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5th INTERNATIONAL TRAUMA INFORMED CARE ONLINE CONFERENCE

26TH NOVEMBER 2024

CONFERENCE POSTERS & WIDER RESOURCES

Centre for Developmental and Complex Trauma
Part of St Andrew's Healthcare

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Integrating Psychologists into Voluntary Sector (Second Step) Teams: What We've Learned in Somerset

Graham Ball & Lauren Hawksley

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SECOND STEP
PUTTING MENTAL HEALTH FIRST

Background

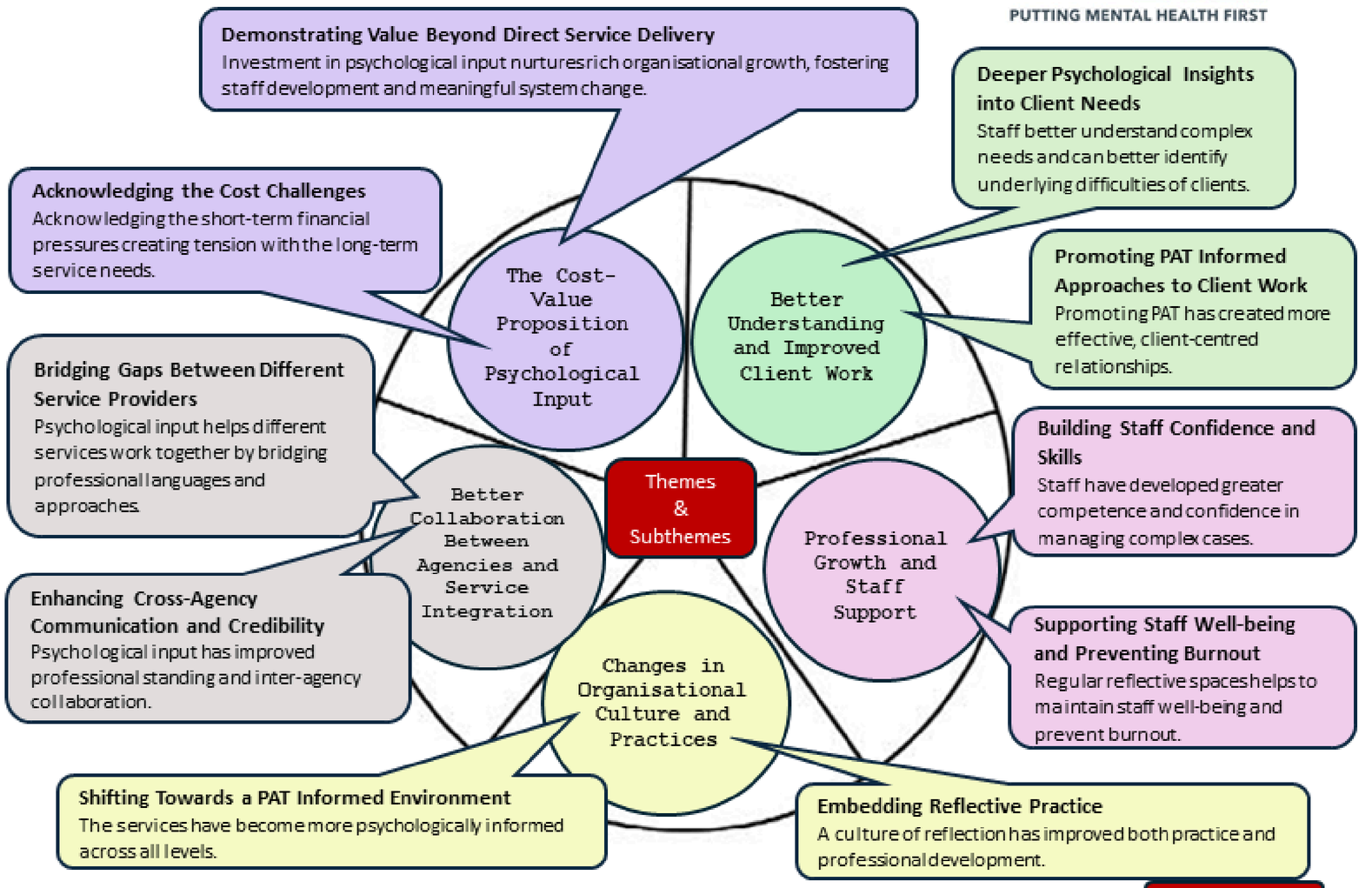
- Second Step, a mental health and housing support charity in the Southwest of England, employed psychology teams into two of their Somerset services: Step Together and Family Safeguarding
- The Psychological, Adversity, and Trauma (PAT) informed approach (developed by Second Step) is based on the idea that "we are all the product of our experiences" (Second Step, 2020). Instead of asking "what's wrong" with a person, it asks "what happened" in their life, recognising that how people act and cope often comes from their difficult life experiences.
- The Step Together service offers support to people experiencing homelessness and multiple disadvantages in Somerset. The psychology team consists of two psychologists.
- The Family Safeguarding team in Somerset offers support to parents who are working with children's social care to improve their family situation. The psychological team consists of a Senior Psychologist, and a Family Systemic Psychotherapist.
- Across both services the responsibilities of the psychological teams are to provide reflective one-to-one and group spaces, formulation, direct client therapy work, developing training and resources for staff, and some provide external consultation to partnering agencies.
- This service evaluation aims to qualitatively explore the benefits and challenges of having psychologists working within these teams.

Evaluation Question

"What can be learnt from having psychologists working within homelessness services and safeguarding services in Somerset?"

Methods & Participants

- Eighteen participants were recruited to four focus groups, conducted via Teams: i) client-facing staff and ii) managers from Step Together, iii) combined client-facing staff and a manager from Family Safeguarding Team, and iv) psychologists across Second Step.
- A semi-structured interview guide focused on experiences of working with psychologists exploring the benefits and challenges was used.
- The Teams sessions were recorded and transcribed, and Thematic Analysis (Braun & Clarke, 2006) was used to develop emerging themes from the data.
- Ethical approval was obtained from Second Step, the organisation overseeing the services. Informed consent was secured from all participants prior to involvement.



Conclusions

- The stories shared by the staff show psychological input has helped create empathetic, trauma-informed environments, and foster deeper relationships between the staff and their clients. Staff talked about feeling more confident in managing complex cases and being more resilient, crediting this growth to the supportive spaces and reflective practices that psychologists provide.
- Having psychologists on board has sparked changes in organisational culture, weaving reflective practices and psychological thinking into the everyday work of the service. This has led to better conversations between agencies and boosted credibility within the wider networks these services reside.
- Whilst staff were open about the financial challenges of keeping psychologists in their roles, their stories consistently showed that the benefits outweigh the costs. The wide-ranging impact of psychological input on service quality, staff growth, and overall improvements highlights its real value.
- Looking ahead, keeping and possibly expanding this model of integrating psychological support has both opportunities and challenges. However, the overwhelmingly positive experiences shared suggest that continuing to invest in psychological input holds significant benefits in providing high-quality, responsive services to the populations that use these services.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Second Step (2020). *Becoming Psychological, Adversity and Trauma Informed - Second Step Bristol*. [online] Second Step. Available at: https://www.second-step.co.uk/about-us/psychological-adversity-and-trauma-informed/ [Accessed 25 Oct. 2024].

Complex PTSD as an indicator of internalizing spectrum

Ole Melkevik[1], Anni B.S. Nielsen[1,2], Katrine Friis[3], Caroline Lund[1], Bjarke W. Schmidt[1], Sofie Folke[3]

INTRODUCTION

ICD-11 complex posttraumatic stress disorder (CPTSD) is described as severe and persistent symptoms of PTSD and disturbances in self-organization (DSO). Validation studies argue that CPTSD and PTSD are empirically distinguishable constructs. We are not convinced in light of limitations in the literature.

1. I**nconsistent results:** 9 out of 18 validation-studies identify the ICD-11 model to be relatively superior to other tested models
2. Relative comparisons are frequently limited to one or two competing models, **thus most models are rarely compared or rejected**
3. **Inconsistent use of model selection criteria** in ITI studies
4. Defining CPTSD as a latent variable while **defining other symptoms as sum-scores** may conceal poor model fit and ensure apparent discriminant validity
5. **Impossible estimates are frequent** and consistently ignored in the commonly preferred operationalization of CPTSD

AIM

To investigate whether symptoms of CPTSD fit the proposed ICD-11 operationalization, or if an internalizing spectrum could explain symptoms

METHOD

124 treatment-seeking veterans at the Military Psychology Department, The Danish Veterans Centre, in the Danish Defense were interviewed with the International Trauma Interview (ITI). The best fitting CFA model(s) were tested in hierarchical models alongside latent factors measuring depression, anxiety, stress and well-being. The tested models are shown under (Figure 1)

Figure 1. Alternative models of the latent structure of ICD-11 PTSD and CPTSD symptoms

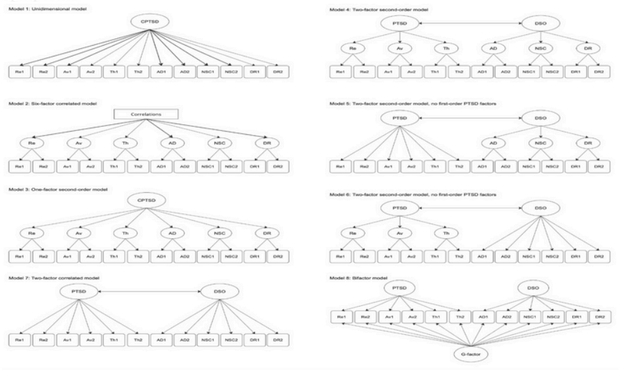
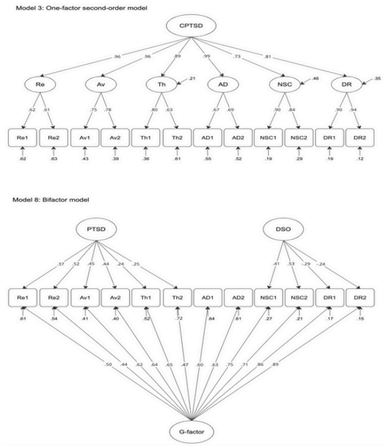


Figure 2. Models showing standardized factor loadings and residual errors for the single-factor higher-order model (M3) and the Bifactor model (M8)



RESULTS

Prevalence: 80 veterans (65%) had CPTSD, 17 (14%) had PTSD and 26 (21%) had no diagnosis.
Severity: Veterans with CPTSD had, on average, higher levels of all symptoms on the ITI, relative to those with PTSD
Model comparison: M3 shows the best fit, M8 fits the data adequately, M4 is rejected due to lacking discriminant validity between PTSD and DSO (table 1)
Internalizing Spectrum: A higher order factor explains relationships between CPTSD symptoms and other internalizing symptoms (Table 2 & figure 3)

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Symptoms of CPTSD do not reliably fit the proposed ICD-11 factor structure

A single higher order factor explains the relationship between CPTSD and other internalizing symptoms

A single factor solution may be inevitable in a sample where CPTSD is highly prevalent

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DISCUSSION

Discriminant validity as a model selection criterion
DSO collapses if used in a bifactor model (M8)
CPTSD requires the endorsement of all symptom clusters. A unidimensional solution may therefore be inevitable in samples where the CPTSD prevalence is very high
Internalizing spectrum: Why do symptoms of anxiety, depression, stress and well being fit well in the same unidimensional model?
Limitations: veteran sample, no women, cross-sectional data

Table 1. Model fit statistics for alternative models of ICD-11 CPTSD based on the ITT

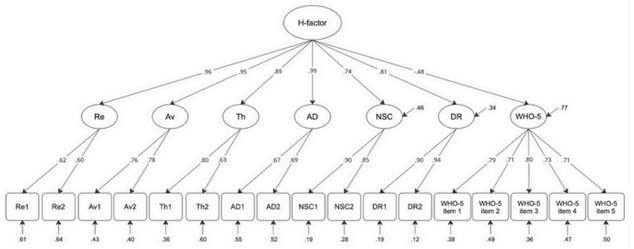
Models	df	Chi-square	P-value	CFI	TLI	RMSEA	AIC	BIC	Heywood case	Lack of discriminant validity
M1	54	165.3	0.000	0.85	0.82	0.13	3397	4098	no	no
M2	39	34.7	0.664	1.00	1.00	0.00	3896	4040	yes	yes
M3	**48**	**52.3**	**0.319**	**0.99**	**0.99**	**0.03**	**3896**	**4014**	**no**	**no**
M4	47	49.5	0.373	1.00	1.00	0.02	3895	4016	yes	yes
M4*	48	49.6	0.418	1.00	1.00	0.02	3893	4011	no	yes
M5	50	53.7	0.335	1.00	1.00	0.00	3893	4006	yes	yes
M5*	51	53.7	0.371	1.00	1.00	0.02	3891	4001	no	yes
M6	50	137.8	0.000	0.88	0.85	0.12	3977	4090	yes	no
M7	53	142.7	0.000	0.88	0.85	0.12	3976	4080	no	no
M8	42	65.3	0.012	0.97	0.95	0.07	3921	4056	no	no

Table 2. Standardized regression coefficients between the H-factor in Figure 1 and the external variables

	Anxiety	Depression	Stress	Well-being
Beta	0.37*	0.45*	0.51*	-0.49*
CFI	0.94	0.95	0.95	0.99
TLI	0.93	0.94	0.95	0.99
RMSEA	0.05	0.05	0.05	0.03
Chi-square	384	394	373	125
Df	290	288	289	112
P-value	0.00	0.00	0.00	0.19

*p<0.001

Figure 3. A single factor higher-order model explaining the relationship between CPTSD and well-being



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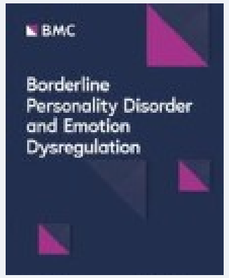
WIDER LITERATURE OF INTEREST

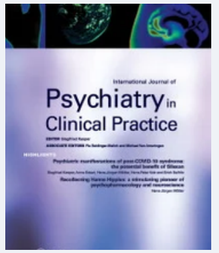


PREDICTORS OF COMPLEX PTSD: THE ROLE OF TRAUMA CHARACTERISTICS, DISSOCIATION, AND COMORBID PSYCHOPATHOLOGY

Background: Complex Posttraumatic Stress Disorder (CPTSD) has previously been associated with earlier trauma onset, repeated interpersonal traumatization, more dissociation, and more comorbid psychopathology. However, it is still debated if the afore-mentioned risk factors are related to CPTSD diagnosis or rather indicative of a more severe form of post-traumatic distress. The aim of this study was to compare patients with a CPTSD diagnosis to those with PTSD in trauma characteristics (onset, chronicity, interpersonal nature, familiarity with perpetrator), dissociation, and psychiatric comorbidities, while accounting for symptom severity.
Methods: In total, N = 81 patients with a trauma history (n = 43 with CPTSD; n = 37 with PTSD) underwent diagnostic interviews by trained clinicians and completed measures on CPTSD symptom severity, trauma characteristics, and dissociation (Screening for Complex PTSD; Dissociative Experience Scale Taxon).
Results: Patients with CPTSD reported earlier onset of trauma, more trauma perpetrated by acquaintances or family members, and more comorbidities than those with PTSD, also when accounting for symptom severity. No group differences in chronicity and dissociation were found. Severity of CPTSD was associated with earlier onset, familiarity with perpetrator, more comorbid (affective) disorders, and dissociation in both diagnostic groups.
Conclusion: Findings largely confirm earlier research, suggesting that CPTSD is associated with traumatic events that start earlier in life and are perpetrated by acquaintances. Focusing on transdiagnostic symptoms, such as dissociation, may help to detain symptom deterioration. Due to the small sample size, findings need to be interpreted with caution and further research is needed to replicate findings in larger samples. Future research should also elucidate possible working mechanisms besides dissociation, such as emotion dysregulation or negative self-image.

ASSESSMENT TOOLS FOR COMPLEX POST TRAUMATIC STRESS DISORDER: A SYSTEMATIC REVIEW

Aim: Appropriate screening tools are required to accurately detect complex post traumatic stress disorder (CPTSD). This systematic review aimed to assess and compare measurement tools.
Method: A literature search using key words ‘complex post traumatic stress disorder’, ‘PTSD’, and ‘assessment’ was undertaken on Embase and PsychINFO during February 2022 by two reviewers. Inclusion criteria included full text papers between 2002–2022 which evaluated CPTSD using assessment tools. Exclusion criteria included reviews, editorials, meta-analyses, or conference abstracts.
Results: Twenty-two papers met selection criteria. Thirteen studies used the International Trauma Questionnaire (ITQ). Two studies each evaluated CPTSD with the International Trauma Interview (ITI) or Symptoms of Trauma Scale (SOTS). The Developmental Trauma Inventory (DTI), Cameron Complex Trauma Interview (CCTI), Complex PTSD Item Set additional to the Clinician Administered PTSD Scale (COPISAC), Complex Trauma Questionnaire (ComplexTQ), and Scale 8 of the Minnesota Multiphasic Personality Inventory Scale (MMPI) were used by a single study each.The ITQ was the most thoroughly investigated, validated across different populations, and is a convenient questionnaire for screening within the clinical setting. Where self-report measures are inappropriate, the ITI, SOTS, and COPISAC are interview tools which detect CPTSD. However, they require further validation and should be used alongside clinical history and examination.

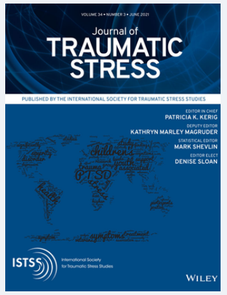


WIDER LITERATURE OF INTEREST

COMPLEX TRAUMA FROM CHILD ABUSE & NEGLECT: "I'M NOT SURE WE'RE EVEN ALL TALKING ABOUT THE SAME THING AND WE'RE PROBABLY NOT"

Aims: This research aimed to assess the conceptual maturity of complex trauma for children and young people who have experienced abuse and neglect by discussing the concept with Australian experts. The research aimed to conceptualise complex trauma through a dimensional lens and impacts-based approach. The overall aim was to increase understanding of the development and maintenance of complex trauma and its distinctiveness from other types of trauma.
Method: Group interviews were conducted, and reflexive thematic analysis was used to analyse the data. A member-checking survey helped review and improve the findings.
Results: Findings suggest a vast array of impacts from complex trauma, that diagnostic boxes may not be right for complex trauma, and that the potentially chaotic cycle of complex trauma perpetuates issues. Results from this pilot indicate that complex trauma may be an immature concept for expert clinicians and researchers alike.
Conclusions: Despite assessing complex trauma as an emerging or even immature concept, the discussion generates direction forward and suggests further research avenues. Associated ideas and emerging concepts begin a conceptual discussion of complex trauma.

A PILOT STUDY OF THE EFFICACY OF THE UNIFIED PROTOCOL FOR TRANSDIAGNOSTIC TREATMENT OF EMOTIONAL DISORDERS IN TREATING POSTTRAUMATIC PSYCHOPATHOLOGY: A RANDOMIZED CONTROLLED TRIAL



The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP) is an intervention that targets common mechanisms that maintain symptoms across multiple disorders. The UP has been shown to be effective across many disorders, including generalized anxiety disorder, major depressive episode (MDE), and panic disorder, that commonly codevelop following trauma exposure. The present study represented the first randomized controlled trial of the UP in the treatment of trauma-related psychopathology, including posttraumatic stress disorder (PTSD), depression, and anxiety symptoms.

Adults (N = 43) who developed posttraumatic psychopathology that included PTSD, MDE, or an anxiety disorder after sustaining a severe injury were randomly assigned to receive 10–14 weekly, 60-min sessions of UP (n = 22) or usual care (n = 21). The primary treatment outcome was PTSD symptom severity, with secondary outcomes of depression and anxiety symptom severity and loss of diagnosis for any trauma-related psychiatric disorder. Assessments were conducted at intake, posttreatment, and 6-month follow-up. Posttreatment, participants who received the UP showed significantly larger reductions in PTSD, Hedges' g = 1.27; anxiety, Hedges' g = 1.20; and depression symptom severity, Hedges' g = 1.40, compared to those receiving usual care. These treatment effects were maintained at 6-month follow-up for PTSD, anxiety, and depressive symptom severity. Statistically significant posttreatment loss of PTSD, MDE, and agoraphobia diagnoses was observed for participants who received the UP but not usual care. This study provides preliminary evidence that the UP may be an effective non–trauma-focused treatment for PTSD and other trauma-related psychopathology.

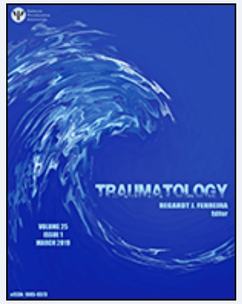
WIDER LITERATURE OF INTEREST

A MULTIFACETED CASE-VIGNETTE INTEGRATING NEUROFEEDBACK AND EMDR IN THE TREATMENT OF COMPLEX PTSD

The methods of neurofeedback (Kirk, 2016) and Eye Movement Desensitization and Reprocessing (Shapiro, 2018; Shapiro & Silk Forrest, 1997) will be reflected in relation to a short-time treatment of a patient with complex PTSD and an unspecified dissociative disorder. The aim is to inspire colleges to integrate therapy methods in their quest to help dysregulated patients to become stabile and regulated enough to endure trauma work. This is considered important, especially when working with patients with severe and complex posttraumatic conditions and dissociative disorders, where the evidence-based treatments often not fit for purpose (Corrigan & Hull, 2015).

An alternative approach is presented with a single case-study of a patient treated with neurofeedback and EMDR in a psychodynamic short-time psychotherapy. The results of these interventions are presented together with the patient's drawings and reflections and finally discussed.

RELATIVE EFFECTS OF CHILDHOOD TRAUMA, INTIMATE PARTNER VIOLENCE, AND OTHER TRAUMATIC LIFE EVENTS ON COMPLEX POSTTRAUMATIC STRESS DISORDER SYMPTOMS.



Complex posttraumatic stress disorder (CPTSD) follows persistent and repeated trauma and is a serious mental health problem among women. One of the strongest predictors of CPTSD symptoms is childhood trauma, especially child abuse and neglect, both of which are traumas that tend to be persistent and repeated. CPTSD is also associated with intimate partner violence (IPV; physical, emotional, and/or sexual violence in an intimate relationship), a trauma that, similar to child abuse and neglect, is also persistent and repeated. However, it is unclear how child abuse/neglect and IPV may jointly influence CPTSD symptoms vis-à-vis other traumatic events. In this study, we examined the relative effects of child abuse/neglect and IPV on CPTSD symptoms over and above other traumatic events in a sample of women (N = 553) using a partial least squares approach to multiple regression and structural equation modeling.

Results indicated that in general childhood trauma was the strongest predictor of CPTSD symptoms. However, when we analyzed specific aspects of child abuse, child neglect, and IPV, we found that childhood emotional abuse was the primary predictor of CPTSD symptoms over and above the effects of other traumatic life events, with sexual and emotional IPV also having small effects. These results highlight the salient effects of childhood emotional trauma on CPTSD symptoms among women, underscoring the importance of assessing for this in women presenting for treatment of CPTSD.

WIDER LITERATURE OF INTEREST

FUNCTIONAL NEUROIMAGING IN PTSD: FROM DISCOVERY OF UNDERLYING MECHANISMS TO ADDRESSING DIAGNOSTIC HETEROGENEITY

Exposure to trauma is highly common worldwide, ranging from interpersonal assaults to disasters, wars, and pandemics. Ensuing trauma-related psychopathology is common, broad, and diverse. Although a history of traumatic events is found across a spectrum of psychiatric disorders, including anxiety, depressive disorders, bipolar illness, and schizophrenia, posttraumatic stress disorder (PTSD) is the most researched trauma-related psychiatric disorder over the past four decades. A 2013 World Health Organization study of 21 countries estimated that 3.6% percent of the world's population suffers from PTSD. In the United States, the lifetime prevalence of PTSD among adults is estimated at 6.8%, with a current past-year prevalence of 3.5%. Military personnel, facing higher risk for trauma exposure through combat, injury, captivity, and sexual assault, face even higher rates, reaching up to 30%.

Despite extensive research, available psychotherapies and pharmacotherapies for PTSD have shown only limited benefits. For example, for prolonged exposure—the gold-standard PTSD treatment—nonresponse rates range from 25% to 60%, with dropout rates reaching 50% (9, 10). Similarly, few medications have been found to ameliorate PTSD, with small effect sizes. Military veterans, a highly trauma-exposed population, benefit even less from existing treatments and have higher attrition rates.

The cause of limited treatment efficacy in PTSD may lie not only in the treatments themselves but in the heterogeneity within the diagnosis of PTSD. PTSD is currently defined by exposure to a wide variety of traumatic events and by a broad constellation of physical, affective, behavioral, and cognitive symptoms. Improving the diagnostic specificity of PTSD would yield more homogeneous patient samples and increase the likelihood of identifying clinically meaningful neurobiological markers, which could in turn serve as objective, measurable targets for novel and specific treatments. In trying to address the problem, functional neuroimaging studies have become central to efforts to characterize neural markers of PTSD. Commonly they include task-based functional MRI (fMRI), aiming to elucidate brain regions that are differentially activated during processing of affective and cognitive stimuli, and resting-state fMRI (rs-fMRI) experiments, aiming to identify brain-wide networks that are altered in psychiatric disorders. This review covers progress in these areas, highlighting current limitations and ways to overcome them.

ADDITIONAL TRAUMA RESOURCES: SCREENING AND ASSESSMENT TOOLS

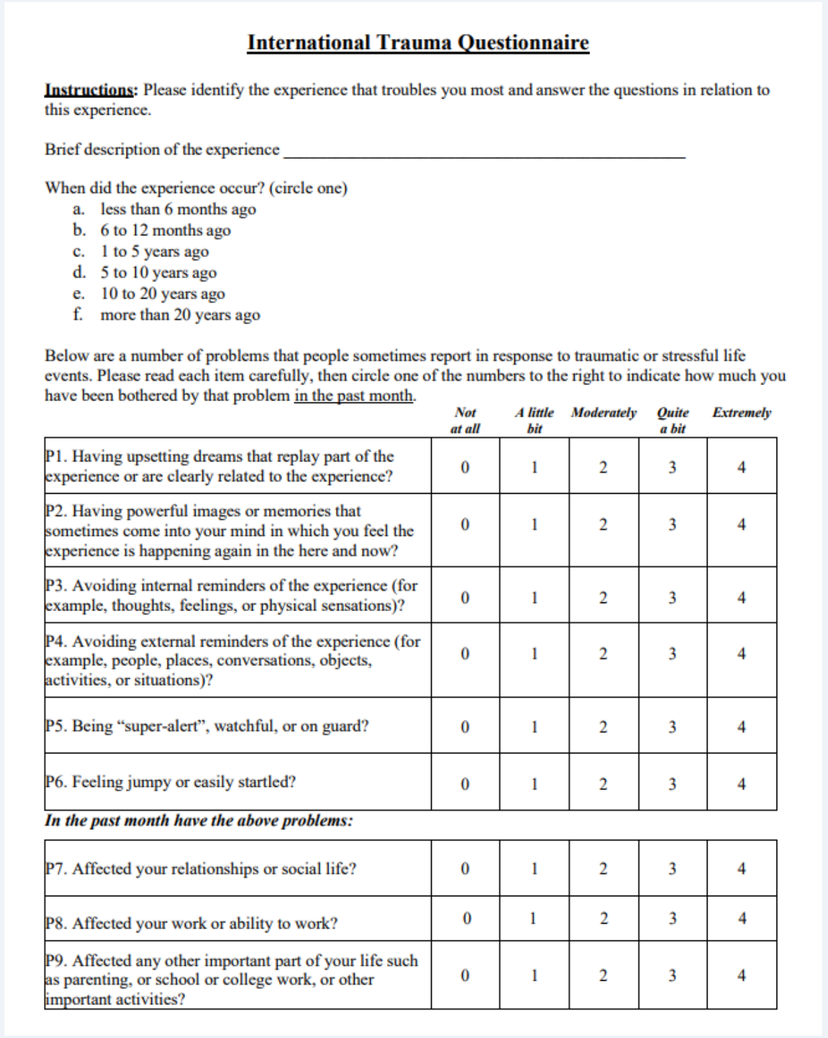
INTERNATIONAL TRAUMA QUESTIONNAIRE

‘”The **International Trauma Questionnaire** (ITQ) is a brief, simply worded measure, focusing only on the core features of PTSD and CPTSD, and employs straightforward diagnostic rules. The ITQ was developed to be consistent with the organizing principles of the ICD-11, as set forth by the World Health Organization, which are to maximize clinical utility and ensure international applicability through a focus on the core symptoms of a given disorder.”

Several versions of the ITQ have been developed and validated, dependent on the needs of the individual being assessed.

The ITQ can be freely accessed at:

https://www.traumameasuresglobal.com/itq



International Trauma Questionnaire

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience _____

When did the experience occur? (circle one)

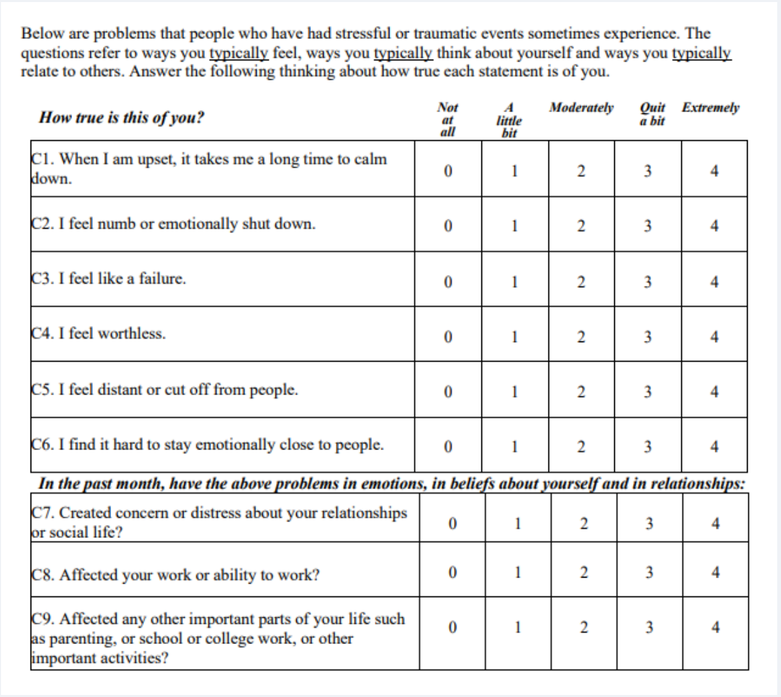
a. less than 6 months ago
b. 6 to 12 months ago
c. 1 to 5 years ago
d. 5 to 10 years ago
e. 10 to 20 years ago
f. more than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?	0	1	2	3	4
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4
P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4
P5. Being “super-alert”, watchful, or on guard?	0	1	2	3	4
P6. Feeling jumpy or easily startled?	0	1	2	3	4

In the past month have the above problems:

P7. Affected your relationships or social life?	0	1	2	3	4
P8. Affected your work or ability to work?	0	1	2	3	4
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4



Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?	*Not at all*	*A little bit*	*Moderately*	*Quit a bit*	*Extremely*
C1. When I am upset, it takes me a long time to calm down.	0	1	2	3	4
C2. I feel numb or emotionally shut down.	0	1	2	3	4
C3. I feel like a failure.	0	1	2	3	4
C4. I feel worthless.	0	1	2	3	4
C5. I feel distant or cut off from people.	0	1	2	3	4
C6. I find it hard to stay emotionally close to people.	0	1	2	3	4

In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:

C7. Created concern or distress about your relationships or social life?	0	1	2	3	4
C8. Affected your work or ability to work?	0	1	2	3	4
C9. Affected any other important parts of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

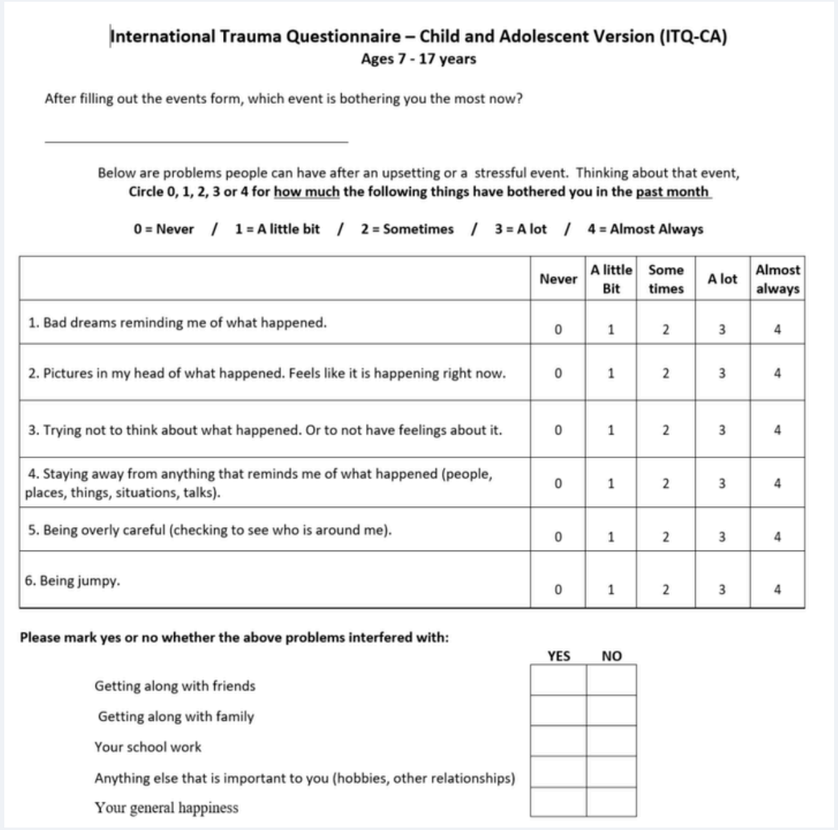
ADDITIONAL TRAUMA RESOURCES: SCREENING AND ASSESSMENT TOOLS

INTERNATIONAL TRAUMA QUESTIONNAIRE - CHILD AND ADOLESCENT VERSION

“The International Trauma Questionnaire Child and Adolescent Version (ITQ-CA) is a brief, simply-worded measure of PTSD and CPTSD symptoms for use with people aged 7 to 17 years. As with the International Trauma Questionnaire, the ITQ-CA was developed to be consistent with the organizing principles of the ICD-11, as set forth by the World Health Organization, which are to maximize clinical utility and ensure international applicability through a focus on the core symptoms of a given disorder”

The ITQ-CA can be freely accessed at:

https://www.traumameasuresglobal.com/itqca



International Trauma Questionnaire – Child and Adolescent Version (ITQ-CA)
Ages 7 - 17 years

After filling out the events form, which event is bothering you the most now?

_____

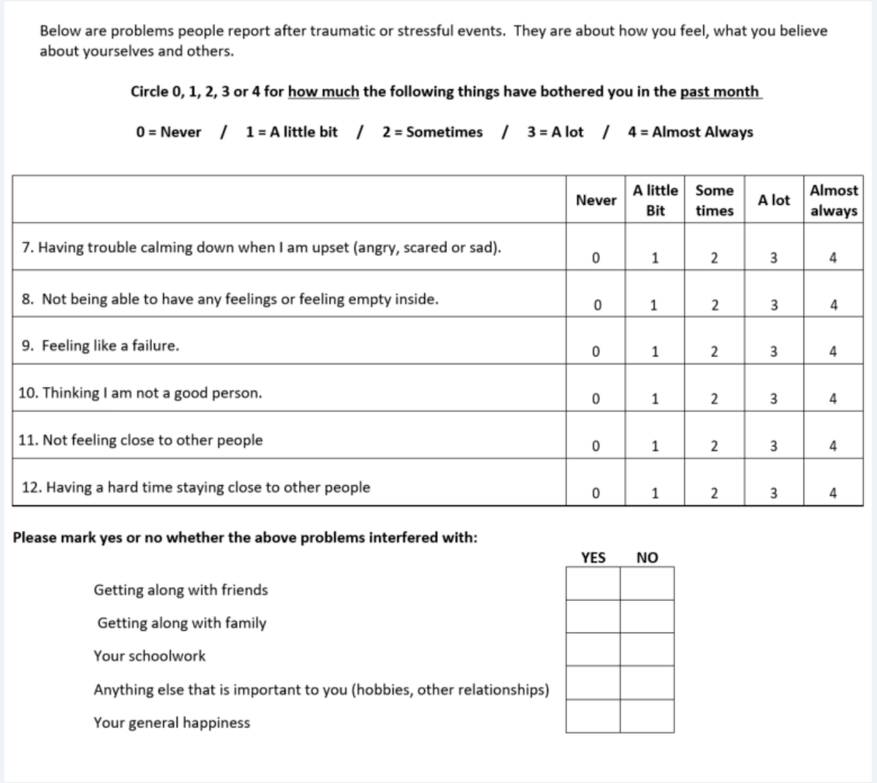
Below are problems people can have after an upsetting or a stressful event. Thinking about that event,
Circle 0, 1, 2, 3 or 4 for how much the following things have bothered you in the past month

0 = Never / 1 = A little bit / 2 = Sometimes / 3 = A lot / 4 = Almost Always

	Never	A little Bit	Some times	A lot	Almost always
1. Bad dreams reminding me of what happened.	0	1	2	3	4
2. Pictures in my head of what happened. Feels like it is happening right now.	0	1	2	3	4
3. Trying not to think about what happened. Or to not have feelings about it.	0	1	2	3	4
4. Staying away from anything that reminds me of what happened (people, places, things, situations, talks).	0	1	2	3	4
5. Being overly careful (checking to see who is around me).	0	1	2	3	4
6. Being jumpy.	0	1	2	3	4

Please mark yes or no whether the above problems interfered with:

	YES	NO
Getting along with friends		
Getting along with family		
Your school work		
Anything else that is important to you (hobbies, other relationships)		
Your general happiness		



Below are problems people report after traumatic or stressful events. They are about how you feel, what you believe about yourselves and others.

Circle 0, 1, 2, 3 or 4 for how much the following things have bothered you in the past month

0 = Never / 1 = A little bit / 2 = Sometimes / 3 = A lot / 4 = Almost Always

	Never	A little Bit	Some times	A lot	Almost always
7. Having trouble calming down when I am upset (angry, scared or sad).	0	1	2	3	4
8. Not being able to have any feelings or feeling empty inside.	0	1	2	3	4
9. Feeling like a failure.	0	1	2	3	4
10. Thinking I am not a good person.	0	1	2	3	4
11. Not feeling close to other people	0	1	2	3	4
12. Having a hard time staying close to other people	0	1	2	3	4

Please mark yes or no whether the above problems interfered with:

	YES	NO
Getting along with friends		
Getting along with family		
Your schoolwork		
Anything else that is important to you (hobbies, other relationships)		
Your general happiness		

ADDITIONAL TRAUMA RESOURCES: SCREENING AND ASSESSMENT TOOLS

INTERNATIONAL TRAUMA EXPOSURE MEASURE

“The International Trauma Exposure Measure (ITEM) is a checklist developed to measure exposure to several traumatic life events in a manner consistent with the definition of trauma exposure in the 11th version of the International Classification of Diseases.

The ITEM measures exposure to 21 different traumatic life events across different developmental periods: childhood, adolescence, and adulthood”

The ITEM can be freely accessed at:

https://www.traumameasuresglobal.com/item

International Trauma Exposure Measure

Instructions: We are interested in knowing if you experienced any of the following traumatic life events during different periods of your life. Please read each description and indicate if it occurred during childhood, adolescence, and/or adulthood.

	Did this event happen…		
	before or during your time in primary school (up to age 12)	**during your time in secondary school** (between ages 13-18)	**after your time in secondary school** (after the age of 18)
1. You were diagnosed with a life-threatening illness.			
2. Someone close to you died in an awful manner.			
3. Someone close to you was diagnosed with a life-threatening illness or experienced a life-threatening accident.			
4. Someone threatened your life with a weapon (knife, gun, bomb etc.)			
5. You were physically assaulted (punched, kicked, slapped, mugged, robbed etc.) **by a parent or guardian**.			
6. You were physically assaulted (punched, kicked, slapped, mugged, robbed etc.) **by someone other than a parent or guardian**.			
7. You were sexually assaulted (rape, attempted rape, or forced sex acts) **by a parent or guardian**.			
8. You were sexually assaulted (rape, attempted rape, or forced sex acts) **by someone other than a parent or guardian**.			
9. You were sexually harassed (received other types of unwanted sexualized comments or behaviours).			
10. You were exposed to war or combat (as a soldier or as a civilian).			
11. You were held captive and/or tortured.			
12. You caused extreme suffering or death to another person.			
13. You witnessed another person experiencing extreme suffering or death.			
14. You were involved in an accident (e.g., transportation, work, home, leisure) where your life was in danger.			
15. You were exposed to a natural disaster (e.g., hurricane, tsunami, earthquake) where your life was in danger.			
16. You were exposed to a human-made disaster (e.g., terrorist attack, chemical spill, public shooting) where your life was in danger.			
17. Another person stalked you.			
18. You were repeatedly bullied (online or offline).			
19. You were repeatedly humiliated, put down, or insulted by another person.			
20. You were repeatedly made to feel unloved, unwelcome, or worthless.			
21. You were repeatedly neglected, ignored, rejected, or isolated.			
22. Any other event not listed (please specify). ----------			

1. Please tell us which event you found the most distressing by entering the number that corresponds to that event from the list above: _____

2. If you experienced this event more than once, please tell us approximately how many times you experienced this event? _____

3. How long ago did this event occur?
   - Less than one month ago ☐
   - 1-6 months ago ☐
   - 6-12 months ago ☐
   - 1-5 years ago ☐
   - 6-10 years ago ☐
   - More than 10 years ago ☐

ADDITIONAL TRAUMA RESOURCES: SCREENING AND ASSESSMENT TOOLS

INTERNATIONAL ADJUSTMENT DISORDER QUESTIONNAIRE

"The International Adjustment Disorder Questionnaire (IADQ) is a brief, simply-worded measure, focusing only on the core features of Adjustment Disorder, and employs straightforward diagnostic rules. The IADQ was developed to be consistent with the organizing principles of the ICD-11, as set forth by the World Health Organization, which are to maximize clinical utility and ensure international applicability through a focus on the core symptoms of a given disorder."

The IADQ can be freely accessed at:

https://www.traumameasuresglobal.com/iadq

THE INTERNATIONAL ADJUSTMENT DISORDER QUESTIONNAIRE (IADQ)

Below is a list of stressful life events that you may have experienced. Please indicate any of the following events that are currently applicable to you:

I am currently experiencing…	**Yes**
1. Financial problems (e.g., difficulty paying bills, being in debt).	
2. Work problems (e.g., unemployment, redundancy, retirement, problems/conflicts with colleagues, change of job role).	
3. Educational problems (e.g., difficulty with course work, deadline pressure).	
4. Housing problems (e.g., stressful home move, difficulty finding a secure residence, lack of secure residence).	
5. Relationship problems (e.g., break-up, sparation or divorce, conflict with family or friends, intimacy problems).	
6. My own health problems (e.g., illness onset or deterioration, medication issues, injury or disability).	
7. A loved one's health problems (e.g., illness onset or deterioration, medication issues, injury or disability).	
8. Caregiving problems (e.g., emotional stress, time demands).	
9. Some other problem not mentioned above.	

This section should be completed only if you have answered 'Yes' to at least one of the events above. The following statements reflect problem that people sometimes experience in relation to a stressful life event(s). Thinking about the stressful life event(s) you identified above, please indicate **how much you have been bothered by each of the following problems in the past month**:

	Not at all	***A little bit***	***Moderately***	***Quite a bit***	***Extremely***
10. I worry a lot more since the stressful event(s).	0	1	2	3	4
11. I can't stop thinking about the stressful event(s).	0	1	2	3	4
12. I often feel afraid about what might happen in the future since the stressful event(s).	0	1	2	3	4
13. I find it difficult to adapt to life since the stressful event(s).	0	1	2	3	4
14. I find it difficult to relax and feel calm since the stressful event(s).	0	1	2	3	4
15. I find it difficult to achieve a state of inner peace since the stressful event(s).	0	1	2	3	4
16. Did these problems start within one month of the stressful event(s)?	**Yes**			**No**	

	Not at all	***A little bit***	***Moderately***	***Quite a bit***	***Extremely***
In the past month have the above problems:	0	1	2	3	4
17. Affected your relationships or social life?	0	1	2	3	4
18. Affected your ability to work or your educational life?	0	1	2	3	4
19. Affected any other important part of your life?	0	1	2	3	4

ADDITIONAL TRAUMA RESOURCES: SCREENING AND ASSESSMENT TOOLS

INTERNATIONAL PROLONGED GRIEF DISORDER SCALE

“The WHO ICD-11 Working Group on Disorders specifically associated with stress developed clinical guidelines for the prolonged grief disorder (PGD) (Maercker et al. 2013). These guidelines are structured following the remit of the new ICD-11 to provide: a narrative definition, to include cultural features, to provide core symptoms and be easy to use in the clinical setting (Reed 2010).

The IPGDS seeks to operationalize the ICD-11 definition of PGD in a self-report questionnaire format…. The threshold for clinical diagnosis of PGD is currently under investigation.”

The IPGDS can be freely accessed at:

https://www.traumameasuresglobal.com/ipdgs

Universität Zürich[UZH]

International Prolonged Grief Disorder Scale (IPGDS)

Killikelly, Stelzer, Zhou and Maercker (2019 in preparation)

Instruction: Using the scale below, please choose the answer that best describes how you have been feeling over the **past week.**

Standard Scale

	Not at all (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
1. I am longing or yearning for the deceased.	1	2	3	4	5
2. I am preoccupied with thoughts about the deceased or circumstances of the death.	1	2	3	4	5
3. I have intense feelings of sorrow, related to the deceased.	1	2	3	4	5
4. I feel guilty about the death or circumstances surrounding the death.	1	2	3	4	5
5. I am angry over the loss.	1	2	3	4	5
6. I try to avoid reminders of the deceased or the death as much as possible (e.g., pictures, memories).	1	2	3	4	5
7. I blame others or the circumstances for the death (e.g., a higher power).	1	2	3	4	5
8. I have trouble or just don’t want to accept the loss.	1	2	3	4	5
9. I feel that I lost a part of myself.	1	2	3	4	5
10. I have trouble or have no desire to experience joy or satisfaction.	1	2	3	4	5
11. I feel emotionally numb.	1	2	3	4	5
12. I have difficulties engaging in activities I enjoyed prior to the death.	1	2	3	4	5
13. Grief significantly interferes with my ability to work, socialize or function in everyday life.	1	2	3	4	5
14. My grief would be considered worse (e.g., more intense, severe and/or of longer duration) than for others from my community or culture	1	2	3	4	5

15. When did the loss occur? (circle one)
a. less than 6 months ago
b. 6 to 12 months ago
c. 1 to 5 years ago
d. 5 to 10 years ago
e. 10 to 20 years ago
f. more than 20 years ago

Cultural Supplement: Accessory items

Instructions: please advise the participant to complete these culturally specific items if their grief experience was not adequately captured by the standard scale above

	Not at all (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
1. I experience strong physical problems since the loss (e.g., headache, problems with appetite).	1	2	3	4	5
2. I would do anything to feel close to the deceased (e.g., visit their grave everyday, sleep next to their picture).	1	2	3	4	5
3. Since the loss my behavior has changed drastically in an unhealthy direction (e.g., excessive alcohol consumption).	1	2	3	4	5
4. The loss shattered my trust in life or faith in God/a higher spiritual power.	1	2	3	4	5
5. It is impossible for me to focus.	1	2	3	4	5
6. My grief is so intense that I feel stuck in grief	1	2	3	4	5
7. I just can’t seem to fall back into a rhythm.	1	2	3	4	5
8. I feel paralyzed and disconnected, (e.g., as if I am not in my own body)	1	2	3	4	5
9. I have no energy or desire to engage in activities.	1	2	3	4	5
10. This life holds no meaning since the death.	1	2	3	4	5
11. I want to die in order to be with the deceased.	1	2	3	4	5
12. I don’t feel close to other people or feel no satisfaction when being around others.	1	2	3	4	5
13. I feel like I have completely lost control.	1	2	3	4	5
14. I am searching for the deceased with the hope to find him/her.	1	2	3	4	5
15. I feel life is hopeless because of the loss.	1	2	3	4	5
16. I constantly look back upon the past relationship.	1	2	3	4	5
17. I feel so helpless since I lost him/her.	1	2	3	4	5
18. I feel he/she is beside me.	1	2	3	4	5
19. I cry loudly when I think of the loss.	1	2	3	4	5
20. I can’t trust others since the loss.	1	2	3	4	5

ADULT TRAUMA ASSESSMENTS | INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES

A list of clinical tools and resources for the assessment of traumatic experiences and related symptomology in child and adult populations is available from the International Society of Traumatic Stress Studies (ISTSS) website here:

https://istss.org/clinical-resources/

Several guidelines and materials for the treatment of trauma in patient and staff populations are also available on the website:

https://istss.org/clinical-resources/trauma-treatment/