

# Factor Structure of the International Trauma Questionnaire in Trauma Exposed LGBTQ+ Adults: Role of Cumulative Traumatic Events and Minority Stress Heterosexist Experiences

Ruby Charak<sup>1</sup>, Ines Cano-Gonzalez<sup>1</sup>, Roman Ronzón-Tirado<sup>2</sup>, Julian D. Ford<sup>3</sup>, Brianna M. Byllesby<sup>4</sup>, Mark Shevlin<sup>5</sup>, Thanos Karatzias<sup>6, 7</sup>, Philip Hyland<sup>8, 9</sup>, and Marylene Cloitre<sup>10, 11</sup>

<sup>1</sup>Department of Psychological Science, The University of Texas Rio Grande Valley

<sup>2</sup>Department of Psychology, Autonomous University of Madrid

<sup>3</sup>Department of Psychiatry, University of Connecticut School of Medicine

<sup>4</sup>Department of Psychology, University of South Dakota

<sup>5</sup>School of Psychology, Ulster University

<sup>6</sup>School of Health & Social Care, Edinburgh Napier University

<sup>7</sup>NHS Lothian, Rivers Centre for Traumatic Stress, Edinburgh, United Kingdom

<sup>8</sup>Department of Psychology, Maynooth University

<sup>9</sup>Trinity Centre for Global Health, Trinity College, University of Dublin

<sup>10</sup>National Center for PTSD Dissemination and Training Division, VA Palo Alto Health Care System, Palo Alto, California, United States

<sup>11</sup>Department of Psychiatry and Behavioral Sciences, Stanford University

Exposure to prolonged and/or multiple types of psychological trauma and stressors has been shown to be more strongly associated with ICD-11 complex posttraumatic stress disorder (CPTSD) than posttraumatic stress disorder (PTSD). Lesbian, gay, bisexual, trans- and queer adults (LGBTQ+) are at a heightened risk of exposure to traumatic events, and minority stressors including harassment, discrimination, rejection by family, and isolation. **Objective:** To examine the factor structure of the international trauma questionnaire (ITQ), a self-report measure of PTSD and CPTSD, and the associations of cumulative lifetime trauma exposure assessed via the life events checklist and minority stress assessed via the daily heterosexist experiences scale, with CPTSD (three PTSD symptom clusters, three clusters reflecting disturbances in self-organization [DSO]) among LGBTQ+ adults. **Method:** Participants comprised 225 LGBTQ+ adults (including 74 transgender and gender diverse individuals; age range: 18–60 years;  $M/SD = 31.35/9.48$ ) residing in Spain. **Results:** Confirmatory factor analyses indicated that both a first-order six-factor model and a hierarchical two-factor model, comprising PTSD and DSO as second-order factors, fit the data best. Cumulative traumatic events score was associated with PTSD, and cumulative minority stress was associated with PTSD and DSO. Among the minority stress subscales, harassment based on gender expression was positively associated with all symptom clusters of PTSD and DSO. **Conclusion:** This is the first study to examine the role of minority stressors alongside exposure to psychological traumas in ICD-11 PTSD and CPTSD and emphasizes the inclusion of minority stressors in trauma-related assessments.

### Clinical Impact Statement

The present study findings validated the structure of CPTSD comprising PTSD and DSO, using the ITQ in LGBTQ+ adults from Spain. Findings further suggested that exposure to cumulative minority stressors (i.e., heterosexism/cissexism) was positively associated with the PTSD and DSO clusters of complex PTSD emphasizing the importance of inclusion of minority stressors in clinical assessments and trauma-focused treatments.

This article was published Online First January 23, 2023.

Ruby Charak  <https://orcid.org/0000-0002-5806-6884>

Ruby Charak served as lead for conceptualization, investigation, methodology, project administration, resources, software, validation and writing—original draft and contributed equally to formal analysis. Ines Cano-Gonzalez served as lead for formal analysis and served in a supporting role for data curation, methodology, project administration and writing—review and editing. Roman Ronzón-Tirado served in a supporting role for writing—review and editing. Julian D. Ford served in a supporting role for writing—review and editing. Brianna M. Byllesby served in a supporting role for writing—review and editing. Mark Shevlin served in a supporting role

for writing—review and editing. Thanos Karatzias served in a supporting role for writing—review and editing. Philip Hyland served in a supporting role for conceptualization, investigation and writing—review and editing. Marylene Cloitre served in a supporting role for conceptualization, supervision and writing—review and editing. Ruby Charak and Roman Ronzón-Tirado contributed equally to data curation. Ines Cano-Gonzalez and Roman Ronzón-Tirado contributed equally to software.

Correspondence concerning this article should be addressed to Ruby Charak, Department of Psychological Science, The University of Texas Rio Grande Valley, 1201 W. University Drive, Edinburg, TX, United States. Email: [charakruby@gmail.com](mailto:charakruby@gmail.com)

*Keywords:* complex PTSD, minority stress, trauma, LGBTQ+, Spain

*Supplemental materials:* <https://doi.org/10.1037/tra0001440.supp>

Exposure to marginalization and stigmatization places lesbian, gay, bisexual, transgender, or queer (LGBTQ+) individuals at risk of mental health problems including PTSD (Dworkin et al., 2018; Meyer, 2003; Schmitz & Charak, 2022; Solomon et al., 2021). Previous research indicates that LGBTQ+ individuals experience psychological trauma, including interpersonal violence and victimization, at higher rates than cisgender heterosexual individuals (Charak et al., 2019; Meyer, 2003). As a result, rates of PTSD tend to be high in LGBTQ+ individuals ranging from 1.3% to 47.6% among sexual minority individuals including LGB people, and 17.8% to 42% in transgender and gender diverse individuals<sup>1</sup> (see Livingston et al., 2020). Within the LGBTQ+ spectrum, transgender and gender diverse individuals are at a heightened risk of marginalization, stigmatization, and mental health disparities including PTSD (Bauerband et al., 2019) compared with cisgender individuals.

Notably, the aforementioned studies focus on the DSM-5 PTSD symptoms and diagnosis, whereas the sibling disorders of PTSD and CPTSD in the International Classification of Diseases-11 (ICD-11) have yet to be examined among LGBTQ+ individuals. These two classificatory systems have similarities in that both moved PTSD from the anxiety disorders category to a new stress-related disorders category by retaining the three symptom clusters, namely, reexperiencing, avoidance, and hyperarousal. However, there are substantial differences in the nosology of PTSD across the two classificatory systems. For instance, DSM-5 conceptualizes PTSD as a disorder with 20 symptoms featured under four clusters, that occur after an event or series of events involving a threat to life, serious injury, or sexual violence, experienced directly, witnessed, learned about, or involves work-related exposure to aversive details (Bovin et al., 2021). ICD-11 on the other hand conceptualizes two sibling disorders, that is, PTSD and CPTSD (details below), and removed all non-specific symptoms that were present in prior versions of ICD and DSMs. ICD-11 has six PTSD symptom clusters and six additional CPTSD symptom clusters (described as symptoms of disturbance of self-organization) with an etiology of general exposure to an extremely threatening or horrific event or series of events. A differential diagnosis of PTSD versus CPTSD is determined by the symptom profiles and is not dependent on the nature of the stressor (Cloitre, 2020). With these differences in mind and the lack of studies focusing on ICD-11 PTSD/CPTSD in LGBTQ+ individuals, the present study examined the factor structure of the ITQ (see measures section; Cloitre et al., 2018) that is used to gauge CPTSD, among LGBTQ+ adults from Spain. This is important as the cornerstone of optimal patient care begins with effective assessments. Furthermore, this study assesses minority stressors faced by LGBTQ+ individuals and their associations with PTSD and CPTSD symptom clusters.

## ICD-11 PTSD and CPTSD

The conceptualization of CPTSD was originally proposed by Herman (1992) to describe symptoms of long-term trauma that were associated with difficulties with emotion regulation, self-

identity, and interpersonal capacities, among other traumatic reactions (see Ford, 2019). The symptoms included in the ICD-11 CPTSD are based on those endorsed by populations exposed to chronic trauma in investigations of DSM-IV complex PTSD (Ford & Kidd, 1998) and observations by expert clinicians treating complex forms of PTSD (Cloitre et al., 2011). Additional research refined the symptom profile and resulted in the development of a now commonly used and validated measure, the ITQ (Cloitre et al., 2018). In 2018, CPTSD was formally accepted as a disorder by the World Health Organization in the 11th version of the ICD-11. Studies using the ITQ in community-based samples of adults (Cloitre et al., 2018) indicate the prevalence of PTSD and CPTSD combined ranges from 2% to 12.7% in high-income countries (see Cloitre, 2020). Specific to Spain, a study based on a high-risk sample, that is, women survivors of intimate partner violence ( $n = 162$ ), 17.9% were diagnosed with PTSD and 39.5% with CPTSD (Fernández-Fillol et al., 2021).

As mentioned, ICD-11 describes two distinct disorders: PTSD and CPTSD. PTSD consists of three symptom clusters: (a) reexperiencing of the trauma in the here and now (reexperiencing), (b) avoidance of traumatic reminders (avoidance), and (c) a persistent sense of current threat that is manifested by arousal and hypervigilance (threat). The PTSD symptoms are generally understood within a conditioning paradigm representing reactions of fear and horror to ongoing traumatic reminders. A sibling disorder of PTSD, CPTSD consists of the three symptom clusters of PTSD and three additional symptom clusters typically labeled DSO namely, (a) affective dysregulation (dysregulation), (b) negative self-concept, and (c) disturbances in relationships (relational disturbance) that take into account disruptions in self-organization that typically occur following exposure to chronic and/or multiple forms of traumatic events such as adverse interpersonal experiences (Brewin et al., 2017). Factor analytic studies consistently indicate a distinction between symptom clusters of PTSD and DSO as measured by ITQ and have found evidence for a correlated six-factor model comprising reexperiencing, avoidance, threat, dysregulation, negative self-concept, and relational disturbance, and a two-factor higher-order model (henceforth referred to as the hierarchical two-factor model; see review Redican et al., 2021). To determine whether this structure characterizes the PTSD and CPTSD symptoms in LGBTQ+ adults, the present study aimed to examine if these two models fit data obtained with the ITQ from LGBTQ+ adults in Spain.

Furthermore, CPTSD is a broader and more severe clinical disorder wherein the traumatic event also impacts an individual's emotion regulation capacity, beliefs about the self, and interpersonal relationships (see Brewin et al., 2017), and is typically associated with prolonged forms of trauma (Cloitre, 2020). Studies examining the additive effects of various types of lifetime traumatic events have found that exposure to multiple types of traumatic experiences is more strongly associated with CPTSD than with PTSD (Hyland,

<sup>1</sup>Gender diverse individuals are people whose gender identity, role, or expression differs from the culturally prescribed norms for people of a particular sex (e.g., transgender, agender, gender fluid, gender nonbinary).

Vallièrès, et al., 2021). These findings have been corroborated in community samples (e.g., Charak et al., 2022) and treatment-seeking samples (e.g., Karatzias et al., 2017). These findings have also suggested a dose-response effect of lifetime exposure to traumatic events on both PTSD and DSO symptoms. Given this, the present study examined the accumulating effect of traumatic events on factors of PTSD and DSO as measured by the ITQ, and their clusters at a latent variable level.

### Role of Minority Stressors Unique to LGBTQ+ Individuals

The minority stress framework posits that mental health disparities in LGBTQ+ individuals are a consequence of stigma, discrimination, and internalization of these prejudices (i.e., internalized homonegativity), and are not a result of any pathology related to their sexual orientation and gender identities (Brooks, 1981; Meyer, 2003). Although support for this framework has been found for internalizing disorders (Feinstein et al., 2012), substance use (Lehavot & Simoni, 2011; Villarreal et al., 2021), and DSM-5 PTSD (Dworkin et al., 2018; Solomon et al., 2021), no study has examined the role of minority stressors vis-à-vis the ICD diagnoses of PTSD and CPTSD. ICD-11's PTSD/CPTSD are conceptualized as responses to extremely threatening or horrific life events or series of events. Notably, indirect threats (e.g., emotional abuse) have been found to be associated with PTSD and CPTSD (Hyland, Karatzias, et al., 2021). For marginalized groups, such as LGBTQ+ individuals, exposure to minority stressors related to their sexual orientation and gender (e.g., social isolation, parental rejection) may be perceived as threatening and horrific (e.g., Schmitz & Charak, 2022; Szymanski & Balsam, 2011). Additional differences in the nosology of DSM-5 PTSD versus the ICD-11's PTSD and CPTSD as mentioned previously warrants the investigation of LGBTQ+ minority stressors' role in the development and prognosis of PTSD and CPTSD. Therefore, an additional aim of this study was to determine whether LGBTQ+ adults' exposure to minority stressors was associated with ICD-11's PTSD and CPTSD symptoms.

Minority stressors involve social and cultural discrimination and oppression of LGBTQ+ individuals. These stressors are rooted in the social beliefs, politics, policies, and discourses of heterosexism—prejudice toward sexual minority individuals based on the assumption that heterosexuality is the norm and superior—and cissexism—prejudice toward transgender and gender diverse individuals based on the assumption that identifying as cisgender is the norm—that causes social and internalized invalidations of LGBTQ+ individuals and are predictive of mental health problems (Dworkin et al., 2018; Villarreal et al., 2021). Exposure to minority stressors can further deplete or challenge one's repertoire of coping mechanisms when confronted by conventionally recognized forms of psychological trauma (e.g., natural disaster; motor vehicle accident), and this can lead to an increase in traumatic stress reactions (Hatzenbuehler, 2009). Related, prior studies examining pathways leading to DSM-5 PTSD suggest a predictive role of daily heterosexist experiences in trauma-exposed (per DSM-5 criterion A) sexual minority groups (Dworkin et al., 2018; Solomon et al., 2021). For instance, examining the associations between heterosexist experiences that fit traditional diagnostic criterion A for DSM-IV PTSD versus heterosexist experiences that did not fit criterion A (e.g., discrimination), Szymanski and Balsam (2011) found that both

experiences were uniquely and positively related to PTSD symptoms in lesbians. Furthermore, Dworkin et al. (2018) found that experiences of psychological trauma and daily heterosexism predicted PTSD symptoms through maladaptive post-trauma cognitions (e.g., self-blame) among lesbian and bisexual women, thus suggesting that minority stressors such as heterosexist experiences can exacerbate symptoms of PTSD in trauma-exposed sexual minorities. Notably, these studies are based on samples from the United States and there is a growing need to examine the lived experiences of LGBTQ+ individuals across different countries. Spain where the current study sample was collected, is recognized as a country that is strongly supportive of LGBTQ+ communities (Poushter & Kent, 2020). However, recent studies suggest that LGBTQ+ individuals in Spain continue to face discrimination, stigma, and harassment (Moya & Moya-Garófano, 2020) that increased during the COVID-19 pandemic (López-Sáez & Platero, 2022). These studies emphasize the need to gauge the minority stress experiences of LGBTQ+ individuals in Spain (and in various other countries) to aid in case conceptualization, intervention planning, and treatment (Livingston et al., 2020). In line with the dose-response framework described above, the present study will examine the relationship between cumulative exposure to both conventional psychological traumas and different heterosexist and cissexist experiences with PTSD and CPTSD symptoms.

### The Current Study

The present study had two aims. First, to examine the factor structure of the ITQ in LGBTQ+ adults from Spain. Based on a recent meta-analytic study, we first hypothesized that a correlated first-order six-factor model (where factors correspond to the six symptoms clusters of PTSD and DSO), and a hierarchical two-factor model (where higher-order PTSD and DSO factors capture covariation in the first-order factors), would optimally represent the latent structure of the ITQ in this sample (see Redican et al., 2021). To the best of our knowledge, this is the first study to examine the factor structure of the ITQ in LGBTQ+ adults. Aim 2 was to examine the unique associations between (a) cumulative exposure to lifetime traumatic events and (b) the cumulative effect of heterosexist minority stressors (henceforth referred to as cumulative minority stress), and symptoms of PTSD/CPTSD. We hypothesized that cumulative trauma and cumulative minority stress would be positively associated with PTSD and DSO symptoms, and the PTSD and DSO clusters of the ITQ (hypothesis 2; Cloitre et al., 2019; Hyland, Vallièrès, et al., 2021), and we explored the associations between specific minority stressors of heterosexism and cissexism with the six clusters of PTSD and DSO, and PTSD and DSO symptoms (Balsam et al., 2013; Dworkin et al., 2018).

## Method

### Participants and Procedure

Participants were 225 LGBTQ+ adults that included 75 gay, 35 lesbian, 90 bisexual, and 7 pansexual individuals in the age range of 18 and 60 years ( $M = 31.35$ ,  $SD = 9.48$ ) residing in Spain. Seventy-four participants identified as transgender or gender diverse. Participants' sexual orientation and gender identities are detailed in Table S1 in the online supplemental materials. This table indicates participants' sexual orientation, gender, and assigned

sex at birth, separately, with the intention of emphasizing the diversity in sexual orientation and gender identities that intersect (e.g., trans man and heterosexual, cis man and bisexual) and can lead to diverse positive and/or negative lived experiences. Participants self-identified mostly as Caucasian/Anglo-Saxon ( $n = 184$ , 82.5%) and to a lesser extent as Latinx ( $n = 23$ , 10.3%), Asian ( $n = 1$ , 0.4%), Biracial/multiracial ( $n = 4$ , 2.2%), and additional category not listed ( $n = 10$ , 4.5%). Most of the participants indicated being Spanish ( $n = 205$ , 91.9%), while 8.1% ( $n = 18$ ) indicated having a nationality other than that of Spain. Most of the participants indicated living in urban areas ( $n = 185$ , 82.2%) and few lived in rural areas ( $n = 40$ , 17.8%). Other demographic details are provided in Table S1 in the online supplemental materials.

Data collection for the present study took place from March 2021 to May 2021. After approval from the ethics committee at the Autonomous University of Madrid, the recruitment script for our study was posted in Spanish language on social media—Twitter, Facebook, and Instagram—under the title “Experiencias heterosexistas, relaciones interpersonales y salud mental en población LGBTQ+ adulta” (English translation: Heterosexist experiences, interpersonal relationships, and mental health in LGBTQ+ adults). Additionally, LGBTQ+ associations in Spain and LGBTQ+ influencers active in Spain were contacted to request their collaboration by posting the link for the survey on their social media profiles. Inclusion criteria were: (a) identifying as an LGBTQ+ person, (b) being 18 years or older, and (c) currently residing in Spain. Participants completed the online questionnaire via the Qualtrics platform. Survey completion took an estimated 35–50 min and was in Spanish. Informed consent was obtained from each participant at the beginning of the survey when they were also notified about confidentiality and the option to leave the study at any time without any type of penalty. All measures (except ITQ as a Spanish version exists; Fernández-Fillol et al., 2020) were translated and back-translated from English to Spanish, and back to English by two bilingual psychologists with graduate degrees from Spain. In case of discrepancy, a third bilingual psychologist with a doctoral degree was consulted.

## Measures

### Lifetime Traumatic Events

The LEC (Gray et al., 2004) is a 17-item self-report measure that screens for potentially traumatic life events as per the DSM-IV definition of a Criterion A event. For this study, lifetime exposure to 16 traumatic events (e.g., natural disaster, sexual assault, severe human suffering, serious injury, harm, or sudden death) was measured on a 5-point Likert scale which indicates the levels of exposure (1 = *Happened to me*, 2 = *Witnessed it happening to somebody else*, 3 = *Learned about it happening to someone close to me*, 4 = *Part of my job*, 5 = *Not sure it applies*, 6 = *Doesn't apply to my experience*). Items were recoded as (1) *presence*, those that indicated 1 (*Happened to me*) and all other options were coded as *absent* (0), except item 14 (*sudden violent death*) and item 15 (*sudden accidental death*) where option 2 was also recoded as present (1). The total score for the 16 items was calculated with scores ranging from 0 to 16.

### ICD-11 PTSD and CPTSD

ITQ is an 18-item self-report measure of ICD-11 PTSD and CPTSD (Cloitre et al., 2018). We used the Spanish translation of

ITQ that consists of 18 items (Fernández-Fillol et al., 2020) of which six items gauged the PTSD symptoms, and six items measured DSO symptoms. In addition, six items measured functional impairment, three related to the PTSD symptoms and three related to the DSO symptoms. PTSD symptoms are answered in relation to trauma per the LEC, and how bothersome they have been in the last month and the DSO symptoms are answered in relation to one's typical reactions. Items are answered on a 5-point Likert-type scale with options ranging from *not at all* (coded as 0) to *extremely* (coded as 4). A symptom is deemed to be present based on a score of 2 (moderately) or higher on the Likert scale (Cloitre et al., 2018). For the diagnosis of PTSD, participants had to endorse at least one symptom in each cluster of reexperiencing, avoidance, and threat, and endorse at least one of the functional impairment items. For a diagnoses of CPTSD, participants required at least one symptom in each PTSD cluster of reexperiencing (e.g., *Tener sueños perturbadores que reproducen parte de la experiencia o están claramente relacionados con la experiencia*), avoidance (e.g., *Evitar pensamientos, sentimientos, sensaciones físicas u otros estímulos internos que le recuerden la experiencia*), and threat (e.g., *Sentirse sobresaltado/a/e o asustarse fácilmente*) as well as at least one symptom in each DSO cluster, that is, dysregulation (e.g., *Cuando estoy molesto/a/e, tarde bastante tiempo en calmarme*), negative self-concept (e.g., *Me siento inútil*), and relational disturbance (e.g., *Me resulta difícil estar emocionalmente cercano/a/e a la gente*), and endorse one of the functional impairment items each for the PTSD and DSO. The Spanish version of ITQ was translated and back-translated, verified and explored for appropriate linguistic and cultural context by a group of experts in the original article by Fernández-Fillol et al. (2020). The internal reliability of the PTSD ( $\alpha = 0.87$ ) and DSO ( $\alpha = 0.88$ ) subscale scores in this sample was good.

### Minority Stressors

The Daily Heterosexist Experiences Questionnaire (DHEQ; Balsam et al., 2013) is a 50-item measure that assesses minority stress as experienced in heterosexist and cissexist attitudes and behaviors across nine domains. It was used to assess minority stress during the past 12 months. For the present study, only the subscales of gender expression (i.e., harassed in public because of your gender expression), vigilance (i.e., watching what you say and do around heterosexual people), discrimination/harassment (i.e., verbally harassed because you are LGBTQ+), vicarious trauma (i.e., hearing about LGBTQ+ people you know being treated unfairly), rejection by the family of origin (i.e., rejected by your mother for being LGBTQ+), and isolation were used (i.e., few people you can talk to about being LGBTQ+) that comprised 34 items were used. The six dimensions were selected as they are most frequently used in the existing literature on minority stressors, and have proven to be reliable for assessing daily heterosexist experiences of cis- and trans LGBTQ+ individuals (e.g., Landes et al., 2021), and are not exclusive to specific stressors of the LGBTQ+ population, such as the HIV status or the parenting dimensions, which are intended only for people with HIV positive status or those with children, respectively.

Each item is measured on a 6-point Likert scale indicating the presence/absence of the stressor and the impact on the individual (0 = *Did not happen/not applicable to me*, or *it happened*, and



1 = it bothered me not at all, 2 = it bothered me a little bit, 3 = it bothered me moderately, 4 = it bothered me quite a bit, 5 = it bothered me extremely). As recommended by Balsam et al. (2013) items were recoded as present (1), if the participants responded with options 1–5, and absent (0), to calculate total scores. A total score for each subscale was calculated by adding all the items, and a cumulative score for the scale was calculated by adding all the items. In this sample, each subscale demonstrated an acceptable internal consistency based on the Likert-scale scores (harassment due to gender expression:  $\alpha = 0.71$ ; vigilance:  $\alpha = 0.79$ ; discrimination/harassment:  $\alpha = 0.78$ ; vicarious trauma:  $\alpha = 0.73$ ; rejection by the family of origin:  $\alpha = 0.75$ ; and isolation  $\alpha = 0.70$ ).

### Data Analytic Approach

First, descriptive statistics of the study variables were conducted in IBM SPSS version 26. Second, confirmatory factor analyses were conducted in *Mplus* version 8.4 to assess the latent structure of the ITQ. Models 1 and 2 represented the first-order six-factor model and hierarchical two-factor model, respectively (see Figures S1 and S2 in the online supplemental materials). Third, structural equation modeling was used to (a) determine the association between cumulative trauma and cumulative minority stress, with the first-order six-factor model, and the hierarchical two-factor model; and (b) the association between cumulative trauma and the six types of minority stress heterosexist experiences, namely, harassment due to gender expression, vigilance, discrimination/harassment, vicarious trauma, rejection by the family of origin, and isolation, and the first-order six-factor model, and hierarchical two-factor model. The predictor variables were allowed to correlate with each other in these models.

Each model was specified and estimated using robust maximum likelihood. Goodness-of-fit for each model was assessed using the chi-square ( $\chi^2$ ), comparative fit index (CFI), Tucker–Lewis Index (TLI), root mean square error of approximation (RMSEA), and standardized root mean square residual (SRMR). Acceptable model fit was considered when the chi-square was non-significant, the CFI and TLI were greater than 0.90, and the RMSEA and SRMR were less than 0.08 (Hu & Bentler, 1999). Additionally, to compare the models the Akaike information criterion (AIC), Bayesian information criterion (BIC), and sample size adjusted BIC (SSABIC) were used wherein the model with the lowest score on these criteria is considered superior.

## Results

### Descriptive Statistics

Descriptive statistics for cumulative exposure to psychological trauma and to minority stressors, and for six types of minority stress experiences, are reported in Table 1. The psychological traumas most often reported on the LEC by the participants were “unwanted or uncomfortable sexual experience” other than sexual assault ( $n = 115$ , 51.1%) and “physical assaults” ( $n = 88$ , 28.1%), followed by “sexual assault” ( $n = 68$ , 30.2%). More than a quarter of the sample ( $n = 60$ ; 26.7%) indicated being exposed to at least one type of traumatic event on the LEC, 31.6% ( $n = 71$ ) to two traumatic events, 11.1% ( $n = 35$ ) to 3–4 events, 11.2% ( $n = 25$ ) reported exposure to 5–6 traumatic events, and a small percentage (3.9%,  $n = 9$ ) reported 7–9 traumatic events. Almost all the participants (92.6%) had

experienced minority stressors related to heterosexism and cissexism. Correlation values between study variables are available in Table S2 in the online supplemental materials. Nearly 6% of participants met the criteria for PTSD ( $n_{\text{total}} = 13$ ;  $n_{\text{transgender/gender diverse}} = 7$ ;  $n_{\text{cisgender}} = 6$ ) and 19.1% met the criteria for CPTSD ( $n_{\text{total}} = 43$ ;  $n_{\text{transgender/gender diverse}} = 23$ ;  $n_{\text{cisgender}} = 20$ ). These diagnoses are mutually exclusive. For distribution of PTSD and CPTSD across sexual orientation and gender see Table S3 in the online supplemental materials.

### The Factor Structure of the ITQ

Goodness-of-fit indices (Table 2) indicated that the first-order six-factor model (model 1) and the hierarchical two-factor model (model 2) fit the data well. Although the BIC of the hierarchical two-factor model was lower than the first-order six-factor model, the SSABIC indicated similar values across the two models. The factor loadings for the first-order six-factor model ranged from 0.53 to 0.94, and the factor correlations ranged from 0.41 to 0.80. The factor loadings were 0.79 to 0.98 ( $p < .05$ ; see Figures S1 and S2 in the online supplemental materials), and factor correlation between PTSD and DSO was positive and statistically significant ( $r = .69$ ,  $p < .001$ ) for the hierarchical two-factors model.

Next, in separate models, the six first-order factors and two second-order factors were regressed on cumulative trauma and cumulative minority stress creating models 3 and 4, respectively (see Figures S3 and S4 in the online supplemental materials). As shown in Table 3, for model 3, findings indicated that the LEC score for cumulative trauma was positively associated with threat whereas cumulative minority stress was positively associated with all first-order six factors. Model 4 suggested that the LEC score for cumulative trauma was positively associated with PTSD only, whereas cumulative minority stress was positively associated with both PTSD and DSO (Table 3).

Finally, the six first-order factors and two second-order factors were separately regressed on the LEC score for cumulative trauma and scores for the six minority stress subtypes from the DHEQ—harassment due to gender expression, vigilance, discrimination/harassment, vicarious trauma, rejection by the family of origin, and isolation, creating model 5 (see Figure S5 in the online supplemental materials). As shown in Table 3, cumulative exposure to multiple types of psychological trauma on the LEC still was significantly associated only with threat, and heterosexism or cissexism related to gender expression was positively associated with all the PTSD (reexperiencing, avoidance, threat) and DSO (dysregulation, negative self-concept, and relational disturbance) factors. Discrimination and harassment were positively associated with reexperiencing, vicarious trauma with negative self-concept, and isolation was positively associated with relational disturbances. Similarly, when the hierarchical two factors were regressed on cumulative trauma and minority stress subtypes creating model 6 (see Figure S6 in the online supplemental materials), the LEC score for cumulative trauma was associated with PTSD only, but harassment due to gender expression was positively associated with PTSD and DSO, and isolation was positively associated with DSO.

## Discussion

The present findings support the factorial validity of the ITQ with the first-order six-factor model and the hierarchical two-factor model

**Table 1**  
Percentage Distribution of Traumatic Events, Minority Stress, and PTSD and DSO

Traumatic event	n (%)	Variables	n (%)	M/SD	Range
Other unwanted sexual experience	115 (51.1)	Cumulative trauma	—	2.70/1.70	0–10
Physical assault	87 (38.7)	Cumulative minority stress	—	18.92/6.77	0–34
Sexual assault	68 (30.2)	DHE Gender expression	190 (86.2)	2.56/1.82	0–6
Life-threatening illness/injury	64 (28.4)	DHE Vigilance	208 (92.4)	3.49/1.92	0–6
Transportation accident	63 (28.0)	DHE Discrimination/harassment	197 (87.6)	3.00/1.97	0–6
Sudden, unexpected death of someone close to you	61 (27.1)	DHE Vicarious trauma	223 (99.6)	5.70/0.84	0–6
Severe human suffering	41 (18.4)	DHE Family of origin	163 (73.1)	1.98/1.82	0–6
Natural disaster	38 (16.9)	DHE Isolation	188 (83.9)	2.19/1.43	0–4
Sudden, violent death	31 (13.8)	PTSD	13 (5.9)	—	—
Assault with a weapon	28 (12.6)	CPTSD	43 (19.1)	—	—
Fire or explosion	25 (11.1)				
Serious accident	15 (6.7)				
Exposure to toxic substance	9 (4.0)				
Combat/warzone	4 (1.8)				
Captivity	4 (1.8)				
Serious injury, harm, or death you caused to someone else	0 (0)				

Note. DHE = daily heterosexist experiences; PTSD = posttraumatic stress disorder; CPTSD = complex posttraumatic stress disorder; DSO = disturbances in self-organization.

(comprising PTSD and DSO as the second-order factors) providing an excellent fit to the sample data derived from trauma-exposed LGBTQ+ adults from Spain (hypothesis 1 supported). Additionally, we found partial support for hypothesis 2 in that cumulative exposure to conventional types of psychological trauma and cumulative minority stress were positively associated, albeit differentially, with PTSD and DSO (Balsam et al., 2013; Dworkin et al., 2018). In addition, specific effects were observed between types of heterosexist and cissexist minority stressors and the first-order six symptom clusters. Notably, a third of our sample self-identified as transgender and gender diverse, which increases the gender diversity of our sample as prior studies on PTSD focus on sexually diverse individuals (i.e., gay, lesbian, bisexual individuals).

Although not included in study hypotheses, it is notable that LGBTQ+ adults in the present study more frequently met criteria for CPTSD (i.e., 19.1%) than did a number of non-clinical adult samples across developed nations (e.g., Israel: 2.6% CPTSD; Ben-Ezra et al., 2018; Ireland: 7.7% CPTSD; Hyland, Vallières, et al., 2021). In the present study, transgender and gender diverse

individuals and cisgender individuals had similar rates of PTSD and CPTSD. Notably, pansexual, asexual, and individuals with sexual orientations not listed in the survey ( $M/SD = 3.47/2.59$ ) and transgender and gender diverse individuals ( $M/SD = 3.12/2.05$ ) had higher mean/SD scores on cumulative trauma (see Table S3 in the online supplemental materials). The mean/SD of the count score of the minority stressors were similar to those found in prior studies on LGBTQ+ adults (Balsam et al., 2013) indicative of the representativeness of minority stressors in the present sample from Spain, and also the widespread nature of minority stressors in LGBTQ+ adult samples.

Support for the two-factor analytical models suggests the distinctiveness of PTSD and CPTSD as separate disorders as measured by the ITQ in LGBTQ+ adults. Notably, the factor correlation between PTSD and DSO was moderate ( $r = .65$ ) in the hierarchical two-factor model, which is in line with prior studies comparing the two constructs (Charak et al., 2022; Redican et al., 2021). Together, the present findings and prior studies indicate that there is an association between the two constructs of PTSD and DSO; however, they are conceptually different. Findings also suggest

**Table 2**  
Model Fit Indices

Models	Chi-square (df)	RMSEA [90% CI]	CFI/TLI	SRMR	AIC	BIC	SSABIC
1. First-order six factors	45.732*** (39)	0.028 [0.000–0.056]	0.994 /0.991	0.024	7,564.713	7,738.934	7,577.305
2. Hierarchical two factors	55.019*** (47)	0.028 [0.000–0.054]	0.993/0.991	0.029	7,558.798	7,705.690	7,569.414
Models with predictors							
3. First-order six factors with predictors as cumulative trauma and cumulative minority stress	57.457*** (51)	0.024 [0.000–0.051]	0.995/0.991	0.024	9,906.495	10,138.789	9,923.284
4. Hierarchical two factors with predictors as cumulative trauma and cumulative minority stress	73.728*** (67)	0.021 [0.000–0.046]	0.995/0.993	0.031	9,891.465	10,069.103	9,904.304
5. First-order six factors with predictors as cumulative trauma and minority stress subtypes	89.650*** (81)	0.022 [0.000–0.044]	0.994/0.989	0.024	13,158.451	13,595.712	13,190.054
6. Hierarchical two factors with predictors as cumulative trauma and minority stress subtypes	141.924*** (117)	0.031 [0.000–0.047]	0.982/0.977	0.036	13,139.523	13,453.804	13,162.237

\*\*\* $p < .001$ . AIC = Akaike information criterion; BIC = Bayesian information criterion; SSABIC = sample size adjusted BIC; RMSEA = Root Mean Square Error of Approximation; CFI/TLI = comparative fit index/Tucker–Lewis Index; SRMR = Standardized Root Mean Square Residual.

**Table 3**

*Regression of Factor Analytic Models of PTSD/CPTSD Onto Cumulative Trauma, Cumulative Heterosexist Minority Stress, and Heterosexist Minority Stress Types*

	First-order six-factor model				Hierarchical two-factor model			
	Model 3				Model 4			
	RE	AV	TH	AD	NSC	DR	PTSD	DSO
Cumulative trauma	0.110	0.101	0.164*	0.019	-0.033	0.013	0.154*	0.001
Cumulative minority stress	0.312***	0.254***	0.273***	0.243**	0.264***	0.310***	0.322***	0.306***
R-squared	0.129*	0.089*	0.126*	0.062	0.066*	0.098*	0.154**	0.094*
	Model 5				Model 6			
Cumulative trauma	0.123	0.096	0.154*	0.031	-0.005	0.051	0.150*	0.029
DHE gender expression	0.199*	0.168*	0.294***	0.251**	0.249**	0.271**	0.269**	0.289**
DHE vigilance	-0.119	-0.099	-0.097	-0.077	-0.029	-0.043	-0.121	-0.059
DHE Discrimination/Harassment	0.291**	0.195	0.081	-0.073	-0.033	-0.037	0.190	-0.058
DHE vicarious trauma	0.038	0.109	-0.023	0.104	0.132*	0.016	0.037	0.100
DHE rejection by family	-0.101	0.041	0.071	0.070	0.010	-0.027	0.018	0.025
DHE isolation	0.134	-0.031	0.062	0.142	0.113	0.297***	0.071	0.204*
R-squared	0.216***	0.144**	0.201***	0.133**	0.121**	0.213***	0.234***	0.185***

*Note.* Values are standardized co-efficient. DHE = daily heterosexist experiences; PTSD = posttraumatic stress disorder; DSO = disturbances of self-organization; RE = reexperiencing; AV = avoidance; TH = sense of threat; AD = affective dysregulation; NSC = negative self-concept; DSO = disturbances in relation.

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

that when working with LGBTQ+ adults, ITQ scores on the dimensions of PTSD and DSO, and their six clusters can be used for the purpose of research, although future studies should focus on replicating the present findings in a treatment-seeking LGBTQ+ sample.

In partial support of hypothesis 2, findings indicated that cumulative lifetime exposure to multiple types of traumatic events was associated with PTSD but not DSO, while cumulative minority stress was associated with both PTSD and DSO. The limited association of cumulative trauma as assessed by the LEC with PTSD is in contrast with prior findings that cumulative trauma exposure was associated with both PTSD and DSO (e.g., Hyland, Vallières, et al., 2021). The divergent results may be due to methodological differences: notably these studies did not analyze the first-order six factors as done in the present study. Although the cumulative trauma score in the present study was similar to rates found in prior studies from other European countries (Hyland, Vallières, et al., 2021), it should be noted that lifetime traumatic events measured via the LEC did not distinguish between LGBTQ+ identity related versus non-LGBTQ+ identity-related instances. Future studies should examine the unique role of LGBTQ+ identity-related traumatic stressors (e.g., sexual assault due to discrimination/stigmatization) versus exposure to conventional traumatic events (e.g., natural disaster) on PTSD/CPTSD to disentangle the associations of identity-related traumatic stressors, compared other types of traumatic stressors, with the symptoms of PTSD and CPTSD.

Furthermore, there was a positive association between cumulative minority stress, PTSD, and DSO, and related clusters (i.e., the six first-order factors). Our findings suggest that minority stressors can have an adverse cumulative effect leading to traumatic stress reactions, such as symptoms of CPTSD, in trauma-exposed LGBTQ+ adults. While these findings are the first to examine the role of LGBTQ+ identity-related minority stressors on symptoms of PTSD/CPTSD per ICD-11, prior literature emphasizes the need to examine minority stressors as forms of insidious trauma when investigating PTSD, along with widely studied conventional traumatic

events (e.g., LEC) that are found across individuals irrespective of one's identities (Szymanski & Balsam, 2011).

Examination of the specifics of heterosexist minority stress indicated that heterosexist experiences related to gender expression were associated with an increase in all six symptom clusters of the ITQ and the two higher-order factors of PTSD and DSO. Since gender expression is overt, it may be that individuals with nonconforming gender expressions face chronic and heightened marginalization and stigmatization that are associated with symptoms of CPTSD (Bos et al., 2019; Pantalone et al., 2017). Our findings that discrimination and vicarious trauma were associated with an increase in symptoms of reexperiencing and negative self-concept, respectively, and were not associated with the higher-order factor of PTSD or DSO, perhaps suggest that these two aspects of minority stress trigger memories of trauma when faced with a traumatic and stressful event (Thompson, 2006) and can initiate feelings of helplessness and worthlessness by observing societal marginalization and stigmatization of LGBTQ+ individuals (Schmitz & Charak, 2022). Findings that heterosexist minority stress-related isolation—difficulty finding partners, friends, feeling of not fitting in—was associated with an increase in relational disturbance is not surprising as the two constructs are semantically similar. Notably, isolation was significantly associated with only DSO and not PTSD. Together, these findings suggest the importance of gauging the role of minority stressors in LGBTQ+ adults along with exposure to traumatic events during PTSD/CPTSD-related interventions.

The present study findings should be interpreted with the following limitations in mind. First, the study was based on a convenience sample of LGBTQ+ identifying adults from Spain and cannot be generalized to LGBTQ+ populations at large. Second, this study was based on a cross-sectional design. Third, as mentioned, when inquiring about lifetime traumatic events measured via the LEC a distinction was not made between LGBTQ+ identity-related and non-LGBTQ+ identity (i.e., conventional) related events. Fourth, data were collected online in Spanish and from those with internet

access. This may limit the sample to those with access to the internet who are invariably in urban settings, and are likely to be more educated and have higher socio-economic status.

The present study findings have important implications and provide direction for future research. The ITQ can be used to assess PTSD/CPTSD when working with LGBTQ+ individuals. Findings emphasize the importance of taking an integrative approach by assessing unique LGBTQ+ identity-related stressors along with conventionally defined traumatic events when providing behavioral healthcare services to sexual and/gender diverse individuals. For instance, clinicians can gauge if identity-related discrimination interferes with help-seeking behavior from peers, family, and police as the client may expect negative reactions (Pantalone et al., 2017). Such an approach would facilitate a clinician's understanding of minority stress factors associated with PTSD/CPTSD symptomatology. Based on the assessment phase, in the intervention phase, it is important to engage in affirmative practices that are consistent with evidence-based treatments (see Effective Skills to Empower Effective Men [ESTEEM]; Pachankis et al., 2015). Affirmative practices are already a part of the recommended and evidence-based treatments and include for instance clinicians supporting clients in defining their own values and beliefs in their words and in navigating their way to positive and affirming social connections in stigma-laden locales (Pantalone et al., 2017). Future studies should focus on corroborating the present findings in treatment-seeking LGBTQ+ individuals and consider multiple marginalized intersecting identities (e.g., race, ethnicity, immigration status). Longitudinal designs should be used to parse out the role of minority stressors alongside exposure to conventional traumatic events and gauge if minority stressors maintain and/or exacerbate the symptom complexity caused by traumatic events. With growing scientific evidence for the validity of PTSD and CPTSD via ICD-11-based measures (e.g., ITQ) across diverse samples, the DSM working committees should deliberate on this newer scientific evidence.

In conclusion, our findings support the distinctiveness between ICD-11's PTSD and CPTSD, as measured by ITQ, and to the best of our knowledge, this is the first study to examine these models in LGBTQ+ adults. LGBTQ+ adults are at risk for PTSD and CPTSD, and therefore it is essential to understand how both conventional and minority stressors may be traumagenic in this vulnerable population—and how this may differ for subgroups who have different sexual orientations and gender identities. Unique to our study are the findings that support the cumulative and detrimental role of exposure to LGBTQ+ identity-related minority stressors on clusters of PTSD and DSO. Future studies focusing on LGBTQ+ individuals are warranted by these findings.

## References

- Balsam, K. F., Beadnell, B., & Molina, Y. (2013). The Daily Heterosexist Experiences Questionnaire: Measuring minority stress among lesbian, gay, bisexual, and transgender adults. *Measurement and Evaluation in Counseling and Development*, 46(1), 3–25. <https://doi.org/10.1177/0748175612449743>
- Bauerband, L. A., Teti, M., & Velicer, W. F. (2019). Measuring minority stress: Invariance of a discrimination and vigilance scale across transgender and cisgender LGBQ individuals. *Psychology and Sexuality*, 10(1), 17–30. <https://doi.org/10.1080/19419899.2018.1520143>
- Ben-Ezra, M., Karatzias, T., Hyland, P., Brewin, C. R., Cloitre, M., Bisson, J. I., Roberts, N. P., Lueger-Schuster, B., & Shevlin, M. (2018). Posttraumatic stress disorder (PTSD) and complex PTSD (CPTSD) as per ICD-11 proposals: A population study in Israel. *Depression and Anxiety*, 35(3), 264–274. <https://doi.org/10.1002/da.22723>
- Bos, H., de Haas, S., & Kuyper, L. (2019). Lesbian, gay, and bisexual adults: Childhood gender nonconformity, childhood trauma, and sexual victimization. *Journal of Interpersonal Violence*, 34(3), 496–515. <https://doi.org/10.1177/0886260516641285>
- Bovin, M. J., Camden, A. A., & Weathers, F. W. (2021). Literature on DSM-5 and ICD-11: An update. *PTSD Research Quarterly*, 32(2), 1050–1835.
- Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., Humayun, A., Jones, L. M., Kagee, A., Rousseau, C., Somasundaram, D., Suzuki, Y., Wessely, S., van Ommeren, M., & Reed, G. M. (2017). A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clinical Psychology Review*, 58, 1–15. <https://doi.org/10.1016/j.cpr.2017.09.001>
- Brooks, V. R. (1981). *Minority stress and lesbian women*. Lexington Books.
- Charak, R., Cano-Gonzalez, I., Shevlin, M., Ben-Ezra, M., Karatzias, T., & Hyland, P. (2022). Dimensional latent structure of ICD-11 posttraumatic stress disorder, complex PTSD, and adjustment disorder: Evidence from Ghana, Kenya, and Nigeria. *Traumatology*, 28(2), 223–234. <https://doi.org/10.1037/trm0000311>
- Charak, R., Villarreal, L., Schmitz, R. M., Hirai, M., & Ford, J. D. (2019). Patterns of childhood maltreatment and intimate partner violence, emotion dysregulation, and mental health symptoms among lesbian, gay, and bisexual emerging adults: A three-step latent class approach. *Child Abuse and Neglect*, 89, 99–110. <https://doi.org/10.1016/j.chiabu.2019.01.007>
- Cloitre, M. (2020). ICD-11 complex post-traumatic stress disorder: Simplifying diagnosis in trauma populations. *The British Journal of Psychiatry*, 216(3), 129–131. <https://doi.org/10.1192/bjp.2020.43>
- Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of Traumatic Stress Studies*, 24(6), 615–627. <https://doi.org/10.1002/jts.20697>
- Cloitre, M., Hyland, P., Bisson, J. I., Brewin, C. R., Roberts, N. P., Karatzias, T., & Shevlin, M. (2019). ICD-11 posttraumatic stress disorder and complex posttraumatic stress disorder in the United States: A population-based study. *Journal of Traumatic Stress*, 32(6), 833–842. <https://doi.org/10.1002/jts.22454>
- Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., Karatzias, T., & Hyland, P. (2018). The International Trauma Questionnaire: Development of a self-report measure of ICD-11 PTSD and complex PTSD. *Acta Psychiatrica Scandinavica*, 138(6), 536–546. <https://doi.org/10.1111/acps.12956>
- Dworkin, E. R., Gilmore, A. K., Bedard-Gilligan, M., Lehavot, K., Guttmannova, K., & Kaysen, D. (2018). Predicting PTSD severity from experiences of trauma and heterosexism in lesbian and bisexual women: A longitudinal study of cognitive mediators. *Journal of Counseling Psychology*, 65(3), 324–333. <https://doi.org/10.1037/cou0000287>
- Feinstein, B. A., Goldfried, M. R., & Davila, J. (2012). The relationship between experiences of discrimination and mental health among lesbians and gay men: An examination of internalized homonegativity and rejection sensitivity as potential mechanisms. *Journal of Consulting and Clinical Psychology*, 80(5), 917–927. <https://doi.org/10.1037/a0029425>
- Fernández-Fillol, C., Hidalgo-Ruzzante, N., Perez-Garcia, M., & Daugherty, J. C. (2020). Translation and adaptation of the Spanish version of the international trauma questionnaire (ITQ) following ITC guidelines for translating and adapting tests. PsyArXiv. <https://doi.org/10.31234/osf.io/gps7k>
- Fernández-Fillol, C., Pitsiakou, C., Perez-Garcia, M., Teva, I., & Hidalgo-Ruzzante, N. (2021). Complex PTSD in survivors of intimate partner violence: Risk factors related to symptoms and diagnoses.



- European Journal of Psychotraumatology*, 12(1), Article 2003616. <https://doi.org/10.1080/20008198.2021.2003616>
- Ford, J. D. (2019). Commentary on the special section on complex PTSD: Still going strong after all these years. *Journal of Traumatic Stress*, 32(6), 877–880. <https://doi.org/10.1002/jts.22474>
- Ford, J. D., & Kidd, P. (1998). Early childhood trauma and disorders of extreme stress as predictors of treatment outcome with chronic posttraumatic stress disorder. *Journal of Traumatic Stress*, 11(4), 743–761. <https://doi.org/10.1023/A:1024497400891>
- Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. *Assessment*, 11(4), 330–341. <https://doi.org/10.1177/1073191104269954>
- Hatzenbuehler, M. L. (2009). How does sexual minority stigma “get under the skin”? A psychological mediation framework. *Psychological Bulletin*, 135(5), 707–730. <https://doi.org/10.1037/a0016441>
- Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377–391. <https://doi.org/10.1002/jts.2490050305>
- Hu, L. T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling*, 6(1), 1–55. <https://doi.org/10.1080/10705519909540118>
- Hyland, P., Karatzias, T., Shevlin, M., McElroy, E., Ben-Ezra, M., Cloitre, M., & Brewin, C. R. (2021). Does requiring trauma exposure affect rates of ICD-11 PTSD and complex PTSD? Implications for DSM-5. *Psychological Trauma: Theory, Research, Practice, and Policy*, 13(2), 133–141. <https://doi.org/10.1037/tra0000908>
- Hyland, P., Vallières, F., Cloitre, M., Ben-Ezra, M., Karatzias, T., Olf, M., Murphy, J., & Shevlin, M. (2021). Trauma, PTSD, and complex PTSD in the Republic of Ireland: Prevalence, service use, comorbidity, and risk factors. *Social Psychiatry and Psychiatric Epidemiology*, 56(4), 649–658. <https://doi.org/10.1007/s00127-020-01912-x>
- Karatzias, T., Shevlin, M., Fyvie, C., Hyland, P., Efthymiadou, E., Wilson, D., Roberts, N., Bisson, J. I., Brewin, C. R., & Cloitre, M. (2017). Evidence of distinct profiles of posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD) based on the new ICD-11 trauma questionnaire (ICD-TQ). *Journal of Affective Disorders*, 207, 181–187. <https://doi.org/10.1016/j.jad.2016.09.032>
- Landes, S. J., Jaffe, A. E., McBain, S. A., Feinstein, B. A., Rhew, I. C., & Kaysen, D. L. (2021). Prospective predictors of work limitations in young adult lesbian and bisexual women: An examination of minority stress, trauma exposure, and mental health. *Stigma and Health*. Advance online publication. <https://doi.org/10.1037/sah0000292>
- Lehavot, K., & Simoni, J. M. (2011). The impact of minority stress on mental health and substance use among sexual minority women. *Journal of Consulting and Clinical Psychology*, 79(2), 159–170. <https://doi.org/10.1037/a0022839>
- Livingston, N. A., Berke, D., Scholl, J., Ruben, M., & Shipherd, J. C. (2020). Addressing diversity in PTSD treatment: Clinical considerations and guidance for the treatment of PTSD in LGBTQ populations. *Current Treatment Options in Psychiatry*, 7(2), 53–69. <https://doi.org/10.1007/s40501-020-00204-0>
- López-Sáez, M.Á., & Platero, R. L. (2022). Spanish youth at the crossroads of gender and sexuality during the COVID-19 pandemic. *European Journal of Women's Studies*, 29(1\_suppl), 90S–104S. <https://doi.org/10.1177/13505068221076319>
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>
- Moya, M., & Moya-Garófano, A. (2020). Discrimination, work stress, and psychological well-being in LGBTI workers in Spain. *Intervención Psicosocial*, 29(2), 93–101. <https://doi.org/10.5093/pi2020a5>
- Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology*, 83(5), 875–889. <https://doi.org/10.1037/ccp0000037>
- Pantalone, D. W., Valentine, S. E., & Shipherd, J. C. (2017). Working with survivors of trauma in the sexual minority and transgender and gender non-conforming populations. In K. A. DeBord, A. R. Fischer, K. J. Bieschke, & R. M. Perez (Eds.), *Handbook of sexual orientation and gender diversity in counseling and psychotherapy* (pp. 183–211). American Psychological Association. <https://doi.org/10.1037/15959-008>
- Poushter, J., & Kent, N. (2020). *The global divide on acceptance of homosexuality*. Pew Research Center. <https://www.pewresearch.org/global/2020/06/25/global-divide-on-homosexuality-persists/>
- Redican, E., Nolan, E., Hyland, P., Cloitre, M., McBride, O., Karatzias, T., Murphy, J., & Shevlin, M. (2021). A systematic literature review of factor analytic and mixture models of ICD-11 PTSD and CPTSD using the International Trauma Questionnaire. *Journal of Anxiety Disorders*, 79, Article 102381. <https://doi.org/10.1016/j.janxdis.2021.102381>
- Schmitz, R. M., & Charak, R. (2022). “I went into this as one person, and then came out a totally different person”: Native LGBTQ2S+ young adults’ conceptions of trauma. *Journal of Interpersonal Violence*, 37(5–6), NP3293–NP3319. <https://doi.org/10.1177/0886260520948523>
- Solomon, D. T., Combs, E. M., Allen, K., Roles, S., DiCarlo, S., Reed, O., & Klaver, S. J. (2021). The impact of minority stress and gender identity on PTSD outcomes in sexual minority survivors of interpersonal trauma. *Psychology and Sexuality*, 12(1–2), 64–78. <https://doi.org/10.1080/19419899.2019.1690033>
- Szymanski, D. M., & Balsam, K. F. (2011). Insidious trauma: Examining the relationship between heterosexism and lesbians’ PTSD symptoms. *Traumatology*, 17(2), 4–13. <https://doi.org/10.1177/1534765609358464>
- Thompson, V. L. S. (2006). Coping responses and the experience of discrimination. *Journal of Applied Social Psychology*, 36(5), 1198–1214. <https://doi.org/10.1111/j.0021-9029.2006.00038.x>
- Villarreal, L., Charak, R., Schmitz, R. M., Hsieh, C., & Ford, J. D. (2021). The relationship between sexual orientation outness, heterosexism, emotion dysregulation, and alcohol use in gay, lesbian, and bisexual emerging adults. *Journal of Gay and Lesbian Mental Health*, 25(1), 94–115. <https://doi.org/10.1080/19359705.2020.1809588>

Received March 12, 2022

Revision received November 6, 2022

Accepted November 16, 2022 ■