Acute Stress Disorder in Physical Assault Victims Visiting a Danish Emergency Ward

Ask Elklit
Aarhus University
Risskov, Denmark

Ole Brink
Århus C, Risskov, Denmark

The purpose of this article is to assess the prevalence of Acute Stress Disorder (ASD) following violent assault in victims who come to the emergency ward, and compare the effects with degrees of injury. Two hundred and fourteen victims of violence completed a questionnaire 1 to 2 weeks after the assault. Measures included the Harvard Trauma Questionnaire, the Trauma Symptom Checklist and the Crisis Support Scale. Results: Twenty-four percent met the full ASD diagnosis and 21% a subclinical ASD diagnosis. Childhood sexual and physical abuse and shock due to a traumatic event that happened to someone close increased the likelihood of ASD four to ten times. Feeling of security and ability to express feelings reduced the likelihood of ASD by one-quarter, while feeling let down by others and hopelessness increased the likelihood of ASD respectively 1.4 and 2.6 times.

Keywords: Denmark; acute stress disorder; emergency room; abuse; trauma

It is estimated that every year 6% of the adult population in Denmark become victims of physical assault (PA), and approximately 30% of them will be injured (Elklit, 1993). In the United States a representative study (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) found that 11% of the men and 7% of the women had been physically assaulted at some point in their lives.

Several studies have shown that victims are at risk for developing a number of psychological sequelae as a consequence of PA. Helzer, Robins, & McEvoy (1987) found a 3% PTSD prevalence among those who had been physically assaulted in the preceding 18 months. Breslau, Davis, Andreski, and Peterson (1991), in a study of young U.S. adults, found lifetime prevalence rates of 23% PTSD in PA victims. Elklit (1993) found a rate of 17% PTSD in Danish PA victims 1 year after a violent episode, and Brewin, Andrews, Rose, and Kirk (1999) found a prevalence of 20% PTSD in British PA victims 6 months after an assault.

The Acute Stress Disorder (ASD) diagnosis in DSM-IV (American Psychiatric Association, 1994) is a relatively new construct, and there is yet little empirical evidence to support the specific assumptions of the diagnosis in DSM-IV. ASD resembles the PTSD diagnosis in having the same stressor criteria and the same three “core” criteria—reexperiencing, avoidance and arousal—but only one symptom from each of the core clusters is required. The dissociative cluster is composed of five symptoms—detachment, restriction of awareness, depersonalization, derealization and amnesia—and at least three symptoms...
must be present to warrant the diagnosis. Functional impairment is also an ASD criterion, more loosely formulated as "significant distress or impairment in social relations, work or other important areas of functioning."

Many variables influence the severity of the traumatization process. Of special interest from a psychological point of view is the fact that the interpretation or appraisal of the situation is very important for the aftermath course. Kilpatrick and colleagues (1989) and Resnick, Kilpatrick, Best, and Kramer (1992) found that threat to life, the subjective perception of threat, and the perpetrator’s intent to harm were important predictors for PTSD. There also is some evidence that dissociative symptoms can be predictive of PTSD for PA victims (Dancu, Riggs, Hearst-Ikeda, Shoyer, & Foa, 1996).

The occurrence of ASD presumably is a forerunner of the development of PTSD in typhoon victims (Staab, Grieger, Fullerton, & Ursano, 1996), in children who were taken hostage (Vila, Porche, & Mouren-Simeoni, 1998), in traffic victims (Harvey & Bryant, 1998, 1999; Koren, Arnon, & Klein, 1999), in traffic victims with mild brain injury (Harvey & Bryant, 2000) and in victims of PA (Brewin, Andrews, Rose, & Kirk, 1999). In other studies of plane crash survivors (Birmes et al., 1999), and of traffic accident victims (Barton, Blanchard & Hickling, 1996), the expected relationship was not found. Recent criticism had suggested that dissociation should be removed as a core diagnostic feature of ASD (Marshall, Spitzer, & Liebowitz, 1999).

For various reasons it is difficult to recruit PA victims and give a reliable and valid picture of this risk group. Most studies are based on convenient samples. Victims of violence generally are difficult populations to study because of problems such as alcohol, criminality, previous trauma, social marginality, socioeconomic factors, and psychological difficulties. Because of the social conditions relating to PA, it is very important for public health authorities to consolidate their knowledge on the psychological consequences of violence for this group.

In Denmark the best strategy for making contact with PA victims is to use emergency wards, which serve the whole population and which have gate functions (i.e., anyone with an acute need will seek treatment at an emergency ward). A study of the sequelae of violence (Brink, 1999, 2000) based on 1451 PA victims (64% response rate), who during 12 months (in 1993–1994) were consecutively registered at the emergency wards at the University Hospital in Aarhus, showed that 2 years later 22% had cosmetic scars, 15% had lasting pain, 38% were afraid to walk in certain areas, and 41% had recurring thoughts about the violent assault. Brink’s study (Brink, 2000) also demonstrated a considerable absence rate (median 8 days) in the workplace due to illness in PA victims, which might be influenced by psychological factors.

The purpose of this study was to assess the prevalence of ASD in PA victims who seek treatment at an emergency ward. This environment allows base data for the total population and allows the subjective experience of PA to be compared with objective measures of physical injury.

METHOD

Participants

The sample consisted of all persons (n = 1084), who, from April 1, 1999, to March 31, 2000, were involved in violence, and who subsequently came to one of the two emergency wards at the University Hospital of Aarhus. Violence here is defined as purposely grievous bodily harm caused by another person. The two emergency wards have a catchment area of 322,000 inhabitants.
Procedure

As part of the victims’ registration, the emergency room physician filled out a sheet about demographics, details of the assault and of the injuries as part of emergency ward intake procedure. The physician also summarized the degree of injury by the Abbreviated Injury Scale (AIS) (Association for the Advancement of Automotive Medicine, 1990). One to 2 weeks later a four-page questionnaire was sent to those 18 years of age and older who had given their consent, which excluded 458 people. Lack of consent might occur when a person requested no more contact or when the staff forgot to ask for consent or decided not to ask because of language problems, or severe intoxication of the victim. A total of 626 questionnaires were mailed with stamped returned envelopes; 22 questionnaires were returned marked “addressee unknown.” The total number of questionnaires returned was 214—a 35.4% return rate. Although this return rate is modest, it is a sample, which can be compared with the total population of PA victims, who seek treatment at emergency wards. The study was approved by the Danish National Authority for Registers and by the Regional Helsinki Committee.

Measures

In the four-page questionnaire, the victims were asked eight questions about the circumstances of the assault, five questions about their immediate reactions during and after the assault, and one question about serious life events (e.g. illness, divorce, job loss etc.) within the last year.

Traumatic experiences were investigated by using 12 categories applied in the U.S. National Comorbidity Survey (Kessler et al., 1995), omitting questions about combat (Denmark has not fought a war for more than a century) and natural disasters (which do not occur). Most questions were answered by yes or no; there were three open-ended questions, and two single items, “anxiety during the assault” and “current feeling of security” each rated as Likert scales ranging from 1 to 7.

The Harvard Trauma Questionnaire-Part IV (HTQ; Mollica et al., 1992) was used to estimate the occurrence of ASD at the time of the event. The HTQ consists of 30 items of which 16 correspond to the PTSD and ASD symptoms in the DSM-IV. The items are scored on a 4-point Likert scale. It measures the intensity of the three core symptom groups (intrusion, avoidance, and arousal) of ASD. The subscales are scored separately. The original Mollica and associates (1992) study found good reliability and validity for the scale. HTQ has a good internal consistency, test-retest reliability, and concurrent validity (Mollica et al., 1992). The alpha values for three scales in the present study were .84 (intrusion), .82 (avoidance), and .85 (arousal); for the total scale alpha was .95.

The Trauma Symptom Checklist (TSC) (Briere & Runtz, 1989) measures the occurrence of psychological symptoms associated with trauma. The original checklist contained 33 items, and Elklit (1990) added two more items. The answers are scored on a 4-point Likert scale. The checklist covers the following dimensions: depression (α = .89), anxiety (α = .82), dissociation (α = .84), sleep problems (α = .87), suspicion of sexual abuse (α = .77), somatization (α = .84), interpersonal sensitivity (α = .74), and hostility (α = .68). The alpha for the total scale was .95. TSC has good psychometric qualities and is a valid instrument measuring the effects of traumatization (Elklit 1990, 1994).

ASD was assessed by a number of items from the HTQ, which corresponds to the DSM-IV symptom groups (American Psychiatric Association, 1994) of intrusion, avoidance, and arousal, and from the TSC-35, which contributed to the dissociative and impairment items of the ASD diagnosis (see Appendix). All symptoms were rated on
4-point Likert scales (0 = not at all; 3 = very often). Only scale items ≥ 2 were counted toward an ASD diagnosis with the exception of dissociative items, which were counted ≥ 1 (cf. Brewin et al., 1999).

The Crisis Support Scale (CSS) was used for rating the experience of perceived social support after a traumatic event through seven items (Joseph, Andrews, Williams, & Yule, 1992). The items include:

1. perceived availability for someone listening,
2. contact with people in a similar situation,
3. the ability to express oneself,
4. received sympathy and support,
5. practical support,
6. the experience of being let down, and
7. general satisfaction with social support.

The items are rated on a 7-point Likert scale, ranging from “never” to “always.” The CSS has been used in several disaster studies, and it has a good internal consistency as well as a good discriminatory power. Elklit, Pedersen, & Jind (2001) analyzed 4213 CSS questionnaires from 11 studies; the results confirmed the psychometrical reliability and validity of the CSS. Alpha for the total CSS score = .74.

RESULTS

Comparison With Nonrespondents

When the group of respondents was compared with all other victims of violence who were treated at the emergency ward in the same period, the two groups were comparable regarding median age (respondent group, 27 years vs. other victims, 28 years), gender distribution (respondent group, 27% women vs. other victims, 31% women), and number of persons born outside of Denmark (respondent group, 13% vs. other victims, 16%). All participants were injured as a result of the PA. Concerning the severity of injuries, the respondent group deviated from the rest of the victims on the Maximum Abbreviated Injury Score (MAIS = the highest single AIS score in people with multiple lesions) (Association for the Advancement of Automotive Medicine, 1990) by a lower score ($F_{(1,1072)} = 4.7; p < .05$).

Type of Violence and Stressors

The most common types of violence were blows with the fists (55%) and kicking (10%). The use of weapons in PA is not common in Denmark; 2% were stabbed by knives; use of glass and bottles caused damages in 8%; 4% were subject to strangling attempts. The remaining were exposed to combinations of the above, mainly blows and kicking. More than two-thirds of the injuries were localized in the head and the face. Sixty-nine percent finished treatment at the emergency wards.

In addition to that less than one-third experienced psychological violence (humiliation and harassment) and threats to their lives, while 37 (17%) witnessed someone being injured and an equal number had been mugged. Seventy-five (35%) were assaulted, while friends or family were present and 24 (11%) saw someone close being injured during the assault. One hundred and twelve (52%) of the victims felt helpless during the assault. Feeling helpless is part of the $A_2$ stressor criteria of the ASD diagnosis following DSM-IV (American
Psychiatric Association, 1994). Another stressor criterion is anxiety during the assault; the average here was 4.2 on a Likert scale (SD = 2.0; n = 212); 32 (15%) thought they were going to die, 52 (25%) had a premonition that the situation would develop the way it did. There were no gender differences in the stressor variables with the exception of psychological violence, which was reported more often by men (F(1,77) = 4.7; p < .05).

**Previous Trauma**

The distribution of other traumatic events in the lives of the respondents was as follows: 47% previously had been exposed to violent assault; 31% had been exposed to an accident; 29% had lost someone close to them; 16% had been threatened by someone with a weapon; 9% had been exposed to fire; 7% had witnessed a traumatic situation; 8% had been victim of childhood neglect; 8% had suffered childhood physical abuse; 6% had experienced childhood sexual abuse; 3.3% had been raped; and 8% reported other trauma (i.e., serious illness, nearly dying and nearly losing someone close to them). In addition, 15% reported having been shocked because a traumatic event happened to someone close. There were no gender differences in relation to former trauma.

**Acute Stress Disorder (ASD)**

Table 1 shows the distribution of the ASD symptoms. The inclusion of the dissociative criterion resulted in a 5% drop of cases (C-E compared with B-E); the inclusion of the stressor and the functional impairment criteria caused an additional drop of 14%. In combining the criteria groups, 24% of the PA victims received the ASD diagnosis. Twenty-one percent missed the diagnosis by one criteria and could be characterized as a subclinical ASD group. Only 5.6% were totally symptom free.

All dissociative items were interrelated in a positive and significant way and associated with the overall dissociation criterion (r = .42–1.00; all ps < .0005). All symptom clusters also were interrelated in a positive and significant way (r = .19–.61; p < .005), and associated with the ASD diagnosis (r = .20–.41; all ps < .05).

**Relationships and Violence**

Besides analyses of contingencies between demographic factors, one-way ANOVAs were performed between demographic factors, life events, assault variables, and degree of injury. A surprisingly small number of relationships were found; less perceived sympathy and support (CSS item 4) was reported more by assaulted women than by assaulted men (F(1,209) = 4.55; p < .05). Also, there was less perceived sympathy and support when the assault was committed by a partner or an ex-partner than if it were committed by an acquaintance or an unknown person (F(2,160) = 3.90; p < .05). If a partner committed the assault, there was a higher degree of avoidance reaction (F(2,159) = 3.70; p < .05) and arousal (F(2,164) = 3.20; p < .05) than if the assault was committed by an unknown person. One single factor—that is that someone close was injured in the assault—was positively and significantly associated with almost every measure of distress.

**Logistic Regression Models for ASD and Total Symptom Score**

A cross-tab analysis revealed there was a total overlap between the two subscales of amnesia and detachment. In Table 2, the result of a logistic regression analysis with ASD as the dependent variable is presented. All demographic factors, the severity of injuries, the circumstances of the assault, previous trauma, and social support variables were first
tested as independent variables. The first model included pretrauma factors; childhood sexual abuse, physical abuse, and previous shock due to a traumatic event happening to someone close. These factors increased the likelihood of ASD by four to seven times. The next model included feelings of security, ability to express feelings, and the feeling of being let down. The pretrauma factors remained statistically significant. Security feeling and ability to express feelings reduced the likelihood of ASD by one-quarter, Exp(B) = .74 and .77 respectively. Feeling let down increased the likelihood of ASD by one-third. The third model included the feeling of hopelessness, which increased the likelihood of ASD by 2.6 times, while the previous factors remained significant.

In a hierarchical regression analysis with TSC total as dependent variable, all predictor variables were entered into the equation, and each variable that did not significantly contribute to the to the equation was removed before a new regression equation was fitted. In the first step, three pretrauma factors explained 31% of TSC total variance \((F_{(3,170)} = 25.3; p < .0005)\); being a robbery victim (in addition to the PA) \((\beta = .13; p = .05)\), previous victim of PA \((\beta = .41; p < .0005)\), and previous shock due to a traumatic event happening to someone close \((F_{(3,170)} = 25.3; p < .0005)\). In the second step, the six ASD criteria explained additional 46% of TSC total variance \((F_{(9,164)} = 58.9; p < .0005)\). Only the avoidance criterion was insignificant; the other criteria were; A2 stressor \((\beta = .10; p < .05)\); dissociation \((\beta = .25; p < .0005)\); intrusion \((\beta = .18; p < .005)\); arousal \((\beta = .18; p < .01)\); and impairment \((\beta = .33; p < .0005)\).
DISCUSSION

Believing one is going to die, believing one’s life is threatened, and seeing other people being injured are factors that form part of the A1 stressor criteria, while intense anxiety and helplessness are essentials in the A2 stressor criterion of the ASD and PTSD diagnoses, according to the DSM-IV (American Psychiatric Association, 1994). The study demonstrated that the A2 stressor criterion was strongly associated with the development of ASD. Just as the experience of perceived helplessness is assumed to be a vulnerability factor (Seligman & Peterson, 1983), the premonition of trauma is assumed to be a protective factor, which, in spite of the factual outcome, implies the illusion of a certain degree of control (Elklit, 1993; Jind, 1999). However, the latter did not seem to be the case in this study, as premonition was not an effective factor in the final analyses.

A number of demographic factors (gender, age, nationality, and occupation) had limited independent significance and the same was true for a number of situational factors (gender of the perpetrator, number of perpetrators, previous acquaintance of the perpetrator, and premonition). Surprisingly, assaulted men reported more cases of psychological violence than did women. Contrary to expectations, there were no apparent gender differences in the reported history of former trauma. This is in contrast to national representative studies of trauma prevalence which demonstrate gender specific differences in relation to, for example, rape, child sexual abuse and PA (Kessler et al., 1995; Elklit, 2002). The absence of gender differences might be an indication of the extent of the psychological and social problems that exist in this group of victims. Severe social and psychological problems including previous trauma history, however, do not preclude the identification of acute and discrete traumatic events that result in ASD or PTSD (Robin et al., 1997).

Reviews of research on the importance of a number of situational aspects of the violent assault (Elklit, 1993; Resnick, Acerno, & Kilpatrick, 1997) proclaim, in line with the above, that it is difficult to indicate the importance of delimited separate PA factors. Specific analyses may demonstrate the occurrence of certain patterns, as when this study found that women in general received less sympathy and support than did men after an assault. Women also received less sympathy when it was violence by a partner or ex-partner; in addition, partner violence increased PTSD symptoms in the victim. So even if the PA victims who come to emergency wards are quite alike in trauma history and in the PA circumstances they had met, there may still be identifiable subgroups that deserve special attention.

It is remarkable that the degree of injuries does not seem to be of special importance for the development of ASD in this sample. Previous studies are ambiguous on that point (Elklit, 1993). The respondents in this study had a great deal of experience with violent

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<th>TABLE 2. Acute Stress Disorder Logistic Regression Models</th>
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<tr>
<td>Model 1</td>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td>Childhood sexual abuse 1.97*</td>
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<tr>
<td>Trauma-related shock 1.86****</td>
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<tr>
<td>Childhood physical abuse 1.55*</td>
</tr>
<tr>
<td>Feeling of security -0.30*</td>
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<tr>
<td>Ability to express feelings -0.27*</td>
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<tr>
<td>Feeling let down 0.32**</td>
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<tr>
<td>Hopelessness 0.97****</td>
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*p < .05. **p < .01. ***p < .005. ****p < .0005.
assault, which indicates that this group generally is a high-risk group. Compared with a
group of Danish trauma clients who received crisis intervention after witnessing violent
death (Elklit, 2000), the victims of PA in this study had been three times more exposed to
violent assault. Childhood sexual and physical abuse were together with previous trauma-
related shock and because a traumatic event happened to someone close, strongly associ-
ated with the development of ASD. In several national epidemiological studies (Kessler et
al., 1995; Elklit, 2002) previous trauma in general and childhood neglect and abuse in par-
ticular have been a significant factor in explaining PTSD development.

The prevalence of ASD in this study is quite high compared with an ASD rate of
13–14% in traffic victims (Harvey & Bryant, 1998, 2000), and it is also somewhat higher
than the Brewin et al. (1999) study of crime victims, mainly PA victims, which found an
ASD prevalence of 19%. One explanation of the latter might be that the Brewin et al. study
was a convenient sample with a low response rate (11%) and a more resourceful group
(who asked for crisis intervention) than this study. However, as with PTSD, rates of ASD
are very likely to differ from one trauma population to another, and reasonable compar-
isons will have to wait until larger studies are performed. One should be aware that a con-
siderable number of PA victims belonged to a subclinical ASD group.

Dissociation in ASD is conceived as the primary coping mechanism in dealing with trau-
matic experiences, minimizing the negative emotional consequences by restricting con-
sciousness (van der Kolk & van der Hart, 1989). The reduction in awareness happens
through perceptual changes, memory blocking and emotional detachment. As suggested in
the Acute Stress Reaction of the ICD-10 (WHO, 1994), the dissociative reaction may be a
“normal” immediate reaction, a part of the shock reaction, which in most cases will decrease
within a short time. In this study there was a considerable overlap between the five compo-
nents that constitute the dissociation cluster. Two “numbing” components—amnesia and
detachment—were identically distributed. The occurrence of amnesia and emotional detach-
ment as acute reactions after severe trauma was central in Lindemann’s seminal study of
acute grief reactions in 1944 (Lindemann, 1944). Dissociative reactions after trauma may be
adaptive (Horowitz, 1976), but there still is little evidence to decide when this is the case.
Maybe dissociative and other peritraumatic responses are predictive for short-term outcome,
but not for long-term adjustment (Holen, 1990). The Brewin and colleagues study (1999)
found that dissociation did contribute to the prediction of PTSD, but the improvement in
prediction was quite small and similar improvements could be easily achieved otherwise.

Avoidance did not contribute to early symptom development. Avoidance was seen origi-
nally as a modulating defense (Horowitz, 1976), which allowed the victim a break before new
waves of intrusive recollections of the trauma would flood consciousness. Avoidance (more
broadly defined in the PTSD diagnosis because it includes emotional numbing) in several
studies was found to be a predictor of chronic PTSD (Solomon, Mikulincer, & Flum, 1988;
Schwarz & Kowalski, 1992). In two prospective Australian studies using path analysis
(Creamer, Burgess, & Pattison, 1992; McFarlane, 1992), avoidance did not predict long-term
outcome of PTSD, but was found to have a secondary reactive role in relation to the early
intrusive symptom development. Still, little is known about the role of this new reduced two-
item avoidance cluster in ASD, as avoidance has been studied almost exclusively as a PTSD
ingredient, which means the numbing factor is included. The numbing factor itself has been
found to be a good predictor of PTSD by Harvey and Bryant (1998) and Feeny, Zoellner,
Fitzgibbons, and Foa (2000).

Arousal and intrusion contributed strongly to symptom development, as did the A2
stressor criteria. The impairment criterion was a strong contributor to TSC total symptom
scores. One might insist that two out of three areas (social relations, work, and sex) should
suffer from impairment before the criterion was fulfilled. In that case we might go back to Freud’s old dictum of “work and love,” and one might ask the benefits of diagnosing psychological components if functional criteria eventually would decide the case.

The shock reaction embedded in the dissociation response, along with security matters and the immediate need for social support and reaffirmation (Elklit, 1994), was very strong at this early stage. The presence of previous trauma-related shock and the history of childhood sexual and physical abuse in the analysis could be understandable signs of reactivation, which underlines the drama that the survivor has just escaped. Feelings of security and social support may be important buffers for an adverse long-term outcome. Evidence for the moderating effect of social support on posttraumatic symptoms is noted (Driscoll, Worthington, & Hurrell, 1995; Fullerton, Ursano, Kao, & Bhartiya, 1992). The role of feeling secure as a predictor of PTSD development was also found in Elklit (2000), where a low level of security feeling was a predictor of posttraumatic stress development following trauma in a Danish group of 214 survivors referred to crisis intervention after sudden and violent death in the workplace, PA, and so on. Six months later security feeling was still a predictor, but now paradoxically with an opposite sign; high feelings of security were now predictor of avoidance reactions and psychological symptoms.

At the time of the study, almost one-quarter of the respondents were suffering from an ASD and one-fifth belonged to a subclinical group of ASD that might also be in need of treatment. The study also showed that victims of violence who did not take part in this study have been exposed to more severe violence, which could be an indication of greater suffering for them. One should keep in mind that the group in this study is a vulnerable group with a history of much violence. The response rate is modest, and the generalizations are limited by sample procedures of written consent in the emergency room, by giving diagnosis via self-report measures, and recollection issues embedded in self-reporting. The study’s strength is that it builds on the admission of all victims of violence in a certain area and that it was possible to investigate the relation among objective measures of injury severity, a number of assault circumstances (all of which are assessed within hours after the assault), and the development of psychological sequelae.

In Denmark, after being assaulted, it is possible to get crisis intervention at a psychologist at a reduced rate through the National Health. Based on the findings from this study, the arrangement seems very needed and warranted. But one might worry whether all who need this arrangement actually do receive the help they need. The emergency ward staff may identify aspects that place the patients at risk and activate procedures that reduce the psychological sequelae. The ASD diagnosis might serve as an efficient tool for the activation of prophylactic and supportive intervention, including referral to psychological crisis intervention or trauma therapy, which should begin at the gate of the emergency ward and ideally be integrated with the follow-up treatment.

REFERENCES


Offprints. Requests for offprints should be directed to Ask Elklit, MPsych, Institute of Psychology, Aarhus University, Asylvej 4, DK-8240 Risskov, Denmark. E-mail: aske@psy.au.dk
APPENDIX

Items and Criteria Used to Diagnose Acute Stress Disorder

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<tr>
<th>Criterion</th>
<th>Item</th>
<th>Rating Scale</th>
<th>Rating Required for Diagnosis</th>
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</table>
| A. Stressor criterion | During the assault:  
1) Did you think you were going to die?  
2) Did you feel completely helpless?  
3) How afraid were you during the assault? | Items 1 and 2,  
0 = no, 1 = yes  
Item 3, 7-point scale (1 = not at all, 7 = very much) | Items 1 and 2,  
Any 1  
Item 3, ≥ 6  
Any of Items 1, 2 or 3 |
| B. Dissociation | HTQ 4, 5, 13, 17; TSC 6 | 0 = never,  
1 = once in a while/seldom,  
2 = somewhat/often,  
3 = most of the time/very often | HTQ, TSC  
Any 1 |
| B2: Restricted Awareness | TSC 11 | same | Any 1 |
| B3. Derealization | HTQ 28, TSC 19, 30 | same | Any 1 |
| B4. Depersonalization | HTQ 29, TSC 32 | same | Any 1 |
| B5. Amnesia | HTQ 12, TSC 31 | same | Any 1 |
| C. Re-experiencing | HTQ 1, 2, 3, 16 TSC 10 | same | Any 2 |
| D. Avoidance | HTQ 11, 15 | same | Any 2 |
| E. Arousal | HTQ 6, 7, 8, 9, 10 | same | Any 2 |
| F. Impairment | TSC 16, HTQ 14, 26, 27, 30 CSS 3, 6 | same  
CSS 7-point scale (1 = not at all, 7 = very much) | TSC, HTQ  
CSS 3 ≤ 2  
CSS 6 ≥ 6  
Any 2 |
| F2. Work | HTQ 18 | same | Any 2 |
| F3. Sexual | TSC 8, 23, 24 | same | Any 2 |

*Note. HTQ = Harvard Trauma Questionnaire—Part 4; TSC = Trauma Symptom Checklist; CSS = Crisis Support Scale.*