Sexual Abuse, Physical Abuse, and Posttraumatic Stress Disorder among Women Participating in Outpatient Drug Abuse Treatment

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Abstract—Findings from a prospective, longitudinal study of 182 women and 148 men in outpatient drug abuse treatment programs indicate that women are significantly more likely than men to experience sexual and physical abuse. Sexual and physical abuse are associated with higher levels of posttraumatic stress disorder (PTSD) symptomatology. Moreover, women are more likely than men to possess an array of psychological factors that predict relapse to drug use after treatment, including low self-esteem, depression, anxiety, and suicidal behavior, among others. But contrary to expectation, PTSD is not associated with relapse to drug use, nor are women more likely than men to relapse within a six-month posttreatment interval. Further analysis indicates that while women have more psychological risk factors associated with relapse, they are also more likely than men to engage in the treatment process. Engagement in treatment, notably frequent participation in group counseling, appears to mitigate the higher risk of relapse for women.

Keywords—drug abuse, outpatient treatment, physical abuse, posttraumatic stress disorder, sexual abuse, women

Although there has been a steady increase in the body of research examining sexual abuse, physical abuse, and posttraumatic stress disorder (PTSD) in the general population, less attention has been devoted to the relationship between sexual and physical abuse, PTSD, and treatment outcomes for substance abuse. It is known, for instance, that about one-third of the women in the general population have been exposed to some type of physical or sexual assault during their lifetime (Resnick et al. 1993; Kilpatrick, Edmunds & Seymour 1992; Koss & Burkhardt 1989). Exposure to physical and sexual abuse often contributes to the development of a variety of short- and long-term psychological disturbances, including PTSD, substance abuse, depression, anxiety, anger, self-destructiveness, suicidal behavior, low self-esteem, and difficulties with interpersonal relationships (Astin et al. 1995; Mullen et al. 1993; Herman 1992; Briere & Runtz 1988). Compared with other traumatic experiences, sexual assault seems to be associated with the highest rate of

Women in drug abuse treatment programs report high rates of sexual and physical abuse. The evidence consistently indicates that about two out of three women entering treatment have a history of sexual and/or physical abuse (Dunn, Ryan & Dunn 1994; Miller, Downs & Testa 1993; Resnick et al. 1993; Paone et al. 1992; Ladwig & Andersen 1989). A drug-using lifestyle seems to increase their likelihood of persistent sexual and physical assaults that, in turn, may increase the risk of PTSD and related symptomatology (Zweben, Clark & Smith 1994; Astin & Lawrence 1993; Cottler et al. 1992). Moreover, a drug-using lifestyle may, in part, be a reaction to the trauma associated with sexual and physical abuse histories. Victims of such trauma frequently do not develop the necessary skills (or lose the capacity) to cope with traumatic events, psychosocial stress, and ordinary life experiences (van der Kolk 1987). Substance abuse may become one coping mechanism for trauma and its sequelae (Young 1990; Briere & Runtz 1988), though it often leads to further psychosocial stress and increased vulnerability to psychopathology (Bremner et al. 1993; Hawkins 1992; Wills 1990).

Although there is some evidence that sexual and physical abuse are associated with greater prevalence and severity of depression, anxiety, phobias, and interpersonal difficulties for individuals seeking treatment for drug problems (Brady et al. 1994; Harvey, Rawson & Obert 1994; Briere 1992), there are few studies that systematically examine the relationship between sexual abuse, physical abuse, PTSD, and the recovery process. Given the known psychological ramifications, sexual and physical abuse could have an important influence on the recovery process. First, women with these histories could be labeled “difficult” by clinicians, since they often have trouble following their recovery plans and/or tend to drop out from treatment (Root 1989; Roman 1988). Also, it may be that victims of sexual and physical abuse have higher levels of PTSD, which could dramatically increase the risk of relapse to drug use. As women in drug abuse treatment programs typically have more extensive histories of sexual and physical abuse, they would be, therefore, more likely to relapse to drug use during and after the treatment period. If this proves to be the case, then assessment of sexual and physical abuse along with PTSD, and the delivery of services dealing with these issues, should be a routine feature of effective drug abuse treatment programs. Indeed, there is some evidence that women are more likely to participate in drug abuse treatment programs that offer services addressing emotional and family problems (Wallen 1992; Roman 1988), and there is increasing support among clinicians that drug abuse treatment settings need to implement alternative approaches to treatment in order to meet the particular needs of women (Brady et al. 1994; Sullivan & Evans 1994; Zweben, Clark & Smith 1994; Root 1989).

This article is an initial effort to examine the relationship between sexual abuse, physical abuse, PTSD, and the recovery process. First, the extent of sexual and physical abuse in a sample of women and men participating in outpatient drug abuse treatment programs in Los Angeles County will be described. Next, the relationship between sexual abuse, physical abuse, and PTSD will be determined; and finally, the association between gender, PTSD (and related psychopathology), and the risk of relapse to drug use will be assessed.

METHODS

This study is part of a larger research effort funded by the Center for Substance Abuse Treatment to evaluate the effectiveness of the Los Angeles Target Cities Treatment Enhancement Project. As one of the eight original cities participating in the project, Los Angeles was awarded approximately $4 million per year for three years beginning in 1991 to enhance services in 17 outpatient programs, two perinatal centers, and five community resource centers (Fiorentine & Anglin 1995a). The general goal of the Los Angeles Target Cities Project was to improve accessibility and effectiveness of drug abuse treatment for individuals with severe drug problems.

Design and Sampling

A prospective longitudinal study of 330 clients in 17 Target Cities and nine comparison outpatient drug-free treatment programs was conducted. Clients were administered a face-to-face in-treatment and a telephone posttreatment interview. Concerning the in-
treatment interview, treatment providers were asked during the first week of July 1993 to provide a list of all clients currently participating in their programs. As most of the programs listed fewer than 20 clients, and none listed more than 35, all clients meeting the selection criterion were interviewed.

In-treatment interviews were completed for 359 clients. Even though client participation was voluntary, between 80% and 100% of clients at each program meeting the selection criterion agreed to be interviewed, and more than half of the programs had a client participation rate of 95% or higher. Client confidentiality prevented a detailed analysis of the differences between clients who did, and did not, participate in the evaluation; however, “not wanting to be bothered” was the most commonly voiced reason for nonparticipation when queried by the field interviewers.

Part one of the UCLA Client Needs-Services-Outcomes Questionnaire (Fiorentine & Anglin 1995a), lasting approximately 90 minutes, was administered to each client at the specific treatment facility. A $10 payment was offered to induce cooperation. Information domains of part one include the following: (1) psychosocial background information, (2) barriers to treatment and treatment utilization, (3) current treatment needs, (4) counseling regimen, (5) alcohol and other drug use, (6) criminal activity, (7) family and social functioning, (8) sexual and physical abuse histories, and (9) ancillary health and human service needs.

The posttreatment interview was conducted approximately six months after the in-treatment interview, corresponding to a posttreatment time interval of two to five months. Efforts were taken to track and locate all of the clients interviewed at baseline. Clients were told at the completion of the in-treatment interview that they would receive either $15 or $25 for completion of the follow-up interview. The higher sum was offered to clients who contacted the UCLA Drug Abuse Research Center and completed the interview within one week of the target date given to each client.

When the client was located, his or her identity was verified from information privy only to the client and interviewer. Once verified, the client was administered a 45-minute telephone interview, typically by the same interviewer who administered the in-treatment survey. Each client was given the option of a face-to-face interview in a private conference room at the UCLA Drug Abuse Research Center, and about a dozen clients opted for this method. Follow-up interviews were completed for 330 respondents, yielding a 92% response rate.

Information domains of the follow-up interview, part two of the UCLA Client Needs-Services-Outcomes Questionnaire, included (1) current treatment needs, (2) services received, (3) alcohol and other drug use, (4) criminal activity, (5) employment, vocational training, and education, (6) psychosocial functioning, (7) family functioning, (8) sexual and physical abuse histories, (9) health status, and (10) pertinent psychosocial attitudes and constructs.

The demographic characteristics of the sample generally approximate those of clients participating in publicly funded outpatient drug-free treatment programs in the Los Angeles metropolitan area. The age of participants ranged from 18 to 54 years, with a mean of 35. About 42% were African-American, 25% were Latino, and 30% were European-American. Approximately half of the sample was female and about 38% were employed at the time of the first interview. Nearly 50% completed high school, and less than 10% completed two or more years of college. About 84% of the sample had been arrested, and about 61% had been convicted for a crime. The average age of first drug use was 16 years, and the average age of regular use (defined as three or more times per week) was 20. The primary drugs used in the year preceding treatment include crack cocaine (55%), marijuana (41%), powder cocaine (19%), methamphetamines (17%), heroin (11%), and PCP (11%).

Measures

Clients were asked about their lifetime histories of sexual and physical abuse. Sexual abuse was operationalized as having been “forced or pressured to perform, or being involved in, any sexual act against the individual’s will.” Physical abuse was operationalized as “being hit or beaten so hard that the individual suffered from cuts or bruises.” The frequency of sexual and physical abuse along with its sources (family, acquaintances, strangers) was assessed.

The existence of PTSD symptomatology was measured by the Impact of Event Scale (IES) (Horowitz 1986). This scale has been widely used and validated with both civilian and combat-related PTSD groups. It includes 15 symptom statements occurring within the past seven days. It does not include the full range of symptoms in the criteria for PTSD in DSM-IV (American Psychiatric Association 1994), assessing only
intrusion and avoidance symptoms related to PTSD. It should be noted, of course, that the scale measures PTSD symptomatology and not necessarily the existence of the disorder.

In addition to the IES, the Hopelessness Scale (Beck & Weissman 1974)—used here as a proxy for depression—and the Rosenberg Self-Esteem Scale were administered to the clients. The Rosenberg Self-Esteem Scale (Rosenberg 1979) has been widely used with a variety of populations, showing high reliability and predictive and construct validity. It also has been shown to correlate in predicted directions with measures of depression and anxiety.

**FINDINGS**

The findings of this study indicate that women participating in outpatient drug abuse treatment were nearly five times more likely than men to report sexual abuse. Sixty-one percent of women, compared with 13% of men, reported some sexual abuse (see Table I). Women were more likely to be victimized by all categories of abusers, including family members, acquaintances, and strangers. Of those reporting sexual abuse, however, women and men were equally as likely to be abused by family members, acquaintances, or strangers. Similarly, the frequency of sexual abuse did not differ for women and men. About 68% of sexually abused women and men experienced abuse a few times a year or less, and nearly 20% were abused on a daily or weekly basis. One striking difference in the sexual abuse of women and men, however, was that women were more likely than men to be abused after the age of 12, whereas men were more likely to be abused before the age of 12.

These findings suggest that women in outpatient drug abuse treatment programs are significantly more likely than men to be victims of sexual abuse from all sources, including family members, acquaintances, and strangers. They are more likely to experience sexual abuse as children and as adults; and they remain vulnerable to sexual abuse for a greater part of their lives. Whereas puberty for males in this sample signals the decline in the likelihood of sexual abuse, puberty for females escalates the probability of sexual abuse.

Similar to the findings concerning sexual abuse, women in outpatient drug abuse treatment programs were more likely to report physical abuse. Approximately 62% of women, compared with 45% of men, reported ever having been physically abused. Compared with men, women were more likely to be abused by family members and acquaintances, and less likely to be abused by strangers. Of those women and men who have experienced abuse, women were about as likely as men to be abused by a family member; more likely to be abused by an acquaintance; and less likely to be abused by a stranger. Nearly two-thirds of physically abused women, compared with about one-third of abused men, experienced physical abuse after the age of 12. Further, physically abused women were abused more frequently. Almost half of these women were abused on a daily or weekly basis, compared with less than one-third of abused males.

These findings indicate that in this sample of women and men participating in outpatient drug abuse treatment, women were more likely than their male counterparts to be victims of physical abuse from family members and acquaintances. Men, on the other hand, were more likely to be victims at the hands of strangers. The findings are consistent with the interpretation that women who are physically abused are more likely than men to be frequent victims of adult domestic violence. By contrast, men who experience physical abuse are more likely to experience comparatively infrequent abuse as children from family members and strangers. Similar to sexual abuse, however, this study indicates that puberty was associated with a decline in physical abuse for males and an escalation of physical abuse for females.

It may be that the consequences of sexual and physical abuse extend well beyond the actual acts of violence, and are associated with PTSD. If so, then the higher rates of sexual and physical abuse of women should be associated with higher levels of PTSD.

Those who were sexually or physically abused had significantly higher scores on the IES (see Table II). Specifically, those who had experienced sexual abuse had a mean score of 6.2 on the 15-item IES, compared with 2.7 for those who had not experienced sexual abuse. Similarly, those who were physically abused had a mean score of 5.5, compared with 2.4 for those who were not abused.

Because women had experienced higher levels of sexual and physical abuse and because sexual and physical abuse were associated with PTSD, women had significantly higher levels of PTSD. The mean IES score for them is 5.2, compared with 2.7 for males.
The findings indicate that the present sample of women participating in outpatient drug abuse treatment programs were more likely to be victims of sexual and physical abuse, and both sexual and physical abuse were associated with higher levels of PTSD symptoms, as measured by the IES. One important question, however, is whether higher levels of PTSD (and related symptomatology) are associated with less favorable treatment outcomes. If PTSD is associated with relapse to drug use, then women in outpatient drug abuse treatment programs should be more likely than men to relapse.

Table III indicates that PTSD was associated with a number of psychological characteristics or symptoms shown to be associated with relapse (Miller 1991; Annis 1990; McLellan et al. 1983; McLellan et al. 1981). Specifically, PTSD was associated with lower levels of self-esteem, and higher levels of lifetime depression, depression during the past six months, lifetime anxiety, and anxiety during the past six months. Moreover, it was associated with emotional troubles in the previous six months, a mental illness diagnosis, ever contemplated suicide, ever attempted suicide, and attempted suicide during the past year.

As expected, women were more likely than men to experience many of these characteristics or symptoms associated with relapse, including lifetime depression and emotional troubles in the past six months. Also, women were more likely than men to have ever contemplated suicide, ever attempted suicide, and attempted suicide in the past year. Further, some of these psychiatric symptoms or characteristics are associated with relapse to drug use. High fatalism, low self-esteem, depression and anxiety during the six months prior to treatment intake, and mental illness diagnosis were significantly associated with relapse to drug use during either the six months or the 30-day interval prior to the follow-up interview. Unexpectedly, PTSD was not associated with relapse to drug use. Nor are women in this sample more likely than men to relapse.

Although PTSD was not associated with relapse, a note of caution is in order. This conclusion is based on a six-month posttreatment follow-up interval. It could be that PTSD has an effect on relapse when a longer posttreatment interval is concerned. Future research on the issue should include a 12-month or longer posttreatment interval.1

Nevertheless, it is interesting to note that women had higher rates of sexual and physical abuse, higher levels of PTSD, and more psychiatric symptoms associated with relapse, but they were not more likely to relapse to drug use. In fact, they were somewhat less likely to relapse in the six months prior to the follow-up interview.

Further analysis of these data suggests why women in this sample were less likely to relapse. Although women were more likely to be victims of sexual and physical abuse, women generally were more likely than men to seek professional help for their health-related problems. Consistent with the finding that women are more likely to exhibit help-seeking behavior (Corney 1990; Clearly, Mechanic & Greenley 1982; Anderson & Anderson 1967), women in this sample more likely than men to seek professional help for their health-related problems.

![Table I](image)

### Table I

<table>
<thead>
<tr>
<th></th>
<th>Female (N=111; 61.0%)</th>
<th>Male (N=19; 12.8%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age First Abused</td>
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<td></td>
</tr>
<tr>
<td>&lt;12</td>
<td>51.2</td>
<td>80.0*</td>
</tr>
<tr>
<td>≥12</td>
<td>48.8</td>
<td>20.0*</td>
</tr>
<tr>
<td><strong>Frequency of Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>15.8</td>
<td>9.1</td>
</tr>
<tr>
<td>Weekly</td>
<td>15.5</td>
<td>—</td>
</tr>
<tr>
<td>Monthly</td>
<td>7.3</td>
<td>15.8</td>
</tr>
<tr>
<td>A few times per year or less</td>
<td>68.2</td>
<td>68.4</td>
</tr>
<tr>
<td><strong>Source of Abuse</strong></td>
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<td></td>
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<tr>
<td>Abused by family member</td>
<td>37.8</td>
<td>31.6</td>
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<tr>
<td>Abused by acquaintance</td>
<td>35.1</td>
<td>42.1</td>
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"TABLE I

**AGE, FREQUENCY, AND SOURCE OF ABUSE FOR THOSE REPORTING SEXUAL AND PHYSICAL ABUSE"
Abused by stranger  

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<th>Female (N=112; 61.5%a)</th>
<th>Male (N=66; 44.6%a)</th>
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<td>Physical Abuse</td>
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<td></td>
</tr>
<tr>
<td>Age First Abused</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;12</td>
<td>34.4</td>
<td>65.8**</td>
</tr>
<tr>
<td>≥12</td>
<td>65.6</td>
<td>34.2</td>
</tr>
<tr>
<td>Frequency of Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>23.2</td>
<td>16.7</td>
</tr>
<tr>
<td>Weekly</td>
<td>17.9</td>
<td>12.1</td>
</tr>
<tr>
<td>Monthly</td>
<td>21.4</td>
<td>6.1</td>
</tr>
<tr>
<td>A few times per year or less</td>
<td>37.5</td>
<td>65.2</td>
</tr>
<tr>
<td>Source of Abuseb</td>
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<td></td>
</tr>
<tr>
<td>Abused by family member</td>
<td>58.0</td>
<td>45.5</td>
</tr>
<tr>
<td>Abused by acquaintance</td>
<td>44.6</td>
<td>27.3*</td>
</tr>
<tr>
<td>Abused by stranger</td>
<td>10.7</td>
<td>31.8**</td>
</tr>
</tbody>
</table>

*p<.05  **p<.001  

aPercent of total sample.  
bSome individuals reported more than one source of abuse.

**TABLE II**

**MEAN SCORES ON THE IMPACT OF EVENT SCALE (IES)**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Significance</th>
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<tbody>
<tr>
<td>Sexual Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>130</td>
<td>6.2</td>
<td>5.6</td>
<td>&lt;.001</td>
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<td>No</td>
<td>200</td>
<td>2.7</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Physical Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>178</td>
<td>5.5</td>
<td>5.4</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>No</td>
<td>152</td>
<td>2.4</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>182</td>
<td>5.2</td>
<td>5.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Male</td>
<td>148</td>
<td>2.7</td>
<td>4.4</td>
<td></td>
</tr>
</tbody>
</table>

offered by the outpatient drug-free programs. The participation of women in group counseling averaged 10.9 times per month compared with 7.9 times per month for men (p<.001). (There are no gender differences in participation in individual counseling). Moreover those who were sexually or physically abused were no less likely to participate in group counseling than those who were not abused (p>.10). Frequent participation in counseling is strongly associated with treatment success (Fiorentine & Anglin 1995b). Entering the frequency of group counseling in a logistic regression equation estimating the probability of relapse results in a significant improvement in chi-square (10.55, df=1, p<.001). Adding gender to the equation in a subsequent step, however, does not result in an improvement in chi-square (1.72, df=1, p>.10), indicating that the lower rate of relapse for women is due to the increased frequency in participation in group counseling rather than to other gender differences. (See Fiorentine et al. 1996 for more information on gender differences in treatment engagement.)

**CONCLUSION**

The findings indicate that nearly two-thirds of the women participating in outpatient drug abuse treatment have experienced sexual or physical abuse. Women were more likely than men to be victims of sexual abuse from family members, acquaintances, and strangers, both as children and as adults. They also were more likely to be victims of physical abuse from family members and acquaintances, while men were
more likely to be victims of physical abuse or violence from strangers. Women remain targets of sexual and physical abuse for a greater part of their lives. Whereas puberty signals the decline of sexual and physical abuse in men, puberty in women was associated with an escalation of both sexual and physical abuse.

Because sexual and physical abuse are associated with PTSD, women had significantly higher levels of PTSD. Additionally, PTSD was associated with a number of psychological characteristics or symptoms associated with relapse to drug use, including low self-esteem, depression, anxiety, and suicidal behavior, among others, and women were more likely than men to possess these risk factors.

Unexpectedly, PTSD was not associated with relapse to drug use. Nor were women more likely than men to relapse even though they display a greater number of psychological risk factors. This conclusion should be tempered, somewhat, by the understanding that only a posttreatment period of six months was considered. A 12-month, or longer, posttreatment interval could lead to different conclusions.

Still, the findings are informative. They suggest that there is not a simple, linear relationship between sexual and physical abuse, PTSD, and the risk of relapse to drug use (Wallen 1992; Roman 1988). In fact, women in this study were less likely than men to relapse to drug use in the six months prior to the follow-up interview. Understanding why women were less likely to relapse indicates that there are two sides to gender, at least for women in drug abuse treatment programs. One side is that women are more likely than men to be victims of sexual and physical abuse, which results in higher levels of PTSD, depression, anxiety, and suicidal behavior—factors that increase the risk of relapse. The other side is that women with health-related problems are more likely than men to exhibit help-seeking behavior. Women in this sample more frequently attended group counseling sessions that were part of their treatment regimen. As frequent participation in counseling was strongly associated with treatment success, women in this study were less likely to relapse to drug use even though they possessed greater psychological risks of relapse.

Although women were no more likely than men to relapse to drug use within a six-month posttreatment period, the findings indicate that women and men in outpatient drug abuse treatment programs have very different experiences and treatment needs. Women were more likely to be victims of sexual and physical abuse, to suffer from PTSD, anxiety and depression, and to have attempted suicide within the past year. Comprehensive treatment plans addressing the needs of women in drug abuse treatment programs should routinely consider these issues. It should be noted that women were more likely to engage in treatment, suggesting that women would be likely to participate in, and benefit from, more intensive treatment plans.

Because the experiences, treatment needs and treatment outcomes of women and men are disparate, future research in virtually all aspects of drug use and treatment should attend to possible effects of gender. Researchers should design studies and conduct analyses that regularly assess possible differences between women and men. It may be a wise policy to assume that research findings (and treatment plans) typically cannot be generalized across gender unless otherwise determined.

**NOTES**

1. Funding has been received from the California Department of Alcohol and Drug Programs to conduct a 12-month follow-up assessment of treatment outcomes to extend the scope of the study. The relationship between gender, sexual and physical abuse, PTSD, and relapse to drug abuse is one focus of the follow-up assessment.

**TABLE III**

**CORRELATION COEFFICIENTS: PTSD WITH RISK FACTORS AND RELAPSE TO DRUG USE**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>PTSD</th>
<th>Gender</th>
<th>Months</th>
<th>Past 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatalism</td>
<td>.08</td>
<td>.07</td>
<td>.15**</td>
<td>.22***</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>-.12*</td>
<td>-.02</td>
<td>-.16**</td>
<td>-.13*</td>
</tr>
<tr>
<td>Lifetime experience of serious depression</td>
<td>.20***</td>
<td>.17**</td>
<td>.09</td>
<td>.08</td>
</tr>
</tbody>
</table>
Depression in the past six months .11* .02 .25*** .21***
Lifetime experience of serious anxiety .14*** .09 .03 -.02
Anxiety in the past six months .11* .08 .19*** .05
Troubled by emotions in the past six months .13** .13** .04 .06
Diagnosed as mentally ill .15** .07 .07 -.12
Ever contemplated suicide .11* .13** -.02 -.04
Ever attempted suicide .13* .20*** .11* .05
Attempted suicide in the past year .18*** .22*** .07 .02

PTSD
Gender .24*** — -.03 -.05

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

REFERENCES


