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The Relationship Between Posttraumatic Growth and Substance Abuse in Homeless Women with Histories of Traumatic Experience

Monica J. Stump

RELATIONSHIP BETWEEN POSTTRAUMATIC GROWTH AND SUBSTANCE ABUSE IN HOMELESS WOMEN... - STUMP

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THE RELATIONSHIP BETWEEN POSTTRAUMATIC GROWTH AND SUBSTANCE ABUSE IN HOMELESS WOMEN WITH HISTORIES OF TRAUMATIC EXPERIENCE

BY

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B.A., PSYCHOLOGY, CORNELL UNIVERSITY, 2003

THESIS

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THE RELATIONSHIP BETWEEN POSTTRAUMATIC

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The Relationship between Posttraumatic Growth and Substance Abuse in Homeless Women with Histories of Traumatic Experience

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ABSTRACT

The phenomenon of posttraumatic growth (PTG) may be particularly relevant for homeless women, who have higher levels of trauma exposure than the general population. However, homeless women also have higher rates of substance use, which some research has linked with less PTG. The present study examined the relationship between PTG and substance use in homeless women. It was hypothesized that substance abuse would be associated with less PTG, more avoidant coping, and more Posttraumatic Stress Disorder symptomatology. It was further predicted that PTG would be unrelated to psychological distress. Participants were 50 homeless women with histories of trauma who were recruited from local shelters and service providers. In line with predictions, a continuous measure of substance use severity was negatively related to PTG, positively related to avoidant coping when approach coping was accounted for, and positively related to PTSD symptomatology. Importantly, despite their experience with multiple traumas and chronic environmental stressors, homeless women in this sample displayed substantial levels of PTG and rated that growth as very comforting. In sum, these results suggest that greater use of substances is

negatively associated with PTG. Overall, PTG correlated positively with approach coping but was unrelated to psychological distress.

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Introduction

Although most of the research on psychological functioning after trauma or adversity has focused almost exclusively on the negative consequences, a growing body of literature emphasizes positive changes an individual may experience after such an event. A number of different names have been given to the positive sequelae of trauma, including post-traumatic growth, perceived benefits, positive by-products, stress-related growth, thriving, positive adjustment, and positive adaptation (Linley & Joseph, 2004). In a recent review, Linley and Joseph coined the term "adversarial growth" for this phenomenon and set a precedent by comparing across studies that use different names for positive change following adversity. Tedeschi, Park, and Calhoun (1998) similarly use the term posttraumatic growth (PTG) as an umbrella label for this phenomenon. The term PTG will be used in this paper, although findings from studies using different terminology will be compared (Linley & Joseph, 2004).

PTG has been described as both a process and an outcome in response to traumatic events (Tedeschi et al., 1998). Tedeschi and colleagues choose the term "PTG" because it is the best descriptor of the phenomenon itself: after a traumatic event, some people grow *beyond* their previous level of psychological functioning. The term may be somewhat misleading in that it is called post*traumatic* growth, since the definition of "trauma" here seems to be much broader than the definition used as part of the Posttraumatic Stress Disorder (PTSD) diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000). Specifically, the PTG literature uses the terms "trauma" or "traumatic event" to refer to any kind of extremely negative life event or crisis. This paper uses this broader definition in reviewing the literature on the subject,

although the definition of "trauma" for the current study is the one found in the DSM-IV-TR.

Although estimates vary considerably depending on the type of adverse event and the method of assessment, Schaefer and Moos (1998) report that more than 50% of people who experience life crises report some benefits from them. Others have cited rates as high as 73% (Davis, Nolen-Hoeksema, & Larson, 1998) and 95% (McMillen et al., 1997). In addition, a number of specific types of PTG have now been supported empirically. These include personal growth (Frazier, Conlon, & Glaser, 2001; McMillen, Fisher, & Smith, 1997; McMillen, Zuravin, & Rideout, 1995), increased empathy or compassion for others (Frazier et al., 2001; McMillen & Cook, 2003; McMillen, Howard, Nower, & Chung, 2001), increased closeness to others or improved relationships (Frazier et al., 2001; McMillen & Cook, 2003; McMillen et al., 1997; McMillen et al., 2001; Siegel & Schrimshaw, 2000), increased appreciation of or satisfaction with life (Cordova, Cunningham, Carlson, & Andrykowski, 2001; Frazier et al., 2001; McMillen et al., 1997), changes in life priorities (McMillen et al., 2001; Siegel & Schrimshaw, 2000), and spiritual growth (Cordova et al., 2001; Frazier et al., 2001; McMillen et al., 2001; Siegel & Schrimshaw, 2000).

These types of PTG, among others, have been observed following a wide variety of traumatic events or adversities, such as being sexually assaulted (Frazier et al., 2001), experiencing sexual abuse as a child (McMillen et al., 1995), surviving a tornado, mass shooting, or plane crash (McMillen et al., 1997), overcoming chemical dependency (McMillen et al., 2001), surviving breast cancer (Cordova et al., 2001), losing a child or other family member (Davis, et al., 1998; Polatinsky & Esprey, 2000), suffering a spinal

cord injury (McMillen & Cook, 2003), and living with HIV/AIDS (Siegel & Schrimshaw, 2000).

Posttraumatic Growth and General Psychological Functioning

A number of studies have looked at the relationship between PTG and psychological functioning. Although a few studies have found that greater adversarial growth was associated with less depression or anxiety (Linley & Joseph, 2004), results on the relationship between PTG and distress have often been mixed. In a longitudinal study of breast cancer patients, for example, Carver and Antoni (2004) found that those who initially found benefit in the year following surgery predicted lower distress and depression 4 - 7 years later, even when initial levels of distress and depression were statistically controlled for.

Results were not as straightforward for Pakenham (2005), who tested individuals with multiple sclerosis. Only one particular type of growth, family relations growth, buffered the effect of stress level on overall distress, as measured by the Brief Symptom Inventory. So, for example, individuals with high levels of stress and high family relations growth had less distress than peers with high stress levels and low family relations growth. On the other hand, benefit finding did not correlate directly with distress to a significant degree.

Perhaps most difficult to interpret are the studies that have separately measured distress and well-being and have yielded disparate results. McMillen and Cook (2003) found in a sample of patients with spinal-cord injury that depression and anxiety from the Symptom Checklist-90 were unrelated to any types of "positive by-products." At the same time, well-being, as measured by the Psychological Well-Being scale of the Quality

of Life Questionnaire, was related to certain types of positive by-products. In contrast, when Cordova and associates used Ryff's scales of psychological well-being they found that PTG in breast cancer survivors was unrelated to well-being (Cordova et al., 2001). However, they, found that depression was unrelated to PTG, as well.

Although these findings are somewhat difficult to interpret, it should be noted that all the above studies used different measures of well-being, distress *and* PTG. The only exception to this was that Carver and Antoni (2004) and Cordova and colleagues (2001) both used the Center for Epidemiological Studies – Depression Scale. Ironically, even though both studies were with breast cancer survivors, one found that PTG was associated with reduced depression, while the other found them to be unrelated.

The only agreement on the relationship between PTG and distress seems to be that findings are inconsistent (Tedeschi et al., 1998). Tedeschi and colleagues suggest that PTG may be independent of distress, pointing out that a certain amount of distress appears necessary for growth to occur at all. Indeed, the bulk of the evidence suggests that PTG is unlikely to be related to depression or anxiety, while it is difficult to draw any firm conclusions about the relationship between PTG and well-being. A separate consideration is the fact that most studies have focused on PTG following a single type of adverse event. Given that there does not appear to be any research that has explicitly examined PTG within the context of multiple traumas, it is difficult to know if results would generalize to populations with greater trauma exposure.

Posttraumatic Growth and PTSD

PTSD, a particular and pronounced type of psychological distress, has been called the antithesis of PTG (Tedeschi et al., 1998). McMillen and associates found that those

who reported perceived benefit, a concept often used interchangeably with PTG, within 4 - 6 weeks of a disaster were less likely to have PTSD at a 3-year follow-up than those who did not perceive benefit (McMillen et al., 1997). Perceived benefit also moderated the relationship between severity of exposure to trauma and PTSD. Those individuals who perceived benefit despite having high exposure to the disaster tended to report the most recovery from PTSD, while those with high exposure who did *not* perceive benefit tended to have the poorest recovery. Two other longitudinal studies found this negative association between PTG and PTSD initially, but one study failed to replicate this finding at a 1-year follow-up (Frazier et al., 2001). The second study found that the negative association between PTG and PTSD was not only present but *increased* over time, such that the relationship was strongest at the 13- and 18-month follow-ups (Davis et al., 1998). These results generally support the idea that PTG and PTSD are inversely related. It is noteworthy that none of these studies used published instruments to measure positive change from adversity. Instead, each used a variation of coded responses to an open-ended question about whether or not anything positive had resulted from the trauma for the participant.

Posttraumatic Growth and Substance Use

Given the high concordance of PTSD and substance use disorders within individuals (Najavits, Weiss, & Shaw, 1999), and the unique challenges patients with these comorbid conditions face (Ouimette, Finney, & Moos, 1999), it is surprising that few studies have examined the relationship between PTG and substance abuse. In their study of survivors of three different kinds of disaster, McMillen and colleagues examined the effect of perceived benefit on mental health diagnoses, including substance abuse or

dependence, depression, anxiety and PTSD. With the exception of PTSD, these diagnoses were not frequent enough to examine individually, so these researchers looked at change in number of diagnoses over time. Perceived benefit moderated the effect of severity of trauma exposure on diagnosis change. In other words, if benefit was perceived at the initial time point, then the number of diagnoses decreased as severity increased. Individuals with the greatest severity of exposure who perceived benefit saw the greatest decrease in diagnoses, including substance use disorders.

Consistent with these findings, Milam, Ritt-Olson, and Unger (2004) showed more broadly that substance use, rather than abuse or dependence, was negatively associated with PTG in a normal sample of adolescents. It is unclear, however, whether their results were unique to adolescent populations, or whether they would generalize to a clinical population. In concluding, these authors phrase their explanation in terms of the avoidant coping strategy often linked with substance abuse: "Keeping oneself medicated through substance use may prevent the self-exploration needed for PTG." At present, there appears to be no empirical evidence to support such an explanation. The authors might have been able to explain the apparent negative relationship between PTG and substance use better if they had explicitly examined the coping styles associated with each.

Posttraumatic Growth and Coping

Some researchers consider PTG to be a process and an outcome that is closely linked to the way individuals cope with trauma (Tedeschi et al., 1998), while others view it as a kind of coping style in its own right (McFarland & Alvaro, 2000). The research surrounding this debate has focused on coping styles associated with PTG. Linley and

Joseph (2004) report that certain positive coping styles, including problem-focused, acceptance and positive reinterpretation coping, were associated with adversarial growth. Problem-focused coping, a term sometimes used interchangeably with approach coping, emphasizes taking action to deal with a problem. Acceptance merely means accepting what has happened. Positive reinterpretation, a type of approach coping, involves the use of positive cognitive strategies, such as attempting to see "the good" in a situation. The review's conclusions about PTG and coping have been well-supported elsewhere in the literature. Several recent studies have found positive associations between positive reinterpretation and PTG (Sears, Stanton, & Danoff-Burg, 2003; Widows, Jacobsen, Booth-Jones, & Fields, 2005). Similarly, other research has documented positive relationships between approach or problem-focused coping and PTG (Frazier, Tashiro, Berman, Steger, & Long, 2004; Widows et al., 2005).

Despite the agreement of these studies, some exceptions have been found. Millen and Cook (2003) reported that problem-solving coping was associated with only one specific type of PTG, namely increased community closeness, while acceptance coping was not associated with *any* kind of PTG. It is possible that coping styles may have different outcomes if the trauma left individuals with a chronic reminder, such as a permanent disability. It is also noteworthy that the sample used was also about 80% male. It is possible that the predominance of men contributed to the study's unusual findings. This finding, however, appears to be somewhat anomalous in the midst of the relatively consistent literature linking approach or problem-focused styles of coping to PTG.

Substance Abuse and Coping

Having examined the coping styles associated with PTG, it will be useful to review the coping styles associated with substance abuse. Understanding the kinds of coping related to both PTG and substance abuse may help elucidate the mechanisms underlying their relationship. A cluster of theories generally maintain that certain people use alcohol as an avoidant coping mechanism for dealing with life stressors, depression, or a variety of other negative emotions or events. Included among these theories are the self-medication model (Colder, 2001), the tension-reduction hypothesis (Cooper, Russell, Skinner, Frone, & Mudar, 1992a) and social learning formulations (Cooper, Russell, & George, 1988).

Based on these theories, a number of studies have looked at coping styles and substance use. One study discovered more avoidance coping in problem drinkers than among non-problem drinkers in a sample of older adults (Moos, Brennan, Fondacaro, & Moos, 1990). These authors also suggested that, over time, more severe stressors may lead to a greater use of avoidant coping and less approach coping. At the same time, they found that older problem drinkers with more negative life events used both more avoidant coping *and* more approach coping. Another study showed that reliance on avoidant coping (e.g. "Kept your feelings to yourself" or "Took it out on other people") was predictive of greater alcohol use, drinking problems, and use of alcohol to cope (Cooper et al., 1992a). Holahan, Holahan, Moos, Cronkite, and Randall (2004) found that relying on alcohol to cope was associated with more negative life events and less family support in depressed patients. Together, these studies suggest that for individuals with certain vulnerabilities, drinking tends to be used as a coping mechanism. Some vulnerabilities

that have been empirically supported include a severely stressful event, depression and reliance on avoidant coping styles in general.

Support for one of these theories, the self-medication hypothesis, has also been found in samples using drugs other than alcohol. Alcohol and illicit drug use was related to psychiatric symptom reduction in an adolescent sample with a history of substance abuse (McCarthy, Tomlinson, Anderson, Marlatt, & Brown, 2005). This may be evidence of successful self-medication by using substances. Another study of adolescents found that among those with Attention Deficit Hyperactivity Disorder (ADHD), pharmacotherapy for ADHD was associated with reduced cigarette smoking in comparison with an untreated ADHD control group. In other words, adolescents with untreated ADHD symptomatology were more likely to smoke cigarettes, possibly as self-medication for those symptoms (Whalen, Jamner, Henker, Gehricke, & King, 2003). Authors of the above studies cite the relationship between psychiatric symptoms and substance use as evidence for the self-medication hypothesis. Similarly, in an adult population, higher ADHD scores were associated with more use of cocaine for self-medication purposes (Horner, Scheibe, & Stine, 1996). These studies, among others, document the relationship between psychiatric symptoms and drug use, supporting the self-medication model and expanding it beyond problem drinking. In sum, while substance use has frequently been linked to avoidant coping styles or viewed as an avoidant coping style in its own right, PTG has been consistently associated with problem-focused or approach coping.

The findings on substance use and coping, however, must be taken in context. A number of limitations hamper the generalizability of these findings. First, only a handful

of the above studies sampled from populations that were specifically substance abusive or dependent (Horner et al., 1996; McCarthy et al., 2005; Moos et al., 1990). Cooper and associates (1992a) had a minimum drinking requirement of one drink in the past year for their participants, and Holahan et al. (2004) compared depressed patients with a community sample. Furthermore, participants in the study by Moos and colleagues (1990) were all between the ages of 55 to 65. Only Horner and colleagues (1996) specifically looked at a population that was both diagnosed with substance use disorders *and* not biased toward a particular age group.

In addition, none of the above studies sampled from a population that was homeless or even explicitly lower socioeconomic status (SES), despite the fact that substance use problems are much more prevalent in these subgroups (National Institute on Alcohol Abuse and Alcoholism, 1991). It seems, then, that there may be other vulnerabilities to consider for different populations. Homelessness in itself might well be a risk factor for using substances to cope. Furthermore, since these theories hold that stress in general, and negative life events in particular (Holahan et al., 2004; Moos et al., 1990), are associated with more avoidant coping or more use of substances to cope, individuals who live with the severe stressors and dangers of being homeless may be especially vulnerable to these avoidant coping styles. Less reliance on adaptive coping strategies, which have been associated with growth after trauma, might lead a homeless individual to be less likely to experience PTG.

The combination of increased risk of PTSD because of higher trauma exposure (e.g. Rayburn et al., 2005) and elevated rates of substance abuse in homeless women (e.g. Wenzel, Koegel, & Gelberg, 1996) could put them at a further disadvantage for

experiencing PTG. For this reason, it is useful to consider the association between avoidant coping and both PTSD and substance abuse. Two studies have examined this association, and conflicting findings have emerged. Ouimette and colleagues found in a prospective study of veterans that those individuals with both PTSD and substance abuse showed more avoidant coping than veterans with substance abuse only (Ouimette et al., 1999). These findings lend support to the idea that individuals with comorbid PTSD and substance abuse tend to use more avoidant coping and may, therefore, be less apt to experience PTG.

In contrast, a study that examined the relationship between PTSD, substance use and coping styles in a homeless population found an unexpected relationship between avoidant coping and PTSD. Specifically, more avoidant coping was associated with *less* PTSD symptomatology (Milford, 2003). Furthermore, avoidant coping was not associated with substance use in this sample of homeless women. To explain these unexpected findings, Milford speculated that avoidant coping could actually be adaptive and effective for homeless women. Specifically, avoiding the trauma may actually lead to less PTSD symptomatology in this population. These women may be successfully keeping the trauma out of mind, thereby preventing trauma-related distress. She also suggested that avoidant coping may be built into the lives of homeless women from an early age due to trauma and other adversities, thereby rendering them less cognizant of their avoidance behaviors and, thus, less likely to report them.

A final caveat offered by Milford (2003) is that her measure of coping, the Coping Inventory for Stressful Situations: Situation Specific Coping (CISS:SSC), had several avoidance-coping items that may not have been appropriate for homeless women.

For example, several items on the avoidance scale were about purchasing something in response to an upsetting situation, and one item was about using a telephone to call a friend. Since the CISS:SSC has only 21 items and one avoidance subscale, losing even a few items because they are not applicable to most homeless women could have a large effect on scores. Milford reports that the scores for Distraction, one of two avoidance subscales, were a bit low. Indeed, mean scores on this subscale were lower than means found in a college and an adult community sample (Endler & Parker, 1994). The low levels of avoidant coping reported in Milford's study make the unusual relationship between PTSD symptomatology and avoidant coping difficult to interpret. Since Milford's results are in contrast to the study by Ouimette et al. (1999) and since her measure of avoidance coping may be less than ideal for the population, more research is needed to clarify these findings.

Considering the prevalence of trauma among homeless women, they are vastly underrepresented in the PTG literature. Importantly, there is reason to think that homeless women may experience PTG even amidst the chronic stress of being homeless. Siegel and Schrimshaw (2000) found that 83% of their sample of women living with the ongoing stress of having HIV/AIDS reported positive growth from their illness. There is also reason to believe that PTG in homeless women, as in other samples, may be associated with less PTSD symptomatology (Davis et al., 1998; Frazier et al., 2001; McMillen et al., 1997; Tedeschi et al., 1998). Because of the high rates of substance abuse and trauma in homeless populations in general, it is important to know if substance abuse may be negatively associated with PTG. The findings of Milam and colleagues support the idea that this relationship is inverse, but offer little by way of an explanation

(Milam et al., 2004). It is possible that this negative association could also be understood in terms of coping styles, since substance abuse, as well as trauma, has been positively correlated with avoidant coping styles (Cooper et al., 1992a; Moos et al., 1990; Ouimette et al., 1999), while PTG has been positively correlated with problem-focused coping styles (Linley & Joseph, 2004; McMillen & Cook, 2003).

Purpose

The purpose of the current study was to examine the relationship between PTG and substance abuse in homeless women, to determine the coping styles associated with each, and to report on the association between PTG and psychological functioning, especially PTSD symptomatology. It was hoped that the present study would bring a new perspective on the relationship between PTG and well-being by using a sample with multiple traumatic experiences. Previous studies in this area used samples that had a single adverse event in common, making it difficult to know if the observed relationships would apply to individuals who suffered different kinds of adversity (Cordova et al., 2001; McMillen & Cook, 2003; McMillen et al., 1995). This study also used an established measure of PTG to examine the relationship between PTG and PTSD, rather than simply relying on coded responses to open-ended questions about PTG as in previous studies (Davis et al., 1998; Frazier et al., 2001; McMillen et al., 1997). It was believed that the use of a psychometrically-sound instrument would help clarify this relationship and make it possible to compare these results to similar studies in the future.

Only one previous study looked at the association between PTG and current substance use, and the sample was limited to adolescents (Milam et al., 2004). This study, then, is unique in that it looked at the relationship in an adult population and examined

illicit drugs in addition to alcohol. By examining the coping mechanisms associated with both PTG and substance abuse, the present study hoped to offer a better understanding of their relationship and yield more information about avoidant coping and substance use.

Because of the cited research, which suggests that substance use can be considered a kind of avoidant coping mechanism, this study included a measure of drinking to cope. As Milford (2003) suggests, women in this population may not recognize their own avoidance behaviors and so may be less likely to report those PTSD symptoms explicitly regarding avoidance. It seemed prudent, therefore, to ask about trauma symptomatology more broadly and not PTSD symptoms alone. For this reason, the Trauma Symptom Inventory was included to assess trauma-related symptoms. The Posttraumatic Diagnostic Scale was also included both to diagnose PTSD and to assess the more narrow domain of PTSD symptom severity. In addition, the present study used a more extensive and possibly more appropriate measure of coping strategies than the situation-specific version of the CISS, albeit the CISS in its entirety was also included in order to compare results from the two measures.

The main coping instrument, the Coping Responses Inventory (CRI), breaks down avoidance coping into subscales. Consequently, avoidance behavior can be assessed from a variety of perspectives (e.g., avoidance through seeking alternative rewards and avoidance through taking a resigned attitude toward a problem). It was hoped that the CRI would, therefore, provide more insight into the precise role avoidance coping plays for homeless women. In addition, none of the items appeared inappropriate or inapplicable to homeless women. A further contribution of the present study was using a diagnostic interview to diagnose substance dependence, rather than relying on a screening

instrument alone. Substance use was also assessed more comprehensively by using an abbreviated version of the Form 90 (Miller & Del Boca, 1994).

In brief, the present study examined the relationships between PTG, substance abuse and coping by comparing two groups of homeless women with a history of trauma: one with at least one current substance use disorder (Trauma-SUD group) and one with no current substance use disorder (Trauma-only group). The following predictions were made: (1) The Trauma-SUD group would have less PTG, as measured by the Posttraumatic Growth Inventory, than the Trauma-only group; (2) The Trauma-only group would show more use of approach (i.e. problem-focused) coping than would the Trauma-SUD group, while the Trauma-SUD group would show greater reliance on avoidant coping and using substances to cope than the Trauma-only group; (3) PTG would not be associated with depression, anxiety, or global distress, as measured by the Brief Symptom Inventory. Documenting the absence of such an association was considered important because it would indicate that growth could still happen in the midst of distress (Tedeschi et al., 1998); and (4) Since PTG has been associated with less trauma symptomatology, the Trauma-only group would not only have more PTG but also less trauma symptomatology, as shown by the Trauma Symptom Inventory, than would the Trauma-SUD group.

Method

Participants

Participants were 50 homeless women with trauma histories, age 18 or older, recruited from local shelters and meal-sites by posting flyers announcing a study about how homeless women deal with stress (Milford, 2003). Case managers at the

various agencies were also informed about the study and encouraged to refer appropriate potential participants. Of the 112 women who expressed interest in the study, 31 (27.7%) were excluded, 25 (22.3%) did not show up for their interview, and 6 (5.4%) withdrew. Exclusions were made for the following reasons: 15 women manifested untreated psychotic symptoms (48.4%); 11 women did not qualify as homeless (35.5%); 4 did not speak sufficient English (12.9%); and one woman chose not to participate when she discovered that past traumas would be assessed (3.2%).

The experience of a trauma was assessed using the first part of the Posttraumatic Diagnostic Scale (PDS; Foa, Cashman, Jaycox & Perry, 1997), which assesses both the objective and subjective criteria for a trauma, according to the DSM-IV. Psychosis was assessed by asking participants if they had ever felt out of touch with reality in the past month (e.g. seen things that were not really there or heard things other people could not hear, especially voices). Potential participants who responded affirmatively were excluded from the study if their experiences were clearly not mediated by the effects of a substance or a general medical condition, or if their psychotic symptoms were unmedicated. If there was any doubt, the psychosis screening section of the SCID (First, Spitzer, Gibbon, & Williams, 1996) was administered.

Homelessness was defined in the present study as living on the streets, in a shelter or motel, being provided housing as part of a program (even if some token amount of rent was eventually charged), or "couch surfing," namely, staying with relatives, friends or strangers for short and unpredictable periods of time. Potential participants who were staying with family or friends but who were welcome to stay as long as they liked were not considered homeless. To assess whether potential participants were under the

influence of drugs or alcohol at the time of interview, each was asked when they had last used alcohol or drugs. Any participants reporting drug use on the day of the interview were asked to reschedule for a later date. Similarly, any participants reporting alcohol use on the day of the interview and breathalyzing over .05 percent blood alcohol content were asked to reschedule. Participants were judged to have sufficient English skills if they reported having completed the sixth grade on the demographics questionnaire.

On the basis of the presence or absence of a substance use disorder (i.e., substance abuse or dependence) participants were divided into two groups: Trauma-substance use disorder (Trauma-SUD) and Trauma-only. Using a series of univariate ANOVAs, comparisons were made across demographic variables by group. No differences were found between groups in terms of age, education, time homeless currently and in lifetime, employment status, number of days worked in the past month, and total traumas. Group differences on the categorical variables of marital status and ethnicity were tested using chi square analyses. No group differences were found for marital status. Because of small cell sizes within certain ethnicities, the smallest groups were collapsed into a single 'Other' category, so that only Native American, Hispanic, White, and Other categories were included. Significant differences were, however, found between groups on ethnicity, χ^2 (3, N=50) = 15.26, $p < .01$. Consistent with this finding, 80% of the Trauma-SUD group were ethnic minorities, while only 20% were White. In contrast, 56% of the Trauma-Only group were minorities, while 44% were White.

To test ethnic differences on drug and alcohol dependence separately, only the ethnicities with the largest N were considered. Using chi square analyses with continuity correction, it was determined that Native Americans were significantly more likely than

Whites and Hispanics to be diagnosed with alcohol dependence, χ^2 (1, N=50) = 17.12, p < .001. Hispanics were more likely than Whites and Native Americans to receive a diagnosis of drug dependence, χ^2 (1, N=50) = 6.59, p < .05. Details on demographic variables by group are given in Table 1.

General Psychological Functioning and Demographics

Demographics Questionnaire This short survey established the participant's age, height, weight, race, marital status, educational level, employment status and length of time homeless both currently ("this time around") and cumulatively in her lifetime.

Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983). This is a shorter version of the Symptom Checklist 90R (SCL-90R; Derogatis, 1983). Its 53 items compose nine subscales (e.g. hostility, psychoticism) and three global indices of psychological distress, including a total score. Participants are instructed to rate how much they were distressed by the symptom described in each item in the past week (e.g. "Feeling easily annoyed or irritated"). Items are rated on a Likert-type scale from 0 (Not at all) to 4 (Extremely). The construct validity, test-retest reliability, and internal consistency of the BSI have proved acceptable (Derogatis, 1993). The total score was used here as an overall index of psychological distress.

Trauma Inventories

Posttraumatic Diagnostic Scale (PDS; Foa et al., 1997). This is a paper-and-pencil instrument used to diagnose PTSD and to yield a symptom severity score. It is composed of a 12-item trauma checklist, and includes such traumas as: "Natural disaster (for example, tornado, hurricane, flood, or major earthquake)" and "Sexual contact when you

were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts)" Other events included are serious accident, illness or injury, sexual assault by a family member or stranger, non-sexual assault by a family member or stranger, imprisonment, combat, torture and an 'Other' category. This checklist is followed by a series of questions based on the DSM-IV criteria for PTSD. Respondents are instructed to answer with regard to the event that "bothers [them] most." Questions about personal reaction to the trauma, such as "Did you feel helpless?" are answered "yes" or "no." Questions about post-trauma symptomatology, for example, "Having bad dreams or nightmares about the traumatic event," are answered on a Likert-type scale from 0 ("Not at all or only one time") to 3 ("5 or more times a week/almost always"). The trauma symptomatology questions are then summed to yield a severity index. Possible scores range from 0 to 51. Time elapsed since the trauma, time of symptom onset, and duration of symptoms are also assessed. Finally, participants respond to a series of true-or-false questions about the impact of PTSD symptoms on various areas of their functioning.

The PDS has shown high internal consistency. In a sample of 110 participants, its test-retest reliability obtained a kappa of .74 and an 87% diagnostic agreement rate between the two time points. It has demonstrated good convergent validity with other trauma measures, including diagnoses based on the SCID, and good sensitivity and specificity (Foa et al., 1997). The PDS was chosen to screen for traumas and to diagnose PTSD because of its paper-and-pencil format. Since this was a one-time interview, efforts were made to make the study as non-invasive as possible.

Given that homeless women tend to have high levels of trauma exposure, the trauma checklist was expanded to include an additional seven kinds of events, which were taken from the Clinician Administered PTSD Scale (CAPS; Blake, Weathers, Nagy, Kaloupek, Gusman, Charney et al., 1995). These were "Other unwanted or uncomfortable sexual experience," "Life-threatening illness or injury," "Exposure to toxic substance (for example, dangerous chemicals, radiation)," "Severe human suffering," "Sudden, violent death (for example, homicide, suicide)," "Sudden, unexpected death of someone close to you," and "Serious injury, harm, or death you caused to someone else." For the broader of these categories, such as "Severe human suffering" and "Other," participants were asked orally to give more detail about the event. This box was checked only if the event did not fit into one of the other categories. Although participants were allowed to report any event they felt qualified as a trauma, events that did not meet the DSM-IV's first criterion for a trauma (i.e., experiencing, witnessing or being confronted with actual or threatened death, serious injury or threat to physical integrity) were subsequently not counted as traumas. This includes responses, such as, "Being homeless" and "Having my car police impounded." Altogether, three such responses were excluded. Some responses that were included in the "Other" category include, "Being forced to have an abortion by my mother" and "Stalking." To assess reliability of the "Other" category, these responses were categorized according to whether they fulfilled the DSM-IV Criterion A for a trauma by two independent raters. Kappa obtained was .5 (75% agreement).

Trauma Symptom Inventory (TSI; Briere, 1996). This is a 100 item instrument with 10 clinical scales subsumed under three broad categories of distress (trauma, self, and dysphoria). Participants are asked to rate the frequency with which they have

experienced each item in the past six months on a scale from 0 (never) to 3 (often). The ten scales have shown internal consistency (mean alphas ranging from .84 to .86 gathered from clinical, university and military samples) and reasonable convergent, predictive and incremental validity (Briere, 1996). Although both the PDS and the TSI assess trauma symptomatology, the PDS gives a total trauma severity score, whereas the TSI gives more detailed information about specific categories of trauma symptoms.

Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). The PTGI is one of the most widely used instruments in the field of PTG research (Calhoun, Cann, Tedeschi, & McMillan, 2000; Milam et al., 2004; Polatinsky & Esprey, 2000). It is a 21-item measure with five subscales: Relating to Others (e.g., "A sense of closeness with others"), New Possibilities (e.g., "I developed new interests"), Personal Strength (e.g., "A feeling of self-reliance"), Spiritual Change (e.g., "I have a stronger religious faith"), and Appreciation of Life (e.g., "My priorities about what is important in life"). Total scores range from 0 to 105. The full scale and subscales of the PTGI have shown good reliability (.90 and .67-.85 respectively). Test-retest reliability (.71) has also proved acceptable. The PTGI was not significantly correlated with a measure of social desirability (Cohen et al., 1998). Results of the two administrations of the PTGI were averaged into one summary PTGI score for each participant. In other words, for participants who used the same trauma for both administrations, this was identical to their total score on the PTGI. For those who selected different traumas as the most bothersome and the most growth traumas, the composite score was an average of the total PTGI score across the two administrations. This resulting composite growth variable was used in all analyses involving PTG.

An additional, exploratory question was included at the end of the PTGI: "How comforting have you found these positive changes to be in the aftermath of your traumatic experience?" This item, as with all the others on this instrument, was answered on a Likert scale from 0 ("I did not experience this change as a result of my crisis") to 5 ("I experienced this change to a very great degree as a result of my crisis").

Substance Use Measures

The Structured Clinical Interview for the DSM-IV (SCID; First et al., 1996). The SCID is widely used in clinical research. Reports on the psychometric properties of earlier versions of the SCID have been good (Segal, Hersen, & Van Hasselt, 1994), but little information is available on the lastest version. For the present study, the substance use section was administered to diagnose alcohol or drug use disorders. To assess interrater reliability, 20% of the taped diagnostic interviews were randomly selected and assessed by an independent rater. Kappa obtained was .80 (90% agreement). Disputed cases were discussed with the rater for consensus.

Timeline FollowBack (TLFB; Sobell & Sobell, 1996). The TLFB employs a calendar to assess quantity and frequency of alcohol and drug use retrospectively. Despite the general objections to retrospective self-report, reliability ratings for the TLFB are typically quite high, $r > .85$. It has also demonstrated convergent validity through significant, albeit modest, correlations with biochemical tests that assess alcohol-related acute hepatic function (Sobell & Sobell, 1996). The time period assessed is flexible, ranging from 30 days up to 12 months. To aid in recalling details of substance use during the time period, respondents are encouraged to recall any special occasions or notable events that occurred. When possible, steady patterns of substance use are established and

recorded. Respondents are told to give their best estimate when in doubt. The TLFB can be self-administered or conducted as an interview. In their manual, Sobell and Sobell suggest that often individuals with more severe substance problems may have some difficulty completing the TLFB unaided. For this reason, the TLFB was conducted as an interview in the present study to ensure accurate comprehension and completion. The 30 days prior to participation were assessed for quantity and frequency of alcohol use, as well as frequency of drug use.

In terms of scoring, a wide variety of substance use indices can be calculated from the TLFB. These include the maximum number of drinks in one day, maximum number of continuous abstinent days, weekly consumption, percentage of drinking or using days, total incidence of substance use in a given time period, and even cost of drinking in terms of both money and calories (Sobell & Sobell, 1996). In the present study, a summary substance use index was created in order to better capture the severity of substance use. Because it was expected that a portion of participants would report using more than one drug on a given day, simply counting days of drug and alcohol use would not capture the full extent of the substance use reported. Under such a system, a day of marijuana use would be equivalent to a day on which marijuana, crack and methamphetamine were all used. To account for the possibility of polydrug use on any given day, a coding system was employed in which a participant received one point for each incidence of drug or alcohol use on a given day. To illustrate, suppose a participant reported a total of two days of substance use in the past 30: one on which both crack and marijuana were used and one on which marijuana alone was used. They would receive one point for each day

of marijuana use and one point for the day on which crack was used, leading to a total of three points in the past 30 days.

This way of indexing the severity of substance use is similar to methods used in other related substance abuse research. For example, the one previous study to examine directly the relationship between PTG and substance use also summed days of use on a 30-day calendar followback, specifically for alcohol, marijuana and nicotine. They then used the mean of this sum for each participant as their continuous substance use variable (Milam et al., 2004). A similar procedure was used by Stein and Gelberg (1995). Also using a homeless sample, these researchers summed days of drug use over the past month within specific drug categories, including marijuana/hashish, dampeners/downers, and enhancers/uppers. Finally, the Personal Experience Inventory (Winters & Henly, 1989), a self-report adolescent substance use questionnaire, also uses the sum of reported frequencies within different drug classes: alcohol, marijuana, and an other illicit drug category that includes LSD, other psychodelics, cocaine, amphetamines, barbiturates, tranquilizers, heroin/other narcotics, and inhalants. Summing frequencies of substance use across an identified time period, then, is precedented in the substance abuse literature. Results of this substance severity coding system, termed here 'substance points,' were used as a continuous measure of substance use in the analyses that follow.

Drinking Motives Questionnaire (DMQ; Cooper, Russell, Skinner, & Windle, 1992b). The DMQ is a 15-item measure with three subscales: Social, Coping and Enhancement Motives. The main interest for the present study was the Coping Motives subscale, since it has been used as a measure of drinking to cope (Colder, 2001; Cooper et al., 1992a). Each item (e.g. "How often do you drink to relax?") has response options

on a scale from 1 (Almost never/never) to 4 (Almost always). The five items in each subscale are averaged. Thus, scores on each scale range from 1 to 4. The DMQ does not yield a total score. Confirmatory factor analysis showed an underlying 3-factor structure (i.e., coping, social and enhancement motivations for drinking), supporting the measure's construct validity. The Coping Motives subscale has been shown to be predictive of symptoms of abusive drinking (Cooper et al., 1992a).

Coping Instruments

Coping Responses Inventory–Adult Form (CRI-A; Moos, 1988). This is a 48-item measure, which assesses eight types of approach and avoidance coping responses. The Approach subscales include Positive Reappraisal (e.g., "Try to see the good side of the situation"), Problem Solving (e.g., "Make a plan of action and follow it"), Logical Analysis (e.g., "Think of different ways to deal with the problem"), and Seeking Guidance and Support (e.g., "Talk with a friend about the problem). The avoidant coping scales are Cognitive Avoidance (e.g., "Try to forget the whole thing"), Acceptance or Resignation (e.g., "Lose hope that things will ever be the same"), Seeking Alternative Rewards (e.g., "Get involved in new activities"), and Emotional Discharge (e.g., "Cry to let your feelings out"). There are two separate response categories. Part 1 asks for answers varying from "Definitely no" to "Definitely yes" in response to general questions about the stressor, such as "When this problem occurred, did you think of it as a challenge?" Part 2 allows for responses from "Not at all" (0) to "Fairly often" (3) for the questions that make up the subcales (e.g., "Did you think of different ways to deal with the problem?") Scoring involves summing the responses for each subscale. The CRI is widely used (Moos et al., 1990; Ouimette et al., 1999), and the eight subscales show

internal consistencies ranging from .61 to .74, which are modestly intercorrelated (average r = .29) (Moos et al., 1990). Participants are instructed to answer the questions about the most important problem or stressful situation they have experienced in the past year. The CRI was chosen to measure coping because each item seemed appropriate for a homeless population.

Due to the number of coping variables in this analysis yielded by the most bothersome and most growth administrations of the CRI, an exploratory factor analysis was conducted to determine the underlying structure of the set. Using maximum likelihood extraction and promax rotation, the 16 coping variables (the CRI's 8 scales across the two administrations) loaded onto one of the two theoretical variables, Approach or Avoidance Coping, all factor loadings > .500. The one unexpected finding was that in this sample, the Avoidance scale called Seeking Alternative Rewards (SAR) loaded with the Approach scales. This scale includes items such as, "Did you try to make new friends?" and "Did you read more often as a source of enjoyment?" For this reason, SAR was included with the Approach scales in subsequent analyses. As in other research, the CRI scales were then collaped into two summary scores for each participant, yielding a total Approach and total Avoidance score for each participant (e.g. Sharkansky, King, King, Wolfe, Erickson, & Stokes, 2000; Widows et al., 2005). As for the PTGI, these scores for the two administrations of the CRI were then averaged to yield a single composite score for each participant. These composite coping variables were used in the analyses that follow.

Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999). The CISS has 48 items that measure coping with three subscales: task-, emotion-, and

avoidance-oriented coping. Responses are on a 1-5 point Likert scale, in which 1 indicates that a person does "not at all" engage in a particular behavior and 5 indicates that the person engages in the behavior "very much." Items on each subscale are summed. The subscale scores range from 16 to 80. The CISS has shown good reliability and validity. In college and adult samples, the internal alpha reliabilities for the subscales varied from .76 to .92 (Endler & Parker, 1994). Additionally, the three-dimensional factor structure of the CISS was supported in a sample of Scottish doctors and farmers (Cosway, Endler, Sadler, & Deary, 2000). The CISS was included here for comparison with the CRI, since both instruments have been used in previous studies in the area of PTSD and coping. Since its items do not ask the participant to focus on their coping responses to a particular trauma, it could not be given for the most bothersome and the most growth traumas. Instead, it was given only once.

Procedure

After the screening for psychosis, current drug influence, and English skills, potential participants were given an informed consent form to sign. Then the selected sections from the PDS were administered to screen for trauma history. Once eligibility was established, the substance-use section of the SCID and the TLFB were administered by a trained interviewer, namely the author, and the participant was given seven questionnaires to complete in a random order: Demographics Questionnaire, BSI, TSI, CRI, CISS, DMQ, and PTGI.

If a participant had multiple traumas, she was asked to indicate the one "that bothers you most." This event was then used as the reference trauma for the remainder of the PDS, as well as for the PTGI and the CRI. Since it is possible for a person to have

experienced PTG from other traumas, which might then be less likely to 'bother' her most, participants were also asked to fill out the PTGI and the CRI for a second trauma. This event was selected in response to the following prompt: "Sometimes people find that something good has come out of even their most awful experiences. You have seen some examples of common positive things that some people experience after a trauma on this questionnaire [indicating the PTGI]. Has anything positive like that come about from any of these other events you indicated?" If more than one trauma was indicated as having some positive sequelae, then the participant was asked to select the one trauma that led to the most or the most *significant* positive consequences. If no trauma was indicated, the participant was asked to pick the trauma that was "bothering her the least" at the moment. The trauma selected from these questions was then used to fill out the PTGI and the CRI a second time.

The study took between 1.5 and 3.5 hours to finish. To compensate for their participation, participants were given either a gift certificate to Walmart for $20 (about two-thirds of the sample) or a bus pass for the month (roughly one-third). After completing the questionnaires, each participant was debriefed fully. This involved explaining that the study was looking at how much homeless women had grown after trauma, and that one of the main questions was whether or not substance use hindered this growth. Each participant was then given her compensation and directed to local resources for substance abuse services or other counseling, when appropriate. An additional meeting was scheduled with interested participants (approximately 10% of the sample) to discuss and contact resources.

Results

Descriptive Statistics

The mean age of the sample was 41.1 years (*SD* = 8.9, range = 21 to 55 years). Participants had an average of 12 years of education (*SD* = 2.3, range = 8 to 21 years). Average length of time homeless currently was 1.1 years (*SD* = 1.5, range = .06 to 10 years) while mean lifetime homelessness was 3.8 years (*SD* = 5.3, range = .08 to 24 years). In the month prior to the interview, participants reported working an average of 3.6 days (*SD* = 7.9, range = 0 to 30), and 16% of the sample was employed. The ethnic make-up was 32% White, non-Hispanic (n = 16), 26% Native American (n = 13), 24% Hispanic (n = 12), 10% 'Other' (n = 5), and 8% African American (n = 4).

A diagnosis of PTSD was given to 54% of the sample. Of the Trauma-SUD group, 60% received a PTSD diagnosis compared to 48% of the Trauma-only group. This difference was not statistically significant in a chi square analysis. In terms of substance dependence, 34% were alcohol dependent, 20% were drug dependent. Of the individuals with a substance use disorder (SUD), 4% were both alcohol and drug dependent, so that overall 50% of the sample had a SUD.

The means (reported in Table 2) for substance points, the number of drinking days, total SECs consumed and days of illicit drug use were tested as dependent variables in a MANOVA with substance group status as the independent variable. The overall test was significant, $F(4, 45) = 3.32$, $p < .05$. In a subsequent series of univariate ANOVAs, differences between groups were significant for three of the individual substance use variables: substance points ($F(1, 48) = 9.88$, $p < .01$), number of drinking days in the past month ($F(1, 48) = 6.52$, $p < .05$), total SECs consumed in the past month ($F(1, 48)$

= 8.76, $p < .01$). The fourth variable, number of days illicit drugs were used in the past month, approached significance, $F(1, 48) = 3.31$, $p = .075$. Particulars on drug dependence are given in Table 3. Table 4 shows a breakdown of days of drug use in the 30 days prior to the interview.

Total time homeless in a participant's lifetime was significantly positively correlated with time homeless currently and negatively correlated with years of education, $r = .431$ and -.296 respectively, $ps < .05$. On average, participants reported 7.48 traumas (SD = 3.65, range = 1 to 15) on the modified PDS checklist. Some events in the 'Other' category were not included, such as 'Being kicked out of the house' or 'Losing my job.' Altogether, three such responses were dropped. Total time homeless also approached significance in its correlation with total number of traumas reported, r = .259, p = .069. Table 5 presents details about levels of exposure to various traumas in this sample.

Posttraumatic Growth from the Most Bothersome and Most Growth Traumas

The PTGI was given once for the 'most bothersome' trauma (MBT) and once for the trauma from which participants reported having grown the most, the 'most growth' trauma (MGT). Interestingly, half the sample (50%) used the same trauma for both. In other words, the trauma that was currently most bothersome to them was also the one from which they felt they had grown the most. Only one participant used the same trauma by default because she reported only one traumatic event. Three participants (6%) chose to use the trauma that 'bothered them the least' in lieu of a 'most-growth' trauma because they did not feel as if they had grown much from any traumatic event. Indeed, two of these individuals had total growth scores that were well below the mean of the sample for

both traumas. The third participant was near the mean in both cases. She also reported that growth from her least bothersome trauma was 'greatly comforting.' Results for the two administrations of the PTGI are given in Table 6.

Because the sample was strikingly divided between those who used the same trauma and those who used different events for the two administrations, a MANOVA was conducted with growth scores from the MBT and MGT administrations of the PTGI as the dependent variables. Grouping by whether or not the same trauma was used for both served as the independent variable. The overall MANOVA was significant, $F(2, 47) = 8.09$, $p < .01$. No group differences were found for growth from the MGT; however, those who used different traumas for the MBT and MGT administrations had significantly lower scores from the MBT than those who used the same trauma for both, $F(1, 48) = 7.38$, $p < .01$. To determine if this was related to difference in PTSD diagnosis, an ANOVA was conducted. No differences were found on PTSD status for those who used the same or different traumas for the two administrations.

Substance Use and Growth

Contrary to hypothesis 1 that the Trauma-SUD group would show less PTG than the Trauma-Only group, a one-way ANOVA revealed no differences between the Trauma-SUD group and the Trauma-only group on the composite growth score from the two administrations of the PTGI. Growth was next looked at in relation to a continuous substance use variable, substance points, created from the 30-day TLFB (Milam et al., 2004). The bivariate correlation between substance points and composite growth scores was significant, $r = -.298$, $p = .035$. As predicted, more substance use was associated with less posttraumatic growth.

Substance Use and Coping

To test hypothesis 2 that more avoidance coping would be used by the Trauma-SUD group and more approach coping by the Trauma-only group, two univariate ANOVAs were conducted using substance dependence status as the independent variable and composite Approach and Avoidance scales as dependent variables. No significant differences between groups were found for either coping variable. As in the analysis above, number of substance points was then used as a continuous variable, and a linear regression analysis was conducted. The Approach and Avoidance composites were entered as predictors of substance points. The overall model was not significant, $F(2, 47) = 2.315$, $p = .110$. The Avoidance composite, however, was a significant predictor of substance points, $F(1,47) = 4.418$, $r_{y(2.1)} = .325$, $p = .041$. Essentially, the semi-partial correlation between Avoidance and growth was significant. Interestingly, the simple bivariate correlation between the Avoidance composite and substance points was not, $r = .236$, $p > .05$. The fact that the semi-partial correlation between Avoidance and substance points was slightly larger in the regression model with the Approach composite suggests that Approach coping was acting as a suppressor variable, removing some of the variability in Avoidant coping that was unrelated to substance use.

The final piece of hypothesis 2 was that the Trauma-SUD group would show more use of substances to cope, as assessed with the DMQ. This was tested using a multivariate analysis of variance (MANOVA), in which substance group was the independent and DMQ scales the dependent variables. Because items on the DMQ are phrased, "How often do you drink because...," the number of days participants reported drinking in the past month was also entered as a covariate to control for the possible

confound of overall drinking level. The overall MANOVA was significant, $F(3, 45) = 5.18$, $p < .01$. All three DMQ scales: Coping Motives, Social Motives, and Enhancement Motives, were significantly higher for the Trauma-SUD group than the Trauma-only group (Fs(1, 47) = 13.42, 9.50 and 15.49, respectively; ps < .01). The results were still significant when overall substance use, the substance points variable, was used as the covariate, and the significance only increased when drinking days and substance points were not entered as a covariates.

It seems, then, that the Trauma-SUD group relied more on using substances to cope, albeit they were also drinking more for enhancement and social motives, as well. Means and standard deviations for the DMQ are given by group in Table 7. Overall means in the present study tended to be higher than those reported in an undergraduate sample of problem drinkers (Birch et al., 2004), while means for the Trauma-SUD group were roughly comparable to those reported in a sample of college athletes (Martens, Cox, Beck, & Heppner, 2003).

Growth and Coping

No hypotheses were formulated exclusively about the relationship between PTG and coping. However, the idea in hypotheses (1) and (2) predicted that less substance use would be associated with more growth and more approach coping. These hypotheses encompass the idea that growth itself should be associated with the use of approach coping. Indeed, the correlation between the Approach composite and the composite growth score was significant, $r = .312$, $p = .027$.

Growth and Distress

Hypothesis 3 predicted that PTG and distress, as measured by the BSI, would be unrelated. As predicted, the simple bivariate correlation between BSI score (M = 61.92, SD = 41.39, range = 0 to 163) and the composite growth score was not significant, r = -.017, $p > .05$. Also related to the concept of distress is PTSD symptomatology, a particular kind of psychological distress. Not surprisingly, PTSD symptom severity from the PDS (M = 20.94, SD = 13.30, range = 0 to 46) was also unrelated to the composite growth score using a bivariate correlation, r = -.059, $p > .05$. PTSD symptom severity and BSI scores were positively correlated, r = .668, p < .001. In sum, overall distress and PTSD symptomatology were both unrelated to growth, but were positively correlated with each other.

Trauma Symptomatology and Substance Use

Finally, it was predicted (hypothesis 4) that greater trauma symptomatology would be found in the Trauma-SUD group than in the Trauma-only group, as measured by the TSI. Six participants scored out of acceptable ranges on the TSI's validity scales. In accordance with the TSI manual's recommendation, they were excluded from this analysis (Briere, 1996). A MANOVA was then conducted for the remaining 44 TSI profiles using substance dependence status as the fixed factor. The overall multivariate test conducted on the subscales was not significant, $F(13, 30) = 1.18$, $p > .05$. For exploratory reasons, the univariate analyses of the individual subscales were nonetheless considered. Significant differences were found between groups on the 5 of the 10 clinical subscales: Anxious Arousal, Anger/Irritability, Intrusive Experiences, Defensive

Avoidance and Dissociation, all *p*s < .05. Further details about the results of the TSI are given by group in Table 8.

An index of PTSD symptomatology was obtained from the PDS, which yields a single symptom-severity score. No differences were found on this variable between the Trauma-SUD and the Trauma-only group. This variable was further examined in relation to a continuous measure of substance use severity. The bivariate correlation between substance points and PTSD symptom severity scores was significant, $r = .303$, $p < .05$. This is consistent with Hypothesis 4. Higher levels of substance use were associated with greater PTSD symptomatology. In addition, PTSD diagnosis was also significantly correlated with substance points, $r = .324$, $p < .05$, although total number of traumas reported was not.

In sum, two separate measures of trauma symptomatology yielded somewhat disparate findings. The TSI assesses trauma symptoms broadly, including those outside the range of DSM-IV diagnostic criteria, with items such as "Wanting to set fire to public buildings," for example. Its items are also not tied to any traumatic event. This measure showed significant differences on certain subscales between those with and without a substance use disorder. The PDS, in contrast, yields an index of PTSD symptomatology that follows the DSM-IV criteria for the disorder and is, therefore, also related to a specific trauma. The single symptom severity rating from the PDS was not significantly different between substance groups in a univariate ANOVA. It did, however, reveal higher PTSD symptomatology for individuals with more substance use in the month prior to the interview. This way of indexing substance use is different from dividing along substance dependence status. Not only is it a continuous variable, but it also takes into

account the frequency and severity of use that may or may not be problematic. Substance dependence status, in contrast, distinguishes those individuals whose substance use is or is not causing clinically significant impairment in functioning.

PTSD Symptomatology, Traumas, and Coping

Although no specific predictions were made about PTSD and coping, two interesting findings emerged. Avoidance coping, as measured by the Avoidance composite, was positively correlated with PTSD symptom severity, as measured by the PDS, $r = .497$, $p < .001$. Furthermore, the total number of traumas reported was correlated positively with both the Approach and Avoidance composites. The Pearson correlation coefficients were .310, $p < .05$, and .364, $p < .01$, respectively. So, the greater the PTSD symptomatology a participant was experiencing, the more avoidance coping she reported. The more trauma exposure a participant had, the more coping of both kinds was being used.

Coping: CRI and CISS

Scores from the Avoidance and Approach composites were significantly and positively correlated with one another, $r = .436$, $p = .002$. This was an unexpected finding, which contradicts the assumption in Hypothesis 2 that those using more avoidant coping would report using less approach coping. As described above, these results are based on the CRI. Results for the individual scales of the CRI across both administrations are given in Table 9. The CISS was included in this study for comparison with results from the CRI. Table 10 reports results of the CISS scales according to group.

Examining the bivariate correlations between results of the CRI and the CISS, several interesting findings emerged. First, the CRI Avoidance composite did not

significantly correlate with the CISS Avoidance scale (or the Task scale) but instead with the CISS Emotion scale, $p < .001$. The CRI Approach composite correlated significantly with the CISS Task scale and also the CISS Avoidance scale, $p = .001$ and .005 respectively. Finally, the CISS Task and Avoidance scales were themselves positively correlated, $p < .001$.

On both the CRI and the CISS, then, Approach/Task and Avoidance coping were positively correlated. The task and approach coping scales from the two instruments were significantly and positively correlated with one another, as would be expected. In contrast, the two avoidance scales from the CRI and CISS did not significantly correlate with one another. Rather, avoidance from the CRI significantly and positively correlated with emotion-focused coping from the CISS. Further details about the correlations between the CRI and the CISS are given in Table 11.

To better understand the correlation between the CRI Avoidance composite and the CISS Emotion scale, all four of the CRI's original avoidance subscales, including Seeking Alternative Rewards, were examined in relation to emotion-focused coping from the CISS using bivariate correlations. Emotional Discharge and Cognitive Avoidance from the CRI both correlated with the CISS Emotion scale, $ps < .01$, but Acceptance/Resignation and Seeking Alternative Rewards did not. These correlations are given in Table 12.

Growth and Taking Comfort

For both the MBT and the MGT administrations of the PTGI, participants were asked how comforting they had found the growth they reported to be. For both administrations, the average response was between 3 and 4, namely, very comforting to

greatly comforting. Neither comfort score correlated with indices of distress as measured by the BSI and the PTSD symptom severity from the PDS. Taking comfort in PTG, then, was unrelated to psychological distress. For the MGT, comfort scores positively correlated with total traumas reported, $r = .284$, $p = .046$. The more traumas a participant had experienced, the more comforting she found growth from the MGT to be. Both MBT and MGT comfort scores did, however, correlate with the PTGI composite score, $r = .628$ and .607, $ps < .001$. The more growth a participant indicated, the more comforting she found that growth to be.

Discussion

It was hypothesized that participants with a substance use disorder (SUD) would show more avoidant coping and less posttraumatic growth (PTG) than their non-substance abusing peers, who would use more approach coping and report more PTG. The overarching theory behind these predictions was that substance use, conceivably a type of avoidance itself, would be associated with avoidant coping more generally. Avoidant coping, in turn, was thought to be opposed to growth. So, it was predicted that growth would be found in women who relied on substances less and approach coping more after experiencing trauma. Overall, the results of this study show that participants with diagnosable substance dependence did not have less growth than those with no SUD. However, when substance use diagnoses were set aside and substance use was treated as a continuous variable that took into account the frequency of use, the amount of substance use in the past 30 days did correlate negatively with growth. Specifically, the more substances used in the past month, the less growth reported. This correlation was consistent both with hypothesis 1 and findings by Milan et al. (2004).

No differences were found between the group with and without a SUD on coping variables. Using a continuous measure of substance use, the semi-partial correlation between avoidant coping and substance use was significant. This finding is in agreement with predictions from hypothesis 2 that substance use would be associated with more avoidant coping. At the same time, as detected elsewhere in the PTG literature, approach coping was positively correlated with PTG (e.g. Frazier et al., 2004; Linley & Joseph, 2004). This was one of the strongest coping relationships that emerged in these data.

In sum, simply examining problematic substance use in terms of diagnosable SUDs did not reveal any relationships with coping or growth variables. Regardless of whether the substance use reported was causing significant impairment in functioning, the "density" of substance use (as defined by summing the total incidence of use for each substance in the month prior to the interview) was related to avoidant coping, less posttraumatic growth and greater PTSD symptomatology. Thus, how often an individual is using substances, including polysubstance use on a given day, may signal corresponding differences in coping styles and reactions to trauma for those using substances less or more than matched peers.

A final comment must be made on the relationship between substance use and avoidant coping. This has to do with the prediction in hypothesis 2 that the Trauma-SUD group would show more use of drinking to cope, as assessed with the DMQ. In fact, the Trauma-SUD group did show more drinking to cope, as well as more drinking for social and enhancement motives. Those with diagnosable substance dependence were more highly motivated by each of these three motives, even when the amount of drinking and even the overall amount of substance use in the past month were controlled for.

As in other populations, more approach coping was associated with more avoidant coping in this sample (Litt, Kadden, & Stephens, 2005; Sharkansky et al., 2000). One possible explanation, suggested by Sharkansky and colleagues (2000), is that women displayed a positive response bias. While this possibility cannot be entirely ruled out, it is more probable that homeless women in this sample were using more coping of both kinds, rather than more of one kind or another. This idea is supported by the finding in the present study that both approach and avoidance coping positively correlated with total number of traumas reported. The more trauma exposure a participant had, the more of both kinds of coping she was likely to use. Perhaps the high levels of trauma exposure and stress among homeless women (e.g., Rayburn et al., 2005) prompted participants to use all possible coping strategies.

This interpretation is consistent with other literature that cites greater use of both approach and avoidant coping in response to a higher incidence of stressors. For example, Holahan and Moos (1987) found greater use of both coping styles in those depressed patients who reported more stressful events than their depressed peers. In a subsequent study, Moos and associates (1990) found that older problem drinkers who had higher rates of negative events in the past year were more likely to use both approach and avoidant strategies to cope than peers who had fewer negative events. If greater stress levels lead to greater use of both adaptive and maladaptive coping strategies, then the positive correlation between approach and avoidant coping in the present study is just what would be expected in this sample.

Probably due to the strong correlation between approach and avoidant coping in the present study, a suppressor effect was observed in the relation between avoidance and

substance use. The unique variance associated with avoidant coping was significantly related to substance use, while the total variance, which includes that shared between the two types of coping, was not. This suggests that approach coping was helpful in suppressing variability in avoidance that was unrelated to substance use, thus more clearly revealing the relationship between substance use and avoidance per se. Essentially, using more of both approach and avoidant coping was not related to substance use; only using more avoidant coping alone was related. Although avoidance has frequently been correlated with substance use, there appear to be no studies in which approach coping has shown a suppressor effect on this correlation (e.g. Moos et al., 1990).

In contrast to findings reported by Milford (2003), avoidant coping in this sample was strongly positively correlated with PTSD symptom severity. This is consistent with other literature on PTSD and coping (e.g. Benotsch et al., 2000; Jacobsen et al., 2002). Indeed, avoidance is part of the DSM-IV criteria for the disorder (APA, 2000). It is possible that the use of different coping instruments accounts for the conflicting results of the present study and those by Milford (2003; see the discussion below comparing the CRI and the CISS). Also consistent with the PTSD literature, substance use itself was positively correlated with both PTSD symptomatology and diagnosis (e.g. Najavits et al., 1999; Ouimette, Moos, & Brown, 2002), although not with total traumas. The more PTSD symptoms a woman experienced, the more likely she was to use substances and to cope avoidantly. She was not, however, less likely to experience growth after trauma. The relationship between growth and psychological distress is discussed further below.

Individuals with diagnosable substance dependence showed higher levels of general trauma symptomatology on certain TSI subscales; however, they did not have greater PTSD symptomatology than those without substance dependence. Differences on individual TSI clinical subscales deserve brief consideration here. The Trauma-SUD group experienced significantly higher levels of anxiety and chronic hyperarousal symptoms (Anxious Arousal), greater irritability and angry mood (Anger/Irritability), more frequent intrusive symptoms, such as nightmares or flashbacks (Intrusive Experiences), increased avoidance of aversive internal experience (Defensive Avoidance), and more dissociation, such as emotional numbing or depersonalization (Dissociation; Briere, 1996). These symptoms correspond to the DSM-IV PTSD symptom clusters of hyperarousal, re-experiencing the trauma, avoidance/numbing (DSM-IV-TR; APA, 2000). The TSI subscales that were not different between substance groups were not directly related to PTSD criteria (e.g., Depression and Sexual Concerns).

It is difficult to interpret the fact that PTSD symptom severity from the PDS did not differ by substance groups while the TSI subscales corresponding to those same symptom clusters did show significant differences. Differences in phrasing or wording of the two instruments may be important. Another consideration is the fact that the PDS symptom severity rating is in reference to a particular trauma, while the TSI addresses these symptoms generally without a focal event. In sum, PTSD symptomatology, albeit from two separate indices, was related to substance use in the past month and to diagnosable substance dependence.

Further Exploration of Coping Instruments

Results of the CRI revealed some usual findings about its subscales, beginning with its Seeking Alternative Rewards (SAR) scale. First, the SAR loaded with the Approach coping scales. These same results were found by Kung, Castaneda and Lee (2004) in a study that examined differences in predictors of depression levels between native-born and immigrant Mexican-Americans. As in the present study, they found that although SAR was theoretically categorized as avoidant coping, it actually clustered with the Approach scales. Second, as part of the Approach composite, SAR correlated positively with total growth scores. This is in line with a study of Portugese diabetic patients that found higher scores on SAR, but not other CRI avoidance scales, linked to better quality of life. (Coelho, Amorim & Prata, 2003). In fact, a number of items from the SAR look remarkably like items from the PTGI. For example, the PTGI item, "I developed new interests," bears a striking resemblance to the SAR item, "Did you get involved in new activities?" Thus, there may be a conceptual problem in this area of research, given that similar behaviors have been characterized both as the supposedly maladaptive avoidant type of coping and as PTG (Moos, 1988; Tedeschi & Calhoun, 1996).

A final note on the CRI should be made in relation to its comparison with the CISS. Given the fact that avoidance and approach coping were correlated on the CRI, perhaps it is not surprising that the CRI Approach composite correlated positively with both the CISS Task and Avoidance scales. It is harder to explain why the CRI Avoidance composite did not correlate with the CISS Avoidance scale (or the Task scale, for that matter) but correlated instead with the Emotion scale. Briefly, this may explain why

Milford (2003) found avoidant coping to be negatively related to PTSD symptomatology, albeit she used a shorter form of the CISS than that used here.

The CRI's Avoidance subscales include Emotional Discharge, which may be conceptually similar to the CISS's Emotion scale, and indeed these two variables were significantly correlated. On the other hand, the CRI Cognitive Avoidance scale was also significantly correlated with emotion-focused coping on the CISS. Although this finding should be replicated, it suggests that greater standardization is needed in the terms 'avoidant' and 'emotion-focused' coping. While these two coping styles may be conceptually different, this data raises questions about the validity of that distinction. Other researchers have also pointed out that the field of coping research has had difficulty conceptualizing and measuring key concepts (Skinner, Edge, Altman, & Sherwood, 2003). In particular, Bittinger and Smith (2003) called attention to the fact that the concept of 'emotion-focused' coping should not be considered consistent across coping instruments.

Growth

To date, research about PTG does not appear to have been conducted with a homeless population. Thus, it is important to note the amount of growth reported. Although norms for the PTGI are not yet available, means for the current study (M = 66.5 and 72.6 for the most bothersome and most growth traumas, respectively) are highly comparable to total scores reported from very different samples in the literature. For example, Calhoun, Cann, Tedeschi, and McMillan (2000) found mean total growth scores of 76.5 in a college sample. Other studies using a range of samples, including emergency medical personnel, hospital patients, and parents who had lost a child, found mean total

PTGI scores ranging from 42.45 to 87.00 (Calhoun et al., 2000; Polatinsky & Esprey, 2000; Shakespeare-Finch, Smith, Gow, Embelton & Baird, 2003; Snape, 1997).

Because of the chronic nature of the stressors homeless women are subject to, it is particularly relevant to compare this sample to other populations under continuous stress in the literature, such as those with chronic illness. Widows and colleagues (2005) found mean PTG levels of 64.67 in a population of cancer patients who had undergone bone marrow transplant. The most apt comparison group in the growth literature may actually be breast cancer survivors, since this is typically a population of *women* living with chronic stress, albeit the stress of illness rather than of homelessness. Cordova and associates (2001) found mean growth scores of 64.1 in a sample of female breast cancer survivors who were no more than 5 years post diagnosis of Stage 0-IIIB breast cancer and at least 2 months post surgery, radiation and chemotherapy. Both of these studies report growth scores on the PTGI that are almost identical to the amount of growth reported from the MBT in this sample ($M = 66.5$) and actually slightly lower than MGT growth levels ($M = 72.6$). A final distinguishing feature in the current study was the presence of multiple traumas. This study appears to be the first to document growth from a sample in which all but one participant reported more than one trauma. Growth levels here were quite comparable to those elsewhere in the literature, even those of other women under chronic stress. This speaks to the resilience of these women.

It is interesting that the sample was evenly divided between those who felt their most bothersome trauma was the one they had grown the most from and those who chose separate events for the most growth and most bothersome traumas. For the MGT administration of the PTGI, however, these two groups displayed similar levels of

growth. For the MBT administration of the PTGI, those who chose separate events for the MBT and MGT reported less growth from the most bothersome trauma than those who used the same event for both. It would appear, then, that some individuals may have chosen a separate event as their most growth trauma because they did not experience much growth from their most bothersome trauma. Those who used different traumas, however, were not more likely to be diagnosed with PTSD for the most bothersome trauma, despite their lower growth scores. For those who have experienced multiple traumas, it seems that some individuals experience significant growth from their most disturbing experience, while others do not.

The Value of Posttraumatic Growth

Homeless women in this sample rated their PTG as relatively comforting: average 'comfort' ratings of the reported growth ranged from 'very comforting' to 'greatly comforting.' These ratings were positively correlated with the total amount of growth reported: the more growth, the more comforting that growth was. Neither comfort scores nor total growth correlated with overall psychological distress or PTSD symptom severity. Although a positive response bias cannot be ruled out, participants in this study had relatively high rates of growth and high ratings of how comforting that growth was to them. This does not seem to have impacted distress levels or PTSD symptomatology in any uniform way.

Some research has documented the positive effects of PTG on psychological outcome variables, such as distress and adjustment (e.g. Carver & Antoni, 2004; Frazier et al., 2001; McMillen et al., 1995; McMillen et al., 1997; Park, Cohen, & Murch, 1996). Other research, the present study included, has failed to document such a relationship

(e.g. Cordova et al., 2001) or has documented it at only certain time-points and not others (Davis et al., 1998). The lack of beneficial impact of growth in this study, measured by the BSI and the PDS, could be due to the presence of additional traumas and chronic environmental stressors. Although levels of growth in this sample with multiple traumas were comparable to growth rates in other populations, perhaps the positive psychological effect of that growth was overwhelmed by the impact of additional traumas (Kubiak, 2005). Alternatively, Tedeschi, Park and Calhoun (1998) suggest that PTG may be independent of well-being. Linley and Joseph (2005) state unequivocably that posttraumatic distress and posttraumatic growth are distinct phenomena that do not fall on one continuum.

Limitations and Strengths

One limitation of the present study was the use of only a month-long timeframe for the substance use data. Such a short period of time may not give a complete picture of an individual's typical level of substance use, since unusual events, such as hospitalization or incarceration, may restrict access to substances. On the other hand, since participants were only asked to recall substance use within this relatively recent timeframe, it is likely that the self-reported substance use data were reliable. A second limitation of the present study was its cross-sectional design. Future research with this population should examine PTG longitudinally to assess the relationship between growth and psychological distress over time.

In addition, the sample size used was relatively small and did not allow a comprehensive examination of ethnic differences. The use of a non-standardized method for quantifying the 'density' of substance use was suboptimal. On the other hand, this

index took into account polydrug use on a given day, which was a strength given this population's propensity for such use. The fact that half the sample used the same trauma for what was meant to be two separate administrations of the CRI and the PTGI was also not ideal. However, this proved to be an interesting finding in its own right. In populations with multiple traumas, the distinction between most bothersome and most growth traumas may be worthy of future investigation.

A final limitation is that the PTGI is typically used for populations with only one trauma. Using it to measure PTG from a single trauma among many was a novel approach, and there is no precedent for drawing conclusions about such growth. On the other hand, this methodology facilitated examining PTG among homeless women with multiple traumas, a hitherto unstudied population. Growth and positive adjustment after trauma have particular clinical relevance for this group. Further research should consider the effects of multiple traumas on PTG in this population or others, for whom multiple traumas are normative. Other benefits included using a standardized measure of PTG rather than coding answers to open-ended questions, the gold standard in diagnostic interviews (i.e., the SCID) to diagnose substance use disorders instead of a screening instrument, and a coping instrument appropriate for a homeless population. Although it has been unaddressed in PTG research thus far, the present study broached the topic of the subjective import of growth. This is an area that should be looked at in greater depth because of its potential clinical relevance.

This study also went further than previous research by examining coping mechanisms possibly underlying the relationship between growth and substance use. The frequent comorbidity between PTSD and substance use disorders has merited significant

investigation. Likewise, the relationship between PTG, a positive reaction to trauma, and substance use is equally important. Understanding this relationship has great clinical relevance, especially for populations struggling to recover from both trauma and substance abuse. Finally, the fact that substantial growth rates were seen among the homeless women in this study has clinical implications for service providers. Although it may be tempting to think that the prevalence of multiple traumas in this group makes the possibility of PTG unlikely, these results contradict such an assumption. Rather, they suggest that PTG is possible for homeless women, and thus should be considered a viable treatment goal.

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Table 1

Demographic Information by Group

	Trauma-SUD (n = 25)		Trauma-Only (n = 25)		Total (N = 50)	
	M	*SD*	*M*	*SD*	*M*	*SD*
Age in Years	39.64	7.96	42.56	9.65	41.10	8.88
Years of Education Completed	11.60	2.00	12.32	2.59	11.96	2.32
Years Homeless Currently	0.85	0.81	1.30	2.01	1.07	1.53
Years Homeless Lifetime	3.62	4.93	4.05	5.66	3.83	5.26
Days worked in the Past Month	5.24	9.59	1.92	5.31	3.58	7.85
Lifetime Total Number of Traumas	7.12	3.94	7.84	3.37	7.48	3.65

Note. Trauma-SUD = Trauma-Substance Use Disorder group.

Table 2

Substance Use in the Month Prior to the Interview

	Trauma-SUD (n = 25)		Trauma-Only (n = 25)		Total (N = 50)		
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*Range*
Substance points	15.40	15.81	3.88	9.26	9.64	14.08	0 – 63
Days drank	8.04	10.21	2.00	5.97	5.02	8.82	0 – 30
Total SECs consumed	208.46	344.83	4.24	9.43	106.35	262.53	0 – 1358.08
Days used illicit drugs	5.92	9.32	1.88	6.05	3.90	8.04	0 – 30

Note. SEC = Standard Ethanol Content; Substance points = sum of all incidences of alcohol or illicit drug use in the month prior to the interview. In a series of univariate ANOVAs, differences between groups were significant for all substance use variables above, all *ps* < .05, except "Days used illicit drugs."

Table 3

Numbers and Percentages for Drugs on which Participants were Dependent

Drug	*N*	% of Entire Sample	% of Drug Dependent
Crack	6	12%	60%
Crack & Heroin	2	4%	20%
Methamphetamine	1	2%	10%
Minor Tranquilizers	1	2%	10%

Table 4

Days of Drug Use in the Month Prior to the Interview by Drug

			For Those Who Used That Drug		For Entire Sample (N = 50)	
Drug	*N*	*Range*	*M*	*SD*	*M*	*SD*
Crack	10	0 – 24	10.50	8.75	2.04	5.57
Marijuana	9	0 – 30	10.56	11.99	1.90	6.34
Anxiety pills	1	0 – 14	14.00	NA	0.28	1.98
Meth	1	0 – 8	8.00	NA	0.16	1.13
Heroin	1	0 – 7	7.00	NA	0.14	0.99
Speed	1	0 – 4	4.00	NA	0.08	0.57
Analgesics	1	0 – 1	1.00	NA	0.02	0.14

Note. Meth = Methamphetamine. "Speed" is a stimulant. The range given is in days of use.

Table 5

Percentage of Participants Reporting Different Kinds of Traumas and by Group Total

	Trauma-SUD		Trauma-Only		Total	
Traumatic Event	*N*	%	*N*	%	*N*	%
Sudden unexpected death of someone close	15	60%	16	64%	31	62%
Life-threatening illness or injury	13	52%	18	72%	31	62%
Sexual assault by a stranger	14	56%	16	64%	30	60%
Non-sexual assault by a stranger	16	64%	13	52%	29	58%
Sexual assault by a family member or familiar other	10	40%	18	72%	28	56%
Serious accident, fire or explosion	16	64%	12	48%	28	56%
Non-sexual assault by a family member or familiar other	13	52%	15	60%	28	56%
Sexual contact before age 18 with someone 5 or more years older	13	52%	14	56%	27	54%
Imprisonment	12	48%	11	44%	23	46%
Other unwanted or uncomfortable sexual experience	13	52%	9	36%	22	44%
Sudden violent death	8	32%	12	48%	20	40%

Natural disaster	7	28%	10	40%	17	34%
Severe human suffering	7	28%	8	32%	15	30%
Torture	8	32%	7	28%	15	30%
'Other'	6	24%	6	24%	12	24%
Serious injury harm or death you caused another	5	20%	5	20%	10	20%
Exposure to toxic substance	2	8%	5	20%	7	14%

Note. An example of an event in the 'Severe human suffering' category might be, as one participant responded, 'Witnessing the severe suffering of other homeless acquaintances.' An example of a response in the 'Other' category might be 'Miscarriage,' for which the participant reported thinking her own and someone else's life was in danger, as well as feeling helpless and terrified. At least one response in the 'Torture' category was in the context of ongoing domestic violence.

Table 6

Posttraumatic Growth Inventory by Group

	Trauma-SUD (n = 25)		Trauma-Only (n = 25)		Total (N = 50)	
PTGI Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*
MBT Relating to Others	20.08	7.86	19.28	9.88	19.68	8.85
MBT New Possibilities	15.00	6.23	16.32	5.91	15.66	6.05
MBT Personal Strength	12.96	4.97	14.14	4.72	13.55	4.83
MBT Spiritual Change	6.76	3.21	6.44	3.18	6.60	3.16
MBT Appreciation of life	10.40	2.97	11.60	3.21	11.00	3.12
MBT PTGI Grand Total	65.20	20.05	67.78	23.00	66.49	21.40
How comforting was this MBT PTG?	3.16	1.18	3.12	1.30	3.14	1.23
MGT Relating to Others	21.68	8.30	21.80	9.97	21.74	9.08
MGT New Possibilities	16.00	5.31	17.92	5.46	16.96	5.42
MGT Personal Strength	14.60	3.89	15.18	4.49	14.89	4.17
MGT Spiritual Change	7.36	2.91	6.80	3.40	7.08	3.15
MGT Appreciation of Life	11.56	2.87	12.36	2.98	11.96	2.93
MGT PTGI Grand Total	71.2	17.71	74.06	21.30	72.63	19.44
How comforting was this						

MGT PTG?	3.48	.92	3.76	1.09	3.62	1.01

Note. PTGI = Posttraumatic Growth Inventory; MBT = Most Bothersome Trauma; MGT = Most Growth Trauma; PTG = Posttraumatic Growth.

Table 7

The Drinking Motives Questionnaire by Group

	Trauma-SUD (n = 25)		Trauma-Only (n = 25)		Total (N = 50)	
DMQ Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*
Social Motives	2.18	0.98	1.27	0.51	1.73	0.90
Coping Motives	2.28	0.97	1.26	0.51	1.77	0.92
Enhancement Motives	2.22	0.98	1.19	0.35	1.71	0.90

Note. DMQ = Drinking Motives Questionnaire. For individual respondents, scores on each scale are an average rather than a sum of responses. Responses are: "1 = Almost Never/Never;" "2 = Sometimes;" "3 = Often;" "4 = Almost always."

Table 8

TSI Scale Scores by Group

	Trauma-SUD (n = 25)		Trauma-Only (n = 25)		Total (N = 50)			
TSI Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*
ATR	4.24	4.31	5.00	5.53	4.62	4.92	0.00	.971
RL	1.00	2.18	1.12	1.72	1.06	1.94	1.26	.267
INC	4.48	2.77	6.08	3.11	5.28	3.02	1.56	.219
AA	13.28	5.68	10.52	6.46	11.90	6.18	5.02	.030
D	11.44	5.76	11.36	5.76	11.40	5.70	0.18	.671
AI	12.52	6.87	9.52	6.32	11.02	6.71	4.12	.049
IE	12.96	6.52	10.16	7.04	11.56	6.86	4.16	.048
DA	16.56	5.24	12.60	6.30	14.58	6.07	10.26	.003
DIS	11.16	7.12	8.08	6.68	9.62	7.01	4.31	.044
SC	5.52	6.82	4.44	4.83	4.98	5.87	0.36	.549
DSB	4.88	6.33	3.60	5.48	4.24	5.90	0.74	.395
ISR	11.24	6.03	8.76	6.64	10.00	6.40	2.42	.127
TRB	5.96	4.47	4.48	4.02	5.22	4.27	1.85	.181

Note. TSI = Trauma Symptom Inventory; AA = Anxious Arousal; D = Depression; AI = Anger/Irritability; IE = Intrusive Experiences; DA = Defensive Avoidance; DIS = Dissociation; SC = Sexual Concerns; DSB = Dysfunctional Sexual Behavior; ISR = Impaired Self-Reference; TRB = Tension Reduction Behavior; MISS = The number of questions left unanswered. F and p values are results of a multivariate analysis of variance in which substance-dependence group was the fixed factor and the TSI scales were the dependent variables. The $df = 1, 42$ for each scale.

Table 9

Coping Responses Inventory by Group

	Trauma-SUD (n = 25)		Trauma-Only (n = 25)		Total (N = 50)	
CRI Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*
MBT Logical Analysis	8.44	4.15	9.72	4.12	9.08	4.14
MBT Positive Reappraisal	8.28	4.65	9.00	4.43	8.64	4.51
MBT Seeking Guidance	8.20	4.36	9.12	4.54	8.66	4.43
MBT Problem Solving	8.44	4.22	10.56	4.27	9.50	4.34
MBT Cognitive Avoidance	11.44	3.55	10.32	3.93	10.88	3.75
MBT Acceptance/Resignation	10.10	3.63	8.88	4.22	9.49	3.94
MBT Seeking Alternative Rewards	6.52	4.02	7.28	4.04	6.90	4.01
MBT Emotional Discharge	8.56	4.05	9.40	3.48	8.98	3.76
MGT Logical Analysis	8.44	3.76	9.96	4.26	9.20	4.05
MGT Positive Reappraisal	9.52	4.04	10.40	5.27	9.96	4.67
MGT Seeking Guidance	8.26	4.26	9.88	4.43	9.07	4.38
MGT Problem Solving	10.12	3.80	11.40	4.29	10.76	4.06
MGT Cognitive Avoidance	11.12	3.76	9.48	4.58	10.30	4.23
MGT Acceptance/Resignation	10.04	3.01	9.16	3.69	9.60	3.36

MGT Seeking Alternative						
Rewards	6.77	3.87	8.28	4.38	7.52	4.16
MGT Emotional Discharge	7.60	4.28	8.04	3.46	7.82	3.86
Avoidance Composite	58.86	17.14	55.28	17.40	57.07	17.19
Approach Composite	82.98	30.86	95.60	30.34	89.29	30.95

Note. CRI = Coping Responses Inventory; MBT = Most Bothersome Trauma; MGT = Most Growth Trauma.

Table 10

CISS Scale Scores by Group

	Trauma-SUD (n = 25)		Trauma-Only (n = 25)		Total (N = 50)	
CISS Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*
Task	48.72	17.86	53.48	12.23	51.10	15.34
Emotion	45.12	13.41	43.72	10.78	44.42	12.06
Avoidance	41.76	13.53	43.44	12.31	42.60	12.83
Avoidance Subscale:						
Distraction	19.32	7.16	21.40	6.06	20.36	6.65
Avoidance Subscale:						
Social Diversion	13.92	5.64	14.36	5.45	14.14	5.50

Note. CISS = Coping Inventory for Stressful Situations.

Table 11

Pearson Correlations between Scales of the CISS and the CRI

	CISS				
				Avoidance Subscales	
Scale	Task	Emotion	Avoidance	Distraction	Social Diversion
CRI					
Avoidance Composite	.140	.513***	.143	.232	.089
Approach Composite	.451**	.201	.388**	.454**	.310*

Note. CISS = Coping Inventory for Stressful Situations; CRI = Coping Responses Inventory.

* $p < .050$. ** $p < .010$. *** $p < .001$.

Table 12

Pearson Correlations between the CRI Avoidance Subscales and the CISS Emotion Scale

CRI Scale	CISS Emotion Scale
MBT Cognitive Avoidance	.491**
MBT Acceptance/Resignation	.184
MBT Seeking Alternative Rewards	.183
MBT Emotional Discharge	.430**
MGT Cognitive Avoidance	.553**
MGT Acceptance/Resignation	.154
MGT Seeking Alternative Rewards	.246
MGT Emotional Discharge	.461**

Note. CRI = Coping Responses Inventory; CISS = Coping Inventory for Stressful Situations; MBT = Most Bothersome Trauma; MGT = Most Growth Trauma.

** $p < .010$.

Appendix A:

Consent Form

Consent to Participate in Research:
Posttraumatic Growth in Homeless Women

Introduction

You are being asked to be in a research study that I, Monica Stump, am running. Dr. Jane Ellen Smith from the Department of Psychology at the University of New Mexico is supervising me in this research. The results of this study will be used for my masters thesis.

As a woman who does not have a stable place to live right now, you have unique experiences and knowledge. The information you give me may be useful to counselors and other women, who are also homeless. This is why you were chosen as a possible participant in this study.

Purpose of the Study

Sometimes after going through a very bad, traumatic experience, people notice changes for the better in themselves or in their lives. I am interested in studying how it is possible for people to change for the better after going through traumas. I am also interested in how using alcohol or drugs may relate to these changes for the better in people.

What You Will Be Asked To Do

First, you will be asked to look over a checklist of traumas and mark any you have gone through. You will be asked very briefly about how you felt after any traumas you marked. You will also be asked how old you were when they occurred. After this you may be asked to complete a series of questionnaires and interviews. I will ask you about how much schooling you had, and about how much you have or have not worked in the past month. Some questions will be about how much you use drugs and alcohol, if at all. You will be asked whether or not you've experienced certain consequences of using drugs or alcohol. Some will questions will be about how you coped with certain stressful situations. There will be some questions about symptoms you may be experiencing from past traumas or ways you feel you have or have not changed after traumas you've been through. There will be some questions about how you feel about your body and about your eating habits. These questionnaires and interviews will take about 3 hours. Once you are finished, or if you decide to stop sooner, I will give you either a bus pass for the month or a $20 Walmart gift certificate for participating in the study. I appreciate your willingness to participate and honest answers.

Possible Risks to You

Being in this study and answering my questions may remind you of unpleasant memories or feelings about past traumas. It may be uncomfortable to be asked about problems from using alcohol or drugs. Also, some people do not like being asked how they feel about their body or what their eating habits are like. Because of these risks, I will offer to help

you find local agencies that provide counseling for past trauma or drug/alcohol problems. I will help you get in touch with any agencies you are interested in and give you a referral. I am happy to spend whatever time it takes to help you connect with services such as these.

Possible Benefits to You

By being in this study, you may see something positive that came out of a trauma. You might also find out if you are experiencing problems from using alcohol or drugs. Also, you may learn more about where you can go for counseling in Albuquerque. It is also possible that being in this study will not do you any good, although I hope it will.

Your participation may also help us understand more about how people can experience changes for the better after traumas. In the future, this may help other women, who are also trying to deal with past traumas.

How Any Information You Give Will be Kept Confidential

Any information you give me by being in this study will remain confidential and will not be given out without your permission, unless required by law (for example if you or someone else were in danger). If you participate in this study, I will give you a study number, so that your name does not show up anywhere except on this consent form. All other paperwork you fill out will only have your study number on it. Your paperwork will be stored in a locked office in the Psychology Department at UNM. Everything you tell me and all your answers to the questionnaires will be kept strictly confidential and anonymous. No one except for me and my supervisor will have access to information, which could identify you, unless you give us your written consent for someone else to see it or if what you tell me shows that someone's safety is in danger somehow, such as: (1) a medical emergency; (2) if your own life or another's life is threatened; (3) if you reveal information about child abuse.

Participation and Withdrawal

Whether or not you choose to be in this study is completely up to you. If you volunteer to participate, you may withdraw or stop any time you want to without any kind of penalty and still be paid. I may withdraw you from this study myself if situations come up that force me to, such as being under the influence of alcohol or drugs at the time you are trying to complete the study. If I withdraw you from the study for these reasons, you reschedule your assessment for a later time.

Identification of Investigators and Review Board

If you have any questions or concerns about the research, please feel free to contact: Monica Stump, 766-6876 ext. 290, Department of Psychology, University of New Mexico, Albuquerque, NM 87131, or Dr. Jane Ellen Smith, 277-2650, at the same university address. If you have other concerns or complaints, contact the Institutional

Research Compliance Services

Approved

From 3/7/05 To 3/6/06

Review Board at the University of New Mexico: Professor Jose Rivera in Scholes Hall, Room 255, Albuquerque, NM 87131, 277-2257.

YOUR SIGNATURE AND CONSENT

I have read and understand the procedures described above. Any questions I have about the study have been answered to my satisfaction. I voluntarily agree to be in this study. I understand that I will receive a copy of this consent form for my records.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

SIGNATURE OF INVESTIGATOR

In my judgment, the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

_____ _____
Signature of Investigator Date

Research Compliance Services
Approved
From 3/7/05 To 3/6/06

Appendix B:

Posttraumatic Diagnostic Scale

PDS

Part 1

Many People have lived through or witnessed a very stressful and traumatic event at some point in their lives. Below is a list of traumatic events. Put a checkmark in the box next to ALL of the events that have happened to you or that you have witnessed.

(1) ☐ Serious accident, fire, or explosion (for example, an industrial, farm, car, plane, or boating accident)

(2) ☐ Natural disaster (for example, tornado, hurricane, flood, or major earthquake)

(3) ☐ Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)

(4) ☐ Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)

(5) ☐ Sexual assault by a family member or someone you know (for example, rape or attempted rape)

(6) ☐ Sexual assault by a stranger (for example, rape or attempted rape)

(7) ☐ Military combat or war zone

(8) ☐ Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts)

(9) ☐ Other unwanted or uncomfortable sexual experience

(10) ☐ Imprisonment (for example, prison inmate, prisoner of war, hostage)

(11) ☐ Torture

(12) ☐ Life-threatening illness or injury

(13) ☐ Exposure to toxic substance (for example, dangerous chemicals, radiation)

(14) ☐ Severe human suffering

(15) ☐ Sudden, violent death (for example, homicide, suicide)

(16) ☐ Sudden, unexpected death of someone close to you

(17) ☐ Serious injury, harm, or death you caused to someone else

(18) ☐ Other traumatic event

(19) ☐ If you marked item 12, specify the traumatic event below.

_____

Part 2

(14) If you marked more than one traumatic event in Part 1, put a checkmark in the box below next to the event *that bothers you the most.* If you marked only one traumatic event in Part 1, mark the same one below.

- ☐ Accident
- ☐ Disaster
- ☐ Non-sexual assault by family or someone you know
- ☐ Non-sexual assault by a stranger
- ☐ Sexual assault by family or someone you know
- ☐ Sexual assault by a stranger
- ☐ Combat
- ☐ Sexual contact under 18 with someone 5 or more years older
- ☐ Other unwanted or uncomfortable sexual experience
- ☐ Imprisonment
- ☐ Torture
- ☐ Life-threatening illness or injury
- ☐ Toxic substance
- ☐ Severe human suffering
- ☐ Sudden, violent death
- ☐ Sudden, unexpected death of someone close to you
- ☐ Serious injury, harm, or death you caused to someone else
- ☐ Other

In the lines below, briefly describe the traumatic event you marked above.

_____

_____

_____

_____

Below are several questions about the traumatic event you just described above.

(15) How long ago did the traumatic event happen? (circle ONE)

1 Less than 1 month
2 1 to 3 months
3 3 to 6 months
4 6 months to 3 years
5 3 to 5 years
6 More than 5 years

How old were you at the time? _____

For the following questions, circle Y for Yes or N for No.

During this traumatic event:

(16) Y N Were you physically injured?

(17) Y N Was someone else physically injured?

(18) Y N Did you think that your life was in danger?

(19) Y N Did you think that someone else's life was in danger?

(20) Y N Did you feel helpless?

(21) Y N Did you feel terrified?

Part 3

Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE PAST MONTH. Rate each problem with respect to the traumatic event you described in Item 14.

0 Not at all or only one time
1 Once a week or less/once in a while
2 2 to 4 times a week/half the time
3 5 or more times a week/almost always

(22)	0	1	2	3	Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to
(23)	0	1	2	3	Having bad dreams or nightmares about the traumatic event
(24)	0	1	2	3	Reliving the traumatic event, acting or feeling as if it was happening again
(25)	0	1	2	3	Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)
(26)	0	1	2	3	Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast)
(27)	0	1	2	3	Trying not to think about, talk about, or have feelings about the traumatic event
(28)	0	1	2	3	Trying to avoid activities, people, or places that remind you of the traumatic event
(29)	0	1	2	3	Not being able to remember an important part of the traumatic event
(30)	0	1	2	3	Having much less interest or participating much less often in important activities
(31)	0	1	2	3	Feeling distant or cut off from people around you
(32)	0	1	2	3	Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)
(33)	0	1	2	3	Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life
(34)	0	1	2	3	Having trouble falling or staying asleep
(35)	0	1	2	3	Feeling irritable or having fits of anger
(36)	0	1	2	3	Having trouble concentrating (for example, drifting in and out of conversation, losing track of a story on television, forgetting what you read)
(37)	0	1	2	3	Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)
(38)	0	1	2	3	Being jumpy or easily startled (for example, when someone walks up behind you)

(39) How long have you been experiencing the problems that you reported above? (circle ONE)

1 Less than 1 month

2 1 to 3 months

3 More than 3 months

(40) How long after the traumatic event did these problems begin? (circle ONE)

1 Less than 6 months

2 6 or more months

Part 4

Indicate below if the problems you rate in Part 3 have interfered with any of the following areas of your life DURING THE PAST MONTH. Circle Y for Yes and N for No.

(41) Y N Work

(42) Y N Household chores and duties

(43) Y N Relationships with friends

(44) Y N Fun and leisure activities

(45) Y N Schoolwork

(46) Y N Relationships with your family

(47) Y N Sex life

(48) Y N General satisfaction with life

(49) Y N Overall level of functioning in all areas of your life

Appendix C:

Structured Clinical Interview for Diagnosis:

Psychotic Disorders

Subject ____

B/C PSYCHOTIC SCREENING MODULE (FOR SCID-I/NP OR P W/PSYCHOTIC SCREEN)

THIS MODULE IS FOR CODING PSYCHOTIC AND ASSOCIATED SXS THAT HAVE BEEN PRESENT AT ANY POINT IN THE PERSON'S LIFETIME. IT CAN BE USED FOR CLINICAL AND RESEARCH SETTINGS WHERE THOSE WITH A HISTORY OF PSYCHOTIC SXS THAT ARE NOT DUE TO SUBSTANCE USE OR A GENERAL MEDICAL CONDITION OR THAT OCCUR OUTSIDE THE CONTEXT OF A MOOD DISORDER ARE TO BE EXCLUDED.

FOR EACH PSYCHOTIC SYMPTOM CODED "3," DESCRIBE THE ACTUAL CONTENT AND INDICATE THE PERIOD OF TIME DURING WHICH THE SYMPTOM WAS PRESENT.

FOR ANY PSYCHOTIC AND ASSOCIATED SYMPTOMS CODED "3," DETERMINE WHETHER THE SYMPTOM IS DEFINITELY "PRIMARY" OR WHETHER THERE IS A POSSIBLE OR DEFINITE ETIOLOGIC SUBSTANCE (INCLUDING MEDICATIONS) OR GENERAL MEDICAL CONDITION. THE FOLLOWING QUESTIONS MAY BE USEFUL IF THE OVERVIEW HAS NOT ALREADY PROVIDED THE INFORMATION:

Just before (PSYCHOTIC SXS) began, were you using drugs? ...on any medications? ...did you drink much more than usual or stop drinking after you had been drinking a lot for a while? ...were you physically ill?

IF YES TO ANY: Has there been a time when you had (PSYCHOTIC SXS) and were not (USING DRUGS/TAKING MEDICATION/CHANGING YOUR DRINKING HABITS/ILL)?

Now I am going to ask you about unusual experiences that people sometimes have.

DELUSIONS

False personal beliefs based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture. Code overvalued ideas (unreasonable and sustained beliefs that are maintained with less than delusional intensity) as "2."

Has it ever seemed like people were talking about you or taking special notice of you?

IF YES: Were you convinced they were talking about you, or did you think it might have been your imagination?

What about receiving special messages from the TV, radio, or newspaper, or from the way things were arranged around you?

Delusion of reference, i.e., events, objects, or other people in the individual's immediate environment have a particular or unusual significance.

DESCRIBE:

? 1 2 3 BC1

1 3 BC2

POSS/DEF SUBST/GMC PRIMARY

What about anyone going out of their way to give you a hard time, or trying to hurt you?

Persecutory delusion, i.e., ' the individual (or his or her, group) is being attacked, harassed, cheated, persecuted, or conspired against.

DESCRIBE:

? 1 2 3 BC3

1 3 BC4

POSS/DEF SUBST/GMC PRI-MARY

Did you ever feel that you were especially important in some way, or that you had special powers to do things that other people couldn't do?

Grandiose delusion, i.e., content involves exaggerated power, knowledge or importance, or a special relationship to a deity or famous person.

DESCRIBE:

? 1 2 3 BC5

1 3 BC6

POSS/DEF SUBST/GMC PRI-MARY

Did you ever feel that something was very wrong with you physically even though your doctor said nothing was wrong...like you had cancer or some other terrible disease?

Have you ever been convinced that something was very wrong with the way a part or parts of your body looked?

(Did you ever feel that something strange was happening to parts of your body?)

Somatic delusion, i.e., content involves change or disturbance in body appearance or functioning.

DESCRIBE:

? 1 2 3 BC7

1 3 BC8

POSS/DEF SUBST/GMC PRI-MARY

(Did you ever have any unusual religious experiences?)

(Did you ever feel that you had committed a crime or done something terrible for which you should be punished?)

Other delusions

Check if:
___ religious delusions
___ delusions of guilt
___ jealous delusions
___ erotomanic delusions

DESCRIBE:

? 1 2 3 BC9

1 3 BC10 BC11 BC12 BC13 BC14

POSS/DEF SUBST/GMC PRI-MARY

HALLUCINATIONS (PSYCHOTIC)
A sensory perception that has the compelling sense of reality of a true perception but occurs without external stimulation of the relevant sensory organ.
(CODE "2" FOR HALLUCINATIONS THAT ARE SO TRANSIENT AS TO BE WITHOUT DIAGNOSTIC SIGNIFICANCE)

Did you ever hear things that other people couldn't hear, such as noises, or the voices of people whispering or talking? (Were you awake at the time?) IF YES: What did you hear? How often did you hear it?	Auditory hallucinations when fully awake, heard either inside or outside of head DESCRIBE:	? 1 2 3 1 3 POSS/DEF SUBST/GMC PRIMARY	BC15 BC16
IF VOICES: Did they comment on what you were doing or thinking?	A voice keeping up a running commentary on the individual's behavior or thoughts as they occur	? 1 2 3	BC17
How many voices did you hear? Were they talking to each other?	Two or more voices conversing with each other	? 1 2 3	BC18
Did you ever have visions or see things that other people couldn't see? (Were you awake at the time?) NOTE: DISTINGUISH FROM AN ILLUSION, I.E., A MISPERCEPTION OF A REAL EXTERNAL STIMULUS.	Visual hallucinations DESCRIBE:	? 1 2 3 1 3 POSS/DEF SUBST/GMC PRIMARY	BC19 BC20

What about strange sensations in your body or on your skin?

Tactile hallucinations, e.g., electricity

? 1 2 3 BC21

DESCRIBE:

1 3 BC22

POSS/DEF SUBST/GMC | PRIMARY

(What about smelling or tasting things that other people couldn't smell or taste?)

Other hallucinations, e.g., gustatory, olfactory

? 1 2 3 BC23

Check if:
___ gustatory
___ olfactory

1 3 BC24 BC25 BC26

DESCRIBE:

POSS/DEF SUBST/GMC | PRIMARY

ANY ITEM CODED "3" IN "PRIMARY" SECTION

? 1 3 BC27

GO TO NEXT MODULE

A PRIMARY PSYCHOTIC SX HAS BEEN PRESENT

IF A MAJOR DEPRESSIVE OR MANIC EPISODE HAS EVER BEEN PRESENT: Has there ever been a time when you had (PSYCHOTIC SXS) and you were not (DEPRESSED/MANIC)?

Psychotic symptoms occur at times other than during mood syndromes

NOTE: CODE "3" IF NO MOOD SYNDROMES OR PSYCHOTIC SXS W/O MOOD EPISODES. CODE "1" ONLY IF PSYCHOTIC SYMPTOMS OCCUR EXCLUSIVELY DURING UNEQUIVOCAL MOOD SYNDROMES.

? 1 3 BC28

PSYCHOTIC MOOD DISORDER. IF ALLOWED BY STUDY, GO TO NEXT MODULE

PSYCHOTIC DISORDER LIKELY

EXPLORE DETAILS AND DESCRIBE DIAGNOSTIC SIGNIFICANCE:

Appendix D

Structured Clinical Interview for Diagnosis:

Substance Use Disorders

Subject ___

E. SUBSTANCE USE DISORDERS

ALCOHOL USE DISORDERS (LIFETIME)

IF SCREENING QUESTION #1 ANSWERED "NO," CHECK HERE ___ AND SKIP TO *NON-ALCOHOL SUBSTANCE USE DISORDERS,* E. 10.

SCREEN Q#1 YES || NO E1a

IF NO: GO TO *NON-ALCOHOL USE DISORDERS* E. 10

IF SCREENER NOT USED OR IF QUESTION #1 IS ANSWERED "YES." CONTINUE:

What are your drinking habits like? (How much do you drink?) (Has there ever been a time in your life when you had five or more drinks on one occasion?)

When in your life were you drinking the most? (How long did that period last?)

RECORD DATE OF HEAVIEST USE AND DESCRIBE PATTERN:

_____ E1b

_____ E1c

During that time...

how often were you drinking?

what were you drinking? how much?

During that time...

did your drinking cause problems for you?

did anyone object to your drinking?

IF ALCOHOL DEPENDENCE SEEMS LIKELY, CHECK HERE ___ AND SKIP TO *ALCOHOL DEPENDENCE,* E. 4.

E1

IF ANY INCIDENTS OF EXCESSIVE DRINKING OR ANY EVIDENCE OF ALCOHOL-RELATED PROBLEMS, CONTINUE WITH *ALCOHOL ABUSE,* ON NEXT PAGE.

IF NEVER HAD ANY INCIDENTS OF EXCESSIVE DRINKING AND THERE IS NO EVIDENCE OF ANY ALCOHOL-RELATED PROBLEMS, SKIP TO *NON-ALCOHOL SUBSTNCE USE DISORDERS,* E. 10.

LIFETIME ALCOHOL ABUSE

Let me ask you a few more questions about (TIME WHEN DRINKING THE MOST OR TIME WHEN DRINKING CAUSED MOST PROBLEMS). During that time...

ALCOHOL ABUSE CRITERIA

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a twelve month period:

Did you miss work or school because you were intoxicated high, or very hung over? (How often? What about doing a bad job at work or failing courses at school because of your drinking?) IF NO: What about not keeping your house clean or not taking proper care of your children because of your drinking? (How often?) IF YES TO EITHER OF ABOVE: How often? (Over what period of time?)	(1) recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household)	?	1	2	3	E2
Did you ever drink in situations in which it might have been dangerous to drink at all? (Did you ever drive while you were really too drunk to drive?) IF YES AND UNKNOWN: How many times? (When?)	(2) recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol use)	?	1	2	3	E3
Did your drinking get you into trouble with the law? IF YES AND UNKNOWN: How often? (Over what period of time?)	(3) recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct)	?	1	2	3	E4
IF NOT ALREADY KNOWN: Did your drinking cause problems with other people, such as with family members, friends, or people at work? (Did you get into physical fights when you were drinking? What about having bad arguments about your drinking?) IF YES: Did you keep on drinking anyway? (Over what period of time?)	(4) continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol (e.g., arguments with spouse about consequences of intoxication, physical fights)	?	1	2	3	E5

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

AT LEAST ONE "A" ITEM CODED "3" 1 3 E6

IF ALCOHOL DEPENDENCE QUESTIONS HAVE ALREADY BEEN ASKED (I.E., DEPENDENCE SEEMED LIKELY AFTER ALCOHOL SCREENING ON E.1 BUT FULL CRITERIA WERE NOT MET), GO TO *NON-ALCOHOL USE DISORDERS,* E. 10.

IF ALCOHOL DEPENDENCE QUESTIONS HAVE NOT YET BEEN EVALUATED AND THERE IS ANY POSSIBILITY OF PHYSIOLOGICAL DEPENDENCE OR COMPULSIVE USE, GO TO *ALCOHOL DEPENDENCE,* ON PAGE E.4.
OTHERWISE, GO TO *NON-ALCOHOL USE DISORDERS,* E. 10.

ALCOHOL ABUSE

IF ALCOHOL DEPENDENCE QUESTIONS HAVE ALREADY BEEN ASKED (I.E., DEPENDENCE SEEMED LIKELY AFTER ALCOHOL SCREENING ON E.1, BUT FULL CRITERIA WERE NOT MET), GO TO *ALCOHOL ABUSE CHRONOLOGY,* E. 6.

IF ALCOHOL DEPENDENCE QUESTIONS HAVE NOT YET BEEN EVALUATED, CONTINUE WITH *ALCOHOL DEPENDENCE,* ON PAGE E. 4.

ALCOHOL DEPENDENCE	ALCOHOL DEPENDENCE CRITERIA					
I'd now like to ask you some more questions about (TIME WHEN DRINKING THE MOST OR TIME WHEN DRINKING CAUSED MOST PROBLEMS). During that time...	A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same twelve month period: NOTE: CRITERIA FOR ALCOHOL DEPENDENCE ARE NOT IN DSM-IV-TR ORDER.					
Did you often find that when you started drinking you ended up drinking much more than you were planning to? IF NO: What about drinking for a much longer period of time than you were planning to?	(3) alcohol is often taken in larger amounts OR over a longer period than was intended	?	1	2	3	E7
Did you try to cut down or stop drinking alcohol? IF YES: Did you ever actually stop drinking altogether? (How many times did you try to cut down or stop altogether?) IF NO: Did you want to stop or cut down? (Is this something you kept worrying about?)	(4) there is a persistent desire OR unsuccessful efforts to cut down or control alcohol use	?	1	2	3	E8
Did you spend a lot of time drinking, being high, or hung over?	(5) a great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects	?	1	2	3	E9
Did you often have times when you would drink so often that you started to drink instead of working or spending time with your family or friends or engaging in other activities, such as sports, gardening, or playing music?	(6) important social, occupational, or recreational activities given up or reduced because of alcohol use	?	1	2	3	E10

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

IF NOT ALREADY KNOWN: Did your drinking cause any psychological problems like making you depressed or anxious, making it difficult to sleep, or causing "blackouts?"

IF NOT ALREADY KNOWN: Did your drinking cause any significant physical problems or make a physical problem worse?

IF YES TO EITHER OF ABOVE: Did you keep on drinking anyway?

(7) alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption) ? 1 2 3 E11

Did you find that you needed to drink a lot more in order to get the feeling you wanted than you did when you first started drinking?

IF YES: How much more?

IF NO: What about finding that when you drank the same amount, it had much less effect than before?

(1) tolerance, as defined by either of the following: ? 1 2 3 E12

(a) a need for markedly increased amounts of alcohol to achieve intoxication or desired effect

(b) markedly diminished effect with continued use of the same amount of alcohol

Did you ever have any withdrawal symptoms when you cut down or stopped drinking like...

...sweating or racing heart?

...hand shakes?
...trouble sleeping?
...feeling nauseated or vomiting?
...feeling agitated?
...or feeling anxious?

(How about having a seizure or seeing, feeling, or hearing things that weren't really there?)

IF NO: Did you ever start the day with a drink or did you often drink or take some other drug or medication to keep yourself from getting the shakes or becoming sick?

(2) withdrawal, as manifested by either (a) or (b): ? 1 2 3 E13

(a) at least TWO of the following:

-- autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
-- increased hand tremor
-- insomnia
-- nausea or vomiting
-- psychomotor agitation
-- anxiety

-- grand mal seizures
-- transient visual, tactile, or auditory hallucinations or illusions

(b) alcohol (or a substance from the sedative/hypnotic/anxiolytic class) taken to relieve or avoid withdrawal symptoms E14

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

IF UNKNOWN: When did (SXS CODED "3" ABOVE) occur? (Did they all happen around the same time?)

AT LEAST THREE DEPENDENCE ITEMS CODED "3" AND ITEMS OCCURRED WITHIN THE SAME TWELVE MONTH PERIOD — 1 3 — E15

→ ALCOHOL DEPENDENCE GO TO *CHRONOLOGY,* E. 7

IF ALCOHOL ABUSE QUESTIONS (PAGES E. 1-E. 3) HAVE NOT YET BEEN ASKED, GO TO PAGE E. 2. AND CHECK FOR ABUSE.

IF ABUSE QUESTIONS HAVE BEEN ASKED AND ABUSE IS PRESENT, CODE "3" OTHERWISE. IF QUESTIONS HAVE BEEN ASKED AND ABUSE IS NOT PRESENT, GO TO *NON-ALCOHOL USE DISORDERS,* E. 10. — 1 3 — E16

→ GO TO *NON-ALCOHOL USE DISORDER,* E. 10

→ ALCOHOL ABUSE

ALCOHOL ABUSE CHRONOLOGY

How old were you when you first had (ABUSE SXS CODED "3")?

Age at onset of Alcohol Abuse (CODE 99 IF UNKNOWN) — — — E17

IF UNCLEAR: During the past month, have you had anything at all to drink?

IF YES: Tell me more about it. (Has your drinking caused you any problems?)

Criteria for Alcohol Abuse met at any time in past month — ? 1 3 — E18

→ PAST ABUSE

→ CURRENT ABUSE

→ GO TO *NON-ALCOHOL USE DISORDER,* E. 10

CHRONOLOGY FOR DEPENDENCE

How old were you when you first had (LIST OF ALCOHOL DEPENDENCE OR ABUSE SXS CODED "3")?

Age at onset of Alcohol Dependence or Abuse (CODE 99 IF UNKNOWN) — — E19

IF UNCLEAR: During the past month, have you had anything at all to drink?

IF YES: Tell me more about it. (Has your drinking caused you any problems?)

Full criteria for Alcohol Dependence met at any time in past month (or never had a month without symptoms of Dependence or Abuse since last onset of Dependence) ? 1 3 E20

CURRENT DEPENDENCE

GO TO *REMISSION SPECIFIERS,* E. 8

Indicate if: E21

1 - With Physiological Dependence (current evidence of tolerance or withdrawal)

2 - Without Physiological Dependence (no current evidence of tolerance or withdrawal)

NOTE SEVERITY OF DEPENDENCE FOR WORST WEEK OF PAST MONTH (Additional questions about the effect of alcohol on social and occupational functioning may be necessary.) E22

1 Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning or in usual social activities or relationships with others (or criteria met for Dependence in the past and some current problems).

2 Moderate: Symptoms or functional impairment between "mild" and "severe."

3 Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

GO TO *NON-ALCOHOL USE DISORDERS,* E. 10.

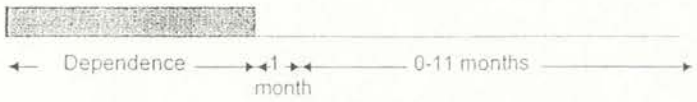
REMISSION SPECIFIERS FOR DEPENDENCE

THE FOLLOWING REMISSION SPECIFIERS CAN BE APPLIED ONLY AFTER NO CRITERIA FOR DEPENDENCE OR ABUSE HAVE BEEN MET FOR AT LEAST ONE MONTH IN THE PAST.

Note: These specifiers do not apply if the individual is **In a Controlled Environment** (next page).

Number of months prior to interview when last had some problems with Alcohol. ___ ___ ___ E23

1 **Early Full Remission**: For at least one month, but less than twelve months, no criteria for Dependence or Abuse have been met. E24



2 **Early Partial Remission**: For at least one month, but less than twelve months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).

3 **Sustained Full Remission**: None of the criteria for Dependence or Abuse have been met at any time during a period of twelve months or longer.

4 **Sustained Partial Remission**: Full criteria for Dependence have not been met for a period of twelve months or longer; however, one or more criteria for Dependence or Abuse have been met.

Check ____ if **In A Controlled Environment**: The individual is in an environment where access to alcohol and controlled substances is restricted and no criteria for Dependence or Abuse have been met for at least the past month. Examples are closely-supervised and substance-free jails, therapeutic communities, and locked hospital units. E26

NON-ALCOHOL SUBSTANCE USE DISORDERS (LIFETIME DEPENDENCE AND ABUSE)

IF SCREENING QUESTIONS #2 AND #3 ARE BOTH ANSWERED "NO," CHECK HERE ___ AND SKIP TO THE NEXT MODULE.

SCREEN Q# 2 YES | NO E26a

SCREEN Q# 3 YES | NO E26b

IF NO TO BOTH: GO TO NEXT MODULE

IF SCREENER NOT USED OR IF QUESTION #2 OR QUESTION #3 WAS ANSWERED "YES," CONTINUE:
Now I am going to ask you about your use of drugs or medicines.

SHOW DRUG LIST TO SUBJECT.

Have you ever taken any of these to get high, to sleep better, to lose weight, or to change your mood?

REFERRING TO LIST ON NEXT PAGE, DETERMINE LEVEL OF DRUG USE USING GUIDELINES BELOW

GUIDELINES FOR RATING LEVEL OF DRUG USE:

FOR EACH DRUG GROUP EVER USED:	Either (1) or (2):
-> IF STREET DRUG: When were you using (DRUG) the most? (Has there ever been a time when you used it at least ten times in a one-month period of time?)	(1) has ever taken street drug more than 10 times in a one-month period
-> IF PRESCRIBED: Did you ever get hooked (become dependent) on (PRESCRIBED DRUG) or take much more of it than was prescribed?	(2) reports becoming dependent on a prescribed drug OR using much more of it than was prescribed

-> IF DRUG GROUP NEVER USED OR USED ONLY ONCE, OR IF PRESCRIBED DRUG USED AS DIRECTED, CIRCLE "1" FOR DRUG GROUP ON E. 11.

-> IF DRUG GROUP USED AT LEAST TWICE, BUT LESS THAN LEVEL INDICATED ON (1), CODE "2" FOR DRUG GROUP ON E. 11.

-> IF DRUG GROUP USED AT LEVEL INDICATED IN ITEM(1) OR IF POSSIBLY DEPENDENT ON PRESCRIBED DRUG (ITEM [2] IS TRUE), CODE "3" ON E. 11.

CIRCLE THE NAME OF EACH DRUG EVER USED (OR WRITE IN NAME IF "OTHER")	RECORD PERIOD OF HEAVIEST USE (AGE OR DATE, AND DURATION) AND DESCRIBE PATTERN OF USE	INDICATE LEVEL OF USE (USE GUIDELINES, E. 10)	
Sedatives-hypnotics-anxiolytics: Quaalude, Seconal, Valium, Xanax, Librium, barbiturates, Miltown, Ativan, Dalmane, Halcion, Restoril, or other: _____	_____	? 1 2 3	E27
Cannabis: marijuana, hashish, THC, or other: _____	_____	? 1 2 3	E28
Stimulants: amphetamine, "speed," crystal meth, dexadrine, Ritalin, "ice", or other: _____	_____	? 1 2 3	E29
Opioids: heroin, morphine, opium, Methadone, Darvon, codeine, Percodan, Demerol, Dilaudid, unspecified or other: _____	_____	? 1 2 3	E30
Cocaine: intranasal, IV, freebase, crack, "speedball," unspecified or other: _____	_____	? 1 2 3	E31
Hallucinogens/PCP: LSD, mescaline, peyote, psilocybin, STP, mushrooms, PCP ("angel dust"), Extasy, MDMA, or other: _____	_____	? 1 2 3	E32
Other: steroids, "glue," paint, inhalants, nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers"), nonprescription sleep or diet pills, unknown, or other: _____	_____	? 1 2 3	E33
	ANY DRUG GROUPS CODED "2" OR "3"	1 3	E34
		GO TO NEXT MODULE	

IF AT LEAST THREE DRUG GROUPS USED AND PERIOD OF INDISCRIMINANT USE SEEMS LIKELY, ASK THE FOLLOWING:

You've told me that you've used (DRUG/ALCOHOL). Was there a period where you were using a lot of different drugs at the same time and that it did not matter what you were taking as long as you could get high?

Behavior during the same 12-month period in which the person was repeatedly using at least three groups of substance (not including caffeine and nicotine), but no single substance predominated. Further, during this period, the Dependence criteria were (likely) met for substances as a group but not for any specific substance.

1 2 3 E35

USE POLY DRUG COL-UMN

NOTE: IN CASES THAT INCLUDE PERIODS OF INDISCRIMINANT USE AND OTHER PERIODS OF USE OF SPECIFIC DRUGS, POLY DRUG SHOULD BE CODED IN ADDITION TO SPECIFIC DRUG COLUMNS.

IF NO DRUG CLASSES WERE CODED "3" ON PREVIOUS PAGE (I.E., "2"S ONLY), GO TO *SUBSTANCE ABUSE*, E. 23.

FOR DRUG CLASSES CODED "3" CIRCLE THE APPROPRIATE COLUMNS ON PAGES E. 12 TO E. 18.

NON-ALCOHOL SUBSTANCE DEPENDENCE

Now I'm going to ask you some specific questions about your use of (DRUGS CODED "3").

ASK EACH OF THE FOLLOWING QUESTIONS FOR EACH DRUG CODED "3": For (DRUG), during (TIME WHEN TAKING THE MOST OR TIME WHEN CAUSED MOST PROBLEMS)...

Did you often find that when you started using (DRUG), you ended up using much more of it than you were planning to?

IF NO: What about using it over a much longer period of time than you were planning to?

NOTE: CRITERIA FOR DEPENDENCE ARE IN A DIFFERENT ORDER THAN IN DSM-IV-TR	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	POLY	OTHER
(3) the substance is often taken in larger amounts OR over a longer period than was intended	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E36	E37	E38	E39	E40	E41	E42	E43

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

Did you try to cut down or stop using (DRUG)?

IF YES: Did you ever actually stop using (DRUG) altogether?

(How many times did you try to cut down or stop altogether?)

IF UNCLEAR: Did you want to stop or cut down?

IF YES: Is this something you kept worrying about?

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	POLY	OTHER
(4) there is a persistent desire OR unsuccessful efforts to cut down or control substance use	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E44	E45	E46	E47	E48	E49	E50	E51

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

Did you spend a lot of time using (DRUG) or doing whatever you had to do to get it? Did it take you a long time to get back to normal? (How much time? As long as several hours?)

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	POLY	OTHER
(5) a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E52	E53	E54	E55	E56	E57	E58	E59

Did you often have times when you would use (DRUG) so often that you used (DRUG) instead of working or spending time on hobbies or with your family or friends or engaging in other activities, such as sports, gardening, or playing music?

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	POLY	OTHER
(6) important social, occupational, or recreational activities given up or reduced because of substance use	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E60	E61	E62	E63	E64	E65	E66	E67

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

IF NOT ALREADY KNOWN: Did (DRUG) cause any psychological problems, like making you depressed, agitated, or paranoid?

IF NOT ALREADY KNOWN: Did (DRUG) cause any significant physical problems or make a physical problem worse?

IF YES TO EITHER OF ABOVE: Did you keep on using (DRUG) anyway?

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	POLY	OTHER
(7) the substance use is continued despite knowledge of having had a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., recurrent cocaine use despite recognition of cocaine-related depression)	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E68	E69	E70	E71	E72	E73	E74	E75

Did you find that you needed to use a lot more (DRUG) in order to get the feeling you wanted than you did when you first started using it?

IF YES: How much more?

IF NO: What about finding that when you used the same amount, it had much less effect than before?

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	POLY	OTHER
(1) tolerance, as defined by either of the following:								
(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
(b) markedly diminished effect with continued use of the same amount of the substance	?	?	?	?	?	?	?	?
	E76	E77	E78	E79	E80	E81	E82	E83

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

Did you ever have withdrawal symptoms, that is, felt sick when you cut down or stopped using (DRUG)?

IF YES: What symptoms did you have? REFER TO LIST OF WITHDRAWAL SYMPTOMS ON E. 17.

IF NO: After not using (DRUG) for a few hours or more, did you often use it to keep yourself from getting sick with (WITHDRAWAL SXS)?

IF NO: What about using (DRUG IN SAME GROUP) when you were feeling sick with (WITHDRAWAL SXS) so that you would feel better?

(2) withdrawal, as manifested by either of the following:	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	POLY	OTHER
(a) the characteristic withdrawal syndrome for the substance	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E84	E85	E86	E87	E88	E89	E90	E91

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

LIST OF WITHDRAWAL SYMPTOMS (FROM DSM-IV CRITERIA)

Listed below are the characteristic withdrawal symptoms for those classes of psychoactive substances for which a withdrawal syndrome has been identified. (NOTE: A specific withdrawal syndrome has not been identified for CANNABIS AND HALLUCINOGENS/PCP). Withdrawal symptoms may occur following the cessation of prolonged moderate or heavy use of a psychoactive substance or a reduction in the amount used.

SEDATIVES, HYPNOTICS, AND ANXIOLYTICS:

Two (or more) of the following, developing within several hours to a few days after cessation (or reduction) of sedative, hypnotic, or anxiolytic use, which has been heavy and prolonged:

(1) autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
(2) increased hand tremor
(3) insomnia
(4) nausea or vomiting
(5) transient visual, tactile, or auditory hallucinations or illusions
(6) psychomotor agitation
(7) anxiety
(8) grand mal seizures

STIMULANTS/COCAINE

Dysphoric mood AND two (or more) of the following physiological changes, developing within a few hours to several days after cessation (or reduction of substance use which has been heavy and prolonged):

(1) fatigue
(2) vivid, unpleasant dreams
(3) insomnia or hypersomnia
(4) increased appetite
(5) psychomotor retardation or agitation

OPIOIDS:

Three (or more) of the following, developing within minutes to several days after cessation (or reduction) of opioid use which has been heavy and prolonged (several weeks or longer) or after administration of an opioid antagonist (after a period of opioid use):

(1) dysphoric mood
(2) nausea or vomiting
(3) muscle aches
(4) lacrimation or rhinorrhea
(5) pupillary dilation, piloerection, or sweating
(6) diarrhea
(7) yawning
(8) fever
(9) insomnia

IF UNKNOWN: When did (SXS CODED "3" ABOVE) occur? (Did they all happen around the same time?)	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	POLY	OTHER
SUBSTANCE DEPENDENCE At least 3 items are coded "3" AND items occurred within the same twelve-month period	3	3	3	3	3	3	3	3
	E92	E93	E94	E95	E96	E97	E98	E99

FOR EACH CLASS CODED "3," GO TO *CHRONOLOGY,* E. 19.

Fewer than 3 items coded "3"	1	1	1	1	1	1	1	1

FOR DRUG CLASSES CODED "1": IF THE NUMBER OF DIFFERENT DEPENDENCE SYMPTOMS (TAKEN FROM AT LEAST THREE DIFFERENT DRUG CLASSES INCLUDING ALCOHOL) AND OCCURRING DURING THE SAME 12-MONTH PERIOD ADDS UP TO AT LEAST THREE, MAKE A DIAGNOSIS OF POLYSUBSTANCE DEPENDENCE (ABOVE) AND GO TO *CHRONOLOGY,* E. 19.

OTHERWISE, GO TO *LIFETIME SUBSTANCE ABUSE,* E. 22 AND ASK THE FOUR ABUSE ITEMS FOR EACH DRUG CLASS CODED "1" ABOVE.

CHRONOLOGY FOR DEPENDENCE

FOR EACH DRUG CLASS IN WHICH CRITERIA HAVE BEEN MET FOR DEPENDENCE DURING LIFETIME:

AGE AT ONSET

How old were you when you first had (LIST OF SUBSTANCE DEPENDENCE OR ABUSE SXS CODED "3")?

	SED.-HYPN.-ANX.	CANN ABIS	STIMU LANTS	OPI OID	COC-AINE	HALL/PCP	POLY	OTHER
Age at onset of Substance Dependence or Abuse (CODE 99 IF UNKNOWN)	___	___	___	___	___	___	___	___
	E107a	E107b	E107c	E107d	E107e	E107f	E107g	E107h

MEETS CRITERIA IN PAST MONTH

IF UNCLEAR: During the past month, have you used (DRUG) at all?

IF YES: Has your (DRUG) use caused you any problems?

(How about being high when you were at school or work, or taking care of children? How about missing something important because of being high or hung over? How about using (DRUG) while you were driving? How about getting into trouble with the law because of your use of (DRUG)?)

NOTE: YOU MAY NEED TO REFER TO ABUSE CRITERIA, PAGE E. 22-E. 24.

	SED.-HYPN.-ANX.	CANN ABIS	STIMU LANTS	OPI OID	COC-AINE	HALL/PCP	POLY	OTHER
Full criteria for Dependence met at any time in past month (or never had a month without symptoms of Dependence or Abuse since last onset of Dependence)	3	3	3	3	3	3	3	3
No symptoms of Dependence or Abuse in past month or meets partial criteria after one month without symptoms	1	1	1	1	1	1	1	1
	E108	E109	E110	E111	E112	E113	E114	E115

TYPE AND SEVERITY OF CURRENT DEPENDENCE

FOR EACH CLASS CODED "3" ON ITEMS E108-E115, INDICATE TYPE AND SEVERITY OF CURRENT DEPENDENCE:

	SED.-HYPN.-ANX.	CANN ABIS	STIMU LANTS	OPI OID	COC-AINE	HALL/PCP	POLY	OTHER
Indicate current type:								
With Physiological Dependence (current evidence of tolerance or withdrawal)	3	3	3	3	3		3	3
Without Physiological Dependence (no current evidence of tolerance or withdrawal)	1	1	1	1	1	1	1	1
	E116	E117	E118	E119	E120	E121	E122	E123

USE SCALE BELOW TO RATE SEVERITY OF DEPENDENCE FOR WORST WEEK OF PAST MONTH (Additional questions about the effect of the substance on social and occupational functioning may be necessary)	SED.-HYPN.-ANX.	CANN ABIS	STIMU LANTS	OPI OID	COC-AINE	HALL/PCP	POLY	OTHER
	1	1	1	1	1	1	1	1
	2	2	2	2	2	2	2	2
	3	3	3	3	3	3	3	3
	E132	E133	E134	E135	E136	E137	E138	E139

1 Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning or in usual social activities or relationships with others.

2 Moderate: Symptoms or functional impairment between "mild" and "severe."

3 Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

REMISSION SPECIFIERS

FOR EACH CLASS CODED "1" ON ITEMS E108-E115, INDICATE THE APPROPRIATE REMISSION SPECIFIER (SEE PAGE E. 8 FOR DEFINITIONS OF THESE SPECIFIERS).

NOTE: THE FOLLOWING REMISSION SPECIFIERS CAN BE APPLIED ONLY AFTER NO CRITERIA FOR DEPENDENCE OR ABUSE HAVE BEEN MET FOR AT LEAST ONE MONTH IN THE PAST. FURTHERMORE, EARLY PARTIAL/FULL AND SUSTAINED PARTIAL/FULL DO NOT APPLY IF THE INDIVIDUAL IS ON AGONIST THERAPY OR IN A CONTROLLED ENVIRONMENT.

USE SCALE BELOW TO INDICATE TYPE OF REMISSION	SED.-HYPN.-ANX.	CANNABIS	STIMULANTS	OPIOID	COCAINE	HALL/PCP	POLY	OTHER
Early Full Remission	1	1	1	1	1	1	1	1
Early Partial Remission	2	2	2	2	2	2	2	2
Sustained Full Remission	3	3	3	3	3	3	3	3
Sustained Partial Remission	4	4	4	4	4	4	4	4
Check if On Agonist Therapy				—			—	—
Check if In a Controlled Environment	—	—	—	—	—	—	—	—
	E140	E141	E142	E143	E144	E145	E146	E147
				E143a			E146a	E147a
	E140b	E141a	E142b	E143b	E144b	E145a	E146b	E147b

On Agonist Therapy: The individual is on a prescribed agonist medication (e.g., methadone) and no criteria for Dependence or Abuse have been met for that class of medication for at least the past month (except tolerance to, or withdrawal from, the agonist). This category also applies to those being treated for Dependence using a partial agonist or a mixed agonist/antagonist.

In A Controlled Environment: The individual is in an environment where access to alcohol and controlled substances is restricted and no criteria for Dependence or Abuse have been met for at least the past month. Examples are closely-supervised and substance-free jails, therapeutic communities, and locked hospital units.

LIFETIME SUBSTANCE ABUSE

-> FOR EACH DRUG CLASS CODED "2" ON E. 11 (I.E., DRUGS USED AT A LEVEL OF <10 TIMES IN ANY ONE MONTH), START THIS SECTION WITH THE FOLLOWING INTRODUCTION:

Now I'm going to ask you some specific questions about your use of (DRUGS CODED "2").

-> FOR EACH DRUG CLASS CODED "3" ON PAGE E. 11 THAT DID NOT MEET CRITERIA FOR DEPENDENCE (I.E., CODED "1" ON E.18):

Now I'd like to ask you a few more questions about your use of (DRUGS CODED "3" THAT DID NOT MEET CRITERIA FOR DEPENDENCE).

For (DRUG), during (TIME WHEN TAKING THE MOST OR TIME WHEN IT CAUSED THE MOST PROBLEMS)...

Did you miss work or school because you were intoxicated, high, or very hung over? (How often? What about doing a bad job at work or failing courses at school because of your [DRUG] use?)

IF NO: What about not keeping your house clean or not taking proper care of your children because of your (DRUG) use?

IF YES TO EITHER OF ABOVE: How often? (Over what period of time?)

SUBSTANCE ABUSE CRITERIA

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a twelve month period:

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	OTHER
(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
	1	1	1	1	1	1	1
	?	?	?	?	?	?	?
	E148	E149	E150	E151	E152	E153	E155

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

Did you ever use (DRUG) in a situation in which it might have been dangerous to be using (DRUG) at all? (Did you ever drive while you were really too high to drive?)

IF YES AND UNKNOWN: How often? (Over what period of time?)

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	OTHER
(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
	1	1	1	1	1	1	1
	?	?	?	?	?	?	?
	E156	E157	E158	E159	E160	E161	E163

Did your use of (DRUG) get you into trouble with the law?

IF YES AND UNKNOWN: How often? (Over what period of time?)

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	OTHER
(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
	1	1	1	1	1	1	1
	?	?	?	?	?	?	?
	E164	E165	E166	E167	E168	E169	E171

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

IF NOT ALREADY KNOWN: Did your use of (DRUG) cause problems with other people, such as with family members, friends, or people at work? (Did you ever get into physical fights or bad arguments about your drug use?)

IF YES: Did you keep on using (DRUG) anyway? (Over what period of time?)

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	OTHER
(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
	1	1	1	1	1	1	1
	?	?	?	?	?	?	?
	E172	E173	E174	E175	E176	E177	E179

	SED/ HYPN/ ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/ PCP	OTHER
SUBSTANCE ABUSE (LIFETIME): At least one "A" item is coded "3"	3	3	3	3	3	3	3
	1	1	1	1	1	1	1
	E180	E181	E182	E183	E184	E185	E187

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

FOR DRUG CLASSES WITH LIFETIME ABUSE (I.E., CODED "3" ON PRIOR ITEM):

AGE AT ONSET

How old were you when you first had (LIST OF SUBSTANCE DEPENDENCE OR ABUSE SXS CODED "3")?	SED.-HYPN.-ANX.	CANN ABIS	STIMU LANTS	OPI OID	COC-AINE	HALL/PCP	OTHER
Age at onset of Substance Dependence or Abuse (CODE 99 IF UNKNOWN)	___	___	___	___	___	___	___
	E187a	E187b	E187c	E187d	E187e	E187f	E187g

	SED/HYPN/ANX	CANN ABIS	STIMU LANTS	OPI OID	COC AINE	HALL/PCP	OTHER
Has some symptoms of Substance Abuse in past month	3	3	3	3	3	3	3
IF UNCLEAR: When was the last time you had problems with (SUBSTANCE)?	1	1	1	1	1	1	1
	E188	E189	E190	E191	E192	E193	E195

1=no Abuse symptoms in past month 3=some Abuse symptoms in past month

Appendix E

Timeline Followback

DY MO YR
DATE OF ADMINISTRATION

TIMELINE FOLLOWBACK (TLFB) CALENDAR

Name: _____ Age: _____ Gender: _____

Interviewer Instructions:

Complete Start Date and the End Date (yesterday).

Start Date: DY MO YR

End Date: DY MO YR

Total Days in TLFB Interval: _____

Check (✓) appropriate box and complete corresponding information:

❑ Timeline Followback for Alcohol

BAC: _____

Weight: _____

Occasionally, people engage in morning drinking to avoid withdrawal symptoms from the previous night's drinking. For shift workers this refers to drinking immediately upon waking. Drinking upon waking to avoid withdrawal symptoms is known as "relief drinking."

Have you engaged in relief drinking during the timeline interval?

❑ Yes ❑ No

❑ Timeline Followback for Cigarettes

❑ Timeline Followback for Marijuana

❑ Timeline Followback for Other Drugs

PRIMARY Drug Name: _____ ___

SECONDARY Drug Name: _____ ___

88 = no secondary drug assessed

Date Enter _____
Staff Initials _____

COMBINE
TLFB (TLF ver. A)

Center ☐☐ Participant # ☐☐☐☐☐☐☐ Participant Initials ☐☐☐ Week ☐☐ Sequence ☐☐

Date ☐☐ (month) / ☐☐ (day) / ☐☐☐☐ (year) Staff ID ☐☐☐

From: ☐☐ (month) / ☐☐ (day) / ☐☐☐☐ (year) To: ☐☐ (month) / ☐☐ (day) / ☐☐☐☐ (year)

Instructions: Complete the TLFB between visits (within treatment) to assess drinking. If there are ≥ 6 weeks between treatment visits, use the Form 90 (FED) to collect the drinking data.

2003 *July* 2003

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
		1 # of drinks ☐☐.☐	2 # of drinks ☐☐.☐	3 # of drinks ☐☐.☐	4 # of drinks ☐☐.☐	5 # of drinks ☐☐.☐
6 # of drinks ☐☐.☐	7 # of drinks ☐☐.☐	8 # of drinks ☐☐.☐	9 # of drinks ☐☐.☐	10 # of drinks ☐☐.☐	11 # of drinks ☐☐.☐	12 # of drinks ☐☐.☐
13 # of drinks ☐☐.☐	14 # of drinks ☐☐.☐	15 # of drinks ☐☐.☐	16 # of drinks ☐☐.☐	17 # of drinks ☐☐.☐	18 # of drinks ☐☐.☐	19 # of drinks ☐☐.☐
20 # of drinks ☐☐.☐	21 # of drinks ☐☐.☐	22 # of drinks ☐☐.☐	23 # of drinks ☐☐.☐	24 # of drinks ☐☐.☐	25 # of drinks ☐☐.☐	26 # of drinks ☐☐.☐
27 # of drinks ☐☐.☐	28 # of drinks ☐☐.☐	29 # of drinks ☐☐.☐	30 # of drinks ☐☐.☐	31 # of drinks ☐☐.☐		

Drinking Conversion Scale: Standard Drinks=10 oz. Beer (1 can); 4 oz. Wine; 1.2 oz. Hard liquor

Appendix F

Posttraumatic Growth Inventory

Posttraumatic Growth Inventory

Indicate for each of the statements below the degree to which this change occurred in your life as a result of your crisis, using the following scale.

0 = I did not experience this change as a result of my crisis.
1 = I experienced this change to a very small degree as a result of my crisis.
2 = I experienced this change to a small degree as a result of my crisis.
3 = I experienced this change to a moderate degree as a result of my crisis.
4 = I experienced this change to a great degree as a result of my crisis.
5 = I experienced this change to a very great degree as a result of my crisis.

Please circle a number:

1. I changed my priorities about what is important in life.
   0 1 2 3 4 5

2. I have a greater appreciation for the value of my own life.
   0 1 2 3 4 5

3. I developed new interests.
   0 1 2 3 4 5

4. I have a greater feeling of self-reliance.
   0 1 2 3 4 5

5. I have a better understanding of spiritual matters.
   0 1 2 3 4 5

6. I more clearly see that I can count on people in times of trouble.
   0 1 2 3 4 5

7. I established a new path for my life.
   0 1 2 3 4 5

8. I have a greater sense of closeness with others.
   0 1 2 3 4 5

9. I am more willing to express my emotions.

0 1 2 3 4 5

10. I know better that I can handle difficulties.

0 1 2 3 4 5

11. I am able to do better things with my life.

0 1 2 3 4 5

12. I am better able to accept the way things work out.

0 1 2 3 4 5

13. I can better appreciate each day.

0 1 2 3 4 5

14. New opportunities are available which wouldn't have been otherwise.

0 1 2 3 4 5

15. I have more compassion for others.

0 1 2 3 4 5

16. I put more effort into my relationships.

0 1 2 3 4 5

17. I am more likely to try to change things which need changing.

0 1 2 3 4 5

18. I have a stronger religious faith.

0 1 2 3 4 5

19. I discovered that I'm stronger than I thought I was.

0 1 2 3 4 5

20. I learned a great deal about how wonderful people are.

0 1 2 3 4 5

21. I better accept needing others.

0 1 2 3 4 5

Additional question:

How comforting have you found these positive changes to be in the aftermath of your traumatic experience?

____ Not at all comforting
____ A little comforting
____ Moderately comforting
____ Very comforting
____ Greatly comforting

Comments you would like to add: (optional)

Appendix G

Coping Responses Inventory

CRI-ADULT FORM

Item Booklet

Rudolf H. Moos, Ph.D.

Directions:

On the accompanying answer sheet, please fill in your name, today's date, and your sex, age, marital status, ethnic group, and education (number of years completed). Please mark all your answers on the answer sheet. **Do not write in this booklet.**

PAR Psychological Assessment Resources, Inc./P.O. Box 998/Odessa, FL 33556/Toll-Free 1-800-331-TEST

4 5 6 7 8 9 Printed in the U.S.A.

This form is printed in blue ink on recycled paper. Any other version is unauthorized. Reorder # RO-2327 Toll Free 1-800-331-TEST

Part 1

This booklet contains questions about how you manage important problems that come up in your life. Please think about the most important problem or stressful situation you have experienced **in the last 12 months** (for example, troubles with a relative or friend, the illness or death of a relative or friend, an accident or illness, financial or work problems). Briefly describe the problem in the space provided in Part 1 of the answer sheet. If you have not experienced a major problem, list a minor problem that you have had to deal with. Then answer each of the 10 questions about the problem or situation (listed below and again on the answer sheet) by circling the appropriate response:

Circle"**DN**" if your response is **D**EFINITELY **N**O.	(DN) MN MY DY
Circle "**MN**" if your response is **M**AINLY **N**O.	DN (MN) MY DY
Circle "**MY**" if your response is **M**AINLY **Y**ES.	DN MN (MY) DY
Circle "**DY**" if your response is **D**EFINITELY **Y**ES.	DN MN MY (DY)

1. Have you ever faced a problem like this before?
2. Did you know this problem was going to occur?
3. Did you have enough time to get ready to handle this problem?
4. When this problem occurred, did you think of it as a threat?
5. When this problem occurred, did you think of it as a challenge?
6. Was this problem caused by something you did?
7. Was this problem caused by something someone else did?
8. Did anything good come out of dealing with this problem?
9. Has this problem or situation been resolved?
10. If the problem has been worked out, did it turn out all right for you?

Part 2

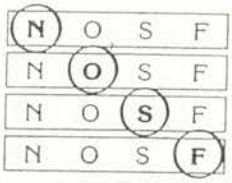
Read each item carefully and indicate how often you engaged in that behavior in connection with the problem you described in Part 1. Circle the appropriate response on the answer sheet:

Circle "**N**" if your response is NO, **N**ot at all.

Circle "**O**" if your response is YES, **O**nce or Twice.

Circle "**S**" if your response is YES, **S**ometimes.

Circle "**F**" if your response is YES, **F**airly often.



There are 48 items in Part 2. Remember to mark all your answers on the answer sheet. Please answer each item as accurately as you can. All your answers are strictly confidential. If you do not wish to answer an item, please circle the number of that item on the answer sheet to indicate that you have decided to skip it. If an item does not apply to you, please write **NA** (**N**ot **A**pplicable) in the box to the right of the number for that item. If you wish to change an answer, make an **X** through your original answer and circle the new answer. Note that answers are numbered across in rows on Part 2 of the answer sheet.

1. Did you think of different ways to deal with the problem?
2. Did you tell yourself things to make yourself feel better?
3. Did you talk with your spouse or other relative about the problem?
4. Did you make a plan of action and follow it?
5. Did you try to forget the whole thing?
6. Did you feel that time would make a difference--that the only thing to do was wait?
7. Did you try to help others deal with a similar problem?
8. Did you take it out on other people when you felt angry or depressed?
9. Did you try to step back from the situation and be more objective?
10. Did you remind yourself how much worse things could be?
11. Did you talk with a friend about the problem?
12. Did you know what had to be done and try hard to make things work?
13. Did you try not to think about the problem?
14. Did you realize that you had no control over the problem?
15. Did you get involved in new activities?
16. Did you take a chance and do something risky?
17. Did you go over in your mind what you would say or do?
18. Did you try to see the good side of the situation?
19. Did you talk with a professional person (e.g., doctor, lawyer, clergy)?
20. Did you decide what you wanted and try hard to get it?

21. Did you daydream or imagine a better time or place than the one you were in?

22. Did you think that the outcome would be decided by fate?

23. Did you try to make new friends?

24. Did you keep away from people in general?

25. Did you try to anticipate how things would turn out?

26. Did you think about how you were much better off than other people with similar problems?

27. Did you seek help from persons or groups with the same type of problem?

28. Did you try at least two different ways to solve the problem?

29. Did you try to put off thinking about the situation, even though you knew you would have to at some point?

30. Did you accept it; nothing could be done?

31. Did you read more often as a source of enjoyment?

32. Did you yell or shout to let off steam?

33. Did you try to find some personal meaning in the situation?

34. Did you try to tell yourself that things would get better?

35. Did you try to find out more about the situation?

36. Did you try to learn to do more things on your own?

37. Did you wish the problem would go away or somehow be over with?

38. Did you expect the worst possible outcome?

39. Did you spend more time in recreational activities?

40. Did you cry to let your feelings out?

41. Did you try to anticipate the new demands that would be placed on you?

42. Did you think about how this event could change your life in a positive way?

43. Did you pray for guidance and/or strength?

44. Did you take things a day at a time, one step at a time?

45. Did you try to deny how serious the problem really was?

46. Did you lose hope that things would ever be the same?

47. Did you turn to work or other activities to help you manage things?

48. Did you do something that you didn't think would work, but at least you were doing something?

CRI-ADULT ANSWER SHEET

Form: Actual____ Ideal____

Name _____ Date _____ / _____ / _____ Sex _____ Age _____

Marital Status_____ Ethnic Group _____ Education _____

Part 1

Describe the problem or situation _____

_____

_____

_____

DN = **D**efinitely **N**o **MN** = **M**ainly **N**o **MY** = **M**ainly **Y**es **DY** = **D**efinitely **Y**es

1.	Have you ever faced a problem like this before?	DN MN MY DY
2.	Did you know this problem was going to occur?	DN MN MY DY
3.	Did you have enough time to get ready to handle this problem?	DN MN MY DY
4.	When this problem occurred, did you think of it as a threat?	DN MN MY DY
5.	When this problem occurred, did you think of it as a challenge?	DN MN MY DY
6.	Was this problem caused by something you did?	DN MN MY DY
7.	Was this problem caused by something someone else did?	DN MN MY DY
8.	Did anything good come out of dealing with this problem?	DN MN MY DY
9.	Has this problem or situation been resolved?	DN MN MY DY
10.	If the problem has been worked out, did it turn out all right for you?	DN MN MY DY

Part 2

N = No, **N**ot at all **O** = Yes, **O**nce or twice **S** = Yes, **S**ometimes **F** = Yes, **F**airly often

1 N O S F	**2** N O S F	**3** N O S F	**4** N O S F	**5** N O S F	**6** N O S F	**7** N O S F	**8** N O S F
9 N O S F	**10** N O S F	**11** N O S F	**12** N O S F	**13** N O S F	**14** N O S F	**15** N O S F	**16** N O S F
17 N O S F	**18** N O S F	**19** N O S F	**20** N O S F	**21** N O S F	**22** N O S F	**23** N O S F	**24** N O S F
25 N O S F	**26** N O S F	**27** N O S F	**28** N O S F	**29** N O S F	**30** N O S F	**31** N O S F	**32** N O S F
33 N O S F	**34** N O S F	**35** N O S F	**36** N O S F	**37** N O S F	**38** N O S F	**39** N O S F	**40** N O S F
41 N O S F	**42** N O S F	**43** N O S F	**44** N O S F	**45** N O S F	**46** N O S F	**47** N O S F	**48** N O S F

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Appendix H

Coping Inventory for Stressful Situations

CISS

Instructions: The following are ways people react to various difficult, stressful, or upsetting situations. Please circle a number from 1 to 5 for each item. Indicate how much you engage in these types of activities when you encounter a difficult, stressful, or upsetting situation.

	Not at all				*Very Much*
1. Schedule my time better.	1	2	3	4	5
2. Focus on the problem and how I can solve it.	1	2	3	4	5
3. Think about the good times I've had.	1	2	3	4	5
4. Try to be with other people.	1	2	3	4	5
5. Blame myself for putting things off.	1	2	3	4	5
6. Do what I think is best.	1	2	3	4	5
7. Become preoccupied with aches and pains.	1	2	3	4	5
8. Blame myself for having gotten into the situation.	1	2	3	4	5
9. Window shop.	1	2	3	4	5
10. Outline my priorities.	1	2	3	4	5
11. Try to go to sleep.	1	2	3	4	5
12. Treat myself to a favorite food or snack.	1	2	3	4	5
13. Feel anxious about not being able to cope.	1	2	3	4	5
14. Become very tense.	1	2	3	4	5
15. Think about how I solved similar problems.	1	2	3	4	5
16. Tell myself that it is really not happening to me.	1	2	3	4	5
17. Blame myself for being too emotional about situations.	1	2	3	4	5
18. Go out for a snack or meal.	1	2	3	4	5
19. Become very upset.	1	2	3	4	5
20. Buy myself something.	1	2	3	4	5
21. Determine a course of action and follow it.	1	2	3	4	5
22. Blame myself for not knowing what to do.	1	2	3	4	5
23. Go to a party.	1	2	3	4	5
24. Work to understand the situation.	1	2	3	4	5
25. "Freeze" and not know what to do.	1	2	3	4	5
26. Take corrective action immediately.	1	2	3	4	5
27. Think about the event and learn from my mistake.	1	2	3	4	5
28. Wish that I could change what had happened or how I felt.	1	2	3	4	5
29. Visit a friend.	1	2	3	4	5
30. Worry about what I am going to do.	1	2	3	4	5
31. Spend time with a special person.	1	2	3	4	5
32. Go for a walk.	1	2	3	4	5
33. Tell myself that it will never happen again.	1	2	3	4	5
34. Focus on my general inadequacies.	1	2	3	4	5
35. Talk to someone whose advice I value.	1	2	3	4	5
36. Analyze my problem before reacting.	1	2	3	4	5
37. Phone a friend.	1	2	3	4	5
38. Get angry.	1	2	3	4	5
39. Adjust my priorities.	1	2	3	4	5
40. See a movie.	1	2	3	4	5
41. Get control of the situation.	1	2	3	4	5
42. Make an extra effort to get things done.	1	2	3	4	5
43. Come up with several different solutions to the problem.	1	2	3	4	5
44. Take some time off and get away from the situation.	1	2	3	4	5
45. Take it out on other people.	1	2	3	4	5
46. Use the situation to prove that I can do it.	1	2	3	4	5
47. Try to be organized so I can be on top of the situation.	1	2	3	4	5
48. Watch TV.	1	2	3	4	5

Appendix I

Drinking Motives Questionnaire

Drinking Motives Questionnaire

Below is a list of reasons people sometimes give for drinking alcoholic beverages. Using the scale provided, tell me how often you drink for each of the following reasons.

1 = Almost never/never
2 = Sometimes
3 = Often
4 = Almost always

1. How often do you drink to forget your worries?
   1 2 3 4
2. How often do you drink because it is exciting?
   1 2 3 4
3. How often do you drink to cheer up when you're in a bad mood?
   1 2 3 4
4. How often do you drink to relax?
   1 2 3 4
5. How often do you drink because it makes a social gathering more enjoyable?
   1 2 3 4
6. How often do you drink because it's fun?
   1 2 3 4
7. How often do you drink because it is what most of your friends do when you get together?
   1 2 3 4
8. How often do you drink because you like the feeling?
   1 2 3 4
9. How often do you drink to get high?
   1 2 3 4
10. How often do you drink because it is customary on special occasions?
    1 2 3 4
11. How often do you drink because it helps when you feel depressed or nervous?
    1 2 3 4
12. How often do you drink as a way to celebrate?
    1 2 3 4
13. How often do you drink because you feel more self-confident or sure of yourself?
    1 2 3 4
14. How often do you drink because it makes you feel good?
    1 2 3 4
15. How often do you drink to be sociable?
    1 2 3 4

Appendix J

Brief Symptom Inventory

BRIEF SYMPTOM INVENTORY

Please fill in one circle that most accurately describes your symptoms **in the last week**

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	(0)	(1)	(2)	(3)	(4)	Nervousness or shakiness inside
2	(0)	(1)	(2)	(3)	(4)	Faintness or dizziness
3	(0)	(1)	(2)	(3)	(4)	The idea that someone else can control your thoughts
4	(0)	(1)	(2)	(3)	(4)	Feeling others are to blame for most of your troubles
5	(0)	(1)	(2)	(3)	(4)	Trouble remembering things
6	(0)	(1)	(2)	(3)	(4)	Feeling easily annoyed or irritated
7	(0)	(1)	(2)	(3)	(4)	Pains in heart or chest
8	(0)	(1)	(2)	(3)	(4)	Feeling afraid in open spaces or on the streets
9	(0)	(1)	(2)	(3)	(4)	Thoughts of ending your life
10	(0)	(1)	(2)	(3)	(4)	Feeling that most people cannot be trusted
11	(0)	(1)	(2)	(3)	(4)	Poor appetite
12	(0)	(1)	(2)	(3)	(4)	Suddenly scared for no reason
13	(0)	(1)	(2)	(3)	(4)	Temper outbursts that you could not control
14	(0)	(1)	(2)	(3)	(4)	Feeling lonely even when you are with people
15	(0)	(1)	(2)	(3)	(4)	Feeling blocked in getting things done
16	(0)	(1)	(2)	(3)	(4)	Feeling lonely
17	(0)	(1)	(2)	(3)	(4)	Feeling blue
18	(0)	(1)	(2)	(3)	(4)	Feeling no interest in things
19	(0)	(1)	(2)	(3)	(4)	Feeling fearful
20	(0)	(1)	(2)	(3)	(4)	Your feelings being easily hurt
21	(0)	(1)	(2)	(3)	(4)	Feeling that people are unfriendly or dislike you
22	(0)	(1)	(2)	(3)	(4)	Feeling inferior to others
23	(0)	(1)	(2)	(3)	(4)	Nausea or upset stomach
24	(0)	(1)	(2)	(3)	(4)	Feeling that you are watched or talked about by others
25	(0)	(1)	(2)	(3)	(4)	Trouble falling asleep
26	(0)	(1)	(2)	(3)	(4)	Having to check and double-check what you do
27	(0)	(1)	(2)	(3)	(4)	Difficulty making decisions
28	(0)	(1)	(2)	(3)	(4)	Feeling afraid to travel on buses, subways, or trains
29	(0)	(1)	(2)	(3)	(4)	Trouble getting your breath
30	(0)	(1)	(2)	(3)	(4)	Hot or cold spells
31	(0)	(1)	(2)	(3)	(4)	Having to avoid certain things, places, or activities because they frighten you
32	(0)	(1)	(2)	(3)	(4)	Your mind going blank
33	(0)	(1)	(2)	(3)	(4)	Numbness or tingling in parts of your body
34	(0)	(1)	(2)	(3)	(4)	The idea that you should be punished for your sins
35	(0)	(1)	(2)	(3)	(4)	Feeling hopeless about the future
36	(0)	(1)	(2)	(3)	(4)	Trouble concentrating
37	(0)	(1)	(2)	(3)	(4)	Feeling weak in parts of your body
38	(0)	(1)	(2)	(3)	(4)	Feeling tense or keyed up
39	(0)	(1)	(2)	(3)	(4)	Thoughts of death or dying
40	(0)	(1)	(2)	(3)	(4)	Having urges to beat, injure, or harm someone
41	(0)	(1)	(2)	(3)	(4)	Having urges to break or smash things
42	(0)	(1)	(2)	(3)	(4)	Feeling very self-conscious with others
43	(0)	(1)	(2)	(3)	(4)	Feeling uneasy in crowds, such as shopping or at a movie
44	(0)	(1)	(2)	(3)	(4)	Never feeling close to another person
45	(0)	(1)	(2)	(3)	(4)	Spells of terror or panic
46	(0)	(1)	(2)	(3)	(4)	Getting into frequent arguments
47	(0)	(1)	(2)	(3)	(4)	Feeling nervous when you are left alone
48	(0)	(1)	(2)	(3)	(4)	Others not giving you proper credit for your achievements
49	(0)	(1)	(2)	(3)	(4)	Feeling so restless you couldn't sit still
50	(0)	(1)	(2)	(3)	(4)	Feelings of worthlessness
51	(0)	(1)	(2)	(3)	(4)	Feeling that people will take advantage of you if you let them
52	(0)	(1)	(2)	(3)	(4)	Feelings of guilt
53	(0)	(1)	(2)	(3)	(4)	The idea that something is wrong with your mind

Appendix K

Trauma Symptom Inventory

Item Booklet

John Briere, PhD

Please read all of these instructions carefully before beginning. Mark all of your answers on the accompanying answer sheet and write only where indicated. DO NOT write in this item booklet.

On the answer sheet, please write your name, the date, your age, your sex, and your race in the spaces provided.

This questionnaire contains 100 items describing experiences that may or may not have happened to you. Please circle the one answer that best indicates how often each of the following experiences have happened to you **in the last 6 months**.

Circle 0 if your answer is NEVER; it has not happened at all in the last 6 months.	(0) 1 2 3
Circle 1 or 2 if it has happened in the last 6 months, but has not happened often.	0 (1) 2 3
	0 1 (2) 3
Circle 3 if your answer is OFTEN; it has happened often in the last 6 months.	0 1 2 (3)

If you make a mistake or change your mind, **DO NOT ERASE**! Make an "X" through the incorrect response and then draw a circle around the correct response.

Please answer each item as honestly as you can. Be sure to answer every item. You can take as much time as you need to finish the TSI.

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0	1	2	3
Never			Often

In the last 6 months, how often have you experienced:

1. Nightmares or bad dreams
2. Trying to forget about a bad time in your life
3. Irritability
4. Stopping yourself from thinking about the past
5. Getting angry about something that wasn't very important
6. Feeling empty inside
7. Sadness
8. Flashbacks (sudden memories or images of upsetting things)
9. Not being satisfied with your sex life
10. Feeling like you were outside of your body
11. Lower back pain
12. Sudden disturbing memories when you were not expecting them
13. Wanting to cry
14. Not feeling happy
15. Becoming angry for little or no reason
16. Feeling like you don't know who you really are
17. Feeling depressed
18. Having sex with someone you hardly knew
19. Thoughts or fantasies about hurting someone
20. Your mind going blank
21. Fainting
22. Periods of trembling or shaking
23. Pushing painful memories out of your mind
24. Not understanding why you did something
25. Threatening or attempting suicide
26. Feeling like you were watching yourself from far away
27. Feeling tense or "on edge"
28. Getting into trouble because of sex
29. Not feeling like your real self
30. Wishing you were dead
31. Worrying about things
32. Not being sure of what you want in life
33. Bad thoughts or feelings during sex
34. Being easily annoyed by other people
35. Starting arguments or picking fights to get your anger out

0	1	2	3
Never			Often

In the last 6 months, how often have you experienced:

36. Having sex or being sexual to keep from feeling lonely or sad
37. Getting angry when you didn't want to
38. Not being able to feel your emotions
39. Confusion about your sexual feelings
40. Using drugs other than marijuana
41. Feeling jumpy
42. Absent-mindedness
43. Feeling paralyzed for minutes at a time
44. Needing other people to tell you what to do
45. Yelling or telling people off when you felt you shouldn't have
46. Flirting or "coming on" to someone to get attention
47. Sexual thoughts or feelings when you thought you shouldn't have them
48. Intentionally hurting yourself (for example, by scratching, cutting, or burning) even though you weren't trying to commit suicide
49. Aches and pains
50. Sexual fantasies about being dominated or overpowered
51. High anxiety
52. Problems in your sexual relations with another person
53. Wishing you had more money
54. Nervousness
55. Getting confused about what you thought or believed
56. Feeling tired
57. Feeling mad or angry inside
58. Getting into trouble because of your drinking
59. Staying away from certain people or places because they reminded you of something
60. One side of your body going numb
61. Wishing you could stop thinking about sex
62. Suddenly remembering something upsetting from your past
63. Wanting to hit someone or something
64. Feeling hopeless
65. Hearing someone talk to you who wasn't really there
66. Suddenly being reminded of something bad
67. Trying to block out certain memories
68. Sexual problems
69. Using sex to feel powerful or important
70. Violent dreams

0	1	2	3
Never			Often

In the last 6 months, how often have you experienced:

71. Acting "sexy" even though you didn't really want sex
72. Just for a moment, seeing or hearing something upsetting that happened earlier in your life
73. Using sex to get love or attention
74. Frightening or upsetting thoughts popping into your mind
75. Getting your own feelings mixed up with someone else's
76. Wanting to have sex with someone who you knew was bad for you
77. Feeling ashamed about your sexual feelings or behavior
78. Trying to keep from being alone
79. Losing your sense of taste
80. Your feelings or thoughts changing when you were with other people
81. Having sex that had to be kept a secret from other people
82. Worrying that someone is trying to steal your ideas
83. Not letting yourself feel bad about the past
84. Feeling like things weren't real
85. Feeling like you were in a dream
86. Not eating or sleeping for 2 or more days
87. Trying not to have any feelings about something that once hurt you
88. Daydreaming
89. Trying not to think or talk about things in your life that were painful
90. Feeling like life wasn't worth living
91. Being startled or frightened by sudden noises
92. Seeing people from the spirit world
93. Trouble controlling your temper
94. Being easily influenced by others
95. Wishing you didn't have any sexual feelings
96. Wanting to set fire to a public building
97. Feeling afraid you might die or be injured
98. Feeling so depressed that you avoided people
99. Thinking that someone was reading your mind
100. Feeling worthless

TSI Answer Sheet

Date _____

Name _____ Identification No. _____ Age _____ Sex _____ Race _____

Fill in your name, the date, and other information above. Follow the instructions in the TSI Item Booklet and enter your ratings on this sheet. Indicate your ratings by circling the appropriate number for each item.

0 Never 1 2 3 Often

1	0 1 2 3	21	0 1 2 3	41	0 1 2 3	61	0 1 2 3	81	0 1 2 3
2	0 1 2 3	22	0 1 2 3	42	0 1 2 3	62	0 1 2 3	82	0 1 2 3
3	0 1 2 3	23	0 1 2 3	43	0 1 2 3	63	0 1 2 3	83	0 1 2 3
4	0 1 2 3	24	0 1 2 3	44	0 1 2 3	64	0 1 2 3	84	0 1 2 3
5	0 1 2 3	25	0 1 2 3	45	0 1 2 3	65	0 1 2 3	85	0 1 2 3
6	0 1 2 3	26	0 1 2 3	46	0 1 2 3	66	0 1 2 3	86	0 1 2 3
7	0 1 2 3	27	0 1 2 3	47	0 1 2 3	67	0 1 2 3	87	0 1 2 3
8	0 1 2 3	28	0 1 2 3	48	0 1 2 3	68	0 1 2 3	88	0 1 2 3
9	0 1 2 3	29	0 1 2 3	49	0 1 2 3	69	0 1 2 3	89	0 1 2 3
10	0 1 2 3	30	0 1 2 3	50	0 1 2 3	70	0 1 2 3	90	0 1 2 3
11	0 1 2 3	31	0 1 2 3	51	0 1 2 3	71	0 1 2 3	91	0 1 2 3
12	0 1 2 3	32	0 1 2 3	52	0 1 2 3	72	0 1 2 3	92	0 1 2 3
13	0 1 2 3	33	0 1 2 3	53	0 1 2 3	73	0 1 2 3	93	0 1 2 3
14	0 1 2 3	34	0 1 2 3	54	0 1 2 3	74	0 1 2 3	94	0 1 2 3
15	0 1 2 3	35	0 1 2 3	55	0 1 2 3	75	0 1 2 3	95	0 1 2 3
16	0 1 2 3	36	0 1 2 3	56	0 1 2 3	76	0 1 2 3	96	0 1 2 3
17	0 1 2 3	37	0 1 2 3	57	0 1 2 3	77	0 1 2 3	97	0 1 2 3
18	0 1 2 3	38	0 1 2 3	58	0 1 2 3	78	0 1 2 3	98	0 1 2 3
19	0 1 2 3	39	0 1 2 3	59	0 1 2 3	79	0 1 2 3	99	0 1 2 3
20	0 1 2 3	40	0 1 2 3	60	0 1 2 3	80	0 1 2 3	100	0 1 2 3

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Appendix L

Community Resources Debriefing Form

Community Resources

Night Shelters

Barrett House (all women; can stay up to 3 weeks): 243-4887
Joy Junction: 877-6967
Salvation Army: 242-3112
Amistad (ages 13-17): 877-0371
Casa Hermosa (ages 16-21): 265-6799
Rescue Mission (men only): 346-HOPE
Good Shepherd (men only): 243-2527
Haven of Love (ages 18-21, men only): 877-9915

Day Shelters

Noon Day Ministry (meals): 246-8001
St. Martin's Hospitality Center (meals, vouchers, mental health services): 764-8231 ext.241
Rescue Mission (men and women): 346-HOPE
-contact Ellen LaCourse at x. 255 for the Women's Day Room

Transitional Housing

Dismas House: 266-6129, 343-0764
-adults on parole, both men and women, must apply, housing for 3-12 months
Women's Housing Coalition (two-year program): 884-8856
-single women with kids, must be going to school or working, no significant others, Rent is $300-380.
Transitional Living Services (TLS): 268-5295
-women over 40 with mental illness, Medicaid will pay
Casa Milagro: 883-8870
-homeless women over 40 with mental illness, no insurance needed, no substance abuse in the past 6 months.
Villa de Paz: 254-0320
-coed single occupancy rooms, must be at least 4 months into recovery and going to school or looking for work and doing a treatment program, costs 3% of income.
HCH: 242-4644
-they can put you in touch with AMHHC (Alb. Mental Health Housing Coalition); there is currently a waiting list a few months long, but AMHHC provides apartments and some other supportive programming for a long period of time, e.g. 2 years.
Susan's Legacy: 843-8450
-for women with children under 12 years old; must have drug and mental health problems, must be in a program and be clean for 6 months.

Career Services

Career Works: 277-0562
-must apply through human services; must be receiving TANF or food stamps; call 841-2600 to make an appointment with human services.
UNM Career Services: 277-2531
-$40 for a year of services or $10 per visit; meet with one-on-one career counselor in your area of interest; walk-in hours are Mon-Thurs 10:30am-2:30pm; fees may be waived or reduced possibly, if needed.
DVR: 232-8701 (Marble office)
-must have a medically diagnosed physical or mental illness that significantly impairs ability to work.

Child Care

Catholic Charities: 247-0442
Cuidando Los Ninos (homeless kids 6 weeks to 5 years old): 843-6899

Substance Abuse Treatment Services

New Dawn: 265-6066
-intensive outpatient
Sobering Services: 275-8730
-free live-in detox program
Tierra Del Sol: 831-7815
-free, homeless women 18 and older, can have kids there, any substance problem
Turquoise Lodge: 841-8978
-free, coed, no kids, prefer referrals, any substance problem, no more than 30 mg methadone unless on maintenance.
Alcohol and Substance Abuse Prevention (ASAP): 925-2400
-outpatient only, any substance problem, walk-ins accepted M-F from 7:30-10am, accept UNM CARE plan and will help people get it, too.
Silver Street Clinic: 262-1538
-methadone and substance counseling, two programs: one is once a week through AMCI (money for treatment available through AMCI), other is once a month or as needed for $8/session.
Stepping Stones: (505) 766-5197
-mental health assessment and case management, walk-ins from open 8-10:30 and 1-3 except for Wednesday mornings and no case management Friday afternoons. Come as soon as they open to get name on the list.
Narcotics Anonymous: 260-9889
Alcoholics Anonymous: 266-1900
-both NA and AA are free.
Relevancy, Inc: 830-1038
-free, outpatient only, any substance problem, individual and group therapy, coed, 18 and older with some limited room for teens, at San Pedro and Menaul near

Coronado and near the bus line, no waiting list

Victory Love: 765-1318

-free, coed, any substance problem, no psychotropic meds, no pregnant women, inpatient for a year.

St. Martin's Hospitality Center: 764-8231 ext. 241

-free (funding available on case-by-case basis) or accept medicare/aid mental health case management, substance abuse, dual diagnosis, employment program, nurse available for emergencies, self-sufficiency program, case workers; need diagnosis to qualify for programs related to those needs, duration is also determined case-by-case.

Healthcare for the Homeless: 242-4644

-Stepping Stones program: free, no vouchers needed, drop-ins welcome or assessments from 1-3pm daily, substance abuse counseling, case management, no requirements.

Crossroads (Dennis Good): 242-1010

-Transitional program for women only, must be homeless, at risk for homelessness, or just out of jail, need dual diagnosis of substance use disorder and other mental illness, provide housing, 20 beds, 18 and older, will try to get insurance for all participants.

Christ In Power (Joy Junction): 877-6967

-free transitional program, incl. drug and alcohol classes, Bible studies, parenting courses, legal aid and community resources, financial counseling, move into one of 26 individual apartments after graduating CIP, must apply.

Syringe Exchange: 938-7128 or 1-888-882-2437

-free, 625 Trumanne, off San Mateo and Lomas, Saturdays from 11am to 3pm

Almas de Amistad: 242-2840

-free substance abuse counseling for women and their children, will deal with related issues, such as past trauma, no insurance or vouchers needed, group and individual counseling, HIV prevention

Indian Center: 268-4418

FREE Referral Agencies

Albuquerque Metro Central Intake (AMCI): 272-9187.

Counseling Services

Resources, Inc: 884-1241 or 768-2104

Family Developmental Program: 247-4337 or 764-8218

Presbyterian Women's Resource Center (women must have insurance): 823-8840

All Faith's Counseling Center: 243-8855 (not taking anyone right now, 10/22/04)

Catholic Charities: 724-4670

-sliding pay scale

Samaritan Counseling: 842-5300

-sliding pay scale

Dragon Fly Counseling: 265-0753

-co-op of therapists, offer individual and group therapy (women's group Monday nights); relapse class; takes most insurance, incl. Salud and Medicaire; sliding pay scale ($45, or $25 for interns).

UNM Psych Clinic: 277-5164

-sliding pay scale

(See Relevancy, Inc., too)

Crisis and Domestic Violence

Agora Crisis Center (at UNM, student run): 277-3013

Hogares: 345-8471

-for teens mostly, families of troubled teens, too: SA, suicide, family problems; inpatient and outpatient. (Outpatient is from 8am-12pm or 3pm-6pm, weekdays?)

Rape Crisis Center: 266-7711

Suicide Crisis Line: 265-7557

Albuquerque Women's Resource Center: 242-7033

Domestic Violence Family Program: 262-4324

Women's Community Association: 247-4219

Rent Assistance

Clearing House: 346-1504

-they help with rent, groceries, and certain other expenses or material needs; call them and they will put you in touch with the nearest Catholic parish participating in the program; do not have to be a member of any parish.

St. Martin's: 766-6876 x. 241

HELP New Mexico: 265-3714

-must qualify: income not more than $970/month per individual in household, appropriate picture ID, social security cards for all members of the family, proof of income for the past 12 months for all working members of the household, assist with overdue utilities and rent, prescriptions, school books, and job searching

Legal and Advocacy Services

Homeless Advocacy Coalition, Inc.: 255-8323

Homeless Court: 841-8173 (Edwina Abeyta: 841-8230

Metro Court: 841-8100

ABQ Bar Asociation Lawyer Referral Service (has fee): 243-2615

State Bar of New Mexico Lawyer Referral Service: 876-6227

Financial Assistance

NM Income Support Division: 432-6217

Salvation Army -- Project Unite: 242-1416

St. Vincent De Paul Society: 242-3434

Medical Services

Healthcare for the Homeless (medical, dental and psychiatric): 242-4644
First Nations (Native Americans or underserved populations): 262-2481
UNM Mental Health Center: 272-2800

Native American Services

ABQ Indian Center: 268-4418
All Indian Pueblo Council: 884-3820
Indian Hospital

Other Services

Teamworks: 244-3038
Literacy Volunteers: 224-4313
NM Children, Youth and Families Department: 1-800-432-2075
AIDS Services: 266-0911
Alta Mira: 294-7994
Birthright: 262-2235
Women Infant/Children: 272-2507
ABQ Public School New Futures School: 883-5680
Welfare Offices: 841-2307 (SW), 841-2600 (SE), 841-7740 (NE)

Meals, Pantries, etc.
St. Vincent De Paul Society: 242-3434
Road Runner Food Bank: 247-2052
St. Felix Pantry: 891-8075 (Sister Mary Genevieve)
First United Methodist Church: 243-5646
Project Share: 242-5677
St. Michaels and All Angels Food Pantry: 345-0742
The Storehouse: 842-6491
St. Martin's Hospitality Center: 843-9505
Noon Day Ministry: 246-8001

Education

ABQ Technical Vocational Institute: 224-3000
SW Employment and Training Program (ages 16-24): 268-4500
SW Indian Polytechnic Institute: 346-2340
TVI