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6th INTERNATIONAL TRAUMA INFORMED CARE ONLINE CONFERENCE

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CONTENTS

Adapting to new realities: Ukrainian caregivers' resilience in the UK and Ukraine

This project is funded by the BA/Cara/Leverhulme Research Support Grants (LTRSF24\100113)

T.Fedotiuk, E.Ward, L.Marzano, V.Voloshyna

Background

The mental health and resilience of refugee mothers with young children are critical for successful adaptation and integration into new social environments. The armed conflict in Ukraine, which began in 2022, has led to mass displacement, with 7.6 million individuals becoming refugees and 4.9 million internally displaced. These groups face challenges such as loss of home, social isolation, psychological trauma, and uncertainty.

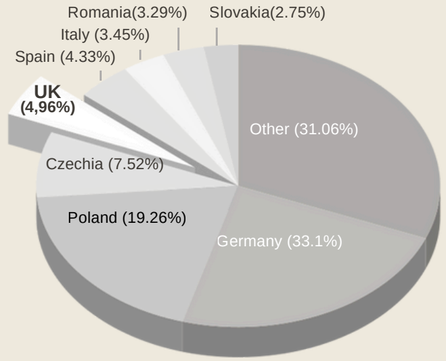


Figure 1. Distribution of forcibly displaced people from Ukraine across the top host countries (UNHCR, mid-2025)

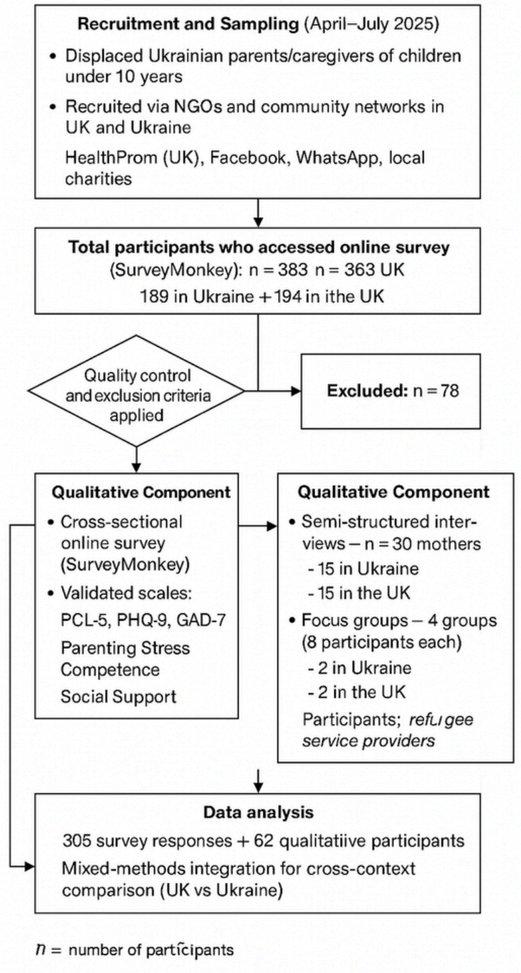
Mothers are particularly vulnerable, and their experiences can have adverse effects on their children's development. This study addresses this critical issue through a comparative analysis of Ukrainian mothers with young children who have been forcibly displaced and are currently residing in the United Kingdom and Ukraine. Our aim is to identify key factors that foster psychological resilience and to develop practical support strategies for governmental and non-governmental organisations.

Hypotheses

Based on our research design, we anticipate several key findings. Mothers in Ukraine will likely show higher levels of anxiety and PTSD compared to those in the UK. The study will reveal significant differences in access to support services between the two groups. Social support will likely emerge as a critical protective factor. We will discuss how different national contexts influence the types of trauma and coping mechanisms.

Discussion

The war in Ukraine, despite its enormous human toll, offers a unique opportunity to deepen our understanding of trauma and resilience in times of crisis. The experiences of displaced parents show how families maintain stability and hope in the face of uncertainty. Exploring these realities highlights the extraordinary capacity for adaptation and recovery, inspiring future research and guiding the development of trauma-informed, compassionate responses to global displacement. The findings will provide evidence-based recommendations for government and non-governmental organizations to support forcibly displaced people.



Keywords: *adaptation factors, children's well-being, forced displacement, internally displaced persons, mental health, parenting capacity, psychological resilience, refugee mothers, support strategies, trauma.*
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Patient and stakeholder collaboration in trauma-informed care education and training – a scoping review

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Background

- Trauma-informed care (TIC) recognises and responds to trauma and promotes recovery for individuals by transforming healthcare services[1].
- Principles of TIC include "collaboration and mutuality", which advocates for partnership working with patients. "Empowerment, voice and choice" recognises how patients have traditionally been disempowered and seeks to restore autonomy 2,3.
- These principles are strongly congruent with approaches to "patient involvement" in healthcare and healthcare professions education (HPE)4,5.
- TIC education should include collaboration and empowerment, ensuring that patient perspectives inform professionals' development[6].
- Evidence-based guidance for patient involvement in TIC education in wide-ranging specialties is lacking.

Safety	Physical Emotional Social
Trustworthiness & transparency	Explain approaches, acknowledge setbacks Build, maintain trust
Peer support	Mutual support to overcome challenges
Collaboration & mutuality	Mutual respect Partnership
Empowerment, voice & choice	Restore power and control Acknowledge strengths
Cultural, historical & gender issues	Acknowledge and address bias and discrimination

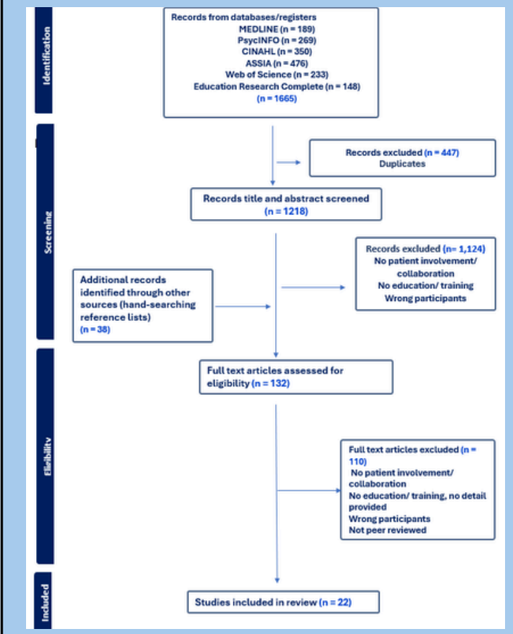
Principles of TIC including "Collaboration" and "Empowerment, voice and choice"

Methods

A scoping review was used to identify evidence for patient involvement in TIC education for healthcare learners7

•Key databases - Medline, PsychInfo, CINAHL, Education Research Complete, Web of Science, ASSIA - were systematically searched for terms relating to TIC, HPE, and wide-ranging terms relating to patient involvement.

- A scoping review was used to identify evidence for patient involvement in TIC education for healthcare learners[7]
- Key databases - Medline, PsychInfo, CINAHL, Education Research Complete, Web of Science, ASSIA - were systematically searched for terms relating to TIC, HPE, and wide-ranging terms relating to patient involvement.



PRISMA overview of study selection

Link to references and list of included studies

Results

22 studies were included. Disciplines included mental health, primary care, emergency medicine, gastroenterology and clinical skills. Dates ranged from 2015 – 2025.

Summary of qualitative themes

Diverse approaches to patient involvement in TIC education

Approaches included patient narrative sharing, flexible alternatives to embedding narratives, codesign and codelivery, consultation, arts-based approaches.

Patient involvement redistributes power to highlight trauma impacts

Incorporation of patient perspectives challenge privileges regarding which knowledge is valued in HPE and enabled understanding of experiences of marginalised groups

Patients' alternative perspectives promote authentic and impactful learning regarding TIC

Alternative perspectives to medicalised models of trauma, led to more impactful learning and were identified as most valuable part of learning

TIC principles are variably applied in enabling patient involvement in TIC education

Approaches include; Relationship-building through transparency and power-sharing , use of guiding principles, proactive measures for wellbeing and distress and compensation for involvement. These were inconsistently applied or described.

Discussion and conclusions

Wide-ranging educational interventions were identified. TIC was relevant in diverse clinical disciplines and particularly necessary for marginalised groups. Descriptions and approaches to patient involvement varied with some studies provided limited reflection.

Patient involvement prioritised alternative perspectives in learning, providing richer authentic insights on trauma beyond medicalised models. Wide-ranging approaches to patient involvement offer diverse, creative options for embedding patient voice, while upholding patient safety. Reflection on rationale and application of TIC principles, and theoretical underpinnings of learning, alongside patient-centred evaluation, may enhance future practice in TIC

Identifying exposure to traumatic life events, post-traumatic stress, and subsequent support needs in urology patients

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Background

Despite widespread agreement on the importance of Trauma-Informed Care, significant gaps remain in research & implementation, particularly in general hospital settings

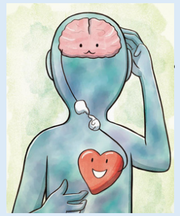
Trauma history is an important consideration for Urology patient population.

People with trauma found to experience ↑ *urology needs & disproportionately represented in Urology* patient populations[1, 2]

Invasive nature of examinations, tests, treatments in Urology (e.g. cystoscopy, prostate biopsy, digital rectal examination, BCG treatments, catheterisation)

Systematic review by Marshall and colleagues[3]

- Trauma + ↑ cancer risk: e.g. *increased likelihood of engaging in risk-taking health behaviours* such as drug or alcohol misuse, smoking, and sexually risky behaviours, increased exposure to HPV in cases of sexual abuse, and other hypotheses discussed such as *chronic inflammation and immune dysregulation*



Challenges to health seeking behaviours for people with trauma experiences

- ↑ distress and discomfort with cancer screening procedures
- Perceived similarities of tests/procedures and the original trauma
- Perception of losing control, lying still, exposing body, and physical touch
- Clinician-level factors including gender and/or unknown care providers
- Confined clinical spaces

Aim

To identify rates of reported trauma in patients attending a urology outpatient service; and, to explore patient views on adaptations to delivery of patient care.

Methods

Full ethical approval from CREC (Reference Number: ECM 4 (x) 10/09/2024; ECM 5 (5) 30/07/2024; ECM 3 (i) 11/09/2025

Patients provided with information sheet at check-in to urology outpatient clinics.

Participants who completed questionnaires and consented, were contacted to schedule interview.

Debrief sheet provided with a list of services to access further support if required.

Measures:

Trauma exposure & (c)PTSD:

International Trauma Exposure Measure[4]

International Trauma Questionnaire (ITQ)[5]

Accommodation/Support Need Request: (bespoke scales)

Patient trust in health care professionals (HCPs) ability to respond to disclosures of trauma sensitively and appropriately (1=No trust – 5=Complete trust)

Confidence to request an accommodation or adaptation to care (1=No confidence – 5=Complete confidence).

Types of accommodation/support needs based on the principles of Trauma-Informed Care.

Results

Patient Characteristics

N=349 patients completed questionnaires (January-April 2025; response rate, 69.66%)

Respondents were predominantly male (n=220, 63.0%), over 65 years (n=133, 38.1%), married/cohabiting (n= 220, 63.0%), owned their homes (n=229, 65.6%), no reported past or current mental health difficulties (n=253, 72.5%).

Trauma Exposure

Lifetime exposure: **n=206** (**59.03%,** range 1-22 traumatic events) endorsed at least 1 traumatic event.

Childhood exposure: **n=105** (**50.97%** of all trauma exposed respondents; 30.09% of all study respondents) endorsed at least 1 traumatic event aged <18 years; range 1-16 traumatic events.

Post-Traumatic Stress: n= 23 (**12.14%** of trauma exposed patient) met the criteria for PTSD or Complex PTSD (Table 1).

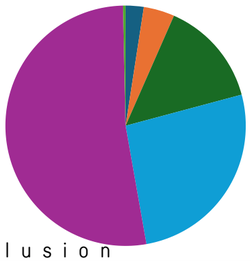
Trust & Confidence in Clinicians: 65.1% reported some or complete trust in their clinician**; 50.4%** reporting confidence to ask for changes to their care (Figures 1 & 2).

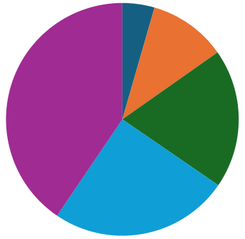
Table 1. Post-Traumatic Stress Symptomatology (ITQ)

	Mean Score	Score Range	PTSD Criteria Met [N (% trauma exposed)]
PTSD	4.79	0-23	3 (1.46%)
Disturbance in Organised Activity	5.83	0-24	22 (10.68%)
criteria [N (% trauma exposed)]			**23 (12.14%)**

Most Frequently Reported Accommodations

1. Explaining the details of any examination and the reason for performing it (n=158, 45.3%)
2. Knowing the details of examinations before appointment (including items of clothing to remove; n=121, 34.7%)
3. Providing chaperones or allowing a trusted friend/family to be present (n=118, 33.8%)
4. Warning before physical touch (n=76, 21.8%)
5. Asked preference for HCP gender for examinations (n=76, 21.8%)
6. Hearing your HCP acknowledge that examinations could feel difficult emotionally without having to self-disclose (n=58, 16.6%)
7. Ensuring another member of staff is present (n=53, 15.2%)
8. Conducting the examination in a different position (e.g. lying or sitting in different way; n=38, 10.9%)





Most Frequently Reported Traumatic Events

1. Someone close to you was diagnosed with a life-threatening illness or experienced a life-threatening accident. (n=98, 28.1%)
2. Someone close to you died in an awful manner. (n=89, 25.5%)
3. You were repeatedly humiliated, put down, or insulted by another person. (n=67, 19.2%)
4. You were diagnosed with a life-threatening illness. (n=66, 18.9%)
5. You were physically assaulted by someone other than a parent or guardian. (n=61, 17.5%)
6. You were repeatedly made to feel unloved, unwelcome, or worthless. (n=60, 17.2%)
7. You were repeatedly bullied. (n=52, 14.9%)
8. You witnessed another person experiencing extreme suffering or death. (n=51, 14.6%)
9. You were sexually harassed (unwanted sexualised comments or behaviours). (n=45, 12.9%)
10. You were repeatedly neglected, ignored, rejected, or isolated. (n=45, 12.9%)

Conclusion

High proportion of urology patients have been exposed to traumatic life events.

Relatively **low numbers currently meeting criteria for post-traumatic stress** suggests significant resilience in the population, however nature of medical appointments may result in re-traumatisation.

Accommodations endorsed by respondents (regardless of trauma exposure) and mixed trust and confidence in clinicians to respond to disclosures/support requests **supports the need for universal implementation of trauma-informed care strategies**.

Simple strategies may facilitate patients who have experienced trauma and are attending urology to feel **more comfortable and supported**.

Results suggest that inclusion of trauma-informed care as a component of urology training would equip clinicians with knowledge, skills, and understanding to better support this patient population in light of the identified trauma needs.

Next steps:

Further data analysis (qualitative interviews – patients & HCPs) to better understand patient experiences & support needs.

Dissemination of study findings to HCP staff in MUH.

References: [1] Link et al., 2007; [2] Selai, et al., 2023; [3] Marshall, et al., 2023; [4] Hyland, et al., 2021; [5] Cloitre, et al., 2018

Special thanks to clerical, clinical, and support staff in MUH OPD & St John's Urology for their support for this

Investigating the Association Between Complex Post-Traumatic Stress Disorder and Hoarding Disorder

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INTRODUCTION

Hoarding Disorder (HD) is a chronic, debilitating condition characterised by persistent difficulties in discarding possessions
Trauma is a proposed vulnerability factor in the cognitive-behavioural model of HD (Steketee & Frost, 2003)
Studies report that experiences of childhood and lifetime trauma are pervasive in the HD population, but the prevalence of diagnosed Post-Traumatic Stress Disorder (PTSD) in this population is low
And yet empirical evidence suggests that trauma sequelae comparable to symptoms of the Complex PTSD (CPTSD) Disturbances in Self Organisation (DSO; affective dysregulation, negative self-concept, and difficulties in relationships), is associated with hoarding severity
This cross-sectional study investigated the relationship between symptoms of CPTSD DSO and hoarding severity.

METHOD

Participants. Participants (*N* = 89) over 18y (*M*age = 37.48, *SD* = 14.64) recruited online. All participants reported clinically significant HD symptoms (≥14 HRS-SR; excluding brain injury or neurological conditions).
Procedure. Participants completed an online survey on their experiences of hoarding, trauma, and DSO symptoms. Participants had the option to enter a prize draw for a £25 voucher.
Measures. Hoarding Rating Scale Self-Report (HRS-SR; Tolin et al., 2010), Savings Inventory–Revised (SI-R; Frost et al., 2004), International Trauma Questionnaire (ITQ; Cloitre et al., 2018), Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004), Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS; HS, hated self; IS, inadequate self; Gilbert et al., 2004), Experiences of Close Relationships–Short Form (ECR-S; Wei et al., 2007), Childhood Trauma Questionnaire–Short Form (CTQ-SF; Bernstein et al., 2003), Life Events Checklist for DSM-5 (LEC-5; Weathers et al., 2013).

Contact Bronwen Dawson DawsonBY@cardiff.ac.uk

RESULTS

Sample Descriptives (*N*).

Gender. 76.4% (68) female	*Ethnicity*. 60.7% (54) White
Marital status. 64.0% (57) single	*Education*. 37.1% (33) Undergraduate
Living status. 46.1% (41) alone	*HD as primary difficulty*. 53.9% (48)

Variable Means (*SD*)	
SI-R total. 53.91 (13.03)	*ECR-S anxious*. 26.65 (7.60)
DERS. 106.67 (23.74)	*ECR-S avoidant*. 20.52 (7.18)
FSCRS HS. 8.38 (5.47)	*CTQ*. 53.00* (20.69)
FSCRS IS. 22.91 (8.24)	*LEC-5*. 5.00* (3.51) *median

From the CTQ, 68.7% (*n* = 62) of participants reported exposure to at least one type of childhood traumatic event
From the LEC-5, 91.0% (*n* = 81) of participants reported exposure to at least one type of lifetime traumatic event

Hypothesis 1. ***A greater proportion of participants would meet the diagnostic criteria for CPTSD than PTSD.***
PTSD (10.7%, *n* = 9); CPTSD (34.5%, *n* = 29); DSO only (22.6%, *n* = 19); No symptoms (32.1%, *n* = 27)
Differences between groups differed from equal distribution: $\chi^2(3, N = 84) = 11.81$, $p = .008$. Probable CPTSD emerged more frequently than PTSD with large effect after Bonferroni correction ($\alpha = .0083$): $\chi^2(1, N = 38) = 10.53$, $p = .006$. No other comparisons significant

Hypothesis 2. ***Hoarding severity is associated with the DSO symptoms individually and in combination.***
Hoarding severity (SI-R total) correlated with affective dysregulation (DERS, $r = .305$, $p < .001$) and negative self-concept (FSCRS HS, $r = .283$; IS, $r = .297$; both *ps* < .001) but not with difficulties in relationships (ECR-S anxious, $r = .166$; avoidant, $r = .122$; both *ps* > .05)
Hierarchical regression. Model 1 (predictors: DERS, FSCRS HS and IS) accounted for 11% variance in hoarding severity: $F[3, 84] = 3.32$, $p = .02$. Entering the predictors' interaction term at step 2 did not account for any additional variance of hoarding severity ($\Delta F = .01$, $p = .922$). None of the predictors were individually significant (*p*s < .05)

Hypothesis 3. ***The relationship between traumatic exposure and hoarding symptom is mediated by DSO symptoms.***
The relationship between childhood traumatic experiences and hoarding severity was fully mediated by DSO symptoms: $\Sigma ab = .10$, Boot SE = .05, Boot 95% CI [.01, .20]; none of the DSO symptoms alone was significant
Although lifetime traumatic experience was positively associated with hoarding symptoms, there was no evidence to suggest that this relationship operated through the DSO symptoms: $\Sigma ab = .04$, Boot SE = .20, Boot 95% CI [-.31, .49]

DISCUSSION

Elevated CPTSD and most participants reporting adverse childhood or lifetime traumatic experience may suggest an increased risk of CPTSD in HD population
Affective dysregulation and negative self-concept related to hoarding severity replicates prior research findings and suggests these constructs are pertinent in HD
Neither anxious nor avoidant attachment correlated with hoarding severity; contrary to existing evidence suggesting HD to be most strongly related to an anxious interpersonal attachment type (Chia et al., 2021). Possibly due to methodological factors (e.g., orientation of ECR-S)
Existing evidence of traumatic exposure preceding the onset of HD, and our mediation findings, suggests childhood traumatic experience may be a vulnerability of HD through its impact on developmental processes associated with DSO constructs such as emotional regulation strategies and identity

Implications. Findings provide a new basis for understanding how traumatic experiences may be linked to hoarding symptoms. Clinicians may consider using cognitive therapies specifically targeted for the treatment of CPTSD in the context of supporting individuals with HD

Limitations. Findings due to HD or some other diagnosis? Susceptibility to self-reporting bias. Cannot determine causal inference.

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Profiles of observed PTSD symptoms arising from autogenic Criterion A events: A UK survey of clinicians

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Introduction

Autogenic PTSD (APTSD) refers to PTSD in response to one's own actions. It has also been referred to as 'self-induced' or 'offence-related PTSD'.

Research has typically focused on PTSD arising from one's own offending behaviour (or externalising behaviours). Prevalence rates of offence-related PTSD are up to 76.6% in perpetrators of violent crimes (Soh et al., 2023). and 42.6% related to a perpetrated homicide (Badenes-Ribera et al., 2021).

Less research has focussed on PTSD occurring due to one's own non-suicidal self-injury and suicide attempts (or internalising behaviours). Westermair et al. (2020) found deep wrist lacerations with associated suicidal ideation were associated with greater PTSD symptoms than similar accidental injuries. Of those who survived suicide attempts, 27.5% to 46.7% met the criteria for PTSD in relation to the attempt.

There is a lack of existing guidance on how to identify and treat APTSD. This could lead to perpetuated mental distress and risk presentations. Thus, an understanding of how APTSD presents in relation to different autogenic behaviours is a starting point for developing evidence-based clinical practice.

The aim of this study is to explore the profiles of PTSD symptoms in relation to autogenic behaviours (offending, self-harm, and suicide attempts) as observed by treating clinicians.

Methodology

Design

- A non-experimental, cross-sectional e-survey design was utilised

Paticipants

- Registered healthcare workers (n=102) aged between 21 and 70 years; mostly female, and registered psychologists.
- The majority reported working with psychological trauma presentations 'frequently' or 'all the time'.

Materials

An e-survey exploring clinician's observations off PTSD symptom clusters within patients due to their own self-harm, suicide attempts, and offending behaviour

Procedure

- The survey hosted via Microsoft Forms.
- Snowball and purposive sampling
- Data collected between May - July 2024.

Approvals

Permission was gained from the research governance structures in the lead authors' organization.

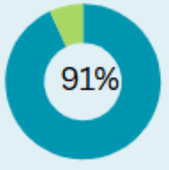
Results

All PTSD symptom clusters were endorsed (see Figure) as having been observed in patients' as a result of their own self-harm, suicidal and offending behaviours, to some degree. Avoidance was the most commonly endorsed symptom cluster, followed by re-experiencing and hypervigilance.

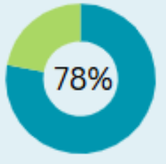
The proportion of respondents who endorsed working with patients with any PTSD symptoms related to their own behaviour was significantly higher for offending behaviour, than for self-harm and suicidal behaviour. ($p<0.001$)

Symptom Endorsement by Autogenic Behaviour

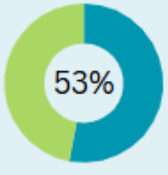
Binomial Tests Exploring Differences in Proportions of Staff



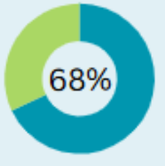
Reported working with a patient who displayed any PTSD symptoms related to their own behaviour. The proportions of respondents was significantly higher for offending behaviour ($p<0.001$)



Worked with a patient who had received treatment for trauma needs related to their own behaviour. The proportions of staff were significantly higher for those with offending and suicidal behaviours, compared to self-harm ($p<0.05$)



Worked with a patient formally diagnosed with PTSD related to their own behaviour. The proportion of staff was significantly higher for offending behaviour compared to self-harm and suicidal behaviour ($p<0.05$)



Worked with a patient meeting probable PTSD criterion, exclusive & inclusive of the functional impairment criterion. The proportion of staff was significantly higher for offending behaviour (all p's<0.001).

Discussion

APTSD is frequently observed by clinicians working in healthcare. This study highlights the need for greater awareness of the potential for APTSD in clinical populations, as well as a deeper understanding of the symptom-profiles.

All PTSD symptom clusters were endorsed, though there were differences in the symptom profiles across the autogenic behaviours. Understanding such differences might help to explain differences in prevalence rates and clinician awareness of APTSD reported elsewhere.

There are implications for assessment and treatment.

- Self-harm and suicide attempts should be considered as potential Criterion A events when assessing for PTSD.
- Offence paralleling behaviours could be conceptualised within the APTSD framework.
- Exploration of the role of avoidance in psychological treatment (e.g., driven by PTSD vs. driven by shame/guilt).
- A trauma-sensitive approach is needed in offence focussed work.

Further investigation into PTSD due to internalising behaviours is needed to understand prevalence and profiles. Examination of profiles between different types of externalising and internalising behaviours may also be useful. Exploration of the efficacy of existing PTSD treatments for APTSD is also critical.

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Factors impacting on the integration of autogenic sources of PTSD into clinical practice: A UK survey

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Introduction

PTSD arising from autogenic (self) sources is under explored. Whilst it's most commonly explored in regard to offending behaviour, research has identified that to non-suicidal self-injury (NSSI) and suicidal attempts (MacNair,2015; Jallade et al., 2005; Mahlako et al., 2024) can also lead to PTSD for the person engaging in the behaviour.

Prevalence rates of PTSD arising from violent crimes are 1.5% - 76.6% (Soh et al., 2023), for suicide attempts, and between 27.5% (Stanley et al.,2019) – 46.7% (Bill et al., 2012) surviving suicide. These prevalence rates appear comparable to traditional Criterion A events, such as serious physical trauma (30%) and sexual assault (41.5%).

Untreated PTSD can lead to poorer treatment responses and an ongoing risk of harm to others (Gray et al., 2011). Therefore, not recognising APTSD and leaving it untreated is likely to have negative impacts on the individual' and society

Despite this, APTSD is absent from Clinical guidance, protocols and training and education programmes. Resultantly, we have limited understanding of how clinicians approach working with autogenic sources of PTSD, as well as their understanding and acceptance of the notion that PTSD can arise from one's own actions.

This poses a number of challenges to services, clinicians and service users. as we have little understanding of how clinicians integrate this area of need into trauma practice. Establishing clinical practice and factors underpinning clinician behaviour is essential to establish clinical and research priories.

Moreover, it is important to explore the factors that are hindering integration between awareness of autogenic sources and implementing this in clinical practice.

Aims

The current study sought to establish:

- Clinical awareness of APTSD, and its different sources
- Clinician's attitudes of autogenic sources meeting Criterion A
- Current consideration and integration of APTSD needs in clinical practice
- Factors that impact on the integration of APTSD into clinical practice

Methodology

Design A non-experimental, cross-sectional e-survey design was utilised

Participants Registered healthcare workers were invited to complete the study

Materials An e-survey exploring

- Experience of working with psychological trauma
- Awareness & attitudes of PTSD arising form ones own actions
- integration of autogenic sources in clinical practice.

Procedure

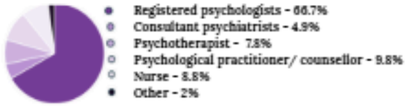
- The survey was hosted via Microsoft Forms.
- Data was collected between May - July 2024.
- Informed consent was obtained from participants prior survey completion.
- A de-brief statement was offered following completion

Approvals Permission was gained from the research governance structures in the lead authors' organization.

Results

Demographics

N=102 20.6% 79.4%



Average age 43.1 years

Average years of professional registration 12.4 years

Awareness that PTSD can arise from ones own actions

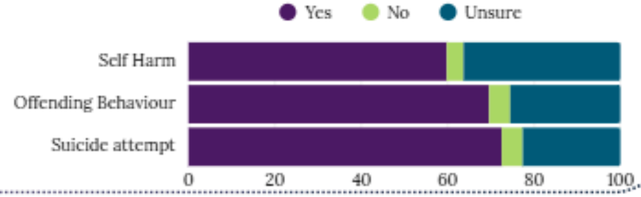
'Limited' Awareness vs. Good awareness = significantly less liley to integrate autogenci sources of PTSD into clinical practice 'frequently' or 'all the time' to integrate into clinical practice p<.001)

'Limited' Awareness vs. Good awareness = Less likely to integrate into:

- Assessment activities (p=.014),
- Psychoeducation (p=.024)
- Trauma processing activities (p=.026)

The impact of the type of autogenic sources are Criterion A experiences

Most respondents were supportive of autogenic experiences being Criterion A experiences, with only a minority rejecting the notion, a degree of ambivalence was noted. Analysis, using the McNamar's Test of proportion demonstrated greater levels of ambivalence relating to NSSI sources, compared to suicide attempts (p<0.001) and offending behaviour (p=0.027).



Impact of being 'unsure ' whether behaviour meets criterion A requirements on integrating autogenic sources into clinical practice

Type of clinical activity	Offending behaviour	Suicide Attempt	Self Harm
Assessment Activities	p=.04	p=.0011	p=.05
Psychoeducation	ns	p=.004	p=.04
Trauma Processing	ns	p=.048	ns

The impact of Gender and type of autogenic source

Female respondents were significantly more likely to be unsure that offending behaviour met criterion A requirements (p=.01). Further exploration revealed this association was found for females working in forensic/prison settings only (p=.035).

Discussion

Most clinicians reported having an awareness of autogenic sources of PTSD (APTSD). Additionally, most clinicians affirmed their validity for the criterion requirements for PSTD, however a degree of ambivalence towards autogenic sources was noted, especially for NSSI, where a third of respondents were unsure if engaging in NSSI was potentially a traumatic experience.

Whilst most reported awareness of APTSD, and considered them to be criterion A experience's, only half of respondents reported integrating APSTD into clinical activities, suggesting that some sources of PTSD are left untreated. Lower levels of integration were associated with

- limited awareness of APTSD
- ambivalent attitudes towards, APTSD as a Criterion A experience
- The source of APTSD, with self harm reporting the lowest support and integration into clinical activities

Implications

Current findings suggest a systematic approach to training, inclusive of frontline staff through to trauma specialists and service commissioners is needed to ensure that autogenic sources of PTSD are effectively recognised, responded to, and treated.

Factors underlying the discordance between acceptance of APTSD as a Criterion A experience and the limited integration in clinical practice indicate warrant further exploration. Relatedly, ambivalence towards NSSI autogenic sources reflects a clinical research priority, especially in the context of wider evidence suggesting some health professionals hold negative views of this population. Similarly, the role of gender, in the recognition of offending related autogenic sources reflects a key area of investigation given the predominance of female psychologists in secure settings.

Finally, addressing the lack of clinical guidance from professional, national and specialist trauma bodies is a priority. Clinical guidance documents have demonstrated efficacy in the effective management of mental health presentations (Setkowsk et al., 2021) and could address the current relative invisibility of autogenic sources of PTSD.

Conclusions

It is apparent that currently autogenic sources of PTSD are poorly reflected in education, training activities and national guidelines. The study's findings and existing evidence base demonstrate the validity of APTSD and highlight the need to include it in frameworks ,education and practice. Therefore increasing awareness of APTSD and addressing negative attitudes are crucial as without confident understanding, clinicians risk being to provide holistic and compassionate care.

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Risk and Protective Factors for Post Traumatic Stress Disorder (PTSD) and Disturbances in Self-Organisation (DSO) Symptom Severity in Trauma-Exposed Perinatal Women: The Role of Adverse Childhood Experiences and Perceived Social Support

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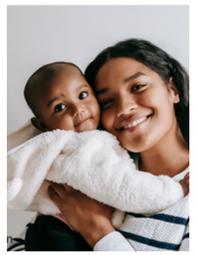


Introduction

Perinatal women are at increased risk of Post Traumatic Stress Disorder (PTSD), but less is known about Complex PTSD (CPTSD) and Disturbances in Self-Organisation (DSO) among pregnant and postnatal women. Perinatal women can be particularly vulnerable to trauma-related symptomology due to the profound emotional, physiological, and identity changes associated with pregnancy and motherhood, childbirth-related stressors and the possibility of the reactivation of past traumas.

This study sought to examine the rates of PTSD, CPTSD, and DSO in a trauma-exposed perinatal sample. It investigated the predictive roles of childhood maltreatment (direct forms of abuse of neglect such as physical or sexual abuse), household dysfunction (indirect stressors within the home environment such as incarceration or domestic violence), and perceived social support from friends, family, and significant others on PTSD and DSO symptom severity.

Methodology

Seventy-four trauma-exposed perinatal women participated in the study and completed the following measures.

Childhood Maltreatment & Household Dysfunction: *Adverse Childhood Experiences Questionnaire (ACE-10; Chapman et al., 2004)*

Perceived Social Support from friends, family and others: *Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et et al., 1988)*

PTSD and DSO Symptom Severity:
International Trauma Interview (Cloitre et al., 2018)

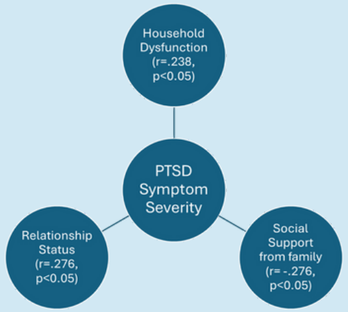
Statistical Analysis: Bivariate correlations and hierarchical regressions examined relationships between predictors and symptom severity, controlling for significant covariates.

Findings & Results

The majority of participants (67.6%) did not meet any diagnostic criteria. 16.2% met criteria for PTSD, 10.8% for DSO only, and 5.4% for CPTSD.

PTSD Symptom Severity

Higher PTSD symptom severity was associated with greater household dysfunction, lower family support, and the absence of a partner relationship.



All three factors were key predictors of PTSD symptom severity. Household dysfunction lost significance once family support was included, suggesting that the impact of early household dysfunction may be partly explained by current relational support.

Model 1 — **Relationship Status (RS)**
(*B* = 7.592,** β = .362), R^2 = 0.131, ΔF =10.866**

Model 2 — **RS & Household Dysfunction (HD)**
RS: (B = 8.220**, β = .392) HD: (B=0.712*, β=0.236)
R^2=0.186, ΔR^2 = .055, ΔF = 4.777*

Model 3 — **RS, HD & Family Support (FS)**
RS: (B = 8.626*, β = .412) HD: (B=0.492,β=0.163)
FS: (B = -0.142*, β=-0.245)
R^2=0.240, ΔR^2 = .054, ΔF = 4.964*

*p≤0.05 **p≤0.01

DSO Symptom Severity

Higher DSO symptom severity was associated with greater childhood maltreatment, lower family, friend and significant other support, and lower educational attainment.

Lower levels of education and reduced support from friends were the strongest predictors of DSO symptom severity. Childhood maltreatment was not significant in the model, but this may be explained by shared variance with education (r=.279, p<.05)

Model 1 — **Education(E):**
(B = −3.190**,β = −.314), R^2 = 0.099, ΔF =7.899**

Model 2 — **E & Childhood Maltreatment (CM)**
E: (B = -2.825**, β =-0.278)
CM: (B=0.399 β=0.118)
R^2=0.112, ΔR^2 = .013, ΔF =1.015

Model 3 — **E, CM & Social Support from Friends, Family & Sig. Others**
E: (B = -1.666, β =-0.164) CM: (B=0.156 β=0.46)
Fr: (B = -.249**, β =.385) Fa:(B =.078, β =-132)
SO:(B =.076 β = -.245), R^2=0.236,ΔR^2 = .125, ΔF=3.702*

*p≤0.05 **p≤0.01

Fa: Social Support from Family, Fr: Social Support from Friends, SO: Social Support from Significant Others

Discussion

Overall, these findings highlight both shared and distinct mechanisms underlying PTSD and DSO symptomatology in trauma-exposed perinatal women.

While social support was a critical protective factor for both outcomes, the specific sources of support differed, with family support more closely linked to PTSD symptoms and friend support emerging as protective for DSO symptoms.

Early relational adversity, such as household dysfunction, and demographic factors, such as education level, differentially influenced symptom severity across the two profiles.

These results underscore the importance of considering the unique developmental and relational pathways contributing to different trauma-related outcomes.

Clinical Implications

The findings from this study highlights the need for:

The recognition of a 'DSO-only' group, underscoring the importance of services that are guided by individual needs rather than diagnostic thresholds.

Emphasis on a relational approach in perinatal care; encouraging clinicians to assess social support and implement interventions that strengthen social connectedness.

Interventions tailored to educational backgrounds, ensuring accessibility and promoting equitable engagement.

Overall, the findings support a trauma-informed, relational approach to assessment and treatment within perinatal services.

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Subjective–Objective Sleep Discrepancy and Sleep-Related Psychological Factors in Individuals With Complex PTSD

N. Mumenah[1,2,3], I. Hartescu[1], D.J Morris[4,5] , J.B Barker[1]

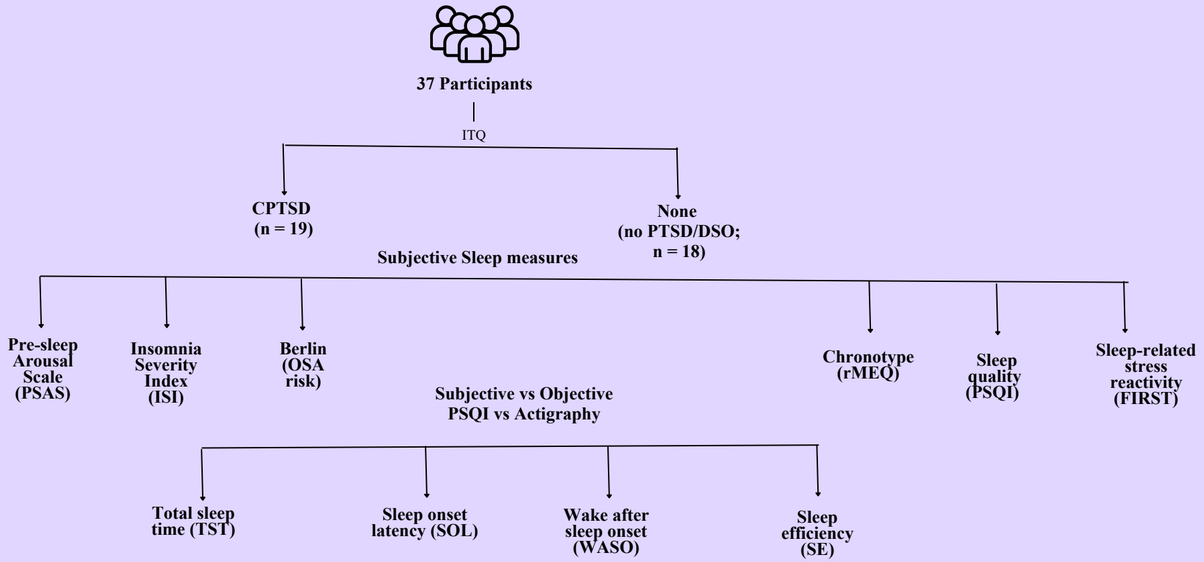
BACKGROUND

CPTSD is characterised by enduring trauma-related symptoms, emotional dysregulation, and cognitive hyperarousal, all of which may disrupt sleep.

While subjective sleep disturbances are well documented in trauma-exposed populations, objective sleep findings are often inconsistent.

This study examined subjective and objective sleep parameters, sleep-related psychological factors, and subjective–objective sleep discrepancy in adults with CPTSD compared to none

METHODS



RESULTS

The groups did not differ significantly in age, sex, or education. The CPTSD group showed markedly elevated cognitive hyperarousal, with PSAS-cognitive scores significantly higher than the None group (Fisher's Exact p = .034, φ = .33). Somatic hyperarousal was not significantly different. FIRST and ISI scores were higher in the CPTSD group but did not reach statistical significance (p = .055, d = 0.65), (p = .15). Chronotype and OSA risk also did not differ between groups.

Between-Group Comparison of Actigraphy Sleep Parameters (None vs. CPTSD)

ctigraphy ariable	None (n = 18)M ± SD	CPTSD (n = 19)M ± SD	Test Statistic	p-value
OL (min)	30.89 ± 29.44	24.58 ± 22.79	U = 162	.784
WASO (min)	93.11 ± 32.02	80.84 ± 22.55	t(35) = 1.38	.176
ST (min)	368.22 ± 38.34	373.53 ± 63.76	t(35) = −0.31	.760
leep Efficiency (%)	73.88 ± 8.62	75.22 ± 7.19	t(35) = −0.52	.607

te. None = participants without PTSD or DSO; CPTSD = participants meeting criteria for Complex SD.

PSQI vs. Actigraphy Results Within-Subject Comparison of PSQI and Actigraphy Sleep Measures

Variable	PSQI (M ± SD)	Actigraphy (M ± SD)	Mean Difference	Statistic	p-value
D (min)	59.55 ± 65.00	88.98 ± 28.59	−29.43	t(39) = −2.86	.007*
Efficiency	83.95 ± 12.46	74.24 ± 8.02	9.72	t(39) = 5.07	< .001*
Onset cy (min)	39.54 ± 46.24	27.65 ± 26.06	— (Wilcoxon)	Z = −1.45	.147
Sleep (min)	429.75 ± 86.38	371.13 ± 50.48	58.63	t(39) = 4.42	< .001*

sitive differences indicate PSQI > actigraphy. Negative differences indicate PSQI < actigraphy.
ally significant at p < .05.

CONCLUSION

CPTSD was characterised by heightened cognitive hyperarousal and elevated stress-related vulnerability to sleep disturbance. The prominent mismatch between subjective and objective WASO suggests that perceptual alterations of sleep may be a key feature in trauma-related sleep disturbance. These findings highlight the importance of incorporating both subjective and objective methods when assessing sleep in CPTSD and suggest that interventions targeting hyperarousal may help improve sleep quality.

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Introducing Trauma-Informed Practice Education in the Radiology Department: Assessing Feasibility, Acceptability, and Need

Dr Dominique McGinlay, Radiology Registrar, Dr Gemma McGivern, Radiology Consultant NHS Greater Glasgow and Clyde

Background

Trauma-informed practice is an approach that recognises the widespread impact of trauma and prioritises safety, trust, empowerment, and collaboration within healthcare interactions. In clinical settings such as radiology where intimate, invasive, or potentially distressing procedures may occur there is growing recognition of the need to integrate trauma-informed principles.

The Scottish Government's National Trauma Transformation Programme has highlighted the importance of embedding trauma-informed approaches across public services, including healthcare.

This quality improvement project aimed to assess the current knowledge, attitudes, and practices of radiology professionals regarding trauma-informed care, evaluate the feasibility and acceptability of trauma-informed education within the department.

Methodology

A brief, anonymous questionnaire was developed and distributed electronically to all radiology consultants, registrars, and sonographers in the department. The questionnaire consisted of 10 items assessing:

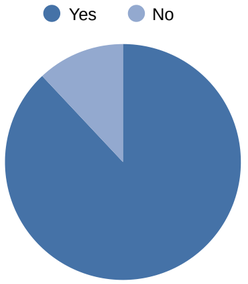
- How familiar are you with the concept of trauma-informed care?
- Have you received any formal training or education on trauma-informed approaches in clinical practice?
- How often do you consider a patient's potential history of trauma when planning or conducting radiological procedures?
- In your practice, how comfortable do you feel adapting communication or procedure protocols to better support patients with a history of trauma?
- Which of the following do you routinely do during patient interactions? (Select all that apply)
- Do you feel your department supports or encourages trauma-informed practice (e.g., through policies, training, debriefing)?
- How confident are you in identifying signs of patient distress or trauma during imaging procedures?
- Are you aware of the Scottish Government's National Trauma Transformation Programme or similar national policies on trauma-informed care?
- Would you engage electively in undertaking a learn-pro module on trauma informed practice?
- What is your job role?

Results

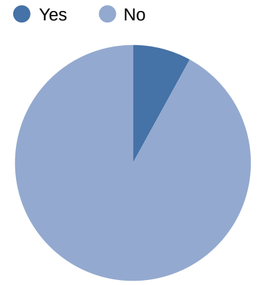
A total of 25 departmental staff completed the survey, comprising radiology consultants (32%), registrars (36%), and sonographers (32%).

- Familiarity and Training
  - Only 4% (1 respondent) reported being very familiar with trauma-informed practice, while 56% had no familiarity at all.
  - 88% had not received any formal trauma informed training; the remainder were unsure if they had.
- Current Practice and Confidence
  - Only 12% reported always considering a patient's potential trauma history when planning or conducting imaging; 44% rarely did.
  - In terms of comfort adapting communication to support trauma-affected patients, 56% felt moderately comfortable, while 28% felt slightly or not at all comfortable.
  - 64% reported being only somewhat confident in identifying signs of distress or trauma, with just 8% feeling very confident and 28% feeling not so confident or not at all confident.
- Routine Supportive Practices
  - Respondents indicated the following practices during patient interactions:
    - 92% routinely explained procedures in advance.
    - 88% allowed time for patient questions or concerns.
    - 76% offered choices or control (e.g., who is present, stopping the scan).
    - Only 8% reported using trauma-sensitive language.
- Departmental Support and Awareness
  - 44% of participants felt the department does not support or encourage trauma informed practice, whilst 56% felt neutral.
  - No participants felt the department supports or encourages trauma informed practice.
  - Only 8% were aware of the Scottish Government's National Trauma Transformation Programme.
- Education Acceptability
  - 88% indicated they would be willing to complete a LearnPro module on trauma-informed care.

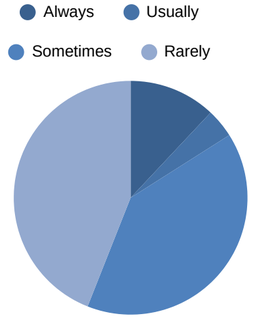
Are you aware of the Scottish Government's national trauma transformation programme or similar national policies on trauma informed care?



Would you engage electively in undertaking a learnpro module on trauma informed practice?



How often do you consider a patient's potential history of trauma (e.g., sexual violence, medical trauma) when planning or conducting radiological procedures?



Conclusion

This quality improvement project has demonstrated a clear need and high level of acceptability to trauma-informed education in the radiology department. The feasibility of delivering relevant education has been established, laying the groundwork for possible change in education and ultimately improved patient care.

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INTERGENERATIONAL IMPACT OF HOMELESSNESS ON MATERNAL MENTAL HEALTH AND CHILD OUTCOMES: A NARRATIVE REVIEW

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INTRODUCTION

The traumatic impact of homelessness on families can be severe and long lasting. It can affect children through the negative impact of insecure housing on maternal mental health. However, studies regarding the association between maternal mental health and child outcomes in homeless families have not yet been synthesised. This systematic review explored the prevalence of this association in research literature, the quality and strength of the evidence, and whether the Family Stress Model helped to explain the relationship between parental distress and child outcomes in the context of homelessness. This aimed to develop greater understanding of the impact of these experiences on under-served homeless family populations.

Definitions

Mental Health: A *'person's condition with regard to their psychological and emotional well-being' (Oxford Dictionary).*

Child outcomes: *Outcomes pertaining to cognitive, educational, academic, behaviour, or mental health domains.*

Homelessness: *Any experience of housing instability, housing insecurity, temporary accommodation, unsuitable housing, and previous homelessness (Children's Commissioner, 2019; Children's Society, 2020; Hock et al., 2024).*

METHODOLOGY

The systematic review was completed according to The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) framework (Page et al., 2021). Full searches of Pubmed, Psychinfo, Medline, CINAHL and SCOPUS databases were conducted. The protocol for this review was registered with the International Prospective Register of Systematic reviews (PROSPERO) in November 2023 (Registration number: CRD42023487596).

Inclusion Criteria for Papers:	Exclusion Criteria for Papers:
Original, quantitative research which included reference to maternal mental health, child outcomes, and empirical association between these variables within the context of homelessness.	Papers without substantial focus on the association between maternal mental health and child outcomes
Maternal mental health disorders e.g. anxiety, depression, bipolar disorder, psychosis etc., or distress or poor mental wellbeing measured through psychometric screening, self-reported data or questionnaires	Reports of a sole measure of 'parental stress' rather than mental health
Child outcomes measured through cognitive screenings, school reported data, parent reported data, behavioural observations, psychometric screening and relevant questionnaires	Solely physical health concerns, or external risk towards children
Experience of housing instability, housing insecurity, temporary accommodation, unsuitable housing, and previous homelessness. If cross sectional data, experience of homelessness needed to be current	Families living specifically in domestic violence shelters

Data Extraction: Key data was extracted including demographics, homelessness status, aims, design, sample size, measures, analysis and findings. A second rater independently extracted data for 50% of the texts.

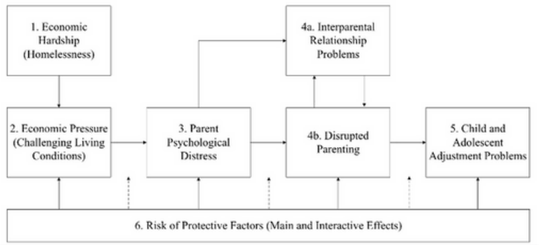
Quality Appraisal: Quality was assessed using the Quality Assessment with Diverse Studies (QuADS) appraisal tool (Harrison et al., 2021). 30% of papers were independently assessed by the second rater.

Narrative Synthesis: The studies were analysed using narrative synthesis, following guidance developed by the Economic and Social Research Council (Popay et al., 2006). Preliminary synthesis of the studies distilled key elements of the papers and observed patterns across the data. Initial thematic analysis was undertaken using a deductive approach, with key elements of each paper treated as 'codes'. Relationships between studies were then explored. Quality of studies were examined to discern the weight attributed to each finding. Studies were grouped by design, and patterns were explored within these groupings. This data was then coded, and as these codes pertained more to methodological patterns, these elements were used as a lens through which to view the initial themes. Finally, the poorest quality studies were excluded to establish whether the themes still held.

LITERATURE

Research suggests a 'continuum of risk' exists among children living in poverty (Brumley et al., 2015), with homeless children the most likely to suffer poor outcomes in mental health, behaviour (Rafferty & Shinn, 1991), language and communication (Haskett et al., 2015), education participation (Keogh et al., 2006) and neurodevelopment (DeCandia et al., 2023). Adults who face homelessness are also more likely to experience mental health problems (Fazel et al., 2008; Downing et al., 2016). Homeless parents, particularly mothers, are especially vulnerable within this population (Roll et al., 1999), and, after adjusting for domestic violence and economic hardship, mothers experiencing problems with housing are more likely to experience anxiety and depression (Suglia et al.'s (2011). Maternal mental health has been shown to impact child outcomes, and exposure to poor parental mental health is considered an Adverse Childhood Experience (Felitti et al., 1998). The Family Stress Model (Fig. 1) proposes an explanation that the impact of adversity such as homelessness on children is mediated through parents who experience distress as a result of economic hardship and pressure (Conger, 2010), which in turn disrupts parenting.

Fig. 1
Family Stress Model (Adapted from Masarik & Conger, 2017)



RESULTS

Of the 17 papers, seven papers took a cross-sectional design, five analysed longitudinal data and five compared outcomes between homeless and housed groups. The majority (n=15) of study scores ranged between 26-33 out of a possible total of 39, with two studies scoring 21.

Themes and Findings

Thematic analysis developed four key themes to conceptualise the findings (Fig 3).

Theme 1: Environmental factors negatively impacted maternal mental health. In multiple studies, housing instability directly predicted poor mental health in mothers (Hatem et al., 2020; Du & Kim, 2021; Du, 2022; Torrance, 1997).

Theme 2: When parents experienced distress, they were more likely to demonstrate negative parenting behaviours. Parental stress mediated the link between maternal depressive symptoms and child behaviour, suggesting maternal distress worsened the stress associated with being a parent (Wu et al., 2018). However, depression did not mediate the link between parent stress and child outcomes in this study. This suggested a directional relationship where distress predicts negative parent approaches.

Fig. 2
PRISMA flowchart outlining study selection procedure

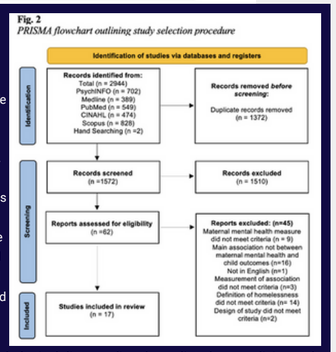
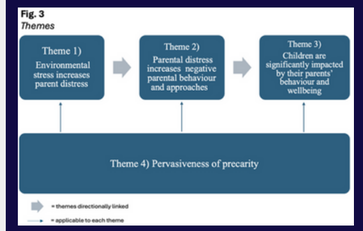


Fig. 3
Themes



Theme 3: Parental psychological distress directly predicted externalising and internalizing behaviour difficulties in children (Abenavoli et al., 2025; Du, 2022; Du & Kim, 2021; Graham-Bermann et al., 1996 Herbers et al., 2023; McNeil Smith et al., 2015; Torrance, 1997; Wu et al., 2018; Zima, 1996). Additionally, studies demonstrated indirect effects of housing instability on child outcomes: housing instability increased parental distress, which in turn increased child behavioural problems (Du & Kim, 2021; Du, 2022; Hatem et al., 2020).

Theme 4: The relationship between maternal mental health, housing instability and child outcomes existed across all age groups and time points. Additionally, some research found no difference in psychological distress between homeless mothers and housed, but financially distressed, mothers (Masten, 1998). This suggests that economically distressed families also experience high psychological burden, conceptualised here as pervasiveness of precarity across these groups.

STUDY AIMS

The study aimed to synthesise research examining the association between homelessness, maternal mental health and child outcomes, to evaluate the quality of this research and apply the Family Stress Model framework to help understand the intergenerational impact of homelessness.

Research Questions

1) Is there an association between maternal mental health and child outcomes in families experiencing homelessness?

2) How are associations between maternal mental health and child outcomes conceptualised and measured and what is the strength of that evidence?

3) Does the Family Stress Model framework provide a helpful conceptualisation through which to understand this association?

ANALYSIS

Association between maternal mental health and child outcomes

The analysis showed poorer maternal mental health negatively impacted child outcomes, consistent with previous literature (Sutherland et al., 2022). Housing instability alone did not appear to cause negative child outcomes; the impact of this environment was mediated through worsened maternal mental health. The studies demonstrated parenting behaviour and approaches were key mechanisms underpinning the association between parental distress and child symptoms. Depression may directly impact the quality of parenting through reduced energy levels, higher irritability, less positive, contingent and frequent responses within parent-child interactions, thus negatively affecting child development (Downey & Coyne, 1990). The current review noted positive parenting attenuated the relationship between parental distress and child internalising and externalising symptoms (McNeil Smith et al., 2015; Wu et al., 2018).

Conceptualisation of findings and strength of evidence

The relationships between maternal mental health and child outcomes were examined using cross-sectional data and longitudinal data. Both types of studies found significant associations between maternal mental health and child outcomes, which supports previous research showing that homelessness causes both immediate distress and poorer long-term outcomes (Caton et al., 2007; Rowley, 2024). Heterogeneity of studies meant direct effect sizes could not be directly compared across studies. However, generally small but significant effects were found across research. Many papers did not consider ethnicity and gender in depth.

The Family Stress Model

This review found a directional association between homelessness, disrupted parenting and child and adolescent adjustment problems. This mapped directly onto the pathway in the Family Stress Model, suggesting this framework is a helpful way to conceptualise the relationship between economic hardship and child outcomes (Conger et al, 2010). Crucially, this review found maternal mental health impacted child outcomes in both homeless and financially distressed families. This suggests that it is not solely the difference in housing status that is relevant to understanding this relationship. Poverty is a direct predictor of homelessness, and Masarik and Conger (2017) suggest more theoretical development is needed to understand which risks moderate the key pathways between such economic hardship and child outcomes. This review proposes similarities in precarity of living situations, experienced by both homeless and financially distressed families as a result of poverty, (Johnsen & Watts, 2014) may help understand this association, and calls for further research to explore this.

Limitations

All studies were conducted in the United States; some papers included parents other than mothers; the role of domestic violence was not examined; chronicity and severity of maternal depression was not considered.

Implications and Future Directions

This review advocates for secure and stable housing for families and mental health and parenting support for homeless parents. Additionally, it suggests the Family Stress Model could be a helpful clinical conceptualisation. Findings suggest that examining the experience of precarity across groups of vulnerable families may help explain a significant risk factor moderating the relationship between economic hardship, parental distress and child outcomes. Future qualitative research is needed to understand the lived experience of parents living in precarious situations and how this impacts on their mental health and outcomes of their children.

CONCLUSION

This narrative synthesis of 17 studies highlighted the negative impact of homelessness on parental mental health. This association was seen to detrimentally affect child outcomes, particularly mental health and behaviour. Parenting was found to be a key mechanism underpinning this relationship, supporting the Family Stress Model. However, the review also suggests precarity of living situations may be an important moderator in the relationship between economic hardship and child outcomes. Despite limitations in the quality of some studies, significant associations across a range of cross-sectional, longitudinal and case comparison designs highlighted the prevalence of this association and the vulnerability of families living in precarious contexts. These findings advocate for long-term stability in housing for families to reduce the intergenerational transmission of distress.