Chapter 18
Acute Stress Disorder and Posttraumatic Stress Disorder: A Brief Overview and Guide to Assessment

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Clinicians working in a wide variety of settings, including inpatient units, outpatient clinics, and primary care centers, will inevitably encounter clients experiencing a range of levels of psychological distress in response to potentially traumatizing events (PTEs). However, whether the trauma history of these clients is identified and included in the clinician's conceptualization of the case is dependent on the nature and scope of the assessment. Posttraumatic stress disorder (PTSD), one of the most significant trauma-related disorders, is frequently overlooked in mental health settings (e.g., Mueser et al., 1998; Zimmerman & Mattia, 1999). Thus, structured assessment of PTEs and related psychopathology is critical for the application of effective treatments.

The purpose of this chapter is to provide a broad overview of issues related to the assessment of both PTEs and possible symptoms associated with these events. The assessment of trauma-related symptomatology will be described as it relates to two of the most common stress-related responses, acute stress disorder (ASD) and PTSD. As a comprehensive review of this topic is beyond the scope of this chapter, readers are referred to in-depth reviews published elsewhere (e.g., Briere, 1997; Foa & Rothbaum, 1998; Litz, Miller, Ruef, & McTeague,

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in press; Litz & Weathers, 1994). All instruments mentioned in this chapter are described elsewhere in this book, along with full citations.

POTENTIALLY TRAUMATIZING EVENTS

Definition, Prevalence, and Relationship to Psychopathology

In DSM-IV, a traumatic event, as defined within the diagnostic criteria of ASD and PTSD, is evaluated by both objective and subjective criteria. First, the event must involve some threat to safety and physical integrity. Second, the individual must experience a significant emotional response to the event including fear, helplessness, or horror. This two-part definition of a traumatic event is critical, because responses to events are affected by an individual's context, and not all individuals perceive similar events to be "traumatic." Thus, in this chapter, we will use the term *potentially traumatizing event* to describe events that fit DSM-IV criteria and that may or may not be associated with the development of ASD or PTSD. A list of the specific PTEs that minimally should be assessed was developed following the National Institute of Mental Health–National Center for PTSD Conference on Assessment Standardization (Keane, Weathers, & Foa, 2000; see Table 1).

Epidemiological studies confirm that exposure to PTEs is unfortunately quite common. For instance, in the National Comorbidity Study, 60.7% of men and 51.2% of women reported that they had experienced at least one traumatic event, and the majority of respondents who reported any lifetime trauma were likely to have actually experienced two or more traumatic events (Kessler et al., 1999). However, whereas most individuals demonstrate immediate symptoms of psychological distress immediately following a PTE (e.g., Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992), only a minority will develop chronic psychological distress related to their exposure. A variety of factors contribute to the development of posttrauma psychopathology, including: pretrauma psychological and demographic characteristics, characteristics of the trauma such as type of event, duration, and intensity, immediate psychological reactions to the event, posttrauma social support, additional posttrauma stressful events, and coping efforts directed toward managing posttrauma symptoms (e.g., Boscarino, 1995; Green, Grace, Lindy, Gleser, & Leonard, 1990; Harvey & Bryant, 1998; King, King, Foy, & Gudanowski, 1996).

Table 1. Minimum Categories of PTEs to be Assessed

War-zone stressors
Sexual assault in childhood and adulthood
Robbery
Accidents
Technological disasters
Natural disasters or hazardous exposures
Sudden death of a loved one
Life-threatening illnesses
Witnessing or experiencing violence

Assessment of PTEs

General Issues. The assessment of PTEs can be a difficult and complex process that requires sensitivity and skill. Given that the assessment process for trauma survivors can be much more distressing and anxiety-provoking than for other clients, it is important that the assessor begin by making an effort to establish rapport with the client. Many trauma survivors, especially those with a history of interpersonal trauma, experience shame or guilt about the nature and extent of their traumatic histories. Clinicians should be sensitive to these possible reactions and should approach their contacts with trauma survivors in a direct but nonjudgmental way that conveys to the client that the therapist is comfortable discussing distressing material, while not insensitive to the personal nature of these experiences. Clinicians also need to be aware of their own emotional response to the client's disclosure and ensure that they do not unintentionally reinforce the client's potential avoidance as a way to manage their own discomfort with the material and with their client's distress.

Finally, as the assessment of trauma may be distressing in and of itself, it is important that the clinician discuss with the client the possibility of symptom exacerbation during the assessment process (Flack, Litz, & Keane, 1998). For example, a female client with PTSD may experience an increase in nightmares after describing her rape during an assessment session. Or, a man with a history of childhood sexual assault may experience significant shame in disclosing this event to a male clinician. Before the assessment process begins, the client's potential use of substances or engagement in self-injurious behaviors as a means of managing symptom intensification should be assessed, as well as the presence of any suicidal or homicidal risk. If necessary, a plan should be developed to help the client identify and manage these behaviors or ask for help if their intensity increases.

The specific questions that are asked to assess the lifetime occurrence of PTEs can significantly impact the accuracy of their assessment. Individuals are more likely to report traumatic experiences when asked directly about specific events than during free recall or unstructured conversation (Lanktree, Briere, & Zaidi, 1991). Further, the exact wording used can affect whether a person reports exposure to a given traumatic event. It is recommended that behaviorally anchored terminology be used to assess PTEs, rather than using more subjective words like "abuse" or "rape" that may be understood differently from individual to individual and may impact on whether an event is reported during an assessment (Keane et al., 2000; Resnick, Falsetti, Kilpatrick, & Freedy, 1996). The skilled clinician should also take a person's cultural context into account and recognize that there are cultural differences with respect to which events are considered traumatic or bear reporting to a clinician (Keane, Kaloupek, & Weathers, 1996). Finally, in addition to simply asking the respondent to indicate whether he or she has experienced a particular event, it is also essential to ask whether the person's response to each event involved intense fear, helplessness, or horror (American Psychiatric Association [APA], 1994). Without this piece of information, a person's response to a PTE cannot be classified as meeting the criteria for ASD or PTSD, and the evaluation may increase the probability of overestimating the presence of psychiatric disorder.

Other considerations involved in the assessment of PTEs include the level of detail gathered during the assessment. Depending on the purpose of the assessment, more or less detail may be required, and clients should not be subjected to a lengthy evaluation process unless there will be a clear clinical or research utility for the assessment. However, especially for clinical purposes, it is often useful to gather comprehensive information about the client's complete trauma history, given the research presented earlier showing that most trauma survivors have experienced more than one PTE (Kessler et al., 1999), and the fact that previous

exposure to a PTE often signals a greater risk of developing PTSD in response to a subsequent PTE (Breslau, Chilcoat, Kessler, & Davis, 1999). In addition, it can be of notable clinical relevance to collect details about the PTE to place the event into a more complete context. Such details may include events or situations that preceded the PTE, pretrauma beliefs and functioning, who the perpetrator was, how or why the traumatic situation ended, responses from significant others in the person's life after disclosing the trauma, and coping styles used both before and after the traumatic event occurred. For each event, it can be helpful to obtain information assessing event frequency, duration, perceived life threat, harm, injuries, and age at the time of the event.

Methods of Assessing PTEs. Depending on the purpose of the assessment, a variety of instruments may be utilized to determine exposure to PTEs. Some instruments such as the Stressful Life Events Screening Questionnaire, the Traumatic Events Questionnaire, and the Traumatic Life Events Questionnaire assess a wide variety of PTEs, each with one or two questions. These instruments allow for a breadth of assessment, but they often lack depth. In contrast, some instruments focus on assessing one type of traumatic event, such as exposure to childhood abuse. Measures that assess a wide range of PTEs are reviewed in Chapter 19. Some examples of measures that assess one type of PTE are presented in Table 2.

As the context of the evaluation allows, either interviews, self-report checklists, or a combination of the two may be used,. However, each mode of assessment has potential benefits and limitations. Assessment of PTEs via self-report questionnaires may be helpful, in that individuals may be more likely to disclose personal information in a setting that they feel has less opportunity for social judgment. In addition, such measures are often more efficient to administer. However, the use of semistructured interviews allows for a therapeutic context in which the clinician can provide support and empathy through the assessment process. Further, in an interview, the clinician can better ensure that respondents comprehend the nature and meaning of the assessment questions. Structured interviews for PTEs are sometimes preferable to facilitate the management of potential psychological distress during the evaluation process. Finally, from a clinical standpoint, it would seem that clients might be more likely to disclose their exposure to traumatic events in an interview rather than on a questionnaire. However, the data comparing these formats thus far are equivocal (e.g., Dill, Chu, Grob, & Eisen, 1991; Stinson & Hendrick, 1992).

Table 2. Common Instruments for Assessment of PTEs

Assessment instrument	Type of PTE
Childhood Trauma Questionnaire (Bernstein et al., 1994)	Childhood maltreatment
Psychological and Physical Maltreatment Scale (Briere & Runtz, 1988)	Childhood maltreatment
Assessing Environments III (Berger, Knutson, Mehm, & Perkins, 1988; Knutson & Selner, 1994)	Punitive childhood experiences
Wyatt Sexual History Questionnaire (Wyatt, 1985; Wyatt, Lawrence, Vodounon, & Mickey, 1992)	Childhood sexual abuse
Sexual Experiences Survey (Koss & Gidycz, 1985; Koss & Oros, 1982)	Adolescent and adult sexual assault
Conflict Tactics Scale (Straus, 1979)	Verbal and physical acts of aggression
Psychological Maltreatment of Women (Tolman, 1989)	Psychological aggression
Wartime Stressor Scale (Wolfe, Brown, Furey, & Levin, 1993)	Stressful wartime experiences
Combat Exposure Scale (Keane et al., 1989)	Combat experiences

ASSESSMENT OF POSTTRAUMATIC SYMPTOMATOLOGY

Acute Stress Disorder

Individuals who develop psychological symptoms within 1 month of exposure to a PTE may fulfill the criteria for ASD (APA, 1994). This diagnosis may be given if a person has experienced a PTE during which his or her response involved intense fear, helplessness, or horror. The characteristics of ASD involve symptoms of dissociation or numbing, reexperiencing, avoidance of stimuli related to the trauma, and symptoms of high anxiety or hyperarousal, and the person's level of distress must be enough to cause clinically significant distress or impairment in life functioning. The main feature that distinguishes ASD from PTSD (described below) is the time frame for the development and experience of symptoms. ASD can only be diagnosed if the posttraumatic symptoms develop within 4 weeks of the traumatic event and last between 2 days and 4 weeks. If the symptoms persist for more than 4 weeks, the person's diagnosis must be changed, most often to PTSD or an adjustment disorder. The prevalence of ASD in populations exposed to PTEs depends on the severity and duration of the event (APA, 1994). The Acute Stress Disorder Interview, the Acute Stress Disorder Scale, and the Stanford Acute Stress Reaction Questionnaire are all published measures that were developed for assessing ASD.

Posttraumatic Stress Disorder

As with ASD, PTSD may also be diagnosed when a person has been exposed to a PTE, during which the person experienced fear, helplessness, or horror (APA, 1994). However, PTSD is diagnosed when posttraumatic symptoms last for more than 30 days. There are three main classes of symptoms in PTSD: reexperiencing, avoidance, and arousal. Reexperiencing symptoms may include distressing memories, nightmares, flashbacks, and intense distress or physiological reactivity on exposure to internal or external cues related to the event. Avoidance symptoms may include avoidance of thoughts, feelings, situations, or people associated with the event, problems with memory for the event, anhedonia, and restricted range of affect. Finally, symptoms of increased arousal may consist of trouble sleeping or concentrating, irritability or anger, hypervigilance, and exaggerated startle response.

Estimates of the lifetime prevalence of PTSD in the general population range from 1 to 14%, with 3 to 58% of individuals exposed to a PTE developing PTSD (APA, 1994). A diagnosis of PTSD is often associated with a notably chronic course, and more than one third of individuals diagnosed with PTSD have been found to still meet criteria for the disorder 5 years later (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Special considerations in the assessment of PTSD will be discussed below.

Assessment of PTSD

General Issues. The general issues related to the assessment of PTSD are quite similar to those discussed in the assessment of PTEs. In addition to the points already raised, part of the assessment can be focused on normalizing the disparate symptoms of PTSD and educating the client as to how these symptoms reflect an attempt to adapt to and cope with the PTE he or she has experienced.

One additional factor to consider when conducting a PTSD assessment is the potential impact of pending compensation for distress related to the traumatic event. For instance, a motor vehicle accident victim may be seeking an insurance settlement at the same time that he or she is seeking an assessment. Or, a veteran may be interested in receiving service-related compensation. Some measures of PTSD such as the Minnesota Multiphasic Personality Inventory PTSD Scale are sensitive to the overendorsement of symptoms that often reflects malingering. However, overendorsement of symptoms can also reflect extreme distress or a cry for help and thus interpretation should be made with caution. There is some suggestion that compensation-seeking malingering may be less common than typically thought (e.g., Blanchard & Hickling, 1997).

Clinical Interview. During the clinical interview, the clinician's main goal is to establish a safe and therapeutic context for the client. In addition to assessing the client's history of PTEs, his or her personal and family psychological history, previous therapy experience, and current functioning should be assessed.

A fear and avoidance hierarchy can be developed, including situations, places, and people that are currently problematic for the client. To our knowledge, there is currently no psychometrically established measure of situational fear and avoidance for PTSD as there is for many other anxiety disorders. The development of such an instrument would greatly facilitate the identification of feared situations. In the absence of such a measure, the clinician should be knowledgeable about the types of situations that are typically problematic for survivors of different types of PTEs (e.g., cologne, alcohol, and sexual activities for a rape victim, forests, helicopters, and people of Asian descent for Vietnam veterans). Further, there may be idiosyncratic stimuli (a particular street, a shirt of a certain color) that are significantly fear inducing and that require careful assessment to identify.

As with other chronic anxiety disorders, it can be difficult for clients to recognize and report on longstanding, chronic avoidance patterns such as driving a particular route to work or preferring quiet evenings at home to interacting with others in a social context. Often a client will see these as personal preferences, and the relationship between these choices and the onset of PTSD can only be demonstrated through a careful, thorough functional analysis.

Semistructured Interviews. A number of semistructured interviews designed to assess PTSD have been developed and psychometrically validated (see Chapter 19). The use of a semistructured interview can greatly increase the probability that the presence of PTSD is identified (e.g., Zimmerman & Mattia, 1999). These interviews differ from one another primarily in the extent of their use and validation across trauma groups, their ability to provide dichotomous and/or continuous measures of severity, and their ease in administration.

Questionnaires. Many different questionnaires have been developed to assess PTSD symptomatology (see Chapter 19). The vast majority of measures consist of 17 questions directly corresponding to the 17 symptoms of PTSD described in DSM-IV criteria B (reexperiencing), C (avoidance and numbing), and D (hyperarousal). Many of the questionnaires allow for estimates of caseness if the requisite number and pattern of symptoms is endorsed. It is important to note that many of the questionnaires have not been validated across a variety of trauma groups, and that the recommended cutoffs may vary for trauma type, gender, and ethnicity. Of the questionnaires reviewed in Chapter 19, only the Posttraumatic Diagnostic Scale includes questions that tap into all of the diagnostic criteria of PTSD (although the Distressing Events Questionnaire includes all criteria with the exception of A-1, the presence

of a traumatic event). Most questionnaires also allow continuous estimates of overall symptom severity as well as severity within each symptom cluster.

Very few PTSD questionnaires assess broader clinical features beyond the diagnostic criteria. Some exceptions that include both PTSD symptoms and associated features are the Civilian Mississippi Scale, the Trauma Symptom Inventory, the Los Angeles Symptom Checklist, and the Penn Inventory for PTSD.

Cognitive Factors. The experience of trauma is thought to significantly impact on an individual's belief system (e.g., Janoff-Bulman, 1992). Thus, assessment of the content of the cognitions of a client with PTSD (e.g., self-blame, meaning of the world) can be helpful in case conceptualization and treatment planning. Several cognitive measures are reviewed in Chapter 19, including the Posttraumatic Cognitions Inventory.

Behavioral Assessment. Self-monitoring can be an important component of the PTSD assessment. Foa and Rothbaum (1998) suggest that clients self-monitor the occurrence of target behaviors (e.g., nightmares, startle response, outbursts of anger) as they occur over the course of the week. A client can be asked to record the date and time of the symptom, the situation in which it was elicited, thoughts that were present at the time of the symptom, physiological responses, and subjective fear ratings related to the symptom expression.

Little has been written about the use of behavioral assessment tests (BATS) in the assessment of PTSD. However, their utility in the assessment of other anxiety disorders is well established. An example of a BAT for PTSD might include a simulated social interaction with someone of the opposite sex or making small talk with a group of strangers (if applicable to the client's specific avoidance pattern). BATs could also include trips to a crowded mall or a feared parking garage. Self-reported anxiety before and during the BAT could be assessed in addition to behavioral indicators such as eye contact, distance between the client and the confederate, and so on. Psychophysiological response during the BAT can also be continuously assessed. Of course, exposure to feared or avoided situations should only be undertaken when the avoidance is unreasonable and the exposure would not actually constitute a potential threat to the client's well-being.

Psychophysiological Assessment. Psychophysiological assessment is commonly used in research to examine the response of clients with PTSD to the presentation of trauma cues (e.g., a video of combat-related sights and sounds, the imaginal presentation of a rape script). Several indices have been used including heart rate, skin conductance, and facial EMG. In a recent, large-scale study, Keane et al. (1998) found that a combination of four physiological indices correctly classified two thirds of male Vietnam veterans with current PTSD. Although psychophysiological assessment can be expensive and is often not available to clinicians (but see review in Chapter 19), it can provide additional assessment information that can guide the conceptualization and treatment of PTSD.

Associated Features. Given that PTSD is associated with high levels of comorbidity (e.g., Orsillo, Weathers, et al., 1996), a full semistructured assessment of additional Axis I and relevant Axis II disorders (e.g., Borderline Personality Disorder, Antisocial Personality Disorder) is recommended (Keane et al., 2000). Also, measures such as the Minnesota Multiphasic Personality Inventory and the Symptom Checklist (SCL-90-R) can both provide an index of PTSD symptomatology and additional psychopathology (see Chapter 19). Certainly the functional relationship between comorbid disorders is critically important to the develop-

ment of a case conceptualization and treatment plan. For instance, comorbid PTSD and substance abuse often reflects the use of substances as a means of attempting to control the reexperiencing and hyperarousal symptoms that are perceived as unacceptable. A client with comorbid PTSD and panic disorder may need to decrease his or her sensitivity to panic symptoms before exposure therapy is indicated. A client with comorbid PTSD and social phobia may be socially avoidant because of the shame and guilt he or she feels about the traumatic experience or about the social rejection that was endured as a result of the traumatic exposure (Orsillo, Heimberg, Juster, & Garrett, 1996).

Several theorists and researchers have suggested that PTSD does not capture the full range of responses to traumatic events, particularly for traumatized children, rape victims, and battered women (Herman, 1992). Changes in affect regulation, self-identity, and interpersonal functioning seem to be common. The Structured Interview for Disorders of Extreme Stress has been developed to assess the presence of these symptoms. PTSD is also frequently associated with guilt and shame related to the traumatic experience. The Trauma-Related Guilt Inventory can be a useful tool for assessing these emotional responses.

CONCLUSION

In summary, the assessment of posttraumatic symptomatology involves a set of complicated but extremely important methodological issues. Given the fact that virtually all medical professionals and mental health providers will encounter clients who have been exposed to PTEs, it is important that the clinician know how to assess both the stressful event experienced and the possible symptoms related to that event in a manner least likely to lead to either under- or overendorsement of symptoms. The use of a multimethod assessment package, integrating standardized interviews and questionnaires discussed in the current chapter and reviewed in more detail in Chapter 19 is highly recommended.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Berger, A. M., Knutson, J. F., Mehm, J. G., & Perkins, K. A. (1988). The self-report of punitive childhood experiences of young adults and adolescents. *Child Abuse and Neglect, 12*, 251–262.

Bernstein, D. P., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K., Sapareto, E., & Ruggiero, J. (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry, 151*, 1132–1136.

Blanchard, E. B., & Hickling, E. J. (1997). *After the crash: Assessment and treatment of motor vehicle accident survivors*. Washington, DC: American Psychological Association.

Boscarino, J. A. (1995). Post-traumatic stress and associated disorders among Vietnam veterans: The significance of combat exposure and social support. *Journal of Traumatic Stress, 8*, 317–336.

Breslau, N., Chilcoat, H. D., Kessler, R. C., & Davis, G. C. (1999). Previous exposure to trauma and PTSD effects of subsequent trauma: Results from the Detroit Area Survey of Trauma. *American Journal of Psychiatry, 156*, 902–907.

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

Briere, J., & Runtz, M. (1988). Multivariate correlates of childhood psychological and physical maltreatment among university women. *Child Abuse and Neglect, 12*, 331–341.

Dill, D. L., Chu, J. A., Grob, M. C., & Eisen, S. V. (1991). The reliability of abuse history reports: A comparison of two inquiry formats. *Comprehensive Psychiatry, 32*, 166–169.

Flack, W. F., Litz, B. T., & Keane, T. M. (1998). Cognitive–behavioral treatment of warzone-related posttraumatic stress disorder: A flexible, hierarchical approach. In V. M. Follete, J. I. Ruzek, & F. R. Abueg (Eds.), *Cognitive–behavioral therapies for trauma* (pp. 77–99). New York: Guilford.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape*. New York: Guilford.

Green, B. L., Grace, M. C., Lindy, J. D., Gleser, G. C., & Leonard, A. (1990). Risk factors for PTSD and other diagnoses in a general sample of Vietnam veterans. *American Journal of Psychiatry, 147*, 729–733.

Harvey, A. G., & Bryant, R. A. (1998). The relationship between acute stress disorder and posttraumatic stress disorder: A prospective evaluation of motor vehicle accident survivors. *Journal of Consulting and Clinical Psychology, 66*, 507–512.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*, 377–392.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: The Free Press.

Keane, T. M., Fairbank, J. A., Caddell, J. M., Zimering, R. T., Taylor, K. L., & Mora, C. A. (1989). Clinical evaluation of a measure to assess combat exposure. *Psychological Assessment, 1*, 53–55.

Keane, T. M., Kaloupek, D. G., & Weathers, F. W. (1996). Ethnocultural considerations in the assessment of PTSD. In A. J. Marsella & M. J. Friedman (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 183–205). Washington, DC: American Psychological Association.

Keane, T. M., Kolb, L. C., Kaloupek, D. G., Orr, S. P., Blanchard, E. B., Thomas, R. G., Hsieh, F. Y., & Lavori, P. W. (1998). Utility of psychophysiology measurement in the diagnosis of posttraumatic stress disorder: Results from a Department of Veteran's Affairs cooperative study. *Journal of Consulting and Clinical Psychology, 66*, 914–923.

Keane, T. M., Weathers, F. W., & Foa, E. B. (2000). Diagnosis and assessment. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD* (pp. 18–36). New York: Guilford.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*, 1048–1060.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., Nelson, C. B., & Breslau, N. (1999). Epidemiological risk factors for trauma and PTSD. In R. Yehuda (Ed.), *Risk factors for posttraumatic stress disorder* (pp. 23–59). Washington, DC: American Psychiatric Press.

King, D. W., King, L. A., Foy, D. W., & Gudanowski, D. M. (1996). Prewar factors in combat-related posttraumatic stress disorder: Structural equation modeling with a national sample of female and male Vietnam veterans. *Journal of Consulting and Clinical Psychology, 64*, 520–531.

Knutson, J. F., & Selner, M. B. (1994). Punitive childhood experiences reported by young adults over a 10-year period. *Child Abuse and Neglect, 18*, 155–166.

Koss, M. P., & Gidycz, C. A. (1985). Sexual Experiences Survey: Reliability and validity. *Journal of Consulting and Clinical Psychology, 53*, 422–423.

Koss, M. P., & Oros, C. J. (1982). Sexual Experiences Survey: A research instrument investigating sexual aggression and victimization. *Journal of Consulting and Clinical Psychology, 50*, 455–457.

Lanktree, C., Briere, J., & Zaidi, L. (1991). Incidence and impact of sexual abuse in a child outpatient sample: The role of direct inquiry. *Child Abuse and Neglect, 15*, 447–453.

Litz, B. T., Miller, M. W., Ruef, A. M., & McTeague, L. M. (in press). Assessment of adults exposed to trauma. In M. M. Antony & D. H. Barlow (Eds.), *Handbook of assessment, treatment planning, and outcome evaluation: Empirically supported strategies for psychological disorders*. New York: Guilford.

Litz, B. T., & Weathers, F. W. (1994). The diagnosis and assessment of post-traumatic stress disorder in adults. In M. B. Williams & J. F. Sommer (Eds.), *The handbook of posttraumatic therapy* (pp. 20–37). Westport, CT: Greenwood Press.

Mueser, K. T., Goodman, L. B., Trumbetta, S. L., Rosenberg, S. D., Osher, F. C., Vidaver, R., Auciello, P., & Foy, D. W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology, 66*, 493–499.

Orsillo, S. M., Heimberg, R. G., Juster, H. R., & Garrett, J. (1996). Social phobia in Vietnam veterans. *Journal of Traumatic Stress, 9*, 235–252.

Orsillo, S. M., Weathers, F. W., Litz, B. T., Steinberg, H. R., Huska, J. A., & Keane, T. M. (1996). Current and lifetime psychiatric disorders among veterans with war zone-related posttraumatic stress disorder. *Journal of Nervous and Mental Disease, 184*, 307–313.

Resnick, H. S., Falsetti, S. A., Kilpatrick, D. G., & Freedy, J. R. (1996). Assessment of rape and other civilian trauma-related PTSD: Emphasis on assessment of potentially traumatic events. In T. W. Miller (Ed.), *Theory and assessment of stressful life events* (pp. 235–271). Madison, CT: International Universities Press.

Rothbaum, B. O., Foa, E. B., Riggs, D., Murdock, T., & Walsh, W. (1992). A prospective examination of posttraumatic stress disorder in rape victims. *Journal of Traumatic Stress, 5*, 455–475.

Stinson, M. H., & Hendrick, S. S. (1992). Reported childhood sexual abuse in university counseling center clients. *Journal of Counseling Psychology, 39*, 370–374.

Straus, M. A. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics (CT) Scales. *Journal of Marriage and the Family, 41*, 75–88.

Tolman, R. M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims, 4*, 159–177.

Wolfe, J., Brown, P. J., Furey, J., & Levin, K. (1993). Development of a war-time stressor scale for women. *Psychological Assessment, 5*, 330–335.

Wyatt, G. E. (1985). The sexual abuse of Afro-American and white American women in childhood. *Child Abuse and Neglect: The International Journal, 9*, 507–519.

Wyatt, G. E., Lawrence, J., Vodounon, A., & Mickey, M. R. (1992). The Wyatt Sex History Questionnaire: A structured interview for female sexual history taking. *Journal of Child Sexual Abuse, 1*, 51–68.

Zimmerman, M., & Mattia, J. I. (1999). Is posttraumatic stress disorder underdiagnosed in routine clinical settings? *Journal of Nervous and Mental Disease, 187*, 420–428.