

# ETI

## Essen Trauma – Inventory

**Code/ Name:** \_\_\_\_\_

**Sex:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Date of testing:** \_\_\_\_\_



**Instruction:** Below is a list of traumatic events, which people may experience during their life. Please mark for each item, whether you experienced it (**YES**) or not (**NO**). If the answer is YES please mark if the event happened to you **in person** or if you observed it **as a witness**. If both is the case, please mark both answers. All of your answers will be confidential. Please answer every question.

**1. Natural disaster (e.g. flood, thunderstorm, earthquake)**

**NO:**  | **YES:** in person  as a witness

**2. Serious accident, fire or explosion (e.g. car, industrial, plane, or boating accident)**

**NO:**  | **YES:** in person  as a witness

**3. Life threatening illness/injury (e.g. stroke, cancer, heart attack, severe surgery)**

**NO:**  | **YES:** in person  as a witness

**4. Assault by a stranger (e. g. being physically attacked, robbed, threatened with a gun)**

**NO:**  | **YES:** in person  as a witness

**5. Assault by a family member or someone you know (e. g. being physically attacked, robbed, threatened with a gun)**

**NO:**  | **YES:** in person  as a witness

**6. Death of a close person or family member (e.g. by accident, suicide or murder)**

**NO:**  | **YES:** as a witness

**7. Imprisonment (e.g. prison inmate, prisoner of war, hostage)**

**NO:**  | **YES:** in person  as a witness

**8. Sexual abuse by a stranger when you were a child (e.g. unintentional sexual contact, rape)**

**NO:**  | **YES:** in person  as a witness

**9. Sexual abuse by a family member or someone you know when you were a child (e.g. unintentional sexual contact, rape)**

**NO:**  | **YES:** in person  as a witness

**10. Military combat or a war zone**

**NO:**  | **YES:** in person  as a witness

**11. Torture (e.g. sleep deprivation, electroshocks, attempted suffocation)**

**NO:**  | **YES:** in person  as a witness

**12. Neglect, estrepement (e.g. constant denial, not enough parental care)**

**NO:**  | **YES:** in person  as a witness

**13. Sexual assault by a stranger as an adult (e.g. rape or attempted rape)**

**NO:**  | **YES:** in person  As a witness

**14. Sexual assault by a family member or someone you know as an adult (e.g. rape or attempted rape)**

**NO:**  | **YES:** in person  as a witness

**15. Other traumatic events**

**NO:**  | **YES:** in person  as a witness

Which: \_\_\_\_\_

**Attention!**

**Which event had the greatest impact on you?** (Please choose the one which bothers you the most from the list above. In case your worst experience is not listed above, please name it.)

16.

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Please answer the following questions **CONCERNING THE EVENT YOU CHOSE ABOVE**

17. When did the event take place?

days: \_\_\_\_\_ weeks: \_\_\_\_\_ months: \_\_\_\_\_ years: \_\_\_\_\_

18. During this traumatic event...?

*(please mark YES or NO)*

- |   | <b>YES</b>            | <b>NO</b>             |
|---|-----------------------|-----------------------|
| A1. Were you physically injured?.....                     | <input type="radio"/> | <input type="radio"/> |
| A2. Did you think your life was in danger?.....           | <input type="radio"/> | <input type="radio"/> |
| A3. Was someone else physically injured?.....             | <input type="radio"/> | <input type="radio"/> |
| A4. Did you think someone else's life was in danger?..... | <input type="radio"/> | <input type="radio"/> |
| A5. Did you feel helpless?.....                           | <input type="radio"/> | <input type="radio"/> |
| A6. Were you frightened?.....                             | <input type="radio"/> | <input type="radio"/> |
| A7. Did you feel horrified?.....                          | <input type="radio"/> | <input type="radio"/> |
| A8. Did you feel powerless?.....                          | <input type="radio"/> | <input type="radio"/> |

**Instruction:** Below is a list of difficulties people sometimes suffer from after stressful life events. Please read each item carefully, and then choose the number (not at all (0), seldom (1), often (2), very often (3)) which represents best how you felt **DURING THE PAST MONTH** (meaning the past four weeks until today) with respect to the traumatic event you described in Item 16.

**1. Did the event cause upsetting thoughts or images that came to your mind although you didn't want them to?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**2. Have you tried not to think about the event, not to talk about it or to suppress feelings about it?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**3. Did you have trouble falling or staying asleep?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**4. Did you have moments in which you lost track of what was happening or did you feel like not being a part of what was going on?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**5. Did you have nightmares about the event?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**6. Did you try to avoid situations that remind you of the event (e.g. activities, people or places)?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**7. Did you have fits of rages or were you often nervous?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**8. Did your sense of time change, as if everything was happening in slow motion?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**9. Has it ever happen to you that you felt like living through the event suddenly again?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**10. Were you unable to remember an important part of the event?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**11. Did you have trouble concentrating (e.g. forgetting what you just wanted to do, or forgetting what you just read or what you saw on television)?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**12. Did the event appear unreal to you, as if you were dreaming or watching a film or a play?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**13. Did you feel emotionally upset when you were reminded of the event (feeling helpless, angry, sad, guilty)?**

Not at all (0) Seldom (1) Often (2) Very often (3)

**14. Did you lose interest in activities which had been important for you before the event took place (e.g. hobbies, sport)?**

Not at all (0) Seldom (1) Often (2) Very often (3)

15. Were you overly alert (e.g. checking to see who is around you, having a phone close-by for calling help if it was necessary)?

Not at all (0) Seldom (1) Often (2) Very often (3)

16. Were there occasions when you felt like you were unable to be aware of your mirror image?

Not at all (0) Seldom (1) Often (2) Very often (3)

17. Did you have physical reactions when you were reminded of the event (e.g. uneasiness, shiver or fast heartbeat)?

Not at all (0) Seldom (1) Often (2) Very often (3)

18. Did you feel alienated or isolated from people in your environment?

Not at all (0) Seldom (1) Often (2) Very often (3)

19. Were you easily startled or highly nervous (e.g. by loud noises)?

Not at all (0) Seldom (1) Often (2) Very often (3)

20. Did you feel disoriented? Were there moments in which you were not sure where you were and what time it was?

Not at all (0) Seldom (1) Often (2) Very often (3)

21. Did you feel emotionall numb (e.g. being unable to cry or unable to have positive feelings)?

Not at all (0) Seldom (1) Often (2) Very often (3)

22. Did you feel like your plans for the future and hopes will not come true (e.g. to start a family, less luck in life or in business than the others)?

Not at all (0) Seldom (1) Often (2) Very often (3)

23. Did you sometimes feel like your body does not belong to you?

Not at all (0) Seldom (1) Often (2) Very often (3)

24. Ever since the event, did you have more physical complaints? If yes, which of these?

abdominal pain (a)      headache (b)      nausea (c)      diarrhea (d)  
tremble (e)      dizziness (f)      tachycardia (g)      breathlessness (h)  
seizure (i)      Other?: If yes, which?: \_\_\_\_\_

25. How much does the event bother you right now?

not at all..... (1)  
very little..... (2)  
a little bit ..... (3)  
moderately..... (4)  
strongly..... (5)  
extremely..... (6)

**26. How long have you experienced the problems that you reported above (question 1–23)?**  
 (please choose only one answer)

- less than 1 month.....  1
- 1 to 3 months.....  2
- more than 3 months.....  3

**27. How much time after the traumatic event did these problems (question 1–23) occur?**  
 (please choose only one answer)

- less than 6 months.....  1
- 6 months or more.....  2

**Instruction:** Indicate below how much, the problems you described above, affected you in any of the listed areas of your life **DURING THE PAST MONTH**. Please mark how much impairment was caused by the problems (none, little, moderate, strong).

**28.**

	<b>impairment</b>			
	<b>none</b>	<b>little</b>	<b>moderate</b>	<b>strong</b>
a. General satisfaction with life .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. School/work/job .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Household chores and duties .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Hobbies and leisure activities .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Relationships with friends .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Relationships with family members .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Sexuality.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>