eagala
The Global Standard for Equine Assisted Psychotherapy & Personal Development

eagala MILITARY SERVICES

Dear Participant,

Your equine mental health services are being funded by The Veterans Administration Adaptive Sports Grant that was awarded to the Equine Assisted Growth and Learning Association (eagala). Eagala has a network of specially trained and credentialed Military Services Programs across the nation who are the partners in providing services under this grant.

The attached packet of mental health assessments is being administered to you prior to and immediately following your complete treatment as a means of measuring any changes in your symptoms as a result of the treatment. This is a quality assurance practice that is commonly utilized in a mental health practice as a way of gauging your progress, and ensuring quality care. Additionally, as a condition of the grant proposal, Eagala intends to utilize the outcomes of these measures in aggregate (combined with data from other participants) to be able to report back to the grant funder about the overall success of this program. Data which reflects a successful program will support future grant proposals and will allow Eagala to apply for additional grants so that more of these services will be available to Veterans and Servicemembers in the future.

The data in this packet will be de-identified, meaning there should be no name or any other identifying information about you which could be used to personally identify you and match you with your data. Please do not place your name or any other identifying information on any of the assessment pages of this packet. Program staff will instead assign a unique ID code to the completed packet in order to match and track your pre- and post- assessments for purposes of assessing any changes. Completed packets will then be mailed to the Grant Coordinator who will combine the data with data from other participants so that we can assess overall impacts of this program.

Your participation in providing your personal health information is voluntary, you do not have to provide your personal health information in these assessments, however you may not be able to receive services under this grant if you decline because the reporting of overall outcomes (general, aggregated data combined from all participants) is a requirement within the approved grant program.

INFORMED CONSENT:

To allow the Eagala to collect data on your personal health for purposes of quality assurance/improvement and for the reporting of the overall outcomes of this program to the grant funder please print, sign and date below:

Name (please print legibly): _____ Date: _____

Signature: _____

You have the additional option to elect to have your data utilized for archival research and publication. Archival research is research that is done to an existing dataset – in this case, with your consent, data collected on you for the explicit and restricted purposes described above, could be further utilized for analysis at an aggregate (combined with data from other participants) level to look for additional outcomes. This clinical outcome data could also be reported in aggregate within publications. Eagala intends to utilize data collected within this program for archival research and publication as a means of generating greater awareness about the impact of Eagala model equine assisted psychotherapy with the goal of supporting more of these services becoming available more widely to Veterans and Servicemembers in the future.

To allow the Eagala to collect data on your personal health for purposes of archival research and reporting of the overall aggregated outcomes of this program through publication please print, sign and date below:

Name (please print legibly): _____ Date: _____

Signature: _____

*Participant ID*_____ *Date*_____

DEMOGRAPHICS QUESTIONNAIRE

BASIC

1. Age: _____

2. Gender:
    a. male
    b. female

3. Race/Ethnicity:
    a. White/ Caucasian
    b. Black/ African American
    c. Asian/ Pacific Islander
    d. Native American
    e. Hispanic/Latino/Latina
    f. Other _____

4. Marital Status: _____

5. Number of Children: _____

6. Years of Formal Education (mark highest):
    a. Less than High School Diploma
    b. High school graduate/ GED
    c. Some college or technical school
    d. Graduate of technical school
    e. Graduate of college
    f. Some graduate school
    g. Advanced/ professional degree (master's, Ph.D. MD, etc)

7. Current Employment
    a. unemployed, disabled
    b. unemployed, looking for work
    c. working part time
    d. working full time
    e. in school only
    f. in school and working PT
    g. in school and working FT

8. Occupation: _____

*Participant ID*_____ *Date*_____

MILITARY SERVICE

9. Branch of service:
    a. Army
    b. Marine Corps
    c. Navy
    d. Air Force
    e. Coast Guard

10. Were you deployed outside of the U.S.? YES NO

IF yes:

10a. number of deployments? _____

10b. How many OIF/OEF/OND deployments? _____

10c. At the time you were activated for deployment(s) were you:
    a. National Guard (Army or Air Force)
    b. Reserves
    c. Active duty

10d. Location and time period of any Deployments:

1st Deployment: _____

2nd Deployment: _____

3rd Deployment: _____

10e. Primary deployment duties: _____

11. Did you experience combat during your military service? YES NO

12. Did you experience Military Sexual Trauma (MST) during your military service? YES NO

MENTAL HEALTH HISTORY

13. Have you ever been diagnosed with PTSD? YES NO

14. Have you experienced a traumatic event at any point in your life? YES NO

IF Yes, was it combat related? YES NO

IF NO, was it related to your military service? YES NO

15. Have you ever been diagnosed with another mental health condition(s)?

YES NO

If Yes, please specify: _____

16. Are you currently receiving any other/additional mental health treatment?

YES NO

If yes, please specify: _____

If yes, do you plan to continue this other treatment concurrently while receiving services under this grant program? YES NO

Thank you for your time and service!

*Participant ID*_____
*Date*_____

Therapy Evaluation Form

We would like you to indicate below how much you believe, right now, that the therapy you are receiving will help to reduce your PTSD. Belief usually has two aspects to it: (1) what one thinks will happen and (2) what one feels will happen. Sometimes these are similar; sometimes they are different. Please answer the questions below. In the first set, answer in terms of what you think. In the second set, answer in terms of what you really and truly feel.

Set I

1. At this point, how logical does the therapy offered to you seem? (Circle one number)

1	2	3	4	5	6	7	8	9
not at all logical			somewhat logical					very logical

2. At this point, how successfully do you think this treatment will reduce your PTSD? (Circle one number)

1	2	3	4	5	6	7	8	9
not at all useful			somewhat useful					very useful

3. How confident would you be in recommending this treatment to a friend who experiences PTSD? (Circle one number)

1	2	3	4	5	6	7	8	9
not at all confident			somewhat confident					very confident

4. By the end of the therapy period, how much improvement in your PTSD do you think will occur? (circle one number)

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

(PLEASE COMPLETE PAGE 2)

*Participant ID*_____
*Date*_____

Set II

For this set, close your eyes for a few moments, and try to identify what you really feel about the therapy and its likely success. Then answer the following questions.

1. At this point, how much do you really feel that the therapy will help you reduce your PTSD? (Circle one number)

1	2	3	4	5	6	7	8	9
not at all			somewhat logical					very

2. By the end of the therapy period, how much improvement in your PTSD do you really feel will occur? (Circle one number)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: Participant ID ONLY DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

The Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985)

Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

The 7-point scale is:

1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Neither Agree nor Disagree
5 = Slightly Agree
6 = Agree
7 = Strongly Agree

_____ In most ways my life is close to my ideal.

_____ The conditions of my life are excellent.

_____ I am satisfied with my life.

_____ So far I have gotten the important things I want in life.

_____ If I could live my life over, I would change almost nothing.

Subject ID: _____

Sheehan Disability Scale

Test Date: _____

Examiner: _____

INSTRUCTIONS:
Please circle the number based upon how much your symptoms bothered or distressed you during the past week.

1. WORK/SCHOOL:
The symptoms have disrupted your work / school work.

Not at all	Mildly			Moderately			Markedly			Extremely
0	1	2	3	4	5	6	7	8	9	10

2. SOCIAL LIFE:
The symptoms have disrupted your social life.

Not at all	Mildly			Moderately			Markedly			Extremely
0	1	2	3	4	5	6	7	8	9	10

3. FAMILY LIFE / HOME RESPONSIBILITIES:
The symptoms have disrupted your family life / home responsibilities.

Not at all	Mildly			Moderately			Markedly			Extremely
0	1	2	3	4	5	6	7	8	9	10

Days Lost:
On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

Days Underproductive:
On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? _____

AAQ-II

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	2	3	4	5	6	7
never true	very seldom true	seldom true	sometimes true	frequently true	almost always true	always true

1.	My painful experiences and memories make it difficult for me to live a life that I would value.	1	2	3	4	5	6	7
2.	I'm afraid of my feelings.	1	2	3	4	5	6	7
3.	I worry about not being able to control my worries and feelings.	1	2	3	4	5	6	7
4.	My painful memories prevent me from having a fulfilling life.	1	2	3	4	5	6	7
5.	Emotions cause problems in my life.	1	2	3	4	5	6	7
6.	It seems like most people are handling their lives better than I am.	1	2	3	4	5	6	7
7.	Worries get in the way of my success.	1	2	3	4	5	6	7

This is a one-factor measure of psychological inflexibility, or experiential avoidance. Score the scale by summing the seven items. Higher scores equal greater levels of psychological inflexibility.

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (in press). Preliminary psychometric properties of the Acceptance and Action Questionnaire – II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy*.