that attempts to demonstrate the influence of everyday sexism on the mental health of women, and that study, conducted by Landrine and Klonoff (1997), does not fully explain the transformation of discrimination into symptoms. Nevertheless, their study produced compelling results: 99% of the women tested experienced some type of sexist discrimination in their lifetimes, 97% in the year prior to the study; sexist events accounted for a statistically significant and large percentage (up to 46%) of the variance in respondents' mental health symptoms, as measured by standardized tests; and the strength of the relationship between sexist events and symptoms varied with a woman's ethnicity and feminism, being greater for minority and nonfeminist women (p. 122).

This was the first empirical study of the impact of daily life sexism on women's mental health symptoms, and therefore an important addition to the canon of scientific work in the area of stress studies. However, Landrine and Klonoff limited the effectiveness of their study by relying on traditional diagnostic instruments to determine

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the detrimental effects of sexism on women's mental health. These instruments were designed to measure diagnostic categories that have been criticized for being socially constructed concepts that reflect biases and assumptions within the culture (Kaplan, 1983; Brown, 1990; Loring & Powell, 1988; Sprock, Blashfield, & Smith, 1990; Stoppard, 1991; Warner, 1978). Critics of this diagnostic taxonomy suggest that it tends to hinder rather than promote understanding of people struggling with disturbing symptoms because it reduces behaviors to a standard contaminated by stereotypical attitudes regarding gender differences (Caplan, 1995; Mirowsky & Ross, 1989).

Landrine and Klonoff's (1997) use of traditional testing measurements produced standard diagnoses for their participants that did not explain the plethora of symptoms exhibited. The tests revealed diagnoses of depression, anxiety, obsessive-compulsive disorder, interpersonal sensitivity (feelings of inferiority and inadequacy, low self-esteem) and somatic symptoms (p. 73), without providing a unifying conceptualization of their etiology. Once again women received labels that neither described the circumstances of their lives nor provided a rationale for their behavior. Within these diagnoses there is no mention of physiological factors which may be responsible for the symptoms, or an explanation of symptoms as feasible coping mechanisms. There is only a diagnostic label that often directs treatment toward exploration of a woman's intrapsychic dynamic or toward use of psychotropic medication for relief of symptoms. By concluding that victims of sexism are prone to suffer from "anxiety," "depression,"

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and “somatization,” Landrine and Klonoff directed the treatment options for these women toward therapies that may overlook the traumatic basis for their disorder and focus instead on intrapsychic examination or psychotropic medication, while trauma-focused therapies may be more effective.

In addition, Landrine and Klonoff's (1997) explanation of the causative relationship between daily life stress and women’s mental health problems is incomplete and unsatisfying. They stated that both major and minor stressful life events such as daily hassles suppress immune functions in human beings, a finding that many studies have produced and corroborated. They also stated that “depression is one of the major mechanisms through which stress compromises immune function: Stressful life events affect the psyche by creating depression and both mild and severe depression cause immuno-suppression, which then renders people vulnerable to invading viruses” (p. 24). This explanation may produce useful insights into how people become physically ill, but Landrine and Klonoff failed to provide a theoretical rationale for the development of psychiatric symptomatology as a stress response.

The present study attempts to remedy the deficits in the Landrine and Klonoff's study by determining the correlations between women’s experience of sexism and PTSD, using the Trauma Symptom Inventory (TSI; Briere, 1995) as a measuring instrument. It has been the introduction of biophysical information on how the brain responds to traumatic stress and the development of trauma theory and that has produced the most

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comprehensive explanation of the "victim-to-patient" process (Carmen, Rieker, & Mills, 1984). PTSD offers a comprehensive and logical explanatory theory for women's mental health symptoms as a response to the chronic, often traumatic, stress that results from being victimized. It also validates women's experience as survivors of assault and directs the clinical treatment of those who suffer the psychological consequences of sexism toward appropriate and meaningful exploration of life events (Brady, 1997; Foa, 1997; Friedman, 1997; Herman, 1997, Waites, 1993).

The present study seeks to demonstrate that everyday sexism is a chronic traumatic stressor and its sequelae are likely to be trauma-related symptoms, which should be recognized and treated as such. The goal of the study is to examine the relationship between the types of everyday sexism experienced by women and the possible traumatic effects that are expressed via symptoms. The larger goal of the study is to support the contention that the prevalence of sexism that is woven into the fabric of our patriarchal system may be the genesis of the epidemic of observed mental disorders in American women.

Everyday sexism. As discussed earlier, Benokraitis and Feagin have created a comprehensive paradigm that describes the various manifestations of blatant, subtle, and covert discrimination against women. In their book, Modern Sexism (1995), they reminded readers that everyday sexism is being ignored by the general public although

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this quotidian discrimination is part of a system that encourages and reinforces sex inequality. They wrote, "Whether intentional or unintentional, the values, attitudes, and behaviors due to sex discrimination are harmful not only to women and men as individuals, but also to such basic institutions as the family, the economy, education, health, housing, religion, and the legal and political systems" (p. viii). Sexism is not just an individual pathology, albeit one shared by most men, it is a social pathology that serves the goals of an entrenched patriarchy.

Benokraitis and Feagin (1995) stated that blatant sexism that includes violence and abuse is often documented and its effects quantifiable, while subtle and covert sexism are more difficult to observe. The authors asserted that subtle sex discrimination is the result of the internalized belief that women are inferior to men. It is often not noticed because "most people have internalized (it) as 'normal,' 'natural,' or customary (p. 41)...It has been built into norms, values and ideologies and is usually informal rather than formal" (p. 82). Some of the ways that women experience subtle sexism are via condescension, stereotyping, exploitation, demeaning flattery, objectification, isolation, humor, and exclusion. Covert sexism refers to the unequal and harmful treatment of women that is hidden, clandestine, and maliciously motivated. Some aspects of covert sexism which Benokraitis and Feagin presented are tokenism, containment, manipulation, sabotage, revenge and co-optation. The authors suggested that to eliminate all forms of sexism, the first step is to expose it (p. ix). The dissemination of this survey on the

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subjective experience of sexism—and the resultant discussion—is an attempt to expose its manifestation in everyday life.

The Schedule of Sexist Events (SSE; Klonoff & Landrine, 1995) is an effective instrument for the measurement of chronic, nonviolent, everyday sexism. It provides a descriptive language for women coping with sexism in their environments and offers a unifying concept for the myriad of negative male-to-female behaviors that occur repeatedly in women's lives; most questions are framed with the words *because you are a woman* (e. g., "How many times have you been treated unfairly by strangers *because you are a woman*"?). By constructing the SSE with this language, Klonoff and Landrine have chosen to make explicit that which is often implicit, and often denied by the larger culture: that much of male behavior toward women is determined by sexist perceptions of gender.

The SSE is important, too, because it places everyday acts of rudeness, exclusion, and disrespect on a continuum with being abused, either verbally or physically. It thus implies that sexism has protean manifestations, including the minute interactions that are practiced unconsciously. Only one question pertains to the occurrence of violence ("How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm *because you are a woman*?"). The remainder ask respondents to enumerate acts of disrespect, discrimination and unfairness perpetrated by teachers, employers, neighbors, physicians, service workers, strangers and family members.

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The SSE presents specific, common acts in ordinary circumstances as a way of operationalizing everyday sexism. The SSE delineates the multiple and cumulative ways this behavior structures and maintains a sexist society, thus supporting the view that this society is an ongoing social construction, rather than a natural result of biological determinants. Researchers are just beginning to recognize the subtle means by which daily sexism operates as a subordinating force; this instrument is a means of quantifying the less obvious interactions that hold a patriarchal system in place.

Gender-related stressors. Russo (1995) has written that violence, poverty and multiple roles all contribute to elevated levels of mental disorder in women. However, she notes that studies on women's mental health stressors have typically used event checklists that fail to include many events associated with common experiences for women, particularly those related to violence and poverty. For example the 60-item Life Experiences Survey (Sarason, Johnson, & Siegel, 1978; Turner & Avison, 1989) has no questions asking if a person has experienced forced intercourse, physical or verbal violence, sexual or racial harassment or discrimination, or tokenism (Russo, 1995, p. 380). This is a serious omission, considering that economic and social deprivation may decrease women's coping skills, leaving them vulnerable to mental disorder. Wolfe and Kimerling (1997) note that the current methodology utilized in studies of PTSD among women fails to evaluate "role-related, social/contextual, and symbolic or connotative

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factors associated with prominent stressors for women" (p. 217).

For these reasons, a Gender-related Stressors Questionnaire (GRS) designed to assess these factors was created for the present survey. The GRS checklist includes questions regarding the occasions of sexual, physical, and verbal abuse in women's lives ("Were you ever abused or physically attacked by someone you knew...?"). In addition, it asks participants to enumerate the structural conditions of their lives ("Are you responsible for childcare and household duties in addition to employment?") and the ways their gender has limited their life experiences ("Have you been prevented from continuing your education/career because you are a woman?"). These structural abuses against women are often ignored because they seem ordinary and normal. Nevertheless, as Wolfe and Kimerling (1997) suggest, information regarding the interaction between more general stress and PTSD may provide data on the relationship of gender to this disorder.

Research on the traumatagenic effects of blatant sexism against women have succeeded in helping the psychiatric community identify and treat the resultant mental health syndromes. However, for most women subtle and covert sexism are more prevalent in their lives and therefore more important as formative experiences. The present study seeks to substantiate the contention that the incessant encounter with injustice and inequality, as expressed in everyday acts, contributes to alterations of a woman's brain and mind that are similar to those created by violent assaults.

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Analogue Studies

There are several studies in the realm of racism and its consequent effects on the physical and mental health of African Americans that inform the present study on sexism. Kreiger and her associates, in a major review of the literature on racism and health, concluded that "both subtle and overt forms of racism...can invalidate people's sense of self-worth and lead to internalized oppression." Specifically, they stated that "everyday aspects of racism adversely affect health." They explained, "These daily realities of racism could, for instance, act as chronic stressors and block aspirations,...shape the content of 'life events'...and limit the range of feasible responses to problems" (1993, p. 88). Kreiger et al. cited emerging information that implicates racial discrimination, rather than economic conditions among minorities, as the major contributor to hypertension among African American males and pre-term delivery among African American females.

In her study of depression among low-income Black women, Belle (1990) found that financial stress, as well as lack of access to housing and safe neighborhoods, had a pronounced negative effect on symptoms. She concluded that there were important interactions between social context and demographic characteristics that affect the course of psychological illness among women of color.

In 1996, Landrine and Klonoff developed the Schedule of Racist Events, a measurement of both physical and mental health consequences of racism. They used this scale to produce one of the few studies on the negative health impact of racial

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discrimination on its victims. Moritsugu and Sue (cited in Turner & Kramer, 1995) demonstrated that minority status alone is a source of stress, apart from explanations based on economic class. Harrell, cited in Shapiro (1997), also found significant relationships between incidence of racism and overall life stress, psychological distress, and trauma-related symptoms. Fields et al. have studied the detrimental impact of daily acts of racism on anger among African American women of all classes and emphasized that the discriminatory treatment described in their study "was an everyday occurrence, not an episodic aberration" (1998, p. 368). They cited Williams and Jackson as having deemed everyday discrimination as more detrimental to mental and physical health than time-limited incidents of major discrimination.

The common constructions of racism and sexism present similar problems to their victims. Among these are attacks upon the very nature of one's personhood, assaults to one's inherent self-worth, and chronic humiliation and devaluation via multiple personal and institutional sources. The constant need to defend against hostility, gauge one's responses, and maintain self-respect is an ongoing source of stress, often leading to trauma. Pierce (1995) has written that the problems of racism and sexism are "daily, regular, and ceaseless" (p. 279) and concluded that the effects of "(r)acism and sexism are stress-related public health illness" (p. 282). The present study attempts to illuminate these processes by demonstrating a relationship between the experience of sexism and PTSD symptoms among women.

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Chapter V – Research Design

This chapter states the research problem, describes the instruments used in the study, defines the variables, and presents the hypotheses. It also outlines the research design, including method, data collection, data analysis and limitations of the study.

Statement of the Problem

Theoretical understanding of women's mental illness is generally derived from psychological theories that emphasize intrapsychic, familial, or interpersonal determinants, rather than societal structures. However, recent information on post-traumatic stress disorder has helped mental health theoreticians and practitioners recognize the traumatic effects of gender-based violence as a major contributor to the mental disorders of women, thereby expanding our understanding of the role of sexist abuse as an etiological factor. Nevertheless, little attention has been given to whether everyday nonviolent occurrences of sexism, as expressed in sexist treatment of women, can produce mental health trauma in women as well. In order to address this concern, this study examines the relationship between sexism/gender-related stress and PTSD symptoms within a selected sample of women.

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Instrumentation and Definitions

In order to explore the role of sexism as a factor in PTSD among women, two testing instruments were administered to a sample of women: the Schedule of Sexist Events (Klonoff & Landrine, 1995) to measure the independent variable of sexism, and the Trauma Symptom Inventory (Briere, 1995) to measure the dependent variable of PTSD symptoms. In addition, a measure of Gender-Related Stressors provided information on role burdens and stressors that may also contribute to PTSD in women.

Definition of Terms

Sexism is defined by Kreiger et al. (1993) as an oppressive system of gender relations, justified by ideology, premised on the subordination of women by men. They write, "(L)ike racism, sexism involves harmful and degrading beliefs and actions expressed and implemented in both overt and subtle forms by institutions and by individuals, as linked to their membership in gender-defined groups" (p. 89). Sexism, as conceptualized by Landrine and Klonoff (1997), is evidenced by sexist events against women. These sexist events are discriminatory acts that happen to women because they are women.

Gender-related stressors, as defined by Wolfe and Kimerling (1997), are those negative life events specifically linked to women via their gender-related roles in society, or having greater impact on women than men. They cite Verbrugge, whose 1985 study

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found that recurrent exposure to daily, negative life events reliably affected women's mood states (p. 219). Gender-related stressors, as measured on this questionnaire, include family problems, caretaking burdens, reproductive functions, financial difficulties, and exposure to violence.

PTSD symptoms, as measured by the Trauma Symptom Inventory, conform to the PTSD symptoms outlined in the DSM-IV (See Appendix A). The DSM-IV (1994, p. 424) states that the "characteristic symptoms resulting from [PTSD] include persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal...The full symptom picture must be present for more than 1 month and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."

Instruments

Schedule of Sexist Events (SSE). This instrument was modeled on those used to measure generic stress by quantifying life-events that are deemed stressful, such as the Psychiatric Epidemiology Research Interview-Life Events Scale (PERI-LES; Dohrenwend, Krasnoff, Askenasy, & Dohrenwend, 1978). The SSE authors conceptualized sexist discrimination as the occurrence of gender specific negative life events, or gender-specific stressors. These events can be measured in a similar manner

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to the PERI-LES, i.e., via subjective estimation of their frequency and duration (Klonoff and Landrine, 1995).

Although many studies have attested to widespread institutional discrimination against women in health care, employment opportunities, salaries, education and media representation, Landrine and Klonoff (1997) found that when surveyed, most women listed daily, interpersonal sexist acts as the most disturbing discriminatory events. Therefore, when designing their Schedule of Sexist Events, they focused on these nonviolent everyday occurrences in the development of their questions.

The SSE is a self-report inventory consisting of 20 items rated on a scale that ranges from 1 (the event never happened) to 6 (the event happens almost all of the time). The 20 questions assess the frequency with which a woman has experienced sexist events of various types in a diversity of settings, ranging from discrimination at work to abuse at home. Each item in the SSE is completed twice, once for the frequency of the event in the woman's entire life, and once for the frequency of the event in the past year (Landrine & Klonoff, 1997, p. 32). These two dimensions can be treated as separate scales, SSE-Lifetime and SSE-Recent. The questions on the SSE are grouped into four categories: Sexist Degradation and its Consequences (SD), Sexism in Distant Relationships (DR), Sexist Discrimination in the Workplace (WK), and Sexism in Close Relationships (CR), along two dimensions: Lifetime and Recent, i.e., within the previous year (see Appendix B).

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A factor analysis demonstrated high internal reliability for each of the above scales, as well as their factors. The total Cronbach's alpha for SSE-Lifetime was .92; that of SSE-Recent was .90. Split-half reliability for the SSE-Lifetime and SSE-Recent were r=.87 and r=.83, respectively (p=.0005 for both). Although test-retest reliability may be confounded by the occurrence of a recent sexist event, tests reissued to a small group within two weeks produced an acceptable reliability score of .70 for the SSE-Lifetime and .63 for SSE-Recent (Landrine & Klonoff, 1997, p. 45).

To ascertain validity, SSE scores were compared to those of similar stress measurements, such as the PERI-LES (Dohrenwend, Krasnoff, Askenasy & Dohrenwend, 1978) and the Hassles-Freq (Kanner, Coyne, Schaefer & Lazarus, 1981) scales, two traditional stress-measuring instruments with a long history of use within the scientific community. While correlations among the three tests were low, the SSE correlated with the two well-known measures of stressful events as well as they did with each other. The scores were r=.32 comparing the two standard measurements, and r=.27 for SSE and PERI-LES and r=.24 for the SSE and Hassles-Freq scale, (p=.0005 for all; Landrine & Klonoff, 1997, p. 46-47). When all three stress tests were administered in conjunction with measurements for psychiatric and physical symptoms the findings revealed that overall, the SSE scores were "much better predictors (of symptoms among women) than scores on the two generic stress inventories" (p. 103), therefore demonstrating its concurrent validity.

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In fact, in testing the SSE against both PERI-LES and Hassles-Freq scales as predictors of women's mental health scores on the Hopkins Symptom Checklist (HSCL), a standard mental health measurement, Landrine and Klonoff report that SSE-Lifetime was the single best (and only) predictor of women's total psychiatric/somatic symptoms, accounting for 16.65% of the variance in scores (1997, pp.71-73). The single best predictor of women's obsessive-compulsive symptoms, as measured by that subscale of HSCL, was SSE-Recent, the only predictor selected in a stepwise multiple regression, accounting for 10.24% of the variance. The best predictor of women's interpersonal sensitivity symptoms, for example, feelings of inferiority, inadequacy and low self-esteem, as measured on that subscale of the HSCL, was SSE-Recent, which alone accounted for 12.19% of the variance. The single best predictor of women's symptoms of depression, measured by that subscale of the HSCL, was SSE-Recent, the only predictor selected, accounting for 12.65% of the variance. Also, the single best predictor of women's symptoms of anxiety, as measured by that subscale of the HSCL, was SSE-Lifetime, the only predictor selected, accounting for 13.14% of the variance. The authors conclude that scores on the SSE scales were better predictors of women's mental health symptoms than were scores on generic stress scales for the majority (7 of 10) of the types and measures of symptoms (p. 74).

The scale has been made available for reproduction for research purposes by the authors (Klonoff, personal communication, 5/10/99).

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Gender-Related Stressors Questionnaire (GRS). In order to explore the potential traumatic impact of gender-related stressors in women's lives, 22 questions were added to this survey that pertain to common events that have particular influence on women due to their assigned cultural roles (Appendix D). These questions are based on the Life Stressor Checklist – Revised, (LSC-R) created by Wolfe, Kimerling, Brown, Chrestment and Levin in order to explore the specific stresses resulting from the cultural expectations and role burdens of women—items often overlooked by trauma researchers (Wolfe & Kimerling, 1997). Wolfe et al. created this questionnaire because of their belief that existing instrumentation does not identify these salient concerns for women and thereby distorts research findings (p. 192).

The items included in the LSC-R , adapted here as the Gender-related Stressors (GRS) questionnaire, were designed to fill the gap in the existing literature on PTSD and women. The authors state that the "relative paucity of testable hypotheses as to how female gender is conceptualized as a 'risk' factor' for PTSD" and the lack of "gender correlates...that permit empirical testing of a vulnerability construct for this disorder" stimulated the construction of the LSC-R (p. 218). They encouraged use of this model to create an "operational model involving gender that explicitly specifies parameters associated with women's differential risk" (p. 218). The data collected from the Gender-related Stressors questionnaire is considered exploratory, since the instrument on which

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the questions are based has not been tested for psychometric properties (Wolfe, personal communication, 4/20/99).

Trauma Symptom Inventory (TSI). The TSI was developed by Briere (1995) for both clinical and research use (see Appendix C). It is designed to measure the frequency of the various symptoms subsumed under the diagnosis of PTSD in the DSM-IV (1994). These include re-experiencing of the traumatic event (e. g., flashbacks, nightmares, intrusive memories), numbing of general responsiveness, avoidance of events or stimuli reminiscent of the trauma, and persistent symptoms of autonomic arousal (e. g., heightened startle response, sleep disturbance, poor concentration; Briere, 1995).

The ten clinical subscales of the TSI were designed to assess a wide range of psychological effects that include not only symptoms associated with PTSD and Acute Stress Disorder (ASD), but also those intra- and interpersonal difficulties often associated with more chronic psychological trauma (Briere, Elliott, Harris, & Cotman, 1995). This design was a response to the suggestion of several researchers in the trauma field to broaden the view of post-traumatic disturbance to include symptoms beyond those designated in the DSM (Herman, 1992; Hilberman, 1980; Koss & Harvey, 1991). Most relevant in this regard are victimization-related anger, depression, dissociation, sexual problems, interpersonal difficulties, disturbance in self-functioning, self-destructive behaviors, and compulsive or dysfunctional sexual activity (Briere, 1995).

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The TSI has a total of 100 items, each scored on a 4-point scale, and contains 10 clinical scales: Anxious Arousal (AA; 8 items, alpha = .86), Depression (D; 8 items, alpha = .91), Anger/Irritability (AI; 9 items, alpha = .90), Intrusive Experiences (IE; 8 items, alpha = .89), Defensive Avoidance (DA; 8 items, alpha = .90), Dissociation (DIS; 9 items, alpha = .82), Sexual Concerns (SC; 9 items, alpha = .87), Dysfunctional Sexual Behavior (DSB; 9 items, alpha = .85), Impaired Self-Reliance (ISR; 9 items, alpha = .88), and Tension Reduction Behavior (TRB; 8 items, alpha = .74). In addition, the inventory includes three validity scales. This instrument can be self-administered by anyone with a fifth-grade reading level or higher. Raw scores on each of these scales, as well as total TSI scores, can be converted to T scores, which are percentiles based on the respondents' scores of each administration of the test. Norms and T-scores were derived on the basis of a large mail-survey (n=836) that was approximately representative of the U.S. population in terms of sex, ethnicity, and state of residence.

Briere (1995) provided confirmatory factor analyses as evidence of the Inventory's construct validity. These analyses justify conceptualization of the scale as three higher order constructs. Four of the scales—IE, DA, DIS and ISR—may be considered as manifestations of traumatic stress, whereas three of the scales—AI, D, and AA—are best viewed as manifestations of generalized dysphoria. The remaining subscales appear to reflect a third factor, Self, that may be more specific to the experience of sexual trauma and dysfunction. Also, to assess construct validity, respondents in the

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national survey were categorized as having experienced childhood or adulthood disaster or interpersonal violence and compared to respondents who had not experienced trauma. All four trauma types were significantly associated with elevated TSI scores. TSI scales correlated in predictable ways with subscales of both the Brief Symptom Inventory (Derogatis & Spencer, 1982) and the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979). In a standardization subsample (n=449), TSI scales predicted PTSD status (as determined by other measures) in over 90% of cases (Briere, 1995, p. 3).

In contrast to other scales that were developed with reference to a specific group, such as war veterans or sexual abuse victims, this instrument was based on responses from a wide spectrum of the general population. The TSI is particularly appropriate for the present study because it assesses PTSD symptoms independently of the stressor. Solomon and her associates write that "(o)ne problem with the diagnosis [of PTSD] is that the stressor (the 'cause') is built into the PTSD criteria" (Solomon, Keane, Newman & Kaloupek, 1996, p. 58). They suggest that "in order to really learn about cause and effect it is necessary to use a measurement strategy that optimally separates the two" (p. 58). Solomon et al. also recommend use of self-report measures in assessing PTSD for several reasons: they are more easily standardized than clinicians' assessments, they afford privacy to the respondent, and they reduce the risk of direct influence on response by an interviewer (p. 60).

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In the development of normative data for the TSI, Briere and his associates used a stratified random sample based on geographical location of registered owners of automobiles or individuals with listed telephone numbers. These 836 people were generally comparable to the 1990 census data on most demographic variables, although they overrepresented, to some extent, White, married, and more educated individuals (Briere, 1995). Analysis of the data culled from this sample showed that there was a significant effect of both sex and race on the TSI test scores. Females scored significantly higher than males on 6 of the 10 clinical scales: AA, D, IE, DA, DIS, and ISR, and people of color scored higher than Whites on 3 of the 10 clinical scales: IE, DA, and DSB. The authors of the study recommend, however, that the clinical TSI scale T scores not be adjusted for race, because:

> ...sociocultural forces (e. g., racism, economic deprivation) are likely to increase the frequency of maltreatment and traumatic experiences among African Americans, Hispanics, or others, relative to Caucasians. In these circumstances, adjusting such scores would be equivalent to requiring greater suffering on the part of certain racial groups before their distress would be considered as great as that of other groups. (Briere, 1995, p. 31)

The authors do not make the same recommendation for the scores of women, although several additional validity studies of the TSI also revealed higher scores of females as compared to males. In a follow-up study of the TSI within a clinical

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population, the authors again found being female was predictive of higher scores on 5 out of 10 of the clinical scales (Briere, Elliott, Harris, & Cotman, 1995). However, as a result of several hierarchical multiple regressions of scores by demographics and various victimization histories, the authors conclude:

> ...this sex difference is probably not due to differences between men and women in the incidence of different traumas, because the multiple regression analyses included (controlled for) specific types of childhood and adult victimization. Whatever their basis, these differences support the provision of sex-specific norms in the standardization of the TSI. (p. 397)

The authors apparently decided not to consider "sociocultural forces" (i.e., sexism) that are likely to increase the frequency of maltreatment and traumatic experiences within the female population, as they had with people of color, and instead adjusted their scores. They rationalize that "it does not necessarily follow from these results that women actually experience more distress than men for equivalent traumas. An equally viable possibility is that the sex difference reported here arises from sex-role-specific differences in the expression of psychological distress..." (p. 397). In what appears to be an example of everyday sexism, Briere et al. recognize the probable existence of external causation for the higher trauma scores among people of color, yet they attribute women's higher scores to an internal cause—their expressive style. They assert this although the contention that women report more psychological distress than

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they experience is not supported in the research literature within the field of psychology (Reiker, 1995; Russo, 1995).

The scale is available for purchase from Psychological Assessment Resources, Inc., Odessa, FL.

Demographic Questionnaire. In addition to the above, respondents also completed a demographic inquiry that included questions regarding the characteristics of the population, and also the respondent's feminist beliefs (Appendix E).

An Informed Consent Form. (Appendix F) apprised participants of the voluntary nature of their participation in the study and provided assurance of anonymity in the reporting of results. Participants were given a list of mental health resources in case of emotional upset due to completion of the survey (Appendix G). The researcher provided all participants with means to contact her and to obtain study results.

Hypotheses

This study examined the relationship between sexism/gender-related stress and PTSD symptoms within a sample of women. A measure of sexist discrimination (SSE), a measure of gender-related stressors (GRS), a measure of PTSD symptoms (TSI), and a demographic questionnaire were administered, and results analyzed to test the following hypotheses:

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Hypothesis 1. Women who experience greater numbers of sexist events in their lives also experience more symptoms of trauma. This is substantiated by demonstrating that participants' total scores on the Schedule of Sexist Events, both Lifetime and Recent, (SSE-L, SSE-R; Klonoff & Landrine, 1995) show significant positive correlations with their total scores on the Trauma Symptom Inventory (TSI; Briere, 1995).

Hypothesis 1a. Women who experience greater numbers of sexist events in various dimensions of their lives—close relationships, distant relationships, workplace and society—also exhibit a wide variety of trauma symptoms. This is substantiated by demonstrating that participants' scores on the subscales of the SSE: (Sexist Degradation and Consequences [SD], Sexism in Close Relationships [CR], Sexist Discrimination in Distant Relationships [DR], and Sexist Discrimination in the Workplace [WK]) will have significant positive correlations with both total TSI scores and TSI subscales most closely identified with DSM-IV PTSD symptoms: (Anxious Arousal [AA], Depression [D], Anger/Irritability [AI], Intrusive Experiences [IE], Defensive Avoidance [DA], Dissociation [DIS], Impaired Self-Reference [ISR]; Briere, 1995).

Hypothesis 2. Women who have experienced more gender-related stressors in their lives also experience more trauma symptoms. This is substantiated by demonstrating

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that participants' total Gender-related Stressors (GRS) scores show a significantly positive correlation with total TSI scores.

Hypothesis 2a. Women who have had greater numbers of gender-related stressors in their lives also exhibit a wide range of PTSD symptoms. This is substantiated by demonstrating that participants' total Gender-related Stressors scores show a significantly positive correlation with TSI subscales.

Supplemental Analyses

In addition to the above hypotheses, the data were examined to determine relationships between individual GRS questions and TSI scores that reflect the following life circumstances:

- issues of family care
- unwanted family separations
- reproductive issues/experiences
- financial problems
- violent experiences (verbal/physical/sexual assault or coercion)

Participants' demographic characteristics (age, race, education, income, employment, partnership status, parenthood, clinical status and feminist identity) were

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tested to determine their influence on the experience of sexism, the number of gender-related stressors, trauma-related symptoms, and their interrelationships.

Method

Design

The primary method used to collect data for this study is an explanatory survey. An explanatory survey attempts to find out whether certain variables are related to other variables (Mindel & McDonald, 1996, p. 302), in this case, the experience of sexism/gender-related stress and PTSD symptoms. Obviously, in an explanatory survey, the researcher cannot manipulate the independent variable, but must seek groups of people who vary in their exposure to it. Mindel and McDonald (1988) write, "The survey is probably the best data-gathering method available to us if we require data about a population too large to be directly observed or personally interviewed" (p. 303). In addition, the survey method is cost-effective and time-efficient as a means of reaching as large a sample as possible.

There are two distinct portions of this study: the first is a correlational analysis of sexism (as measured by the SSE) and PTSD symptoms (as measured by the TSI). As stated by Black, "correlational studies...strive to establish the existence of relationships among variables that are not even necessarily causal in nature" (1993, p. 121). However, these relationships, if shown to have statistical significance, may supply important

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inferences for our understanding of the variables and may offer some predictive power as well.

The second portion of the study is an exploratory survey, designed to obtain data regarding the frequency and impact of gender-related stressors among women. Mindel and McDonald (1988) write, "Random sampling is not used in this phase of our research study, and the questionnaire...is very loosely constructed...The point...is to find out what issues to address when we conduct our larger, more formal survey at a future date" (p. 301). For this part of the study, a Gender-Related Stressor Questionnaire (GRS) was designed, using questions based on the Life Stressor Checklist, revised by Wolfe et al. but not tested for psychometric properties (Wolfe, personal communication, 4/20/99). The list of YES/NO questions on the GRS addresses life circumstances that are likely to cause more stress for women than men due to the roles, restrictions, or burdens imposed on them within a sexist environment. This data will be used to broaden understanding of the tested variables and to generate hypotheses for future research.

The present study falls within the provenance of feminist research. Cook and Fonow (1990) define feminist methodology as research that recognizes the necessity of continuously and reflexively attending to the significance of gender and gender asymmetry as a basic feature of all social life. They write:

> Acknowledging the pervasive significance of gender entails several ideas, and the most uniquely feminist of these notions is that women are placed

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> at the center of inquiry. Moreover, attending to the basic significance of gender involves accounting for the everyday life experiences of women which have been neglected by traditional (research). Feminist(s)...are creating an understanding of the taken-for-granted, mundane aspects of social reality that oppress women and the daily occurrences which reinforce male dominance. (p. 88)

The present study examines the prejudice of sexism and the ways its daily expression provokes trauma symptoms, and indirectly, general mental disorders in women.

Sampling

The method of sampling employed in this study is availability sampling, a non-probability sampling procedure in which researchers use the most available appropriate sampling units (Seaberg, 1988). As Seaberg states, "A large proportion of social work research and evaluation relies on this type of sampling procedure," including community surveys (p. 251). The three quantitative testing measurements and the demographic questionnaire were administered to a representative sample of women drawn from the general population. In order that the sample represent the larger population, I drew upon as wide a variance in demographic characteristics as possible—including age, ethnicity, religion, and social class—to obtain data. However, the generalizability of findings may be limited by the homogeneity of the location of the study, namely suburban Long Island,

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New York. After clearance from Hunter College Institutional Review Board, the self-administered questionnaires were presented to a variety of women's groups, organizations, classes and mailing lists, in order to acquire at least 300 completed surveys, following the sample size suggestions of Newman and McNeil (1998, p. 99-101).

Data Analysis

There are several analyses of the data which are useful for the development of information regarding both the independent and dependent variables, as well as their relationships.

To test Hypothesis1 (Participants' scores on the Schedule of Sexist Events - Lifetime and Recent show a positive correlation with their scores on the Trauma Symptom Inventory), a one-tailed bivariate Pearson's correlational analysis was utilized. This method of statistical analysis is recommended for demonstrating the correlations between two continuous variables such as the SSE and TSI scores (Stamm & Bieber, 1996; Weinbach & Grinnell, 1997).

Landrine and Klonoff (1997, p. 224) write that a bivariate correlation measures the extent to which the variance in one variable (e. g., SSE scores) predicts the variance in another variable (e. g., TSI scores). Thus it is a measure of the co-relationship between the variables. The authors state that "correlations are highly precise measures of the extent to which one variable predicts another and are thereby important" as a means of

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predicting outcomes. If a correlation (measured by the correlation coefficient, or r) is statistically significant, it means that the relationship between the two variables is not caused by chance and that it is probably true for the larger population as well (p. 226).

Correlations can be positive or negative and range from r=0.0 to r=1.0 in terms of their strength. A positive correlation indicates a direct relationship (i. e., high scores in one variable are associated with high scores in the other) and a negative correlation indicates an inverse relationship (i. e., high scores in one variable are associated with low scores in the other). The square of the correlation coefficient, r, is an indication of the amount of variance in the dependent variable scores that is accounted for by the independent variable. Correlational analyses may be one-tailed or two-tailed, depending on the stated hypothesis. If the direction of the correlation is predicted, one-tailed analysis is appropriate; if the direction is not predicted, two-tailed analysis should be chosen.

One-tailed bivariate Pearson's correlational analysis was also used to determine the correlations between SSE subscales (CR, DR, SD, and WK, Lifetime and Recent) and the TSI subscales (Anxious Arousal [AA], Depression [D], Anger/Irritability [AI], Intrusive Experiences [IE], Defensive Avoidance [DA], Dissociation [DIS], Impaired Self-Reference [ISR]) as predicted in Hypothesis 1a. A one-tailed analysis was chosen again since the direction of the correlation was predicted in the hypothesis.

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To test Hypothesis 2 (Total GRS scores show a significantly positive correlation with total TSI scores), a one-tailed bivariate Pearson's correlational analysis was used to determine the relationship between total GRS and TSI scores. The same method was used to determine the correlations between GRS scores and the TSI subscales (Hypothesis 2a).

In addition, the correlations between individual Gender-Related Stressor scores and TSI scores were computed with two-tailed bivariate Pearson's correlations in order to determine whether particular types of stressors (family care, unwanted family separations, reproductive issues/experiences, financial problems, violent experiences) are correlated with TSI scores. Two-tailed bivariate analyses are preferred when there is no predetermined direction of the correlation, as is the case where no hypothesis is stated.

Also, to determine the mediating influence of demographic variables on the relationship between SSE and TSI, I used two-tailed partial correlations on all demographic variables, as recommended by Weinbach and Grinnell (1997, p. 144). These analyses helped determine how large (and statistically significant or not) the correlations between SSE and TSI scales would be if the variations in any of the demographic variables were not a factor. A similar analysis was used to determine the confounding influence of Gender-Related Stressors on the SSE and TSI correlations.

In order to examine the impact of demographic variables on women's experience of sexism, gender-related stressors, and trauma symptoms, I ran a series of two-tailed t-tests on demographic variables and SSE-L, SSE-R, GRS, and TSI mean scores. A t-test

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determines if there is a statistically significant difference between the means of two samples. It is used to compare two groups on one dependent variable to see if the groups differ (Landrine & Klonoff, 1997, p. 217). In order to complete this analysis, each demographic variable was divided into two groups representing the opposing values measured by the continuum of that variable.

To examine the role of demographic variables on women's experience of both sexism and trauma symptoms, I ran a series of stepwise multiple regressions utilizing those variables as factors determining both SSE and TSI test results. I also ran a stepwise multiple regression on TSI scores using SSE-L, SSE-R, SSE subscale and GRS scores as independent variables.

Multiple regression (MR) is a sophisticated type of correlational analysis used to examine the amount of variation of the dependent variable that can be explained by several independent, or predictor, variables working in combination with one another (Weinbach & Grinnell, 1997). The MR both controls for the relationships among the independent variables and selects those that have the greatest predictive power on scores of the dependent variable (Van Wagenen, 1991). It also provides an assessment of the relative contribution of different independent variables for predicting values of the dependent, or outcome, variable. The stepwise procedure selects the subset of the independent variables necessary to explain the variance in the dependent variable. It begins with all the predictor variables and eliminates them one by one, winnowing down

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to the relatively small number of factors most useful in explaining the variation of the dependent variable (Weinbach & Grinnell, 1997).

MRs, like bivariate correlational analyses, measure the influence of the independent, or predictor, variable by a correlation coefficient, or r, which can be either positive or negative, and range in magnitude from zero to 1.0. As in bivariate analyses, the r squared represents the amount of variance in the scores of the dependent variable that is accounted for by the independent variable being measured.

Although the MR reports which independent variables are most predictive in determining the variance in scores of the dependent variable, a post- hoc analysis is needed to determine which group(s) within those variables actually account for the finding. In this study, I used the Tukey HSD (honestly significant difference) as a post-hoc t-test to determine the differences among the groups within a variable. These results were reported with all MR findings.

All statistical analyses were completed using the Statistical Package for the Social Sciences (8.0). This package is a comprehensive statistical software system designed to process all steps in analysis, ranging from data listings, tabulations, and descriptive statistics to complex statistical analyses (SPSS Base 8.0 Applications Guide, p. iii).

Limitations

There are several aspects of the study that may limit the applicability of its findings. The most obvious of these is the sampling strategy, which may not produce a

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representative cross-section of the female population. The study was based on Long Island, where there is a lack of heterogeneity within the population, and women's groups, organizations, and classes are often segregated by class and race. For this reason, I instituted outreach to minority organizations for inclusion within the study. Nevertheless, the study results are wholly dependent on convenience and voluntary sampling, which reduces the ability to generalize the findings. In addition, as with all voluntary surveys, the results may be affected by return bias, in that interested parties are more likely to complete the questionnaire than those lacking in interest. Nevertheless, the test norms and demographic features of the sample in this study were remarkably close to those of the normative samples used by the creators of the instruments being utilized, supporting its generalizability (Landrine & Klonoff, 1997; Briere, 1995).

A major difficulty for researchers in the field of PTSD is that of assessment. As Newman, Kaloupek and Keane (1997). state, no existing single measurement can function as a definitive indicator of the disorder. Both PTSD and sexism are wide-ranging, complex terms that vary in meaning and experience within the population. Operationalizing these concepts may provide us with devices for measurement, but they may also limit our comprehension of the complex subjective experience of each phenomenon.

Finally, this study is limited by its methodology. Basically, it is a correlational study, which obscures the directionality of causation. The results are open to the

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interpretation of the researcher and the reader, and should be considered as implications for future research.

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Chapter VI - Results

Descriptive statistics of the sample and their test scores are presented in this chapter. Pearson's bivariate correlation matrices for all variables included in the study are presented, as well as statistical analyses of each research hypothesis and the exploratory research questions.

The first part of this chapter reviews the descriptive statistics of the results of the study.

Descriptive Statistics

Sample

For this study, a survey was designed that included the Schedule of Sexist Events (SSE; Klonoff & Landrine, 1995), a Gender-related Stressors Questionnaire (GRS), the Trauma Symptom Inventory (TSI; Briere, 1995) and a Demographic Questionnaire. A pilot study with 10 community women provided feedback for revision of content of the Gender-related Stressor questions and the Demographic Questionnaire and some revision of format.

A total of 1100 surveys (with stamped return envelopes) were distributed to women on Long Island during the months of September-January, 1999-2000. This distribution occurred at women's organizations, meetings, and classes. (A complete list of

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distribution sites is available from the researcher.) The researcher explained the nature of the study, instructions for completing the survey, and conditions of confidentiality and anonymity for the respondents. In addition, surveys were distributed in doctors' offices, schools, and public spaces. An additional 100 were distributed in New York City and approximately 100 were mailed to women requesting surveys after announcements were posted on a feminist social work listserve and a women's website (iVillage) on the Internet.

Four hundred two completed surveys were returned via mail, recorded by number, and entered into the SPSS data collection system. Of these, 20 were removed as invalid, based on scores on the three validity scales of the TSI, or if more than two scales on the SSE were incomplete. The total number of analyzed surveys was 382. Demographic information regarding the sample is presented in Table 1. For complete questions, see Appendix E.

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Table 1: Demographic Characteristics of Research Participants (N = 382)

	n	% [a]
Age:		
18-25	37	9.7
26-35	78	20.4
36-45	102	26.7
46-55	93	24.3
56-65	56	14.7
66 or older	14	3.7
Race:		
White	335	87.7
Non-White	46	12.0
Education:		
Elementary school	0	0.0
Junior high school	0	0.0
High school	26	6.8
Some college	67	17.5
College	106	27.7
Post-graduate	179	46.9
Other training	3	0.8
Personal gross annual income:		
Less than $10,000	51	13.4
$10,000-$29,999	87	22.8
$30,000-$49,999	121	31.7
$50,000-$69,999	64	16.8
$70,000 or more	57	14.9
Total gross household income:		
Less than $30,000	30	7.9
$30,000-$49,999	58	15.2
$50,000-$69,999	68	17.8
$70,000-$89,999	77	20.2
$90,000 or more	144	37.7
Current employment status:		
Employed full time	252	66.0
Employed part-time	66	17.3
Not working for wages at this time	13	3.4
Volunteer work only	15	3.9
Student	22	5.8
Other	13	3.4

(table continues)

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	n	% [a]
Past employment status:		
Have never worked for wages	6	1.6
Have worked on and off for wages	71	18.6
Have always worked for wages	289	75.7
Other	15	3.9
Present job category:		
Professional	230	60.2
Technical	14	3.7
Service	32	8.4
Sales/Retail	18	4.7
Clerical	37	9.7
Other	39	10.2
Current partnership status:		
Single (Heterosexual)	138	36.1
Married/Living with opposite-sex partner	205	53.7
Living with same-sex partner	24	6.3
Single (Lesbian)	9	2.4
Single (Bisexual)	5	1.3
Current parenthood status		
Living with child(ren) under 18	98	25.7
Living with child(ren) over 18	35	9.2
Grown child(ren) living outside the home	89	23.3
Without children	149	39.0
Other	10	2.6
Geographic Location:		
Urban	67	17.5
Suburban	277	72.5
Rural	32	8.4
Current clinical status:		
Neither in therapy nor using psychoactive medication	230	60.2
In therapy	86	22.5
Using psychoactive medication	17	4.5
Both in therapy and using psychoactive medication	22	5.8
Feminist Identity:		
Strongly identify	82	21.5
Identify	113	29.6
Somewhat identify	138	36.1
Somewhat do not identify	22	5.8
Do not identify	17	4.5
Strongly do not identify	5	1.3

[a] For each characteristic, per cents do not total 100 due to missing data.

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Schedule of Sexist Events

Frequency distributions. Percentages of responses to all questions of the SSE-Lifetime and SSE-Recent are presented in Table 2 and Table 3 on the following pages. These responses are grouped by SSE subscales: SD (Sexist Degradation and its Consequences), DR (Sexist Discrimination in Distant Relationships), WK (Sexist Discrimination in the Workplace), and CR (Sexism in Close Relationships), presented as percentages. For the complete scale, see Appendix B.

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Table 2: Percentage of Respondents Reporting Specific Sexist Events in Their Lifetimes (N = 382)

		Lifetime Frequency of the Event: Percentage of Time Event Happened						
Subscale	*Questionnaire Item*	*1 Never Happened*	*2 Up to 10% of the Time*	*3 10-25% of the Time*	*4 26-49% of the Time*	*5 50-70% of the Time*	*6 > 70% of the Time*	*Ever Happened (100% minus column 1)*
SD	11. Sexually harrassed	6.0	23.4	28.3	29.7	7.6	5.0	94.0
	12. Got no respect	7.3	29.1	33.2	22.0	7.1	1.3	92.7
	13. Wanted to tell someone off	4.7	24.3	28.3	26.2	11.5	5.0	95.3
	14. Angry about sexism	8.1	36.9	27.2	18.1	6.0	3.7	91.9
	16. Was called sexist names	14.1	38.2	24.9	16.8	4.2	1.8	85.9
	17. Argued over sexism	20.5	33.3	26.0	13.6	5.8	0.8	79.5
	18. Was picked on, harmed	36.5	33.6	12.6	13.9	2.4	1.0	63.5
	19. Heard sexist jokes	1.8	12.9	28.1	34.1	13.9	9.2	98.2
DR	1. Sexism by teachers	24.9	36.2	25.5	11.0	1.3	1.0	75.1
	4. Sexism by people in service jobs	10.2	26.2	31.2	24.7	6.0	1.6	89.8
	5. Sexism by strangers	12.3	37.4	29.1	16.2	4.2	0.8	87.7
	6. Sexism by people in helping jobs	21.5	34.4	23.4	16.0	3.4	1.3	78.5
	7. Sexism by neighbors	48.3	33.1	11.5	5.2	1.0	0.8	51.7
WK	2. Sexism by employer	12.3	32.0	30.2	17.3	5.0	3.1	87.7
	3. Sexism by colleagues	19.9	36.5	28.3	11.3	3.4	0.5	80.1
	9. Sexism at work	39.1	29.3	18.5	7.4	4.5	1.3	60.9
	15. Took drastic steps	69.6	21.0	6.3	1.0	1.0	1.0	30.4
CR	8. Sexism by boyfriend, mate	16.5	27.2	22.9	17.9	10.9	4.5	83.5
	10. Sexism by family	33.2	20.6	20.3	11.1	9.8	5.0	66.8
		The Same As Now	*A Little Different*	*Different in a Few Ways*	*A Lot Different*	*Different in Most Ways*	*Totally Different*	*Would Be Different (100%-Column 1)*
	20. How different life would be	20.3	20.0	24.0	21.9	8.3	5.6	79.7

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Table 2 displays the percentages of participants' responses to each SSE question for the Lifetime scale. The columns indicate how frequently each sexist event occurred, and cells show the percentage of women reporting that frequency. The last column on the right shows the percentage of women who report having ever experienced the sexist event in question. One-hundred percent of respondents experienced some type of sexist discrimination in their lifetimes. (In the Landrine and Klonoff sample [1997, pp. 77-78], 99.95% of the sample reported experiencing sexist behavior in their lifetimes.)

Table 3 reports percentages of participants' responses to each SSE question for the Recent scale.

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Table 3: Percentage of Respondents Reporting Specific Sexist Events in The Past Year (N = 382)

		Recent Frequency of the Event: Percentage of Time Event Happened in Past Year						
Subscale	*Questionnaire Item*	*1* *Never Happened*	2 *Up to 10% of the Time*	3 *10-25% of the Time*	4 *26-49% of the Time*	5 *50-70% of the Time*	6 *> 70% of the Time*	*Ever Happened (100% minus column 1)*
SD	11. Sexually harrassed	41.5	31.2	15.2	6.8	3.7	1.6	58.5
	12. Got no respect	27.5	43.2	18.1	6.8	3.1	1.3	72.5
	13. Wanted to tell someone off	18.3	38.7	20.7	11.5	6.3	4.5	81.7
	14. Angry about sexism	35.6	38.7	13.4	6.3	3.4	2.6	64.4
	16. Was called sexist names	55.0	25.7	9.4	7.3	1.8	0.8	45.0
	17. Argued over sexism	45.7	34.6	11.0	5.2	3.1	0.3	54.3
	18. Was picked on, harmed	75.9	15.2	5.5	2.9	0.3	0.3	24.1
	19. Heard sexist jokes	13.7	39.5	18.9	18.2	5.3	4.5	86.3
DR	1. Sexism by teachers	74.9	17.9	5.1	1.6	0.3	0.3	25.1
	4. Sexism by people in service jobs	24.2	40.0	21.1	10.3	3.4	1.1	75.8
	5. Sexism by strangers	27.7	44.8	17.3	7.6	2.4	0.3	72.3
	6. Sexism by people in helping jobs	50.9	30.6	13.5	4.0	1.1	0.0	49.1
	7. Sexism by neighbors	74.7	16.3	4.7	2.9	0.3	1.1	25.3
WK	2. Sexism by employer	55.3	26.2	10.6	4.2	2.6	1.1	44.7
	3. Sexism by colleagues	56.1	28.6	8.5	4.0	2.1	0.8	43.9
	9. Sexism at work	75.3	14.2	6.1	1.6	1.3	1.6	24.7
	15. Took drastic steps	90.0	6.3	1.6	0.8	0.5	0.8	10.0
CR	8. Sexism by boyfriend, mate	48.5	26.4	14.1	5.1	3.5	2.4	51.5
	10. Sexism by family	57.1	24.9	8.5	5.6	2.1	1.9	42.9
		The Same As Now	*A Little Different*	*Different in a Few Ways*	*A Lot Different*	*Different in Most Ways*	*Totally Different*	*Would Be Different (100%-Column 1)*
	20. How different life would be	50.1	20.5	16.8	7.2	2.7	2.7	49.9

Table 3 displays the percentages of participants' responses to each SSE question for the SSE-Recent scale. The columns indicate how frequently each sexist event occurred, and cells show the percentage of women reporting that frequency. The last column on the right shows the percentage of women who have experienced the sexist event in question during the past year. One-hundred percent of respondents experienced some type of sexist discrimination in the past year. (In the Landrine and Klonoff sample [1997, pp. 77-78], 98.3% of the sample reported experiencing sexist behavior within the past year.)

Summary statistics. Table 4 contains summary statistics regarding the scores of participants on the SSE and each of the SSE subscales: Sexist Degradation and Its Consequences (SD), Sexist Discrimination in Distant Relationships (DR), Sexist Discrimination in the Workplace (WK), and Sexism in Close Relationships (CR), for both Lifetime and Recent scales.

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Table 4: Means and Standard Deviations of the SSE and Subscale Scores (N = 382)

	Lifetime		Recent	
	M	SD	M	SD
Schedule of Sexist Events (SSE)	52.71	15.71	37.26	13.39
Sexist Degradation (SD)	23.41	7.16	16.72	6.68
Sexist Discrimination in Distant Relationships (DR)	14.60	4.98	8.89	3.49
Sexist Discrimination in the Workplace (WK)	6.37	2.68	6.03	2.98
Sexism in Close Relationships (CR)	8.34	3.63	5.62	2.82

The maximum possible total score for the total SSE is120 for both the Lifetime and Recent scales. The Sexist Degradation subscale is comprised of Questions 13, 19, 16, 14, 11, 17, 12, and 18 and could produce a maximum score of 48 on both Lifetime and Recent dimensions (See Appendix B). The Distant Relationships subscale is comprised of Questions 1, 4, 5, 6, and 7 could produce a maximum score of 30 on each dimension. The Workplace subscale consists of Questions 2, 3, 9 and 15 with a maximum score of 24 on each dimension. The Close Relationships subscale is comprised of Questions 8, 10, and 20, for a maximum score of 18 on each dimension.

According to Landrine and Klonoff's formulation, average SSE scores can be defined as those within one standard deviation of the mean. In this study, average SSE-L

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scores would fall between 37.00 and 68.42, low scores below 37 and high scores over 68.42. Average SSE-R scores range between 23.87 and 50.65, with low scores falling below that range and high scores above it. In the present study, scores fell within the normal distribution, as designated by the scale's authors.

The scores displayed in Table 4 are comparable to those reported by Landrine and Klonoff (1997) from their sample of 1,279 women. Their mean score on the SSE-L was 47.22, with a standard deviation of 16.27; the present study obtained a mean score of 52.71 with a standard deviation of 15.71. They obtained a mean of 37.97 on the SSE-R, with a standard deviation of 14.17; this study produced a mean of 37.26 on the SSE-R, with a standard deviation of 13.39.

The remainder of the table presents mean scores and standard deviations for each of the SSE subscales. Although Landrine and Klonoff do not report normative data on the SSE subscales, the norms obtained from their primary sample of 631 women during their factor analysis are similar to those obtained in this study, although there are some minor discrepancies due to scale modifications. For Lifetime scales they report the following: Sexist Degradation & Its Consequences, M=20.40, SD =7.55; Sexist Discrimination in Distant Relationships, M=11.75, SD=4.40; Sexist Discrimination in the Workplace, M=4.97, SD=2.23; Sexism in Close Relationships, M=9.31, SD=3.86. For Recent scales they report: Sexist Degradation & Its Consequences, M=16.16, SD=6.91; Sexist

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Discrimination in Distant Relationships, M=7.96, SD 2.95; Sexist Discrimination in the Workplace, M=5.57, SD=2.47; Sexism in Close Relationships, M=5.33, SD=2.57.

Demographic characteristics - Schedule of Sexist Events. A series of t-tests were run in order to identify the relationship between demographic characteristics of respondents and the SSE scores. These are presented in Table 5.

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Table 5: T-tests on Demographic Characteristics with SSE-L and SSE-R Scores (N = 382)

	Demographic Characteristic	n	SSE-L Scores M	SSE-L Scores SD	SSE-L Scores t	SSE-R Scores M	SSE-R Scores SD	SSE-R Scores t
D1	Age 35 and under	115	54.05	16.37		42.57	14.55	
	Age 36 and over	265	52.30	15.35	-1.00	35.06	12.19	-4.85 ***
D2	White	335	53.00	15.53		37.12	13.19	
	Non-White	46	51.13	16.86	-0.76	38.61	14.87	0.71
D3	College degree	288	53.98	15.68		37.49	12.99	
	No college degree	93	49.03	15.16	2.67 **	36.71	14.63	0.49
D4	Personal income < $50,000	259	53.05	15.01		37.70	13.31	
	Personal income $50,000+	121	52.07	17.10	-0.57	36.41	13.63	-0.87
D5	Household income < $90,000	233	53.68	15.14		37.89	13.08	
	Household income $90,000+	144	51.31	16.47	-1.43	36.31	13.25	-1.11
D6	Employed full-time	252	52.17	15.56		36.92	12.36	
	Not employed full-time	129	53.94	15.93	1.04	38.03	15.23	0.72
D7	Always worked for wages	304	52.43	15.56		36.58	12.92	
	Worked occasionally or not at all	77	54.10	16.19	-0.83	40.12	14.84	-1.91
D8	Professional	230	53.41	15.67		36.93	12.96	
	Non-professional	140	51.86	15.57	-0.93	37.83	13.92	0.63
D9(a)	Single (heterosexual)	138	52.95	15.94		39.49	14.16	
	Married/cohabitating (heterosexual)	243	52.67	15.57	-0.17	36.05	12.79	-2.43 **
D9(b)	Gay/bi-sexual	38	63.00	16.30		43.08	15.03	
	Heterosexual	343	51.64	15.22	4.34 ***	36.66	13.06	2.83 **
D10	Parents	222	51.82	15.45		35.09	12.29	
	Non-parents	159	54.09	15.96	1.40	40.37	14.27	3.77 ***
D11	Urban	67	54.87	15.91		39.60	12.44	
	Suburban/Rural	309	52.29	15.66	-1.22	36.77	13.64	-1.56
D12	Neither in therapy nor using medication	230	50.02	14.46		36.08	13.15	
	In therapy and/or using medication	125	57.69	17.09	4.26 ***	39.46	13.52	2.29 *
D13	Feminists	333	53.56	15.22		37.59	13.43	
	Non-feminists	44	45.95	16.64	-3.08 **	34.86	12.49	-1.27

*p<.05. **p<.01. ***p<.001.

Comparison Summary of the Klonoff and Landrine Study (1997) and the Present Study:

	Klonoff & Landrine		Present Study	
Sample	N=631, mostly students Ages 18-73 64% White Two-thirds earned less than 40K 38% married 19% had college/graduate degrees 37% were "feminist"		N=382, mostly community women Ages 18-56+ 88% White Two-thirds earned less than 50K 53% married 73% had college/graduate degrees 89% "identify with feminist beliefs"	
SSE Scores	Mean	(SD)	Mean	(SD)
SSE-L	47.22	(16.27)	52.71	(15.71)
SSE-R	37.99	(14.17)	37.26	(13.39)
SD-L	20.40	(7.55)	23.41	(7.16)
SD-R	16.16	(6.91)	16.72	(6.68)
DR-L	11.7	(4.40)	14.60	(4.98)
DR-R	7.96	(2.95)	8.89	(3.49)
WK-L	4.97	(2.23)	6.37	(2.68)
WK-R	5.57	(2.47)	6.03	(2.98)
CR-L	9.31	(3.86)	8.34	(3.63)
CR-R	5.33	(2.57)	5.62	(2.82)
Age	Women 29 and younger experienced significantly more sexism in the previous year than those 30 and over		Women 35 and younger experienced significantly more sexism in the previous year than those 36 and over	
Education	In the first sample only, higher educated women experienced significantly more sexism during their lifetimes than their counterparts		Higher educated women experienced significantly more sexism over their lifetimes than their counterparts	
Marital Status	Single (never married) women experienced significantly more sexism both in the previous year and during their lifetime than married women		Single (heterosexual) women experienced significantly more sexism over a lifetime than married women	
Race	Women of color experienced significantly more sexism in the previous year than White women		No differences due to race	
Income	No differences due to income		No differences due to income	
Feminism	Feminists experienced significantly more sexism both in the previous year and during their lifetimes than non-feminists		Feminists experienced significantly more sexism in their lifetimes than non-feminists	

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Gender-Related Stressors Questionnaire

In order to examine the role of gender-related burdens and stressors that might impact on the trauma symptoms of women, a checklist of common events in women's lives was included in the survey. These events were chosen to reflect issues of family care, family separations, reproductive experiences, financial problems, and experiences of violence and abuse.

Table 6 reports the frequencies and percentages of respondents' YES/NO answers to questions on the Gender-Related Stressors (GRS) Questionnaire. The total means score for G-RS is 6.07, with a standard deviation of 3.56. For complete questions, see Appendix C.

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Table 6: Responses to Gender-Related Stressors Questionnaire (N = 382)

	Yes		No	
	n	%	n	%
1. Separated or divorced	138	36.1	244	63.9
2. Serious relationship problems	292	77.2	86	22.8
3. Serious money problems	99	25.9	283	74.1
4. Prevented from continuing your education	95	25.1	284	74.9
5. Prevented from pursuing or continuing a career	108	28.6	270	71.4
6. Unwanted pregnancy that was brought to term	25	6.5	357	93.5
7. Abortion or miscarriage	150	39.4	231	60.6
8. Experienced infertility (for longer than one year)	45	11.8	337	88.2
9. Separated from your child against your will	7	1.8	375	98.2
10. Given up a baby for adoption	5	1.3	377	98.7
11. Responsible for child care and/or household duties	203	53.3	178	46.7
12. Single parent	83	22.0	295	78.0
13. Severely handicapped/ill baby or child	11	2.9	368	97.1
14. Severely handicapped/ill family member	134	35.1	248	64.9
15. Sent to jail	10	2.6	369	97.4
16. Close family member sent to jail	78	20.7	298	79.3
17. Serious mental illness	104	27.3	277	72.7
18. Sexual harassment at work or school	175	45.9	206	54.1
19. Emotionally or verbally abused in a relationship	215	56.7	164	43.3
20. Abused or physically attacked by someone you knew	137	35.9	245	64.1
21. Touched or forced to touch someone in a sexual way	115	30.3	264	69.7
22. Forced sex (oral, anal, or genital)	88	23.2	291	76.8

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Demographic characteristics - Gender-Relates Stressors (GRS) A series of t-tests were run to examine the demographic characteristics in relation to GRS scores. These are presented in Table 7.

Table 7: T-tests on Demographic Characteristics and GRS Scores (N = 382)

		GRS Scores			
	Demographic Characteristic	n	M	SD	t
D1	Age 35 and under	115	4.63	3.06	
	Age 36 and over	265	6.72	3.57	5.81 ***
D2	White	335	6.09	3.58	
	Non-White	46	5.89	3.41	-0.36
D3	College degree	288	6.03	3.67	
	No college degree	93	6.19	3.23	-0.39
D4	Personal income < $50,000	259	6.00	3.47	
	Personal income $50,000+	121	6.24	3.78	0.62
D5	Household income < $90,000	233	6.25	3.42	
	Household income $90,000+	144	5.83	3.73	-1.13
D6	Employed full-time	252	6.14	3.67	
	Not employed full-time	129	5.93	3.34	-0.56
D7	Always worked for wages	304	6.11	3.57	
	Worked occasionally or not at all	77	5.91	3.54	0.44
D8	Professional	230	6.23	3.68	
	Non-professional	140	5.92	3.33	-0.80
D9(a)	Single (heterosexual)	138	6.05	3.54	
	Married/cohabitating (heterosexual)	243	6.08	3.58	0.07
D9(b)	Gay/bi-sexual	38	6.95	3.12	
	Heterosexual	343	5.97	3.60	1.61
D10	Parents	222	6.86	3.65	
	Non-parents	159	4.97	3.13	-5.41 ***
D11	Urban	67	5.43	3.92	
	Suburban/Rural	309	6.21	3.49	1.61
D12	Neither in therapy nor using medication	230	5.45	3.58	
	In therapy and/or using medication	125	7.00	3.89	3.98 ***
D13	Feminists	333	6.10	3.59	
	Non-feminists	44	5.70	3.23	-0.69

*p<.05. **p<.01. ***p<.001.

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Trauma Symptom Inventory

Table 8 summarizes participants' scores on the TSI, including all clinical subscales: Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Dysfunctional Sexual Behavior (DSB), Impaired Self-Reliance (ISR), and Tension Reduction Behavior (TRB). For the complete inventory, see Appendix D.

Table 8: Means and Standard Deviations of the TSI and Subscale Scores (N = 382)

	M	SD
Trauma Symptom Inventory (TSI)	66.21	42.08
Anxious Arousal (AA)	8.86	5.08
Depression (D)	7.65	5.88
Anger/Irritability (A/I)	10.06	6.06
Intrusive Experiences (IE)	6.59	5.63
Defensive Avoidance (DA)	8.09	6.38
Dissociation (DIS)	7.26	5.42
Sexual Concerns (SC)	4.97	5.01
Dysfunctional Sexual Behavior (DSB)	2.30	4.13
Impaired Self-Reference (ISR)	7.35	5.96
Tension Reduction Behavior (TRB)	3.08	3.33

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As shown in Table 8, the present sample produced a total Trauma Symptom Inventory mean of 66.21, with a standard deviation of 42.08. Although Briere does not report overall norms, current scores on the TSI subscales can be compared to those of the Briere (1995) standardization sub-sample of 431 women under the age of 55. In each of the TSI subscales, Briere reported the following means for this group: AA, 7.68 (SD 5.22), D, 7.10 (SD 6.13), AI, 8.31 (SD 6.24), IE, 6.03 (SD 5.55), DA, 7.15 (SD 6.15), DIS, 5.46 (SD 5.00), SC, 4.06 (SD 5.27), DSB, 2.29 (SD 3.94) and 0.68 (SD 1.47), ISR, 6.46 (SD 5.94), TRB, 2.66 (SD 3.35).

The TSI scores were fairly evenly distributed throughout the sample population. Based on Briere's (1995) calculation, scores more than one and one-half times above the standard deviation would indicate the existence of PTSD. In this sample, 8% of the total (31 women) would qualify as having PTSD symptoms within the past six months, a finding that falls within the range reported in similar epidemiological surveys (Breslau et al.,1997; Kessler et al., 1995; Norris, 1992; Resnick et al., 1993).

Demographic characteristics - Trauma Symptom Inventory. A series of t-tests were run to investigate the relationships between demographic characteristics and TSI scores. These are presented in Table 9.

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Table 9: T-tests on Demographic Characteristics and TSI Scores (N = 382)

		TSI Scores			
	Demographic Characteristic	n	M	SD	t
D1	Age 35 and under	115	79.67	43.53	
	Age 36 and over	265	60.76	40.10	-4.11 ***
D2	White	335	66.14	40.46	
	Non-White	46	67.78	52.82	0.20
D3	College degree	288	63.13	39.38	
	No college degree	93	76.26	48.38	-2.38 **
D4	Personal income < $50,000	259	70.37	43.06	
	Personal income $50,000+	121	57.78	38.82	-2.74 **
D5	Household income < $90,000	233	68.79	43.62	
	Household income $90,000+	144	62.82	39.17	-1.34
D6	Employed full-time	252	61.81	40.88	
	Not employed full-time	129	75.18	43.09	2.97 **
D7	Always worked for wages	304	62.67	40.92	
	Worked occasionally or not at all	77	80.82	43.67	-3.43 ***
D8	Professional	230	61.37	38.02	
	Non-professional	140	73.71	46.24	2.67 **
D9(a)	Single (heterosexual)	138	75.60	47.49	
	Married/cohabitating (heterosexual)	243	61.07	37.75	-3.08 ***
D9(b)	Gay/bi-sexual	38	70.16	40.19	
	Heterosexual	343	65.91	42.30	0.59
D10	Parents	222	57.51	35.82	
	Non-parents	159	78.65	46.89	4.77 ***
D11	Urban	67	65.81	38.01	
	Suburban/Rural	309	66.52	43.21	0.13
D12	Neither in therapy nor using medication	230	57.30	38.64	
	In therapy and/or using medication	125	85.17	42.64	6.26 ***
D13	Feminists	333	66.41	41.59	
	Non-feminists	44	66.70	47.11	0.04

*p<.05. **p<.01. ***p<.001.

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Comparison Summary of the Briere Study (1995) and the Present Study:

	TSI- Briere's Study	Present Study
Sample	N=855, men and women Ages 18-88 77.5% White Three-quarters earned less than 55K 57% married 61% employed 20% college/graduate degree 87% neither in therapy nor taking medication	N=382, women only Ages 18-56+ 88% White Two-thirds earned less than 50K 53% married 66% employed full-time 73% college/graduate degrees 60% neither in therapy nor taking medication
TSI Scores	Mean (SD) - Subsample of 431 women < age 55	Mean (SD)
Total TSI	Not available	66.21 (42.08)
AA	7.68 (5.22)	8.86 (5.08)
D	7.10 (6.13)	7.65 (5.88)
A/I	8.31 (6.24)	10.06 (6.06)
IE	6.03 (5.55)	6.59 (5.63)
DA	7.15 (6.15)	8.09 (6.38)
DIS	5.46 (5.00)	7.26 (5.42)
SC	4.06 (5.27)	4.97 (5.01)
DSB	2.29 (3.94)	2.30 (4.13)
ISR	6.46 (5.94)	7.35 (5.96)
TRB	2.66 (3.35)	3.08 (3.33)
Age	In the normative sample, younger respondents (< age 55) had significantly more PTSD symptoms than older respondents	Younger women (< age 36) had significantly more PTSD symptoms than older women
Race	Race accounted for 2%-3% variance in scores; persons of color scored higher than Whites on IE, DA, and DSB scales only	No differences due to race

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Findings

Hypothesis 1, women who experience greater numbers of sexist events in their lives also experience more trauma-related symptoms was confirmed: Total scores in Lifetime Sexism and Recent Sexism show a significant positive correlation with total TSI scores.

Table 10 presents the Pearson's bivariate correlations of SSE scores and all SSE subscale scores (Lifetime and Recent) with total TSI scores and scores of the TSI subscales most identified with PTSD symptoms, as delineated by Briere (1995, p. 12).

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Table 10: Correlations of SSE and Subscale Scores with TSI and Selected Subscale Scores ($\underline{N}$ = 382)

	TSI	AA	D	AI	IE	DA	DIS	ISR
SSE-L	.33 ***	.27 ***	.27 ***	.26 ***	.34 ***	.24 ***	.29 ***	.28 ***
SSE-R	.43 ***	.30 ***	.34 ***	.31 ***	.40 ***	.34 ***	.36 ***	.36 ***
SD-L	.33 ***	.26 ***	.26 ***	.29 ***	.33 ***	.21 ***	.27 ***	.28 ***
SD-R	.44 ***	.28 ***	.35 ***	.34 ***	.38 ***	.32 ***	.35 ***	.37 ***
CR-L	.34 ***	.25 ***	.26 ***	.25 ***	.34 ***	.27 ***	.30 ***	.29 ***
CR-R	.42 ***	.28 ***	.34 ***	.30 ***	.36 ***	.35 ***	.35 ***	.38 ***
DR-L	.24 ***	.23 ***	.19 ***	.18 ***	.24 ***	.17 ***	.25 ***	.21 ***
DR-R	.29 ***	.26 ***	.24 ***	.20 ***	.30 ***	.22 ***	.29 ***	.25 ***
WK-L	.15 **	.12 **	.14 **	.08 *	.22 ***	.16 ***	.12 **	.08 *
WK-R	.20 ***	.13 **	.15 **	.10 *	.26 ***	.23 ***	.19 ***	.14 **

*$\underline{p}$<.05. **$\underline{p}$<.01. ***$\underline{p}$<.001.

SSE-L = Schedule of Sexist Events – Lifetime (Total scores)

SSE- R = Schedule of Sexist Events – Recent (Total scores)

SD = Sexist Degradation and Its Consequences Subscale

CR = Sexism in Close Relationships Subscale

DR = Sexist Discrimination in Distant Relationships Subscale

WK = Sexist Discrimination in the Workplace Subscale

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In Table 10, the left-hand column presents the abbreviations of the SSE scales and subscales, both Lifetime (L) and Recent (R). The heading of the remaining columns presents abbreviations for total Trauma Symptom Inventory (TSI) scales and those subscales identified by Briere (1995) as based on DSM-IV PTSD symptoms. These are: Anxious Arousal (AA), Depression (D), Anger/Irritability (A/I), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), and Impaired Self-Reliance (ISR).

The correlation between total Lifetime Sexism (SSE-L) and total Trauma Symptom Inventory (TSI) scores is r=.33 (p<.001) and the correlation between total Recent Sexism (SSE-R) scores and total TSI scores is r=.43 (p=<.001). When these numbers are squared, it indicates that Lifetime Sexism scores account for nearly 11% of the variance in PTSD scores within this sample, and Recent Sexism accounts for more than 18% of that variance. Landrine and Klonoff (1997) write that "to be able to account for 10% of the variance in the outcome behavior [dependent variable] with a single independent variable is good, and that independent variable is regarded as a powerful one" (p. 214). It can concluded from Table 10 that women who experience a greater number of sexist events in their lives also experience a greater number of PTSD symptoms.

Hypothesis 1a, which states that women who experience greater numbers of sexist event in various dimensions of their lives—close relationships, distant relationships, workplace, and society—also experience a wide range of PTSD symptoms was

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confirmed: SSE subscale scores, both Lifetime and Recent, show a significant positive correlation with the scores on the TSI subscales comparable to the DSM-IV PTSD symptoms.

As can be seen on Table 10, scores on all subscales of the SSE show a significant positive correlation with all TSI subscale scores. All correlations are significant to the $p<.001$ level, except correlations between scores on the Sexist Discrimination in the Workplace (Lifetime and Recent) scales, which include correlations to the $p<.01$ and $p<.05$ levels. It can be concluded that women's experience of sexism, in all four dimensions measured on the SSE, is related to PTSD symptoms, as measured by the TSI clinical subscales. In all SSE subscales, correlations between SSE and TSI scores were higher for Recent scores than Lifetime scores, suggesting that the traumatic impact of sexist events is somewhat ameliorated by the passage of time.

The strongest correlations occur between the subscales of Sexist Degradation-Lifetime and Sexism in Close Relationships-Recent and TSI/TSI subscale scores. This indicates that personal sexist interactions have more traumatic impact on women than social or workplace interactions. Within the selected TSI subscales, the measurements of Intrusive Experiences (IE) and Dissociation (DIS) had the strongest correlations with the SSE subscales. These trauma subscales represent the DSM-IV Criterion B and C for PTSD, which describe symptoms of persistent reexperiencing of traumatic events and numbing of general responsiveness following trauma (1994, p. 428).

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Hypothesis 2, that women who have more gender-related stressors in their lives also experience more trauma-related symptoms was confirmed: Total Gender-Related Stressors (GRS) scores show a significantly positive correlation with total TSI scores.

Hypothesis 2a, that women who have more gender-related stressors in their lives will experience a greater number of PTSD symptoms was confirmed: Total GRS scores show a significantly positive correlation with TSI subscales.

Table 11 presents correlations between the GRS (total score and individual item scores) and TSI (total score and selected subscale scores).

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Table 11: Correlations Between GRS Scores/Individual Items and TSI Scores/Selected Subscales (N=382)

	TSI	AA	D	AI	IE	DA	DIS	ISR
Total GRS	.25 ***	.18 ***	.21 ***	.18 ***	.27 ***	.28 ***	.14 **	.16 **
1. Separated/divorced	-.06	-.11 *	-.04	-.07	-.04	.01	-.05	-.09
2. Relationship problems	.26 ***	.22 ***	.24 ***	.21 ***	.22 ***	.24 ***	.19 ***	.20 ***
3. Money problems	.08	.05	.08	.06	.08	.09	.05	.03
4. Education	.10	.03	.07	.05	.14 **	.13 *	.08	.07
5. Career	.03	.05	.03	.02	.08	.07	.03	-.02
6. Unwanted pregnancy	-.04	-.06	-.05	-.06	-.02	.01	-.09	-.06
7. Abortion/miscarriage	.04	.02	.04	.06	.04	.03	-.03	-.02
8. Infertility	.09	.06	.06	.10	.04	.03	.06	.10 *
9. Separated from child	.02	.00	.02	.01	.05	.07	.02	-.01
10. Adoption	-.05	-.05	-.06	-.06	-.01	.01	-.07	-.06
11. Household duties	-.11 *	-.03	-.08	-.07	-.06	-.06	-.16 **	-.14 **
12. Single parent	-.08	-.04	-.03	-.10	-.03	.01	-.09	-.11 *
13. Handicapped child	-.03	.00	-.02	-.07	-.02	.01	-.05	.04
14. Handicapped other	.04	.01	.02	.01	.10 *	.15 **	.03	.00
15. Sent to jail	.14 **	.02	.11 *	.15 **	.13 **	.10 *	.03	.08
16. Other sent to jail	.01	.00	.03	.00	.06	.05	-.01	-.03
17. Mental illness	.39 ***	.35 ***	.38 ***	.29 ***	.34 ***	.33 ***	.30 ***	.34 ***
18. Sexual harassment	.26 ***	.27 ***	.22 ***	.23 ***	.25 ***	.22 ***	.19 ***	.21 ***
19. Verbal abuse	.28 ***	.19 ***	.20 ***	.20 ***	.25 ***	.24 ***	.19 ***	.23 ***
20. Physical abuse	.26 ***	.21 ***	.20 ***	.24 ***	.26 ***	.23 ***	.16 **	.20 ***
21. Sexual molestation	.17 ***	.07	.10	.11 *	.16 **	.14 **	.10 *	.17 ***
22. Rape	.18 ***	.08	.10 *	.11 *	.19 ***	.18 ***	.12 *	.13 *

*$p<.05$. **$p<.01$. ***$p<.001$.

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In Table 11, the left-hand column contains abbreviations for each of the Gender-Related Stressors (GRS) questions and the top row has the abbreviations for selected Trauma Symptom Inventory (TSI) subscales. Total GRS scores can be conceived as a scale ranging from 0 to 22, with one point added for each YES response to questions related to gendered stressors. As can be noted, the total GRS scores show a significant positive correlation with total TSI scores at $r = .25$ ($p < .001$). Thus, total GRS scores account for 6% of the total variance in TSI scores in this sample. Total GRS scores also achieved a positive correlation with each of the TSI subscales associated with PTSD: AA, D, AI, IE, DA, DIS and ISR. These correlation coefficients ranged from $r = .14$ to $r = .27$, accounting for only 2% to 7% of the variance on the selected TSI subscales. Landrine and Klonoff (1977) report that correlation coefficients with this range are considered to be weak (p. 227).

Further examination of the individual Gender-related Stressors shows a lack of statistical significance for any of the correlations of individual GRS items and TSI scores, except for Questions 2, 11, 15, 17-22. The questions that achieved a significant positive correlation with TSI scores and TSI subscale scores were: Question 2, which asks if the respondent had ever experienced serious relationship problems; Question 15, which asks if the respondent had ever been sent to jail; Question 17, which asks if the respondent had ever had a serious mental illness; and Questions 18-22, which ask about sexual harassment, verbal abuse, physical abuse, sexual molestation and rape. The only category

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of gender-related stressors that achieved a significant positive correlation with total TSI and TSI subscale scores was violent experiences (verbal/physical/sexual assault or coercion).

Question 11, regarding the assumption of household and childcare duties, achieved a small but significant negative correlation ($p<.05$) with total TSI scores. This question also revealed an inverse correlation with each of the TSI subscales as well (although without significance in 5 out of 7 of these scales).

It can be observed that within this sample gender-related stressors and role burdens did not contribute significantly to women's PTSD symptoms, but that interpersonal abuse—including violence or coercion—did have an impact on those symptoms.

Controlling for Intervening Variables

In any correlational study, the presence of mediating variables may confound the results obtained (Black, 1993). In this study, the presence of gender-related stressors in a woman's life may have a substantial impact on her development of PTSD, and therefore affect the relationship between her experience of everyday sexism and her trauma symptoms. In order to determine the confounding influence of gender-related stressors (GRS) on SSE and TSI correlations, a partial correlation analysis was run controlling for GRS scores. The SSE and TSI correlations dropped from .33 (SSE-L and TSI) to .15

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($p<.01$) and from .43 (SSE-R and TSI) to .28 ($p<.001$), although they retained significance. When questions concerning the experience of violence or coercion (Questions 18-22) and Question 17 on mental illness were removed from the GRS, a second partial correlation analysis revealed that SSE and TSI correlations were not affected very much. The second partial correlation only lowered the correlations from .33 (SSE-L and TSI) to .28 ($p<.001$) and from .43 (SSE-R and TSI) to .39 ($p<.001$). It appears that the only gender-related stressors that have a mediating influence on the relationship between SSE scores and TSI scores are those associated with violence or coercion.

Similarly, in order to determine whether demographics are confounding variables in the correlations between SSE and TSI scores, a two-tailed partial correlational analysis was conducted controlling for all demographic characteristics. Although there was some decrease in the overall correlation, (from .33 to .29 in the SSE-L and total TSI scores and from .43 to .36 in the SSE-R and TSI scores) the correlations between the two scales remained at a $p<.001$ level. When a series of similar tests were run controlling for each demographic variable, the correlations between SSE-L and TSI remained very stable, varying from a high of .35 (feminist identity) to a low of .31 (clinical status). The correlations between SSE-R and TSI scores only varied from .45 (clinical status) to .37 (age). Again, all correlations remained significant at a $p<.001$ level. This supports the view that the demographic variables of this sample did not have a significant impact on

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the orrelation between the Schedule of Sexist Events scores and the Trauma Symptom Inventory scores. The relationship between the experience of sexism and the development of trauma symptoms appears to be independent from demographic profiles and characteristics.

Supplemental Analyses

Bivariate correlational analysis of demographic characteristics Since the demographic variables may have overlapping influences on the test scores, I ran a bivariate correlational analysis to examine their intercorrelations.

Table 12 presents a Pearson's bivariate intercorrelation among the demographic variables.

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Table 12: Intercorrelations of Demographic Items (N = 382)

	D.1	D.2	D.3	D.4	D.5	D.6	D.7	D.8	D.9	D.10	D.11	D.12
D.1 Age:												
D.2 Race:	-.25 ***											
D.3 Education:	.09	-.13 *										
D.4 Personal gross annual income:	.32 ***	-.12 *	.30 ***									
D.5 Total gross household income:	.18 ***	-.15 **	.16 ***	.41 ***								
D.6 Current employment status:	-.03	.11 *	-.18 ***	-.41 ***	-.16 **							
D.7 Past employment status:	.05	.00	.16 **	.18 ***	.01	-.18 ***						
D.8 Present job category:	-.04	.09	-.49 ***	-.39 ***	-.14 **	.34 ***	-.04					
D.9 Current partnership status:	.15 **	-.02	.15 **	.09	.17 ***	-.13 *	.04	-.17 ***				
D.10 Current parenthood status	-.19 ***	.02	.04	.02	-.27 ***	.06	.00	-.05	-.08			
D.11 Geographic location:	.20 ***	-.08	-.03	.04	.24 ***	-.09	.04	-.01	.05	-.16 **		
D.12 Current clinical status:	.05	-.09	.12 *	-.05	-.04	.11 *	.04	-.02	.11 *	.05	.08	
D.13 Feminist identity:	-.15	.06	-.29 ***	-.07	.02	-.02	-.05	.13 *	-.11 *	.08	.07	-.01

*p<.05. **p<.01. ***p<.001.

Examination of Table 12 reveals several significant intercorrelations between demographic variables that should be noted. Older age is associated with greater income (both personal and household), and with being partnered, which may obscure the relative importance of these variables in this study. Similarly, race is correlated with education as well as income (with Whites reporting higher education and income than non-Whites), which may influence the strength of the effect of this variable. Education is associated with higher income (both personal and household), being employed full-time and having a feminist identity. These overlaps may affect the interpretation of the impact of demographic characteristics on the dependent variables in this study. The interdependence of these variables, and their relative impact on test scores, will be examined in the following analyses.

Schedule of Sexist Events

In order to clarify the impact of demographic variables on SSE test outcomes, a series of stepwise multiple regressions (MR) were run. Follow-up analyses were conducted using Tukey's HSD. Table 13 presents the results of a stepwise multiple regression with the demographic variables entered as the independent variables and Lifetime Sexism (SSE-L) entered as the dependent variable.

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Table 13: Linear Stepwise Regression of SSE-L Scores on Demographic Variables

Step	Variable Entered		R	R Square	F	p
1	D.13	Feminist Identity	.29	.09	31.20	.001
2	D.12	Current Clinical Status	.34	.11	21.38	.001
3	D.10	Parenthood Status	.35	.12	15.73	.001

Post-hoc Tukey HSD at $p < .05$
D.13: Group 1 > Groups 2, 3, 4 and :
D.12: Group 2 > Group 1
D.10: No differences among groups

Table 13 reveals that when the demographic variables were entered simultaneously as independent variables into the computer program, the most predictive factors of Lifetime Sexism scores that emerged were feminist identity, clinical status, and parenthood status, in that order ($p<.001$). Follow-up Tukey's analyses were used to determine the relative influence of the lettered answer groups within each of these variables (a, b, c, d, e, f).

The Tukey's (HSD) found that women who report that they "a. strongly identify" as feminists have higher SSE-L scores than all other respondents.

A woman's current clinical status was the second most powerful determinant of Lifetime Sexism scores. Follow-up analysis revealed that those who were "b. presently in therapy" had significantly higher Lifetime Sexism scores than those who were "a. neither in therapy nor taking psychotropic medication."

The MR indicated that parenthood status also contributed significantly to Lifetime Sexism scores. However a follow-up Tukey revealed no significant differences among

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the groups of parents and nonparents. This apparent contradiction is most likely due to the effects of the first two variables (feminist identity and clinical status), which may have nearly total predictive power regarding this test.

Since a woman's feminist identity and clinical status appeared to dominate the impact of her demographic features on test scores, additional MRs were run, eliminating these questions. These will be presented simultaneously with MRs conducted for all test variables.

Table 13.1 presents results of a stepwise multiple linear regression on Lifetime Sexism scores with demographic variables, excluding current clinical status and feminist identity.

Table 13.1: Linear Stepwise Regression of SSE-L Scores on Demographic Variables (Excluding Current Clinical Status and Feminist Identity)

Step	Variable Entered	R	R Square	F	p
1	D.09 Partnership Status	.14	.02	6.91	.01

Post-hoc Tukey HSD at $p < .05$
D.09: Group 3 > Groups 1 and 2

When the MR was run without entering either clinical status or feminist identity as independent variables (Table 13.1), the only significant demographic predictor variable for Lifetime Sexism to appear was partnership status (or, sexual orientation). The

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Tukey's analysis indicated that cohabitating Lesbians had significantly higher Lifetime Sexism scores than both single and married/cohabitating heterosexuals.

Table 14 presents the results of a stepwise multiple linear regression on Recent Sexism scores with the demographic variables.

Table 14: Linear Stepwise Regression of SSE-R Scores on Demographic Variables

Step	Variable Entered		R	R Square	F	p
1	D.01	Age	.28	.08	28.80	.001
2	D.13	Feminist Identity	.35	.12	23.03	.001
3	D.10	Parenthood Status	.36	.13	16.78	.001

Post-hoc Tukey HSD at $p < .05$
D.01: Group 1 > Groups 2, 3, 4, 5 and 6
Group 2 > Group 5
D.13: Group 3 < Groups 1 and 2
D.10: Group 4 > Group 3

Table 14 reveals that the only significant demographic predictors of Recent Sexism scores were age, feminist identity, and parenthood status, in that order ($p<.001$). The age of the respondent was most responsible for the variance in the Recent Sexism scores. A follow-up Tukey analysis indicated the youngest cohort, a. ages 18-25, reported higher SSE-R scores than any other age group.

The variable of feminist identity showed a similar impact on Recent Sexism scores as with Lifetime Sexism scores. The Tukey's analysis revealed that women who

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reported being "a. strongly identified" or "b. identified" with feminism scored higher than those "c. somewhat identified" as feminists.

Parenthood status also had a significant impact on Recent Sexism scores. However, in this instance, follow-up Tukey's analysis indicated that nonparents had higher Recent Sexism scores than those with children living outside the home.

Table 14.1 presents the results of a stepwise multiple regression on Recent Sexism scores with the demographic variables, excluding current clinical status and feminist identity.

Table 14.1: Linear Stepwise Regression of SSE-R Scores on Demographic Variables (Excluding Current Clinical Status and Feminist Identity)

Step	Variable Entered	R	R Square	F	p
1	D.01 Age	.27	.07	27.53	.001

Post-hoc Tukey HSD at $p < .05$
D.01: Group 1 > Groups 2, 3, 4, 5 and 6

When the MR on Recent Sexism scores was run without entering either feminist identity or clinical status (Table 14.1), the only significant demographic variable to appear was age, with the youngest cohort (a. 18-25 years) having the highest scores.

Trauma Symptom Inventory

A series of multiple regressions (MR) were run on total TSI scores to determine the relative influence of the independent variables.

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Table 15 presents the results of a stepwise multiple regression on total Trauma Symptom Inventory (TSI) scores with the demographic variables.

Table 15: Linear Stepwise Regression of Total TSI Scores on Demographic Variables

Step	Variable Entered		R	R Square	F	p
1	D.12	Current Clinical Status	.32	.11	39.21	.001
2	D.01	Age	.44	.19	39.91	.001
3	D.03	Education	.46	.21	29.55	.001
4	D.07	Employment History	.47	.22	23.74	.001

Post-hoc Tukey HSD at $p < .05$
D.12: Group 4 > Groups 1, 2 and 3
D.01: Group 1 > Groups 2, 3, 4, 5 and 6
D.03: Group 4 > Group 6
D.07: Group 2 > Group 3

Table 15 reveals that the significant predictor demographic variables on TSI scores were current clinical status, age, education, and employment history ($p<.001$). Current clinical status scores would be expected to predict TSI scores, since it is a mental health measurement. In fact, this correlation helps substantiate the validity of the test. The follow-up Tukey revealed that women who were both in therapy and using psychotropic medication had higher TSI scores than all other respondents.

The next predictor variable, age, reflects the finding that younger women had higher TSI scores than older women. In fact, a follow-up Tukey revealed that the youngest cohort (ages 18-25) had the highest scores on this test.

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Education scores correlate negatively with TSI, i.e., less educated women have more trauma symptoms. A follow-up Tukey test disclosed that women with only some college had more trauma symptoms than those with college and post-graduate degrees.

Examination of the employment history variable reveals that women who had worked "b. off and on" outside the home were likely to have more trauma symptoms than those who have always worked.

Table 15.1 reports the results of a MR on TSI scores with demographic variables, eliminating clinical status and feminist identity.

Table 15.1: Linear Stepwise Regression of Total TSI Scores on Demographic Variables (Excluding Current Clinical Status and Feminist Identity)

Step	Variable Entered		R	R Square	F	p
1	D.01	Age	.28	.08	30.40	.001
2	D.04	Personal Income	.31	.10	19.37	.001
3	D.07	Employment History	.33	.11	14.52	.001
4	D.10	Parenthood Status	.35	.12	12.03	.001

Post-hoc Tukey HSD at $p < .05$
D.01: Group 1 > Groups 2, 3, 4, 5 and 6
D.04: Group 1> Groups 3,4,5
D.07: Group 2 > Group 3
D.10: Group 4> Groups 2 and 3

As shown in Table 15.1, when the MR was conducted on TSI with the demographic variables, eliminating feminist identity and current clinical status, the significant variables reported were age, income, employment history and parenthood

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status, in that order ($p<.001$). Tukey's analysis confirmed that women between 18 and 25 years of age, those earning below $10,000 per annum, those with "on and off" employment histories, and those who were not mothers reported the highest scores within this scale.

Bivariate correlational analysis of SSE scores and GRS scores. In order to determine the interrelationships among the scores of both SSE (total scores and subscale scores) and GRS scores, a Pearson's bivariate correlational analysis was run, and presented in Table 16.

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Table 16: Intercorrelations of GRS, SSE and SSE Subscale Scores (N = 382)

	GRS	SSE.L	SSE.R	SD.L	SD.R	DR.L	DR.R	WK.L	WK.R	CR.L
SSE.L	.44 ***									
SSE.R	.26 ***	.70 ***								
SD.L	.38 ***	.91 ***	.64 ***							
SD.R	.21 ***	.62 ***	.92 ***	.69 ***						
DR.L	.29 ***	.87 ***	.62 ***	.65 ***	.46 ***					
DR.R	.17 ***	.65 ***	.80 ***	.49 ***	.60 ***	.76 ***				
WK.L	.33 ***	.73 ***	.48 ***	.51 ***	.33 ***	.64 ***	.49 ***			
WK.R	.18 ***	.45 ***	.77 ***	.33 ***	.57 ***	.43 ***	.59 ***	.50 ***		
CR.L	.50 ***	.82 ***	.53 ***	.67 ***	.43 ***	.62 ***	.43 ***	.51 ***	.32 ***	
CR.R	.33 ***	.57 ***	.78 ***	.47 ***	.64 ***	.46 ***	.52 ***	.36 ***	.52 ***	.65 ***

*p<.05. **p<.01. ***p<.001.

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Examination of Table 16 reveals highly significant positive interrelationships among the test scores of the SSE, both total and subscale scores, and GRS scores. These results demonstrate that women who have higher numbers of gender-related stressors in their lives also experience more sexism in all four dimensions of their lives: close relationship, distant relationships, workplace and general sexist degradation. These results indicate that women who are overburdened both at work and at home may experience their stressors as sexist events in their lives.

In order to assess the relative impact of types of sexism on PTSD symptoms, a MR was run using the SSE and GRS scores as independent variables. Table 17 presents the results of a stepwise multiple regression on TSI scores with the testing instruments within this survey: SSE-L, SSE-R, SSE subscales, and GRS scores.

Table 17: Linear Stepwise Regression of Total TSI Scores on SSE.L, SSE.R, SSE Subscales and Total GRS Scores

Step	Variable Entered	R	R Square	F	p
1	SD.R (Sexist Degradation - Recent)	.44	.19	91.15	.001
2	CR.R (Close Relationships - Recent)	.47	.22	54.80	.001
3	GRS (Gender-Related Stressors)	.49	.24	39.48	.001
4	WK.R (Workplace - Recent)	.50	.25	31.51	.001

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Table 17 demonstrates that the most powerful indicator of total TSI scores within these variables is the SD-R scale (Recent Sexist Degradation and Its Consequences). The second most powerful predictor of TSI scores is CR-R (Recent Sexism in Close Relationships), the third is total Gender-Related Stressor scores (GRS) and the final most important variable is WK-R (Recent Sexist Discrimination in the Workplace). (Tukey's tests are not applicable since these variables are continuous.) This finding supports the contention that everyday sexism—especially recent events related to sexist degradation and those within close relationships—is more important in determining trauma symptoms than gender-related role burdens or stressors, which include violent events in women's lives.

Finally, Table 18 exhibits the results of a stepwise multiple regression on total TSI scores with all tested variables: SSE-L, SSE-R, SSE subscales, Gender-Related Stressors and demographic characteristics.

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Table 18: Linear Stepwise Regression of Total TSI Scores on SSE.L, SSE.R, SSE Subscales, Total GRS Scores and Demographic Variables

Step	Variable Entered		R	R Square	F	p
1	SD.R	(Sexist Degradation - Recent)	.44	.20	81.30	.001
2	D.12	Current Clinical Status	.53	.28	65.24	.001
3	CR.R	(Close Relationships - Recent)	.56	.31	49.98	.001
4	D.1	Age	.58	.34	42.39	.001
5	GRS	(Gender-Related Stressors)	.60	.36	37.72	.001
6	D.7	Employment History	.61	.38	33.21	.001
7	D.3	Education	.62	.39	29.63	.001

Table 18 reveals that when all the independent variables in this study are entered simultaneously, the most significant predictors of TSI scores are Recent Sexist Degradation subscale scores, current clinical status, Recent Close Relationship subscale scores, age, total Gender-Related Stressor scores, employment history, and education. Together these variables account for nearly 40% of the variance in TSI scores within this sample.

Again, this finding indicates the importance of everyday sexism, particularly recent events of sexist degradation and recent sexist events in close relationships, and a woman's age, as factors in developing trauma symptoms among women. Indeed, these types of everyday sexist events have greater impact in this regard than gender-related stressors and all other demographic variables.

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Summary of Results.

The descriptive statistics of this sample indicate that their demographic characteristics are similar to those of the standardization sample of both Landrine and Klonoff (1997) and Briere (1995), with the exception of education and household income. This sample reported higher levels of education and household income than the prior studies, but their personal income was consistent with that of the normative group. In addition, the test scores of the present sample were remarkably similar to the normative data of both the Schedule of Sexist Events and the Trauma Symptom Inventory, for both totals and subscales.

Sexism. There were few demographic variables that seem to affect the experience of sexism in women's lives. As Landrine and Klonoff (1997) reported, the experience of everyday sexism seems to cut across all socioeconomic and educational levels. The present sample showed no consistent variations in SSE scores due to race, educational level, income, employment status, marital status, or parenthood status. However, a significant difference in the experience of sexism was apparent between gay women and heterosexual women, with Lesbians showing clear evidence of higher scores on both Lifetime and Recent scales. Also, for Recent events, younger women exhibited elevated rates of exposure to sexism in their lives, with most of that variance determined by those 18-25 years of age. In addition, women currently in therapy and/or using psychotropic drugs had also experienced more sexism, both in their lifetimes and within the past year.

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Gender-related stressors. When a series of t-tests were run testing the relationship between the demographic variables and Gender-Related Stressor scores, it was found that only a woman's age, parenthood status, and clinical status had a significant impact on the number of gender-related stressors. Younger women (below age 36), nonparents, and those not in therapy have fewer gender-related stressors. In other words, as a woman ages and becomes a parent, she is likely to increase her number of gender-related stressors. She is also more likely to become a therapy patient.

PTSD. On TSI scores, younger women, less educated women, single women, and unemployed women scored significantly higher than their counterparts. In addition, women earning under $50,000 and those not working full-time scored significantly higher on TSI scores. Those with higher TSI scores tended to work occasionally or not at all, and were likely to not have children, although this finding may be an artifact of the younger age of those with the highest scores.

There were no apparent differences in TSI scores in regards to race, sexual orientation, or household income, but, as expected, those either in therapy and/or using psychotropic medication had higher TSI scores than the non-clinical population. Feminists scored higher on Lifetime Sexism scales, and somewhat higher than nonfeminists on Recent Sexism (although without significance), but showed no differences from nonfeminists on TSI scores.

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Relationships between variables. In the correlational study, Hypothesis 1, that total SSE- L/SSE-R and total TSI scores would be positively correlated, was supported with moderately strong correlations. Recent sexist events (SSE-R) were most strongly correlated with trauma symptoms, accounting for 18% of the total variance on TSI scores. Hypothesis 1a, that subscales of the SSE would correlate positively with subscales of the TSI associated with DSM-IV definitions of PTSD, was supported, since all SSE subscales correlated positively with all TSI subscales. Hypothesis 2, that total Gender-Related Stressor scores would correlate positively with total TSI scores, was supported, and Hypothesis 2a that total Gender-Related Stressor scores would correlate positively with TSI subscales was supported as well.

The exploratory study provided evidence that although many of the participants report a wide range of gender-related stressors in their lives, the only categories of stressors (as measured by the Gender-Related Stressor Scale) that provide a positive correlation with trauma scores are those of violence (verbal/physical/sexual abuse and coercion) and "serious relationship problems," which may also reflect relationship abuse. In fact, when questions on violence and coercion (and one on mental illness) were removed from the GRS, the modified GRS score had very little statistical impact on the relationship between SSE and TSI scores.

A bivariate intercorrelation analysis among the demographic variables helped clarify the overlapping influence of those factors, revealing that age, income and being

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married are positively intercorrelated, as are being White, educated, and having higher income. Higher education is also associated with higher income, full-time employment, and being feminist.

A stepwise multiple regression revealed that the demographic variables most predictive of Lifetime Sexism scores were feminist identity and clinical status; those who "strongly identify" as feminist and those presently in therapy revealed the highest scores on this scale. Within Recent Sexism scales, the most predictive demographic variables were age and feminist identity, with the youngest cohort (ages 18-25) and women who "identify" and "strongly identify" as feminists having the highest scores. Omitting clinical status and feminist identity from the demographic factors revealed that sexual orientation (partnership status) was singularly predictive of Lifetime Sexism scores, with cohabitating Lesbians having the highest scores, and age was the only predictor of Recent Sexism scores, with those 18-25 having the highest scores.

Similar analyses on TSI scores revealed that clinical status, age, education and employment history scores were the most predictive demographic variables. Obviously, clinical status reflects trauma symptoms, accounting for its prominence on this scale. Women who were presently in therapy and using psychotropic medication at the time of the survey had the highest scores on the TSI of all respondents. In addition, younger women, less educated women and women who have worked sporadically (rather than consistently) scored higher on TSI than their counterparts. When clinical status and

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feminist identity were removed from the analysis, the predictor variables were: age, personal income, employment history and parenthood status, in that order. The youngest cohort, who are those earning below $10,000 per annum, have worked sporadically, and are nonparentss, had the most trauma symptoms.

Among the remaining independent variables, a bivariate correlational analysis confirmed highly significant relationships between GRS scores and all SSE test scores, including subscales. When these variables were tested against the TSI, scores on the Recent Sexist Degradation subscale were most predictive of TSI results, followed by Recent Sexism in Close Relationship scores, total Gender-Related Stressor scores, and Recent Sexist Discrimination in the Workplace scores. This results supports the supposition that everyday sexism, particularly as experienced as recent sexist degradation, or in close relationships, is more predictive of trauma scores than gender-related stressors.

When all independent variables were analyzed simultaneously, the order of the most significant predictors of PTSD was: (1) Recent Sexist Degradation and Its Consequences (2) current clinical status (3) Recent Sexism in Close Relationship (4) age (5) total Gender-Related Stressors (6) employment history and (7) education, accounting for nearly 40% of the total variance on that test. Again, the experiences of recent everyday sexism were more predictive of trauma scores than all other factors.

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Chapter VII - Discussion

This chapter will review the findings of the study and discuss their implications for understanding the traumatic impact of everyday sexism on women's mental health. I will discuss the survey results, the analyses of the collected data, and their relationship to evolving theories of sexism and trauma.

Sample Characteristics

The women surveyed in this study reflect the age distribution of the population of Long Island, NY, the site at which the study was primarily held (Long Island Regional Planning Board, 1998). The majority (71.4%) fall within ages 26-55; nearly ten percent are between 18 and 25 years of age; and 18.4% are over the age of 56—a population often excluded in survey research (Table 1.). They are mostly White (87.7%), with 12% minority representation (African American, non-White Hispanic, Asian and Other), which also reflects the ethnic composition of the suburban communities of Long Island, NY (Long Island Regional Planning Board, 1998). Over 72% of the respondents reported living in suburbia, 17.5% in an urban center and 8.4% rural.

The population is skewed toward higher education; 46.9% have obtained post-graduate training, as opposed to the 1990 U.S. Census Report which showed 7.2 % post graduate degrees in the general population. However, the personal income of the women,

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which represents their individual salaries, does not reflect their educational status. Nearly sixty-eight percent of the respondents reported earning below $50,000 per annum, which is similar to that of samples in both Briere's (1995) TSI standardization sample (male and female, n=836) and Landrine and Klonoff's (1997) SSE sample (females, n=631). Briere reported 59.5% of respondents earning below $40,000 and Landrine and Klonoff reported two thirds earning below $40,000. However, household income in the present sample, which includes all the salaries within one home, does reflect the higher levels of suburban incomes, with 37.7% of households earning more than $90,000.

The majority of the respondents are employed full-time (66%) and 17% are employed part-time, some while they are students. Seventy-five per cent have "always worked for wages," and an additional 18.6% have "worked on and off for wages." (The national norm for women is 58% employed full-time, according to the Bureau of Labor Statistics for 1999.) The overwhelming majority (60%) categorize their jobs as "professional."

Fifty-three per cent are married or living with a man, 36% are single heterosexuals and 10% self-identify as either Lesbian or bi-sexual (6.3% living with another woman.) These figures are comparable to the 1990 Census Report, which reports 54.8% of the population as married and 45.2% as unmarried. They also parallel Briere's (1995) TSI standardization sample, in which 57.1% are married and 42% are unmarried. Landrine and Klonoff's (1997) lower "married" rates—30% and 37% in two

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samples—reflect their use of college students as major participants in their study. The current sample also reflects a wide distribution of parenthood status: 25.7% live with children under 18; 23.3% have grown children outside the home; 9.2% live with children over 18; 39% are without children.

Respondents represent both clinical (those presently receiving psychotherapy) and non-clinical status. Within this sample, 60.2% are neither in therapy nor using psychotropic drugs; 22.5% are in therapy; 4.5% are using medication only; while 5.8% utilize both drugs and therapy. These clinical rates are higher than those of Briere's sample, in which 87.2% of respondents were neither in therapy nor taking psychotropic medication. Since Briere's sample included both sexes, this difference may reflect women's greater tendency to seek mental health services (Russo, 1995), or may be due to the propensity of New York suburban well-educated women to enter therapy.

The final question on the demographic questionnaire asks about one's self-identification as a "feminist." No definition of feminism was included, allowing for a subjective interpretation of the question. A majority of the women classified themselves as feminists: 36% "somewhat identified" with feminism; 30% "identified" with feminism; and 20% "strongly identified" with feminism, while less than 12% "did not identify" as feminists. This response may be due to the fact that the preponderance of subjects in this study were White highly-educated women living in households with high incomes. This population is likely to identify with the women's movement, while poor

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women of color are less inclined to adopt its goals. (Several women of color wrote in their survey commentary that they were more sensitive to the existence of racism in their lives than the presence of sexism.)

On the other hand, this result may reflect feminist sentiment among women in general, which is often distorted and diminished in the public media. Women in American society profess strong feminist views on many national surveys. In most polls, between 75% and 95% of women credit the women's movement with improving their lives (Faludi, 1991). The 1995 Harris Poll on National Women's Equity found that by a margin of 51% to 35%, a majority of women identify as feminists. A1989 Time survey reported that 82% of all women believe the women's movement is still improving the lives of women and fully 90% of young women (aged 22-29) believe the movement is still improving women's lives (Feminist Majority Foundation, 2000).

Sexism/SSE

One purpose of the present study was to expand the definition of gender-related violence against women to include everyday sexist events. For many women, the experience of being hassled, harassed, demeaned or ridiculed can be as psychologically damaging as being assaulted. In addition, the vicarious threat of assault that is experienced by being part of an oppressed group can be considered a form of violence as well. By demonstrating that the experience of everyday sexism contributes to trauma

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symptoms, it is possible to include these common nonviolent sexist acts on the continuum of violence against women.

In order to measure the impact of everyday sexist events, the women in this study all completed the Schedule of Sexist Events (SSE; Klonoff and Landrine, 1995). This instrument was modeled on standardized tests that measure generic stress by quantifying life-events that are deemed stressful. The SSE authors conceptualized sexist discrimination as the occurrence of gender-specific negative life events, or gender-specific stressors, that can be measured in a similar manner (Klonoff and Landrine, 1995). These events were tested along two dimensions: Lifetime Sexism (SSE-L scores) and Recent Sexism (SSE-R scores) and within four domains: Sexism in Close Relationships, Sexist Discrimination in Distant Relationships, Sexist Discrimination in the Workplace and Sexist Degradation and Its Consequences. One hundred percent of the women in this sample experienced some type of sexist behavior within their lifetimes. Similarly, 100% of the women experienced sexist behavior within the past year.

The women's experience of Lifetime Sexism (Table 2) attests to the widespread prevalence of sexism in society: 98% report hearing sexist jokes within their lifetime; 94% have been sexually harassed; more than 92% have been disrespected because they are women; and nearly 90% experienced sexist behavior from people in service jobs. Within these categories, approximately one fourth of the respondents had experienced these events "A LOT (26-49%) of the time." More than 85% have been called sexist

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names; 87% experienced sexism by strangers; 87% experienced sexism by their employers; and more than 83% experienced sexist behavior from their boyfriends or spouses. In these categories, approximately one fourth of the women had these experienced "SOMETIMES (10-25% of the time)" and more than one third had them "ONCE IN A WHILE (Up to 10% of the time)." Eighty percent experienced sexism from colleagues, over 78% from people in helping jobs, and more than 75% from teachers, with one quarter of them reporting this happening "A LOT." Nearly 61% experienced sexism at work; more than 66% experienced sexism in their families; and more than 63% were picked on or physically harmed because they are women. A total of 79.7% of all respondents felt their lives would be different had they not been treated unfairly because they were women.

Women who completed this survey also reported that they had many encounters with Recent Sexism, i. e., within the past year (Table 3). This, too, attests to the rampant and pervasive presence of sexism in our society. Within the past year, more than 86% of respondents had heard sexist jokes; more than 81% wanted to tell someone off for being sexist; nearly 76% had experienced sexism by people in service jobs; more than 72% were disrespected due to their sex; more than 72% experienced sexism from strangers; and over 58% were sexually harassed. Also, in the past year nearly half of respondents experienced sexism by people in helping jobs, half were treated in a sexist way by

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boyfriends or mates, and nearly half felt that their lives would be different if they had not experienced sexist treatment.

Ironically, the ubiquity of sexist behavior encountered by women may contribute to its invisibility as an oppressive force in their lives. Young-Bruehl (1996) suggests that this may explain why social reformers often overlook the need for social change related to sexism. Women themselves are often unaware of the sexist motivation of their interpersonal interactions. Indeed, several women reported that answering the questions for this study had a "consciousness-raising" effect, because they realized that events that theyconsidered accidental happenstance, were in fact due to their gender.

Demographic factors in experiencing sexism. When statistical tests were run to determine differences in the experience of sexism among demographic groups, it was discovered that age was not a significant factor in Lifetime Sexism (Table 5), nor was it a predictive factor for this scale (Table 13). However, age did play a major role in women's experiences of Recent Sexism (Table 6). Younger women (under age 36) reported significantly more exposure to sexism in the past year than older women (age 36 and older). In fact, age was the most predictive demographic factor accounting for Recent Sexism in this sample; the youngest cohort within the sample, aged 18 - 25 years, experienced more recent sexism than any other age group (Table 14). Because "feminist identity" and "clinical status" dominated the results of the multiple regressions, a second regression was run, eliminating these factors from consideration. When this was done, the

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only factor predicting exposure to recent sexist events was being between the ages of 18 and 25 (Table 14.1).

These data suggest either that younger women are targeted for more sexist behavior, or that they have a greater awareness of sexism due to a cohort factor, that is, being born after the women's movement. Younger women may have a heightened awareness of sexism due to exposure to the ideas of the women's movement, which broadened public consciousness of sexism via women's studies classes, popular media and feminist therapies. However, older women have not been immune to the influence of the women's movement, yet their scores do not reflect as many sexist events in their lives as those of the younger women. It is therefore likely that young women do suffer greater numbers of sexist abuses than their older counterparts.

In fact, the literature indicates that younger women encounter more sexist behavior in dating situations, on campuses, and at the workplace than older women (Baker, 1989; Gutek, 1985; Koss, 1994). They are more likely to experience date and acquaintance rape, sexual harassment, stalking, verbal abuse and objectification as sex symbols than women who have some protection due to their older (and perhaps married) status (Klein, 1984).

Landrine and Klonoff (1997) also reported that age was insignificant in determining lifetime experiences of sexism, but highly significant in determining sexism within the past year. In their study, women under the age of 30 experienced more sexist

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events in the year prior to the test than women 30 and older. Moreover, by determining that different age groups scored inconsistently—older women scored higher than middle-aged women—Landrine and Klonoff discounted the birth cohort effect (p. 54).

(The difference in scores between Lifetime and Recent Sexism in women's lives should not be taken to indicate an inconsistency in reporting the strength of demographic characteristics. Factors that were most influential in the past year, such as age, may decrease in importance over a lifetime, while factors such as partnership status increase.)

Higher education had some impact on the experience of sexism within the present sample. Among these women, those with college degrees reported more Lifetime Sexism than women with no college degrees, but showed no difference in Recent Sexism (Table 5). Landrine & Klonoff (1997) showed significant educational differences in Lifetime scores only in their first study, and no educational differences at all—in either Lifetime or Recent scores—within their second sample. They also found that although women with some college scored higher than those with a high school diploma in Lifetime Sexism, there were no differences between these two groups and women with a college or graduate degree (p. 52). This variation in scores among educational groups led to their conclusion that education was not directly related to a woman's experience of sexism.

Among the participants of the present study, college education is significantly correlated with being White, partnered, having higher job status and income, and with being feminist (Table 12). In fact, educational level may be entirely subsumed by

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"feminist identity," which appeared on the multiple regressions (Tables 13 and 14) as a determining factor in experiencing sexism: being feminist was the most predictive factor on the Lifetime Sexism scale and the second most predictive factor on the Recent Sexism scale, after age. Nevertheless, the higher Lifetime Sexism scores among college educated women should not be ignored. It may be an indication that higher education increases women's awareness of the injustices in their lives and provides a vocabulary for addressing them. Education exposes women to political, economic and social theories that stimulate alternate modes of assessing human dynamics that otherwise appear immutable.

Single heterosexual women experienced more sexism within the past year than married or cohabitating women, but showed no difference in lifetime experiences (Table 5). Landrine and Klonoff (1997) found that single women (never married) reported experiencing sexist discrimination significantly more often than married women both for their lifetimes and for the past year. Similarly, nonparentss encountered more sexism within the previous year, but showed no significant differences from women who were mothers over a lifetime (Table 5).

These results indicate that single women and those who do not have children—often an overlapping group—experienced greater discrimination in the year prior to the test than women who choose to enter marriage and have families. While some of this effect may be explained by their younger age, there is a strong possibility that

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women who live outside the prescribed roles of wife and mother are more likely to suffer sexist victimization than those who conform. Also, Lott (1994) has reported that single working women often have a higher employment status than married women, and therefore may be targeted for more harassment at work, and in the culture at large, for their ascendancy in the typically male world of work. They also likely to experience the effects of hitting the "glass ceiling" in their professional lives (Kleinman, 1991).

The demographic factor that had the most consistent impact on the experience of sexism within this sample was that of sexual orientation: Lesbians experienced more sexism both with the past year and during their lifetimes than heterosexual women. (Table 5). In fact, when "feminist identity" and "clinical status" were eliminated as demographic factors, the only significant predictive demographic factor to emerge on a multiple regression on Lifetime Sexism was partnership status (or, sexual orientation) (Table 13.1). Further analysis revealed that cohabitating Lesbians, who are more easily identifiable than single Lesbians, had greater experience with sexism than both single and married (or cohabiting) heterosexuals.

Lesbians suffer from homophobia that is often infused with sexism. In fact homophobia toward both sexes has been conceptualized as a more extensive and virulent form of sexism. Young-Bruehl writes, "Lesbian baiting is so common a method of control...that there are analysts of homophobia who take it to be completely describable as sexism" (1996, p. 151). One such analyst entitled her well-known work Homophobia:

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A Weapon of Sexism (Pharr, 1988). Apparently, those women who obviously choose to live outside the normative structure of heterosexism face additional discrimination and abuse from the majority community.

There were no significant differences on either Recent Sexism or Lifetime Sexism scores due to race, income (personal or household), employment status, job category, or geographic location (Table 5). (The lack of racial differences in scores deviates from Landrine and Klonoff's finding that women of color had greater numbers of sexist events in their lives, particularly within the year prior to the test.) The consistency of SSE scores within demographic categories supports the findings of Landrine and Klonoff (1997), who discovered in their study that women on welfare and wealthy women reported similar experiences with sexist discrimination, and therefore concluded that the experience of sexism cuts across nearly all socio-economic categories. In reviewing their results, they wrote that:

> (The) absence of...social class differences is perhaps consistent with what feminists might expect: The privilege associated with higher social class or education does not exempt women from their status as women in a patriarchal society. Women who differ in social class, education, and culture may indeed differ in their customs, socialization experiences, behavioral patterns and even in their inner lives, but they nonetheless have

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> one thing in common: the way they are treated in the world for being women. (p. 62-63)

Benokraitis and Feagin (1995) also addressed this phenomenon when they wrote that "being a woman is frequently a better predictor of discrimination and inequality than such variables as age, religion, intelligence, achievements or socioeconomic status." They continue:

> Although men may be discriminated against because, for example, of their education, religion, race or political affiliations, they are seldom treated unequally *because* they are men. Quite to the contrary, being a man may neutralize or override racial, age, sexual orientation, or religious discrimination. At many points in their lives, all women, on the other hand, will be treated unequally simply *because* they are women and regardless of other variables. (p. 39)

The present study, too, revealed that women are not protected from sexist acts by ethnicity, wealth, profession, or place of residence; they are still targeted for discrimination and abuse regardless of their social or financial status.

The demographic questionnaire also included two additional questions: one asked about the respondent's present clinical status (i. e., current experience with mental health services), and the second asked about her feminist beliefs. The relationship between these factors and sexism will be discussed below.

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Clinical status. In the present study, women who were currently in therapy and/or using psychotropic drugs experienced significantly more sexism both during their lifetimes and during the prior year than women who were not in therapy or using medication (Table 5). In fact, a woman's current clinical status was the second most likely predictor of Lifetime Sexism scores after feminist identity, with women who were presently in therapy exhibiting higher scores than those neither in therapy nor using medication (Table 13). These results indicate that women who are in therapy may have a greater awareness of sexism in their lives. The experience of being in therapy is often a consciousness-raising event for many patients, as they begin to understand the sexist motivation of much of the treatment they are encountering in the world (Nes & Iadicola, 1989). Particularly if women engage in feminist-oriented therapy, they often cease to see their stress as determined solely by internal deficiencies. Rather than continuing to engage in self-blame for their treatment, they learn instead to recognize instances of discrimination and abuse, and assert their rights to be respected (Espin & Gawelek, 1992; Prozan, 1992).

Another interpretation of these results is that women who experience more sexist events in their lives develop more psychiatric symptoms, and therefore seek therapy and/or medication. As with physical and sexual abuse, everyday sexist treatment may provoke cognitive and affective responses that lead to psychological distress (Landrine &

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Klonoff, 1977; Landrine, Klonoff, Gibbs, Manning, & Lund, 1995). The veracity of this interpretation is further supported by the findings of this study.

Feminist identity. The last question on the Demographic Questionnaire asked the participants about their identification with feminist beliefs, ranging through six levels from "strongly identify" to "strongly do not identify" with feminism. Feminism is not defined, allowing women to respond from their individual subjective understanding of the concept.

Landrine and Klonoff (1997) asked a similar but dichotomous question in their study ("Are you a feminist?") and found that those who responded affirmatively scored significantly higher on both Lifetime Sexism and Recent Sexism scales than those who did not (p. 116). A variant of this question was included in the present study as a result of Landrine and Klonoff's suggestion that feminism is a critical factor in a woman's demographic profile. They wrote:

> Feminist and non-feminist women may be two very different populations of women—as different as minority and White women—for whom psychological and sociological principles and variables play different and perhaps opposite roles. It may be as important to ask women (in studies of every type) if they are feminists as it is to ask them about their age, social class, and ethnicity. (p. 117)

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In the present study, those who self-identified as feminists (from "somewhat" to "strongly") experienced significantly more sexism throughout their lifetimes than those who did not identify as feminists. And, although they failed to be significant, scores of feminists in Recent Sexism were also higher than nonfeminists (Table 5). When a stepwise multiple regression was run on Lifetime Sexism scores with all demographic variables (Table 13), feminist identity was chosen as the best predictor of women's scores on that scale, with those who reported that they "strongly identify" as feminists providing the highest scores. Similarly, when a multiple regression was run on the Recent Sexism scale with all demographic variables (Table 14), feminist identity was chosen as the second best predictor of scores, after age. Follow-up analysis revealed that those who "strongly identify" and those who "identify" as feminists provided the highest scores on this scale.

It is unknown whether feminists are targeted for maltreatment because of their beliefs and behaviors, or whether they perceive, and label as sexist, behaviors that nonfeminists might see as "normal." Since sexism appears to affect all women of differing ethnic, educational, and economic strata, and because most feminists are not readily identifiable to the public, the latter rationale seems more plausible. The framework of feminist ideology helps women to recognize and acknowledge unfair behavior being perpetrated against them. Feminists are sensitive to subtle instances of

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oppression, and can more easily identify interactions that are motivated by misogyny. Thus their experience of sexism in their lives is increased.

Gender-Related Stressors Questionnaire

Sexism includes both interpersonal behaviors between the sexes and culturally determined roles that are supported by societal institutions, including government, religion, law, and education. As Kreiger et al. state, one aspect of sexism is the "linkage of male sexuality with power and prerogatives, with women's sexual/social roles often reduced to the categories of 'virgin,' 'mother,' or 'whore' " (1993, p. 90). The Schedule of Sexist Events (Klonoff & Landrine, 1995) used in this study was designed to elicit information regarding sexist treatment of women, but does not address social roles as an aspect of sexism. Nor does the SSE specifically ask about physical, sexual and verbal abuse perpetrated against women. For these reasons, the present survey added a YES/NO checklist of questions that investigates gender-related stressors in women's lives other than their "unfair" treatment.

Questions included on this checklist, termed the Gender-related Stressors Questionnaire (GRS), were drawn from the work of Wolfe and Kimerling (1997), who designed a Life Stressor Checklist-Revised which measures gender-related stressors and burdens that might induce trauma symptoms. Their goal was to broaden the range of Criterion A events commonly tested for trauma symptoms—war, crime, and natural

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disasters—by adding developmental and psychosocial disruptions that are particular to women, or more burdensome to women, such as reproductive loss, childcare, poverty, education/career restrictions, and gendered abuse. The twenty-two questions on the Gender-Related Stressors Questionnaire (GRS) used in the present study cover issues related to family care, family separations, reproductive issues/experiences, financial problems, and violent experiences (verbal/physical/sexual assault or coercion). A review of the responses to this checklist reveals the high percentage of gender-related stressors endured by the studied population.

For the women within this sample, there was a high degree of negative experiences within their close relationships (Table 6). More than 77% percent of the respondents reported having had "serious relationship problems," the highest score of all GRS questions. (The second highest was having experienced emotional or verbal abuse within a relationship – 56.7%). Since ninety percent of respondents were heterosexual, these scores mostly represent problems in male-female unions. Other researchers in the trauma field (Frazier, 1998; Yehuda, cited in Murburg, 1999) have reported that women being surveyed or treated for trauma symptoms tend to cite relationship problems as their worst lifetime trauma, rather than the typical Criterion A events which were being targeted. It is the personal, intimate interactions with males closest to them that create the greatest distress for most women in our culture. Shere Hite, the social scientist known for her 1970s groundbreaking work on women's sexuality, conducted a national survey on

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sexuality and relationships that presented the views of 4,500 women. This 922-page report concluded that most of the respondents were "distressed and despairing over the continued resistance from the men in their lives to treat them as equals. Four-fifths of them...still had to fight for respect...at home, and only 20 percent felt they had achieved equal status in their men's eyes" (1987, p. 41-42).

Relationships serve as a means of self-enhancement for women, both emotionally and financially. Thus, problematic intimate relationships may induce psychological distress for women. Marriage is viewed as the ultimate goal for single women and female worth is often measured in terms of their ability to attract and hold the attention of men. As a result, a woman is rewarded in our culture for gaining a husband, while a man is typically rewarded for remaining a bachelor, the living symbol of American independence. (Men are designated as Most Eligible Bachelors, while single women are often derided for being spinsters.) Women are likely to be economically dependent on a male partner sometime in their lives due to the unequal earning potential between the sexes and women's greater responsibility for domestic duties. Inability to create or maintain a successful relationship is therefore perceived not only as a mark of a woman's inferiority, but as a threat to her financial security as well. These ideas persist although the traditional family is often the site of male domination and abuse, and only rarely provides the kind of financial security women seek.

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Women continue to be given the major responsibility for maintaining relationships and for making home life successful. Even theorists in the field of feminist psychology, such as Jean Baker Miller and Carol Gilligan, have promoted the idea that women have a special capacity for empathy, caretaking, and relatedness (Jordan et al., 1991). Feminist family therapists Holmes and Anderson (1994) stated that these newer theories of female development "describe the structuring of women's sense of self [as] organized around being able to make and then to maintain affiliations and relationships" (p. 42). Wright and Fish, who are also feminist therapists, have written that "family therapists have defined women solely in terms of the couple or family and have thus measured women's growth, health and emotional functioning from that vantage point" (1997, p. 206). These theories reflect the general view that responsibility for successful interactions in personal relationships rests with women and that failure in this realm reflects poorly on their capacity for intimacy. Thus, for women, problems in intimate relationship tend to create feelings of decreased self-worth, guilt, ineffectiveness, and anxiety as well as grief over the loss of a loved one.

According to the responses in this study, more than a third of the women were separated or divorced at some time (36.1%) and many of the women have endured serious abuse within their relationships with men (Table 6). More than half were emotionally or verbally abused; more than a third had been abused or physically attacked by someone they knew; nearly one third had been sexually molested; and almost one

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quarter had been forced to complete oral, anal or genital sex. These figures are especially startling to find within a mainly suburban, upper-middle class, highly educated population, where it is generally believed fewer sexist abuses occur. (Most epidemiological studies of interpersonal abuse report that women living in poverty experience higher rates of victimization, regardless of race or ethnicity [Koss et al., 1994]. This excludes rape, which cuts across class boundaries [O'Toole, 1997]).

These results, however, are consistent with data that corroborate the broad scope of gender-related abuse in women's lives. As Koss et al. reported in their major review of the extant literature,"...the prevalence of...these forms of violence is extraordinarily high; far from being unusual events, acts of violence against women are commonplace" (1994, p. xvii). By and large, the perpetrators of these assaults are known to their victims. Women are more likely to be attacked, injured, raped, or killed by current or former male partners than by any other type of assailant (American Medical Association, 1991).

Women also face discrimination and abuse in the workplace and academe. Gutek and Koss (1993) term sexual harassment the "last great open secret," an assertion supported by the fact that 45.9% of respondents in this study reported having experienced this type of abuse either at work or at school (Table 6). This figure is close to that of recent surveys that concluded that half of all working women have been sexually harassed while on the job or in school (Fitzgerald & Shullman, 1993). Like other types of abuse, sexual harassment is a structural problem, not simply an instance of individual

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misbehavior. Koss et al. (1994) have written that "(s)exual harassment operates as an instrument of social control, as demonstrated by studies showing that women are most at risk in occupations traditionally reserved for men, and that women who report harassment commonly experience retribution, including being fired or forced to quit their jobs" (p. 113).

Sexual discrimination and harassment may contribute to the financial problems reported by respondents. In the present study, nearly 60% of the women reported a household income of more than $70,000 per annum (Table 1), and nearly forty percent had household incomes above $90,000, while the personal incomes of the women were generally below $50,000 (67.9%). Although nearly one half of the women had post-graduate degrees, one quarter of them reported having had "serious money problems" during their lives (Table 6). This was true even though 66% were currently employed full-time, 60% define themselves as "professionals," and more than 75% had always worked for wages (Table 1). These facts reflect the continuing wage gap in American life; in 1994, women who worked full time earned only 77.9% of the median earning for men (Davis, 1999, p. 25). As reflected in this survey, this discrepancy persists even within the highest strata of education and income brackets. The U.S. Bureau of the Census (1992, pp. 94-95) has reported that some of the higher educated women have the worst earnings relative to men. For example, female college graduates earn 71% of what comparable males earn, while females with post-graduate professional degrees earn 63%

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of a comparable male's salary. (Women with doctorate degrees earn 76% of a comparable male's salary.)

These examples of sexist discrimination at work and school are compounded and reinforced by the familial demands made upon women. More than one quarter of the present respondents reported that they had been prevented from continuing their education because they were women and an equal number felt they had been prevented from pursuing or continuing a career for that reason (Table 6). More than half (53.3%) were responsible for childcare and/or household duties in addition to working outside the home, and more than a third (35.1%) were responsible for care of a severely handicapped or ill family member. In spite of their increased presence in the job market, women still do the majority of household and childcare duties. Time-budget surveys in the U.S. have shown that women (both employed and non-employed) spend an average of 214 minutes per day on domestic chores, and men spend 27 minutes per day, with employed women doing nearly twice as much housework as men (Benokraitis & Feagin, 1995, p. 103-104).

Women in the present study also reported experiences related to reproduction that create particular stress for women. Over 39 percent had had miscarriages or abortions; 11.8% experienced infertility for longer than one year; 6.5% had an unwanted pregnancy that was brought to term; five women had given up a baby for adoption (1.3%) and 7 (1.8%) women had been separated from their children against their will (Table 6). These numbers reflect the fact that every year, millions of women suffer a childbearing loss. In

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1995, the National Center for Health Statistics reported that 6.1 million women, or 10.2% of the female population, experienced infertility. Others suffered from miscarriage (10% of all pregnancies), ectopic pregnancies (1 in 66 pregnancies), and perinatal deaths (7 in 1,000 births), as well as loss due to abortion—1.3 million in 1997 (Centers for Disease Control and Prevention, 2000). In describing her emotional state, Kathryn March, who experienced pregnancy loss, infertility, and a perinatal death, wrote of her experience, which seems to parallel trauma victims :

> I felt like a failure...I came to recognize some of the characteristics of my situation: the night sweats, the forgetting to breathe, the inability to complete sentences, the fatigue, the anger, an increased...desire for more children, my monochrome vision and the general two-dimensional flatness to the world, the sense that time had stopped still, the fear that my own ill fortune could become contagious. (1994, p. 152)

The fact that the American medical system is frequently insensitive to the emotional needs of these women often adds to their sense of loss and grief.

Surprisingly, another source of loss for women in this study was incarceration. One fifth of the respondents reported having a close family member sent to jail (Table 6). Again, this is not consistent with our stereotype of this White, suburban, upper-middle class, profession sample. Yet, 20% of this population has suffered the pain of having a relative in jail. Ten of the women, or 2.6%, had been jailed themselves.

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It is perhaps not surprising that more than twenty-seven percent of the sample reported having had a serious mental illness—panic attacks, eating disorder, suicidal depression, or hospitalization (Table 6). This finding is similar to that of the National Comorbidity Survey, conducted in 1990-1992, which found that among the 8,098 people interviewed, 23% of the women had experienced an affective disorder in their lifetime (of these, 21.3% had experienced a major depressive disorder) and 30% had experienced an anxiety disorder during their lives, including panic disorder, phobias, or generalized anxiety disorder (Kessler et al., 1994). The authors of this study commented on the finding that women had higher prevalences than men of affective disorders, anxiety disorders, and nonaffective psychosis, at an average rate of almost two to one.

Conceptualizing mental illness as a stress response helps in understanding the high rates of mental disorder displayed among women. Rather than isolating individual cases of psychopathology, theoreticians and clinicians can better perceive the causation and contours of female mental distress by examining women's lives, and their symptoms, in the aggregate. As Adams (1990, p. 366) stated, "For some groups of people, psychosocial stresses become so regular, chronic and additively severe that they are said to make such people more vulnerable to psychopathology and to place them at significantly greater risk."

Additional analysis of the impact of demographic factors on gender-related stressors revealed that within this sample, as a woman aged and became a parent, her

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number of gender-related stressors increased. She was also more likely to become a therapy patient (Table 7).

Post-Traumatic Stress Disorder/TSI

Trauma theory has been instrumental in understanding the high rates of mental illness among women. Although men suffer equal, if not greater, numbers of violent occasions in their lives, including combat, accidents, and physical assaults, it is women who develop more PTSD, both acute and chronic, at rates twice those of males (Kimerling & Wolfe, 1997). It is the contention of the present study that everyday sexism is a major contributor to these high rates of PTSD. Therefore, a trauma measurement scale was used to determine the existence of trauma symptoms within the tested sample.

The Trauma Symptom Inventory (Briere, 1995) included in the third section of this survey was developed to assess both acute and chronic trauma symtomatology. It is a 100-item testing instrument designed to assess Post-traumatic Stress Disorder (PTSD) symptoms that might result from a variety of circumstances, including natural catastrophes, combat, and interpersonal victimization. The TSI is based on a broad view of post-traumatic disturbance and includes many of the more characterological effects of chronic traumatization. Results are measured within ten clinical scales: Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation,

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Sexual Concerns, Dysfunctional Sexual Behavior, Impaired Self-Reference, and Tension Reduction Behavior (Briere,1995). For a discussion of TSI subscales, see Appendix H.

The present study revealed a current PTSD rate of 8% among the women tested. This finding falls within the range of PTSD rates found in similar studies: Resnick et al. (1993) found a current rate of 4.6% within a sample of four thousand women (lifetime rate of 12.3%); Norris (1992) reported a 7% rate within 1,000 people in a mixed gender sample; Kessler et al. (NCS; 1995) found a lifetime rate of 10.4% within their female sample; Breslau et al. (1997) found that 11.3% of her female sample (n=624) had a lifetime history of PTSD. In all of these surveys, women tended to report levels of PTSD at twice the rate of men. Differences in diagnostic criteria and sampling procedures may account for the variance in these rates, although designation of a traumatagenic event does not seem to be a significant factor. Kessler et al. (1995) reported that when respondents are asked about the existence of specific traumatic incidents, or asked whether they had experienced “any other terrible event that most people never go through,” the response rates for PTSD varied very little (p. 1057).

The PTSD rate within the present sample (8%) can be compared to the rates of other mental disorders found in the National Comorbidity Study of 1992. Kessler, et al. (1994) reported that within the year prior to the study, the female rate of generalized anxiety disorder was 4.3%; the rate of panic disorder was 3.2%; the rate of substance

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abuse was 6.6%; the rate of dysthymia (chronic depression) was 3.0%; the rate of major depressive episode was 12.9%; and the rate of simple phobia was 13.2%.

Demographic factors in trauma scores. A series of statistical tests helped to determine whether specific demographic factors affect trauma scores (Table 9). Results showed that when participants in this study were divided into two age groups, those age 35 and younger and those 36 and older, the younger women reported significantly higher rates of trauma symptoms. In fact, when a stepwise multiple regression was run on TSI scores with all the demographic variables entered (Table 15), age was the second most predictive variable selected, after current clinical status, with the youngest cohort (ages 18-25) obtaining the highest scores. When a multiple regression was run on TSI with all the independent variables entered (Table 18), including GRS scores and SSE subscales, age was selected as the fourth most important predictor out of seven variables chosen. Further analysis again indicated that younger women are more likely to have PTSD than their older counterparts.

Briere (1995) also found that older people (age 55 and over) in his normative sample had significantly lower scores than younger people on all 10 clinical scales of the TSI. In her 1992 epidemiological study of the impact of traumatic events on various demographic groups (race, sex, age), Norris reported that age was the strongest predictor for the emergence of PTSD following a traumatic event, with older persons (over 60 years of age) showing consistently lower rates, especially with regard to crime and

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accidents. In addition, older persons showed a strong trend toward a decrease in exposure to traumatic events with age. The National Comorbidity Study (Kessler et al., 1995) only tested persons between the ages of 15 and 54, but within this sample the oldest cohort of women (ages 45-54) exhibited a marked decrease in prevalence rates of PTSD. The authors found that among the women in their sample, there was a non-significant trend for lifetime PTSD to be negatively associated with age. Breslau et al. (1999) also noted the high prevalence of PTSD among the youngest women (ages 16-22) in their sample.

Younger women not only report more instances of trauma, they also are more likely to develop subsequent post-traumatic symptoms than older women (Breslau et al., 1999; Kessler, 1995; Norris, 1992). This may be the result of greater exposure to the types of events that cause trauma coupled with lack of exposure to the kinds of emotional support, education, and therapy available to older women that help to alleviate symptoms. It can be theorized that younger women are more exposed to abuse that is situated within families than older women, who have begun to lead more independent lives. Dependent female adolescents are helpless to escape their homes and wives with young children are unlikely to leave their marriages. It has been documented that abuse committed by family members creates greater injury to the psyche than extra-familial or societal abuse, and is subsequently more traumatagenic (Briere, 1988; Harney, 1992; Herman, Perry, van der Kolk, 1989; Russell, 1984).

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Also, as indicated in the demographic intercorrelations in this study, as women age they obtain higher income and become partnered (Table 12). Younger women therefore have a lower financial, legal, and social status than older women, which may affect their vulnerability for the development of symptoms.

The results of the present study suggest that in addition to aging, higher education has a protective effect on women's mental health. In this sample, those with a college degree had significantly lower trauma scores than those without one (Table 9). Also, women earning a personal income of $50,000 or more per annum had lower trauma scores than those earning less, although their total household income had no impact on these scores. These data replicate those found by Breslau et al., (1998) who reported that lower levels of education and income were risk factors for PTSD.

It is important to note that being partnered with someone with high income does not provide the same protection from PTSD as earning one's own high income. It is possible that women do not have adequate access to the family income, so that they do not share in the benefits of that financial status. Or, perhaps achieving one's own financial success creates psychological benefits that assist in preventing trauma symptoms.

Those who have always worked for wages, those who work full-time, and those who consider themselves professionals, also had significantly fewer PTSD symptoms than nonworkers, part-time workers, and nonprofessionals (Table 9). (It is likely that

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working "on and off" reflects the employment history of the youngest cohort within the sample, who had the most PTSD symptoms.) These results affirm the importance of enhanced economic status for women's well-being, particularly as a shield against the formation of PTSD symptoms. This finding is similar to those found in studies of female depression, which indicate that women who work outside the home have less depression than those who do not, provided the job offers good social support (Gregory, 1999). Full employment offers a venue for personal satisfaction to women by providing a sense of empowerment and success. It eliminates the strains of poverty and also provides the financial resources for psychotherapy when needed.

These results may also indicate that women with trauma symptoms are less able to be employed full-time than those who not afflicted. Having PTSD symptoms prevents women from participating fully in the work world, and therefore limits their ability to increase their personal earnings. In 1998, L. B. Berger studied the employment patterns of poor women enrolled in job training programs and discovered that many were unable to maintain success because of a history of childhood sexual abuse. By conducting 200 interviews with these women, Berger discovered that traumatized women had difficulty participating in the cultural expectations and daily demand of the workplace. In her sample, 41% of the victimized women were work "dabblers" who moved frequently from job to job; the average time at any one place of employment for them was 18 months.

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Any consideration of women's decreased earnings, lower employment rates, or use of social services must take into account the real possibility that PTSD symptoms are inhibiting their educational and vocational success. Impaired memory function makes learning difficult and concomitant psychological distress makes interpersonal interaction at school or work stressful. Intrusive memories, poor affect control, irritability, anxiety reactions and phobias all serve to interfere with completion of duties, tasks and responsibilities. In addition, inadequate social problem-solving has been implicated as a result of PTSD. Kuhn, Dowdall, Levasseur, Lam and Riggs (1998) reported that the repeated activation of trauma memories interferes with the processing of necessary information needed to navigate the social world.

In her study of abused women who interface with the welfare-to-work programs being instituted across the country, Brandwein (1999) wrote that, "For some women, achieving financial independence will not be as clear-cut as just obtaining the needed education or training...Counselors working with victims of abuse have documented that many suffer form PTSD... simply forcing (these) women to 'get it together'...will not motivate them" (pp. 152-153). In their study of women receiving welfare, Danziger, Kalil and Anderson (2000) reported that one third met the diagnostic criteria for depression, PTSD, or generalized anxiety disorder. They assert that "these [mental health] problems are very serious and require temporary or long-term exemptions from work requirements" (p. 20).

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There was no significant difference in TSI scores between Lesbians and straight women (Table 9). Single (heterosexual) women, however, had significantly higher TSI scores than married or cohabitating women, although this may be an artifact of their younger age. (In this study, age was positively correlated with being partnered.) Women who were not parents had significantly higher TSI scores as well. One explanation of these data may be that women suffering from PTSD are unable to form and maintain successful relationships and therefore remain unpartnered and childless. It may be that the chronic feelings of anxiety, dysthymia, anhedonia, dissociation and irritability that accompany PTSD may interfere with their ability to engage in social interaction and to build sustaining relationships.

A multiple regression on TSI scores with all demographics entered, eliminating clinical status and feminist identity, indicated that age, personal income, employment history and parenthood status—in that order of importance—are the most predictive demographic factors for trauma symptoms in this sample (Table 15.1). The youngest cohort (ages 18-25), those with a personal income below $10,000 per year, those who have worked "on and off," and those without children, had the highest PTSD rates. These young, financially dependent women are most vulnerable in our society. They are unprotected by marital, income, or job status and therefore bereft of the resources that might protect them from the unremitting discrimination and abuse which increase their vulnerability to PTSD.

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Clinical status. Within the sample of women in this study, there is a clear and obvious correlation between being in therapy and/or using psychtropic drugs and having higher TSI scores (Table 9). Since the TSI measures clinical features, such as depression, anxiety, intrusive experiences, dissociation, sexual dysfunction, and impaired self-regulation, it is logical to assume that high scorers would also seek therapy and/or medication.

Feminist identity. In this study there was no significant difference in trauma scores between feminists and nonfeminists.

The Relationship of Sexism and PTSD

Correlational study (Table 10). The primary hypothesis in the present study was that women who experience more sexism in their lives also demonstrate greater numbers of PTSD symptoms. This hypothesis was supported with significantly positive correlations between both Lifetime Sexism and Recent Sexism scores on the SSE and total Trauma Symptom Inventory scores.

Statistical analyses revealed that the relationship between sexism and PTSD remained strong despite differences in demographic characteristics. There was very little variance in SSE and TSI correlations, both Recent and Lifetime, when controlling for all demographic variables within this sample. Similarly, the relationship between SSE scores and TSI scores remained significant despite the influence of gender-related stressors.

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The secondary hypothesis was that women who experience more sexism within all four tested domains—close relationships, distant relationship, workplace and society—would also have more trauma symptoms, as described in the clinical subscales of the TSI. This hypothesis was supported as well, by demonstrating that the SSE subscales scores correlated positively with both total TSI scores and selected TSI subscales. In fact, all four subscales of the SSE, on both Lifetime and Recent measurements, were significantly correlated with all ten of the TSI subscales, as well as total TSI scores (Table 10). (Only seven of the TSI subscales most closely identified with characteristics of the *DSM-IV* definition of PTSD are presented in the text.) An item analysis of the individual questions on the SSE revealed that *every* question on *every* scale, both Lifetime and Recent, had a significantly positive correlation with total TSI scores except Question 9, which asks about sexist treatment on the job. These data strongly indicate that the experience of sexism within all four dimensions studied—close relationships, distant relationships, workplace and sexist degradation—is related to the development of PTSD symptoms in women.

In his discussion of prejudice, social psychiatrist Paul Adams has written that "stress is the concept that explains how sociocultural conditions drive people mad" (1990, p. 368). In particular, he stated, "(f)or a person to be labeled inferior throughout the life cycle can create stress, and often, pathology" (p. 373). The findings in the present study confirm the pathogenic influence of prejudice, discrimination, and abuse toward

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women. Young-Bruehl writes that in a sexist society, "women bear the marks of the conflicts on their bodies and minds" (1996, p. 37). This is true although the instances of abuse may be subtle, unconscious, or disguised. They may be nearly invisible because they are supported by the institutional structures of society, including religion, law, and custom. Nevertheless, the impact of daily, personal sexist interaction has an incremental but cumulative effect that results in the disturbing pattern of PTSD symptomatology.

It is possible that women's exposure to chronic sexism contributes to the imbalance of PTSD rates between the sexes. This study implies that the traumatic effects of sexism have a significant impact on PTSD rates for women, which indirectly affect comorbid symptoms and women's rates of general mental illness.

In the present study, recent sexist events had the most prominent impact on trauma symptoms; scores on the Recent Sexism scale accounted for more than 18% of variance of the total TSI scores. However, lifetime experiences were also impactful; scores on the Lifetime Sexism scale accounted for nearly 11% of the variance (Table 10). A stepwise multiple regression of TSI scores using SSE-L, SSE-R and all eight SSE subscale scores, as well as GRS scores, determined the relative importance of types of sexism upon trauma symptoms. Results indicated that Recent Sexist Degradation and Its Consequences was the most predictive factor for PTSD, accounting for 19% of the variance in TSI scores (Table 17). The second most predictive factor was Recent Sexism in Close Relationships, and the last was Recent Sexist Discrimination in the Workplace.

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(These results were close to those of Landrine and Klonoff [1997, p. 122], who found that Recent Sexist Degradation and Its Consequences and Lifetime Sexism in Close Relationships were most predictive of women's psychiatric symptoms, in that order.) Each of these scales, and its relevance to the formation of PTSD, will be discussed below.

Sexist Degradation and Its Consequences (SD) An examination of the scale most predictive of trauma scores, Recent Sexist Degradation and Its Consequences, reveals the types of encounters which were most disturbing to women in this sample. These include being called sexist names, arguing over sexism, hearing sexist jokes, wanting to tell someone off, being angry about sexism, being sexually harassed, getting no respect and being picked on or physically harmed. Although physical abuse is included in one question ("How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm *because you are a woman*?"), most of the items in this scale are related to everyday, nonviolent, customary interchanges between the sexes. It may be that the universality of these circumstances both disguises the sexist underpinnings of their nature and contributes to their pathogenic effect. The constant barrage of humiliating and demeaning insults and threats that women routinely encounter creates chronic frustration and anger. This was evidenced in the high response rate in this study to the three items in this scale that refer to anger: In the past year, 82% wanted to tell someone off due to sexist treatment; 64% were angry about sexism; and 54% argued about sexism (Table 3).

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Pierce has written that the most difficult task for victims of sexism (and racism) is defending against these assaults that he terms "microaggressions," since deciding how and when to engage in such a process can be energy-consuming and emotionally exhausting. He explained, "Gauging, titrating, regulating, expressing appropriate, safe outrage is never an easy task, even though one may handle thousands of microaggressions in a lifetime" (Pierce, 1995, p. 282). In 1993, Sandra Thomas conducted the first large-scale comprehensive examination of women's anger in everyday life. Over 500 participants were given a battery of psychological tests to quantitatively analyze the prevalence of anger disorders among women. Thomas concluded that although chronic anger may induce psychological and physical distress, "(a)nger is an extremely powerful but frequently misunderstood emotion. It is important for defense of one's boundaries and assertion of one's rights as a human being" (cited in Fields et al., 1998, p. 354). In an analogous study with African American women, Fields et al. reported that situations of "disrespectful treatment, whether on the basis of gender or race or both, are frequent precipitants of women's anger throughout the data sets" (p. 367). They concluded:

> The anger of African American women in this study cannot be understood without its undergirding of profound racism...Deleterious health consequences of racism have been documented in a few...studies...and [others] have found significant relationships between incidence of racism

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> and overall life stress, psychological distress, and trauma-related symptoms such as intrusive thoughts and avoidance behaviors. (p. 368)

The anger reported by women in their responses to the Sexist Degradation scale is an expected outcome of the treatment they are receiving. Kirkwood's work on partner abuse defined degradation as "the perception that as a human being, one is markedly less valued or even unacceptable to others. It is a sense that there is something inherent and essential about oneself that is soiled" (1993, p. 46). This may be caused by a variety of behaviors, including being told you are unattractive, inadequate, and incompetent, or by means of "low-level criticism which, seemingly invisibly, erode(s) women's sense of self-value" (Kirkwood, 1993, p.47). Although anger and irritability are often provoked by this treatment, the opposite response is equally probable, and a woman may withdraw into a dissociated mental state as a defense. The resultant psychological profile is then one of depression, alexithymia, anhedonia and passivity. Herman writes:

> ...the features of PTSD that become most exaggerated in chronically traumatized people are avoidance or constriction. When the victim has been reduced to a goal of simple survival, psychological constriction becomes an essential form of adaptation. This narrowing applies to every aspect of life—to relationships, activities, thoughts, memories, emotions and even sensations. (1992, p. 87)

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As noted earlier, these alternating states of anger/irritability and defensive avoidance are the hallmark of PTSD symptoms (Brady, 1997; Friedman, 1997; van der Kolk, 1997). According to documentation presented in the DSM-IV (1994) PTSD is known to present primarily as a chronic bimodal expression of hyperarousal and persistent avoidance (p. 428).

Sexism in Close Relationships (CR) The second most predictive factor in trauma scores was Recent Sexism in Close Relationships. This aspect of sexism refers to acts perpetrated by family members, boyfriends, and mates. The scale also asks how different a woman's life would be if she had not been treated in sexist and unfair ways throughout her life, based on incidents from the past year. The personal and intimate nature of the relationships in which women experience this type of unfair treatment likely accounts for the high correlations between this dimension of sexism and trauma symptoms.

It is exactly the dissonance between the expectation of safety in a home setting and the reality of abusive behavior that creates emotional wounding and psychological shock, leaving the victim with an altered perception of her world. As Janoff-Bulman (1992) has written, it is the experience of "shattered assumptions" of a just and secure environment that is the precursor to trauma symptoms. In her schema, an interpersonal assault interrupts and contradicts commonly held notions of an orderly and reasonably predictable world in which the individual is valued and worthy. The disruption of these

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beliefs and the loss of a familiar world create shock and persistent feelings of dislocation in victims. A similar theme appears in Elizabeth Waites' Trauma and Survival:

> The common and often correct assumption that families protect the best interests of [their members] is so expedient that it often becomes a barrier against recognizing the traumatic potential of families themselves. Idealizations of the family as a safe haven, rationalizations about the family as a bulwark of authority...[and]...social factors, such as the family's right to privacy...protect traumatizing families from scrutiny...Females, who are typically socialized for dependency, are doubly disadvantaged by the secretive family. (1993, pp. 69-70)

In marriage, especially, women are acculturated in the belief that they will be cherished and protected by their mates. However, the marital union often reflects the larger patriarchal system in which males retain an economic advantage and emotional power. In her conclusion to her survey on marital violence, Russell stated, "Not everyone who has power in an unbalanced power situation abuses it, but in general, where there is power imbalance, there is abuse" (1982a, p. 5). This abuse may take the form of physical assault, or it might be one of the following categories: (1) psychological abuse, which includes instilling fear via intimidation or limiting one's access to friends or family; (2) emotional abuse, in which a spouse undermines one's sense of self-worth via criticism, silent treatment, or manipulation; (3) economic abuse, where a spouse creates financial

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dependency, controls all finances, and /or interferes with one's employment; or (4) sexual abuse, in which sex is forced, or pornography is used, or one's sexuality is demeaned via criticism of one's sexual performance or accusations of infidelity (NYS Office for the Prevention of Domestic Violence, 1990).

These private forms of assault, although less blatant than criminal acts of abuse, can be deeply disturbing, since they violate a woman's sense of trust and safety with those closest to her. As Kirkwood stated, "The idea that, at such an intimate level, a partner was coercive, carrie(s) a strong emotional message to the woman: the message that her most personal levels of intimacy were open to manipulation and not respected by the person with whom she entrusted this intimacy" (1993, p. 48). This type of treatment is also debilitating to a woman because of its chronic and continuous presence in her life.

Psychiatrist Judith Herman (1992) believes that people subjected to prolonged, repeated trauma develop an "insidious, progressive form of PTSD that invades and erodes personality" (p. 86). She states that chronically traumatized people no longer have any baseline of physical or psychic comfort and therefore become constricted in their capacities for active engagement with the world. Their condition is further complicated by the presence of comorbid features such as depression. Herman wrote:

> Protracted depression is the most common finding in virtually all clinical studies of chronically traumatized people...The chronic hyperarousal and intrusive symptoms of post-traumatic stress disorder fuse with the

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> vegetative symptoms of depression, producing...insomnia, nightmares and psychosomatic complaints. The dissociative symptoms of the disorder merge with the concentration difficulties of depression. The paralysis of initiative of chronic trauma combines with the apathy and helplessness of depression. The disruption of attachment of chronic trauma reinforces the isolation of depression. The debased self-image of chronic trauma fuels the guilty rumination of depression. And the loss of faith suffered in chronic trauma merges with the hopelessness of depression. (1992, p. 94)

Sexist Discrimination in the Workplace (WK) The third most predictive factor for trauma in this study was Recent Sexist Discrimination in the Workplace. The questions on this scale ask the respondent if she has experienced sexist discrimination (or, "unfair treatment *because you are a woman*") from her boss, supervisor, teachers, colleagues, or fellow students, if she was denied a promotion or raise, or if she took drastic action, such as filing a grievance or quitting a job.

Unfair treatment in the workplace or academy may take the form of sexual harassment, a type of abuse that has been shown to produce a range of psychological effects, including PTSD (Dansky and Kilpatrick, 1997; Gutek & Koss, 1993; McDermut, Haaga, & Kirk, 2000). In addition, women may also face sexist discrimination that limits their achievement or advancement. This type of unfair treatment may be independently traumatagenic or it may contribute to women's reduced earning power and thus increase

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their vulnerability to trauma. Not only are women routinely paid less than men, they are also more likely than men to be laid off and to be fired (Kleinman, 1988), less likely to be promoted (Kleinman, 1991), and they are less likely to have adequate health insurance and other fringe benefits, such as vacations and opportunities for travel, even when number of hours worked are taken into account (Lott, 1994). This inequality is even greater among minority women, where racial and ethnic discrimination intersects with sexism to yield extremely low salaries among Black and Latina women in all job categories (Landrine, Klonoff, Alcaraz, Scott, & Wilkins, 1995).

Trauma symptoms induced by workplace sexism may prevent women from protesting effectively against their maltreatment. The National Victims Center Report (1992) survey found that although women diagnosed with PTSD and depression were just as likely to have responded assertively to the harassment as employed women in general, those with PTSD were less likely to have filed a complaint. This passive approach to discrimination was apparent in the present study. Although 87% of the women reported being treated unfairly by their boss or supervisor, and nearly 70% reported being denied a raise, promotion tenure, a good assignment or a job because of their sex, only 30.4% had ever "taken drastic steps," such as filing a grievance, filing a lawsuit, quitting her job, or moving away (Table 2).

The combined feelings of inadequacy, anger, and helplessness that result from being oppressed as a female worker, and the inability to remedy the situation, may create

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"psychic numbing" or "emotional anesthesia" as a defensive mechanism. These PTSD symptoms are described in the DSM-IV (1994) as having "markedly diminished or estranged interest or participation in previously enjoyed activities…of feeling detached or estranged from other people, or having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness or sexuality)" (p. 425).

Sexism in Distant Relationships (DR). This scale did not appear as a predictor variable in the multiple regression run on TSI scores. However, it did correlate positively (in both Lifetime and Recent scales) with total trauma scores and the trauma subscales (Table 10). The correlations between this scale and TSI scores were actually higher than the Workplace scales (WK), but their colinearity caused WK to be chosen as a more powerful predictor.

The Sexist Discrimination in Distant Relationships scale questions respondents on their experience of sexism with people in public places: those in service and helping jobs, neighbors, strangers and teachers. Interactions with these public figures are often marked by behavior that is termed "friendly harassment" by Benokraitis and Feagin (1995, p. 91). This is sexually oriented behavior that, at face value, looks harmless or playful ("Smile for me, honey") but creates discomfort, embarrassment, or humiliation for most women. In the public sphere, popular culture and the media bombard women with sexist messages and advertisers incessantly objectify women's bodies for the purpose of marketing consumer goods, services and entertainment. Daily interactions with storekeepers, service

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providers, and professionals are often marked by sexist and stereotyping behavior, and health workers, counselors, police, and others in the helping professions routinely discriminate against women (Benokraitis & Feagin, 1995; Kreiger et al., 1993). The response to this is often hypervigilance and arousal, a need to be "on guard" for an insult, rudeness, hostility or ridicule that might emerge within even impersonal environments such as hospitals, treatment centers, courts, banks, stores, and schools. Chronic hypervigilance and arousal restricts one's range of affect, disturbs somatic functions, and interrupts concentration, memory, and learning.

The Trauma Response

It is possible to construct a descriptive rationale for the development of PTSD as sequela to exposure to sexist events. The chronic expectation of maltreatment in society and the pervasive fear of harm may keep women in the condition of "intense fear, helplessness, or horror" that is mentioned as a criterion precipitant to trauma symptoms in the PTSD diagnosis (DSM-IV; 1994, p. 428). Many forms of harassment or verbal assault create a perception of "threatened death or serious injury, or a threat to the physical integrity of self or others," which is also included in the DSM-IV criteria for the PTSD diagnosis (1994, p. 427). In particular, the chronicity of sexist discrimination and abuse fosters the self-protective symptoms of dissociation, depression, and defensive avoidance—each a subscale on the TSI and a noted symptom of PTSD. The assault to a

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woman's psychic self that is inherent in sexism also produces "increased arousal," a PTSD symptom that manifests as anxious arousal, anger/irritability, intrusive experiences and impaired self-reliance—which are also measured on the TSI.

Many sexist events can be classified as "interpersonal stressors" since they are caused by individuals rather than impersonal circumstances or structural conditions. In describing the features of PTSD, the DSM-IV authors specified the distinctiveness of these stressors. They wrote:

> The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor:...impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics. (1994, p. 425)

Rather than perceiving these features as personality defects, this study suggests the usefulness of recognizing the possibility of the existence of PTSD (or subthreshold PTSD) in persons exhibiting these symptoms, even if an obvious traumatic event may be absent. For many women, the existence of subtle traumatic experiences may be endemic

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to all spheres of their lives—at work, at home, in close and distant relationships—and responsible for the disturbing pattern of affect, cognition and behavior outlined above.

Feminism as a Protective Mechanism

As noted earlier, although feminists reported experiencing more sexist events than nonfeminists in this study, especially Lifetime Sexism, they did not score differently from nonfeminists on the trauma scales (Table 5 and 9). This finding is similar to that of Landrine and Klonoff (1997), who reported that feminists had significantly higher scores in both Lifetime Sexism and Recent Sexism, but did not differ from nonfeminists on any of the psychiatric tests they were administered. In the Landrine and Klonoff study, feminists were more likely to identify sexist acts and more likely to appraise these acts as more stressful. However, they did not suffer more mental distress than nonfeminists (p. 118). This finding substantiates the theory that feminism is a useful organizing principle for women to use in understanding and coping with the assault of daily sexism. Landrine and Klonoff theorized that a feminist ideology serves as a "buffer" against the pernicious mental health effects of everyday sexism. They wrote, "By providing a cognitive framework for understanding sexism, feminist consciousness should decrease the perception of sexist events as one's own fault, increase active coping, and decrease the negative impact of these events" (1997, p. 27).

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Feminism may indeed serve to moderate the damaging effects of chronic, often daily, encounters with sexism in women's lives. Although these encounters are demeaning and discouraging, women are not as likely to internalize the message of personal worthlessness if they can place it in a political context. One possible factor in this defensive process is that of attributional style, a theory of personality concerned with the process by which an individual interprets the causation of life events. It has been postulated that an internal versus external attribution of the cause of negative events in one's life will determine its affective consequences for the individual, especially that of internal attribution (Weiner, 1972). This hypothesis has been tested and supported in many well-designed studies within various population groups (Hackett, 1982). In particular, it has been demonstrated that those who attribute internal (rather than external) causation for failure—both in intellectual performance and interpersonal relationships—are at greater risk for psychological distress such as depression. Cognitive theorist Aaron Beck (Beck & Rush, 1978) has written that the depressive person:

> ...perceives himself as deficient, inadequate, or unworthy, and tends to attribute adverse experiences to a physical, mental or moral defect in himself. In his opinion, he is undesirable and worthless because of his presumed defects and he tends to reject himself because of them. (pp. 236-237)

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Trauma theorists have noted that one's perception of events may influence the development and duration of PTSD following or during traumatic events, and that attributional style in particular was often a significant predictor of symptoms (Falsetti & Resnick, 1995; Feireing, Taska, & Lewis, 1998; Goldwater, 1993; Joseph, Williams, & Yule, 1997; McCormick, Taber, & Kruedelback, 1989; Mikulincer & Solomon, 1988; Paunovic, 1998; Wenninger & Ehlers, 1998; Wolfe, Gentile, & Wolfe, 1989). In a review of post-traumatic stress disorder that offers a psychosocial perspective, Joseph, Williams, and Yule (1997) concluded that evidence has implicated a role for causal attributions in mediating emotional distress following trauma. They reported that more internal attributions for events were related to measures of intrusive thoughts, depression and anxiety, while external attributions for emotional responses may, in reverse, be associated with less emotional distress. They also noted that attendant reactions, such as shame and rage, may be related to causal attributions as well.

Research has also demonstrated that women are far more likely to attribute negative life events to an internal cause than men, and also to attribute positive events to external causes, a tendency that may be contributory to their development of depressive symptoms (Ickes & Layden, 1978). Clinical researchers have consistently noted that battered women internalize the derogatory designations and justifications of the violence against them (Walker, 1979, 1984) and among rape victims, self-blame repeatedly has been found to predict poorer adjustment and greater distress (Koss et al., 1994).

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Therefore, it is critically important for women to develop a framework of cognitive assessment of life events that helps counterbalance the socially induced style of attribution that is detrimental to women's psychological health. Feminist theory offers such a conceptualization. As Bronstein (1997) wrote in her discussion of the Landrine and Klonoff study:

> Feminists are more likely to attribute the sexist inequities, denigration, and abuse they experience to social and political factors whereas non-feminists, lacking a broader political explanation, are more likely to believe sexist messages about their inadequacies, and to blame themselves for the inequitable, disrespectful, and abusive treatment they receive. (p. 139)

The findings of the present study attest to the importance of young women becoming educated in feminist thought as a means of protecting themselves against the sexist behavior that might otherwise prove injurious to their mental health.

Gender-Related Stressors (GRS) and Trauma (TSI)

The second correlational study determined the relatedness of gender-related stressors and trauma symptoms (Table 11). Results indicated that women who had greater numbers of stressors in their lives were more likely to have PTSD symptoms. That is, total GRS scores (the total numbers of gender-related life stressors reported by each

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woman) were significantly positively correlated with total TSI scores. GRS scores also showed a significant positive correlation with all ten TSI subscales. In other words, women with more of these stressors in their lives exhibited more PTSD symptoms than those who had fewer stressors. In fact when a multiple regression was run on TSI with all ten SSE scales and GRS scores (Table 17), GRS was chosen as the third most predictive factor for trauma scores. When a multiple regression was run on TSI scores with all the independent variables, including demographics (Table 18), GRS scores were chosen as the fifth most predictive factor, out of seven chosen.

However, an item analysis of the answers to the twenty-two GRS questions indicated that the correlation between the two questionnaires (GRS and TSI) was largely dependent upon one class of stressors—that of violence against women (Table 11). Other than one question on serious relationship problems and one on mental illness, the only individual stressors that obtained a significant positive correlation with TSI scores were those related to verbal/physical/sexual abuse or coercion.

These results suggest that although women's roles in society and in the home may be burdensome, depressogenic, and even debilitating, they do not provoke PTSD symptoms unless they are accompanied by verbally or physically abusive behavior. Sexist behavior, on the other hand, because it is intrinsically abusive, motivated by hostility, and without any redeeming benefit, induce a trauma response. This can be conceptualized as a distinguishing feature between structural sexism, which encompasses

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gender-determined roles and responsibilities, and interpersonal sexism, which is often a more direct form of domination and control of women. The experience of daily sexism was much more predictive of PTSD symptoms within this sample than any of the other tested variables, including gender-related role burdens and demographic characteristics. The result supports the view that Criterion A events (i. e., those that qualify as PTSD determinants) should be expanded to interpersonal behaviors which reflect oppressive conditions in society (Bloom 1997; Brown, 1992; Frazier, 1998; Herman, 1992; Koss, et al., 1994; Murburg, 1999; Root, 1992)

Of course it is conceptually difficult to separate gender role burdens and conflicts from interpersonal sexism. Both the creation of unfair and unequal roles at work and home, and the manifestation of abusive treatment, stem from the same source, namely, oppression of women by a patriarchal system. However, women may not perceive their role within society as inequitable or unrewarding and therefore do not suffer as greatly from its consequences as they do from the interpersonal assault of sexism. (In fact, women who were responsible for either childcare and/or household duties in addition to their paid employment had significantly fewer PTSD symptoms than those who did not shoulder these additional responsibilities.) Gender-related roles are structural conditions that appear natural, inevitable and normal, and although they contribute substantially to women's rates of depression, anxiety and somatic disorders, they do not create the level and intensity of duress that interpersonal sexist remarks, behaviors, and attitudes provoke.

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The present study offers a rationale for the level and intensity of that duress; it indicates that the personal attacks of sexism, no matter how mundane or routine, may create a post-traumatic stress response replete with the array of symptoms characteristic of this profoundly distressful disorder.

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Chapter VIII – Summary and Conclusions

Summary

This study surveyed a large and varied sample of women to determine the relationship between their experience of sexism and the occurrence of PTSD symptoms. Although the participants were predominantly White, well-educated, suburban women, the total sample spanned a wide age range (from 18 and including women over age 65) and a varied income level. They represented differing sexual orientations, living arrangements, and parenthood status as well.

The results of the survey suggest that: (a) everyday sexist events in women's lives are substantial, chronic, and disturbing; (b) the experience of being treated unfairly because one is a woman is not mediated by race, income, or employment status, although younger women and gay women do experience more of these occasions; (c) gender-related stressors, such as role burdens and gendered violence, are common in women's lives; (d) younger women with children experience the greatest number of gender-related stressors; (e) 8% of the women surveyed qualify as PTSD sufferers; (f) young, single, less educated and poorer women had the highest rates of PTSD; (g) women who experience greater numbers of sexist events in their lives also experience more trauma symptoms; (h) women who experience more gender-related stressors in their lives also experience more trauma symptoms, but this is primarily due to the presence of physical,

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sexual, verbal or emotional abuse in their lives; (i) the most significant predictors of PTSD were Recent Sexist Degradation and its Consequences, current clinical status, Recent Sexism in Close Relationships, young age, Gender-related stressors, and low employment and educational levels, in that order; and (j) although feminists reported experiencing more sexist events in their lives, they did not report higher levels of PTSD.

Everyday Sexism

This study demonstrates the traumatic effect of everyday sexism on women's mental health. The results verify that everyday nonviolent sexist acts occur with frequency and ubiquity in women's lives, although they are often ignored aspects of daily living. The existence and persistence of sexism as an oppressive force—and its impact on women—is minimized and even denied in our society. Certainly mental health experts have failed to recognize these daily interactions as sources of mental distress. Instead, victims of sexism are often misdiagnosed by the psychiatric community as having a pathological response to ordinary environmental stimuli.

The sexist beliefs that men are inherently superior to women, both mentally and physically, and that each sex has particular realms of activity that reflect innate attributes pervade the general consciousness. Kreiger et al. state, "As expressed in daily life, these beliefs and practices both justify and result in vast inequalities between men's and women's living conditions and opportunities" (1993, p. 90). Many effects of sexism are

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obvious and easily quantifiable; in all spheres of life, women fare poorly compared to men. Their lower position in the workplace is the most obvious demonstration of sexism: women's lower status, reduced pay, and unequal opportunity continue to reflect society's discrimination against women. Women hold a subordinate status within the realms of government, the military, education, the arts, sports, religion, and science as well. Moreover, their roles as primary caregivers, homemakers, and nurturers create additional burdens and obstacles to self-fulfillment. However, the interpersonal aspects of oppression that hold this patriarchal system in place are often overlooked because they are difficult to delineate and observe.

The ongoing interactions between men and women serve to support, maintain and promote structural inequities that benefit males. These daily interactions, like those of other types of oppression, are so pervasive and so well-defended by the power structure that they have become invisible. It benefits the patriarchy to deny the common aspects of sexism so that it may endure and reinforce the prevailing hegemony. Without the shared assumption of female inferiority, sexist structures and the elevation of male power would be impossible. Political, social, economic, religious and educational institutions alike promote similar sexist tenets, leaving few avenues for the examination of sexism and its impact on victims. It is only when sexism becomes brutal and blatant that society will address the phenomenon and its damaging results. Even in these cases, which include the epidemic of gendered violence and sexual assault, there is often debate regarding the

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underlying causation of that brutality and denial of the role of sexism in these behaviors. Moreover, social scientists who recognize the psychological harm that brutal sexism creates for women often fail to notice the linkages between blatant acts of violence and the daily social interactions that harm women.

Nevertheless, a body of knowledge on the subject of everyday sexism is developing. It is becoming apparent that although most women are not direct victims of brutal violence or sexist assault, all females, young and old, live in an environment that distorts a woman's personality, limits her potential, and threatens her physical and psychological well-being. As the results of this study reflect, women are routinely treated unfairly—because they are women—by family members, acquaintances, employers, colleagues, teachers, students and strangers. It is reasonable to assume that such a constant personal onslaught would result in alterations in female self-concept and self-esteem. As stated earlier, Landrine and Klonoff's study of the psychiatric effects of sexist discrimination offered persuasive evidence that everyday sexism contributes substantially to women's mental distress (1997). However, their reliance on traditional testing instruments failed to provide indications of a causative factor for the development of mental symptoms. The present study utilized a well-respected trauma scale, the Trauma Symptom Inventory (TSI; Briere, 1995), to determine that everyday sexism contributes to PTSD symptoms in women. Since these symptoms are demonstrably quantifiable as disruptions in brain activity following trauma, they offer material evidence and a

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plausible rationale for the linkages between nonviolent maltreatment of women and mental disorder. The results indicate that chronic devaluation of the female, via daily interactions among intimates and strangers, creates serious psychological impairment in women and girls.

PTSD

The disproportionate rates of PTSD between the sexes that remain constant in all epidemiological surveys offer compelling information for understanding the similar gender disparity in general mental health rates. As discussed earlier, women have twice the rates of PTSD as men, including situations where the traumas are similar, or where men report equal, or greater, numbers of traumatic events in their lives (Breslau & Davis, 1992; Breslau et al., 1997; Kessler at al., 1995; Wolfe & Kimerling, 1997). There are several evolving rationales for these disproportionate rates of PTSD, including the assumption that male-to-female sexual assault (or threat) is common and highly traumatagenic (Herman, 1992a); family-based violence, where females are likely to be targets, is more psychologically disturbing than impersonal violence (Janoff-Buloff, 1992); female response to trauma is biologically different from males (Perry, 1995); or the repetition of abuse pre-dispossess females to PTSD following subsequent traumas (Breslau et al., 1999). However, none of these theories has been successfully demonstrated to be the sole determinant for this disparity.

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Kimerling has advised that research on the question of the female preponderance of PTSD focus on factors that covary with female gender, such as life conditions and situations (1999). The present study sought to determine if chronic sexism was a distal predictor of PTSD, a disorder which often presents in a protean manner and is comorbid with other mental disturbances (Herman, 1992; Friedman, 1997, 1998). The positive results obtained through analysis of nearly 400 surveys supports the contention that sexism, expressed in the daily unfair treatment of women, is a traumatagenic force in women's lives, resulting in the serious affective, cognitive and behavioral disturbance associated with PTSD. In fact, the daily experience of sexism proved to have far greater impact on the development of trauma symptoms in this sample of women than either structural conditions or occasions of violence in their lives.

Everyday sexism may therefore be a contributory factor to the high rates of PTSD among women, as compared to men. All women in our culture are victims of sexist treatment that has the propensity to provoke trauma symptoms. The chronic and cumulative effects of these symptoms may leave women vulnerable for re-traumatization and may therefore substantially increase their PTSD rates in epidemiological studies. This hypothesis is substantiated by the fact the youngest cohort of women in this sample, aged 18-25, reported the highest number of sexist events compared to other age groups. Most studies of PTSD rates report that the very youngest women are disproportionately represented as trauma victims, although they may not report more (or any) traumatic

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events in their lives (Breslau et al., 1999; Kessler et al., 1995). Since they appear to be the group most targeted by sexist behavior, it is plausible that their experience of everyday nonviolent sexism is contributing to their PTSD rates in subtle and covert ways.

Implications for mental health diagnoses. The results of this study support the concept of psychosocial diagnosis, as promoted within the social work community (Karls & Wandrei, 1994; Mailick & Vigilante, 1997). It is imperative that mental health clinicians utilize the diagnostic schema presented in the DSM (APA, 1994), which encourages the use of Axis IV in the coding system. This axis is "for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II)" (p. 29). The results of this study imply that it is as important to question clients about their experience of daily oppression as it is to inquire about their history of abuse.

There are several important benefits that emerge from considering psychosocial diagnoses. Primarily, it is helpful for the clinician to focus on external causation of mental disorder rather than assuming intrapsychic debility within the client. Clinicians' continued reliance on traditional theories of mental disturbance will result in misdirected practice that does not address the actual etiology of symptoms and cannot achieve success. In fact, practice that only views the pathology of the client, rather than the environment, may re-victimize and re-traumatize those who suffer. Vivero and Jenkins

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(1999) note that although the effects of disadvantaged status may not always be obvious, care providers should not overlook the difficulties arising from discrimination. They warn that silence and unawareness about structural oppression are two of the most invalidating and re-traumatizing experiences for clients.

As Sandra Bloom (1997) reminds us, psychiatric disorder was once thought to reflect the basic "otherness" of the afflicted, until trauma theory taught us that most psychiatric disorder is the culmination of normal reactions to failures of our social systems to care for and protect its citizens (p. 11). A trauma-related diagnosis respects trauma victims, acknowledges their experience, values their survival, and directs treatment toward appropriate review of both external and internal influences in their lives. Clinicians should bear in mind that presentation of symptoms that resemble PTSD could indicate the effects of societal and interpersonal oppression.

This study demonstrates that when making a psychosocial diagnosis, it is important for mental health practitioners to assess more than the typical Criterion A events associated with PTSD (i. e., precipitant traumatic events) such as physical or sexual assault, accidents, criminal acts or disasters. Criterion A should be expanded to encompass the every day acts of oppression and discrimination that are harmful to people. These include the interpersonal behaviors that demean, disrespect, and threaten minorities, women, and children, as well as the imposition of structures that create unfair burdens and stresses for classes of people (see Brown, 1992; Root, 1992; Scott &

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Stradling, 1994). Bloom (1997) adds school and work violence, media violence, economic disparity, poverty, hunger, war, and environmental destruction as traumatagenic forces in all our lives that also deserve the attention of mental health workers.

In addition, if mental health practitioners use methods of psychosocial assessment, they will be encouraging oppressed groups to utilize mental health services. Presently, mental health outpatient services are underutilized by people of color, the elderly, immigrants and poor people (Brooks, Zuniga, & Penn, 1995). (In contrast, inpatient facilities house a disproportionate number of disenfranchized persons, although they do not offer substantial rehabilitative treatment.) The avoidance of psychotherapeutic services by minority groups may be due to the fact that the mental health field does not address the pertinent issues of oppression that are relevant in their lives. Mental health practice today is generally disengaged from the political, social and economic realities that shape clients' lives. Practitioners should be prepared to encounter these larger forces that impact on the lives of their clients, and to help clients develop strategies to combat societal abuse.

Implications for mental health treatment. A major benefit of screening mental health clients for socially-induced trauma is that the exploration is often enlightening, and curative, for the client. This type of assessment can be a consciousness-raising experience

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for women, who tend to overlook the serious damage inflicted by a sexist culture. Feminist practitioners have been using "critical consciousness-raising" as a therapeutic tool to help female clients understand that their distress is often situated within a matrix of social, economic and political forces that are unhealthy for them (Burstow, 1992). Assessment of sexist discrimination and abuse that occurs in the home, workplace and public spaces helps women recognize the daily assaults they live with and the ways they cope. Clinicians and clients can then determine the effect such encounters have on their mental state and emotional well-being.

Van Den Bergh and Cooper have outlined nine principles of feminist social work intervention that are useful for helping women overcome the emotional and social problems that result from sex discrimination (1987). These are summarized below:

1. A client's problems should be viewed within a sociopolitical framework. This principle maintains that a woman's experience in her personal life is directly related to societal dynamics that affect all women. Van Den Bergh writes, "An individual women's experiences of pejorative comments based on sex and of blocked opportunities are directly related to societal sexism. For ethnic minority women, racism and classism also are factors that affect well-being" (1992, p. 103).

2. Traditional sex roles are pathogenic, and clients need encouragement to free themselves from traditional gender-role bonds. Van Den Bergh writes, "Oversubscription

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to sex-role stereotypes engenders a state of powerlessness in which a woman is likely to become involved in situations where she becomes victimized" (1992, p. 101).

3. Clinical intervention should focus on the identification and enhancement of the client's strengths rather than pathologies. Treatment should include education, access to resources, and concrete services that ameliorate clients' life conditions.

4. Self-esteem and self-confidence can be gained by helping clients cease self-blame for their problems and work toward claiming their rights.

5. Women should be encouraged to develop their identities based on their own strengths, attributes, interests and achievements, rather than those of the males in their lives.

6. Clients need to develop social support systems and resource networks with other women.

7. Women should be encouraged to pursue financial independence and career goals, in addition to being nurturing members of their communities.

8. Feminist practitioners should encourage equality in their therapeutic relationships. They should act as catalysts for the development of client autonomy, rather than experts on the client's mental health.

9. Clients should be helped to express themselves assertively. Assertiveness training can help women recognize their right to be angry over being victimized by sex discrimination and gender stereotyping.

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Nes and Iadicola (1989) expanded on this paradigm for feminist practice by including treatment measures preferred by radical and socialist feminists. In their schema, radical feminist practitioners would utilize consciousness-raising to create awareness of the patriarchal roots of personal problems, and encourage politicization and mobilization of women to protest sexist treatment and to restructure sexual relations in society. Socialist feminist practitioners would create consciousness-raising groups to examine issues of alienation and self-fulfillment as they relate to systems of domination, and would use coalition-building to empower women to meet their needs and to encourage them toward political action, as well (p. 17).

In addition to feminist therapies, specific treatment modalities have been developed that have proven effective in the treatment of PTSD, and can be combined with a feminist orientation. These include the phase-oriented treatment outlined by Herman (1992) and successfully utilized at the Victims of Violence Program which she heads at Cambridge Hospital and the Sanctuary model developed by Sandra Bloom (1997) at the Friends Hospital in Pennsylvania. The exposure-based modality created by Edna Foa (1997) and cognitive restructuring techniques (Horowtiz, 1991; Resick & Schnicke, 1992) have been evaluated as highly effective treatments as well.

In addition, the contribution of relational theory in the treatment of PTSD has offered a feminist version of attachment theory that has been adopted by many trauma therapists (Jordan, et al., 1991). Several body-oriented therapies aid the PTSD sufferer.

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Eye-movement Desensitization and Reprocessing (EMDR), created by Francine Shapiro,(1989) and "bodypsychotherapy" developed by Babette Rothschild (1996) are two of the most widely used techniques for relief of symptoms. These models present new avenues for treatment of individuals that can reduce the adverse psychological difficulties, disturbed interpersonal behaviors, and somatic complaints produced by PTSD. It is important for clinicians to recognize that PTSD is a treatable condition that responds well to mental health intervention and social support.

Implications for mental health practice. The expansion of Critrion A events to include instances of societal oppression and interpersonal expressions of discrimination is a natural result of current trauma studies. Emerging data have advanced the theory of daily oppression as traumatagenic and help explain the high rates of PTSD among women, especially young women. Fran Norris' research is particularly relevant to the present study. Her finding that Mexican women suffer greater rates of PTSD following a natural disaster than American women in a similar situation supports her contention that women in traditional, highly sexist environments are predisposed to PTSD (1999). This information is congruent with the results of the present study, which suggests that everyday sexism creates chronic PTSD symptoms that are additive to those that occur in response to particular traumata. The effects of racism may impact upon people of color in like manner, which would account for Norris' 1992 finding that Blacks in her

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epidemiological survey reported higher rates of PTSD although the number of traumas they encountered was not greater than those of Whites. This model may be useful for determining the impact of other oppressions—ageism, heterosexism, classism—on targeted populations. Bloom writes:

> For several decades, feminist activists, and theorists have been taking to task the white male establishment for its endemic abuse of hierarchical authority in the family, in government, in corporate offices, in schools, and in hospitals. But this abuse of authority is not the domain of white males...Once the dynamic of power divorced from responsibility enters a system, it spreads like a virulent infection. (1997, p. 217)

Future research in the field of PTSD should focus on the impact of abusive power not only on the psyche of women, but all subjugated people: immigrants, poor people, gays, the disabled, workers and laborers. Results that demonstrate a relationship between exogenous factors and personal pain would give strong support for disadvantaged people seeking redress. In addition, the accretion of similar findings would have a substantial impact on the entire diagnostic taxonomy, forcing theorists to consider the existence of external causal determinants for most affective, cognitive, behavioral and personality disorders that are included in the DSM. Ultimately, the psychiatric field may be forced to abandon diagnoses that rely solely on theories of internal causation as determinants of mental illness.

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In this vein, trauma theorists Freedy and Hobfall write:

> There is a bias in standard mental health practice toward the assessment and treatment of anxiety, depression, and other internalized psychological states. The emphasis is upon understanding and fixing things that are endogenous in nature. However, given the clear connection between trauma and mental health problems, it is very likely that a higher percentage of current mental health problems are environmentally induced than is currently recognized. If this assertion is correct, it implies that mental health professionals should focus more on preventing and managing the environmental causes of human suffering than is currently the case. (1995, p. 365)

Implications for social policy. Results of this study are significant for social scientists, reformers, politicians, policy planners, and others concerned with improving the living conditions of the polity. Accruing evidence that social and economic domination result in PTSD indicates a need to dismantle the structures of oppression. It also offers an explanatory theory for the high rates of job, school and social failure among oppressed people, including poor, uneducated, young women. In the present sample, the very youngest women (ages 18-25) reported both higher rates of sexist abuse and PTSD symptoms. It has been documented that PTSD symptoms are biologically

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based and result in impairment of cognitive abilities (concentration, memory, learning), affect regulation (impulsivity, withdrawal, psychic numbing, aggression toward self and others) and attendant behaviors (hypervigilance, poor interpersonal skills, overreaction to environmental stimuli, unpredictability, self-harm, substance abuse; Friedman, 1997; van der Kolk 1997). Thus, PTSD may be a contributory factor in such social problems as addiction, conduct disorders, antisocial behavior, disturbed sexual behavior, underemployment, and child abuse/neglect among young women. Rather than imposing blame on these victims of oppressive conditions, society would benefit from recognizing their life conditions as the result rather than the cause of their discrimination and exclusion. Knowledge regarding PTSD allows policy makers to reframe social problems so that victims of societal conditions are not blamed for their life circumstances.

Understanding PTSD and its effect on the lives of young women may have a positive impact on social policy decisions. Comprehending the links between the etiology and symptomatology of PTSD can provide insights for creating social policies that correct the conditions that lead to trauma symptoms. Advocating for the elimination of sexist oppression should not be the sole province of feminists; all persons concerned with building a healthy society must be actively engaged in reconstructing a nonsexist society that affords opportunity for the safety, freedom, and integrity of all persons. Sandra Bloom (1997) states, “What is clear from what we know now [about trauma] is that we must change our way of dealing with ourselves and each other at every level of society”

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(p. 236). She advocates "significant changes in all of our social systems and in the very way we think about those systems" (p. 190) with a goal of creating a society wherein every individual is valued and respected, and each life is honored.

Feminist ideology. Examination of the daily conditions of female life reveals the reality of sexist oppression and lends credence to feminist claims of victimization. The quantifiable data collected in trauma studies offer demonstrable evidence of the psychological toll of societal oppression. In this study, the collected information represents the maltreatment of women in society. The collected data substantiate the existence of subtle, chronic, ubiquitous nonviolent victimization that has the power to inflict psychological harm. Clearly, any account of the material conditions of women's lives must include the daily occurrences of unfair sex-based treatment.

Overall, the experience of sexism contributed to the creation of PTSD in the women within the present sample. However, a few demographic characteristics served as a protection against having a traumatic response the instigating circumstances. Older age, higher education and income, being married and a parent all served to moderate PTSD symptoms. Notably, the feminists in this study, similar to self-identified feminists in the Landrine and Klonoff study (1997), reported more instances of sexist treatment in their lives than nonfeminists, but demonstrated an equal number of psychological symptoms as

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nonfeminists. Apparently, having a feminist orientation creates a barrier to sexist-motivated mental distress. Landrine and Klonoff (1997) write:

> Feminism may be an important schema that mediates and decreases the negative impact of sexism on women and acts as a buffer protecting their physical and mental health. This, in turn, means that feminism, however much maligned in the popular press these days, is beneficial to women not only in the larger social arena...(r)ather feminism also may be beneficial to women in the smaller personal arena of a woman's everyday thoughts and feeling about herself...Feminism then may be a neglected resource for women, one that may play as important a role as social support and similar resources in mediating the negative impact of stressors but has yet to be sufficiently investigated. (p. 119)

Feminist philosophy can serve not only as a guide for social activism among those committed to eliminating sexism in social and interpersonal realms, it can also be a protective and curative cognitive practice for women. We need to educate young women in feminist thought so that they can withstand the psychological damage incurred by living in a sexist environment. Feminist theory can interrupt the tendency of women to attribute personal distress to qualities inherent in themselves; it can clarify the origination of their psychic pain; and it can serve as a mobilizing force for collective action with their peers and thus create feelings of personal power and communal effectiveness.

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Conclusion and Recommendations

The data collected and analyzed in this study present a powerful portrait of the daily conditions of women's lives. The great majority of women surveyed experienced unfair treatment because of their sex in all arenas of their lives, and many live with unfair expectations and limitations imposed because of their sex. The results demonstrated a relationship between this sexist oppression and PTSD symptoms within this sample of women. Among the tested variables, the predominant predictor of their trauma symptoms was the daily expression of sexism via unfair treatment perpetrated by friends and strangers, at home, work and the public sphere. In particular, recent experiences of sexist degradation and recent experiences of sexism in close relationships were the most predictive factors for PTSD (accounting for 22% of the variance in trauma scores).

Since this particular sample was skewed toward a high socioeconomic status, in a White suburban locale, future researchers may wish to replicate the study within a more diverse population. In order to expand the findings of this study, research should include more women of color, greater geographic diversity, and varying levels of education and income. In addition, since young women reported high rates of both sexism and trauma, future research in this arena should include women younger than 18. Exploration of sexist abuse and maltreatment should begin early, perhaps during the early teenage years, in order to gain insight into the realities of young women's struggles.

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A more diverse population might also produce a more equitable balance of feminists and nonfeminists, allowing for more extensive exploration of the role of feminism in recognizing sexist events and in reducing female PTSD. Future researchers may wish to broaden the inquiry on women's feminist beliefs and their impact on the attributional style of female victims of sexism. This might provide information on developing cognitive schemas for women that enhance their sense of self-worth and that combat the deleterious effects of oppression. Feminist researchers and theoreticians might then construct feminist-oriented educational materials, organizing tools, and outreach programs that would serve to prevent, as well as treat, sexist-induced trauma.

In an effort to change the social science pattern of examining the victim rather than the perpetrator, researchers should explore ways of reformulating the Schedule of Sexist Events so that it can be administered to men. This might help men to see—and measure—the ways that they behave in a sexist manner, both in public and private spheres. This might serve as a critical consciousness-raising device to heighten awareness of subtle sexist practices that men engage in, often at an unconscious level. It would also remind men that reversing societal sexism is a process that requires the engagement all people.

Both the Schedule of Sexist Events and its parent test, the Schedule of Racist Events, are outstanding examples of testing instruments that can be formulated to investigate abusive forces in society. They should serve as models for others who wish to

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measure the presence and extent of additional oppressive forces in society, such as heterosexism and ageism, and the ways they effect the health and well-being of people. The accumulation of such studies would help reinforce the concept of mental illness as a stress response to social ills and obstacles created when we structure societies that are unfair and abusive to its citizens.

Contemporary research in oppression and trauma has provoked a synergistic collaboration of mental health clinicians and social reformers that is unique and groundbreaking. The field of trauma studies has welcomed a diversity of researchers, academics, practitioners, policy planners, activists, writers, and survivors to investigate and understand the ways our social life creates psychic pain and impoverished lives. As we extend and expand this collaborative effort, we will find that differentiation between specialties will be reduced and common ground will broaden. As trauma research, theory development, practice technique, and preventive measures coalesce, they will form a design not only for individual psychotherapeutic work, but also for social reformation and, quite possibly, transformation.

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Appendix A

Posttraumatic Stress Disorder 309.81

(Diagnostic and Statistical Manual for Psychiatric Disorders-IV; APA, 1994)

A. The person has been exposed to a traumatic event in which both of the following were present:

1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others
2. the person's response involved intense fear, helplessness, or horror

(Note: In children, this may be expressed instead by disorganized or agitated behavior)

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perception. (Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. recurrent distressing dreams of the event. (Note: In children, there may be frightening dreams without recognizable content.)
3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashbacks,

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including those that occur on awakening or when intoxicated). (Note: in young children, trauma-specific reenactment may occur)

4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. efforts to avoid activities, places, or people that arouse recollections of the trauma

3. inability to recall an important aspect of the trauma

4. markedly diminished interest or participation in significant activities

5. feeling of detachment or estrangement from others

6. restricted range of affect (e.g., unable to have loving feelings)

7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

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1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hypervigilance
5. exaggerated startle response

E. Duration of the disturbance is more than 1 month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

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Appendix B

Schedule of Sexist Events

Please think carefully about your life as you answer the questions below. For each question, read the question and then answer it twice: Answer once for what your ENTIRE LIFE (from when you were a child to now) has been like, and then once for what the PAST YEAR has been like. Circle the number that best describes events in YOUR ENTIRE LIFE, and in the PAST YEAR, using these rules:

Circle 1 = NEVER
Circle 2 = ONCE IN A WHILE (less than 10% of the time)
Circle 3 = SOMETIMES (10-25% of the time)
Circle 4 = A LOT (26-49% of the time)
Circle 5 = MOST OF THE TIME (50-70% of the time)
Circle 6 = ALMOST ALL OF THE TIME (more than 70% of the time)

(Note: Please base your answers on YOUR perception of why the event happened.)

1. How many times have you been treated unfairly by teachers or professors *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

2. How many times have you been treated unfairly by your employer, boss or supervisors *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

3. How many times have you been treated unfairly by your co-workers, fellow students or colleagues *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

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Never/Once in a while/Sometimes/A lot/Most of the time/Almost all of the time
1 2 3 4 5 6

4. How many times have you been treated unfairly by people in service jobs (by store clerks, waiters, bartenders, waitresses bank tellers, mechanics and others) *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

5. How many times have you been treated unfairly by strangers *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

6. How many times have you been treated unfairly by people in helping jobs (by doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, pediatricians, school principals, gynecologists, and others) *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

7. How many times have you been treated unfairly by neighbors *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

8. How many times have you been treated unfairly by your boyfriend, husband, or other important man in your life *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

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Never/Once in a while/Sometimes/A lot/Most of the time/Almost all of the time
1 2 3 4 5 6

9. How many times were you denied a raise, a promotion, tenure, a good assignment, a job, or other such thing at work that you deserved, *because you were a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

10. How many times were you treated unfairly by your family *because you were a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

11. How many times have people made unwanted or inappropriate sexual advances to you *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

12. How many times have people failed to show you the respect that you deserve, *because you are a woman?*

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

13. How many times have you wanted to tell someone off for being sexist?

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6

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Never/Once in a while/Sometimes/A lot/Most of the time/Almost all of the time
1 2 3 4 5 6

14. How many times have you been really angry about something sexist that was done to you?

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

15. How many times were you forced to take drastic steps (such as filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions) to deal with some sexist thing that was done to you?

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

16. How many times have you been called a sexist name like bitch, cunt, chick, or other names?

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

17. How many times have you gotten into an argument or a fight about something sexist that was done or said to you or done to somebody else:

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

18. How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm *because you are a woman?*

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

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Never/Once in a while/Sometimes/A lot/Most of the time/Almost all of the time
1 2 3 4 5 6

19. How many times have you heard people making sexist jokes, or degrading sexual jokes?

How many times IN YOUR ENTIRE LIFE?	1	2	3	4	5	6
How many times IN THE PAST YEAR?	1	2	3	4	5	6

20. How different would your life be now if you HAD NOT BEEN treated in a sexist and unfair way THROUGHOUT YOUR LIFE:

The same as it is now	A little different	Different in a few ways	Different in a lot of ways	Different in most ways	Totally different
1	2	3	4	5	6

IN THE PAST YEAR:

The same as it is now	A little different	Different in a few ways	Different in a lot of ways	Different in most ways	Totally different
1	2	3	4	5	6

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Appendix C

Trauma Symptom Inventory

This questionnaire contains 100 items describing experiences that may or may not have happened to you. Please circle the one answer that best indicates how often each of the following experiences have happened to you in the last 6 months.

Circle 0 if your answer is NEVER. It has not happened at all in the last 6 months.
Circle 1 or 2 if it has happened in the last 6 months, but has not happened often.
Circle 3 if your answer is often; it has happened often in the last 6 months.
Please answer each item as honestly as you can. Be sure to answer every item.

In the last 6 months, how often have you experienced:	Never			Often
1. Nightmares or bad dreams	0	1	2	3
2. Trying to forget about a bad time in your life	0	1	2	3
3. Irritability	0	1	2	3
4. Stopping yourself from thinking about the past	0	1	2	3
5. Getting angry about something that wasn't very important	0	1	2	3
6. Feeling empty inside	0	1	2	3
7. Sadness	0	1	2	3
8. Flashbacks (sudden memories or images of upsetting things)	0	1	2	3
9. Not being satisfied with your sex life	0	1	2	3
10. Feeling like you were outside of your body	0	1	2	3
11. Lower back pain	0	1	2	3

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In the last 6 months, how often have you experienced:	Never			Often
12. Sudden disturbing memories when you were not expecting them	0	1	2	3
13. Wanting to cry	0	1	2	3
14. Not feeling happy	0	1	2	3
15. Becoming angry for little or no reason	0	1	2	3
16. Feeling like you don't know who you really are	0	1	2	3
17. Feeling depressed	0	1	2	3
18. Having sex with someone you hardly know	0	1	2	3
19. Thoughts or fantasies about hurting someone	0	1	2	3
20. Your mind going blank	0	1	2	3
21. Fainting	0	1	2	3
22. Periods of trembling or shaking	0	1	2	3
23. Pushing painful memories out of your mind	0	1	2	3
24. Not understanding why you did something	0	1	2	3
25. Threatening or attempting suicide	0	1	2	3
26. Feeling like you were watching yourself from far away	0	1	2	3
27. Feeling tense or "on edge"	0	1	2	3

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In the last 6 months, how often have you experienced:	Never			Often
28. Getting into trouble because of sex	0	1	2	3
29. Not feeling like your real self	0	1	2	3
30. Wishing you were dead	0	1	2	3
31. Worrying about things	0	1	2	3
32. Not being sure of what you want in life	0	1	2	3
33. Bad thoughts or feeling during sex	0	1	2	3
34. Being easily annoyed by other people	0	1	2	3
35. Starting arguments or picking fights to get your anger out	0	1	2	3
36. Having sex or being sexual to keep from feeling lonely or sad	0	1	2	3
37. Getting angry when you didn't want to	0	1	2	3
38. Not being able to feel your emotions	0	1	2	3
39. Confusion about your sexual feelings	0	1	2	3
40. Using drugs other than marijuana	0	1	2	3
41. Feeling jumpy	0	1	2	3
42. Absent-mindedness	0	1	2	3
43. Feeling paralyzed for minutes at a time	0	1	2	3
44. Needing other people to tell you what to do	0	1	2	3

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In the last 6 months, how often have you experienced:	Never			Often
45. Yelling or telling people off when you felt you shouldn't have	0	1	2	3
46. Flirting or "coming on" to someone to get attention	0	1	2	3
47. Sexual thoughts or feelings when you thought you shouldn't have them	0	1	2	3
48. Intentionally hurting yourself (for example, by scratching, cutting, or burning) even though you weren't trying to commit suicide	0	1	2	3
49. Aches and pains	0	1	2	3
50. Sexual fantasies about being dominated or overpowered	0	1	2	3
51. High anxiety	0	1	2	3
52. Problems in your sexual relations with another person	0	1	2	3
53. Wishing you had more money	0	1	2	3
54. Nervousness	0	1	2	3
55. Getting confused about what you thought or believed	0	1	2	3
56. Feeling tired	0	1	2	3
57. Feeling mad or angry inside	0	1	2	3
58. Getting into trouble because of your drinking	0	1	2	3
59. Staying away from certain people or places because they reminded you of something	0	1	2	3

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In the last 6 months, how often have you experienced:	Never			Often
60. One side of your body going numb	0	1	2	3
61. Wishing you could stop thinking about sex	0	1	2	3
62. Suddenly remembering something upsetting from the past	0	1	2	3
63. Wanting to hit someone or something	0	1	2	3
64. Feeling hopeless	0	1	2	3
65. Hearing someone talk to you who wasn't really there	0	1	2	3
66. Suddenly being reminded of something bad	0	1	2	3
67. Trying to block out certain memories	0	1	2	3
68. Sexual problems	0	1	2	3
69. Using sex to feel powerful or important	0	1	2	3
70. Violent dreams	0	1	2	3
71. Acting "sexy" even though you didn't really want sex	0	1	2	3
72. Just for a moment, seeing or hearing something upsetting that happened earlier in your life	0	1	2	3
73. Using sex to get love or attention	0	1	2	3
74. Frightening or upsetting thoughts popping into your mind	0	1	2	3
75. Getting your own feelings mixed up with someone else's	0	1	2	3

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In the last 6 months, how often have you experienced:	Never			Often
76. Wanting to have sex with someone who you knew was bad for you	0	1	2	3
77. Feeling ashamed about your sexual feelings or behavior	0	1	2	3
78. Trying to keep from being alone	0	1	2	3
79. Losing your sense of taste	0	1	2	3
80. Your feelings or thoughts changing when you were with other people	0	1	2	3
81. Having sex that had to be kept a secret from other people	0	1	2	3
82. Worrying that someone is trying to steal your ideas	0	1	2	3
83. Not letting yourself feel bad about the past	0	1	2	3
84. Feeling like things weren't real	0	1	2	3
85. Feeling like you were in a dream	0	1	2	3
86. Not eating or sleeping for 2 or more days	0	1	2	3
87. Trying not to have any feelings about something that once hurt you	0	1	2	3
88. Daydreaming	0	1	2	3
89. Trying not to think or talk about things in your life that were painful	0	1	2	3
90. Feeling like life wasn't worth living	0	1	2	3

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In the last 6 months, how often have you experienced:	Never			Often
91. Being startled or frightened by sudden noises	0	1	2	3
92. Seeing people from the spirit world	0	1	2	3
93. Trouble controlling your temper	0	1	2	3
94. Being easily influenced by others	0	1	2	3
95. Wishing you didn't have any sexual feelings	0	1	2	3
96. Wanting to set fire to a public building	0	1	2	3
97. Feeling afraid you might die or be injured	0	1	2	3
98. Feeling so depressed that you avoided people	0	1	2	3
99. Thinking that someone was reading your mind	0	1	2	3
100. Feeling worthless	0	1	2	3

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Appendix D

Gender-Stressors Questionnaire

DIRECTIONS: For each of the following questions, please indicate whether or not you had this experience.

1. Have you ever been separated or divorced?

YES NO

2. Have you ever experienced serious relationship problems?

YES NO

3. Have you ever had serious money problems (for example, not enough money for food or a place to live)?

YES NO

4. Have you ever been prevented from continuing your education due to the objections of family members or life circumstances related to being a woman?

YES NO

5. Have you ever been prevented from pursuing or continuing a career due to the objections of family members or life circumstances related to being a woman?

YES NO

6. Have you ever had an unwanted pregnancy that was brought to term (the baby was born)?

YES NO

7. Have you ever had an abortion or miscarriage?

YES NO

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8. Have you ever experienced infertility (for longer than one year)?

YES NO

9. Have you ever given up a baby for adoption?

YES NO

10. Have you ever been separated from your child against your will (for example, lost custody or had a child removed from the home)?

YES NO

11. Have you ever been primarily responsible for child care and/or household duties, in addition to paid employment?

YES NO

12. Were you ever a single parent?

YES NO

13. Has a baby or child of yours ever had a severe physical or mental handicap (for example, mentally retarded, can't walk, see or hear)?

YES NO

14. Have you ever been responsible for taking care of someone close to you (not your child) who had a severe physical or mental handicap (for example, cancer, stroke, Alzheimer's disease, AIDS, emotional or psychological problems)?

YES NO

15. Were you ever sent to jail?

YES NO

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16. Was a close family member ever sent to jail?

YES NO

17. Have you ever had serious mental illness (panic attacks, wanting to kill yourself, having an eating disorder, or being hospitalized)?

YES NO

18. Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sex
by someone at work or school (for example, a coworker, boss, customer, another student, or teacher)?

YES NO

19. Were you ever emotionally or verbally abused in a relationship (called names, cursed at, demeaned or put-down)?

YES NO

20. Were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, girlfriend, or spouse hit, slapped, choked, burned or beat you)?

YES NO

21. Were you ever touched or made to touch someone else in a sexual way because someone forced you in some way or threatened harm if you didn't?

YES NO

22. Did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened harm if you didn't?

YES NO

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Appendix E

Demographic Questionnaire

Please complete this section in order to provide information about yourself.

1. Please indicate your age:

    (a) 18 - 25_____
    (b) 26 - 35_____
    (c) 36 - 45_____
    (d) 46 - 55_____
    (e) 56 - 65_____
    (f) Over 65_____

2. Please indicate your race:

    (a) White_____
    (b) African American_____
    (c) Hispanic (non-white)____
    (d) Asian_____
    (e) Other (please specify)__________

3. Please indicate the highest level of education completed:

    (a) Elementary School_____
    (b) Junior High School____
    (c) High School____
    (d) Some College____
    (e) College____
    (f) Post-Graduate____
    (g) Other training (please specify)_______________________

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4. Please indicate your own PERSONAL gross annual income (not household income):

   (a) Less than $10,000_____
   (b) $10,000 - $29,999_____
   (c) $30,000 - $49,999_____
   (d) $50,000 - $69,999_____
   (e) $70,000 or more_____

5. Please indicate your TOTAL household income (including all persons you live with):

   (a) Less than $30,000_____
   (b) $30,000 - $49,999_____
   (c) $50,000 - $69,999_____
   (d) $70,000 - $89,999_____
   (e) $90,000 or more_____

6. Which of the following best describes your CURRENT employment status:

   (a) Employed full time______
   (b) Employed part-time______
   (c) Not working for wages at this time_____
   (d) Not working for wages at this time, but do regular and substantial volunteer work_____
   (e) Student - Full-time_________Part-time___________
   (f) Other (please specify) ____________________________

7. Which of the following best describes your PAST employment status:

   (a) Have never worked for wages____
   (b) Have worked on and off during the years_____
   (c) Have always worked for wages______
   (d) Other (please specify)____________________________

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8. Which of the following best describes your present job category:

    (a) Professional_______
    (b) Technical______
    (c) Service______
    (d) Sales/Retail______
    (e) Clerical______
    (f) Other (Please describe)____________________________

9. Current partnership status:

    (a) Single (Heterosexual)_____Lesbian______Bi-sexual_____
    (b) Married, or living with opposite-sex partner______
    (c) Living with same-sex partner______

10. Current parenthood status (you may check more than one):

    (a) Living with child(ren) under 18_____
    (b) Living with child(ren) over 18_____
    (c) Grown child(ren) living outside the home_____
    (d) Without children______
    (e) Other (please specify) ____________________

11. Which of the following best describes the area in which you live:

    (a) Urban_____
    (b) Suburban____
    (c) Rural_____

12. Current clinical status:

    (a) Neither in therapy nor using psychoactive medication_____
    (b) Presently in therapy_____
    (c) Presently using psychoactive medication_____
    (d) Both in therapy and using psychoactive drugs_______

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13. To what extent would you identify yourself as a feminist:

(a) Strongly identify____
(b) Identify____
(c) Somewhat identify____
(d) Somewhat do not identify____
(e) Do not identify____
(f) Strongly do not identify____

Please use the space below to make additional comments about any items in this survey, or to mention anything that occurs to you which was not asked about, but which seems relevant to you. Thank you for taking the time to complete this survey.

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Appendix F

Informed Consent Form

Dear Participant,

I am asking you to participate in a research project that is designed to provide information about women's mental health issues. The enclosed survey contains questions regarding your experiences as a woman -- at home, on the job, in society, and with your family. It also contains questions about your health, mental health, and your life in general. The results of the study will be used to improve the lives of women. All responses are kept strictly confidential and no names will be attached to the survey. This is a completely anonymous and confidential study.

This survey is being conducted by me, Susan H. Berg, a student at CUNY/Hunter School of Social Work, in partial fulfillment for my doctorate in social work. (I am also a social worker with two decades of experience as a clinician and educator.) If you have any questions about the study, you may contact me at 516-928-2175.

The content of the questions in this survey may be psychologically disturbing or upsetting to you as you complete it. If you need a referral for counseling, or a list of community resources for mental health services, please call me at the above number, and I will send the information you need.

I appreciate your participation in this study, which will help us understand the social issues that have an impact on women's mental health. Your participation is completely voluntary; if you choose to participate, please answer all the questions that you can.

Thank you,

Susan H. Berg

516-928-2175

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Appendix G

Resources

If you are experiencing any distress as a result of this questionnaire, you may consult any of the resources listed below:

SUFFOLK COUNTY

Hotlines:

Huntington Hotline	549-8700
Islip Hotline	277-4700
Response of Suffolk County	751-7500
S.C. Dept. of Social Services (4:30 p.m. – 9 a.m.)	854-9100
Victims' Information Bureau of Suffolk	360-3730

Information and Referral:

Family Service League	427- 3700
S.C. Mental Health Association	543-8600

Mental Health Counseling:

Brentwood Mental Health Clinic (Hauppauge)	853-7304
Catholic Charities (Medford)	654-1919
Family Service League (Huntington)	427-3700
Farmingville Mental Health Clinic	854-2552
Huntington Hospital	351-2000
Jewish Community Service/FEGS (Smithtown)	724-6300
Mather Memorial Hospital (Pt. Jefferson)	476-2830
No. Suffolk Mental Health	667-4783
Pederson-Krag Center (Huntington)	421-7800
Pederson-Krag Center (Smithtown)	265-3311
Pederson-Krag Center (St. James)	862-0301
Riverhead Mental Health Center	852-1440
South Oaks Hospital (Amityville)	264-4000
Sunrise Psychiatric Hospital (Amityville)	789-4325
University Medical Center – Stony Brook	632-8850

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NASSAU COUNTY

Hotlines:

Domestic Violence Hotline	542-0404
Middle Earth Hotline (Bellmore)	679-1111
N.C. Dept. of Health (5 p.m. – 9 a.m.)	742-6154
N.C. Dept. of Social Services (6 p.m. – 8 p.m.)	542-3143

Information and Referral:

Family and Children's Association	746-0350
N.C. Mental Health Association	489-2322

Mental Health Counseling:

Adelphi U. Counseling Center (Garden City)	877-4820
Angelo J. Melillo Center (Glen Cove)	676-4160
Central Nassau Guidance/Counseling (Hicksville)	822-6111
Jewish Community Service/FEGS	
- Hempstead	485-5710
- Syosset	364-8040
L.I. Jewish Medical Ctr./Hillside Hospital Outpatient Services (Glen Oaks)	718-470-8100
Mercy Medical Center (Rockville Center)	255-0111
North Shore U. Hospital Psychiatric Outpatient	562-4927
Peninsula Counseling Center (Woodmere)	569-6600
Roosevelt Community Mental Health	623-1644
S. Nassau Communities Hospital (Baldwin)	546-1370
Southeast Nassau Guidance Ctr. (Seaford)	221-3030
Woodward Mental Health Center (Freeport)	379-0900

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Appendix H

Trauma Symptom Inventory Subscales

(TSI Professional Manual; Briere, 1995)

Anxious Arousal (AA) - refers to symptoms of anxiety and autonomic hyperarousal. These are often exhibited as nervousness, jumpiness, feeling "on edge," excessive worrying, tension, and fears of bodily harm. The reaction to stress or sudden intrusive stimuli is often fearfulness or an exaggerated startle response, accompanied by anxiety or panic attacks. Presentation is hyperalert and hypervigilant with or without somatic symptoms consistent with sympathetic nervous system hyperarousal.

Deprression (D) - refers to depressed mood and depressive cognitions. Symptoms include frequent feelings of sadness and unhappiness, perceptions of oneself as worthless and inadequate, a view of the future as hopeless, and a tendency to think about dying. The depressive may seclude or isolate from others, self-injure, or engage in suicidal behaviors.

Anger/Irritability (A/I) - refers to angry, irritable affect, the presence of angry cognitions (wanting to "tell someone off"), and angry behavior (picking fights). Anger may be

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intrusive and feel out of one's control and/or there may be pervasive feelings of irritability, annoyance, or bad temper, so that frustrations provoke inappropriate angry reactions.

Intrusive Experiences (IE) - refers to intrusive post-traumatic reactions and symptoms. These include nightmares, flashbacks (sudden sensory memories of a previously traumatizing event), upsetting memories triggered by current events, and repetitive thoughts of an unpleasant previous experience that intrude into awareness. These are often perceived as ego-dystonic primarily involving reminiscence or re-experiencing of an upsetting event. (These are often misperceived as psychotic hallucinations.)

Defensive Avoidance (DA) - refers to avoidance responses, i.e., frequent attempts to eliminate painful thoughts or memories from conscious awareness or avoidance of events or stimuli in the environment that might restimulate upsetting thoughts or memories. Symptoms may also include a desire to neutralize negative feelings about previous traumatic experiences. (These are conscious, intentional cognitions and behaviors designed to manage post-traumatic stress.)

Dissociation (DIS) - refers to a largely unconscious defensive alteration in conscious awareness, developed as an avoidance response to overwhelming psychological distress.

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The symptoms include: cognitive disengagement, depersonalization and derealization, out-of-body experiences, and emotional numbing. Persons may report distractibility, "spacing out," and feeling out-of-touch with themselves and their bodies. They may report anxiety related to the aversive quality of intense depersonalization.

Impaired Self-Reference (ISR) - refers to a variety of difficulties associated with an inadequate sense of self and personal identity. These include problems in discriminating one's needs and issues from those of others, confusion regarding one's identity and goals in life, an inability to understand one's own behavior, an internal sense of emptiness, a need for other people to provide direction and structure, and difficulties resisting the demands of others. These individuals appear to have less self-knowledge and self-confidence than others, may be more easily influenced by others, and may present as easily excitable and less functional under stress.

The following TSI subscales are not directly related to the DSM-IV definition of PTSD, but reflect symptoms often associated with the disorder. Although they were not reported in the text of this study, they were also significantly correlated with total SSE scores and all SSE subscales.

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Sexual Concerns (SC) - refers to sexual distress and dysfunction, including sexual dissatisfaction, negative thoughts and feelings during sex, confusion regarding sexual issues, sexual problems in relationships, unwanted sexual preoccupation, and shame regarding sexual activities or responses. There is often concomitant anxiety and fearfulness regarding sexual matters.

Dysfunctional Sexual Behavior (DSB) - refers to reports of sexual behavior that is, in some way, dysfunctional or problematic. The symptoms include indiscriminate sexual contact, getting into trouble because of one's sexual behavior, using sex to combat loneliness or internal distress, engaging in unsafe sexual practices, flirtation or seductiveness for non-sexual reasons and sexual attraction to potentially dangerous or dysfunctional persons.

Tension Reduction Behavior (TRB) - refers to engaging in external activities as a way to modulate, interrupt, avoid, or soothe negative internal states. These are attempts to externalize distress through suicidality, aggression, inappropriate sexual behavior, self-mutilation, and activities intended to forestall abandonment or aloneness. Often, these individuals "act out" negative affect and may become injurious to self or others when stressed or dysphoric. (These behaviors, in conjunction with ISR and DSB, may result in an inappropriate Borderline or Histrionic Personality Disorder diagnosis.)

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