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Validation of the Early Trauma Inventory Self Report-Short Form and Trauma Prevalence in Colombia

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Objective: Early traumatic experiences are related to profound and long-lasting negative effects on mental and physical health. Colombia has been involved in a war for the last six decades. Thus, the main objective was to adapt and validate the Early Trauma Inventory Self Report-Short Form in Colombia, as well as assess trauma prevalence in this country. ***Method:*** For this purpose, a total of 2,080 Colombians participated in this study (57.3% women and 42.4% men). Age ranged from 18 to 77 years old. They answered the 27-item version of the Early Trauma Inventory Self Report-Short Form and a sociodemographic evaluation tool. Web-based sampling was carried out between March 16 and March 30, 2020. ***Results:*** Original four factor structure was successfully explored and confirmed here. Reliability indexes were good with alphas ranging from .69 to .93. Items properties were also adequate. Most of the assessed sample suffered trauma in their early stages (99.8%). Gender differences were analyzed observing significant differences. As expected, sexual abuse is more prevalent in women. ***Conclusions:*** To the best of our knowledge, the Colombian population has suffered the highest prevalence of early trauma experiences so far when compared to other countries. Emotional and social implications are discussed.

Clinical Impact Statement
In Colombia, 99.8% of the evaluated sample presented events of trauma during childhood. The repercussions on the mental health of Colombia are not yet clear, but public policies should be created to reduce exposure to these events.

Keywords: Early Trauma Inventory, trauma, Colombia, posttraumatic stress, Latin

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Early traumatic experiences (ETIs) are related to profound and long-lasting negative effects on mental and physical health (Croft et al., 2019). There is increasing evidence of such effects on a variety of aspects. ETIs can affect physical health (Porcerelli et al., 2017; Rueness et al., 2020) by affecting a multitude of processes, such as increasing the likelihood of suffering from cardiovascular (Kendall-Tackett, 2007; Kumari & Mukhopadhyay, 2020), respiratory and gastrointestinal diseases (Bradford et al., 2012; Sowder et al., 2018), chronic pain (Kendall-Tackett et al., 2003), immune system deficiencies (Baumeister et al., 2016. Danese & Lewis, 2017), fibromyalgia (Haviland et al., 2010), sleep disorders (Clum et al., 2001), obesity (Danese & Tan, 2013), migraines (Tietjen et al., 2010), among others. Furthermore, ETIs can also reduce treatment adherence (Klest et al., 2019; Kumari & Mukhopadhyay,

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2020), and have profound impacts on mental health (Copeland et al., 2018; Devi et al., 2019; El-Khodary & Samara, 2020; Larson et al., 2017; Sweeney, & Taggart, 2018), effects that are related to increasing the risk of posttraumatic stress (Breuer et al., 2020; Kessler et al., 2017; Voth Schrag & Edmond, 2018), psychotic disorders (Devi et al., 2019; Mørkved et al., 2017), depression (Dunn et al., 2017; Xie et al., 2018), anxiety disorders (Devi et al., 2019; Syed Sheriff et al., 2019), bipolar disorder (Green et al., 2016; Xie et al., 2018), acute stress (Holman et al., 2020), borderline personality disorder (Breuer et al., 2020), dissociative disorders (Akyüz et al., 2017), adjustment disorders (O'Donnell et al., 2016), and suicide attempts (DiGuiseppi et al., 2020). ETIs are also predictors of problems related to alcohol, marijuana, and illicit drug use (DiGuiseppi et al., 2020; Green et al., 2016), sexual risk behaviors (Abajobir et al., 2017; Mota et al., 2019), and sexual dysfunction (Holla et al., 2012). The associated disruption of quality caregiving also results in significant economic costs for society (Bachmann et al., 2019). In addition, early trauma is one of the most important public health challenges, as shown by their elevated prevalence levels worldwide (World Health Organization, 2014). A key step on the strategy to confront and resolve this public health challenge requires increasing the assessment of their prevalence, particularly for developing countries.

Early traumatic experiences prevalence research in Latin American countries is still worryingly small, in glaring contrast to preliminary analysis suggesting that South America presents the highest estimates of childhood trauma in the world (Viola et al., 2016). Sociopolitical conditions in Colombia have deepened the forms of abuse and violence against children and adolescents (Barrera-Valencia et al., 2017; Bermúdez Rodríguez & Garavito Ariza, 2019; Chaux, 2002; Hewitt Ramírez et al., 2014; Sánchez et al., 2019). In the context of an armed conflict of more than 60 years, children and adolescents have been victimized and revictimized in different ways. For example, they were direct victims of forced recruitment by armed groups, many were maimed after falling into antipersonnel mines, they were also victims of forced displacement, the murder of their parents or even killed themselves as a revenge strategy against their parents from armed groups. According to the National Centre of Historical Memory (2017), recruited children became a type of war slave, were sexually abused within the ranks of combatants, or forced to perform acts of barbarism with the intention of proving their worth, and in many cases used as the first line in confrontations against their opponents.

Although the Colombian armed conflict has been one of the most intense and extended in South America, additional research indicates that it is not the only or largest cause of the so-called external injuries in Colombia. According to the most recent report from the National Institute of Legal Medicine and Forensic Sciences (INMLCF, 2019), in 2018 there were 25,807 autopsies for violent deaths in Colombia, from which 12,140 were due to homicides, 6,879 due to transport accidents, 3,075 were accidental deaths, 2,696 suicides, and 1,027 undetermined violent deaths. In addition, during the same year, 116,115 assessments were performed related to interpersonal violence, 78,314 related to domestic and partner violence, 39,537 for transport accidents, 26,065 related to alleged sexual offenses, and 3,226 accidental injuries. Reported data show that domestic violence was more frequent against women, sexual crimes were more common against children and adolescents, and homicides were more common against men under 35 years of age. In addition to the above, other statistics indicate that, according to Colombia's DNP (Departamento Nacional de Planeación, 2018) and the National Nutrition Survey (Ministry of Health, 2018), 10.8% of children under the age of 5 suffered from malnutrition problems that directly affect brain development and the ability to learn. This percentage was higher in indigenous communities, where 29.6% of children showed signs of stunting. Regarding sexual violence, the figures showed a prevalence of child abuse of 53% among women. In addition, in 2018, 5,713 girls between the ages of 10 and 13 were pregnant because of such sexual abuse, which shows the inequality, gender-based violence, and harshness of the violence (INMLCF, 2019).

The Early Trauma Inventory Self-Report (ETI-SR; Bremner et al., 2007) is commonly used. It was originally validated in the U.S. Its long (62 items) and brief (27 items) versions have shown adequate psychometric properties. It has been adapted and validated in Korea (Jeon et al., 2012), Greece (Antonopoulou et al., 2017), Spain (Plaza et al., 2011), Sweden (Hörberg et al., 2019), and Brazil (Osorio et al., 2013). It also has been used in research with irritable bowel syndrome patients (Bradford et al., 2012), or military populations (Rademaker et al., 2008), among others. Some of the performed studies in Latin American countries used the ETI-SR (Bremner et al., 2007). For instance, the Spanish version from Spain (Plaza et al., 2011) is commonly used in Latin America. But the Spain version needs adaptation and validation for its Latin-America use (Vallejo-Medina et al., 2017). In fact, there is a new version of the scale in Colombia composed by 84 items called ETI-SRCol (Posada et al., 2019). However, the novel items and differences of the scale with the originals and other adapted scales make international comparisons challenging.

Thus, attending to the high level of violence in Colombia within the last decades, and in absence of a validated brief version of ETI-SR, the main objective of this study is to adapt and validate a Colombian version of the ETI-SR SF, including the analysis of trauma occurrence among an extensive adult sample.

Method

Participants

A total of 2,080 Colombians participated in this study (57.3% women and 42.4% men). Age ranged from 18 to 77 years old (M = 29.19; SD = 9.25). Only 0.09% of the sample was living outside of the country. The highest proportion of the sample obtained an undergraduate degree (i.e., 16 educational years; 40.66%), followed by high school degree (18%), and graduate degree (14.22%). The most common marital status was single (63.24%), followed by people having a significant other (19%), married (11.31%), divorced (6.25%), and widowed (0.2%). Most people (77%) earned a minimum professional wage per month ($469.02 USD). Inclusion criteria were age, living in Colombia, being able to read and write, and to accept the informed consent.

The sample was randomly split in two subsamples to perform an exploratory factor analysis (EFA) and a confirmatory factor analysis (CFA). The first subsample included 1,059 participants, while the second subsample was composed by 1,021.

Instruments

The Early Trauma Inventory Self Report-Short Form (ETISR-SF; Bremner et al., 2007) evaluates the occurrence of traumatic experiences occurring before age 18, across four dimensions: *general*, *physical*, *emotional*, and *sexual*. Physical abuse is understood as situations of restraint, isolation, or physical contact with the purpose of hurting or harming; emotional abuse is the use of verbal expressions to humiliate or degrade; sexual abuse is any unwanted sexual contact with the intent to dominate or degrade and for the gratification of the perpetrator; and general traumatic events involve stressful and shocking events (Bremner et al., 2007). It was designed using 27 items of dichotomous response (Yes = 1/No = 0). Two items are usually included, at the end of the scale, to subjectively assess if a traumatic event has been experienced and its emotional impact. The ETISR-SF has shown an internal consistency higher than .80 (Jeon et al., 2012; Osório et al., 2013) and its four domains higher than .70 (Alafla & Manjula, 2020; Bremner et al., 2007). Higher scores indicate higher levels of trauma experiences. The Colombian adapted version is available in the online supplemental material.

Procedure

The scale was translated from the original English version by two expert translators. The three members of the research team and a panel of three experts analyzed the two versions and made the cultural adaptation to Colombian Spanish attending to understanding and content equivalence. The Spanish version of the instrument was tested in a pilot study with 10 college students. No further adjustments were necessary, and the final version was created. Finally, we compared the Spanish items content with the original English ones. This procedure was based on international guidelines (AERA, APA, & NCME, 2015; Muñiz et al., 2013 WHO, 2020).

A nonprobabilistic convenience sample was used. Web-based sampling was carried out between March 16 and March 30, 2020. The SurveyMonkey web platform was used. A boosted Facebook post was used to promote the survey. A total amount of $300 was paid. The image linked to the survey had the following text: "*If you are a man or woman over 18 years old, do not hesitate to answer the survey and share. Only 20 minutes!*" The project was approved by the Research Ethics Committee of the Universidad del Rosario. Ethical standards for research with human subjects were preserved throughout the study. An informed consent process was included to ensure that only consenting participants could enter to fill out the questionnaire.

Data Analysis

Results were performed with R (R Core Team, 2017; Version 3.6.3) and the R Studio interface (RStudio Team, 2016; Version 1.2.5033). Due to the dichotomous nature of the item scales, a tetrachoric matrix was used when a matrix was needed. Thus, the presented α is not Cronbach but ordinal. The number of dimensions to be extracted was calculated with the following methods: optimal coordinates, acceleration factor, parallel analysis, eigen-

Table 1
Exploratory Factorial Analysis Extracted for Four Dimensions

Item	Emotional	Sexual	Physical	General	h^2	com
ETI SR18	**.93**				.90	1.1
ETI SR19	**.83**				.74	1.1
ETI SR17	**.82**				.76	1.3
ETI SR20	**.80**				.72	1.3
ETI SR21	**.66**				.52	1.4
ETI SR10				—	.09	2.7
ETI SR9				—	.06	2.0
ETI SR24		**.87**			.80	1.1
ETI SR26		**.85**			.73	1.0
ETI SR25		**.76**			.62	1.1
ETI SR22		**.75**			.65	1.3
ETI SR23		**.73**			.59	1.2
ETI SR27		**.71**			.56	1.2
ETI SR14	.38		**.80**		.79	1.5
ETI SR16			**.77**		.72	1.4
ETI SR15	.33		**.69**		.60	1.5
ETI SR12			**.59**		.42	1.4
ETI SR13	.39		**.58**		.56	2.2
ETI SR8			**.32**		.22	2.7
ETI SR5				—	.06	3.4
ETI SR2				**.80**	.66	1.1
ETI SR3				**.64**	.42	1.1
ETI SR1				**.51**	.30	1.4
ETI SR11				**.46**	.24	1.4
ETI SR7				**.43**	.19	1.1
ETI SR4				**.39**	.16	1.1
ETI SR6				—	.01	2.1
Variance	.16	.15	.10	**.07**		*M* = 1.5

Note. h^2 = communality of the item; com = Hoffmann's item complexity; *M* = mean. Corresponding weights in its corresponding dimensions are bold marked.

Table 2
Fit Indexes of the Three Tested Models

Model	χ^2	*df*	*p*	CFI	TLI	RMSEA	[90% CI] RMSEA
A (second order)	706.40	320	<.01	.957	.952	.036	[.032, .039]
B (four clean)	518.87	224	<.01	.966	.962	.037	[.033, .042]
C (original four)	709.13	318	<.01	.956	.952	.036	[.033, .040]

Note. χ^2 = chi-square statistic; *df* = degrees of freedom; CFI = comparative fit index; TLI = Tucker Lewis index; RMSEA = root mean square error of approximation; CI = confidence interval.

values (Kaiser Criterion), Velicer MAP, BIC, Sample Size Adjusted BIC, VSS Complexity, and VSS Complexity 2. Major consensus across methods was used to decide the extraction of the number of factors. EFA was computed through an ML(Robust) method using an Equamax rotation—recommended for dichotomous items (Finch, 2011)—over the tetrachoric matrix of the Subsample 1. FCA was performed using the weighted least square mean and variance adjusted-robust (WLSMV-R) estimator in the tetrachoric matrix based on Subsample 2. Three different models were tested. Fit indexes consulted were root mean square error approximation (RMSEA; Browne & Cudeck, 1993) and its 90% confidence interval (90% CI), the comparative fit index (CFI; Bentler, 1990), and Tucker Lewis Index (TLI; Tucker & Lewis, 1973). Values up to .08 for RMSEA are usually considered as acceptable, but it is desirable not going over a .06 threshold; while a value above .90 is acceptable, but higher than .95 is desirable for CFI and TLI (Hu & Bentler, 1999). Listwise deletion method was used for missing values.

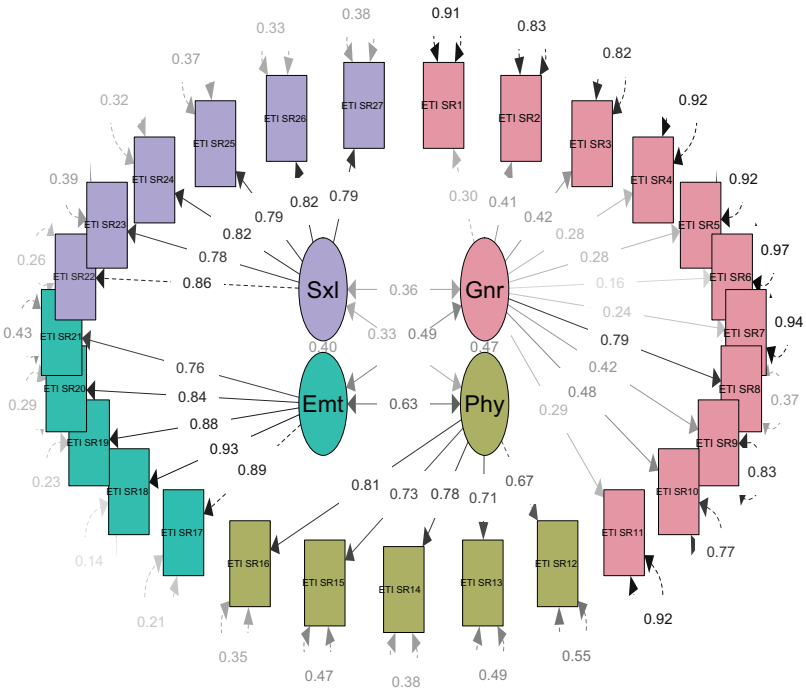
We highlight the use of the following packages: ggplot2 (Version 3.3.0; Wickham, 2009), psych (Version 1.8.12; Revelle, 2018), psychometric (Version 2.2; Fletcher, 2010), lavaan (Version 0.6–5; Rosseel, 2012), psycho (Version 0.4.9.1; Makowski, 2018), semPlot (Version 1.1.2; Epskamp, 2019), and semTools (Version 0.5.2; Jorgensen et al., 2019).

Results

Exploratory Factorial Analysis

First, we explored construct validity using an EFA. Eight different extraction methods suggested four different numbers of factors. Optimal coordinates and parallel analysis agreed with a six-factor solution. While accelerator factor and VSS Complexity 1 defended a one-dimensional structure. BIC and Sample Size Adjusted BIC suggested eight factors and Kaiser seven. Finally, Velicer MAP and VSS Complexity 2 proposed—as previous

Figure 1
Path Diagram of the Four Related Dimensions Proposed



Note. Standardized weights are shown. Gnr = general; Phy = physical; Emt = emotional; Sxl = sexual. See the online article for the color version of this figure.

Table 3
Psychometric Items Properties

Dimension	Item	*M*	*SD*	Skew	Kurtosis	citc	Alpha - Item	Alpha	Total *M* (*SD*)
General	1	0.17	0.38	1.76	1.10	.42	.65	.69	0.31 (0.17)
	2	0.15	0.35	2.01	2.06	.45	.64		
	3	0.30	0.46	0.89	−1.20	.40	.65		
	4	0.61	0.49	−0.47	−1.78	.39	.66		
	5	0.38	0.49	0.48	−1.77	.15	.69		
	6	0.10	0.30	2.65	5.04	.25	.68		
	7	0.36	0.48	0.57	−1.68	.37	.66		
	8	0.66	0.47	−0.69	−1.52	.38	.66		
	9	0.42	0.49	0.33	−1.89	.20	.69		
	10	0.20	0.40	1.54	0.36	.26	.68		
	11	0.15	0.35	2.01	2.05	.40	.65		
Physical	12	0.61	0.49	−0.47	−1.78	.60	.84	.86	0.41 (0.28)
	13	0.02	0.15	6.48	40.07	.55	.86		
	14	0.30	0.46	0.86	−1.25	.77	.80		
	15	0.49	0.50	0.02	−2.00	.71	.82		
	16	0.66	0.47	−0.68	−1.53	.72	.81		
Emotional	17	0.41	0.49	0.36	−1.87	.81	.91	.93	0.40 (0.38)
	18	0.45	0.50	0.20	−1.96	.89	.90		
	19	0.38	0.49	0.50	−1.75	.83	.91		
	20	0.32	0.47	0.77	−1.40	.83	.91		
	21	0.48	0.50	0.06	−2.00	.71	.93		
Sexual	22	0.51	0.50	−0.03	−2.00	.78	.90	.92	0.26 (0.27)
	23	0.49	0.50	0.04	−2.00	.72	.91		
	24	0.20	0.40	1.54	0.36	.84	.89		
	25	0.11	0.31	2.53	4.39	.75	.90		
	26	0.09	0.29	2.78	5.73	.79	.90		
	27	0.17	0.37	1.79	1.20	.71	.91		

Note. *M* = mean; *SD* = standard deviation; citc = corrected item-total correlation; alpha presented is ordinal (based in the tetrachoric matrix).

theory—four factors. Thus, we explored the last solution. The equamax-rotated solution is presented in Table 1. This model explains 49% of the variance and have four items with a weight minor to .30.

Confirmatory Factor Analysis

Next, we performed a confirmatory factor analysis. We tested three different models: (a) the original four-factor structure with a second-order factor; (b) the original four-factor structure without the four items that showed problems in the EFA (Items 5, 6, 9, and 10); and (c) the original four-factor structure. All—but of course the second-order factor model—were not considered orthogonal. Fit indexes can be consulted in Table 2. All tested fit indexes are optimal, and minimal differences were observed between models. Indeed, significant differences were not observed between the nested models ($p = .12$). Thus, and to keep a replicable version of the scale, we chose to preserve the original version with all 27 items. Standardized weights are in Figure 1. We would like to highlight five items (Items 4, 5, 6, 7, and 11) with low (<.30) weight. We also accepted the possibility to use the scale as single dimension according to indexes observed for the second order model.

Some Psychometric Item Properties

Table 3 shows that overall items that showed some problematic behavior previously (Items 5, 6, 9, and 10) remain with a low corrected item-total correlation (citc). However, its presence does not seem to affect the general trauma subscale alpha. Overall, the scale alpha was .89.

Trauma Occurrence in Colombia

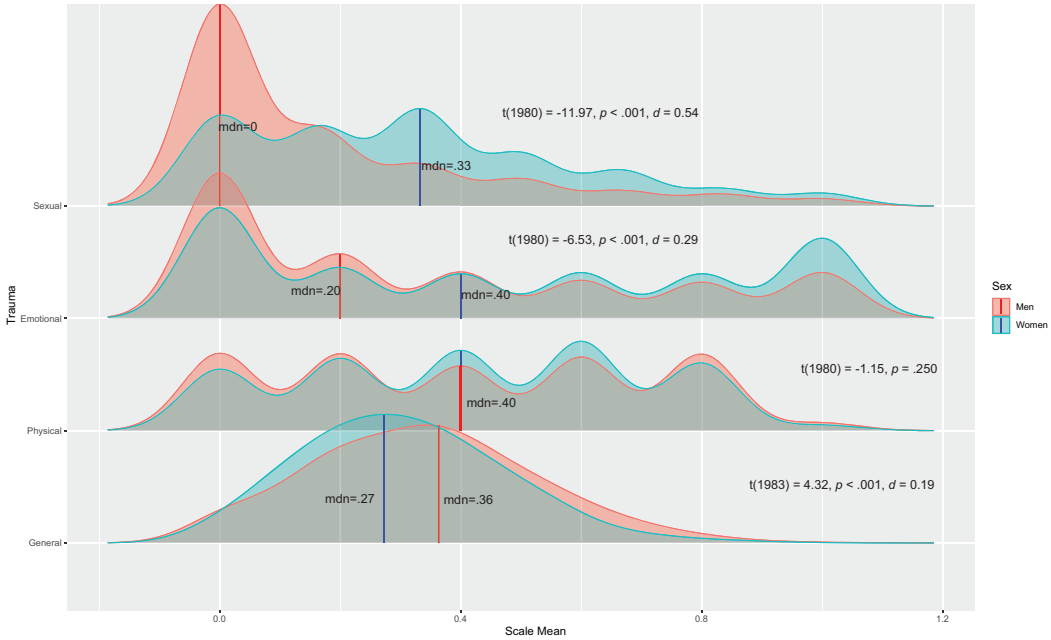
Startlingly, 99.8% of the sample reported to had suffered at least one type of early traumatic event. Of those, 69.40% reported having experienced emotions of intense fear, horror, or helplessness, while 43.30% reported feeling out-of-your-body or as if you were in a dream (both of them regarding to the trauma that has the greatest impact on your life). For all participants, significant differences were observed between the four dimensions of the Early Trauma Inventory, $F(3, 1953) = 202$; $p < .01$. Furthermore, we found two interesting sex differences in three of the four subscales. First, men reported suffering more general trauma than women. Second, women reported higher levels of trauma for the sexual and emotional subscales. No differences were observed for physical trauma. For more details, see Figure 2. Figure 3 shows specific sex differences by item. Other differences regarding socioeconomic status where minimal and correlations minor to .20 were observed with age and socioeconomic status. Only emotional trauma showed significant differences with marital status, and general trauma with economic income. All effect sizes are negligible and no interference in results are expected.

Discussion

In the current study we adapted and validated the ETI-SR in Colombian adults. The original factor structure successfully rep-

Figure 2

Ridge Plot Representing Trauma Subscales Densities



Note. Median are plotted for both men and women. See the online article for the color version of this figure.

licated the original four dimensions. Items properties were optimal and internal consistency allows its use in Colombia for both research and contextual use. In addition, significant differences between men and women were found.

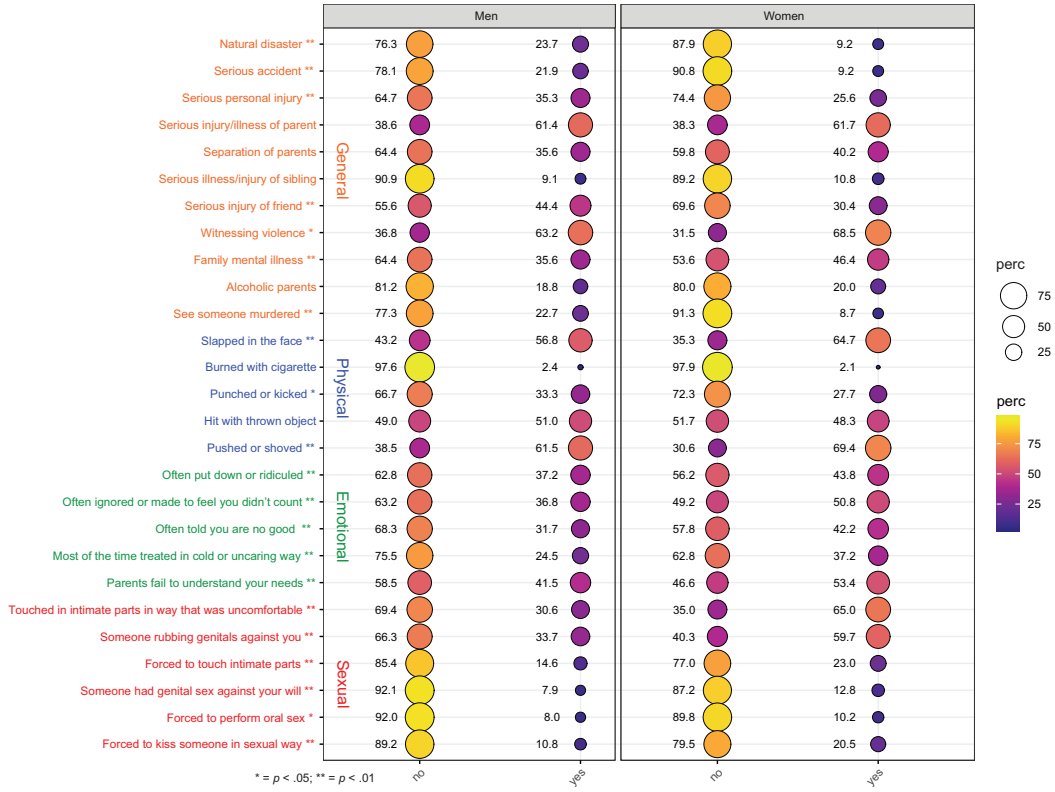
We observed the original four dimensions, which provides the ETI-SR a good international agreement regarding its construct validity. In the original validation this dimensionality was settled down (Bremner et al., 2007), and replicated consistently in Korea (Jeon et al., 2012), Brazil (Osorio et al., 2013), or Sweden (Hörberg et al., 2019). To the best of our knowledge, no dissonances have been observed in this regard. To evaluate internal consistency, Cronbach's alpha has been commonly used. Its value has fluctuated between .55 to .91 (Antonopoulou et al., 2017; Bremner et al., 2007; Hörberg et al., 2019; Jeon et al., 2012; Mello et al., 2010; Park, 2018; Osorio et al., 2013). In the present study, alphas ranged from .69 to .93, indicating an adequate internal consistency of the four dimensions. The psychometric item properties were also good in our data—consistent with other studies (Bremner et al., 2007; Mello et al., 2010)—and no item elimination or change has been required. Thus, the present psychometric validation for the ETI-SR in Colombia can be considered as established.

The present study strongly suggests a high prevalence of early traumatic events in Colombia, considering both the reported higher levels of trauma for our sample and previously reported studies. As described before, general trauma was more common in men. For instance, 22.7% of men witnessed someone murdered, compared to 8.7% of women. The highest differences occurred for sexual trauma, where some items for women doubled—or are close to it—the occurrence for men. Examples of this are: "forced to touch intimate parts," "someone rubbing genitals against you," "touched in intimate parts in way that was uncomfortable," and "someone had genital sex against your will." Women also scored higher on emotional trauma; however, differences were modest. For instance, 50% of women reported that they were "often ignored or made to feel you didn't count," in contrast to 36.8% of men. Finally, to be burned with a cigarette (2%) was the most uncommon memory, while being witnesses of violence and pushed or shoved were the most common (66%). Only four people (0.2%) reported to never have experienced at least one trauma.

One anecdotic, yet significant data: For Sweden, the item "seeing someone murdered" was set constant at 0. For our study 91.3% of women reported yes to that item. This simple data can highlight how common exposure to trauma is in Colombia. This item had a prevalence of 4% for the U.S. (Bremner et al., 2007). Indeed, it is hard to compare trauma levels of Colombia with other countries. Startlingly, 99.8% of the sample reported to had suffered at least one type of early traumatic event. A higher prevalence for all types of traumatic events for Colombia, when compared with other countries, is shown by comparisons between item score ranges for each brief subscale (Bremner et al., 2007; Hörberg et al., 2019; Osorio et al., 2013; Plaza et al., 2011): general trauma (Colombia: 10.0%–65.9%; Brazil: 7.5%–29.2%; Spain: 0.4%–27.8%; Sweden: 0%–51%; U.S.: 4%–48%); physical trauma (Colombia: 2.3%–65.5%; Brazil: 10.7%–49.0%; Spain: 0.0%–61.2%; Sweden: 3.5%–46.9%; U.S.: 9%–50%); emotional trauma (Colombia: 30.1%–47.8%; Brazil: 12.6%–23.7%; Spain: 7.9%–33.2%; Sweden: 29.4%–57.3%; U.S.: 24%–50%); and sexual trauma (Colombia: 10.4%–47.8%; Brazil: 5.9%–15.4%; Spain: 0.4%–5.7%; Sweden: 11.2%–30.8%; U.S.: 14%–39%). Only Sweden and the U.S. showed higher prevalence for emotional trauma. Both scored higher for the item: "parents fail to understand your needs." Our results and comparisons highlight the profound challenges for

Figure 3

Balloon Plot Representing Cross Tables Ocurrence × Item and Facet by Sex



Note. Percentages are represented by color luminosity, circle circumference, and numerically. Significance represented at $\alpha = .95$. Items are in order and grouped by dimensions. See the online article for the color version of this figure.

Colombia in terms of the prevalence of all types of early traumatic events. A metaregression analysis performed by Viola et al. (2016) suggests the highest levels of childhood trauma in the world for South America. Our analysis suggests that childhood trauma in Colombia is quite high even for South America, when compared with Brazil. In addition, our results reveal higher levels of early traumatic events than a previous study in Colombia (Posada et al., 2019).

Several of the results of this study are consistent with the INMLCF (2019) numbers in its 2018 report. First, regarding sexual violence, it is evident that female children and adolescents were the main victims of sexual violence. In Colombia, 562.50 girls (per 100,000 inhabitants) between the ages of 10 and 13 were victims of this type of violence. In addition, it is estimated that 35,000 minors in Colombia suffered from commercial sexual exploitation (Figueroa, 2016). Thus, it is consistent for women to show higher scores in terms of early trauma experience related to sexual violence. Second, in terms of overall violence, our results are consistent with the statistics described by the INMLCF (2019). This report indicates that, of the total number of homicide cases, 91.3% corresponded to men. It is noteworthy that these homicide cases occurred mainly in regions where the armed conflict had a greater incidence during 2018, where it is generally men who are most exposed to these forms of violence. Considering women's scores with respect to emotional violence, Gómez-Garibello and Chaux (2014) observed differences in the ways in which aggression between men and women occurs in school contexts. According to their studies, physical aggression is more frequent among males (with behaviors such as hitting, kicking, pushing, throwing objects, or attempting to harm others). However, relational aggression was more frequent among females. In other words, aggression between females was aimed to rupture the relationships and status of other females within the groups (the behaviors associated with relational aggression were gossip, manipulation of relationships, and exclusion from the groups).

In summary, this study evaluated the adaptation of a scale that allows the correct measurement of 27 types of trauma grouped in four dimensions in Colombia. The results showed high prevalence levels of trauma in Colombia. However, some limitations need to be mentioned. The sampling, despite being broad, is not random and therefore cannot be considered representative of the Colombian territory. Moreover, web-based sampling may have led to more selective access to the sample, making it difficult to assess people with fewer resources or living in rural contexts. Discriminant or convergent validity was not evaluated in this study either, so future studies should address them. Taking advantage of the appropriate and needed validation of the present scale, future studies will have the possibility to expand our study sample, also including persons in direct contact with the postconflict. In addition, it becomes possible to assess the relationship between expo-

sure to trauma and mental health. For instance, although the levels of depersonalization reported in the present study for the general population are within the range of a previous meta-analysis (Hunter et al., 2004), more research is needed to clarify if the reported out-of-your-body feelings are transient or are present in the context of a clinical depersonalization (Lee et al., 2012), which is related to early adverse experiences (Thomson & Jaque, 2018). Expanding the research on early trauma prevalence and its relationship with concurrent and subsequent physical and mental health is one of the key health and social challenges for Colombia.

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