The Polish adaptation of the Disclosure of Trauma Questionnaire (DTQ)

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Summary

Aim. Trauma disclosure is one of the key concepts of the social-interpersonal model of posttraumatic stress disorder (PTSD). This study aimed to present the Polish adaptation of the Disclosure of Trauma Questionnaire (DTQ).

Method. The study was conducted among 120 participants (51 females and 69 males) aged 18–58 years (M = 34.52; SD = 9.95). The reliability of the DTQ was measured using Cronbach's alpha coefficients and intraclass correlation coefficients. The validity of the DTQ compared to the scores acquired with the PTSD Diagnostic Scale for DSM–5 (PDS–5), the Impact of Event Scale (IES), the Social Acknowledgment Questionnaire (SAQ), and the Beck Depression Inventory (BDI) was confirmed through confirmatory factor analysis and correlation analysis.

Results. The Cronbach's alpha coefficient was 0.87 for reluctance to talk subscale, 0.74 for urge to talk subscale, 0.85 for emotional reactions subscale, and 0.85 for the total DTQ questionnaire score. The intraclass correlation coefficients were high: 0.83 for reluctance to talk, 0.71 for urge to talk, 0.77 for emotional reactions, and 0.76 for the total DTQ questionnaire score. The factorial structure of the DTQ was confirmed through confirmatory factor analysis. The DTQ subscale scores correlated positively with the severity of PTSD symptoms and depressive symptoms, as well as the lack of social acknowledgement, as expected.

Conclusions. The observed empirical results confirmed the satisfactory psychometric properties of the DTQ. This inventory may be useful for a broader understanding of how trauma disclosure is related to the social context of dealing with traumatic events.

Key words: traumatic events, trauma disclosure

Introduction

Although a huge body of research on risk factors for posttraumatic stress disorder (PTSD) exists, [see: meta-analyzes and reviews of research, e.g., 1–3] contemporary studies have predominantly concentrated on external factors related to a traumatic event itself and/or intrapersonal characteristics of trauma victims – such as selected personality traits, peri – and posttraumatic negative cognitions, or dysfunctional coping styles. Much less investigated are the socio-interpersonal factors involved in the recovery process after trauma [4]. In line with growing empirical data on this topic, Maercker and Horn [5] presented the PTSD socio-interpersonal model, which is described by two central theoretical constructs: the social acknowledgement of a person as a trauma victim or survivor and self-disclosure. With regard to the first construct, Maercker and Müller [4] defined social acknowledgement as "a victim's experience of a positive response from the society that shows appreciation for their exceptional condition and acknowledges their current difficult situation" [p. 345]. On the other hand, victims may experience negative reactions such as being ignored, rejected, or blamed. In line with these observations, the above-mentioned authors constructed a questionnaire to assess the social responses to traumatic event survivors. The Social Acknowledgment Questionnaire (SAQ) includes both positive (e.g., acknowledgement) and negative aspects (e.g., rejection and disapproval) related to the reaction of a close intimate partner, family, friends, and the wider social environment in general. Several researchers have found that social acknowledgement is negatively associated with PTSD symptoms among individuals after traumatic experiences [e.g., 5–8]. In general, a review of various studies conducted by Maercker and Horn [5] indicated that the level of social acknowledgement (from negative to positive) can be used to predict the well-being and health status of various populations of trauma survivors. Self-disclosure is the second key concept in the above-mentioned model. It refers to the extent to which trauma survivors share their traumatic experiences with other people [5].

Pennebaker et al. [9] observed that expressing their thoughts, feelings, and behaviors related to a traumatic experience (e.g., via writing or talking) can positively impact the immunity and well-being of trauma victims. The results of several subsequent studies, both experimental and field studies, have shown that 'self-disclosure' is essential for trauma recovery [10]. More recently, some authors found that the disclosure of traumatic events may even be related to positive changes after trauma, which constitute the phenomenon of posttraumatic growth [11]. Furthermore, other studies have also indicated that beneficial and dysfunctional disclosure patterns can be distinguished from each other. Specifically, dysfunctional disclosure occurs when victims encounter negative reactions from others or when the listener overreacts to the victim's disclosure [12]. Based on empirical data, Maercker and Horn [5] also found that the absence of dysfunctional disclosure is a strong predictor of resilience.

To evaluate the trauma disclosure patterns among trauma survivors, the Disclosure of Trauma Questionnaire (DTQ) was created by Mueller, Beauducel and Raschka [13]. The authors started work on this inventory by performing a substantial review of studies on communication patterns after traumatic events [14]. Consequently, the following four patterns emerged: the attitude towards disclosure, the emotional way of disclosing (hesitating or crying), the cognitive components while disclosing (clearness about the traumatic event and intrusions), and the subject's reactions while disclosing (being agitated or scared). All these subscales initially generated 65 items. However, Mueller et al. [13] examined this scale comparing its results with the results of inventories measuring PTSD symptoms (the Impact of Event Scale – Revised; IES–R) and social support (Perceived Social Support Questionnaire; F–SozU) among former East German political prisoners. The principal component analysis reduced the number of factors to three, and the whole scale finally comprised 34 items. The subscales are as follows: reluctance to talk (13 items), which describes the reluctance to tell others about the trauma (e.g., "I find it difficult to talk to people about the incident"); urge to talk (11 items), which evaluates the victim's need to disclose the traumatic event (e.g., "I feel compelled to talk about my experiences again and again"); and emotional reactions (10 items), which measures the emotional states of the victim while disclosing the trauma (e.g., "Describing the event makes me feel very sad"). The participants answered on a Likert scale, from 0 (not at all) to 5 (completely). The psychometric characteristics of the original DTQ proved to be very satisfactory [13], and the subscales had the following Cronbach's alphas: urge to talk: $\alpha = 0.88$; reluctance to talk: $\alpha = 0.82$; and emotional reactions: $\alpha = 0.87$. The test–retest reliabilities (rtt) for intervals one to three months were also very good – urge to talk: $rtt = 0.76$; reluctance to talk: $rtt = 0.89$; and emotional reactions: $rtt = 0.77$. As a result, the authors obtained the final version of the DTQ, which is used together with the aforementioned SAQ as complementary tools for examining the socio-interpersonal model of PTSD by Maercker and Horn [5]. In addition, a positive relationships between DTQ subscales and PTSD symptoms indicate that the DTQ may be used as one of the tools related to PTSD diagnosis and therapy.

Aim of the study

The purpose of the study is to present the Polish version of the DTQ and assess its reliability, stability of measurement, factorial structure, and validity. The reliability of measurement was assessed using Cronbach's alpha reliability coefficients. The stability of measurement was assessed by applying the intraclass correlation coefficient to the results of two consecutive measurements. The factorial structure was verified with confirmatory factor analysis based on the maximum likelihood method. The validity was assessed by analyzing the correlation coefficients between DTQ scores and the severity of PTSD symptoms, the severity of depressive symptoms and the level of social acknowledgement.

Method

Participants

The study was conducted among 120 respondents who were divided into two groups: 70 university students and 50 persons undergoing psychotherapy with diagnoses of anxiety, mood and personality disorders. 51 females and 69 males aged 18–58 years (M = 34.52; SD = 9.95) participated in the study. After filling the informed consent form, the participants filled the paper and pencil version of the measure. The reliability of the DTQ was measured by the test-retest method. The second assessment was conducted two weeks after the first assessment. The validity of the DTQ was assessed by analyzing the correlation between the DTQ and Polish versions of the following tools: PTSD Diagnostic Scale for DSM–5 (PDS-5), the Impact of Event Scale (IES), the Beck Depression Inventory (BDI), and the Social Acknowledgment Questionnaire (SAQ). The reliability analysis was carried out only on a group of students, while the validity was checked on the whole sample of participants, i.e., n = 120. This study was approved by the Ethics Committee of the Institute of Psychology, University of Social Sciences and Humanities in Warsaw.

The group of students who participated in the study did not have any relationship with the project manager from another academic center that invited them to the study through a personal letter. The letter was enclosed in an envelope with the informed consent form and battery of tests. Anyone interested in the study after finishing the didactic classes could take an envelope with the research materials and read them. On this basis, students ultimately decided whether they wanted to take part in the study or return the envelope. In cases where anyone was willing to proceed with the test, they sealed the envelope with the battery of filled tests inside it. In both cases, the envelopes were folded and returned to the same place they were taken from.

Measures

1. The PTSD Diagnostic Scale for DSM-5 (PDS–5)
    The PDS-5 consists of 20 items that assess the symptoms of PTSD according to the DSM-5 criteria [15]. Each of the items is related to the symptoms of PTSD from specific clusters diagnosed with DSM-5. The Polish version adapted by Zawadzki et al. [16] was used in this study.
2. The Impact of Event Scale (IES)
    The IES is a popular tool for assessing two groups of PTSD symptoms: intrusions and avoidance. The IES consists of 15 items that describe symptoms belonging to both categories [17]. Participants report their responses on a four-point Likert scale. The Polish adaptation of the tool developed by Lis-Turlejska and Łuszczyńska [18] was applied in this study.
3. The Beck Depression Inventory (BDI)

The BDI is a well-known 21-item multiple-choice self-report inventory that is used to assess and measure the presence and severity of depression, including both cognitive and somatic aspects of depression. The severity of each symptom is rated from 0 to 3 [19]. The Polish version of the tool translated by Lewicka and Czapiński [20] was applied in this study.

4.   The Social Acknowledgment Questionnaire (SAQ)

The SAQ [4] is a self-report measure consisting of 16 items that assess the degree to which an affected individual perceives that his or her traumatic experience is acknowledged by his or her social network following a traumatic event. The scale consists of three subscales: general disapproval (which refers to general society), recognition as a victim (which refers to acquaintances, friends and local public figures), and family disapproval. The Polish version adapted by Drapała and Lis-Turlejska [21] was used in this study.

Translation of the DTQ

There were five versions of the Polish translation of the English version of the DTQ prepared by professionals with experience in psychotherapy. Two of the coauthors of this study (MLT and MK), after discussing each item, prepared the final version of the translation. It was translated back to English by a native speaker with experience in psychotherapy. The back-translation was sent to Andreas Maercker, one of the authors of the DTQ, who approved it but suggested two minor changes.

Results

Descriptive statistics

Test-retest measurement was performed on a group of 70 students of faculties of psychology and education in one of the Universities in Warsaw. The interval between the test and the retest was two weeks, with 36 respondents participating in the second measure. The second group of respondents consisted of 50 patients from three private and one community-based psychotherapy centers – three of them in Warsaw and one in Opole. The patients filled the questionnaires at homes or in the centers.

Table 1 presents frequency distribution for traumatic events experienced by the participants and the traumatic events that bothered the participants most.

Table 1. **Traumatic events experienced by participants from the current study**

	Lifetime		Currently	
	exposure		most bothering	
Traumatic events	n	%	n	%
Serious, life-threatening disease	40	33.3	14	11.7

table continued on the next page

Physical assault	11	9.2	4	3.3
Sexual assault	11	9.2	7	5.8
Military combat or lived in a war zone	1	0.8	17	14.2
Child abuse	30	25.0	6	5.0
Accident	22	18.3	2	1.7
Natural disaster	4	3.3	53	44.2
Other trauma	70	58.3	17	14.2

n – number of participants; % – group percentage.

The majority of the participants experienced "other trauma" not included in the PDS-5 questionnaire. In the majority of cases, the participants decided to be more specific by explaining the individual characteristics of traumatic interpersonal experiences using the open-ended questionnaire item. Natural disaster was indicated most frequently as the event that currently bothered the respondents the most.

Table 2 presents descriptive statistics for analyzed interval variables, i.e., mean values, standard deviations, minimum and maximum values, and measures of skewness and kurtosis.

Table 2. **Descriptive statistics for analyzed interval variables**

Questionnaire	Variables	M	SD	min	max	S	K
DTQ	Reluctance to talk	37.43	12.44	17	70	0.66	-0.05
	Urge to talk	28.73	8.78	11	57	0.76	1.02
	Emotional reactions	34.16	10.20	13	58	0.12	-0.55
	Total DTQ score	100.33	22.05	51	146	0.21	-0.22
PDS-5	Number of traumatic events	1.69	1.05	1	9	3.35	19.29
	Criterion B	5.43	3.99	0	16	0.66	-0.22
	Criterion C	2.44	2.01	0	8	0.63	-0.19
	Criterion D	9.90	6.51	0	26	0.38	-0.63
	Criterion E	7.97	5.03	0	20	0.24	-0.75
	Total PDS-5 score	25.63	15.55	0	68	0.42	-0.46
IES	Intrusions	15.04	11.04	0	33	0.14	-0.22
	Avoidance	15.75	9.36	0	34	0.03	-0.84
	Total IES score	30.78	18.02	0	65	-0.06	-0.85
SAQ	General disapproval	3.62	3.70	0	15	0.86	0.44
	Recognition	3.11	2.89	0	12	0.95	0.43

	Family disapproval	5.83	2.96	1	16	0.39	0.12
	Total SAQ score	23.62	6.06	2	33	-0.43	0.71
BDI	Depression	15.12	12.55	0	53	0.83	-0.01

M – mean value; SD – standard deviation; min – minimum value; max – maximum value; S – skewness; K – kurtosis.

The values of the measure of skewness and kurtosis, except for the number of traumatic events, did not exceed – 1 and 1. Thus, the distribution of the analyzed variables did not differ significantly from a normal distribution.

Reliability

The values of Cronbach's alpha coefficients were as follows: 0.87 for reluctance to talk, 0.74 for urge to talk, 0.85 for emotional reactions, and 0.85 for the total DTQ score.

The stability of measurement was tested using the means of two consecutive measurements performed within two weeks on the group of 36 participants – 20 women and 16 men aged 28–58 years (M = 44.05; SD = 6.54).

The values of intraclass correlation coefficients were high: 0.83 for reluctance to talk, 0.71 for urge to talk, 0.77 for emotional reactions, and 0.76 for the total DTQ score.

Validity

Factorial structure of the Polish version of the DTQ was verified with the use of confirmatory factor analysis based on the maximum likelihood method. The model fit was found to be satisfactory. The values of fit indices were as follows: CFI = 0.95; RMSEA = 0.06; NFI = 0.93. Acquired factor loadings for all DTQ items are presented in Table 3.

Table 3. **Factor loadings for the DTQ on the basis of confirmatory factor analysis**

Item no.		DTQ	Factor loadings
no. 1	<—	Reluctance to talk	0.41
no. 9	<—	Reluctance to talk	0.51
no. 12	<—	Reluctance to talk	0.44
no. 16	<—	Reluctance to talk	0.55
no. 17	<—	Reluctance to talk	0.84
no. 18	<—	Reluctance to talk	0.81
no. 20	<—	Reluctance to talk	0.57
no. 23	<—	Reluctance to talk	0.74

no. 24	←—	Reluctance to talk	0.59
no. 29	←—	Reluctance to talk	0.70
no. 33	←—	Reluctance to talk	0.61
no. 34	←—	Reluctance to talk	0.58
no. 2	←—	Urge to talk	0.76
no. 3	←—	Urge to talk	0.60
no. 4	←—	Urge to talk	0.46
no. 5	←—	Urge to talk	0.48
no. 11	←—	Urge to talk	0.66
no. 19	←—	Urge to talk	0.67
no. 22	←—	Urge to talk	0.43
no. 25	←—	Urge to talk	0.46
no. 27	←—	Urge to talk	0.62
no. 28	←—	Urge to talk	0.54
no. 6	←—	Emotional reactions	0.56
no. 7	←—	Emotional reactions	0.45
no. 13	←—	Emotional reactions	0.79
no. 14	←—	Emotional reactions	0.45
no. 15	←—	Emotional reactions	0.84
no. 21	←—	Emotional reactions	0.82
no. 30	←—	Emotional reactions	0.69
no. 31	←—	Emotional reactions	0.72
no. 32	←—	Emotional reactions	0.71

All factor loadings exceeded the recommended value of 0.40. The scores on reluctance to talk scale correlated negatively with the scores on urge to talk scale: $r = -0.30$; $p < 0.01$. The scores on emotional reactions scale correlated positively with the scores on urge to talk scale: $r = 0.35$; $p < 0.01$, and with the scores on reluctance to talk scale: $r = 0.25$; $p < 0.05$.

The Pearson's correlation coefficients between DTQ scales and the severity of PTSD symptoms, social acknowledgement, and the severity of depressive symptoms are presented in Table 4.

Table 4. **Pearson's correlation coefficients between DTQ scores and the severity of PTSD symptoms, social acknowledgement, and the severity of depressive symptoms**

Tool	Variables	DTQ			
		Reluctance to talk	Urge to talk	Emotional reactions	Total score
PDS-5	Criterion B	0.304**	0.357**	0.589**	0.582**
	Criterion C	0.323**	0.252**	0.587**	0.553**
	Criterion D	0.403**	0.228**	0.543**	0.569**
	Criterion E	0.371**	0.192*	0.501**	0.517**
	Total PDS-5 score	0.409**	0.271**	0.616**	0.623**
IES	Intrusions	0.257*	0.392**	0.589**	0.571**
	Avoidance	0.302*	0.179	0.387**	0.417**
	Total IES score	0.314*	0.333**	0.562**	0.566**
SAQ	General disapproval	0.227**	0.298**	0.455**	0.455**
	Recognition	-0.108	0.153	0.061	0.025
	Family disapproval	0.213*	0.330**	0.428**	0.448**
	Total SAQ score	-0.225*	-0.354**	-0.479**	-0.487**
BDI	Depression	0.413**	0.243**	0.498**	0.561**

* $p < 0.05$; ** $p < 0.01$.

The scores of all DTQ scales correlated positively with the severity of the majority of PTSD symptoms except for avoidance. The scores of all DTQ scales also correlated positively with the severity of depression. General disapproval and family disapproval correlated positively with the scores of all DTQ scales. Total SAQ score correlated negatively with the scores of all DTQ scales. The scores of the Recognition subscale did not correlate with DTQ scales scores.

Discussion

The factorial structure of the DTQ tool adapted to Polish conditions turned out to be consistent with the results of studies conducted among former political prisoners of the German Democratic Republic (GDR) by Mueller, Beauducel and Raschka [13]. The number of statements falling into individual subscales turned out not to differ significantly from the original version of this tool: reluctance to talk (12 vs. 13 items, respectively), urge to talk (10 vs. 11 items) and emotional reactions (9 vs. 10 items).

The reliability of the subscales of the DTQ was satisfactory. Cronbach's alpha coefficients for individual subscales were very similar to those obtained by Mueller et al. [13]. The only exception was the urge to talk subscale whose Cronbach's alpha was lower compared to the original version of the DTQ ($\alpha = 0.74$ vs. $\alpha = 0.88$). In addition,

despite the differences in time between the measurements, almost identical intraclass correlation coefficients were obtained in both studies.

Apart from the insignificant relationship between reluctance to talk and avoidance, all DTQ adaptation subscales positively correlated with the severity of most PTSD symptoms both in the IES and in the PDS–5. Other correlations (severity of depression and measures of social recognition) obtained in the process of the DTQ adaptation to Polish conditions also led to the conclusion that this tool has good psychometric properties.

However, a few limitations of this study should be highlighted. The first limitation is the choice of the questionnaires that were used to verify the validity of the DTQ. For example, the BDI has been used in many research projects and this questionnaire was constructed years ago. It would be interesting to investigate the correlations between the DTQ and other, recent measures of depression in future research. Second, in the validity measurements, we focused on patients undergoing psychotherapy with diagnoses of anxiety, mood and personality disorders. Future studies on this topic should include people who meet the criteria for the diagnosis of PTSD, adaptive disorders and other disorders that are related to the survival of crises or traumatic events. Finally, our next stage of work on this tool may be the development of norms on a representative sample of at least 1,000 people, which is very important, especially if it would be used in individual clinical practice. Unfortunately, due to the lack of norms at the current stage of the study, we do not recommend using it in individual diagnostics.

Conclusions

Despite these limitations, the Polish version of the DTQ is a tool with good psychometric properties, which can be helpful in scientific studies on trauma and PTSD. More specifically, the DTQ may be useful in empirical investigations for a broader understanding of how trauma disclosure is related to the social context of trauma victims – a topic still highly neglected in trauma research [5].

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