

**SCREENING INSTRUMENT FOR TRAUMATIC STRESS IN EARTHQUAKE SURVIVORS
(SITSES-R)**

PART I: SURVIVOR INFORMATION FORM

1. *Name*_____
2. *Age*_____
3. *Gender* 1 = Male 2 = Female
4. *Education* 1 = None 2 = Literate 3 = Primary 4 = Secondary 5 = High school 6 = University
5. *Occupation*_____
6. *Marital status* 1 = Married / Cohabiting 2 = Single 3 = Widowed 4 = Separated
7. *Your address*_____
8. *Telephone number*_____
9. *How close were you to the epicentre during the earthquake?*
 1 = Within 50 kms 2 = 50 to 100 kms 3 = More than 100 kms
10. *Did you experience the tremors?* 0 = No 1 = Yes
11. *Where were you during the earthquake?*
 1 = In a building 2 = On the street 4 = In a transport vehicle 5 = Other_____
12. *Were you trapped under rubble?* 0 = No 1 = Yes
13. *Did anyone close to you die in the earthquake?* 0 = No 1 = Yes (If yes) Who?_____
14. *Have you participated in rescue work after the earthquake?* 0 = No 1 = Yes
15. *Have you had any serious financial loss as a result of the earthquake?* 0 = No 1 = Yes
16. *What is the current state of your house?*
 1 = Undamaged 2 = Slightly damaged 3 = Moderately damaged 4 = Severely damaged
 5 = Collapsed 6 = Demolished after the earthquake 7 = Don't know
17. *Where are you living at present?*
 1 = My usual house 2 = A new house 3 = A tent 4 = Temporary shelter 5 = Other_____
18. *Did you ever experience a life-endangering event before the earthquake (e.g. natural disaster, fire, road traffic accident, serious bodily injury, or physical assault)?*
 0=No 1=Yes (Please briefly specify_____)
19. *Did you have any psychiatric illness requiring treatment before the earthquake?* 0 = No 1 = Yes
20. *Using the scale below, how would you rate the intensity of your fear during the earthquake?*
 0 = No fear at all 1 = Slight fear 2 = Marked fear 3 = Severe fear 4 = Extremely severe fear
21. *How anxious / fearful have you been lately thinking about possible earthquakes in the near future?*
 0 = Not anxious / fearful at all 1 = Slightly 2 = Markedly 3 = Severely 4 = Extremely anxious
 / fearful
22. *How much control do you have over your life at present?*
 0 = Not at all in control / Feeling very helpless 1 = Slightly in control 2 = Markedly in control
 3 = Completely in control / Not feeling helpless at all

PART II - TRAUMATIC STRESS SYMPTOM CHECKLIST (TSSC)

Below is a list of problems some people experience after earthquakes. Please indicate how much you were bothered by these problems within the last week by putting X under the appropriate column.

	Not at all bothered	Slightly	Fairly	Very much bothered
1. I cannot help thinking about certain memories/images related to the earthquake.				
2. Sometimes all of a sudden past events pass before my eyes like a movie and I feel as if I am re-living the events.				
3. I frequently have nightmares.				
4. I cannot do certain things easily for fear of an earthquake (e.g. entering undamaged houses, taking a shower, being alone or sleeping in the dark).				
5. I have lost interest in things.				
6. I feel distant and estranged from people.				
7. I feel as if my feelings are dead.				
8. I have sleeping difficulty.				
9. I lose my temper more easily.				
10. I have difficulty remembering things or concentrating on what I am doing.				
11. I am on edge all the time for fear of an earthquake.				
12. I get startled when there is a sudden noise or movement.				
13. I feel upset when something reminds me of my experiences during the earthquake.				
14. I try to get rid of thoughts and feelings about my experiences during the earthquake.				
15. I have difficulty remembering certain parts of my experiences during the earthquake.				
16. Making long-term plans seems meaningless to me because the earthquake made me realize I may die anytime.				
17. I have physical symptoms such as palpitations, sweating, dizziness, and tension in my body when something reminds me of my experiences during the earthquake.				
18. I feel guilty.				
19. I feel depressed.				
20. I cannot enjoy life as I used to.				
21. I feel hopeless about the future.				
22. I have thoughts of killing myself from time to time.				
23. I have less energy for my daily activities.				

PART III: SEVERITY OF DISABILITY SCALE (SDS)

1. How distressed / bothered are you by the problems listed above?
0=Not at all 1=Slightly 2=Fairly 3=Extremely

2. How impaired is your work, family life, and relationships with others because of the problems above?
0 = No impairment. I can lead my daily life.
1 = Slight impairment. I can lead my daily life with a little effort.
2 = Marked impairment. There is marked disruption in my daily life.
3 = Severe impairment. I cannot do most of the things in my daily life.

3. Would you like to have help from a psychiatrist or psychologist for your problems?
0=No 1=Yes 2=Not sure / don't know