Appendix D. Assessment of Iraq War Veterans: Selecting Assessment Instruments and Interpreting Results

Eve Carlson, Ph.D.

The Assessment section of this Guide discussed general challenges to assessment of veterans returning from Iraq and delineated suggested domains to assess and issues to consider in assessing those domains. This section will focus on suggested instruments to use as part of an assessment to decide what services to offer veterans and to plan psychological treatment.

As indicated in the previous section, responses in the days and weeks following exposure to highly stressful events are highly variable across individuals and high levels of distress in the days and weeks following exposure do not reliably predict longer-term posttraumatic symptoms. Some, but not all, who meet criteria for Acute Stress Disorder two weeks after and event will later have PTSD, but some who do not meet criteria for ASD will also develop PTSD (Bryant & Harvey, 2002). Since no measures of early responses have been found to reliably predict longer-term responses and since most of those exposed to extreme stressors recover within a month, assessment with measures of specific domains is not recommended during this period. This section will make suggestions, therefore, about selecting measures to assess veterans who have been home one month or more.

Many of the domains discussed in the previous section can be adequately assessed during an interview without a specific self-report measure. These include current work functioning, current interpersonal functioning, recreation/self-care, physical functioning, and past distress and coping. For other areas, specific measures or questionnaires may be a useful way to gather detailed information about the veteran's current psychological functioning and past experiences. Domains and potential measures are discussed below along with characteristics of veterans to consider when choosing measures. Sources of information about choosing, administering, and interpreting the results of measures of trauma exposure and responses include: Briere (1997), Carlson (1997), Solomon et al. (1996), and Wilson and Keane (1996).

Psychological Symptoms

PTSD symptoms. For many veterans, a diagnostic label may not be needed and may not facilitate treatment. In some circumstances, applying such a label may be counterproductive and undesirable to the veteran. A brief measure of PTSD symptoms can, however, be useful to get an idea of current PTSD symptoms a veteran might be having and to monitor treatment progress. A wide variety of brief measures of PTSD symptoms are available, and information about these (including contact information to obtain measures) can be found at:

www.ncptsd.org/publications/assessment

Additional information about measures of PTSD can be found in Briere (1997), Carlson (1997), Solomon et al. (1996), and Wilson and Keane (1996).

For convenience, two brief measures are included in this appendix here: the Posttraumatic Checklist - Civilian (PCL-C) and the Screen for Posttraumatic Stress Symptoms (SPTSS). Both are measures that do not key symptoms to a particular event since exposure to multiple events is

common and it is not clear that people can assign symptoms to events with any accuracy or that symptoms are, in fact, uniquely associated with particular events. The PCL-C is recommended rather than the PCL-Military because it is important to assess veterans' responses to military and non-military traumatic events when assessing for treatment purposes. The SPTSS may be useful with veterans who have less formal education because it has a very low reading level. It may also be useful for veterans who are reluctant to report distress because it inquires about the frequency of symptoms rather than the degree of distress they cause.

If assignment of a diagnostic label is required or desired, the Clinician Administered PTSD Scale (CAPS) (Weathers, Keane, & Davidson, 2001) can be used. Detailed information about this structured interview and how to obtain it are available at:

http://www.ncptsd.org/publications/assessment/ncinstruments.html

Dissociation. Dissociative symptoms are very common in trauma survivors, and they may not be spontaneously reported. The Trauma-Related Dissociation Scale (Carlson & Waelde, 2000), a measure of dissociation, is included in this appendix.

Depression. Depression is a very common comorbid condition in those with posttraumatic disorders. It may be secondary to PTSD or associated with aspects of traumatic events such as losses. The Beck Depression Inventory (BDI) – Short Form is a common brief measure of depression and is included in the appendix (Beck & Steer, 2000). This measure is also available for computerized administration via DHCP at VA Medical Centers.

Traumatic grief. Screen for Complicated Grief is a brief measure of symptoms of traumatic grief and is included in this appendix. Further details about the construct this screen measures can be found in Section VI of this Guide.

Alcohol use. Substance use is a common problem for those with PTSD, particularly alcohol abuse and dependence. The AUDIT (Goldman, Brown, & Christiansen, 2000) is a screen for alcohol use that is included in this appendix.

Other domains to assess and suggested measures:

Anger. Anger is a frequent problem for trauma survivors and outbursts of anger is a symptom of PTSD. If a veteran reports problems with anger, detailed assessment of that area may be useful. The State-Trait Anger Expression Inventory (STAX-I) is measure of anger and how it is expressed (Spielberger, 1988). This measure may be useful to assess vets, although it is important to note that it is not ideal to assess recent, post-trauma anger because its trait form assesses both pre-trauma and post-trauma anger and its state form assesses feelings at the time of the assessment (which may not representative of the entire post-trauma period).

Guilt and shame. Guilt and shame are frequently issues for trauma survivors who feel distressed over what they did or did not do at the time of trauma. Kubany et al. (1995) have developed a measure of guilt that may be useful to assess those with clinical issues in that domain.

Relevant History

Exposure to potentially traumatic events. Because exposure to previous traumatic stressors may affect response to traumatic stressors experienced in the military, it is important to broadly assess exposure to traumatic stressors. The Trauma History Screen (Carlson, 2002), a brief assessment tool that can be used for that purpose, is included in this appendix.

Selected scales within the Deployment Risk and Resilience Inventory (DRRI; King, King, & Vogt, 2003) may be used as a vehicle to identify particular combat and other high magnitude and threatening experiences that were potentially traumatic. Because the level of non-traumatic stressors and the overall context in which exposure to traumatic stressors occurs may affect the response to high magnitude stressors, it is important to assess these elements. Several scales from the DRRI (e.g., concerns about life and family disruptions, difficult living and working environment, war-zone social support) may prove useful to gain a broader profile of the deployment experience. Copies of the individual DRRI measures, scoring guides, and a full manual describing instrument development may be obtained by contacting dawne.vogt@med.va.gov.

For women veterans. Because women who serve in the military may be exposed to a number of traumatic stressors that are not assessed in combat measures, specific assessment of military stressors is often helpful for women veterans. Life Stressors Checklist (Wolfe & Kimerling, 1997) is provided in this appendix for this purpose.

References

Beck, A.T., & Steer, R.A. (2000). Beck Depression Inventory. In Task Force for the Handbook of Psychiatric Measures (Ed.), *Handbook of psychiatric measures* (pp. 519-522). Washington, DC: American Psychiatric Association.

Briere, J. (1997). *Psychological assessment of adult posttraumatic states*. Washington, DC: American Psychological Association.

Bryant, R.A., & Harvey, A.G. (2002). Acute Stress Disorder: A synthesis and critique. *Psychological Bulletin, 128*, 886-902.

Carlson, E.B. (1997). *Trauma assessments: A clinician's guide*. New York: Guilford Press.

Carlson, E.B. (November, 2002). *Challenges to assessing traumatic stress histories in complex trauma survivors.* Paper presented at the Annual meeting of the International Society for Traumatic Stress Studies, Baltimore, MD.

Carlson, E.B., & Waelde, L. (November, 2000). *Preliminary psychometric properties of the Trauma Related Dissociation Scale*. Paper presented at the Annual meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.

Goldman, M., Brown, S., & Christiansen, B. (2000). Alcohol Expectancy Questionnaire (AEQ). In Task Force for the Handbook of Psychiatric Measures (Ed.), *Handbook of psychiatric measures* (pp. 476-477). Washington, DC: American Psychiatric Association.

King, D.W., King, L.A., & Vogt, D.S. (2003). *Manual for the Deployment Risk and Resilience Inventory (DRRI): A collection of measures for studying deployment-related experiences in military veterans*. Boston, MA: National Center for PTSD.

Kubany, E.S., Abueg, F.R., Owens, J.A., Brennan, J.M., Kaplan, A.S., & Watson, S.B. (1995). Initial examination of a multidimensional model of trauma-related guilt: Applications to combat veterans and battered women. *Journal of Psychopathology and Behavioral Assessment, 17*, 353-376.

Solomon, S., Keane, T., Kaloupek, D., & Newman, E. (1996). Choosing self-report measures and structured interviews. In E. B. Carlson (Ed.), *Trauma research methodology* (pp. 56-81). Lutherville, MD: Sidran Press.

Spielberger, C.D. (1988). *Manual for the State-Trait Anger Expression Inventory: STAXI*. Odessa, FL: Psychological Assessment Resources.

Weathers, F.W., Keane, T.M., & Davidson, J.R.T. (2001). Clinician-Administered PTSD Scale: a review of the first ten years of research. *Depression and Anxiety, 156*, 132-156.

Wilson, J.P., & Keane, T.M. (Eds.). (1996). *Assessing psychological trauma and PTSD*. New York: Guilford Press.

Wolfe, J., & Kimerling, R. (1997). Gender issues in the assessment of PTSD. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 192-238). New York: Guilford.

Assessment Instruments
Iraq War Clinician Guide

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Posttraumatic Checklist - Civilian (PCL-C)

Screen for Posttraumatic Stress Symptoms (SPTSS)

Trauma-Related Dissociation Scale (TRDS)

Beck Depression Inventory – Short Form (BDI-SF)

Screen for Complicated Grief (SCG)

Alcohol Use Disorders Identification Test (AUDIT)

Trauma History Screen (THS)

Life Stressors Checklist (TSC)

PCL-C

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?	1	2	3	4	5
2.	Repeated, disturbing *dreams* of a stressful experience from the past?	1	2	3	4	5
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4.	Feeling *very upset* when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
6.	Avoiding *thinking about* or *talking about* a stressful experience from the past or avoiding *having feelings* related to it?	1	2	3	4	5
7.	Avoiding *activities* or *situations* because *they reminded you* of a stressful experience from the past?	1	2	3	4	5
8.	Trouble *remembering important parts* of a stressful experience from the past?	1	2	3	4	5
9.	*Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13.	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14.	Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15.	Having *difficulty concentrating*?	1	2	3	4	5
16.	Being *"super-alert"* or watchful or on guard?	1	2	3	4	5
17.	Feeling *jumpy* or easily startled?	1	2	3	4	5

PCL-C for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

SPTSS

IN THE BLANK SPACE BEFORE EACH QUESTION, PUT A NUMBER TO TELL HOW MUCH THAT THING HAS HAPPENED TO YOU DURING THE PAST TWO WEEKS. Use the scale below to decide which number to put in the blank space. Put "0" if you never had the experience during the past two weeks, and put "10" if it was always happening to you or happened every day during the past two weeks. If it happens sometimes, but not every day, put in one of the numbers between "0" and "10" to show how much.

0	1	2	3	4	5	6	7	8	9	10
(never)										(always)

____ 1. I don't feel like doing things that I used to like doing.

____ 2. I can't remember much about bad things that have happened to me.

____ 3. I feel cut off and isolated from other people.

____ 4. I try not to think about things that remind me of something bad that happened to me.

____ 5. I feel numb: I don't feel emotions as strongly as I used to.

____ 6. I have trouble concentrating on things or paying attention to something for a long time.

____ 7. I have a hard time thinking about the future and believing that I'm going to live to old age.

____ 8. I feel very irritable and lose my temper.

____ 9. I avoid doing things or being in situations that might remind me of something terrible that happened to me in the past.

____ 10. I am very aware of my surroundings and nervous about what's going on around me.

____ 11. I find myself remembering bad things that happened to me over and over, even when I don't want to think about them.

____ 12. I get startled or surprised very easily and "jump" when I hear a sudden sound.

____ 13. I have bad dreams about terrible things that happened to me.

____ 14. I get very upset when something reminds me of something bad that happened to me.

____ 15. I have trouble getting to sleep or staying asleep.

____ 16. When something reminds me of something bad that happened to me, I feel shaky, sweaty, nervous and my heart beats really fast.

____ 17. I suddenly feel like I am back in the past, in a bad situation that I was once in, and it's like it was happening it all over again.

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TRDS

(Carlson & Waelde, 1999)

For each statement below, circle one of the choices to show how many times each thing has happened to you in the past week.

	NOT AT ALL	ONCE OR TWICE	3-6 TIMES	7-10 TIMES	MORE THAN 10 TIMES
		(IN THE PAST WEEK)			
1. My body felt strange or unreal.	0	1-2	3-6	7-10	10+
2. Things around me seemed strange or unreal.	0	1-2	3-6	7-10	10+
3. I got reminded of something upsetting and then spaced out for a while.	0	1-2	3-6	7-10	10+
4. I had moments when I lost control and acted like I was back in an upsetting time in my past.	0	1-2	3-6	7-10	10+
5. I noticed that I couldn't remember the details of something upsetting that happened to me.	0	1-2	3-6	7-10	10+
6. Familiar places seemed strange or unreal.	0	1-2	3-6	7-10	10+
7. I felt like I was outside myself, watching myself do things.	0	1-2	3-6	7-10	10+
8. I heard something that I know really wasn't there.	0	1-2	3-6	7-10	10+
9. I got upset about something and can't remember what happened next.	0	1-2	3-6	7-10	10+
10. I felt like I was in a movie - like nothing that was happening was real.	0	1-2	3-6	7-10	10+
11. I didn't feel pain when I was hurt and should have felt something.	0	1-2	3-6	7-10	10+
12. A memory came back to me that was so strong that I lost track of what was going on around me.	0	1-2	3-6	7-10	10+
13. I found myself staring into space and thinking of nothing.	0	1-2	3-6	7-10	10+
14. I couldn't remember things that had happened during the day even when I tried to.	0	1-2	3-6	7-10	10+
15. I felt like I wasn't myself.	0	1-2	3-6	7-10	10+
16. I felt like I was in a daze and couldn't make sense of what was going on around me.	0	1-2	3-6	7-10	10+
17. I saw something that seemed real, but was not.	0	1-2	3-6	7-10	10+
18. I suddenly realized that I hadn't been paying attention to what was going on around me.	0	1-2	3-6	7-10	10+
19. I felt cut off from what was going on around me.	0	1-2	3-6	7-10	10+
20. Parts of my body seemed distorted - like they were bigger or smaller than usual.	0	1-2	3-6	7-10	10+
21. I reacted to people or situations as if I were back in an upsetting time in my past.	0	1-2	3-6	7-10	10+
22. I got so focused on something going on in my mind that I lost track of what was happening around me.	0	1-2	3-6	7-10	10+
23. I noticed there were gaps in my memory for things that happened to me that I should be able to remember.	0	1-2	3-6	7-10	10+
24. I smelled something that I know really wasn't there.	0	1-2	3-6	7-10	10+

BDI - Short Form (A. Beck)

Please read all of the statements in each group. Circle the number beside the statement that best describes the way you have been feeling in the PAST TWO WEEKS. If more than one statement is true, circle the numbers of all statements that are true.

0 I do not feel sad.
1 I feel sad or blue.
2 I am blue or sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

0 I am not particularly pessimistic or discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failure.
3 I feel that I am a complete failure as a person (parent, husband, wife).

0 I am not particularly dissatisfied.
1 I don't enjoy things the way I used to.
2 I don't get satisfaction out of anything anymore.
3 I am dissatisfied with everything.

0 I don't feel particularly guilty.
1 I feel bad or unworthy a good part of the time.
2 I feel quite guilty.
3 I feel as though I am very bad or worthless.

0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

0 I make decisions about as well as ever.
1 I try to put off making decisions.
2 I have great difficulty in making decisions.
3 I can't make any decisions at all any more.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all any more.
0 I don't have any thoughts of harming myself.
1 I feel I would be better off dead.
2 I have definite plans about committing suicide.
3 I would kill myself if I had the chance.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people and have little feeling for them.
3 I have lost all of my interest in other people and don't care about them at all.

0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance and they make me look unattractive.
3 I feel that I am ugly or repulsive looking.

0 I can work about as well as before.
1 It takes extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

0 I don't get any more tired than usual
1 I get tired more easily than I used to.
2 I get tired from doing anything.
3 I get too tired to do anything.

Screen for Complicated Grief

Prigerson, Kasl, Maciejewski, Silverman, Jacobs, & Carlson

Please mark the box next to the answer that best describes how you have been feeling over the past month. The blanks refer to the deceased person over whom you are grieving.

1. I think about _____ so much that it can be hard for me to do the things I normally do.

   Almost never (less than once a month) __
   Rarely (monthly) __
   Sometimes (weekly) __
   Often (daily) __
   Always (several times a day) __

2. I feel myself longing and yearning for _____.

   No sense of longing and yearning __
   Slight sense of longing and yearning __
   Some sense __
   Strong sense __
   Overwhelming sense __

3. I feel disbelief over _____ 's death.

   Almost never (less than once a month) __
   Rarely (monthly) __
   Sometimes (weekly) __
   Often (daily) __
   Always (several times a day) __

4. Ever since _____ died, I feel like I have lost the ability to care about other people or I feel distant from people I care about.

   No trouble feeling close or connected to others __
   Slight trouble feeling close or connected to others __
   Some trouble feeling close or connected to others __
   Much trouble feeling close or connected to others __
   Very much trouble feeling close or connected to others __

5. I am bitter over _____ 's death.

   No sense of bitterness __
   A slight sense of bitterness __
   Some sense __
   A strong sense __
   An overwhelming sense __

6. I feel lonely ever since _____ died.

   No loneliness __
   Feel slightly lonely __
   Feel somewhat lonely __
   Feel very lonely __
   Feel overwhelmingly lonely __

7. It is hard for me to imagine life being fulfilling without _____.

   Not hard to imagine life being fulfilling __
   Slightly hard to imagine life being fulfilling __
   Somewhat hard __
   Very hard __
   Overwhelmingly hard __

8. I feel that a part of myself died along with _____.

   Almost never (less than once a month) __
   Rarely (monthly) __
   Sometimes (weekly) __
   Often (daily) __
   Always (several times a day) __

9. I have lost my sense of security or safety since the death of _____.

   No change in feelings of security __
   A slight sense of security __
   Some sense of security __
   A strong sense of security __
   An overwhelming sense of security __

CLINICAL SCREENING PROCEDURE

Record numerical score in the box at right.

TRAUMA HISTORY

Have you injured your head since your 18th birthday? ☐

(3) Yes (0) No

Have you broken any bones since your 18th birthday? ☐

(3) Yes (0) No

CLINICAL EXAMINATION

Code as follows:

(0) Not present (2) Moderate
(1) Mild (3) Severe

Conjunctival Injection ☐

Abnormal Skin Vascularization ☐

Hand Tremor ☐

Tongue Tremor ☐

Hepatomegaly ☐

GGT Values ☐
(0) Lower normal (0-30)
(1) Upper normal (30-50)
(3) Abnormal (50 or higher)

Record sum of individual items here. ☐

Consult users manual if sum is greater than five.

COMMENTS:

Supplementary information, (defensiveness, state of intoxication, interview conditions, etc.)

_____
_____
_____
_____
_____
_____

Refer to the AUDIT User's Guidelines for questions concerning diagnosis, management and referral.

WARNING:

AUDIT is not a diagnostic instrument.

AUDIT

A Screening Test for Primary Health Care

AUDIT

THE ALCOHOL USE DISORDERS IDENTIFICATION TEST

Audit was developed by the World Health Organization to identify persons whose alcohol consumption has become hazardous or harmful to their health. Persons at high risk include medical patients, accident victims, suicidal persons, drunk driving offenders, and armed forces personnel. Screening with AUDIT can be conducted in a variety of health care settings.

AUDIT is a brief structured interview that can be incorporated into a medical history. It contains questions about recent alcohol consumption, dependence symptoms and alcohol-related problems.

The optional Clinical Screening Procedure consists of two interview items, a brief physical examination and a laboratory test. It is designed to complement the AUDIT under conditions where additional clinical information is required.

REMEMBER:

**Read questions as written*
**Record answers carefully*
**Use the ten AUDIT questions first*

Begin the AUDIT by saying:* **"Now I am going to ask you some questions about your use of alcoholic beverages during the past year." *Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks."*

**Refer to the AUDIT guidelines for detailed instructions.*

AUDIT CORE

Place the correct answer number in the box.

1. How often do you have a drink containing alcohol? [ ]

(0) Never
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking? [ ]

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion? [ ]

(0) Never
(1) < monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started? [ ]

(0) Never
(1) < monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking? [ ]

(0) Never
(1) < monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? [ ]

(0) Never
(1) < monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking? [ ]

(0) Never
(1) < monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? [ ]

(0) Never
(1) < monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking? [ ]

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? [ ]

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Record total of specific items here. [ ]

If total is 8 or greater, consult Users Manual.

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Trauma History Screen

The events below may or may not have happened to you. Circle "YES" if that kind of thing has happened to you or circle "NO" if that kind of thing has not happened to you. **If you circle "YES" for any events**: put a number in the blank next to it to show how many times something like that happened.

				Number of times something like this happened
A.	A really bad car, boat, train, or airplane accident	NO	YES	____
B.	A really bad accident at work or home	NO	YES	____
C.	A hurricane, flood, earthquake, tornado, or fire	NO	YES	____
D.	Getting beat up or attacked - as a child	NO	YES	____
E.	Getting beat up or attacked - as an adult	NO	YES	____
F.	Forced sex - as a child	NO	YES	____
G.	Forced sex - as an adult	NO	YES	____
H.	Attack with a gun, knife, or weapon	NO	YES	____
I.	During military service - seeing something horrible or being badly scared	NO	YES	____
J.	Sudden death of close family or friend	NO	YES	____
K.	Seeing someone badly hurt or killed	NO	YES	____
L.	Some other event that scared you badly	NO	YES	____

Did any of these things really bother you emotionally? NO YES
If you answered "YES", fill out a box to tell about EVERY event that really bothered you.
There are more boxes on the other side of the page. If you run out of boxes, please ask for another page.

Letter from above for the type of event: ____ Your age when this happened: ____
Describe what happened:

When this happened, did anyone get hurt or killed? NO YES
When this happened, were you afraid that you or someone else might get hurt or killed? NO YES
When this happened, did you feel very afraid, helpless, or horrified? NO YES
When this happened, did you feel unreal, spaced out, disoriented, or strange? NO YES
After this happened, how long were you bothered by it? not at all / 1 week / 2-3 weeks / a month or more
At that time, how much did it bother you emotionally? not at all / a little / somewhat / much / very much

Letter from above for the type of event: ____ Your age when this happened: ____
Describe what happened:

When this happened, did anyone get hurt or killed? NO YES
When this happened, were you afraid that you or someone else might get hurt or killed? NO YES
When this happened, did you feel very afraid, helpless, or horrified? NO YES
When this happened, did you feel unreal, spaced out, disoriented, or strange? NO YES
After this happened, how long were you bothered by it? not at all / 1 week / 2-3 weeks / a month or more
At that time, how much did it bother you emotionally? not at all / a little / somewhat / much / very much

GO TO OTHER SIDE IF YOU MARKED "YES" FOR MORE EVENTS.

Letter from above for the type of event: ____ Your age when this happened: ____
Describe what happened:

When this happened, did anyone get hurt or killed? NO YES
When this happened, were you afraid that you or someone else might get hurt or killed? NO YES
When this happened, did you feel very afraid, helpless, or horrified? NO YES
When this happened, did you feel unreal, spaced out, disoriented, or strange? NO YES
After this happened, how long were you bothered by it? not at all / 1 week / 2-3 weeks / a month or more
At that time, how much did it bother you emotionally? not at all / a little / somewhat / much / very much

Letter from above for the type of event: ____ Your age when this happened: ____
Describe what happened:

When this happened, did anyone get hurt or killed? NO YES
When this happened, were you afraid that you or someone else might get hurt or killed? NO YES
When this happened, did you feel very afraid, helpless, or horrified? NO YES
When this happened, did you feel unreal, spaced out, disoriented, or strange? NO YES
After this happened, how long were you bothered by it? not at all / 1 week / 2-3 weeks / a month or more
At that time, how much did it bother you emotionally? not at all / a little / somewhat / much / very much

Letter from above for the type of event: ____ Your age when this happened: ____
Describe what happened:

When this happened, did anyone get hurt or killed? NO YES
When this happened, were you afraid that you or someone else might get hurt or killed? NO YES
When this happened, did you feel very afraid, helpless, or horrified? NO YES
When this happened, did you feel unreal, spaced out, disoriented, or strange? NO YES
After this happened, how long were you bothered by it? not at all / 1 week / 2-3 weeks / a month or more
At that time, how much did it bother you emotionally? not at all / a little / somewhat / much / very much

IF YOU NEED MORE BOXES TO FILL OUT, PLEASE ASK FOR ANOTHER SHEET.

LSC - R

READ THIS FIRST: Now we are going to ask you some questions about events in your life that are frightening, upsetting, or stressful to most people. Please think back over your whole life when you answer these questions. Some of these questions may be about upsetting events you don't usually talk about. Your answers are important, but you do not have to answer any questions that you do not want to. Thank you.

1. Have you ever been in a serious disaster (for example, an earthquake, hurricane, large fire, explosion)? YES NO

a. How old were you when this happened? _____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of ***intense helplessness, fear, or horror***? YES NO
e. How much has this affected your life in the past year? (1) (2) (3) (4) (5)
not at all some extremely

2. Have you ever seen a serious accident (for example, a bad car wreck or an on-the-job accident)? YES NO

a. How old were you when this happened? _____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of ***intense helplessness, fear, or horror***? YES NO
e. How much has this affected your life in the past year? (1) (2) (3) (4) (5)
not at all some extremely

3. Have you ever had a very serious accident or accident-related injury (for example, a bad car wreck or an on-the-job accident)? YES NO

a. How old were you when this happened? _____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of ***intense helplessness, fear, or horror***? YES NO
e. How much has this affected your life in the past year? (1) (2) (3) (4) (5)
not at all some extremely

4. Was a close family member ever sent to jail? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
e. How much has this affected your life in the past year? (1) (2) (3) (4) (5)
not at all some extremely

5. Have you ever been sent to jail? YES NO

a. How old were you when this happened? _____ [b. When it ended?_____]
e. How much has this affected your life in the past year? (1) (2) (3) (4) (5)
not at all some extremely

6. Were you ever put in foster care or put up for adoption? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
e. How much has this affected your life in the past year? (1) (2) (3) (4) (5)
not at all some extremely

7. Did your parents ever separate or divorce while you were living with them? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
e. How much has this affected your life in the past year? (1) (2) (3) (4) (5)
not at all some extremely

8. Have you ever been separated or divorced? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
e. How much has this affected your life in the past year? (1) (2) (3) (4) (5)
not at all some extremely

9. Have you ever had serious money problems (for example, not enough money for food or place to live)? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
e. How much has this affected your life in the past year? (1) (2) (3) (4) (5)
not at all some extremely

10. Have you ever had a very serious physical or mental illness (for example, cancer, heart attack, serious operation, felt like killing yourself, hospitalized because of nerve problems)? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of ***intense helplessness, fear, or horror***? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

11. Have you ever been emotionally abused or neglected (for example, being frequently shamed, embarrassed, ignored, or repeatedly told that you were "no good")? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of ***intense helplessness, fear, or horror***? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

12. Have you ever been physically neglected (for example, not fed, not properly clothed, or left to take care of yourself when you were too young or ill)? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of ***intense helplessness, fear, or horror***? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

13. WOMEN ONLY: Have you ever had an abortion or miscarriage (lost your baby)? YES NO

a. How old were you when this happened? _____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of ***intense helplessness, fear, or horror***? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

14. Have you ever been separated from you child against your will (for example, the loss of custody or visitation or kidnapping)? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

15. Has a baby or child of yours ever had a severe physical or mental handicap (for example, mentally retarded, birth defects, can't hear, see, walk)? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

16. 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, AIDS, nerve problems, can't hear, see, walk)? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

17. Has someone close to you died suddenly or unexpectedly (for example, sudden heart attack, murder or suicide)? YES NO

a. How old were you when this happened? _____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of ***intense helplessness, fear, or horror***? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

18. Has someone close to you died (do NOT include those who died suddenly or unexpectedly)? YES NO

a. How old were you when this happened? _____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

19. When you were young (before age 16). did you ever see violence between family members (for example, hitting, kicking, slapping, punching)? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

20. Have you ever seen a robbery, mugging, or attack taking place? YES NO

a. How old were you when this happened? _____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

21. Have you ever been robbed, mugged, or physically attacked (not sexually) by someone you did not know? YES NO

a. How old were you when this happened? _____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

22. *Before age 16*, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband, hit, slapped, choked, burned, or beat you up)? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

23. *After age 16*, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)? YES NO

a. How old were you when this happened? _____ [b. When it ended?_____]
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

24. Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sexual favors by someone *at work or school* (for example, a coworker, a boss, a customer, another student, a teacher)? YES NO

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed***? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) (2) (3) (4) (5)**
not at all some extremely

25. *Before age 16*, were you ever *touched* or made to *touch someone else* in a sexual way because he/she forced you in some way or threatened to harm you if you didn't? **YES** **NO**

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that *you or someone else* could be *killed* or seriously *harmed*? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) not at all** **(2)** **(3) some** **(4)** **(5) extremely**

26. *After age 16*, were you ever *touched* or made to *touch someone else* in a sexual way because he/she forced you in some way or threatened to harm you if you didn't? **YES** **NO**

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that *you or someone else* could be *killed* or seriously *harmed*? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) not at all** **(2)** **(3) some** **(4)** **(5) extremely**

27. *Before age 16*, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to hurt you if you didn't? **YES** **NO**

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that *you or someone else* could be *killed* or seriously *harmed*? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) not at all** **(2)** **(3) some** **(4)** **(5) extremely**

28. *After age 16*, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to harm you if you didn't? **YES** **NO**

a. How old were you when this happened? _____ [b. When it ended?_____]
c. At the time of the event did you believe that *you or someone else* could be *killed* or seriously *harmed*? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) not at all** **(2)** **(3) some** **(4)** **(5) extremely**

29. Are there any events we did not include that you would like to mention? **YES** **NO**

What was the event? _____

_____

a. How old were you when this happened? _____ b. When it ended?_____
c. At the time of the event did you believe that *you or someone else* could be *killed* or seriously *harmed*? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) not at all** **(2)** **(3) some** **(4)** **(5) extremely**

30. Have any of the events mentioned above ever happened to someone close to you so that even though you didn't see it yourself, you were seriously upset by it? **YES** **NO**

What was the event? _____

_____

a. How old were you when this happened? _____ [b. When it ended?_____]
c. At the time of the event did you believe that *you or someone else* could be *killed* or seriously *harmed*? YES NO
d. At the time of the event did you experience feelings of *intense helplessness, fear, or horror*? YES NO
e. How much has this affected your life in the past year? **(1) not at all** **(2)** **(3) some** **(4)** **(5) extremely**