

## **BEYOND ADVERSITY SURVEY**

**Article: The impact of adverse childhood experiences and recent life events on anxiety and quality of life in university students.**

# PERSONAL CIRCUMSTANCES

Thank you for participating. First, we would like to ask you about your personal circumstances.

If you feel upset responding to any of the questions in this survey, it is OK if you prefer not to answer them. You may want to take a break and come back to the survey later. You may want to contact UEL's Wellbeing Service via the Hub. Wellbeing Advisors are offering telephone support during their usual drop in session times that run from:

1-3pm Mon/Tues/Thurs/Fri or  
5-7pm on Wednesdays at the Stratford Hub.

If you are in acute distress, please contact the Samaritans: [www.samaritans.org](http://www.samaritans.org) / 08457909090 / [jo@samaritans.org](mailto:jo@samaritans.org) for emotional help. They are available 24 hours a day, 365 days of the year.

What is your current relationship status?

- Single
- In a relationship but not living together
- Cohabiting
- Married
- In a civil partnership
- Divorced or separated
- Widowed

What's your sexual orientation

- Gay
- Lesbian
- Bisexual
- Heterosexual
- Other

If you selected Other, please specify:

Please estimate below the approximate number of hours each week you are committed to other activities during term time:

	Number of hours					
	0	1-10	11-20	21-30	31-40	More than 40
Paid work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Volunteering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other caring responsibilities (eg caring for sick parents or disabled grandparents)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have children?

No

Yes

# Children

Please tell us a little about your children.

	How old are your children?				Do your children live with you?		Do your children have a disability?	
	0-5 years	6-10 years	11-17 years	Adults	Yes	No	Yes	No
Child 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child 2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child 3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child 4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child 5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

# Quality of Life

Please rate the following statements about your current life on a 7-point scale:

Please don't select more than 1 answer(s) per row.

Please don't select more than 4 answer(s) in any single column.

	Worst possible	2	3	4	5	6	Best possible
Quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worries about money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you experienced any form of discrimination?

yes
  no

If yes, please provide some information about the discrimination.

Over the **LAST 2 WEEKS**, how often have you been bothered by the following problems?

Please don't select more than 1 answer(s) per row.

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# ADVERSE CHILDHOOD EXPERIENCES

We'd now like to ask you some questions about events that may have happened during your childhood. Some people may feel uncomfortable with these questions. Please keep in mind that you can skip any question you do not want to answer. At the beginning and end of the survey, there is the contact details for student health and wellbeing and a 24-hour mental health crisis line.

While you were growing up, before the age of 18:

Were your parents ever separated or divorced?

- Yes  No  Parents didn't live together

Did you live with anyone who was depressed, mentally ill or suicidal?

- Yes  No

Did you live with anyone who was a problem drinker, alcoholic or drug user?

- Yes  No

Did you live with anyone who served time or was sentenced to serve time in a prison or young offenders' institution?

- Yes  No

Have you been treated badly because of race, sexual orientation, place of birth, disability or religion?

- Never  Once  More than once

Have you been threatened, hit or hurt badly in school or the community?

- Never  Once  More than once

Have you been attacked, stabbed, shot at or robbed by threat?

- Never  Once  More than once

Did a parent or adult in your home ever swear at you, insult you, or put you down?

- Never  Once  More than once

Were there times when there was no adult living with you who made you feel loved?

- Never  Once  More than once

Did your parent/caregiver for long periods of time not provide you with enough food or drink, clean clothes or a clean and warm place to live when they could have?

- Never  Once  More than once

Did your parents or adults in your home slap, hit, kick, punch or beat each other up?

- Never  Once  More than once

Did someone ask you online to take or send pictures of your private parts?

- Never  Once  More than once



Did an adult or person at least 5 years older than you EVER sexually touch or fondle you, have sex with you or force you to engage in sexual acts?

Never

Once

More than once

# STRESSFUL EVENTS

Below is a list of stressful life events that may affect our wellbeing and behaviour. Please indicate those events that happened in the last year and are currently a strong burden to you or have been a strong burden to you in the last six months. Please indicate as many events as applicable.

- Divorce / separation
- Family conflicts
- Conflicts in work life
- Conflicts with neighbours
- Illness of a loved one
- Death of a loved one
- Adjustment due to retirement
- Unemployment
- Too much / too little work
- Pressure to meet deadlines / time pressure
- Moving to a new home
- Financial problems
- Own serious illness
- Serious accident
- Assault
- Termination of an important leisure activity

Other stressful events (please specify)

# RESILIENCE

The following questions ask about your feelings and thoughts during **THE PAST MONTH**. In each question, you will be asked **HOW OFTEN** you felt or thought a certain way. Although some of the questions are similar, there are small differences between them and you should treat each one as a separate question. The best approach is to answer fairly quickly. For each statement, please tell me if you have had these thoughts or feelings: never, almost never, sometimes, fairly often, or very often. (Read all answer choices each time)

[More info](#)

Please don't select more than 1 answer(s) per row.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
In the past month, how often have you been upset because of something that happened unexpectedly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, how often have you felt unable to control the important things in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, how often have you felt nervous or stressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, how often have you felt confident about your ability to handle personal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, how often have you felt that things were going your way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, how often have you found that you could not cope with all the things you had to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the past month, how often have you been able to control irritations in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, how often have you felt that you were on top of things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, how often have you been angry because of things that happened that were outside of your control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, how often have you felt that difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# COMPLETING YOUR DEGREE

This is the last page of questions.

Not all students who start a university degree complete the course; students withdraw from university for many reasons. So we'd like to ask you about your intention to complete your degree and your use of UEL's support services.

How likely are you to complete your degree?

- Definitely
- Probably
- Not sure
- Probably not
- Definitely not

Have you used any of the following support services at UEL?

Please don't select more than 1 answer(s) per row.

	Yes	No	Don't know what this is
Academic Advisor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student Wellbeing Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SMART Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Centre for Student Success	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disability and Dyslexia Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have used any of these services, how helpful were they?

Please don't select more than 1 answer(s) per row.

	Very helpful	Helpful	Neither helpful nor unhelpful	Unhelpful	Very unhelpful
Academic Advisor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Hub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Student Wellbeing Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SMART Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disability and Dyslexia Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Centre for Student Success	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other comments

### NEXT STEPS

	Yes	No
Please email me the results of the overall survey	<input type="radio"/>	<input type="radio"/>
I would like to be informed of the next steps in this project so I can choose whether or not to be involved	<input type="radio"/>	<input type="radio"/>

Email

