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Child multi-type maltreatment and associated depression and PTSD symptoms: The role of social support and stress

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Abstract

Objective— This retrospective, cross-sectional study explored the hypothesis that multiple forms of child abuse and neglect (child multi-type maltreatment; CMM) would be associated with women's lower social support and higher stress in adulthood, and that this, in turn, would amplify their vulnerability to symptoms of depression and posttraumatic stress disorder (PTSD).

Method— Participants were 100 women recruited from an inner-city gynecological treatment center for low-income women. Data were analyzed via structural equation modeling (SEM) with Lisrel 8.0.

Results— CMM was directly predictive of decreased social support and increased stress in adulthood. CMM was also directly predictive of PTSD symptoms, but not depression symptoms in adulthood. Social support partially mediated the relationship between CMM and adult PTSD symptoms, and stress fully mediated the relationship between CMM and adult symptoms of depression.

Conclusions— Findings support both direct and mediational effects of social resources on adult depression and PTSD symptoms in women with histories of CMM, suggesting that resources are key factors in psychological adjustment of CMM victims.

Keywords

Child multi-type maltreatment; Social support; Stress; Depression; PTSD

Introduction

Child maltreatment's negative impact often persists into adulthood. Two potentially negative outcomes of child maltreatment are post-traumatic stress disorder (PTSD) and depression (e.g., Browne & Finkelhor, 1986; Schaaf & McCanne, 1998; Shalev et al., 1998). A connection between child maltreatment and adult depression and PTSD has already been established (e.g.,

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Briere & Runtz, 1988). Recently there has been a proliferation of theoretical and empirical work suggesting that social support and stress are key intervening factors in the manner in which maltreatment survivors function psychologically in adulthood. However, few attempts have been made to test the role of social support and stress simultaneously with victims of child maltreatment. Hence, the purpose of this study is to integrate stress and social support into one model, in an attempt to understand the etiological processes in the mental health of child maltreatment survivors.

Previous research has mainly focused on the effects of single types of maltreatment, typically sexual abuse (e.g., Briere, J. & Runtz, M., 1993; Paolucci & Violato, 2001), and to a lesser extent physical abuse and neglect (e.g., Malinosky-Rummell & Hansen, 1993), emotional abuse (e.g., Briere & Runtz, 1988; O'Hagan, 1995), and witnessing family violence (e.g., Parkinson & Humphrey, 1988). However, most maltreated children experience more than one form of abuse and neglect (Kinard, 1994). This co-existence of multiple types of maltreatment (e.g., sexual abuse, physical, emotional, neglect and witnessing family violence) is termed in the maltreatment literature as child multi-type maltreatment (CMM; Higgins & McCabe, 2001b). Prior investigations identified a general, rather than a unique effect of a particular type of maltreatment on adult psychological functioning (Varia, Abidin, & Dass, 1996; Widom & Ames, 1994). In explaining this general effect, Emery (1989) argued that aversive arousal is common across all types of maltreatment, leading to employment of similar maladaptive coping mechanisms, and indirectly to similar negative psychological outcomes. Higgins and McCabe (1994, 2000) and Zlotnick and her colleagues (1996) argued that studies that found a unique, rather than a general effect of abuse did not assess other forms of abuse and neglect.

Accordingly, results of such studies may, in fact, reflect the cumulative effect of multiple types of maltreatment that went unassessed. This thesis is consistent with previous research done by Felitti and his colleagues (e.g., Chapman et al., 2004; Edwards, Holden, Felitti, & Anda, 2003; Felitti et al., 1999), that found a graded relationship between the number of adverse childhood experiences and adult physical and psychological distress.

Pathways linking CMM to PTSD and depression

Individuals who were maltreated as children have smaller supportive networks, are less satisfied with their supportive networks (Gibson & Harthorne, 1996; Harmer, Sanderson, & Mertin, 1999) and perceive their relationships as less supportive (Stroud, 1999). One potential explanation for these effects is that the maltreatment causes distortions in children's cognitions regarding themselves and others. These distortions become internalized, leading to unhealthy adult relationships (Briere, Berliner, Bulkley, Jenny, & Reid, 1996). It is also likely that maltreated children have less actual support in adulthood because their potential family support is limited as their parents and siblings may have been perpetrators, or may have suffered maltreatment experiences (Browne & Finkelhor, 1996), and thus may be ineffectual as supporter providers (Elliot & Carnes, 2001). In addition, often children who were maltreated grew up in dysfunctional family environments, and may have poor scripts for healthy adult relationships (Browne & Finkelhor, 1996). This social support linkage is important because low social support is consistently related to depression (Brown & Harris, 1987; Cutrona & Troutman, 1986; Dohrenwend, 2000).

Recent research supports the connection between social support and PTSD in adulthood. Studies in veteran samples and victims of natural disasters indicate that low levels of social support after the traumatic event are related to PTSD symptoms (Gold et al., 2000). Further, recent research asserts that individuals newly diagnosed with PTSD endorse lower levels of social support when compared to controls (Kotler, Iancu, Efroi, & Amir, 2001; Widows, Jacobsen, & Fields, 2000). Brewin, Andrews, & Valantines (2000) confirmed these assertions

in a recent metaanalysis of studies assessing populations exposed to trauma in adulthood, where he found that lack of social support was a major risk factor in the development of PTSD.

In addition to having impaired social support, women with a history of child maltreatment are more susceptible to the effects of daily stressors (Thakkar & McCanne, 2000) and report more stress compared to their non-maltreated counterparts (Harmer et al., 1999). Moreover, survivors of maltreatment may perceive life events as more stressful because of their predisposition to a pervasive sense of helplessness (Seligman, 1975) and decreased coping resources (Cole & Putnam, 1992; Davis, Petric-Jackson, & Ting, 2001).

The role of stress in the development of depression has been extensively studied. The majority of studies support the critical role of stress in provoking episodes of depression, including clinical depression among vulnerable individuals (Brown & Harris, 1987; Hammen, 1999; Dohrenwend, 2000). Some individuals may develop only depression following a traumatic stress, whereas others develop PTSD or depression and PTSD.

Although extensive research shows that traumatic stressors lead to the development of PTSD, less research has been conducted on the role of stress in the development of PTSD in victims of child maltreatment. Theories of the effect of traumatic events posit that either the whole event or aspects of the events are carved onto the memory of individuals (Harowitz, Wilner, & Alvarez, 1979). These stimuli that are associated with the event are theorized to become cues that evoke both the visualization and the negative emotions that were originally associated with the occurrences when the new stressors occur. In this vein, Brewin, Andrews, & Valantines (2000) provided evidence that post trauma life stressors place individuals traumatized in adulthood at risk of PTSD. However, former victims' adult sensitivity to new stressors has not been appropriately tested in victims of child maltreatment, and to our knowledge, has never been assessed in women with histories of CMM.

This review leads to an overarching model that specifies how social support and stress can act and be depicted as potential mediators between CMM and depression or PTSD symptoms (see Figure 1).

The present study

The purpose of the current study was to provide a better understanding of the mechanism through which CMM may negatively impact women's lives, by examining the role of social support and stress in the development of depression and PTSD. The present study was built on limitations of previous research by including social support and stress within a comprehensive model and by assessing multiple forms of child maltreatment experienced by women during childhood.

We hypothesized that CMM would be related to women having lower levels of social support and greater exposure to stress during adulthood. We further predicted that this lower social support and greater stress exposure would be related to greater vulnerability to depression and posttraumatic stress disorder (PTSD) symptoms in adulthood.

Method

Participants

Participants were 100 women recruited from a gynecological treatment center for low-income women located in the inner city of a mid-sized, Mid-western US city. We used this site because it has open access to a broad cross-section of healthy inner-city women presenting for regular check-ups. As depicted in Table 1, women were young, with mean age of 28.92 (SD = 10.52), mostly European American (48%) or African-American (47%). Only 7% were high school

graduates. Women were mostly unemployed (73%), with a yearly income of less than \$15,000 (67%). This inner-city, low-income sample was ideal for testing the aforementioned model, given the high rates of childhood trauma and the high risk of inner-city women to experience stressful life events and acute resource losses that occur in the wake of chronically diminished economic conditions (Eckenrode, 1984; Ennis, Hobfoll, & Schroder, 2000; Hobfoll, Johnson, Ennis, & Jackson, 2003).

Measures

Child multi-type maltreatment—Women's experiences before the age of 18 of various types of maltreatments were assessed using the Comprehensive Child Maltreatment Scale (CCMS) for Adults (Higgins & McCabe, 2001b). The CCMS has five continuous scales that comprise 22 items assessing sexual abuse (11 items), physical abuse (3 items), psychological maltreatment (3 items), neglect (3 items) and witnessing family violence (2 items).

Respondents reported the frequency with which they experienced each of these behaviors directed toward them by their mother, their father, or another adult. Two of the items from the sexual scale were asked only twice, because they assess behaviors that can only be performed by male protagonists, and one item which refers only to male victims, was excluded. Ratings used a Likert scale, from *never* (0) to *more than 20 times* (6) for sexual abuse, and from *never or almost never* (0) to *very frequently* (4) for all other forms of maltreatment. A total score representing the experience of CMM, was computed by summing across the five scales. The CCMS was found to be psychometrically sound, with good internal consistency across scales and excellent test-retest reliability (see Higgins & McCabe, 2001b). The concurrent validity of CCMS is evidenced by high correlations between relevant subscales of the Child Abuse Trauma questionnaires (CAT), one of the most widely used measures of physical and sexual abuse observed in previous research (CMM; Higgins & McCabe, 2001). In this study internal consistency for the multi-type maltreatment scale ($\alpha = .94$) was high.

Current depression—The Diagnostic Inventory for Depression (DID; Sheeran & Zimmerman, 2002) was employed to assess current depression severity and diagnosis. This is a Likert scale with 38 items forming three subscales (symptoms, psychosocial functioning, and quality of life), all with good psychometric properties (see Sheeran & Zimmerman, 2002). We used only the symptoms subscale, which yielded a score representing depression severity and had good internal reliability ($\alpha = .91$). The total depression severity score ranged from 0 to 54, with high scores representing high depression. Diagnoses were estimated based on an algorithm consistent with DSM-IV criteria (American Psychiatric Association, 1994; see Sheeran & Zimmerman, 2002 for diagnoses algorithm).

Social support—The Social Support Questionnaire-6 was employed to assess women's current satisfaction with their support network (SSQ-6; Sarason, Sarason, Shearin, & Pierce, 1987). SSQ is a brief social support questionnaire with good reliability and validity. Ratings were done on a 6-point scale from very dissatisfied (1) to very satisfied (6). A total score, ranging from 6 to 36, was computed, with high scores representing reports of high satisfaction with current support. In this study, internal reliability for the scale was good ($\alpha = .94$).

Current perceived availability of social support was measured with the short version (11 items) of the Interpersonal Support Evaluation List (ISEL; Cohen & Hoberman, 1983; Cohen, Mermelstein, Kamarck, & Hoberman, 1985). Ratings were done on a 5-point scale from *definitely false* (1) to *definitely true* (5). A total score, ranging from 11 to 55 was computed, with high scores representing high perceived support. The scale has good psychometric properties (Cohen et al., 1985). In this study, internal consistency ($\alpha = .85$) was good.

Stress—An abbreviated version (45 items) of The Conservation of Resources Evaluation (CORE; Hobfoll & Lilly, 1993) was used to assess whether women have encountered recent stressful conditions that resulted in loss of resources. Women indicated the degree to which they had lost or had threatened loss of resources such as transportation, employment, medical insurance, family stability, and so forth. Ratings were done on a 3-point scale (*no threat or loss, some threat or loss, a great deal of threat or loss*). A total score, with ranges from 0 to 135, was computed with high scores represented a great deal of threat and loss. COR-E is a reliable and valid measure (Ennis et al., 2000; Hobfoll & Lilly, 1993). Internal consistency is not an appropriate statistic for this measure because loss of resources in one domain (e.g., economic, health) does not imply loss in other domains.

Current perceived stress was assessed with the short version of the Perceived Stress Inventory (PSI; Cohen, Kamarck, & Marmelstein, 1983). This is a four-item scale with good psychometric properties. Ratings were done on a 4-point scale, from *never* (0) to *very often* (4). A total score, ranging from 0–16 was computed. High scores represent high perceived stress. In the current study, internal reliability ($\alpha = .92$) was good.

Maltreatment-related PTSD—The PTSD Symptom Scale-Interview (PSS-I; Foa, Riggs, Dancu, & Rothbaum, 1993) was used to measure severity of CMM-related PTSD severity and diagnosis. This is a 17-item scale matching the diagnostic symptoms of PTSD (American Psychiatric Association, 1994). A total score representing PTSD severity was computed, with a range from 0 to 48. High scores represent high PTSD severity. The scale has excellent psychometric characteristics (see Foa et al., 1993). Internal reliability for this study was good ($\alpha = .91$).

Procedure

The project was reviewed and approved by the Human Subjects Review Boards of both Kent State University and Akron General Hospital. Recruitment occurred between November 2001 and April 2002, and most participants were recruited between January and April. Women awaiting medical appointments were invited to participate individually by female interviewers, who explained the nature of the study and offered \$10 for completing the interview. Women were assured that their medical care was in no way contingent upon their participation, and that all information they would provide would remain confidential. Further, women were told that they could withdraw from the study at any point in time. Approximately 80% of those approached chose to participate. The most common reason for refusal was that they had no time before or after their appointment. Data were collected via interviews, rather than self-report paper and pencil, to ensure reliability of reports and avoid missing data. Interviews were conducted in a private room at the medical clinic and lasted between 25–40 minutes. Interviewers were two undergraduate and one graduate student trained in empathic questioning techniques and multi-cultural sensitivity. This manner of interviewing was found to be particularly effective with this population by encouraging responding (Miller & Rollnick, 1991). Interviewers were provided with weekly supervision by a clinical psychology advanced graduate student to discuss interview issues and maintain standardized procedures. All participants completed the entire interview, and there was no loss of data.

Analytic strategy

We conducted confirmatory factor analysis and structural equation modeling (SEM) with LISREL 8.0 (Joreskog & Sorbom, 1993) to assess the adequacy of measurement of latent factors (unmeasured, estimated variables) and to test the study hypotheses. We tested *a priori* specified hypotheses about the underlying structure of the measurement model and the structural controlling of measurement error (Bollen, 1989). Our intent was to estimate a parsimonious, theoretically-based model.

The measurement model consisted of the latent constructs of social support and stress. The social support latent construct's meaning was driven by the individually measured variables of perceived social support and satisfaction with social support. The stress latent construct's meaning was also driven by the individual measured variables of perceived stress and loss of resources individual measured variables. The structural model was constructed according to theory, with a nonrecursive relationship specified as a correlated error coefficient between the two mediating constructs, social support and stress. The relationship between the two dependent variables was also specified as nonrecursive in a similar manner. The structural model consisted of one exogenous (not determined by the model) observed variable (CMM), two endogenous (determined by the model) mediating latent variables (social support and stress), and two dependent observed variables (PTSD and depression). All estimated parameters were hypothesized *a priori*.

Results

Reports of child abuse were frequent, with 85% women having reported at least one instance of child maltreatment. When examined individually, the most frequent form of abuse reported was emotional abuse (66%), followed by witnessing family violence (39%), sexual abuse (36%) and neglect (35%). Most women experienced more than one form of abuse, with physical abuse and neglect as most frequent combination (56%), and 13% women reported having experienced all forms of maltreatment.

The comorbidity of the multiple forms of maltreatment assessed is evidenced by the significance of the bivariate correlations among all forms of maltreatment ($p < .05$) with the exception of witnessing family violence, which was related to all other forms of abuse except sexual abuse ($p > .1$).

Table 2 shows means and standard deviations for primary study variables. Key demographic variables assessed were not significantly related to the outcome variables and thus were not included in the primary analyses.

Primary analyses

The SEM confirmed the factor structure of the latent variables. The results indicated that although the proposed model had an adequate fit, it could be improved, $\chi^2 (7, N = 100) = 10.45$, $p = .16$, adjusted goodness of fit index (AGFI) = .88, root mean square error of approximation (RMSEA) = .075. Furthermore, an examination of the model revealed that the coefficients on the estimated paths from stress to depression and from social support to PTSD were high, but not significant, suggesting problems in the estimation of the model. Therefore, to improve the fit and stability of the model, we fixed all nonsignificant paths in a step-by-step manner. The fit of the model improved, and the regression coefficients deflated only when we constrained the paths from CMM to depression, as well as the path from social support to depression and stress to PTSD (which were not significant in the initial model). As a result of these changes, the model was significantly improved, as measured by AGFI = .90 and RMSEA = .05. All loadings were statistically significant ($p < .01$).

Figure 2 depicts the results of the SEM, the completely standardized structural coefficients, the factor loadings, and the overall R^2 values for the final model. As depicted, CMM was directly predictive of PTSD, but not of depression (the path from CMM to depression, which was not significant in the initial model, was trimmed from the model). CMM was directly predictive of low social support and high stress. Social support and stress were significantly inversely correlated. High stress was significantly predictive of high depression, but not of PTSD (the path from stress to PTSD was trimmed from the final model). Low social support was significantly predictive of high PTSD, but not of depression (the path from social support

to depression was also trimmed from the final model). The indirect effect of CMM on PTSD was statistically significant ($\beta = .26, p < .01$). The total effect of CMM on PTSD was also significant ($\beta = .73, p < .01$). This pattern of results indicated that social support was a significant mediator, partially explaining the effects of CMM on PTSD.

CMM was also directly predictive of high stress. Stress was directly predictive of high depression, but not PTSD (path also trimmed from the final model). Because CMM did not directly predict depression, the total effect of CMM on depression equated its indirect effect, which was statistically significant ($\beta = .58, p < .01$). This pattern of results suggested that in our model stress fully mediated the effects of CMM on depression. Given the significance of the correlational path between social support and stress, indirect mediation effects could emerge, such that social support could impact depression via its interrelation with stress, and stress could impact PTSD indirectly, via its effect on social support.

Discussion

The proposed model whereby social support and stress are depicted as mediating the relationship between experiencing multiple forms of child maltreatment and adult PTSD and depression symptoms was partially supported. Social support partially mediated the impact of CMM on PTSD, but not depression. Stress in women's current lives was a strong mediator of the impact of CMM on depression but not on PTSD. CMM also had significant and direct effects on PTSD, but did not directly impact depression.

Although previous research on the mediating effect of social support in women who experienced CMM has not been conducted, our findings are consistent with studies that assessed single types of maltreatment or other forms of trauma, such as sexual abuse (Runtz & Schallow, 1997) or natural disasters (Kaniasty & Norris, 1993; Norris & Kaniasty, 1996). The fact that CMM was predictive of increased stress, but stress was not directly predictive of PTSD suggests that stress may perhaps act through an indirect pathway, via deteriorating women's already impaired social support resources. This would suggest that CMM may not only impair women's ability to develop necessary social support structures, but also may make them more vulnerable to stressors and additional losses (e.g., material, personal) that in turn, could place an excessive demand on women's lives and further erode women's social support. This hypothesis is consistent with previous research by King, King, Fairbank, Keane, and Adams (1998), that found that postwar stressful events had an indirect effect on PTSD via functional social support deficits. In their study stressful life events depleted social resources, which, in turn, exacerbated PTSD symptomatology.

Taken together these studies suggest that deterioration of social support may occur not only directly through the maltreatment experienced, but also indirectly via increased stress and loss of resources initiated by the maltreatment. Maltreatment places women at risk of deficits in social support deficits and future losses and stressors. These losses and stressors further erode women's already impaired social support systems, ultimately exacerbating their vulnerability for PTSD, as predicted by Conservation Of Resources theory (COR; Hobfoll, 1989). Furthermore, it appears that PTSD may develop similarly across different forms of trauma, from wars to child maltreatment, via the direct and indirect deterioration of social support.

Stress was supported as a full mediator of the relationship between CMM and adult depression, suggesting that CMM may augment vulnerability to depression via increased stress. Specifically, victims of maltreatment may become more susceptible to loss of resources and may perceive their lives as being more stressful. This finding is consistent with previous research on trauma victims and women with histories of child maltreatment (King et al., 1998; Thaakkar & McCane, 2000). The fact that CMM directly predicted social support, but

that social support did not directly predict depression, suggests that social support may indirectly impact depression through an indirect path. As previously discussed, CMM contributes to social support deterioration which may augment women's susceptibility to life stressors. Thus, maltreated individuals' vulnerability to stress and loss of resources may be initiated not only directly from the maltreatment, but also indirectly, via depletion of social resources. This finding highlights the powerful impact of stress and social resources in CMM survivors.

The role of social resources in adjustment is further demonstrated by Holohan et al (Holohan, Moos, Holohan, & Cronkite, 1999; 2000) via two longitudinal studies conducted on victims of natural disasters. They found that losses of interpersonal and personality resources were directly predictive of depressive symptoms over the course of an extended period of years. Further, in their studies, the impact of changes in resources entirely mediated the effect of life events on later depression. That is, only if resources were altered, did life events influence changes in depression. The evidence provided by Holohan et al. in their longitudinal study as well as our own results, suggest that resources may have a central role in the development of depression in trauma survivors.

A fundamental goal of this endeavor was to gain a better understanding of the mechanism through which childhood traumas negatively impact women's lives. It appears that different kinds of traumas may act through similar mechanisms predisposing individuals to deterioration of social resources, raising vulnerability to loss of resources and increasing stress. Because stress and social support are interrelated (see Hobfoll, 1989) changes in one affect the other, particularly in the context of poor coping mechanisms. Specifically, social support can influence perception of stress and availability of protective resources; stress and resource loss can deteriorate social support. The interrelation between stress and social support explains the relationship between CMM and PTSD and depression. Our findings suggest that depression and PTSD may have two different mechanism of development. Stress appears central in the development of depression, and social support in the development of PTSD. Nonetheless, the inter-exchanges between stress and social support highlight the focal role of resources in the mental health of CMM survivors.

The current study had several strengths. First, we assessed the cumulative impact of multiple types of child maltreatment experienced by women during childhood. This is particularly important not only because of the demonstrated comorbidity of multiple forms of maltreatment, but also because the experience of multiple traumatic incidences has augmented damaging effects (see Higgins & McCabe, 2001b for a review). By assessing multiple forms of maltreatment the present study also provides a more comprehensive understanding of PTSD and depression. Second, the present investigation expands on previous research by including social support and stress within a comprehensive model making our findings more ecologically valid. To our knowledge, this is the only study that assessed and found evidence for the mediational impact of social support in the relationship between CMM and PTSD. Likewise, this is the only study that assessed and found evidence for mediation of stress in the relationship between CMM and depression. Third, we used a sample of women from a gynecological treatment center where a broad cross-section of inner-city women is seen. This recruitment strategy resulted in a community sample with equal numbers of European-American and African-American women, making the findings of this study more generalizable to both African-American and European-American inner-city women..

The current endeavor is limited by its cross-sectional design. This is partially addressed by SEM, but remains a concern compared to what is learned from prospective designs. Additionally, women were volunteers and cannot be seen as necessarily representative of the clinic's populations or the general population. Further, it is quite possible that the direct effects

of social support on depression and stress on PTSD, which were not significant in our model, were masked because of the small sample size. Although the fit indices and R^2 coefficients suggest appropriate power, future studies should attempt to replicate these results using larger samples. Finally, although this study provides a comprehensive model for understanding of the process through which CMM impacts adult women's functioning, it allows only a tentative glance into its explanatory mechanisms. Future studies assessing other established maltreatment sequelae which can act as mediators between CMM and PTSD and depression, such as impaired coping styles, perceived control, anger, hostility and shame, would buttress the understanding of the complex etiology of depression and PTSD in victims of child maltreatment.

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Figure 1.
Hypothesized relationships among CMM, social support, stress, depression and PTSD severity.

Figure 2.

Results of the structural equation model for depression and PTSD severity for the trimmed model. All depicted paths are significant at the .01 level.

Table 1

Descriptive statistics for the demographical variables assessed (N = 100)

Variable	Category	Percentage or Mean
Age in Years		M = 28.92, SD = 10.52
Ethnicity	European American	48
	African American	47
	Other	5
Pregnant		37
Highest grade completed	Some high school	24
	High school graduate	40
	Some College	27
	College graduate	7
	Other	2
Employed		27
Yearly income	<\$ 10,000	48
	\$10,001 – \$15,000	19
	\$15,001 – \$25,000	15
	> \$25,001	18
Marital status	Single	52
	Married/living with a partner	22
	Divorced/separated	16
Parents' marital status during childhood	Married/living together	44
	Divorced/separated	37
	Single	19

Table 2
Descriptive statistics for the primary study variables

Scale	M	SD	Range
Child Multi-type Maltreatment	16.28	21.59	0–80
Perceived Support	36.96	9.45	15–48
Social Support Satisfaction	24.27	10.83	6–36
Perceived Stress	7.49	4.64	0–16
Loss of Resources	16.28	15.03	0–61
Depression severity	13.47	12.49	0–54
PTSD symptom severity	6.89	10.48	0–48
PTSD total number symptoms	4.06	5.53	0–17