Defining Trauma: Exploring frameworks, theories, and measurement with clinical psychologists

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Abstract

Traumatic experiences are a devastating part of the human experience, with a significant percentage of the population experiencing at least one traumatic event in their lifetime. The way in which we are affected by these experiences dramatically differs from person to person, yet we are all assessed by the same standards and criteria. The present study aims to investigate the post-trauma presentations seen by psychologists in those seeking trauma treatment, how patients are affected by their experiences and whether this is reflected in quantitative measures designed to evaluate post-traumatic pathology. Most of the literature argues that psychometrics are accurate and effective due to their ability to identify the criteria assigned to a post-traumatic diagnosis. This study suggests that the criteria itself only fits a marginal proportion of those who have experienced trauma; therefore, those measures cannot be universally applicable. This is not an issue that has been examined in literature to date.

Thematic data from interviews with practicing psychologists has been analysed to examine how trauma presents in their clients, their preferred methods of assessment and treatment, as well as how they determine progress.

Contrary to what is often assumed, trauma presents in an unquantifiable manner, with significant variations between individuals. Post-traumatic pathology is influenced by every factor surrounding the event and everything that follows. While quantitative measures provide objectivity and ease of use, trauma is a deeply subjective experience. As such, a qualitative approach to diagnostics and treatment should be the standard in trauma care to give patients the best chance of recovery. This change would have far-reaching implications for those accessing and providing services, especially supplying agencies such as ACC that rely on objective measures to assess need.

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Introduction

Traumatic experiences are a devastating part of the human experience. Despite our best efforts to avoid harm, trauma is commonplace. From natural disasters to intimate partner violence to child abuse, almost everyone will experience at least one traumatic event in their lifetime. The prevalence of trauma is well recognised in the current literature and in our society. Yet, even after decades of research, the way in which trauma can erode an individual or community's entire livelihood is rarely reflected in the literature, and not at all consistent with the longstanding methods of evaluating post-traumatic pathology. Experiencing a traumatic event is one of the most deeply personal things we can go through, despite that, we are all assessed through evaluation of identical symptoms, representative of a diagnostic criteria that is supposably universally applicable. The present study asks how such a subjective experience could possibly be measured objectively, and questions the capability of a single, Westernised criteria in identifying those who are struggling in the aftermath of a traumatic event. This study acknowledges what we know about trauma and how our understanding has evolved over the decades, past and present theories of traumatic pathologies, recognised post-traumatic disorders, assessment and treatment, and how this knowledge compares to first-hand experiences of psychologists treating traumatised populations. This research aims to start a conversation around the discrepancies between how trauma affects us, and the guidelines by which it is evaluated.

Defining Trauma

Despite decades of research in the field, trauma remains a concept without a stipulated definition. Definitions vary depending on whether the writer views trauma as an event or a response. Some explanations focus on occurrences that are collectively considered

traumatic, including war, natural disasters, accidents causing injury, violence and abuse, and death (Benjet et al., 2016; Kessler et al., 2017). Others attend to individual experiences and responses to a specific event or series of events (Wathen, Schmitt & MacGregor, 2021). These events are typically unexpected, uncontrollable, and involve actual or threatened death or injury to oneself or others, eliciting feelings of fear and helplessness (Bartoskova, 2015; Hesse, 2002). Pagel (2020) defined trauma as a catastrophic event in which individuals witnessed or were personally threatened with death, physical harm, or sexual violence. Other definitions of trauma are broader, using the term to explain the stress of a negative event that exceeds a critical level (Christiansen, Iversen, Ambrosi & Elklit, 2016). What is traumatic for one person may not be traumatic for another, and the impact of a trauma leaves a lasting imprint on an individual's nervous system, emotions, behaviours, body, and relationships (de Thierry, Reeves & Music, 2020). Regardless of the exact definition, several types of trauma have been proposed, each with independent pathology, presentation, and necessary treatment.

Theories

Researchers and clinicians alike have long endeavoured to understand the mechanisms behind post-traumatic pathology. The following chapter explores a range of theories, from the early hypotheses of post-traumatic processes to some of the more recent circulating theories.

Nachträglichkeit

Early in the exploration of trauma theory, Freud introduced the concept of Nachträglichkeit, which roughly translates to "afterwardsness" or deferred action (Thöma & Chesire, 1991). Freud's original hypothesis was that individuals presenting with hysteria or obsessive-compulsive behaviour had experienced "physical seduction" (Breuer & Freud,

1957) in childhood or infancy when their minds were unable to interpret the sexual nature of the event. Nachträglichkeit was used to explain how sexual encounters in childhood may not be interpreted as traumatic at the time, but may later manifest in traumatic ways after puberty, when new meanings are ascribed to the memories resulting in feelings such as guilt and shame (Fletcher, 2013). Although Freud's theory was proposed in private and later abandoned, the concept was adopted by various scholars.

The theory of Nachträglichkeit suggests that in some cases, the effects of a potentially traumatic event may be delayed by several years and require significant change, such as aging, to arise. This delayed onset of traumatic pathology may be logically determined. The theory has also been used to explain traumatic pathology in those who do not meet the traumatic event criterion of the DSM criteria for Post-Traumatic Stress, as the meaning of an event may change over time, resulting in traumatic symptomology (Bistoen, Vanhuele & Craps, 2014).

While Freud's point of view relates Nachträglichkeit exclusively to the conversion of previously stagnant memories into sexual trauma, others suggest that the concept should be broader. They propose that every time we revisit our past, we are calling on Nachträglichkeit (Faimberg, 2007; Stern, 2011). This is based on the idea that every present and future experience continues to change how we understand our past experiences. Freud’s theory provides a possible explanation for a delayed onset of symptoms following a traumatic event. However, decades have passed since the conception of Nachträglichkeit, and many theories have been proposed in this time, mostly focusing on the human experience itself playing a role in the onset of pathology, such as Constructivist Self-Development Theory.

Constructivist Self-Development Theory

Constructivist Self-Development Theory (CSDT) is a more modern theory of post-

traumatic mechanisms. CSDT acknowledges a fundamental need we all possess: to believe that the world is safe and that we, personally, are safe (Baird & Kracen, 2006). In response to this belief, everyone develops cognitive schemas about themselves and the world around them, which serve as a guide and personal roadmap (McCormack & Adams, 2016). This theory suggests that changes that occur in the aftermath of traumatic events result from a disturbance in at least one of these schematic areas (Baird & Kracen, 2006).

CSDT is an integrative personality theory that combines aspects of psychoanalytic, social learning, and cognitive developmental theories rooted in constructivist thinking, according to Saakvitne, Tennen, and Affleck (1998). The theory describes personality development as the interaction between core self-capacities (such as early relationships, secure attachments, and internal resources) and constructed beliefs and schemas built upon cumulative experience. This theory highlights the aspects of self that construct an individual's personality and are also the most likely to be affected by a traumatic event. These areas are perhaps the most vulnerable and susceptible to change, but they are also the areas that may be strengthened as an individual heals from trauma. Constructivist self-development theory emphasizes the influence of an individual's developmental, social, and cultural contexts on how they experience a traumatic event and its aftermath.

Conditioning

A further argument for how reminders of an event can trigger an emotional response is rooted in Pavlovian conditioning. One of the earliest and most well-known cases demonstrating the role of classical conditioning in anxiety disorders is that of Little Albert. Conducted by Watson and Rayner in 1920, the study aimed to condition a generalised fear of animals and objects in an 11-month-old infant. After repeatedly pairing a sound that was known to upset the child with a white rat over a short period of time, the child began to get upset at the sight of the rat in the absence of the sound (Watson & Rayner, 1920). This

emotional response was reported to be generalised to other white, fluffy animals and objects. The child also reacted to items that were not directly involved in the experiment but were in the environment at the time of conditioning.

This study has become a point of contention amongst researchers due to ethical issues, confirmation bias, and limitations, as well as concerns for the health of the child (Digdon, 2020). Regardless, fear conditioning remains a common paradigm in the aetiology of anxiety disorders, including post-traumatic stress disorder (PTSD). It is proposed that during a traumatic event, an individual's surroundings and things that may have occurred shortly before the event, including sights, sounds, and smells, are encoded to memory alongside the event (De Houwer, 2020; Franke et al., 2021). Following the event, encountering those same sights, sounds, and smells in the absence of a threat can evoke memories, feelings, and physiological responses associated with the trauma (Franke et al., 2021).

These cues that were present in the environment shortly before or during a traumatic event can become predictors of danger, sometimes on a purely subconscious level (Ehlers & Clark, 2000; Elzinga & Bremner, 2002). This means that someone may begin re-experiencing a trauma seemingly randomly, not realizing that something in the environment - a sight, sound, or smell - has triggered the activation of those memories. People may also experience emotional reactions without recollection of the memories (Ehlers & Clark, 2000), which can make it exceedingly difficult for them to identify their reaction as a trauma response, and even harder for the person to understand that there is no active threat.

This association of environmental cues with danger is a survival mechanism and a normal response of fear memory (Johnson, McGuire, Lazarus & Palmer, 2014). However, in PTSD, these responses are often amplified and fail to extinguish over time, thus becoming

debilitating. The biological processes behind these mechanisms have been proposed as a separate theory, providing a neurological explanation for post-traumatic symptoms.

Physiological

Reactions to trauma can be understood on a physiological basis, as traumatic events take a toll on both the body and the mind. Post-traumatic stress disorder is marked by a significant increase in arousal, which is a result of autonomic nervous system activation (van der Kolk, 1994; Zaleski, Johnson & Klein, 2016). Hyperarousal of the autonomic nervous system typically occurs in response to a threat, leading to heart rate increase, cold sweats, rapid breathing, heart palpitations, hyper-vigilance, and an exaggerated startle response (Rothschild, 2000; Blechert et al., 2007). Although this state is typically short-lived, passing with the perceived threat, it can result in sleep disturbances, loss of appetite, sexual dysfunction, and difficulty concentrating if it becomes chronic, which are common symptoms of PTSD (Nixon et al., 2005). This is largely due to activation of the limbic system, located in the centre of the brain between the cerebral cortex and the brain stem, this system controls all arousal. Regulating survival behaviours such as eating, reproduction, and fight, flight or freeze responses (Tyler, 2012). It also influences emotional expression and memory processing (van der Kolk, 1994).

The limbic system receives information and evaluates a situation, then feeds that information to the autonomic nervous system (ANS). When a threat is perceived, the ANS activates either the sympathetic nervous system (SNS) or the parasympathetic nervous system (PNS). The SNS is involved in the aggressive (fight) and avoidance (flight) response, while the PNS can trigger a dissociative (freeze) response (Tyler, 2012). The freeze response is also observed when the SNS and PNS are activated simultaneously, resulting in an altered state of consciousness in which fear and pain are minimised to provide the best chance of survival (van der Kolk, 1994).

During this process, several chemical changes take place, including the release of epinephrine and norepinephrine (van der Kolk, 1994). Once the threat has passed, cortisol is released to halt this chemical production, enabling the body to return to baseline functioning. People with PTSD may not have sufficient cortisol to stop the alarm reaction, resulting in chronic ANS arousal (Yehuda et al., 1990). ANS activation through the limbic system in reaction to a traumatic event is a healthy, adaptive survival response. However, when this arousal continues despite the threat having passed, it can result in PTSD symptoms. Studies investigating the correlation between this reaction and the onset of PTSD have discovered that those who experienced high levels of panic or dissociation (Bryant & Panasetis, 2001; Nixon & Bryant, 2003) and those with an elevated heart rate immediately, one week, one month, and four months following a traumatic event (Shalev et al., 1998) were more likely to develop post-traumatic pathology.

Traumatic event processing also occurs within the limbic system, specifically the hippocampus and the amygdala. The amygdala is involved in the processing of emotionally charged memories, such as those surrounding a traumatic event (van der Kolk, 1994). The hippocampus processes events within our timeline, providing them with a beginning, middle, and end (Mujawar, Jaideep, Chaudhari & Saldanha, 2021). During traumatic events, this process is often suppressed, and the event is therefore not processed and stored correctly, leading it to continue invading the present (van der Kolk, 1994). The perception of the event being over, and the individual having survived is missed in memory consolidation. This mechanism is a possible cause of flashbacks in PTSD.

Many in the field do not subscribe to any particular theory, rather seeing trauma as a point of intersection between emotional, physical, spiritual, cultural, and structural avenues (Buelens, Durrant & Eaglestone, 2013). Even so, there is a shared acknowledgement of various types of trauma.

Types of Trauma

Acute, Chronic and Complex Trauma

Acute trauma is typically associated with a single event that endangers an individual's safety, such as a car accident or experiencing or witnessing violence. In contrast, incidents that occur repeatedly, such as long-term child abuse, domestic violence, or combat situations can lead to chronic trauma (Fullerton & Ursano, 2009). In certain circumstances, individuals who have experienced extensive, prolonged harm may be exposed to complex trauma. All traumatic events can have a profound impact on an individual's life, both immediately and in the long term. However, the longer someone is exposed to trauma, the greater the impact is likely to be (Bryant et al., 2017).

There are several possible factors that may impede or facilitate healing from a traumatic event. With solitary traumatic events, for example, survivors can often seek safety once the event is over. On the other hand, complex trauma is ongoing or frequently repeated, offering very little time for people to recover. This may be because it often occurs in secrecy, preventing the person from talking about it and getting help, or due to the prolonged nature of chronic trauma. It is also worth acknowledging that many acute events, such as car accidents or natural disasters are shared experiences and are often made public. The collective nature of some singular events promotes awareness and builds connections within a community, potentially validating survivors and reducing shame.

In most cases, complex trauma events are interpersonal and begin early in life (Briere & Scott, 2015; Wamser-Nanney & Vandenberg, 2013). Trauma in childhood can interrupt development, leading to difficulties with emotions, concentration, and memory, which can result in ongoing challenges maintaining safe relationships (Greenberg, 2020). The interpersonal nature of complex trauma means that it occurs within a relationship that is

meant to be safe, and survivors often feel as though they were unable to escape, leading to chronic feelings of helplessness (Greenberg, 2020). The discrepancies between how things should be and how they are create an inner conflict that results in survivors doubting themselves and feeling unsafe when they grow close to people outside of the trauma.

Essentially, complex trauma changes the way people think, behave, and feel about themselves and others. It can lead to difficulties with thinking and concentration, struggling to feel present in one's own life, lack of attention, dissociation, problems with memory, and trouble with emotional regulation (Briere & Scott, 2015). These struggles can result in complex post-traumatic stress disorder, developmental trauma disorder, disorders of extreme stress not otherwise specified, or enduring personality changes (Briere & Scott, 2015; Wamser-Nanney & Vandenberg, 2013).

Secondary Trauma

It is possible to feel the effects of trauma without having experienced a traumatic event directly. The impact of trauma extends far beyond those directly involved and can have a significant effect on those who assist victims of trauma, such as mental health professionals (Jenkins & Baird, 2002). Professionals in these roles dedicate their practice to helping others in the wake of traumatic exposure. As a result, they have a multitude of traumatic narratives relayed to them on a regular basis, which in itself is a form of indirect trauma. Efforts to clarify the stress placed on those who work with survivors of trauma have produced a handful of terms, including burnout, compassion fatigue, secondary trauma, and vicarious trauma (Bride, 2007; Baugerud, Vangbaek & Melinder, 2018). These terms are often used interchangeably, although some clear differences have been identified.

Burnout is a possible side effect across a range of professions and is not specific to trauma-related work. Symptoms of burnout include emotional exhaustion, physical fatigue,

depersonalization, and feelings of self-inefficacy, often in the context of chronic stress (Barrington & Shakespeare-Finch, 2014). Studies have suggested that burnout occurs when the demands of a job outweigh the resources, and that measurement of these factors can be predictive (Bakker, Demerouti & Euwema, 2005). The current central hypothesis follows a job demands-resources model, with the assumption that while every job is likely to have its own risk factors associated with stress or benefit, they can be classified as demands or resources, resulting in a format that can be applied to any role irrespective of field.

Bakker, Demerouti and Euwema (2005) described job demands as any aspects of an individual's role that require sustained physical or mental effort and therefore take a physiological and psychological toll. Job resources, on the other hand, include aspects such as social support from colleagues and supervisors, role autonomy, constructive feedback, and regular appraisal of good performance (Bakker, Demerouti & Euwema, 2005). Several job resources may buffer the impact of various job demands, including stress reactions such as burnout, although these interactions are also likely to differ between individuals and occupational characteristics. Burnout as an idea is far better developed and documented than trauma-specific concepts, as it relates to a wide range of occupational stress. Currently, it is conceptualized as a defensive response to prolonged occupational strain in situations that provide minimal support (Jenkins & Baird, 2002). The symptoms of which can be monitored with measures such as the Maslach Burnout Inventory (Maslach, Jackson & Leiter, 1997). Cases of burnout in those who work with trauma survivors can escalate and cause significant impairment if not addressed or mediated.

A potential decompensation of burnout is compassion fatigue. Definitions of compassion fatigue vary, with many researchers using the term to describe secondary or vicarious trauma (Figley, 1995). A more inclusive definition is provided by Cocker and Joss (2016), who explain that the empathetic ability of the caregiver becomes compromised as a

result of prolonged exposure to overwhelming stress of others' needs. Compassion fatigue often occurs due to burnout in those vulnerable to secondary trauma, such as those working with trauma survivors (Baird & Kracen, 2006). Although it can also occur after short instances of exposure, such as emergency responders assisting survivors of an accident (Baird & Kracen, 2006; Barrington & Shakespeare-Finch, 2014).

Symptoms of compassion fatigue arise from an individual's inability to cope with their everyday environment due to a state of total physical and mental exhaustion. This concept is characterized by exhaustion, irritability, maladaptive coping behaviours, a reduced capacity for sympathy and empathy, loss of interest in work leading to absenteeism, and an impaired ability to make decisions about patient care (Cocker & Joss, 2016).

While practicing mental health professionals are at risk of compassion fatigue, some have suggested that the satisfaction derived from their work is a protective factor. This has been posited as a buffering factor referred to as compassion satisfaction and could include any positive influence within an individual's profession or their beliefs about themselves (Hernandez-Wolfe, Killian, Engstrom & Gangsei, 2015). Despite the use of compassion fatigue to discuss vicarious or secondary trauma, the effects of compassion fatigue do not encompass the cognitive disruptions that occur because of traumatic exposure (Barrington & Shakespeare-Finch, 2014).

The term vicarious trauma was coined by McCann and Pearlman in 1990, having been conceptualized within constructivist self-development theory, to describe the change that occurs within a trauma worker due to empathetic engagement (Pearlman & Mac Ian, 1995). Many believe that vicarious traumatization is an inevitable result of working with trauma survivors and hearing their narratives (Baird & Kracen, 2006; Barrington & Shakespeare-Finch, 2014; Finklestein et al., 2015). It carries a significant cost for the

professional, presenting with many of the same symptoms as post-traumatic stress disorder, the differentiating factor being that the sufferer has not experienced the trauma directly (Linley & Joseph, 2007). Vicarious trauma is most often seen in therapists and other mental health workers due to repeated empathetic engagement with trauma narratives, resulting in disrupted cognitive schemas, hyperarousal, avoidance of triggers and cues, and intrusive imagery related to trauma narratives they have heard (Baird & Kracen, 2006; Finklestein et al., 2015; Linley & Joseph, 2007). Changes within an individual that occur due to vicarious trauma, as with direct trauma, challenge their beliefs about themselves and the world around them. These changes are pervasive and permanent and may significantly impact the ability to do one's job, especially as a trauma worker (Baird & Kracen, 2006). It has been suggested that when a clinician is suffering, they struggle with increasingly negative thinking in five key areas: trust, safety, control, esteem, and intimacy (Barrington & Shakespeare-Finch, 2014).

Mental health workers rely on their ability to form empathic bonds with their clients. Unfortunately, it is this empathy that creates a vulnerability to vicarious traumatization, as clinicians risk taking on the pain of their clients (Hernandez Wolfe et al., 2015). It is important to note that this outcome does not speak to the pathology of the clinician, nor is it the intention of clients. Several characteristics that may influence the development of vicarious trauma in therapists have been posited, including personal trauma history, the meaning of certain events to the therapist, their psychological and interpersonal style, their training, and current stressors and supports (Pearlman & Mac Ian, 1995).

Reactions to trauma

Stress

Stressors, whether positive or negative, are a constant part of life. They are essentially events or circumstances that require us to adapt to maintain our wellbeing. The demand placed on an individual's physical and psychological resources to respond to these events is quantified as stress. Stress reactions are our emotional, physical, cognitive, and behavioural responses to stressors, designed to protect us from harm, achieve goals, or gain access to additional resources (Ford, Grasso, Elhai & Courtois, 2015). The overall goal of our biological stress response is to meet the demands of the stressor and maintain or return to our baseline health. However, resource allocation to a stressor that continues after the circumstance has passed depletes personal resources, and the system can become overwhelmed by the demands of ordinary day-to-day stressors.

Ford et al. (2015) identified three features that consistently distinguished ordinary stressors from those that resulted in traumatic stress: severe life-altering injury, unpredictability, and uncontrollability. They theorized that when individuals are confronted with extreme violence or loss, it shatters their illusion of safety and invulnerability. In situations where events are highly unpredictable or uncontrollable, there is an increase in anticipatory anxiety, vigilance, dread, and a feeling of powerlessness. The resultant stress is higher than if the situation or circumstances were expected. This additional stress is due to having to exacerbate personal resources to regain balance and develop a plan immediately (Lovallo, 2005).

Acute Reactions

Acute reactions to traumatic stressors can occur during and immediately after exposure. These reactions include dissociation, intrusive symptoms, avoidance, hyperarousal, hypervigilance, and difficulties with concentration, memory, problem-solving,

and decision-making (Ford et al., 2015). These reactions are an instinctual response to psychologically overwhelming or potentially life-threatening situations. Acute reactions are survival mechanisms and are expected to resolve within hours or days following traumatic exposure. However, if symptoms persist or worsen within the first month, it may indicate Acute Stress Disorder (ASD). According to Ford et al., ASD occurs when these reactions are "destabilizing rather than a source of helpful physical and psychological readjustment" (2015, p.54).

Acute stress disorder (ASD) was introduced in the DSM-IV as an acute response characterized by dissociative, reexperiencing, avoidance, and hyperarousal symptoms occurring two days to one month following a traumatic event (American Psychological Association, 1994). This allowed for identification of those struggling in the immediate post-trauma phase and presented an opportunity for intervention for those who may be developing symptoms of post-traumatic stress disorder. A diagnosis of ASD initially required at least three of five possible dissociative symptoms, with the rationale that a dissociative response to an event limits emotional processing, contributing to post-traumatic pathology (Bryant, 2021). However, reviews noted that although most people who met the criteria for ASD did go on to develop PTSD, the majority of those with PTSD did not initially meet the criteria for ASD. They suggested that most people experienced acute stress reactions but not in the way the criteria defined (Bryant, 2021). It was proposed that the inclusion of dissociative symptoms limited the ability of the ASD diagnosis to predict PTSD. As such, it became a measure to identify those in need of intervention from mental health services rather than a predictive tool. The DSM-5 revised the criteria, requiring that at least 9 out of a possible 14 symptoms be present at least three days following traumatic exposure. Additionally, only two of the original five dissociative symptoms are listed (American Psychological Association, 2013).

There is increasing evidence that elevated sympathetic nervous system activation in the acute trauma phase may increase the likelihood of subsequent development of PTSD (Bryant, Harvey, Guthrie & Moulds, 2000; Salev et al., 1998).

Post-Traumatic Stress Disorder

The World Health Organization conducted a study across 24 countries to evaluate the association between lifetime traumatic events and post-traumatic stress disorder (Kessler et al., 2017). Of the respondents, 70.4% reported experiencing at least one of the 29 identified traumatic events outlined in the study (see Appendix A). However, the prevalence rate for PTSD sits between 6.1-9.2% depending on the event (Pagel, 2020). This disparity suggests that the development of PTSD is determined by more than just a traumatic event.

It is worth noting that any statistics regarding the prevalence of PTSD are likely underestimations, as people may not seek help for their symptoms due to shame, guilt, and other internal and environmental factors (Pagel, 2020).

Psychological responses to trauma were historically viewed as variations of the normal grieving process up to six months after an event. More recently, this timeframe has been changed from six months to one month, after which individuals still experiencing psychological symptoms should be evaluated for PTSD (American Psychological Association, 2013). Diagnostic criteria have changed extensively since the first publication in 1980, with some requirements being tightened and others made more lenient (Pagel, 2020). As per the current criteria, a diagnosis of PTSD requires a history of exposure to major trauma (Criterion A) and pervasive symptoms belonging to each of the following clusters: avoidance, intrusion, negative alterations in cognitions and mood, and alterations in arousal and reactivity (American Psychological Association, 2013). The symptoms must have been

present for more than one month and cause significant functional impairment. Symptoms cannot be secondary to medication, substance use, or other medical illness.

Although a diagnosis calls for measurable functional impairment in more than one area of life, there are those who, even with severe symptoms of PTSD, can function to a high level. When quantifiable impairment is used to define the presence or absence of a psychiatric disorder, there is a significant risk of overlooking those who mask their symptoms around others.

Research has identified multiple groups that appear to be more susceptible to PTSD following traumatic events. It is more frequently reported in adolescents and young adults than other age groups, more common in women, those in lower socioeconomic classes, living in rural areas, those with lower IQs, and people with a family history of PTSD. It has also been suggested that specific themes within the traumatic event, such as betrayal by a trusted person, sexual violence, and acts of human atrocity increase the likelihood of post-traumatic pathology developing (Layne et al., 2008).

Complex-PTSD

The diagnostic formulation of PTSD is primarily based on the experiences of survivors of singular traumatic events. However, this approach may fail to capture the full range of difficulties faced by those who have experienced prolonged, repeated trauma. The concept of a concomitant diagnosis arose in an effort to explain the complex symptomology seen in the realms of emotional dysregulation, interpersonal difficulties, and negative self-perception.

Early descriptions of a complicated presentation of PTSD came from clinicians working with survivors of childhood sexual assault (Briere, 1988). Many reported a post-

traumatic presentation disguised by chronic depression, dissociative symptoms, substance abuse, impulsivity, self-injury, and suicidality (Herman, 1992). Similar observations were made in instances where individuals were unable to escape the traumatic situation and were in complete control of the perpetrator, establishing an environment of prolonged, repeated trauma. These included people who had spent time in prison, concentration and slave labour camps, and domestic abuse situations. Herman (1992) identified a common theme of coercive control within traumatic events that predated the development of complex symptomology, noting that those held captive by physical, social, economic, or psychological means had similarities in presentation.

The symptomatic observations that differentiate disorders of prolonged trauma from so-called *simple* PTSD are threefold: symptoms are more complex; characterological changes are evident; and vulnerability is increased (Herman, 1992). Regarding the complicated symptomology, somatisation, dissociation, and affect dysregulation have been observed as being amplified in cases of complex trauma (Briere, 1988; Herman, 1992; Taylor, Asmundson & Carleton, 2006; Palgi et al., 2021). People who have suffered long-term, interpersonal trauma have shown to be at a higher risk of developing chronic health conditions and chronic pain than those without traumatic histories and those who experienced acute events (Sachs-Ericsson, Kendall-Tackett & Hernandez, 2007; Tsur, 2022). The interpretation of pain can be mediated by a variety of factors, and several theories have been put forth to explain the higher rate of pain and illness associated with trauma. Due to the biopsychosocial nature of pain, it can be altered by a multitude of factors including an individual's understanding and beliefs around pain, lifestyle, and support system (Turner & Dworkin, 2004; Hinrichs-Rocker et al., 2012). Some have suggested that an increased vulnerability to stressors, hypervigilance, and distorted beliefs around bodily sensations culminate in an amplified pain response (Sachs-Ericsson et al., 2007). Others

have posited that chronic trauma, especially childhood abuse, produces pathophysiological responses that make individuals more vulnerable to pain, particularly when hypervigilant or in times of high stress (Meagher, 2004). This has also been suggested as a possible causal factor in the development of autoimmune diseases and other chronic pain conditions (Macarenco, Opariuc-Dan & Nedelcea, 2022).

Dissociation has been identified as a central construct in the aftermath of complex trauma, with devastating consequences on functioning (Dorahy et al, 2013). People who suffer from prolonged trauma, especially those who are unable to escape the situation they are in, become adept at avoidance. This avoidance can manifest in the ability to alter one's own consciousness to cope with an unbearable reality, resulting in disturbances in time, senses, and memory (Herman, 1992). Dissociation is often conceptualised as a defensive mechanism and serves to separate an individual's mind from their body, senses, and environment (de Thierry, Reeves & Music, 2020). While dissociation can be an effective method of protection during a traumatic event, it can significantly impact an individual's quality of life if it continues. Once someone becomes adept at dissociation, this kind of cognitive separation can be triggered as a result of any kind of stress and can vary within hours or last days at a time.

People exposed to complex trauma suffer from various difficulties in affect regulation alongside dissociation. Affect dysregulation covers problems in “managing or recovering from extreme states of affect, including both under regulation of heightened affect states and maladaptive overregulation of affect” (van Dijke, Hopman & Ford, 2018, p.2). Under regulation refers to the inability to access or implement strategies to cope with intense emotional states, resulting in struggles with impulse control and goal-driven behaviour (Gross, 2013; van Dijke et al., 2018). For example, anxiety that escalates into full-blown terror and anger that manifests into unmanageable rage. Overregulation describes total

suppression and minimal awareness of emotional states resulting in numbness and detachment (Pat-Horenczyk et al., 2015). Dissociation could therefore be considered an extreme form of overregulation, although the most common understanding views it as a failed attempt to regulate emotion (Hébert, Langevin & Oussaïd, 2018).

Herman (1992) reported chronic depression as being the most common finding in repeatedly traumatised populations. Other studies have resulted in similar findings, with depression severity directly correlating with the disturbances in self-organisation seen in complex PTSD, having no significant relationship with other symptoms (Haselgruber et al., 2021; Fung et al., 2022). This depression is often exacerbated by other aspects of affect dysregulation and chronic trauma, including insomnia, nightmares, concentration difficulties, helplessness, apathy, isolation, hopelessness, and guilt (Herman, 1992).

The conceptualization of Complex PTSD as a Disorder of Extreme Stress not otherwise specified (DESNOS) has resulted in further diagnostic markers, described as disturbances in self-organisation (DSO). DSO includes the aforementioned affect dysregulation, which can present as somatisation, dissociation, and mood disorders. This domain also covers negative self-concept and difficulties in relationships. The characterological changes witnessed in DESNOS or Complex PTSD include personality changes, the loss of a sense of self, and difficulties in relating to others (Landy, Wagner, Brown-Bowers & Monson, 2015).

It is common for a victim of a singular traumatic event to feel as though they are not themselves in the immediate aftermath. However, a victim of chronic trauma may lose their sense of self entirely and may not see themselves as a person at all (Cox, Resnick & Kilpatrick, 2014). Just as our past experiences influence how we interpret future events and situations, these processes are thought to establish our continual sense of self over time

(Lanius, Terpou & McKinnon, 2020). Insights we develop about our own identity rely heavily on our autobiographical memories; trauma can result in extremely negative self-beliefs and distorted thoughts about oneself. As such, it is common for those with Complex PTSD to view themselves as an object rather than a person. They often report feeling as though they have been changed on a cellular level by events and like they will never feel normal again (van Dijke et al., 2018). This negative self-concept has previously been operationally defined as “persistent negative beliefs about the self, and feelings of guilt and shame related to the event” (Melegkovits et al., 2022, p.12) and is a hallmark of Complex PTSD.

The loss of a sense of self has been directly linked to pathological changes and difficulties in relationships (Herman, 1992). In cases of chronic trauma, victims often develop beliefs about themselves and the world instilled by the perpetrator. Victims of abusive relationships often become completely cut off from all social ties and come to rely solely on the perpetrator (Hinde, Finkenauer, & Auhagen, 2001). Even after escaping an abusive situation, survivors can find it hard to trust other people and suffer from a learned helplessness that developed due to their inability to engage with the outside world (Lanius et al., 2020). It should also be reiterated that many survivors of repeated trauma struggle to understand that the abuse has ended, changing how people feel able to engage in their own lives. In childhood abuse, this can result in significant attachment difficulties, while adults often enter unstable and sometimes further abusive relationships, in fear of both abandonment and domination (Hébert et al., 2018).

Finding oneself in serial abusive relationships has been found to be a common repetitive phenomenon following prolonged trauma. It has been estimated that survivors of childhood abuse are twice as likely as the general population to be harmed again (Herman, 1992). The risk of repeated trauma is similar for those who have suffered sexual or physical violence at the hands of others. The increased risk of harm following complex trauma also

covers self-harm, which is rarely witnessed after acute trauma (Courtois, 2008). Dyer, Dorahy, Shannon and Corry (2013) identified pervasive self-injurious behaviour within a Complex PTSD population. Altered self-perception, including guilt, shame and an inherent sense of badness were suggested as a "significant predictor of self-destructive behaviour" (p.58). Self-harming behaviours have been correlated with self-hatred and extreme shame (Gilbert et al., 2010). This may explain the high rates of self-injury and self-destructive behaviours in those who have suffered chronic trauma.

The fifth edition of the DSM altered the diagnostic criteria for PTSD, expanding the symptoms to include negative self-concept and changes in belief about the world and others, and elaborated on the avoidance criteria, attempting to capture the symptoms seen in Complex PTSD (American Psychiatric Association, 2013). While the ICD-11 includes Complex PTSD as an illness separate to PTSD (World Health Organisation, 2022). These changes provide an alternative for those who would otherwise be diagnosed with PTSD and a multitude of comorbidities to explain their symptoms, notably those marked by emotional dysregulation, dissociation, disinhibition, identity struggles and addiction (Cloitre et al., 2014). Prior to the acknowledgement of Complex PTSD as a distinguished diagnosis, many people were misdiagnosed with Borderline Personality Disorder (BPD) in an effort to explain the presenting constellation of symptoms (Nestgaard Rød & Schmidt, 2021). BPD is well known for the associated stigma; the presenting behavioural and internalised symptoms can make it a challenging illness to treat (Ring & Lawn, 2019). This can result in practitioners distancing themselves from those with a diagnosis of BPD, and impact how they tolerate and treat these individuals (Aviram, Brodkey & Stanley, 2006). A misdiagnosis of this magnitude can result in patients feeling labelled, stigmatized, and misunderstood, as well as making it difficult for them to access appropriate care. Not only does it negatively impact the people

suffering, but it becomes a struggle for clinicians to decide on sufficient treatment methods, given the misinformation around what they are treating.

Treating Trauma

The treatment of trauma is dependent on the individuals' needs and the experience and favoured methodology of the clinician. Several treatment methods have been developed over the years, including Relational Trauma Psychotherapy, Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Prolonged Exposure (PE) and Eye Movement Reprocessing and Desensitisation (EMDR). These therapies can be used alone but are often combined or altered to focus on trauma processing and recovery.

Relational Trauma Psychotherapy is based on Herman's triphasic model of recovery, established in 1992. It is an entirely client focused method of talk therapy that prioritises the therapeutic relationship and is based on enabling clients to reclaim their sense of empowerment and connection to themselves and the people around them (Zaleski, Johnson & Klein, 2016). As the name suggests, the model has three phases: safety, remembrance and mourning, and reconnection (Herman, 1992a). The safety phase focuses on the nervous system, educating clients on the dysregulation of the autonomic nervous system that can result from trauma. Assisting clients in regulating their autonomic nervous system results in normalizing biological functions that often become dysfunctional following trauma, such as eating and sleeping cycles, as well as hyperarousal and intrusion symptoms, difficulties concentrating and executive dysfunction (Cahill, 1997). Managing these symptoms and allowing an individual to regain control over these aspects of their life allows them to begin to feel safe within themselves. Once this has been completed and the clinician is confident that their client can cope, the remembrance and mourning phase is initiated. This involves

retelling the story of their trauma, allowing them to reintegrate the narrative and facilitate hippocampal memory reprocessing. After processing the trauma, the client is encouraged to reconnect with their life. Allowing them to reengage with all aspects of their life and learn how to regulate their nervous system in different settings and social interactions. This process is the basis for trauma-focused talk therapy, although most clinicians now tend to train in more specific treatment modalities.

Trauma Focused - Cognitive Behavioural Therapy

Trauma focused – Cognitive Behavioural therapy (TF-CBT) was developed specifically for children and adolescents, and has rapidly become one of the leading treatments for trauma and PTSD (Cary & McMillen, 2012). TF-CBT involves prolonged and/or narrative exposure through imaginal reliving with rescripting and cognitive restructuring (Melegkovits et al., 2022). Cognitive restructuring is used to change negative thinking patterns about the self and the world, including negative thinking biases and dysfunctional core beliefs (Ehlers et al., 2005). Practice involves the use of trauma-sensitive interventions alongside essential CBT protocols over 12-16 weeks. The acronym PRACTICE is used to outline each step of therapy: Psychoeducation regarding trauma responses; Relaxation training such as mindfulness and breathing techniques; Affective coping skills; Cognitive reframing to enable clients to differentiate between thoughts, emotions and behaviours; Trauma narration to overcome avoidance, identify cognitive distortions and view the trauma in context of their life; In-vivo exposure in cases where specific places or activities are being avoided; Conjoint child and parent sessions to assist in increasing communication between family members, and; Enhancement of future safety involving additional education as needed (Melegkovits et al., 2022). Meta-analysis evaluating the efficacy of TF-CBT in decreasing symptoms of PTSD and co-occurring depression indicated that TF-CBT was “exceptionally superior to no treatment or wait-list comparisons and

moderately superior to alternative treatments" (Lenz & Hollenbaugh, 2015, p.28). Although TF-CBT is favoured for use in cases of child and adolescent treatment, the principles of gradual trauma exposure and cognitive restructuring have proven to be effective in cases regardless of age, ethnicity, type of trauma and location (Ehlers et al., 2005).

Dialectical Behavioural Therapy

Dialectical Behavioural therapy (DBT) was conceptualised by Marsha Linehan and first published as a method to treat borderline personality disorder in 1993 (Linehan, 1993). Earlier treatment methods had proven ineffective in treating complex cases characterised by emotion dysregulation, interpersonal difficulties, negative self-concept, and self-destructive behaviours (Chapman & Dixon-Gordon, 2020). DBT is a phase-based treatment with modules focusing on emotion regulation, interpersonal effectiveness, and distress tolerance, along with integrated mindfulness practices (Linehan & Wilks, 2015). The majority of those completing DBT have a pervasive history of trauma, incentivising the development of a trauma protocol created to work alongside DBT. DBT-Prolonged Exposure was established by Melanie Harned with the goal of "providing effective PTSD treatment to high-risk, complex, and severely impaired clients who are typically unable to access these treatments" (Harned, 2022, p.4). Studies of the efficacy of DBT-PE have shown significant symptom improvement, with 71-80% of participants no longer meeting criteria for PTSD following treatment (Harned, Schmidt, Korslund, & Gallop, 2021).

Prolonged Exposure

Exposure-based treatments have been used effectively to reduce fear and avoidance in anxiety-based disorders (Feske & Chambless, 1995; Foa, Riggs, Massie & Yarczower, 1995). In these cases, individuals are gradually exposed to the thing that frightens them in a

controlled environment. In PTSD, anxiety is typically linked to memories of the traumatic experiences. Therefore, exposure therapy for PTSD focuses on retelling of the trauma, and repeated reliving of the experience through imagination. Tarrier et al. reported exposure therapy as “the most studied and supported treatment technique for PTSD” (1999, p.13). Therapy involves psychoeducation, breathing retraining, behavioural exposures, and imaginal exposures (Resick et al., 2002). After being educated about the symptoms of PTSD and the rationale behind exposure, clients are asked to create a list of things that scare them, from least to most anxiety-inducing. This hierarchy is based on the Subjective Unit of Distress (SUDs) associated with each item, rated on a scale from 0-100. In-vivo exposure tasks involve physical, behavioural exposures such as being in certain places or around people associated with past trauma. Imaginal exposure requires clients to retell the story of their trauma for at least 45 minutes, this is recorded in session. Clients are then asked to listen to the recording each day between sessions and engage in behavioural exposures wherever possible. Exposure to the memory continues until the emotional reactions decrease. Bryant et al. explained that this therapy is based

> “on the premise that imaginal exposure to the feared stimulus (e.g., traumatic memories or feared situations) leads to symptom reduction because prolonged activation of the traumatic memories leads to emotional processing of the affective information, habituation of anxiety, and integration of corrective information.” (2003, p.706)

As such, a study evaluating the efficacy of PE in treating chronic PTSD discovered that those who had the most severe PTSD pathology and reacted with the most fear during imaginal exposure benefitted more than those with milder pathology and distress during treatment (Foa et al., 1995).

According to Foa and Meadows, PE works through four systems, “promoting symptom reduction by allowing patients to realise the contrary to their mistaken ideas:

a) Being in objectively safe situations that remind one of the trauma is not dangerous;
b) Remembering the trauma is not equivalent to experiencing it again;
c) Anxiety does not remain indefinitely in the presence of feared situations or memories, but rather it decreases even without avoidance or escape; and
d) Experiencing anxiety or PTSD symptoms does not lead to loss of control”

(1997, p.462).

This gradual exposure to fear and anxiety allows for emotional processing with excellent results. Post-treatment assessments have indicated a success rate of up to 53%, with those clients no longer meeting criteria for PTSD after receiving PE (Resick et al., 2002).

Eye Movement Desensitisation and Reprocessing

Eye Movement Desensitisation and Reprocessing (EMDR) is a form of exposure accompanied by saccadic eye movements (Foa & Meadows, 1997). Clients are required to attend to traumatic memories and associations while simultaneously engaging in bilateral physical stimulation such as tapping, eye movements or auditory input (Melegkovits, 2022). EMDR utilises an entirely subjective approach to treatment, focusing on the traumatic events and associated beliefs that are the most damaging to clients.

The benefits of eye movement in relation to memory processing was discovered incidentally by Francine Shapiro in 1989, after noticing she felt less stressed and anxious following a walk in the park, during which she moved her eyes back and forth (Luber & Shapiro, 2009). In 1995, EMDR was recognised as an effective psychotherapy capturing a

total trauma history, focusing on target memories and associations, and processing those memories to resolution (Shapiro, 1989; Hill, 2020). This therapy provides assessment and treatment in the three realms that are affected by trauma: cognitive, emotional, and somatosensory (Hill, 2020; Van der Kolk, 2014).

Following the success of EMDR in trauma treatment, the Adaptive Information-Processing (AIP) model was established to provide a theoretical underpinning for the treatment and so the mechanism of change could be understood (Hill, 2020). The model described how memories are processed and stored in the brain: either adaptively with typical memories or maladaptively in the case of traumatic memories. In essence, highly emotional memories receive little to no logical processing, resulting in some of the information around the event being lost and leaving the emotional memories scattered and not consolidated. AIP hypothesises that the bilateral stimulation occurring in EMDR activates all parts of the brain, increasing communication between structures (Siegel, 2002; Shapiro & Laliotis, 2011). When the brain is completely activated and all structures are focused on an event, all parts of the memory can be located and integrated to be processed in the same way as typical, non-traumatic memories. Hill explained that “AIP theory is built on a model of removing obstacles to the brain’s typical processing, rather than on changing or fixing the brain or its processes” (2020, p.322).

Controlled research found that 85-100% of those who have experienced a single-event trauma can be effectively treated for PTSD in three 90-minute sessions of EMDR or the equivalent (Shapiro, 2002). Practice of EMDR has grown considerably since its conception and is now used to treat all forms of PTSD, a wide range of anxiety and mood disorders, addictions, eating disorders and chronic pain (Hill, 2020). The overwhelming benefit of EMDR lies within the entirely subjective approach to treatment, and many have

found it even more effective when combined with trauma focused CBT or DBT (Melegkovits, 2022).

All of the aforementioned therapeutic practices have yielded positive results, individually and combined. The approach taken depends on both the qualifications and experience of the therapist and needs of the client. The clients presenting problems and their individual needs must be assessed to decide on an effective treatment plan. The following chapter discusses how the clients' needs are most often determined.

Measuring Trauma

Following a traumatic event, people are affected in a myriad of ways. Despite the recognised criteria that has been established for the diagnosis of a post-traumatic syndrome, presentation varies from person to person. As with any illness, many guidelines and accompanying measures have been produced to objectively gauge distress and inform diagnosis. Assessing psychological trauma often consists of a mixture of clinical interviews, standardised measures, and behavioural observations. The following section organises these methods based on the way in which data is collected, either quantitatively or qualitatively, the benefits and potential downfalls are discussed.

Quantitative Data

Quantitative data refers to data represented numerically: anything that can be counted, measured, or given a numerical value. Quantitative measures in psychology refer to psychometrics designed to assess a specific pathology, containing a variety of items that represent known symptoms, and measurement of latent constructs using a numerical scoring system (Michell, 1997). Each item asks the individual to score the symptom on a

scale, often representing the severity or frequency of each over a certain timeframe. Scores are tallied and interpreted based on the corresponding clinical cut off values for each symptom and/or total pathology. All psychometrics undergo rigorous testing and scrutiny to examine their reliability and the accuracy of each item in detecting the focus pathology, as well as the strength of the correlation between items (Edenborough, 1999).

Selecting a measure requires several considerations, including the time available, the health of the client and the goal of the assessment. Psychometrics take time to complete, typically this could be anywhere from 5 to 50 minutes, or longer depending on the length of the measure, the administrator, and the capacity of the client. If a client has a limited attention span, a shorter measure is likely to be more plausible and capture more accurate responses than one with more items. Similarly, if someone is severely unwell and has a significant impairment, the chosen measure might need to be short, with simple, easy to understand wording and directions. The goal of the assessment is crucial in deciding which measure to administer. The administrator needs to know which symptoms they aim to assess, and if there are multiple potential diagnoses to tease apart, this needs to be considered as well (Markon, 2013). The assessor must also decide if they need to understand the individual's current symptoms, their struggles over the preceding months, or their lifelong difficulties. There are a handful of measures that have been developed with the goal of quantifying trauma, the most used psychometrics are discussed below.

The Post-Traumatic Checklist (PCL) was developed at the National Center for PTSD in 1990 and is now reported as one of the most widely used self-report measures (Blevins et al., 2015). The PCL has been adapted for the changes made to the PTSD criteria in the DSM-5, producing the PCL-5. Consisting of 20-items, the PCL is a relatively short measure that asks the client to rate the frequency of their symptoms over the last month. Symptoms cover intrusions, avoidance, negative alterations in cognitions and mood, and marked

alterations in arousal and reactivity, scoring each item based on how they have been affected on a scale that ranges from 0 (not at all) to 4 (extremely) (Stanley et al., 2023). The PCL-5 is an especially valuable measure in that it can be personalised to better suit the person completing it. The measure generally requires identification of the traumatic event and refers to the trauma in relation to each test item. The required score for diagnosis of PTSD ranges from 30-60, depending on the population of the individual completing the measure, the setting in which the assessment is conducted and the purpose of the assessment. The ability to alter the assessment allows for a more subjective approach and takes individual experiences into account, resulting in a more accurate and considerate diagnosis. Tailoring the items to a specific event also makes the items more relevant to the individual doing the measure, making it easier to understand and complete.

The National Center for PTSD also developed the Clinician Administered PTSD Scale (CAPS). Initially formulated in 1989, the scale has now been altered to account for the criteria changes and additions introduced in the DSM-5 and ICD-11 (Weathers et al., 2018). The CAPS is a 30-item structured interview that includes the assessment of the following:

- All PTSD criteria including associated features such as dissociation
- Global ratings of distress, impairment, response validity, symptom severity, and measured comparison to prior assessments
- Dichotomous and continuous ratings for individual symptoms and overall disorder
- Separate assessment of symptom frequency and intensity
- Behaviourally anchored prompts and rating scales
- Assessment of trauma-relatedness for symptoms not exclusively linked to trauma such as low mood, isolation, and concentration difficulties

(Weathers et al., 2018).

The CAPS has three different versions corresponding to various time periods. Depending on the timeframe the assessor wants to examine, they can administer a measure that covers the past week, the past month, or the individual's worst month. There is often an addition to this measure that aims to identify specific traumatic events, the Life Events Checklist (LEC).

The LEC is a 17-item self-report measure of exposure to various events that potentially fulfil the DSM-5 Criterion A for PTSD. Each item asks the individual if that event has happened to them, if they've witnessed it, learned about it, been exposed to it because of their job or if it doesn't apply (Weathers et al., 2013). There is also an option to add in any events that are not listed. The use of the LEC alongside the CAPS allows for more specific answers, similar to the PCL-5.

Another simple and popular measure is the International Trauma Questionnaire (ITQ). The ITQ contains 18 items focusing on core symptoms of both PTSD and Complex PTSD as according to the ICD-11 (Cloitre et al., 2018). The questionnaire has two major subscales with three symptom clusters in each. PTSD related items cover the symptoms of re-experiencing, avoidance, and sense of threat, while the C-PTSD focused items cover affect dysregulation, negative self-concept, and disturbances in relationships, consistent with the disturbances in self-organisation seen in C-PTSD (Schnurr, Vielhauer, Weathers & Findler, 2012). An obvious benefit of the ITQ is the ability to identify symptoms of C-PTSD, allowing for a wider range of assessment and accuracy in diagnosis. There is also a version for children and adolescents, containing 22-items pertaining to the same symptom clusters and subscales as the adult version.

The aforementioned measures are relatively short, which can be beneficial when time or client capacity is limited. However, when a detailed symptom analysis is required, large measures such as the Trauma Symptom Inventory (TSI) are used. The TSI is a complex measure describing 100 trauma-related symptoms, rated on a 4-point scale of frequency over the preceding six months (Fernandez & Gebart-Eaglemont, 2001). These symptoms cover ten domains: anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociation, sexual concerns, dysfunctional sexual behaviour, impaired self-reference, and tension reduction behaviour (Briere, 1995). The measure also contains built in validity scales, designed to identify under- and over-endorsement and inconsistent responding.

There is a shorter version of this measure designed for those under 18, the Trauma Symptom Checklist for Children (TSCC). The full screening contains 54 items, possessing symptoms from six clinical domains: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns (Boyle & Viswesvaran, 2003). There is also an adjusted version that has 44 items and no reference to sexual issues, and a shorter version that only contains 20-items covering general trauma symptoms and sexual concerns. The use of these measures ultimately depends on the age and capacity of the client, and their presenting concerns.

The use of quantitative data in assessing and navigating trauma and other psychological difficulties can provide valuable information in an easily understandable format. Standardised measures allow for simple comparison over time and can provide answers for clinicians and patients who may be struggling to understand or separate symptoms. They are straight forward, user-friendly, and can assist in confirming clinical diagnoses. However, regardless of how expansive these measures are, there are some

phenomena that can never be completely quantifiable by nature.

Qualitative Data

Trauma is an entirely subjective experience, how it is perceived and the way in which it affects a person is unique. How we are impacted by a traumatic event is dependent on everything that has come before, how we understand and make meaning of what has happened, and our personal and sociocultural context surrounding the event. By definition, these factors cannot be measured with numbers or understood based on a rating scale. While a standardised measure can allow us to understand what symptoms a person is struggling with, they cannot tell us how those symptoms present or how they are experienced. The nature of quantitative measures allows for generalisation of findings, while this can be beneficial in strictly empirical scientific settings, it could be argued that nothing about individual trauma responses can be generalised.

A study investigating the use of various trauma measures within a population of women with a history of sexual trauma found that personal interviews were more beneficial and resulted in less discomfort than anonymous questionnaires and psychometrics (Schwerdtfeger, 2009). Stating that while both were reasonably well tolerated, women reported “significantly higher personal benefit” (p.39) from personal interviews. Earlier investigations had similar results, finding that participants who reported the most emotional engagement in the process benefitted the most (DePrince & Chu, 2008; Schwerdtfeger & Nelson Goff, 2008). One of these studies gave participants the choice between personal, face-to-face interviews and individual questionnaires; 92.7% of participants opted for interviews (Schwerdtfeger & Nelson Goff, 2008). These researchers believed that this choice and the high benefit-to-cost ratio associated to the interviews was based on “the creation of a context in which the experience is likely to result in insight and feelings of well-being”

(p.66). Qualitative interviews allow for a personal connection, reciprocation of emotion and familiar language. They also help researchers and therapists to understand the patient's internal beliefs and experiences, and the context of their trauma. This level of insight may also help patients in understanding more about themselves.

DePrince and Chu (2008) acknowledged possible hesitancy in conducting personal interviews within traumatised populations, for the fear that these methods come with a greater risk. The perceived risk is focused on patient experience, given that typically more in-depth information is shared in these settings, and the relational context might increase the risk of shame or embarrassment. However, this risk may be mitigated by the benefits, notably that interviews "might actually create more opportunities for personal meaning-making compared to questionnaires, thus actually increasing participants' perceived benefits" (p.36). Researchers discussed a long-standing argument initiated by female scholars, stating that interview and narrative methods are especially important when investigating the experiences of women and oppressed groups because narrative allows participants to communicate context. DePrince and Chu concluded that "interview procedures may provide participants with more extensive opportunities for reflection, perspective-taking and meaning-making than questionnaires" (2008, p.45), suggesting that qualitative interviews have greater benefit and result in more meaningful information being shared than quantitative measures alone.

The use of qualitative measures in assessing trauma allows for a wide range of exploration and understanding. They provide an opportunity to discuss the context of an event and the aftereffects, and allow individuals to express exactly how their experiences have made them feel. It creates space for connection and trust within a therapeutic relationship, assisting with the recovery process. A focus on qualitative data might also mean that less people fall through the cracks regarding PTSD diagnoses and treatment.

Criterion A of the PTSD criteria has the potential to be problematic in that it excludes many events that may be deeply upsetting but are non-lethal, such as emotional abuse and discrimination. It has also been noted that “the criteria do not address the complicated, severe symptoms of individuals with multiple or recurring traumas” (Hill, 2020, p.318). This is despite the knowledge that repeated traumatic exposures create an “increased vulnerability” to further trauma (Hill, 2020, p.318). A reliance on the hard and fast expected symptoms and causes of PTSD as seen in quantitative measures risks those outside of that box missing out on treatment entirely. It is common for people to meet some but not all of the PTSD, despite significant difficulties in functioning (Dickstein, Walter, Schumm & Chard, 2013). Without a detailed understanding of the presenting problems and the context of the event(s), many people would miss out on a diagnosis and subsequent treatment. This is especially poignant in the case of government funded care. For example, the Accident Compensation Corporation (ACC) provides funding for therapy and counselling under specific conditions. To qualify, one must have suffered either a sexual trauma or have lasting psychological difficulties following an accidental, physical injury (ACC, n.d.). Further, sustained funding is reliant on the diagnosis of a mental injury resulting directly from the event, as per the guidelines presented to registered providers, meaning that if an individual is experiencing symptoms on a subclinical level, they may not have continued access to treatment.

Despite the benefits of quantitative measures, namely the ability to objectively and quickly assess symptoms across the board, access definitive and verified diagnoses and compare specific measures of functioning over time, trauma is far from an objective experience. It should also be considered that these positive aspects of quantitative measures rely on the assumption that psychological attributes can be measured numerically to begin with. Some researchers have drawn attention to the fact that the use of quantitative measures is based on a hypothesis that has not been tested in psychology today (Essex &

Smythe, 1999; Michell, 2000; Michell, 2010; Toomela, 2010). Essex and Smythe (1999) repeatedly refer to psychometrics as “mathematical machinery”. They discuss the conversion of *intensive* variables, such as subjective judgements and psychological states, into *extensive* variables that can be measured. While there are appropriate ways to conduct this translation, including the use of memory and perceptual tasks to transform variables, the writers state that “the more common practice is to proceed unthinkingly from the intensive to the extensive, as in summing the numerical responses to distinct items on a Likert scale to measure the overall ‘strength’ of an attitude” (Essex & Smythe, 1999, p.747). Michell (2000; 2010) shared a similar understanding, explaining that the attributes that psychometrics aim to measure are not directly observable, rather responses to test items are measured and inferences are made. Michell also expressed concern that psychometrics are assumed to be accurate for the ease of use, specifically that “it is not reasonable to infer that psychological attributes must be quantitative just from the fact that quantification offers simpler forms of explanation” (2010, p.64). Despite the overwhelming assumption that psychological factors can be measured numerically, it has been stated repeatedly that there is no evidence to support this. Some researchers have gone as far as to say that these measures are “useless for answering questions about structures and processes that underlie observed behaviours” (Toomela, 2010, p.1). A reliance on quantitative measures suggests a focus on external behaviours, and it needs to be understood that these behaviours may represent different internal processes across the board. Toomela explained that “no quantitative procedure can distinguish qualitatively different mechanisms that may underlie externally the same behaviour” (2010, p.15). Essentially, even if psychologically driven behaviours could be quantified effectively, these behaviours may have different underlying processes from person to person. Given the variations in internal behaviours across individuals, the potential differences between cultures also needs to be considered.

The perceived universality and accuracy of quantitative measures and therefore the criteria they are assessed on generates even more concern across populations. In this case, quantitative measurements of trauma are assumed to accurately identify post-traumatic pathology across the board. Yet, concerns have been raised around the applicability of DSM criteria (Ruchkin et al., 2005) and the use of the PTSD criteria specifically (Bracken, Giller and Summerfield, 1995) within non-westernised cultures. Bracken and colleagues (1995) argued the used of PTSD criteria universally, stating that the idea of individuality and sense of self differs in non-Western cultures, rendering the recognised symptoms of PTSD unreliable in collectivist cultures. There are dangers in expecting universality within psychology, simply because the same symptoms are witnessed across cultures, they do not necessarily mean the same thing. A behaviour that may be considered a symptom of some underlying pathology in one culture, might be an entirely normal experience in another. The genuine internal processes behind any behaviour cannot be understood without trying to truly understand the individual exhibiting the behaviour, and experiencing the thoughts and feelings that go along with it.

While it should be noted that receiving only qualitative information risks the chance of observer bias, given that the information gathered is more open to interpretation than that acquired via standardised measures. It could be argued that this risk is mitigated by the benefits of a personal approach, and pales in comparison to the danger of assuming psychological attributes and behaviours represent an identical pathology in every person.

The present study aims to understand the varying post-traumatic presentations observed in psychological practice, and the perceived efficacy and accuracy of measures psychologists choose to employ.

Method

The present study is driven by the position that qualitative data and research methods should be used over quantitative methods in psychology whenever possible. This is due to the flexibility and inclusivity allowed for within a qualitative approach, and the afforded ability to examine all of the available information, rather than focusing on data that suits preconceived notions. As such, thematic analysis has been chosen to fully assess all information provided within the appropriate context. Employing qualitative content analysis was considered, however this focuses on predetermined key words or concepts (Bengtsson, 2016). Compared to thematic analysis, which focuses on the provided data and makes inferences based solely on the available content, content analysis has the potential to increase the risk of misinterpretation. The use of predetermined key words to form a conclusion also runs a high chance of instilling bias throughout the analysis. Thematic analysis allows for flexibility in approach and interpretation that is somewhat limited in other methods of qualitative analysis (Braun & Clarke, 2006). The nature of this approach allows participants to speak freely and express their own beliefs, opinions, and knowledge on the subject matter, as well as enabling reflexive interpretation.

Due to the subjectivity involved in interpreting qualitative data, my role as the researcher is undoubtedly coloured by my own experiences and understanding of the given field.

I am a 27 year old cis-gender female of British and New Zealand descent. I lived in Cambridgeshire, England before emigrating to New Zealand just prior to my ninth birthday. The culture shock and dramatic differences in how people interacted with one another and their surroundings fostered an early interest in how environment and cultural ties impact the kind of people we become.

I have been living with Complex-PTSD since I was 16 years old. After completing trauma therapy, I went on to work with ACC sensitive claim providers for two years, before becoming a mental health support worker at an adolescent inpatient facility. Despite the circumstances, I consider myself fortunate to have experience within the mental health system both as a patient and a provider. It is this experience that lead to my frustration around the gaps within the mental health system, especially in addressing trauma. Having been significantly affected by trauma, and seeing first-hand the way in which it can manifest in others, I hold a firm position that this is not something that can be measured objectively. As far as I am concerned, the idea that something as personal and life-altering as trauma can be understood based on ratings of predetermined symptoms would be laughable if it wasn't so devastating.

Given my strong feelings about the subject matter, it has been crucial that I remain open and reflexive throughout this process. In conducting qualitative research, I am acutely aware that the information I receive is open to interpretation. With my own beliefs in mind, I have been careful in assuring that the information I discuss throughout the present study is directly from the participants and verifiable academic research. I have also been sure to include information and opinions that do not necessarily align with my position, to provide a complete picture and allow readers to form their own conclusion. In addition, beyond this section, I will refer to myself only as "the researcher" in order to ensure the focus is largely on the contribution of participants.

The risk of imparting bias is greater in qualitative research than quantitative, given the reliance on discussion and interpretation over standardised numerical values. However, the process of reflexivity and the ability to recognise my own emotions, motives and reactions in response to this research allows for a deeper understanding of the material. One that enables me to reflect on my influence and the influence of others, and broaden my own

dynamic acumen. While this is a complex, progressive process, I struggle to see how we can sufficiently investigate any aspect of psychology without accounting for our humanity, the experiences that have shaped us, and the beliefs that we hold.

Participants

Eight psychologists volunteered to participate in the present study, including six females and two males. Of the participants, seven identified as NZ European and one identified as South African. The ages of participants ranged from 35 to 64 years at the time of the interview. Participants had been working as psychologists for between five and 27 years, with a combined total experience of 145 years in practice. Participants were asked to identify the percentage of trauma-related cases in their workload at the time of the interview. Answers ranged from 50 to 100%, with an average of 82.75%. Participants held either a Doctorate, Master's degree or Post Graduate Diploma in Clinical Psychology or Applied Psychology and all possess active registrations on the NZ Psychological Board.

Recruitment

Participants were recruited via snowball sampling, using pre-existing personal networks to circulate information about the research. Massey University Psychology Clinics were also contacted and asked to pass on the study information to psychologists on staff. Potential participants were asked to contact the researcher if interested or to ask any questions. The only inclusion criteria were that they were registered as a psychologist and had professional experience with a traumatised population. Those who met these criteria were emailed an information sheet (Appendix B) and a written informed consent (Appendix C), the interviews were then scheduled. Only eight participants were sought due to the depth of the topic and limited timeframe.

Procedure

Four participants were interviewed over Zoom, with interviews ranging from 20 to 75 minutes based on the responses provided and resulting discussion. Other participants were unable to find an hour to put aside for Zoom interviews, which resulted in Phase Two of interviews, completed in a written format online.

Prior to commencing interviews, written informed consent was collected. The consent form also asked participants if they wanted to receive a copy of their transcript for review and editing, and a copy of the thematic analysis once completed. In cases wherein participants had not filled out and returned the consent form, verbal consent was obtained. In Phase One, the interview schedule was designed with open-ended questions to guide the conversation with a focus on how clinicians understood trauma, the presentations they had seen and their use of psychometrics in diagnostics and treatment (Appendix D). All Zoom interviews were digitally recorded and stored on a secure flash drive for transcription and thematic analysis. If participants indicated that they wanted a copy of their transcript, it was sent to them within 24 hours, after which they had two weeks to advise of any changes they wanted made.

Transcription was completed via Otter.ai, a confidential online service. They were then reviewed by the researcher alongside the recorded audio to make any amendments.

Phase Two interviews were conducted through SurveyMonkey, with questions formulated based on prior literature reviews and interviews (Appendix E). Questions were designed to elicit thoughtful, thorough responses without the need for conversation and follow-up questioning allowed in face-to-face interviews. Participants were automatically sent a copy of their responses and were advised to make contact if they required any changes to be made.

Ethical considerations

Ethical approval for this study was obtained through Massey University Human Ethics Committee: Southern B (Application SOB 22/03; Appendix F). Due to the nature of the interviews, there was potential (bearing in mind the literature on secondary trauma) for participants to become distressed or emotional when discussing their experiences. This was acknowledged in the information sheet provided, and participants were encouraged to discuss any difficulties they were having during the interview or contact their own supervisor to debrief. Participants were also provided a list of available helplines and counselling resources as well as contact information for the researcher and supervisor if needed. No participants appeared distressed or emotional during the interviews, and no one has reached out to the researcher or supervisors with concerns.

The researcher had a prior relationship with two of the participants, as they used to work with ACC Sensitive Claim providers. There was potential for bias, as the participants may have felt obligated to agree with the researcher's point of view. There was also a risk that the conversation would turn casual, rather than focusing on the matter at hand. This relationship was acknowledged and did not appear to hinder the interviews in any way, all participants were very outspoken, and the discussion remained on task. If anything, the shared experiences allowed for more free-flowing conversation, thus providing more information.

Analysis

The data collected for analysis consisted of verbatim transcripts from the participants' interviews. Recorded interviews and transcripts were stored on an external password-protected drive. Participant names were replaced with numerical codes for confidentiality. Transcription was completed via online software, Otter.ai. The researcher listened back to each interview alongside the completed transcript to ensure accuracy. A few amendments

were needed due to diminished sound quality in some areas of the recordings, making it difficult for the automatic software to identify the words accurately. Written responses were reviewed and analysed without any changes being made.

Thematic analysis was used to identify commonalities and differences in how professionals have seen trauma present in practice and their favoured treatment protocols. Analysis was completed through a semantic approach in which coding and theme development was designed to explicitly reflect the qualitative data (Braun & Clarke, 2022). This involved familiarizing the researcher with the data by listening to and reading transcripts and responses, developing codes that reflected the key information, and using these to generate the broader themes of the data. Initially, raw data was organised according to the question; all responses regarding trauma definition were compiled, as were those in reference to presentation, treatment and so on. Commonalities within these sections were identified as themes and interpreted individually as well as in collation with other responses. Outlying responses were also marked for investigation and discussion. Upon development and review of the themes, participant responses were collated to discuss each area of investigation.

Summary

This study aimed to explore how psychologists understand trauma and their use of psychometrics in diagnostics and treatment. Eight psychologists with experience in working with a traumatized population were recruited via snowball sampling. Interviews were conducted over Zoom or in a written format online. Thematic analysis was used to identify commonalities and differences in how professionals have seen trauma present in practice and their favoured treatment protocols.

Analysis and Discussion

The following chapter discusses the main themes that arose during spoken and written interviews. The themes cover how participants defined trauma, the responses they have seen to trauma, the importance of cultural and spiritual awareness in trauma treatment, and a variety of measurement and treatment methods. All names used in this chapter are pseudonyms to protect participant confidentiality.

Defining Trauma

As expected, participants had varying definitions of trauma, including what causes it and its effects on a person. The most cited definition was in line with the traumatic event criterion outlined in the DSM: witnessing or experiencing an event where you feel like your life is threatened, events recognised as "Big T" traumas:

> “I guess I have been influenced by the DSM definition of trauma, which is around kind of, you know, being party to or witnessing an event where you feel like your life is threatened, or your wellbeing threatened. I guess at the same time, I also take a wider view on trauma. I think it’s wider than just things where your life is threatened. Like, I think that not having your emotional needs met by people who are meant to care for you can also be really traumatic, like they think traumatic invalidation can cause just as many difficulties for people down the line as what clinicians often talk about as the big T traumatic events.” (Olivia)

> “Largely would be guided by trauma as defined by DSM-5, i.e. facing actual or threat of death, significant injury or sexual violence. Also consider some little t trauma such as interpersonal trauma like significant traumatic invalidation.” (David)

> “I think of experiencing trauma in the wider sense of the word as – a person experiencing something difficult which profoundly affects and alters their perspective of themselves,

the world, and other people. Often this experience is something that is threatening in a physical sense (physical or sexual abuse, dangerous situation) but sometimes is extremely emotionally threatening." (Sam)

"… this is, I guess, an area that's evolved for me over the course of my career. Because when I trained, we were you know, we were taught a lot about what I consider to be the big T traumas, so capital T traumas. And those are the ones that qualify you for PTSD – you know, the events that you perceive your life is at threat or your integrity as a person – your soul is at threat, you know, like when you've been raped for example. So, we're talking a lot about that, but those are quite often specific events that are identifiable, that someone can say 'in this situation, this was how I felt, feared for my life and I thought, you know, my life as I knew it was going to be over'. But what I, I guess came to realise through my time as a clinician, but also through doing a lot of research in areas of adverse childhood experiences, is – they're kind of what we call the little t traumas, which are those insidious events that cumulate so some of those can qualify individually as being a big T trauma, but they're often repeated chronic, toxic situations that people are in that just change everything, changes their view of themselves, the world and others in a really significant way." (Emma)

As above, the majority of participants discussed the impact of smaller insidious traumas such as neglect, emotional and psychological abuse, coercive control, and other "little t" traumas alongside the more well-known "big T" events. Few went on to identify traumatic events based on an individual's experiences in the aftermath. For example, Louise described trauma as

"something happening in the environment that affects our brains and bodies, fills them up with so much information that the body can't process that amount of information, and it's perceived as dangerous or a threat. So, our body and our brain implement strategies to

protect us from that which may include the fight, flight, freeze response. Or if it's ongoing, they form kind of strategies to protect itself."

A focus on the impact an event has on a person rather than the details of the event itself ensures an individual receives appropriate treatment for whatever they are struggling with, without being held back by the need to subscribe to a rigid definition. Similarly, Alex explained trauma as something that "affects someone's world view, how they see people, the world and their expectations of how they should act and what is normal".

The term "Big T" trauma is used to describe singular events that are objectively traumatic, such as violent attacks, sexual assault, and war. These are the events that meet the first criteria of the DSM outline for PTSD, and are often easily identified, as a result, they make up the bulk of the literature discussing trauma (Benjet et al., 2016; Kessler et al., 2017; Pagel, 2020). The traumatic nature of these events is widely understood by the public, regardless of whether they have experienced such an event themselves. Little "t" traumas, however, are less understood (de Thierry et al., 2020). A "little t" trauma is anything that overwhelms a person and supersedes their ability to cope at the time of the event, but not something that would be considered objectively traumatic, such as non-life-threatening injuries, emotional or psychological abuse, bullying, harassment, and relationship dissolution. These traumas are harder for others to comprehend due to a misunderstanding that these events are less significant as they're not the typical life-threatening emergencies that come to mind when thinking about a traumatic event. We all handle stress differently; we have varying levels of resilience in the face of adversity and everyday stressors. Meaning that what is highly distressing to one person might not elicit the same emotional response in someone else. Therefore, understanding these more insidious traumas requires a focus on the impact they have on an individual, rather than the details of the event itself. Due to these events not being universally recognised as traumatic, those who experience them may be

more inclined to hide their suffering for fear of being judged. Minimising one's own trauma and attempting to suppress the resulting emotions can often lead to more cumulative damage in the long run. Even if an individual is not consciously repressing the events, little t traumas often remain unprocessed in the unconscious and accumulate over time, effectively chipping away at an individual's resilience and emotional resolve (Van der Kolk, 1994). These damaging yet misunderstood events call for a more inclusive and forgiving diagnostic process within trauma treatment, one that looks at the entirety of a patient's experiences and how they are suffering, rather than expecting a specific token trauma and objective diagnostic markers.

Participants alluded to Big T traumas, discussing singular events in which a person is in danger or being a witness to a horrific event such as "facing actual or threat of death, significant injury or sexual violence" (Louise). This included being the victim of or witnessing violence, a natural disaster, or serious medical events. Many referenced these singular events as what they were taught constitutes as trauma in their training, only understanding the significance of smaller cumulative events through practice. Emma described these events as "chronic, toxic situations that change everything" and spoke to the prevalence of trauma occurring in medical settings and the struggles faced in receiving a diagnosis following relationship and developmental trauma due to the complex and insidious nature of the experiences. Similarly, Shelley defined trauma as

> "Firstly, the DSM-5-TR definition around 'big-T' traumas, that are clearly outlined for diagnosis. The other type is 'little-t' trauma which encompasses traumatic invalidation and adverse life events (not captured in diagnostic criteria). The latter is often more pervasive in my experiences and can result in greater impact on psychological wellbeing. That is, it may not result in flashbacks, nightmares etc., but significantly changes the relationship the person has with others, the world, and themselves."

It is due to this discrepancy between the general understanding of a traumatic event as an objectively devastating situation and the impact of lesser-known, insidious cumulative events that many clinicians rely more on symptomology and less on the circumstances surrounding the trauma. A focus on symptomology is reinforced by researchers such as Howell and Itzkowits (2016), who have taken issue with a reliance on objectively traumatic events, given that not everyone who experiences one will develop post-traumatic pathology.

It is also worth mentioning that two participants raised concerns around the overuse of the term trauma within the general public to describe anything unpleasant: "[I am] very resistant to what has come to be the pervasive overuse of 'trauma' to include almost any interpersonally or emotionally painful experience." (David)

> "… so, the way I see it, is where trauma is sort of something that's really quite a significant stressor, that most of us would see as a significant stressor with an emotional reaction, or something that taxes the individual's resources. It's not just something that's unpleasant – an unpleasant occurrence, which I think is how we're often using the term now. I think we're overusing the word 'traumatic' and then people have expectations." (Alex)

Some researchers agree, suggesting that the term trauma is now somewhat of a buzzword, and has expanded as a concept to describe any unfavourable circumstance (Baes, Vylomova, Zyphur & Haslam, 2023). This undoubtedly dilutes the meaning of the concept and can be incredibly invalidating and trivialising to those who have experienced a traumatic event that has drastically impacted their lives.

Responses to Trauma

When asked about the different responses observed after a traumatic event, all participants mentioned symptoms outlined in the DSM-5 criteria for PTSD. These include re-

experiencing through intrusive memories, nightmares, and flashbacks; changes in mood and anxiety; hypervigilance resulting in constant edginess, difficulty relaxing, and sleeping; and avoidance of anything related to the event due to fear (American Psychological Association, 2013). Although many cases present with these symptoms, they manifest differently in each person. Louise discussed significant variations in symptom presentation, explaining that "people with PTSD can present very differently despite having the same clinical diagnosis". Other participants shared this sentiment:

> "The people who present with PTSD can present quite differently … there's this kind of idea of complex PTSD looks a lot like borderline personality disorder. And I think that both of those presentations are due to a kind of trauma, when people have had lots of trauma in their lives, and so that presents quite differently to what the DSM tells us PTSD looks like as well." (Olivia)

> "It's strange whilst you can define it with the DSM four (referring to the four symptom clusters for PTSD), it can present differently within clients." (Louise)

When asked if her experiences with treating PTSD mirrored the symptoms in the DSM, Emma responded:

> "Yeah, for sure. I suppose all of that's there to a certain degree except the awareness of the event. So, there's re-experiencing at a really, it's kind of at that very physiological, emotional, unconscious sort of level. So you know, if I said to someone 'why are you responding in a particular way' they may not be able to explain it … so they have the physical re-experiencing, but they can't explain it or the thoughts that go along with that … and hypervigilance around the world not being a safe place, and you know, not being sure that good things are going to happen and not feeling very lovable or worthy …. I mean, a lot of what we kind of see is, I guess, fits into that sort of borderline category. But, you know, lots of other personality disorders also kind of track back to those early

> experiences interpersonally, it's that insidious interpersonal trauma, rather than particular events. So, re-experiencing but in a different way, kind of a very physiological way, definitely hypervigilance, hyperarousal, and avoidance as well … it manifests in different ways for people, but when I have that trauma lens on things and have that broad conceptualisation of trauma, their behaviour is because of what's happened to them, but it's driven by emotions that they don't necessarily understand."

Emma explained that these unconscious processes are often seen in developmental trauma and used an example of a child having undergone major surgery, "a child who has had a significant medical procedure such as a transplant, later has a visceral response when surrounded by adults, which makes sense when considering this was a precursor to the medical event."

Additionally, these symptoms may be masked by other symptoms or co-occurring mental illnesses, resulting in individuals presenting to mental health services with varying complaints only to uncover these post-trauma symptoms later. Having worked for years in inpatient care, Alex stated that "it often isn't [trauma symptoms] that get them [admitted], they experience them while they are there".

Participants mentioned a range of difficulties that they commonly see in traumatised individuals, including substance abuse, anxiety, depression, obsessive-compulsive disorder, eating disorders, borderline personality disorder, psychotic illnesses, and attachment disorders.

> "I find that trauma can 'seed' into a wide range of mental health problems. I work in addiction, so this is a major problem that has its roots in trauma experiences. Additionally, we would see a lot of anxiety, depression, panic, OCD, disordered eating, interpersonal difficulties, relationship (intimate and non-intimate) difficulties, mistrust, and

isolation. Impacts on self-identity, self-worth, self-esteem, and trust in one's judgement can be affected, as well as the engendering of difficult emotions such as shame and guilt." (Shelley)

"And there's like comorbid stuff, like I have a few come in with comorbid diagnoses, or anxiety, depression, also dissociation, and borderline personality disorder. Attachment stuff and eating disorders as well. And so, I often wonder, you know, did one come first or is one because of the other? How do you tease those out?" (Louise)

"I don't think everybody that has a traumatic event goes on to develop PTSD as the DSM defines it. You know, I think that some people can have traumatic events happen to them, and then develop different difficulties. I mean, I worked on an inpatient ward for about five years, and I saw a lot of people who had experienced trauma in their lives and then went on to develop, you know, psychotic illnesses. And I absolutely think trauma played a role in that, but they didn't meet the criteria for PTSD per se. But I guess, brains kind of – our brains deal with what we've been through in different ways. Also, different anxiety disorders often crop up, so people might not have the re-experiencing, but they might begin to worry about a lot of things, like you see with generalised anxiety disorder. They might start to show symptoms of obsessive-compulsive disorder. Eating disorders too – a big one that kind of crop up for people when they've had things happen to them." (Olivia)

Although these illnesses commonly co-occur with PTSD, it was also emphasised that trauma may result in the development or exacerbation of another mental illness and not PTSD. Shelley stated that in her opinion "if we could prevent trauma, we would solve a hell of a lot of mental health problems".

This notion is supported by a collection of epidemiological surveys, providing evidence for the idea that "in individuals with PTSD, the presence of other psychiatric

disorders is the rule rather than the exception" (Brady, Killeen, Brewerton, & Lucerini, 2000, p.22). According to Brady et al. (2000), of those diagnosed with PTSD, 98.9% met criteria for at least one other psychiatric disorder, while 59% of men and 44% of women met criteria for 3 or more. The symptoms of PTSD overlap with other psychiatric disorders, especially depression and anxiety disorders, which may explain some of the recorded comorbidities. It is also possible that those with PTSD attempt to self-regulate through substances or regain a sense of control over their lives through governable variables, resulting in a high co-occurrence of substance abuse and eating disorders within the population. The potential for comorbid illnesses requires significant consideration, due to the possible complicating factors regarding the anticipated course of illness and treatment.

The internal processes following trauma were also discussed at great length, particularly the burden of extreme shame and internalised blame. This often leaves people feeling isolated and afraid, reinforcing the belief that they are unsafe in the world. Sam spoke to safety and shame as critical consequences of trauma:

> "Significant anxiety, feeling unsafe in the world and/or in regard to particular people and situations – often people or situations that are similar to the traumatic event trigger panic and PTSD symptoms. Also, a profound sense of shame related to the internalising of blame for the traumatic event, particularly with childhood abuse"

These internalised emotions and belief systems can have devastating impacts on an individual, resulting in them feeling as though they deserve what has happened, and making it difficult to navigate the rest of their life.

> "If a person has complex trauma, especially if it's early on then that's more likely to affect their world view in the way they see people in the world and their expectations of how they should act and how other people should, and what they should do and what's

normal for them and other people. And they might also have a big sense of doom or a sense of uncertainty about the future and like, 'I think I deserve this' or 'of course that's happening to me' or things like that, because of the cumulative effect of the repeated experiences." (Alex)

"When you behave in particular ways, which makes sense with a trauma lens, it results in a pattern of behaviour, which can then be self-fulfilling. So, say, if you believe that people are going to leave you at some point – so you're in a relationship and you're fearful your partner's going to leave you, so you start to look for someone else to be with as a backstop, so you won't be alone. You cheat on your partner, then your partner leaves you because you cheated on them and that reinforces the view that relationships don't last. So, that kind of provides evidence that you need to keep protecting yourself, make sure that you always have options so you're never on your own. So, things become self-fulfilling out of fear, anxiety, and trauma responses." (Emma)

David touched on the dire impact avoidance can have on an individual following a traumatic event "at all levels, meaning that a person loses touch with their life as they would have wished to live it. People lose touch with (or don't trust) their emotions, themselves, and other people". Interestingly, investigations into shame, blame and related emotions such as guilt have identified these post-trauma reactions as strong indicators of post-traumatic symptom severity (Andrews, Brewin, Rose, & Kirk, 2000; Leskela, Dieperink, & Thuras; 2002). Research has indicated that these emotions are reported to be stronger following particular trauma, such as physical and sexual assault (Kaysen, Morris, Rizvi, & Resick, 2005). It is difficult to empirically identify reasons as to why these emotions are more prevalent following certain experiences, however, it is understandable given the individual, targeted and stigmatised nature of such events.

Just as the type of traumatic event can impact post-traumatic outcomes, the context of the trauma was mentioned by participants as one of the most crucial influences on the impact of an event on an individual. This includes both the circumstances of the trauma itself and the aftermath. Participants identified age at the time of the event, whether there have been single or multiple events, and the response by others at the time the event occurred or was disclosed as being key to the individual's outcome:

> "[Response] depends on several factors: the age of the person when the trauma occurred, single event versus multiple traumas, response by caregivers at the time the trauma occurred or was disclosed. If it is a single trauma event that occurred to someone who otherwise had good attachment to primary caregivers and supportive resources from the environment when the trauma was disclosed, the event can more readily be integrated into their experience (and they may not present for treatment, or it will not be a significant issue). Conversely, clients who have experienced multiple traumas from a young age where there were not good attachments to caregivers, can present with personality difficulties, suicidality, complex PTSD, and dissociative disorders." (Joe)

Repeated trauma, the inaccessibility of a safe support network, and the reaction of others upon disclosure were discussed as factors that dramatically impact an individual's beliefs about themselves and the world.

The above contextual factors mentioned by participants are, for the most part, mirrored in the literature. Boehnlein (2001), for example, discusses the importance of context in approaching PTSD, involving an understanding of an individual's physical, psychological, socio-cultural, and spiritual needs and history. Concerns are raised around the potential for further harm caused by ignorance in any of these domains. In terms of age at the time of exposure, research suggests that those who experience trauma in childhood are more likely to have more significant and enduring struggles than those who are exposed in adulthood

(Boumpa et al., 2021). While we can assume that children raised in a loving, supportive and protective environment are more able to integrate traumatic events and therefore suffer less symptoms in the long term, evidence-based information to affirm this theory is limited. There is, however, a recent focus on the impact of disclosures of abuse, with research correlating negative social reactions to increased severity of PTSD symptoms (Ullman & Peter-Hagene, 2016)

Many participants expressed other factors that influence symptom severity, with the most frequently raised concern being access to treatment (See Table 1). They spoke about the benefits of early treatment and its efficacy in reducing symptoms and functional impairment in the long term:

> "If a person can access treatment early, this can help with reducing symptoms and therefore functional impairment, and also a psychologist can work with whanau, employers and other medical professionals to provide psychoeducation, increasing empathy and understanding" (Sam)

Lack of access to sufficient treatment with properly trained providers can not only result in an exacerbation of symptoms but also an overall distrust in the therapeutic process. Shelley and Olivia mentioned the harm caused by the system when people fall through the cracks between care providers:

> "The inability for people to gain sufficient treatment – even though that's an 'ambulance at the bottom of a cliff' answer. I have been saddened to hear people talk about their trauma therapy they are getting in a café, or for years when they cite a 'nice chat' with their counsellor. A lot of money is placed into providing this type of support and yet I do hold concerns that not all contracted to ACC Sensitive Claims are sufficiently trained in this type of work. I also feel that the invalidation that can occur from one's environment

about their trauma experience can be incredibly harmful and exacerbate the consequences of trauma." (Shelley)

"I think clinicians are scared to treat trauma. I think, you know, at Te Whatu Ora – trauma work is meant to be done by ACC, not us, which is kind of arbitrary and unrealistic, really. Because often people with trauma, present with other difficulties as well, that are I think better held by clinicians with mental health expertise. So, I think that's the thing that happens, where a lot of people fall through the gaps because their symptoms are too severe to go to ACC. Then the DHB is like, 'well we don't actually treat trauma, ACC is meant to cover it'. And I think particularly for people who are engaging in life threatening behaviours, I think clinicians are really scared about treating trauma because they don't want to make anything worse. And the truth of the matter is, that sometimes you need to do the trauma treatment to resolve all those other difficulties." (Olivia)

While supporting data for this particular oversight in treatment is difficult to find, a study investigating the challenges in treating traumatised populations uncovered a number of hinderances. Kazlauskas (2017) discussed four major barriers to access: acknowledgement and stigmatisation of survivors, avoidance and trauma disclosure, limited resources, and ongoing conflicts and disasters. This study presented the difficulties in accessing appropriate, trauma-informed care within a struggling healthcare system, lacking in properly trained providers, discovering that even in well-developed countries there are a very small number of qualified providers. Age was mentioned as an influencing factor by four participants, with Emma explaining that:

"I think in terms of severity of consequences, I guess it's the kids tend to get picked up earlier. So, the adults that I work with, some of those consequences are quite entrenched views of themselves, the world, and others. So, you get people who are having a middle-aged crisis, but what it actually is, it's all of these things kind of coming to a head at once

… it's tricky when someone's been living in a particular way with a set of beliefs about themselves and the world for a really long period of time. It becomes more behaviourally entrenched, and those I guess, core beliefs, schemas, whichever way you kind of want to think about it, there's a bit more body behind them."

Not only does this make things more difficult for the person to live their life, but it also means therapy will likely be more grueling and take longer. Worth mentioning is a study comparing the prevalence rates of psychiatric illness in populations who experience traumatic events in childhood compared to those who experience their first traumatic event in adulthood. Zlotnick and colleagues (2007) concluded that children exposed to a traumatic event are significantly more likely to develop comorbid conditions, especially panic disorder, than those who experience trauma for the first time in adulthood. The reason behind this is difficult to pinpoint, and could be due to lack of treatment, revictimization, or a pre-disposition to further mental disorder. While this does not negate the notion that distress is easier to identify in children, the potential for long-term vulnerabilities requires consideration.

Table 1 – Influences on Post-Trauma outcomes

Influences on Post-Trauma outcomes	Frequency
Access to treatment (early intervention or improperly trained providers)	7
Age (at the time of event)	4
Support Networks	3
Reactions (at the time of event or disclosure)	2
Trauma Frequency	2
Trauma Type	4
Avoidance behaviours	2

Culture and Spirituality

A discussion about the influence of culture and spirituality on trauma resulted in a consensus among most participants, although it is important to note that no participants were of Māori or Pacifica descent. All but one participant stated that cultural and spiritual

influences cannot be disregarded in the interpretation or treatment of trauma and related mental health difficulties. Cultural and spiritual beliefs, as well as associated cognitive schemas, can alter how individuals process and cope with events, and may influence whether someone develops a pathology in the first place.

> "I would think that [culture and spirituality] do influence how people react to trauma. Just thinking culturally, you know, the culture that you're raised in, and your family or wider family's beliefs about trauma can definitely influence how you then process or cope with it. Some cultures don't encourage talking about difficult things, and that would definitely impact on whether someone would even develop PTSD in the first place. I think spiritually, I'm just thinking of Māori culture, with my experiences working in an inpatient setting, within their culture talking to ancestors and spirits was very much normal and not necessarily a sign of mental illness." (Olivia)

The discussion pointed out that in certain cultures, mental distress may manifest as more somatic complaints, making it harder for clinicians to diagnose and treat the root issue.

> "People from certain cultures (e.g., South East Asian) are more likely to present with somatic complaints rather than 'typical' mental illness symptoms, and therefore less likely to be identified early. Clients from collectivist cultures are more likely to struggle to set appropriate boundaries with family members in particular, which can impact their treatment progression." (Sam)

This was mirrored by studies investigating the effects of trauma in non-Western cultures. Hinton et al. (2013) identified somatic complaints as key features in a post-trauma response among Cambodian refugees; symptoms that are not included in the DSM criteria for PTSD. These symptoms included dizziness, tinnitus, nausea, and widespread pain, presumably as a result of physiological arousal and changes to the nervous system in

response to trauma or chronic stress. The observed symptoms that were consistent with the DSM criteria, such as anxiety, nightmares, and sleep paralysis, were understood to be a result of one's soul being displaced from their body. Yet, soul dislocation is recognised as a separate, culturally bound syndrome (Hinton et al., 2013). Similarly, a study following a mass natural disaster in Sri Lanka found that the expected symptoms of PTSD were almost entirely absent (Alford, 2016). While many professionals claimed that the lack of symptoms was due to the communities being in denial, few suggested that their experience of trauma was simply different than the Western understanding. Following Bracken's (2001) suggestion that PTSD as we understand it is exclusive to the Western, post-modern world, further investigations into the nature of the post-traumatic state within communities was conducted. Alford (2016) concluded that the dissolution of social groups and communities following the event was the main source of distress among the survivors. Our understanding of PTSD is as a psychological injury resulting in inner turmoil and several internalised symptoms, whereas the distinction between inner and outer roles did not exist within the observed communities. Rather than distress manifesting in alienation and avoidance, the physical inability to participate in one's social groups or community due to the destruction of the event was the main concern of individuals. Alford came to the same conclusion as Bracken, that perhaps PTSD is a diagnosis that suits a particular culture at a certain time, and while serving a purpose within our culture, it may be entirely inappropriate for others.

Participants also discussed the damaging effects of trauma caused by someone within an individual's culture or religion, due to the cognitive dissonance it can create. Trauma was identified as a significant factor in people moving away from their cultural ties, particularly when cultural figures are the ones causing harm or are invalidating upon disclosure, resulting in increased guilt and shame.

> “If you had a set of spiritual beliefs, but actually someone within your church was someone who hurt you, then that raises cognitive dissonance for people, how do you navigate that? How do you separate out a person’s behaviour from the bigger picture? And similarly, when I’ve seen people who might have been hurt by someone within the culture, to be able to separate out that that was a person, that wasn’t an entire group of people. That kind of thing is really important as well.” (Sam)

> “Just through the people that have come through my door, I’ve only had European, Māori and Cook Island clients. In my experience, so it won’t be everyone’s experience, those who identified as Māori did not want to bring any Māori practices into our sessions. They didn’t want to reconnect with any iwi or hapu … and then the other one is a lot of shame for speaking out, like they kind of all felt they were going against their family. By stepping out of this circle - they felt terrible for that, they felt disloyal.” (Louise)

> “Not so much culturally other than observing (anecdotally) some Māori with trauma have a tendency to shift away from their cultural roots. Spiritually, I have worked with a number of people who have experienced trauma via religious interactions. I have worked with a disproportionate number of people who were raised in religious cults/closed communities whereby sexual trauma was pervasive. The impact of this has typically been that people can be confused about what is normal and what is not, about their place in the world, about their spiritual beliefs, and a general sense of uncertainty. It is in this way how trauma changes people’s psyche – the damage is often more than the ‘incident’.” (Shelley)

Unfortunately, experiencing trauma within a religious community is not a rare experience, to the point where a collection of symptoms within a particular circumstance is recognised as *Religious Trauma Syndrome* (Ramler, 2023). The involved symptoms closely resemble Complex-PTSD, with the addition of pertaining to a religious context. Religious

trauma syndrome was introduced in 1993 by Marlene Winell and has yet to be recognised as a formal diagnosis. However, many individuals struggling with having faced trauma within their religious community strongly identify with the term and proposed symptoms (Ramler, 2023). Regardless of the circumstances, damage to a person's psyche extends to their environment and context. In this case, trauma significantly impacts how someone might feel about the culture or religion they've been raised in.

While cultural and spiritual identity can result in further difficulties coping with trauma in some cases, it can also be a source of resilience and protection, providing a sense of meaning and belonging. Many participants identified greater resilience that comes with believing in something bigger than oneself, whether that's spirituality, religion, a connection with nature, or the universe. These beliefs provide people with a set of values and a compass for decision-making, as well as a connection with a wider group of people outside of immediate family.

> “I think that a set of beliefs and values around something bigger than yourself can be super protective. So whatever way that manifests – spirituality, whether it’s religion, whether it’s something broader than that, connecting with nature, that scientific being part of the universe, the stars and all the rest of it, I think that often provides people – when people don’t have or haven’t had adults in their lives, who can provide them with a good compass around how to make choices, spirituality and a set of values can be really useful …. Similarly, I think having a strong sense of cultural identity can also be incredibly protective as well because it can give a sense of connection with more than just your immediate family, but with a wider group of people.” (Emma)

Available studies examining this relationship between culture and trauma presentations focus largely on collective trauma, such as war or mass natural disasters (Hendricks, Ortiz, Sugie & Miller, 2007; Johnson, Thompson & Downs, 2009; Hinton &

Hinton, 2015). In these cases, the trauma was shared within a community, resulting in a sense of normalisation; those affected were seemingly able to accept the trauma as a part of their lives. Experiencing a shared trauma as a part of a group meant that those affected were able to support and be supported by everyone around them, rather than feeling personally targeted and alienated. Those with strong religious beliefs were able to see the event as part of a bigger plan and held onto faith that everything was happening for a reason they weren't privy to, providing comfort. However, David pointed out that those who seek therapy are largely those without these variables in their lives:

> "I guess that the resilience engendered in people with strong cultural/religious/spiritual roles and identity, mean that the sample of people that we see as clients is already skewed towards people without these variables in their lives. In the people that I have seen for therapy it is clear that those who are able to embrace meaning and purpose (cultural, spiritual, or otherwise) seem to do better."

It is important to note that Alex was uncomfortable commenting on cultural influences due to individual experiences between and within cultures and the disproportionate representation of Māori in the mental health system.

> "I don't feel it's appropriate for me to say, 'this is my view of lump sum Māori clients I've worked with'. And I don't feel it's fair to quantify Māori experience in that way, we've never looked back at pakeha to say 'Well, in my view, this is the experience of them because clients seemed to do such and such' because it's just not that simple. And I don't think it's fair to treat Māori that way, because pakeha people don't get treated that way. That's just kind of too simplistic. There's so many different Māori perspectives and we have, unfortunately, I say it because it's an indictment on our society, at least 50% of [local inpatient] clients are Māori at any one time. I can't make assumptions when they're in the interview room – 'Because you're Māori we'll have dot dot dot' … We can't make

sort of full coverage intercultural comparisons because, again, it's quantifying something that's a very individualistic experience."

This is understandable, given the current trends in psychiatric morbidity data, which suggest that Māori youth in particular are more susceptible to developing anxiety, mood, and substance use disorders than non-Māori New Zealanders, with Māori adults experiencing mental distress at a rate of 1.5 times the occurrence in non-Māori New Zealanders (Ministry of Health, 2018). The overrepresentation of Māori within the mental health system is believed to be a result of a number of factors, including historical oppression; institutional racism; acculturation stress due to rapid urbanisation; unequal access to treatment services; lack of ethnic matching between clinician and client resulting in clinical biases; and the careless collection of demographic information (Marie, Fergusson & Boden, 2007). Similar to research within other cultures, strong cultural identity has been recognised as a protective factor against poor mental health within the Māori population (Williams, Clark & Lewycka, 2018), furthering the argument that colonisation and the resulting dislocation from traditional culture plays a significant role in wellbeing. Thus, supporting the need for a comprehensive assessment of all aspects of an individual's experiences, rather than a focus on symptomology alone.

Measurement (symptoms)

When it comes to symptom assessment, there are a variety of measurements that can be used to evaluate the presence and severity of symptoms. Participants stated that they generally rely on clinical interviews to assess an individual's struggles and needs. The use of psychometrics was also discussed, with implementation depending on the capability of individual clients.

"I would probably only use psychometrics if I wasn't getting the information I needed from a clinical interview. Like I think if I was working with someone who was reasonably

articulate about what they're experiencing, I probably wouldn't feel the need to do psychometrics. So, I tend to use psychometrics more if maybe the individual is having a lot of difficulty expressing what is going on for them, and I think that their presentation might be due to trauma, but I'm actually maybe not getting that from the conversation … So perhaps more with individuals who might have some traits of autism, I might be more inclined to use a measure, and if they're not kind of telling me what they're struggling with, or if the case was really complex, like there were a lot of things going on, and I felt like I just really needed something objective." (Olivia)

"I tend to mainly use clinical interviews to gather information about presenting issues and background history. I use psychometric evaluations when/if I am unsure about presentation or need to assess a particular issue prior to commencing therapy (e.g., assessing level of dissociation prior to commencing EMDR therapy)." (Sam)

"I typically use qualitative methods to ask a wide range of diagnostic, background, and other pertinent information, which always includes screening for trauma. If the screen alerts a need for more comprehensive assessment, then that is what is proceeded with. I work very closely with my clients around assessing for trauma, being careful not to re-traumatise them. Sometimes I use psychometrics to support the assessment, especially when it is clear that a client may have difficulty speaking about their trauma. The main information I am seeking is two-fold. Firstly, their experience of trauma which I don't need lots of detail on. Namely, for assessment purposes, it's helpful to know if they have experienced trauma (without needing the specifics) and if so, how old they were, was it single-event trauma or chronic, is it still happening now/are they safe from any perpetrator. Secondly, I then ask diagnostic questions to see if there is a diagnosis to be made. This taps into the DSM-5-TR criteria. I don't make the assumption that the experience of trauma automatically means the client has developed a psychological problem as a result." (Shelley)

Clinicians often used psychometrics when they are unable to identify specific difficulties from a clinical interview alone. This includes cases where a patient might have difficulty expressing how they are feeling, or when there are several possible conditions at play and objectivity is needed to separate the symptoms. The most used measurements are discussed.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is used by all participants in distinguishing diagnoses. Although it was acknowledged that symptoms present differently across patients and need to be understood in relation to their individual context, history, and environment. Emma stated that

> ”relationship-based and developmental traumas can result in kids having no specific memories, meaning they can’t meet the current criterion A and qualify for a PTSD diagnosis. They may present with attachment disruptions and relational difficulties but cannot verbalise any specific incident”

stressing the importance of context and interpretation in the face of all measures.

Participants often use the Depression, Anxiety and Stress Scales (DASS; Lovibond & Lovibond, 1995) to quickly assess a patient's emotional state. While assessment of trauma relied on more specific measurements including the PTSD Checklist for DSM-5 (PCL-5; Blevins et al., 2015), Trauma Symptom Inventory (TSI; Briere, 1995), the Trauma Symptom Checklist for Children (TSCC; Briere, 1996), International Trauma Questionnaire (ITQ; Cloitre et al., 2018) and the Complex Trauma Inventory (Litvin, Kaminski & Riggs, 2017). The Impact of Events Scale (Horowitz, Wilner & Alvarez, 1979), Dissociative Experiences Scale (DES; Carlson & Putnam, 1993), Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) and the Multidimensional Inventory of Dissociation (MID; Dell, 2006) are also used to examine particular symptoms.

> “The Dissociative Experiences Scale (DES) is routinely used as a screening tool for dissociation symptoms before starting EMDR, due to the risk of dissociation if processing is started too soon. Otherwise, I used the PTSD Checklist (PCL) as adjunct to the clinical interview. In my current role there is usually not a need for elaborate psychometrics, so it is used more to assist with clinical impressions and to track progress, or to meet ACC reporting requirements.” (Joe)

> “Trauma Symptom Inventory (TSI-2) is reasonably comprehensive, PTSD checklist (PCL-5) is good for tracking therapeutic progress, Difficulties with Emotion Regulation scale (DERS) is helpful to understand a person’s emotion regulation problems” (David)

In addition to these assessments, there are a number of other tools that were mentioned for use in evaluating functioning outside of trauma. The World Health Organisation Disability Assessment Schedule (WHODAS; Üstün et al., 2010) and the Personal Wellbeing Index (PWI; International Wellbeing Group, 2013) are broad, health-focused measures that are often essential in government-ordered reports.

For patients who may have underlying personality pathology affecting their presentation and response to treatment, one clinician utilises the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1977). Additionally, the Ritvo Adult Autism Diagnostic Scale (RAADS; Revised, Ritvo et al., 2011) and the Borderline Symptom List (Bohus et al., 2001) were mentioned in assessing potential differentials. The Difficulties in Emotion Regulation Scale (DERS, Gratz & Roemer, 2004) and Ways of Coping (Folkman & Lazarus, 1988) were used similarly, to identify emotion dysregulation and maladaptive coping mechanisms respectively.

> “If necessary I use a range of psychometrics including: Impact of Events Scale, Dissociative Experiences Scale, Hospital Anxiety and Depression Scale, Milton Clinical

Multiaxial Inventory (only if I think there may be underlying personality pathology affecting the clients' presentation and response to treatment), and sometimes Ritvo Adult Autism Diagnostic Scale and Borderline Symptom List if I feel there is a possible ASD/BPD/Trauma differential to be assessed and teased out." (Sam)

Younger patients often require an adapted measure designed for a younger group of clientele. These measures often contain less items and simpler language, and some may have a caregiver report attached. Other than the TSCC, the Beck Youth Inventory (Beck, Beck, Jolly & Steer, 2005) was the only other adolescent specific tool mentioned by more than one participant. (See Table 2 for a full list of psychometrics)

Table 2 – Psychometric Use Frequency

Psychometric	Frequencies	Psychometric	Frequencies
Detailed Assessment of Post-Traumatic Stress (DAPS)	2	Depression, Anxiety and Stress Scale (DASS)	2
Post-Traumatic Checklist-5 (PCL-5)	3	Trauma Symptom Inventory/Trauma Symptom Checklist for Children (TSI/TSCC)	6
International Trauma Questionnaire (ITQ)	2	Complex Trauma Inventory	1
Impact of Events Scale	3	Dissociative Experiences Scale (DES)	3
Hospital Anxiety and Depression Scale	1	Multidimensional Index of Dissociation (MID)	1
World Health Organisation Disability Assessment Scale (WHODAS)	2	Personal Wellbeing Index (PWI)	2
Milton Clinical Multiaxial Inventory	1	Ritvo Adult Autism Diagnostic Scale	2
Borderline Symptom List	1	Difficulties in Emotion Regulation Scale (DERS)	2
Ways of Coping	1	Subjective Units of Distress Scale (SUDS)	4
Revised Child and Adolescent Depression Scale (RCADS)	1	Screen for Child Anxiety Related Disorders – child/parent	1
Disordered Eating Scale	1	Adult ADHD Self-Report Scale (ASRS v1.1)	1
Beck Youth Inventory	2	Body Dysphoria Screen	1

Dalenberg & Briere (2017) produced a strong argument in favour of psychometrics, stating that actuarial measures are more accurate than clinical prediction. They

recommended that PTSD be measured by self-report measures and interviews that are semi-structured if not fully structured. However, they also mentioned a number of factors that need to be considered, and the ability of any psychometric in measuring these aspects could be debated. These factors are as follows: dissociation; cognitive ability; depression/grief; substance abuse; anger and aggression; emotion regulation; attachment disorders; malingering (potentially rendering other measures unreliable); changes in beliefs, expectations, or schemas; and trauma-related growth. Understanding all of these aspects would be a lengthy and tiring process, especially if one is relying on psychometrics to evaluate every feature. Alongside the insistence that objective measures are used in assessing all of the above attributes, the researchers also outlined considerations that must be made in selecting every measure, including test length and simplicity; reliability; validity; availability of norms; sensitivity and specificity; availability of cross-cultural data; and underreporting identifiers. It is argued that if all of the aforementioned points are met "the evaluator will be able to identify severity of symptoms, treatment avenues that may be helpful, and underlying issues that may not quickly come to light in a less structured setting" (p.56). However, what is not considered is how grueling and likely impersonal this process would be for the client expected to complete the multitude of psychometrics, which was taken into account by participants in their decisions around assessment.

Conversely, Ruscio, Ruscio & Keane (2002) discuss the risks involved for clients when a clinician relies on psychometrics. Namely the rigidity of clinical thresholds the psychometrics impose during interpretation, and the likelihood of overlooking "subsyndromal or partial presentations of PTSD" (p.290). They argue that PTSD operates on a gradient and goes beyond a simple presence or absence of disorder as suggested by quantified thresholds. Presentations below the threshold or perhaps not exhibiting certain criterion symptoms have been associated with clinically significant psychosocial and occupational

impairment regardless. Identification and validation of this suffering requires more than can be gathered from psychometrics alone.

In the present study, it was stressed that the benefit of a personal connection and conversation cannot be overestimated. When evaluating a patient's condition, it is important to consider their emotional responses in certain situations and how often they occur. It is also important to identify any diagnostic identifiers and consequential personal difficulties, such as relationship issues, difficulty with communication or assertiveness, problems with setting boundaries, and self-care issues. Emma explains the importance of this overlap:

> "I think sometimes organisational requirements mean that we need to [use psychometrics], we're asked to look to see if there is a diagnosis that can help capture what's happening for someone. And often times there will be low mood or anxiety or even PTSD, or a substance problem – that's really typical with adults. But if they've managed to avoid a clinically significant level of those things, so they might have some dysthymia but it's not your sort of major depression; they might be a more anxious person; they might have a bit more alcohol than is recommended, but not at a substance abuse level. And maybe one of the biggest things is actually relationship difficulties, that's not going to be captured by psychometrics well …. So, there's the diagnostic stuff and then there's the life stuff. There's just a series of things that happens, which isn't a particular event, but it's a sense of self change, people's relationships in what they expect from other people in the world. It's their world view that shifts …. So, we have these psychometrics but then these interpersonal changes, they don't lend themselves to measures very well."

In addition to these assessments, evaluating a patient's core sense of self and any significant events they may have experienced can also be helpful. Self-reports and clinical interviews can provide valuable information, with psychometrics being used only when necessary to gather information that cannot be obtained through other means.

Progress Measurement

To measure progress, there are a variety of methods that can be used. These methods fall into two main categories: psychometrics and qualitative measures. Psychometric measures of progress include diary cards and re-administration of pre-treatment measures, which can be used to track changes over time. The client or family can also report on progress, which can provide valuable insight into how they are feeling.

> "[I measure progress in treatment] through a combination of psychometrics, client (or family) report, and clinical observation in session (e.g., of the ability to demonstrate grounding, or ability to tolerate exposure to trauma memories while staying in the window of tolerance)." (Joe)

Qualitative measures of progress can include self-reports, which allow individuals to reflect on their progress in a more subjective manner. Behavioural changes over time are extremely valuable in evaluating progress, specifically how an individual coped with certain events before treatment compared to how they cope during and after treatment. Emma pointed out that while some progress can be seen on psychometrics, such as depression and anxiety symptoms, others can't be measured:

> "There are some funny things I look for; when someone disagrees with me or says, 'I don't want to do that', starts to be assertive and starts to voice their own opinion. I love seeing that because often in therapy, I've got people who are really, they're trying to please me, because that's their worldview. So, when they start to assert themselves in therapy, that's awesome. Those are some of those subtle things that don't show up in measures. Obviously if there's a diagnosis, there's measures of that particular diagnosis that we will use … So, there are three parts to it diagnostically; we've got psychometrics to try and get people out of the clinical range; life stuff, like being assertive in relationships, standing up for themselves; and then the sense of self stuff, doing things

which behaviourally show me that they're claiming their place in the world and starting to think of themselves as being important."

Participants identified several specific areas that can be examined to determine progress (see Table 3). These include an increase in productivity and functioning, an improvement in grounding ability, better tolerance of emotions and situations, improved self-care, changes in how individuals present themselves, less avoidance of difficult emotions, better identification of a wider range of emotions, increased connection/participation in life, increased flexibility in thinking, and less cognitive distortions related to the self, world, and others:

> "[ACC] have broad headings about goals. But I know that in the guidelines, they'd like them to be specific, observable and measurable, which is great, because that makes sense. You know, if something wasn't there before, and it is now and you've seen it, or it's gone when it was there before and you've seen it, that's really good. However, some things, some concepts are too different. I mean, they're internalised, and so behaviourism covers both overt and covert behaviours, but we can't see the internal processing, we've only got their words to go by. So that's not a direct measure in itself … [Patients] say that they're setting more boundaries, you can't follow them home and go 'I've seen you change and set a boundary, check that box, look at that data, here's a graph'. What we've got to go by is what they say … [In progress] my measurement is when they can say something that they're doing differently now than they have in the past … So, I'm constantly writing that down in my book – in the past, they would have done this, now they're doing this, so it's all identified by them … It's observing the language, and the reflection around the progress and pointing it out … It needs to be quite specific, they can't just say 'Oh, before I was sad, and now I'm happy'." (Louise)

By examining progress in each of these areas, a more comprehensive picture of an individual's progress can be obtained than with psychometric use alone. Debates around the most effective or accurate method to measure progress in treatment mirror those made regarding initial evaluations of pathology. Overall, participants were strong believers in the idea that people know themselves best, and the best way to understand how someone is progressing is simply having a conversation.

Table 3 – Progress Measurement Frequency

Preferred method of Progress Measurement	Frequencies
Re-administering psychometrics	7
Self-reports	6
Behavioural changes over time (Before and After effects)	5
Diary Cards	2
Productivity	7
Functioning	7
Decrease in Avoidance	8
Increase in Self-care	3
Larger Window of Tolerance	4
Grounding ability	3
Cognitive Changes	6
Greater connection with life	5

Data

The benefits of quantitative and qualitative data were discussed at length. The consensus being that while quantitative data is a valuable tool in diagnostic practice, it is important to understand its limitations. Sam stated that

> "using a wide range [of psychometrics] can be accurate in identifying a presentation, but relies on clinical skills of the therapist and should not be used alone … I don't think any one objective measure can accurately identify and measure all trauma presentations, but effective use of a wide range of measures can do so. This also relies on the clinical skill

of the therapist in identifying which measures should be used and in which combination with any given presentation (e.g., BPD/ASD/trauma complex presentations)."

While it can identify surface level difficulties and provide an outline of a person's struggles, it cannot tell us how these difficulties came to be, how they are expressed or what they are a symptom of. Furthermore, it may not capture the full extent of an individual's experiences or difficulties. Louise pointed out that there are often a number of covert behaviours and internalising processes as play that cannot be measured and can only be understood through conversation and self-reports. However, when used in conjunction with other sources of information, quantitative data can help confirm clinical impressions, inform diagnosis, and provide important collateral/supplementary information. It is also useful in identifying learning and disability issues, with Louise stating that they believe objective measures are more suited to behavioural practice than other areas of practice.

"… my background is behavioural psychology. So, I am born and bred on quantitative data – like, if you can't measure it, it doesn't happen kind of philosophy. That was drilled into me, and it's still true – we should still use measurement tools that are specific, observable, and measurable. That was easier. That whole field is a lot more experienced in – and I feel qualified to say this – in a disability or learning field … what I've been doing is translating to the trauma, mental health world. I feel that that translation can add to a person's treatment, and you can add to your practice diagnostics. As I've said before, it's good to have that skeleton kind of outline, yet it's the person's history and narrative that inform that as well."

It was also mentioned that quantitative measures such as psychometrics may be easier for patients than a clinical interview. Some people, especially early in treatment, may be able to tick boxes on a questionnaire but may not have the capacity for a conversation. While the ease and simplicity of psychometrics provide some benefits, it was stressed that

the use of quantitative data should not be relied upon as the sole source of information. Instead, it should be used as part of a holistic approach to treatment that considers the individual's unique experiences and needs.

Qualitative information is crucial in identifying problems that may not be captured by quantitative measures. It allows for a more personal and culturally sensitive approach to treatment, considering the importance of spiritual practices and individual experiences. By establishing a relationship and engaging in conversation, practitioners can better understand the individual's struggles and identify issues that may not reach a clinically significant level in psychometrics, but still cause significant distress. Emma stressed the difficulties in treatment when treatment plans are based on diagnoses and psychometrics, specifically when the treatment is externally funded.

> "Organisational requirements ask us to look for a diagnosis, often there will be low mood, anxiety, PTSD symptoms, substance abuse problems that crate difficulties for people but don't reach a clinically significant level. Other things like relationship difficulties won't be captured in psychometrics well. Difficulties arise in focusing on symptoms – psychometrics might identify substance abuse as a main issue, but the individual might be using substances to avoid trauma. The reason behind symptoms and mechanisms can't be captured. Surface things can be debilitating, but they're the symptom not the cause – the cause is harder to put a label on … this causes particular difficulties when treatment is externally funded (e.g., ACC), and you have to follow a treatment plan based on the diagnoses, but you need to find an ethical way to address the root causes."

Overall, while quantitative data has its limitations, it remains a useful tool in diagnostic practice when used in conjunction with other sources of information. Qualitative information is also crucial in providing a more personal and culturally sensitive approach to treatment. The fact remains that while quantitative data answers *how much*, qualitative

methods answer the *how* and *why*. Shelley observed that “best practice relies on multiple sources – client report, observed behaviours, psychometrics, other reports, symptoms reduction - to as best as possible be secure in inferences around diagnoses and effectiveness of treatment”. They also stressed that “every approach, subjective or objective, self-report or psychometric, has the potential to engender inaccurate information”, which is important to be aware of, especially given the risk of observer bias in interpreting results.

Of note, Emma highlighted the need for more detailed psychometrics, specifically that there “needs to be a measure around Complex PTSD that isn’t at a personality disorder level … [as] putting a personality disorder label on a pervasive pattern of behaviour from trauma isn’t ethical when those diagnoses are really stigmatizing and hard to remove”. Currently, the ITQ is the most investigated and validated across different populations and has potential in identifying C-PTSD (Seiler et al., 2023). Complex trauma specific measures are limited however, mostly consisting of interviews such as The Cameron Complex Trauma Interview (CCTI; King, Solom & Ford, 2017), and the Complex Trauma Questionnaire (ComplexTQ; Vergano, Lauriola & Speranza, 2015) which aim to identify the occurrence of specific events that could result in complex trauma, rather than the symptoms someone is struggling with. As Emma alluded to, many of the DSO symptoms seen in C-PTSD are also seen in some personality disorders, making a distinction between symptoms caused by trauma and those of a personality disorder is crucial in providing accurate treatment, as well as protecting clients from an incorrect and stigmatising diagnosis.

Treatment

Participants specialised in a variety of trauma treatment methods, with the favoured method depending on the patient’s individual need and present problems. Assessing these needs relies on a thorough clinical interview to understand the individual’s history including past traumatic events, and their current mental health status.

"I predominantly use Eye Movement Desensitisation Reprocessing (EMDR) therapy for both assessing and treating trauma. EMDR uses a very structured approach to assessment and formulation which I find effective." (Sam)

"I have previously worked from a CBT for trauma perspective, and though I now work mostly from an EMDR perspective, CBT skills remain helpful, especially in phase one trauma treatment (stabilisation). The grounding and stabilisation skills are paramount, to increase client's confidence in their ability to manage the intrusion and hyper-arousal that is usually present. Psychoeducation is also very important throughout the process. Initially it helps clients to understand that there is a reason why they have the presenting problems – often there are very unhelpful beliefs associated with the symptoms, e.g., 'I am weak, a failure etc.', and some psychoeducation about trauma symptoms can be very validating." (Joe)

Regardless of the clinician's preferred method, participants stressed the importance of early intervention, stabilisation, safety, and psychoeducation. Clinicians work with their patients to stabilise their current state of mind to ensure they can manage their own safety before delving into trauma treatment. Education about emotions and symptoms is crucial in allowing patients to understand themselves and accept how they are feeling. This understanding allows for more self-compassion in treatment and makes it easier for patients to express how they are feeling throughout. Psychoeducation has been well regarded as the first step of treating traumatised populations. A recent study produced some evidence that although psychoeducation alone does not necessarily reduce symptoms, it does improve the overall attitudes of clients regarding their mental health (Brooks, Weston, Wessely & Greenberg, 2021). Participants also identified the benefits of cognitive restructuring, challenging negative and distorted thought patterns that may have resulted from trauma. Work is done to understand and deconstruct these thoughts and replace them with more positive, realistic, and helpful ones. Research investigating the outcome of treatment

involving cognitive restructuring compared to the same treatment model but without cognitive restructuring found that those in the former group showed greater improvements in symptoms, overall functioning, and social functioning than the latter (Mueser et al., 2015). The participants in this study had PTSD and at least one other severe mental illness, displaying the flexibility of cognitive restructuring as a treatment and the method's benefits across the board.

Participants implement a range of therapies (See Table 4), including Dialectical Behavioural Therapy and Cognitive Behavioural Therapy, both of which can be catered to Trauma Focused practice. Eye-Movement Desensitisation and Reprocessing is a common method of treatment for traumatised clients and was favoured by some participants. Louise emphasised the benefits of Animal therapies, including Equine Therapy, especially for those who struggle with traditional talk therapy.

Table 4 – Treatment Method Frequency

Preferred Treatment Method	Frequencies
Cognitive Behavioural Therapy (CBT, Trauma-focused)	5
Dialectical Behavioural Therapy (DBT, Trauma-focused)	3
Exposure Therapy	2
Psychoeducation	3
Eye Movement Desensitisation and Reprocessing	2
Animal Therapies	1

Regardless of the therapy itself, all participants spoke about the importance of working at the client's pace. Ensuring that clients feel safe, supported and in control of the therapeutic process.

Key factors in treatment

Participants were asked about what they believe are the most important factors in therapy. Therapeutic relationship, time, clinical knowledge, and willingness were identified repeatedly.

The therapeutic relationship is critical to success in trauma treatment. Therapists work to develop an empathetic relationship with their clients, which includes addressing attachment issues and managing any transference issues that may arise. Olivia stated that there is nothing better for healing than “getting into the nitty gritty of someone’s experience”, which relies on a solid and trusting relationship. Joe raised the importance of knowledge around trauma triangle relationships that may play out due to perceived power differentials, and therapists must work to help clients navigate these relationships in a healthy way:

> “… it is crucial that the treating therapist is able to create an empathetic relationship, where attachment traumas can be addressed. This will also mean the ability to identify, tolerate, and manage any transference issues that arise, e.g., ‘trauma triangle’ relationships playing out in the therapeutic relationship,”

All participants identified trust as an essential component of the therapeutic relationship, and Sam expressed her belief that this relationship “is the most important predictor for treating any kind of psychological distress”. The above statements are well grounded, with recent research identifying therapeutic alliance as a key element of successful treatment, particularly with people who have PTSD due to the consequential fear, distrust, and avoidance (Howard, Berry & Haddock, 2022). Howard and colleagues demonstrated a direct relationship between the therapeutic relationship and PTSD outcomes, finding this alliance to be a strong predictor both with in-person and remote therapies. A similar study came to the same conclusion, with patient-rated and therapist-

rated alliance acting as a positive predictor in symptom reduction in patients with PTSD and substance use disorders (Saraiya et al., 2023).

Trauma treatment is a process, and it takes time. Therapists work with clients to ensure that they are pacing treatment appropriately and that they feel comfortable with the pace of treatment. All parties must acknowledge the time that trauma treatment takes and be willing to commit to the process. Therapists who specialise in trauma treatment must have extensive knowledge of trauma treatment and modalities. Sam discussed the importance of "therapist competence and flexibility in providing evidence-based care, including the ability to provide multifaceted care to complex presentations". Similarly, Joe explained that

"Naturally, extensive knowledge of trauma and treatment modalities is very important, especially when working with those who have had early and extensive trauma. Understanding of best practice treatment (phased treatment approaches) is important. At the very basic level, I think clinicians working with trauma need to have undergone CBT for Trauma training, EMDR training, and need to know about dissociation and how to do parts (ego states) work."

Finally, client willingness is an essential component of success in trauma treatment. David spoke to the need for clients to be willing and flexible in learning and practicing new skills and facing unwanted emotions in order to heal. As did Shelley: "Client readiness is also a major factor- I would never coerce a client into trauma therapy."

The above factors have been described as the key factors in trauma treatment and the main influences over outcomes, both by the participants in the present study and empirical research. Note how none of these key factors involve objectivity, rather an entirely subjective, personalised approach to treatment. While initial impressions may be clarified by psychometrics, the process itself requires the building of a trusting relationship, time and patience, practitioner knowledge, and client willingness and understanding. The assets that

involve patients require enduring, respectful, and kind conversation over time, allowing both parties to understand and trust one another and work towards the same goal; healing.

Summary

In sum, the present study is consistent with much of the literature. The psychologists involved possess a wide understanding of trauma, with most stating that a lot of what they have learnt has come from experience rather than their study or training. This suggests that there is a lot more involved in trauma presentation and treatment than what we are taught to expect. Evidently, trauma affects people in a variety of ways, resulting in symptoms that are not captured by the current diagnostic criteria. Survivors may present with only somatic complaints or have symptoms that fly under the radar of clinical criteria despite significant suffering. They may have been dramatically affected by events that are not considered traumatic according to most of the literature, resulting in total avoidance and minimisation of their experiences. They might present with symptoms of mental illnesses other than PTSD, and these illnesses could have been brought on by trauma regardless. Any variation from the norm essentially renders diagnostic psychometrics unreliable at best. While they may be useful in terms of identifying symptoms alone, it is clear that they need to be interpreted within a holistic paradigm. Accurate interpretation requires a complete history, and acknowledgement of all cultural and spiritual ties. The world of trauma work needs to shift the focus from what symptoms people are exhibiting to *how* they are affected and what their experiences mean to them.

Several psychometrics were discussed throughout the present study, although no participants relied on them in the way that some researchers suggest. While they were recognised as a valuable tool in some cases, such as when conversation is a struggle or someone presents with a wide array of symptoms requiring some objectivity, they were by no means represented as the be-all and end-all of diagnostics. Thorough, clinical interviews

were favoured dramatically; a method that allows the clinician to garner a full understanding of how their client is struggling and what they have been through, as well as any cultural or spiritual factors that might influence presentation, treatment, and progress. In turn, while clinicians tend to favour a certain approach to treatment based on their experiences and training, the final decision greatly depended on individual client presentation, with progress mainly being assessed through reflection. The changes seen in individuals going through trauma treatment affect all avenues of their lives and is best understood through discussing wellbeing within relationships, their various communities and how they feel within themselves, present themselves to others and how well they are able to integrate their past experiences into their current reality. The way in which trauma survivors come into themselves, find peace in their surroundings, and allow themselves to take up space in the world is a crucial and unique aspect of the healing process, and one that evades quantifiable measurement.

Perhaps a change in the way we are taught or trained to understand and recognise trauma and the resulting pathology is needed. A wider understanding of traumatic events is required from the very beginning. Rather than focusing on objectively traumatic events and the symptomology outlined in diagnostic criteria, psychological education needs to cover all distressing events, with the understanding that any negative event could be traumatic depending on the circumstances. The way in which an event is interpreted, both consciously and subconsciously, relies heavily on context; everything that has come before the event, the reception of the event itself, the immediate and distant aftermath, as well as any biopsychosocial factors. More comprehensive training would mean our practitioners would be prepared for varying presentations, rather than having to relearn what they have been taught due to the complex presentations they are seeing in practice. While there will

undoubtedly always be more to learn, and new discoveries being made, these are factors that we are aware of and yet fail to teach or publicise.

The assumption that trauma and the impact it has on a person can be measured in the same way one can measure a length of string is a gross injustice. Having experienced a traumatic event is a deeply personal occurrence, that affects people in a myriad of ways; ways that might not make sense to anyone else, or even the survivor themselves. Coming face to face with someone who has been through a trauma that has impacted every facet of their life and expecting a universal reaction is akin to baking cakes with completely different ingredients and expecting identical results; it just doesn't make sense.

Limitations

The present study was small in size due to time constraints, a larger sample size would provide more information and garner a more complete understanding of patterns within trauma presentation or treatment. A sample that extends to those outside of New Zealand is also likely to provide more information regarding the cultural influences on trauma. There is also a significant lack of information on the benefits of qualitative measures in psychology, due to the domination of quantitative methodology within the field. Lastly, the initial research plan aimed to have a culturally representative sample that included Māori clinicians, unfortunately no Māori practitioners responded to advertising or requests. A culturally diverse pool of participants would allow for a wider discussion around the influences of culture and a greater understanding of varying presentations.

Strengths

The small sample size allowed for an in-depth discussion with all participants, and dedicated time for each interview and subsequent analysis. All interviews involved open-ended questions aimed to spark critical thinking and assess the “how” and “why” of the matter. Rather than focusing on the predetermined “what”, energy was spent looking deeper into the expansive impact of trauma. This dedicated focus resulted in a comprehensive discussion of all information.

Participants possessed significant knowledge, based on their study and clinical expertise, with a collective experience of 145 years. Engaging in qualitative methodology meant that nothing was off limits, and context and personal bias were considered by the participants and researcher. The proficiency and awareness these participants brought to the table is incomparable, instilling confidence that the information provided here is a unique and valuable contribution to the field of study.

Finally, undertaking the role as a researcher with lived experience afforded sound knowledge, insight, and reflexivity throughout the process. With an awareness of the flaws within the mental health system, the present study provides food for thought regarding identification, management, and treatment of traumatised populations.

Conclusion

The present study aimed to investigate various areas of trauma presentation, measurement, and treatment within current psychology practices. Interviews were conducted with eight psychologists actively working with traumatised populations. Through thematic analysis, the main themes of the discussions were identified. A recap of the findings is as follows:

- Participants had varying definitions of trauma; some discussed events that are universally recognized as traumatic, while others focused on an individual's reaction to an event. All considered the impact of 'Big T' and 'Little t' events, with the latter presented as more insidious and pervasive by most.
- Regarding responses to traumatic events, all participants outlined the DSM-5 criteria for PTSD: re-experiencing, changes in mood and anxiety, hypervigilance, and avoidance. Despite similar clinical identification, it was acknowledged that people with these symptoms can present very differently, and others may develop mental illnesses other than PTSD.
- Wherein multiple mental illnesses may be present, context is crucial in assessing and separating symptoms and potential causes. Participants stressed the impact of factors such as age, access, support, and type of trauma in traumatic pathology, severity, and outcomes.
- Culture and spirituality are recognised as possessing both protective and detrimental effects, depending on the relationship between an individual's culture and the traumatic event. It was acknowledged that cultural and spiritual beliefs are accompanied by various cognitive schemas that may impact how an individual processes and copes with their experiences.
- In discussing measurement of symptoms, participants reported that they generally rely on a clinical interview to gather information and assess an individual's needs and difficulties. Various psychometrics may be used depending on the capability of the client, goals of the clinician, and technical requirements. It was emphasised that all presenting symptoms need to be understood in relation to the client's context, history, and environment.

- The methods that are used in initial assessments are typically repeated to measure progress. It was noted that many symptoms and markers of progress are internalized, covert processes that cannot be observed or measured.
- Regarding information gathering, participants agreed that while quantitative data is a valuable tool in diagnostic practice, and often required by provider regulations, it is crucial to acknowledge the limitations. While numerical measurements can identify surface level difficulties and tell us what overt symptoms someone is struggling with, they cannot explain how they manifest or why these difficulties are present.
- The importance of qualitative data in interpretation was stressed by all participants, as it is needed in capturing the full extent of someone's suffering and understanding how their life has been impacted. A combination of both methods allows for a verified, individual approach to assessment and treatment.
- Participants specialized in a variety of treatment methods, including EMDR, CBT, DBT and Prolonged Exposure. Choosing a treatment method relies on the needs and capability of the client, and the expertise of the clinician. All methods involved initially providing psychoeducation to allow the client to understand their experiences and identify their struggles.
- Participants identified the therapeutic relationship, time, clinical knowledge, and willingness as key factors in treatment efficacy.

Overall, the findings of present study provide important insights into the qualitative nature of post-traumatic pathology and highlights the need for further research in this area. Participants readily discussed the benefits of qualitative approaches, with quantitative measures only being used when necessary, and only when they can be understood in the wider context. The varying presentations discussed suggest the need for a more thorough understanding of trauma and the way in which it impacts different people. This will be crucial

moving forward, to ensure survivors are validated, understood, and receive the right treatment in a safe, trusting environment. Development of a teaching curriculum that explores the variety of presentations and the multitude of ways individuals and communities can be impacted by traumatic events could make a significant difference to those seeking treatment. I would argue that with this information on board, clinicians would be more prepared, and survivors would feel more seen. Further, moving forward with a focus on qualitative methods that reflect the subjective nature of trauma is likely to greatly improve the quality of treatment available to trauma survivors. This is extremely important given the cultural and spiritual diversity of the New Zealand population, and the barriers to access in qualifying for government-funded treatment. Ongoing research investigating traumatised populations and examining how they respond to qualitative tactics compared to a quantitative approach in terms of treatment, progress and the overall therapeutic relationship would be greatly beneficial. In addition, studies looking at the varying presentations of trauma and how these are influenced by both internal and external factors would be of significant value moving forward. It is my belief that we cannot continue to perceive any mental illness as a stagnant, quantitative matter – least of all post-traumatic pathology – and expect those suffering to benefit.

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Appendix A

WHO Mental Health Survey items

I. War related trauma

   a. Combat experience

   b. Purposely injured/killed someone

   c. Saw atrocities

   d. Relief worker or peace keeper

   e. Civilian in war zone

   f. Civilian in region of terror

   g. Refugee

   h. Any

II. Physical violence

   a. Physically abused in childhood

   b. Physically assaulted

   c. Mugged

   d. Kidnapped

   e. Any

III. Intimate partner or sexual violence

   a. Physically abused by romantic partner

   b. Raped

   c. Sexually assaulted (other than raped)

   d. Stalked

   e. Any

IV. Accident

   a. Automobile accident

   b. Other life-threatening accident

   c. Natural disaster

   d. Toxic chemical exposure

e. Other man-made disaster

f. Accidentally injured/killed someone

g. Life-threatening illness

h. Any

V. Unexpected death of a loved one

a. Any

VI. Other traumas of loved ones or witnessed

a. Child with serious illness

b. Other traumas to loved ones

c. Witnessed parenteral violence

d. Witnessed injury, death, dead body

e. Any

VII. Other traumas

a. 'Other' trauma

b. 'Private' trauma

c. Any

VIII. Any

(Kessler et al., 2017)

Appendix B

Information Sheet

Defining Trauma: a small semi-structured interview design exploring frameworks, theories and measurement

INFORMATION SHEET

My name is Georgia Bishop-Matthews, and I am conducting a research project for my Masters' thesis. The project concerns current definitions and measurements of trauma, with the aim of establishing an argument for the most effective measures of traumatic stress.

The project will begin with an interview over Zoom that will take roughly 60 minutes. During this interview we will have a conversation about your experience as a psychologist dealing with trauma, including how you might define trauma and how you have seen traumatic stress present. We will also discuss your thoughts on current trauma measures. This interview will be recorded and transcribed for thematic analysis, with all identifying features removed. The findings of this analysis will form the basis for a discussion on the efficacy of current trauma measures, and whether we would benefit from a qualitative approach.

I am looking for practicing psychologists willing to take an hour or so to take part in my project and would greatly appreciate your input. If you are interested in taking part or have any questions, please reach out via email or phone as found at the bottom of this form.

Participant Information:
I am only recruiting participants via email or word of mouth. The only criteria is that you are a practicing psychologist and are willing to participate. I will only be recruiting eight participants, as any more would generate too heavy a workload for my available time frame.
As a participant, you would only be involved in the interview. Nothing more would be expected from you after this. You will, however, have the option to review and edit your own transcript if you wish (you will have two weeks to do this, after which time the transcript will be taken as accurate if not returned). The interview is expected to take around one hour.
If you choose to participate, the conversation may cause some discomfort as we will be discussing a heavy topic. Psychological or emotional harm is the only identified risk that may result from participation. Any emotional distress will result in the interview being paused, issues can be discussed at the time or referred to your own supervisor. You can also find help lines at the bottom of this page.

Data Management
Raw data, once transcribed, will be examined for any identifying information, which will be removed. Participant names will be coded for confidentiality. This data will only be held on my personal computer and a backup external hard drive. Data will be stored for five years, at which point it will be destroyed. A summary of the project findings will be sent to you personally once analysis has been completed.

Participant's Rights
You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study at any time before or during participation;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given a copy of the interview transcript for review and editing, with two weeks allocated for editing;*
- *be given access to the thematic analysis once completed;*
- *be given access to a summary of the project findings when it is concluded;*
- *ask for the recorder to be turned off at any time during the interview.*

Contact Information
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Supervisor
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For Anonymous, Confidential Support 24/7

- Call or text 1737
- Lifeline 0800 376 633, text 4357
- Samaritans 0800 726 666
- Depression Helpline 0800 111 757, text 4202

For anonymous support with specific issues, a comprehensive directory is available at https://www.healthed.govt.nz/resource/helplines-and-mental-health-services

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 22/03. If you have any concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83570, email humanethicsouthb@massey.ac.nz .

Appendix C

Consent Form

Defining Trauma: a small semi-structured interview design exploring frameworks, theories and measurement

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time before or during the interview.

1. I agree/do not agree to the interview being sound recorded.
2. I agree/do not agree to the interview being image recorded.
3. I wish/do not wish to have my recordings returned to me.
4. I wish/do not wish to have my transcript returned to me for review and editing.
5. I wish/do not wish to receive a copy of the thematic analysis.
6. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I _____ [print full name]_____ hereby consent to take part in this study.

Signature: _____ **Date**: _____

Appendix D

Interview Schedule (Phase I)

Name:

Age:

Ethnicity:

Qualifications:

Years as a practicing psychologist (General/trauma):

Proportion of trauma cases in workload:

Questions to direct conversation:

1. *Trauma means different things to different people. As a professional, what does experiencing trauma mean to you and how would you define it?*
    a. *Participant's description of trauma as they have seen it.*
    b. *If you had to explain psychological trauma to someone who had never heard of the term, how would you go about it?*
2. *When people experience trauma, they react and are affected in different ways. What comes to mind when you think of how you've seen people respond to trauma?*
    a. *Most common clinical presentations? And outside of the typical presentation?*
    b. *In line with the DSM V?*
3. *What do you think are the most critical consequences affecting people who have experienced trauma?*
    a. *What factors have you seen influence the severity of these consequences?*
4. *The way that we're raised and environment we're brought up in has a lasting impact on our lives and everything we're exposed to continues to influence how we interpret future experiences. In individuals with strong cultural identities and beliefs, do you see any significant differences in presentations, symptoms and complaints in comparison to those without a strong cultural or spiritual identity?*
5. *When people present for therapy there can be a lot to unpack (history, narrative, concerns, problems, behaviours), how do you figure out how to help each person?*

    a. *What information do you need from them to do that?*
6. *What therapeutic interventions have you found to be useful in assessing and treating trauma?*
    a. *Psychometrics?*
7. *Therapy practice differs depending on the person's presenting problems. What do you think are the important factors for successfully treating trauma? (therapist qualities & competencies, therapeutic relationships & environment, client characteristics)*
8. *How do you identify/measure progress in treatment?*
9. *I'm currently looking into whether the current measures we have in place accurately identify and measure the trauma presentations seen in practice, do you have any thoughts?*

Appendix E

Online Interview (Phase II)

Copy of Defining Trauma

1. I have read and I understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time before submitting my responses.

- ◯ Agree
- ◯ Disagree

2. I wish to receive a copy of the thematic analysis

- ◯ Yes
- ◯ No

3. I agree to participate in this study under the conditions set out in the Information Sheet.

- ◯ Yes
- ◯ No

4. Name

5. Age

- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 65+

6. Ethnicity

7. Highest Qualification

8. Years as a practicing psychologist

9. Proportion of trauma cases in your current workload (any person wherein trauma is a factor)

0 Percent 100

10. Trauma means different things to different people. As a professional, what does experiencing trauma mean to you and how would you define it?

11. When people experience trauma, they react and are affected in different ways. What comes to mind when you think of how you've seen people respond to trauma?

12. What do you think are the most critical consequences affecting people who have experienced trauma?

13. What factors have you seen influence the severity of these consequences?

14. The way that we're raised and environment we're brought up in has a lasting impact on our lives, and everything we're exposed to continues to influence how we interpret future experiences. In individuals who have either grown up with strong cultural identities and beliefs or gained them during adulthood, do you see any significant differences in presentations, symptoms, and complaints when presenting with trauma in comparison to those without a strong cultural or spiritual identity?

15. When people present for therapy, there can be a lot to unpack (history, narrative, concerns, problems, behaviours), how do you figure out how to help each person?

16. What information do you need from them to do that and what is your preferred method of gathering that information?

17. What therapeutic interventions have you found to be useful in assessing and treating trauma? If you use psychometrics, please outline which ones you prefer and why.

18. Therapy practice differs depending on the person's presenting problems. What do you think are the important factors for successfully treating trauma? (therapist qualities & competencies, therapeutic relationships & environment, client characteristics)

19. How do you identify and measure progress in treatment?

20. There are times when we must rely on objective measures. Do you believe these measures can accurately identify and measure the trauma presentations you have seen in practice?

Appendix F

Ethics Approval

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 22/03. If you have any concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83570, email humanethicsouthb@massey.ac.nz .