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Araştırma Makalesi / Research Article

Assessing reliability and validity of the Child PTSD Symptom Scale for DSM-5-Self Report in Turkish Adolescents

DSM-5 Travma Sonrası Stres Bozukluğu Belirti Ölçeği Özbildirim Çocuk Formu' nun Türk Ergenlerde Geçerlik ve Güvenirliğinin Değerlendirilmesi

Derya Atalan Engin[1] **Gülendam Akgül**[2]

[1] Department of Psychology, Kapadokya University, Nevşehir, Türkiye
[2] Department of Educational Sciences, Ankara University, Ankara, Türkiye

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Derya Atalan Engin

Kapadokya Üniversitesi,
Çocuk Gelişimi Bölümü
Ürgüp Yerleşkesi
50400 Ürgüp/Nevşehir
Türkiye.

derya.ergin@kapadokya.edu.tr

Abstract: This study examined post-traumatic stress disorder, which emerges following traumatic events and is associated with various emotional and behavioral problems. This study aimed to adapt the Child Post-Traumatic Stress Disorder Symptom Scale-Self-Report (CPSS-5) to Turkish culture. In the study, 348 adolescents aged 11-14 from a low socioeconomic background were reached. The CPSS-5, the emotional problems subscale of the Strengths and Difficulties Questionnaire and the Perceived Social Support Scale were used. Analyses revealed strong validity and reliability results for CPSS-5. By setting a cut-off score, adolescents were classified as "traumatized" and "non-traumatized" based on their post-traumatic stress disorder scores. Accordingly, traumatized adolescents had lower social support and higher emotional problem scores. Findings indicated that the CPSS-5 can be used for Turkish adolescents aged 11-14.

Keywords: Post-traumatic stress disorder, Child PTSD Symptom Scale-Self-Report, adaptation

Öz: Bu çalışmada travmatik olaylar sonrasında ortaya çıkan ve çeşitli duygusal ve davranışsal sorunlarla ilişkilendirilen travma sonrası stres bozukluğu incelenmiştir. Çalışmada çocuklar için Travma Sonrası Stres Bozukluğu Belirti Ölçeği-Öz Bildirim Formu'nun (CPSS-5) Türk kültürüne uyarlanmasını amaçlamıştır. Düşük sosyoekonomik düzeye sahip 11-14 yaş arası 348 ergene ulaşılmıştır. Araştırmada CPSS-5, Güçler ve Güçlükler Anketi'nin duygusal sorunlar alt ölçeği ve Algılanan Sosyal Destek Ölçeği kullanılmıştır. Analizler, CPSS-5'in güçlü geçerlilik ve güvenilirlik sonuçları ortaya koyduğunu göstermiştir. Belirlenen kesme puanı doğrultusunda, ergenler travma sonrası stres bozukluğu puanlarına göre "travmatize" ve "travmatize olmayan" olarak sınıflandırılmıştır. Buna göre, travmatize olan ergenlerin sosyal destek düzeyleri travmatize olmayanlardan daha düşük ve duygusal sorun puanları daha yüksek bulunmuştur. Bulgular, CPSS-5'in 11-14 yaş arası Türk ergenler için kullanılabileceğini göstermektedir.

Anahtar Kelimeler: Travma sonrası stress bozukluğu, Travma Sonrası Stres Bozukluğu Belirti Ölçeği, uyarlama

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Introduction

Posttraumatic stress disorder (PTSD), a psychiatric disorder, develops after exposure or witnessing a traumatic event involving actual death or death threat, serious injury or sexual violence (American Psychiatric Association, 2022). It is estimated that a significant proportion of children and adolescents globally have been exposed to traumatic experiences, with the potential for these experiences to persist throughout their lifespan. Research indicates that between 14% and 43% of children and adolescents have experienced at least one traumatic event, with approximately one in four of those individuals developing PTSD (National Center for PTSD, 2024). A comparative overview of community samples of adolescents with war-related trauma or natural disaster trauma indicates a higher prevalence of PTSD (Abraham et al., 2022; Agbaria et al., 2021; Rezayat et al., 2020).

Traumatic experiences are classified as either interpersonal or non-interpersonal based on the source of the trauma. Individuals who have experienced interpersonal traumas such as childhood physical, emotional or sexual abuse, neglect may be at an increased risk of developing PTSD and more severe symptoms (Birkeland et al., 2022; World Health Organization, 2020). It has been established that girls who have been exposed to interpersonal trauma are at the greatest risk of developing PTSD (Alisic et al., 2014). However, the occurrence of common natural disasters and pandemics (e.g., COVID-19), armed conflicts (e.g., the ongoing conflict between Russia and Ukraine, and the Israeli-Palestinian dispute), and an increasing level of migration may make non-interpersonal traumatic events a significant concern. Therefore, it is important to investigate the prevalence of PTSD symptoms in individuals with both interpersonal and non-interpersonal traumatic events.

Based on the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), PTSD symptoms are re-experiencing, avoidance, negative changes in cognition and mood, and arousal (American Psychiatric Association, 2022). Re-experiencing describes intrusive symptoms that begin after a traumatic event, such as recurrent distressing memories and dreams. Avoidance involves persistent efforts to avoid thoughts and feelings associated with the trauma. Arousal reflects excessive reactions or heightened arousal in the individual, such as outbursts of anger or increased vigilance. Last, negative alterations in cognitions and mood can include cognitive symptoms such as difficulty remembering important aspects of the traumatic event, distorted thoughts and feelings about the causes or consequences of the trauma (e.g. feelings of guilt, shame, and anger) and exaggerated negative beliefs or expectations (e.g. the belief that one could have prevented the traumatic event).

Traumatic experience increases the risk development of PTSD (Boumpa et al., 2022). Additionally, trauma exposed children and adolescents are at risk of developing other mental health disorders such depression and emotional problems (Spinazzola et al., 2014; Vibhakar et al., 2019). It is possible for children and adolescents with PTSD to experience

comorbid emotional and behavioural disorders, including major depressive disorder, generalized anxiety disorder and substance usage disorders (Kar & Bastia, 2006; Messman-Moore & Bhuptani, 2017). A systematic review has demonstrated a link between childhood trauma and the development of mental health problems in adulthood (McKay et al., 2020). Therefore, an accurate diagnosis of PTSD is important for distinguishing it from comorbidities and for providing appropriate treatments.

PTSD results from severe trauma, but the severity and persistence of its symptoms can be related to a range of other factors, such as an individual's positive interaction with their social environment and psychological resilience. A systematic review revealed that social support exerts a limited protective effect on PTSD (Allen et al., 2021). However, a supportive environment can facilitate the prevention of social isolation and the avoidance of negative emotional states in adolescents with PTSD (Cohen & Wills, 1985). Moreover, social support has been demonstrated to facilitate the alleviation of PTSD symptoms, including those pertaining to intrusive thoughts, re-experiencing, and withdrawal (Foa et al., 2007; Stice et al., 2004). A recent meta-analysis showed the reciprocal relationship between social support and PTSD (Wang et al., 2021). In other words, individuals with strong social support tend to be more resilient to the negative impacts of traumatic events, though psychological distress can weaken and diminish these support resources.

The impact of PTSD on well-being is profound, as individuals with PTSD often experience lasting consequences that affect their ability to maintain emotional and physical health. Traumatized adolescents have difficulties emotional regulation (Paulus et al., 2021) and have high level of emotional problems (Hagborg et al., 2022). Additionally, traumatic experiences are particularly associated with low self-esteem, guilt and shame (Carlson & Dalenberg, 2000; Shi et al., 2021). Consequently, a range of emotional difficulties may manifest alongside PTSD.

Türkiye is an important country to assess PTSD due to both interpersonal (e.g. conflict and war-effected immigration) and non-interpersonal traumatic events (e.g. earthquake and flood). A study assessing the prevalence of mental health disorders after the COVID-19 outbreak found a PTSD rate of 28.5% in Turkish adolescents (Selçuk et al., 2021). Moreover, in a study conducted after the 2024 Kahramanmaraş earthquakes, which affected at least 11 provinces, 80.9% of children and adolescents reported moderate to severe PTSD symptoms (Yakşi & Eroğlu, 2024). In addition to natural disaster as a traumatic event in Türkiye, immigrant adolescents are another important issue for PTSD.

There are 4.5 million foreigners in Turkey, most of them from war-torn countries such as Syria, Afghanistan and Ukraine (International Organization for Migration, 2024). Although recent studies on the demographics of immigrants are lacking, it is known that children and adolescents aged 0-18 make up a large portion of the immigrant population (Ministry of Interior Disaster and Emergency Management Presidency, 2017). Some studies have shown that the prevalence of PTSD is higher in immigrant children and adolescents than in non-immigrant children and adolescents (Bulut & Kahraman, 2022; Yektaş et al., 2021). Given the recent exposure of many youths in Türkiye to numerous traumatic experiences, reliable and valid assessment tools for measuring PTSD symptoms are critically important in order to plan appropriate interventions for adolescents.

Current Study

The severity of PTSD has been assessed using several scales such as the Children's Posttraumatic Response Reaction Index (Pynoss et al., 1987) and the Post-Traumatic Stress Disorder Reaction Index for Children (Frederick et al., 1992) for children and adolescents in Türkiye. There are no scales that assess PTSD based on DSM-V criteria in adolescents. Therefore, in the current study, we assessed the psychometric properties of the DSM-V-based CPSS-5 in a sample of Turkish adolescents. The first aim was to determine the most appropriate structure for the CPSS-5 in Turkish adolescents. In addition, we examined the differences in scores for social support and emotional problems between adolescents with and without PTSD. We hypothesized that adolescents with PTSD would have lower levels of social support and higher levels of emotional problems compared to those without PTSD.

Method

Research Design

This study is descriptive in nature. Employing quantitative research methods, it was designed as a cross-sectional study aimed at adapting the CPSS-5 scale into Turkish. Accordingly, the scale was culturally adapted to Turkish, and its psychometric properties were examined within the framework of a descriptive study design.

Participants

The sample consisted of students from a school in a low socioeconomic background in Ankara, Türkiye, where one of the researchers works, selected through convenience sampling. Low socioeconomic students are at risk for traumatic events (Khamis, 2005; Lu et al., 2021). The sample consisted of 348 teenage students between the ages of 11-14 ($M = 12.56$, $SD = 0.71$). More than half of the sample consisted of females ($n = 180$, 51.7%).

Procedure

This study aims to adopt the Child PTSD Symptom Scale-Self-Report (CPSS-5) scale into Turkish. To produce equivalent versions of a measures across different languages and cultures, many different translation methods are used. One of the most common approaches is the “back-translation” method (Geisinger & McCormick, 2013), where the measure is initially translated from a source language (e.g., English) into a target language (e.g., Turkish) by a bilingual individual and then back-translated into the source language (e.g., English) by a second bilingual individual to address the discrepancies.

After obtaining adaptation permission from the authors who develop the original scale, we followed the steps suggested by Geisinger & McCormick (2013) during the translation process. First, scale was translated into the Turkish language (second author). An independent translator back translated the measure into English (an English teacher with a PhD). The backtranslation was sent to original author for review and feedback. Feedback was incorporated into the translation. An independent translator back translated the revised measure into English. The revised back-translation was sent to the original study’s author for review. The revised back-translation was reviewed and approved by the original study’s author. Evaluation, feedback, and approval of the original study’s author at various steps of the translation

process ensured the exact translation of the measure into Turkish.

Ethical approval was obtained from Kapadokya University Ethical Commission (REF: E-64577500-050.99-17759). Parents and participants were approached for consent for permission to approach their child about being in the study. All participants were asked to complete consent forms prior to participating in the study and were informed that they could withdraw from the study at any point. The data collection tools were applied to volunteer adolescents during a class time.

Data Collection

Data was collected by the personal information form prepared by the researcher. The school principal and parents were informed and gave consent for the study. The first researcher of this study who was working as a school counselor collected the data during the regular class hours. Personal information form was prepared by the researchers and includes questions related to gender, class level, and parental sociodemographic information. After, participants filled out data collection tools.

Measures

PTSD. The Child PTSD Symptom Scale (CPSS-5, Foa et al., 2018) was used to assesses PTSD DSM-V diagnosis and symptom severity. The CPSS-5 measure history of Criterion A traumatic experience. Youth were asked about any traumatic experience during the last 24 months.

The scale has two parts and was divided into five subscales. First part includes four subscales: intrusion (items 1-5), avoidance (items 6-7), changes in cognition and mood (items 8-14), and increased arousal and reactivity (items 15-20). The sample items for each subscale are "Did you have bad dreams or nightmares?", "Did you try not to think about, talk about, or have feelings about the experience?", "Did you have trouble remembering an important part of the experience?", "Did you get angry easily? (for example, yelling, hitting others, throwing things)", respectively.

The second part consisted of seven items which specify deterioration of endorsed symptoms on daily functioning (e.g., relationships with friends or fun and hobby activities, items 21-27). This part is also rated on a scale from 0 (not at all) to 4 (6 or more times a week/almost always) by the interviewer that produce an impairment score range between 0 and 28. The total impairment score does not contribute to the overall PTSD severity score. Higher scores reflect higher level of PTSD. The total impairment score is not factored into the overall severity score.

Social Support from Parents and Peers

The multidimensional scale of perceived social support was used to measure social support (SSFP; Eker & Arkar, 1995; Zimet et al., 1988). The scale was divided into three subscales which addressing a different source of support from family (e.g. I can talk about my problems with my family), friends (e.g. My friends really try to help me) and significant other (e.g. There is a special person in my life who cares about my feelings). We used family and friend subscales in the current study. The items are rated on a 7-point scale, ranging from very strongly disagree (1) to very strongly agree (7). Higher scores reflect higher level of perceived social support. Cronbach's alpha indicated good internal consistency for social support from family (α = .81) and friends (α = .86). Fit of the two-factors structure model of the SSFP scores was acceptable, X^2 = 39.179, df = 19, RMSEA = .05 (90% *CI* = .03 - .08), CFI = .98, TLI= .97, SRMR = .03.

Emotional Problems

Emotional problems subscale of Strengths and Difficulties Questionnaire was used to measure emotional problems (SDQ-EP; Goodman, 1997; Guvenir et al., 2008). The subscales included five items (e.g. "Many worries or often seems worried"). The items were rated on a 3-point scale, ranging from "not true" (1) to "certainly true" (3). Higher scores reflect higher level of emotional problems. Cronbach alpha indicated adequate internal consistency (α = .75). Fit of the two-factors structure model of the emotional problems scores was acceptable, X^2 = 10.815, df = 4, RMSEA = .07 (90% *CI* = .02 - .12), CFI = .98, TLI= .95, SRMR = .02.

Data Analyses

All analyses were performed using SPSS statistical program (IBM, 2020) and Mplus statistical modeling software (Version 8.3; Muthén & Muthén, 2019). First, we computed inter item and item total correlations, split-half and internal consistency reliabilities. Reliability was calculated using Cronbach Alpha values. The Alpha values between 0.6 and 0.7 were considered to indicate an acceptable level of reliability, while Alpha values of 0.8 or greater were considered to indicate very good level (Hulin et al., 2001). Additionally, split-half reliability analysis was conducted by comparing the internal consistency and Spearman Brown coefficients of the first 10 items to that of the second 10 items.

Then, we conducted a confirmatory factor analysis (CFA) to confirm the predefined structure of the CPSS-5 within Turkish culture. We expected to support a 5-factor model of the CPSS-5 among Turkish adolescents. Prior to analysis, we checked the missing data and extreme values. Then we did the confirmatory factor analysis (CFA) to see the construct validity of the scale, in the Turkish sample. The goodness of fit indices is accepted as adequate when (X2/df) < 3, CFI (Comparative Fit Index) > .90, SRMR (Standardized Root-Mean-Square Residual) < .08 and RMSEA (Root Mean Square Error of Approximation) < .06 (Hu & Bentler, 1999). For all analyses, statistical significance was set at the < .05 level.

We determined data-driven cut-off scores on the CPSS-5 for identifying likely PTSD diagnoses using ROC analysis. A receiver operating characteristic (ROC) curve analysis was conducted to estimate sensitivity and specificity of the CPSS-5 at different cut-offs for predicting self-reported PTSD. The predictive accuracy was evaluated using the area under the ROC curve. An area of 1 indicates a flawless test, while an area of 0.5 signifies a test with no value. Based on cut-off points, concurrent validity was examined by conducting independent sample t-test for adolescents with and without PTSD. Finally, we examined the discriminant and concurrent validity of the scale and its association with the CPSS-5, emotional problems, and social support from parents and friends using Pearson correlations and independent sample t-test.

Results

Items-Total Correlations

Table 1 shows inter-item and item-total correlations of CPSS-5. The inter item correlations (ranged between .11- .64) and the item total correlations (ranged between .33-.75) were moderate, as recommended (Clark & Watson, 2016). Each of 27 items was correlated with total CPSS-5 score at p < .01

Table 1. Item-item Corelations and Item-total Correlations of CPSS-5

	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Item 12	Item 13	Item 14	Item 15	Item 16	Item 17	Item 18	Item 19	Item 20	Item 21	Item 22	Item 23	Item 24	Item 25	Item 26	Item 27	Total
Item 1	1																											
Item 2	.37**	1																										
Item 3	.46**	.47**	1																									
Item 4	.53**	.43**	.52**	1																								
Item 5	.41**	.40**	.51**	.48**	1																							
Item 6	.32**	.25**	.42**	.41**	.41**	1																						
Item 7	.42**	.29**	.35**	.47**	.40**	.41**	1																					
Item 8	.23**	.36**	.31**	.27**	.26**	.18**	.26**	1																				
Item 9	.32**	.26**	.38**	.37**	.32**	.34**	.39**	.28**	1																			
Item 10	.27**	.38**	.34**	.41**	.30**	.20**	.33**	.26**	.36**	1																		
Item 11	.51**	.35**	.45**	.56**	.48**	.41**	.52**	.22**	.46**	.48**	1																	
Item 12	.34**	.29**	.39**	.37**	.30**	.33**	.43**	.30**	.40**	.40**	.42**	1																
Item 13	.36**	.29**	.36**	.48**	.36**	.34**	.46**	.26**	.60**	.44**	.57**	.48**	1															
Item 14	.32**	.35**	.46**	.44**	.45**	.32**	.47**	.29**	.49**	.41**	.50**	.45**	.48**	1														
Item 15	.37**	.28**	.35**	.30**	.30**	.25**	.31**	.26**	.40**	.39**	.54**	.44**	.47**	.34**	1													
Item 16	.23**	.28**	.24**	.13*	.29**	.11*	.29**	.21**	.36**	.23**	.21**	.24**	.30**	.30**	.26**	1												
Item 17	.32**	.33**	.40**	.45**	.36**	.32**	.32**	.28**	.39**	.31**	.40**	.25**	.35**	.42**	.29**	.22**	1											
Item 18	.37**	.35**	.43**	.42**	.34**	.27**	.39**	.23**	.50**	.34**	.47**	.39**	.43**	.45**	.36**	.28**	.53**	1										
Item 19	.31**	.35**	.36**	.30**	.32**	.25**	.31**	.22**	.39**	.31**	.38**	.33**	.43**	.38**	.41**	.34**	.33**	.41**	1									
Item 20	.35**	.38**	.36**	.28**	.32**	.26**	.41**	.32**	.38**	.35**	.38**	.38**	.37**	.39**	.38**	.36**	.25**	.40**	.39**	1								
Item 21	.13*	.22**	.19**	.26**	.25**	.11*	.14**	.28**	.12*	.09	.26**	.20**	.15**	.33**	.18**	.02	.14**	.15**	.20**	.21**	1							
Item 22	.25**	.33**	.27**	.29**	.32**	.18**	.35**	.22**	.28**	.30**	.40**	.31**	.34**	.36**	.34**	.20**	.17**	.24**	.29**	.31**	.48**	1						
Item 23	.30**	.34**	.35**	.31*	.35**	.24**	.31**	.23**	.25**	.29**	.37**	.34**	.38**	.43**	.30**	.25**	.18**	.25**	.24**	.36**	.42**	.47**	1					
Item 24	.17**	.20**	.24**	.22**	.22**	.11*	.22**	.14**	.14**	.21**	.33**	.22**	.27**	.25**	.26**	.10*	.18**	.16**	.21**	.18**	.43**	.48**	.58**	1				
Item 25	.25**	.31**	.24**	.21**	.27**	.09	.29**	.27**	.23**	.29**	.32**	.27**	.24**	.33**	.32**	.21**	.17**	.21**	.25**	.29**	.44**	.59**	.58**	.62**	1			
Item 26	.24**	.30**	.23**	.33**	.24**	.20**	.29**	.27**	.26**	.31**	.40**	.25**	.36**	.41**	.36**	.17**	.17**	.26**	.25**	.31**	.52**	.55**	.61**	.53**	.60**	1		
Item 27	.16**	.28**	.29**	.24**	.25**	.16**	.27**	.20**	.21**	.25**	.31**	.28**	.24**	.38**	.24**	.19**	.23**	.29**	.26**	.35**	.46**	.45**	.53**	.56**	.61**	.64**	1	
Total	.62**	.58**	.67**	.68**	.64**	.54**	.66**	.46**	.67**	.60**	.75**	.64**	.71**	.69**	.62**	.45**	.59**	.67**	.60**	.62**	.29**	.46**	.48**	.33**	.40**	.45**	.40**	1

*p < .05, **p < .01 ***p < .001.

Reliability Analysis

Total score indicated excellent internal consistency; Cronbach Alpha coefficient was .92. Additionally, Cronbach Alpha internal consistency reliabilities for subscales were ranged from acceptable to excellent: .81 for intrusion, .56 for avoidance, .82 for changes in cognition and mood, and .76 for increased arousal and reactivity. Last, Cronbach Alpha value for symptoms interference with daily functioning was also excellent (α = .88). Additionally, we also investigated *McDonalds Omega* coefficient to examine composite reliability. Additionally, we investigated McDonald's Omega coefficient to assess composite reliability. The reliability values were excellent: .81 for intrusion, .83 for changes in cognition and mood, and .76 for increased arousal and reactivity. For avoidance subscale, McDonald's Omega coefficient cannot be calculated because it includes only two items, whereas a minimum of three items is recommended for this factor-analysis based coefficient (Orçan, 2023).

We also calculated Cronbach Alpha values to evaluate split-half reliability. The internal consistency coefficient values for the first 10 items were .85, and for second 10 items was .82. Moreover, Spearman Brown coefficient was .90. Overall, the Turkish version of the scale had acceptable to excellent reliability coefficients.

Confirmatory Factor Analysis (CFA)

We conducted a CFA to confirm construct validity of CPSS-5 in Turkish adolescent sample. Before CFA, the normality of the multivariate was assessed using Mardia's coefficient of multivariate skewness and kurtosis test. Non-normal distribution will be achieved if the skewness and kurtosis is statistically significant (Wang &Wang, 2020). Therefore, we conducted Robust Maximum likelihood for further analysis. Fit of the five-factors structure model of the CPSS-5 scores was acceptable, X^2 = 463.720, df = 314, RMSEA = .03 (90% CI = .03 - .04), CFI = .94, TLI= .93, SRMR = .04. The standardized estimates of factor loadings were all acceptable (see Fig. 1). Internal consistency of scores was adequate for girls (α = .92, CI = .33 - .45), for boys (α = .90, CI = .27 - .39) and for the total (α = .92, CI = .33-.41).

Table 2. Coordinates of the CPSS-5 ROC curves

Positive if ≥	Sensitivity	Specificity
28.50	1.00	0.95
29.50	1.00	0.98
30.50	1.00	1.00
31.50	.97	1.00
32.50	.94	1.00
33.50	.85	1.00
34.50	.78	1.00
35.50	.71	1.00
36.50	.62	1.00
37.50	.57	1.00
38.50	.53	1.00
39.50	.48	1.00
40.50	.43	1.00
41.50	.36	1.00
42.50	.33	1.00
43.50	.32	1.00
44.50	.25	1.00

Cut-off Point for Probable PTSD Diagnosis

ROC analysis (receiver operating characteristic) curve analysis were performed to determine cut-off point for the CPSS-5 severity score on the basis of English version of CPSS-5(Table 2). Foa et al. (2018) calculated 31 as a cut-off point for identifying probable PTSD diagnosis. In the current study, the score 30.5 showed cut-off point on the CPSS-5. Individuals with a CPSS-5 score 30.5 and above 30.5 have high levels of PTSD criteria.

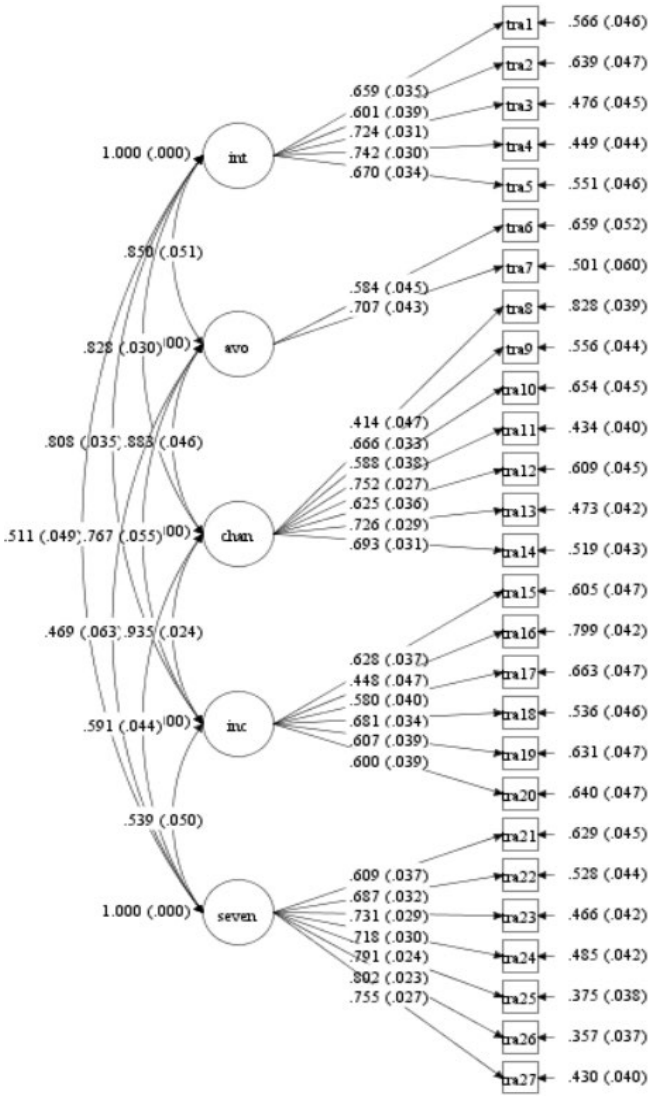

Figure 1. Factor loadings for 5-dimensional model of CPSS-5 scores

Note. Int: Intrusion, Avo: Avoidance Chan: Changes in cognition and mood, Inc: Increased arousal and reactivity, seven: Impairment of endorsed symptoms.

Discriminant and Concurrent Validity

Discriminant validity was assessed using Pearson correlations of the CPSS-5 and SDQ-EP and SSFP (see Table 3). Additionally, we conducted independent sample *t*-test to explore the differences in emotional problems and social support scores among adolescents with and without PTSD to test concurrent validity. The results indicated statistically significant differences in SDQ-EP scores. Adolescents with PTSD exhibited more emotional problems than those without PTSD ($t_{(339)}$ = 12.634, p < .001, 95% *CI* = 2.51, 3.44; M_{PTSD} = 9.55, *SD* = 2.33, $M_{non\text{-}PTSD}$ = 6.57, *SD* = 1.75). Additionally, adolescent without PTSD were more likely to have perceived social support from family compared to those with PTSD ($t_{(346)}$ = 6.828, p < .001, 95% *CI* = -6.54, - 3.61; M_{PTSD}= 18.75, *SD* = 6.79, $M_{non\text{-}PTSD}$ = 23.83, *SD* = 5.78). Similarly, adolescents without PTSD had higher level of perceived social support from peers compared to those with PTSD ($t_{(346)}$ = 3.246, p < .001, 95% *CI* = -4.29, -1.05; M_{PTSD} = 18.47, *SD* = 7.76, $M_{non\text{-}PTSD}$ = 21.15, *SD* = 6.30).

Tablo 3. Means, standard deviations and correlations between CPSS-5, SDQ-EP and SSFP

	1.	2.	3.	4.	5.	6.	7.	8.	9.
1.Emotional Problems	1								
2. Social Support from Family	-.39**	1							
3.Social Support from Peer	-.20**	.35**	1						
4.PTSD_Total	.63**	-.43**	-.19**	1					
5.PTSD_ Intrusion	.51**	-.31**	-.17**	.84**	1				
6.PTSD_ Changes in cognition and mood	.57**	-.44**	-.22**	.92**	.67**	1			
7.PTSD_ Increased arousal and reactivity	.64**	-.42**	-.15**	.87**	.64**	.74**	1		
8.PTSD_ Avoidance	.37**	-.24**	-.07	.72**	.59**	.61**	.52**	1	
9. PTSD_ Impairment of endorsed symptoms	.33**	-.17**	-.09	.51**	.44**	.50**	.44**	.33**	1
M	7.33	22.53	20.46	19.19	5.12	6.93	5.47	1.86	7.54
SD	2.31	6.44	6.79	15.43	4.38	6.28	4.87	2.09	7.04

*p<.05 **p<.01 ***p<.001

Discussion

In the current study, the main aim was to conduct the psychometric investigation of the CPSS-5 with the purpose of adapting it into Turkish children and adolescents. There are no previous scales based on DSM-V in Türkiye. Additionally, we determined the cut-off score in CPSS-5 and classified trauma levels as “traumatized” and “non-traumatized”. We examined the differences between traumatized and non-traumatized adolescents in terms of social support and emotional problems.

The CPSS-5 showed good internal consistency, with acceptable Cronbach Alpha values ranging between .56 and .88 for all five subscales. These values are close to the Cronbach Alpha values in the original scale development study, where the values on the subscales ranged between .63 - .86 (Foa et al., 2018). The lowest Cronbach alpha was found for avoidance, which was measured with two items. Shorter scales often yield lower alpha values (Peterson, 1994). Cronbach Alpha values are sensitive to the number of items and may increase if the number of items increases (Cortine, 1993). Therefore, the relatively low alpha level for this subscale was expected.

The evidence based on CFA confirmed that CPSS has good internal reliability. In other words, the 5-factor structure of the CPSS-5 scale is confirmed in the Turkish adolescent sample. As, each subscale reliably measures its intended constructs, researchers can use both the total and subscale scores similarly across cultures supporting cross-cultural applicability of the scale. Another evidence of internal reliability was inter-item correlations and item-total correlations. It showed that there were moderate correlations between both inter-item and item-total scores. Foa et al. (2018) did not provide results for item-total correlations. However, other adaptation studies have found similar levels of correlations to the correlations in the current study (al-Ammar et al., 2021).

The optimal cut-off points for distinguishing between traumatised and non-traumatised adolescents was determined through ROC analysis. Foa et al. (2018) found that cut-off point is “31”. In the current study cut-off point was calculated as 30.5 in the Turkish sample which is very close to the value found by Foa et al. (2018), potentially providing evidence for the cross-cultural stability of the scale. Following classification, adolescents were assigned a score indicating whether they were "not traumatised" or "traumatised". The discriminant validity of this approach was then examined by utilising social support and emotional problems scores. The results demonstrated that the CPSS-5 has satisfactory psychometric properties regarding discriminant validity.

Adolescence is characterised by an increase in autonomy and the development of social relationships with especially peers. Social support is crucial concepts for non-traumatized adolescents for identity development and positive mental health (Poudel et al., 2020; Scardera et al., 2020). The provision of social support to traumatised adolescents enables them to access a functional social environment, thereby protecting them from the adverse effects of PTSD (Allen et al., 2021; Cohen & Wills, 1985; Wang et al., 2021). However, traumatized adolescents tend to perceive less social support (Muysewinkel et al., 2024). This may be attributed to a proclivity for solitude, potentially driven by the pervasiveness of intrusive thoughts, or by elevated levels of emotional distress, including depression and anxiety (Spinazzola et al., 2014, Vibhakar et al., 2019). The current results were consistent with the previous findings; however, the existence of a supportive environment is a significant factor in the reduction of intrusive thoughts and social isolation associated with PTSD (Foa et al., 2007; Stice et al., 2004).

One of the symptoms of PTSD is negative alterations in cognitions and mood. This may be related to various types of mental health problems such as depression and anxiety (Kar & Bastia, 2006; Messman-Moore & Bhuptani, 2017) or negative emotions such as guilt and shame (Carlson & Dalenberg, 2000; Shi et al., 2021). Furthermore, traumatised adolescents exhibited emotional dysregulation (Paulus et al., 2021), which may result in the long-term maintenance of negative emotional states. A substantial body of research has demonstrated an association between emotional difficulties and PTSD (Hagborg et al., 2022; Vibhakar et al., 2018). Similarly, the current findings indicated that adolescents who have experienced trauma are more likely to experience emotional problems than those who have not. As a results, the findings on social support and emotional problems, which are consistent with existing literature, provide evidence for the discriminant validity.

The study provided a valid and reliable scale for inclusion in the national literature and for use by practitioners. To the best of our knowledge, this is the inaugural study to assess the psychometric properties of a scale developed based on the DSM-5 for adolescents. The scale can be used effectively to identify adolescents with PTSD in clinical settings or to detect students with PTSD in school settings. Screening at schools using CPSS-5 can be practical especially after natural disasters or other kind of collective traumas. It should be noted, however, that the current study is not without limitations. Firstly, the study population comprised adolescents from a low socioeconomic status. This approach enabled us to recruit a higher number of adolescents who had experienced traumatic events, although it did limit our ability to include a representative sample from the wider community. Low socioeconomic status may be considered a risk factor due to

reasons such as difficulties in accessing psychological counseling services, limited awareness of mental health, and low levels of education (Grüning Parache et al., 2024). In particular, low educational attainment of parents may hinder a child's ability to cope with trauma. The literature provides evidence that traumatic experiences in childhood and adolescence may lead to mental health problems in adulthood (McKay et al., 2020). In this regard, future studies may examine the validity and reliability of the scale among adults with different socioeconomic and educational backgrounds. Secondly, the age range of the sample was a limitation. It is recommended that future research extend the age range of participants and conduct a validity and reliability analysis. Also, future studies could examine measurement invariance across gender and other relevant demographic variables, as well as by conducting longitudinal research to evaluate test-retest reliability. Thirdly, a comparison was made between adolescents who had experienced traumatic events and those who had not, in order to provide evidence for the validity of the scale in relation to social support and emotional problems. Nevertheless, PTSD may be associated with a range of emotional and behavioural issues, including suicidal ideation and academic difficulties, among adolescents. It would be beneficial for future studies to examine the risk and buffering factors of PTSD in these domains.

The current study offers a psychometric examination of the CPSS-5, demonstrating satisfactory validity and reliability values in a Turkish adolescent sample aged between 11-14. As anticipated, the findings lend support to the 5-factor model of the CPSS-5 among the Turkish adolescent sample indicating that the underlying construct structure is largely consistent with the original scale. Moreover, additional hypotheses pertaining to discriminant and concurrent validity were substantiated. Adolescents who had experienced traumatic events exhibited lower levels of social support and higher levels of emotional distress relative to their non-traumatized counterparts. Finally, CPSS-5 based on DSM-5 is a scale it can use to determine PTSD level of adolescents in Türkiye.

Author Contributions

The first author contributed to the identification of the problem, obtaining permissions for the scales, data collection and analysis, and writing of the manuscript. The second author contributed to the identification of the problem, completion of the translation processes, data analysis, and writing of the manuscript.

Ethical Declaration

The procedure of the research was approved by the Ethical Committee of Kapadokya University (REF: E-64577500-050.99-17759)

Conflict of Interest

The authors declare that they have no conflict of interest with any institution or individual within the scope of this study.

References

Abraham, E. H., Antl, S. M., & McAuley, T. (2022). Trauma exposure and mental health in a community sample of children and youth. *Psychological trauma: Theory, Research, Practice, and Policy, 14*(4), 624. https://doi.org/10.1037/tra0001035

Agbaria, N., Petzold, S., Deckert, A., Henschke, N., Veronese, G., Dambach, P., ... & Winkler, V. (2021). Prevalence of post-traumatic stress disorder among Palestinian children and adolescents exposed to political violence: A systematic review and meta-analysis. *PLoS One*, *16*(8), e0256426. https://doi.org/10.1371/journal.pone.0256426

al-Ammar, F. K., Attal, B. A., & Ismail, K. (2024). The Child PTSD Symptom Scale among Yemeni School children: Factorial Validity. *European Journal of Social Science Education and Research*, 11(3), 72-93. https://doi.org/10.26417/ejss.v3i1.p119-132

Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: meta-analysis. *The British Journal of Psychiatry*, *204*(5), 335-340. https://doi.org/10.1192/bjp.bp.113.131227

Allen, L., Jones, C., Fox, A., Copello, A., Jones, N., & Meiser-Stedman, R. (2021). The correlation between social support and post-traumatic stress disorder in children and adolescents: A meta-analysis. *Journal of Affective Disorders*, *294*, 543-557. https://doi.org/10.1016/j.jad.2021.07.028

American Psychiatric Association (2022). *Diagnostic and statistical manual of mental disorder.* American Psychiatric Association Publishing

Birkeland, M. S., Skar, A. M. S., & Jensen, T. K. (2022). Understanding the relationships between trauma type and individual posttraumatic stress symptoms: a cross-sectional study of a clinical sample of children and adolescents. *Journal of Child Psychology and Psychiatry*, *63*(12), 1496-1504. https://doi.org/10.1111/jcpp.13602

Boumpa, V., Papatoukaki, A., Kourti, A., Mintzia, S., Panagouli, E., Bacopoulou, F., & Tsitsika, A. (2024). Sexual abuse and post-traumatic stress disorder in childhood, adolescence and young adulthood: A systematic review and meta-analysis. *European Child & Adolescent Psychiatry, 33*(6), 1653–1673. https://doi.org/10.1007/s00787-022-02015-5

Clark, L. A., & Watson, D. (2016). Constructing validity: Basic issues in objective scale development. In A. E. Kazdin (Ed.), *Methodological issues and strategies in clinical research* (4th ed., pp. 187–203). American Psychological Association. https://doi.org/10.1037/14805-012

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98*(2), 310. https://doi.org/10.1037/0033-2909.98.2.310

Cortina, J. M. (1993). What is coefficient alpha? An examination of theory and applications. *Journal of Applied Psychology*, 78(1), 98.

Eker, D., & Arkar, H. (1995). Perceived social support: psychometric properties of the mspss in normal and pathological groups in a developing country. *Social Psychiatry and Psychiatric Epidemiology, 30*, 121-126.

Foa, E. B., Hembree, E. A., Rothbaum, B. O., & Rauch, S. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences: Therapist guide*. Oxford University Press. https://doi.org/10.1093/med:psych/9780195308501.001.0001

Foa, E. B., Asnaani, A., Zang, Y., Capaldi, S., & Yeh, R. (2018). Psychometrics of the child PTSD symptom scale for DSM-5 for trauma-exposed children and adolescents. *Journal of Clinical Child & Adolescent Psychology*, *47*(1), 38-46. https://doi.org/10.1080/15374416.2017.1350962

Frederick, C., Pynoos, R. S., & Nader, K. (1992). *Child Post Traumatic Stress Disorder Reaction Index (CPTSD-RI)*. University of California at Los Angeles Department of Psychiatry

Geisinger, K. F., & McCormick, C. (2013). Testing and assessment in cross-cultural psychology. *Handbook of Psychology: Assessment Psychology*, 114-139.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: a research note. *Journal of Child Psychology and Psychiatry*, *38*(5), 581-586. https://doi.org/10.1111/j.1469-7610.1997.tb01545.x

Grüning Parache, L., Vogel, M., Meigen, C., Kiess, W., & Poulain, T. (2024). Family structure, socioeconomic status, and mental health in childhood. *European Child & Adolescent*

Psychiatry, *33*(7), 2377-2386. https://doi.org/10.1007/s00787-023-02329-y

Güvenir, T., Özbek, A., Baykara, B., Arkar, H., Şentürk, B., & İncekaş, S. (2008). Psychometric properties of the Turkish version of the Strengths and Difficulties Questionnaire (SDQ). *Turkish Association for Child and Adolescent Psychiatry*, *15*(2), 65-74.

Hagborg, J. M., Kalin, T., & Gerdner, A. (2022). The Childhood Trauma Questionnaire—Short Form (CTQ-SF) used with adolescents–methodological report from clinical and community samples. *Journal of Child & Adolescent Trauma*, *15*(4), 1199-1213. https://doi.org/10.1007/s40653-022-00443-8

Hu, L., & 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

Hulin, C., Netemeyer, R., and Cudeck, R. (2001). Can a reliability coefficient be too high? *Journal of Consumer Psychology, 10*(1), 55-69. https://doi.org/10.1207/S15327663JCP1001&2_05.

International Organization for Migration (2024). Migrants' presence monitoring. https://dtm.iom.int/reports/turkiye-migrant-presence-monitoring-situation-report-january-2024

Kar, N., & Bastia, B. K. (2006). Post-traumatic stress disorder, depression and generalised anxiety disorder in adolescents after a natural disaster: a study of comorbidity. *Clinical Practice and Epidemiology in Mental Health*, *2*, 1-7. https://doi.org/10.1186/1745-0179-2-17

McKay, M. T., Cannon, M., Chambers, D., Conroy, R. M., Coughlan, H., Dodd, P., ... & Clarke, M. C. (2021). Childhood trauma and adult mental disorder: A systematic review and meta-analysis of longitudinal cohort studies. *Acta Psychiatrica Scandinavica*, *143*(3), 189-205. https://doi.org/10.1111/acps.13268

Messman-Moore, T. L., & Bhuptani, P. H. (2017). A review of the long-term impact of child maltreatment on posttraumatic stress disorder and its comorbidities: An emotion dysregulation perspective. *Clinical Psychology: Science and Practice*, *24*(2), 154. https://doi.org/10.1111/cpsp.12193

Ministry of Interior Disaster and Emergency Manangement Presidency (2017) Türkiye'deki Suriyelilerin demografik görünümü, yaşam koşulları ve gelecek beklentilerine yönelik saha araştırması. https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://www.afad.gov.tr/kurumlar/afad.gov.tr/25337/xfiles/17a-Turkiye_deki_Suriyelilerin_Demografik_Gorunumu_Yasam_Kosullari_ve_Gelecek_Beklentilerine_Yonelik_Saha_Arastirmasi_2017.pdf&ved=2ahUKEwipsZier8yJAxX0VvEDHWjcFYUQFnoECB0QAQ&usg=AOvVaw3Zgiid44F-4leCcOrpISRF

Muysewinkel, E., Vesentini, L., Van Deynse, H., Gisle, L., Smith, P., Bruggeman, H., Bilsen, J., & Van Overmeire, R. (2024). Trauma exposure, social support and mental health in the general population in Belgium. *European Journal of Investigation in Health, Psychology and Education*, *14*(7), 2047-2056. https://doi.org/10.3390/ejihpe14070136

Muthen, L. K., & Muthén, B. O. (2019). Mplus version 8.3: User's guide. *Los Angeles: Muthén & Muthén.*

National Center for PTSD (2024). *How Common is PTSD in Children and Teens?* https://www.ptsd.va.gov/understand/common/common_children_teens.asp

Orçan, F. (2023). Comparison of cronbach's alpha and McDonald's omega for ordinal data: Are they different? *International Journal of Assessment Tools in Education*, *10*(4), 709-722.

Paulus, F. W., Ohmann, S., Möhler, E., Plener, P., & Popow, C. (2021). Emotional dysregulation in children and adolescents with psychiatric disorders. A narrative review. *Frontiers in Psychiatry, 12*, 628252. https://doi.org/10.3389/fpsyt.2021.628252

Peterson, R. A. (1994). A meta-analysis of Cronbach's coefficient alpha. *Journal of Consumer Research, 21*(2), 381–391.https://doi.org/10.1086/209405

Poudel, A., Gurung, B., & Khanal, G. P. (2020). Perceived social support and psychological wellbeing among Nepalese adolescents: the mediating role of self-esteem. *BMC Psychology, 8*, 1-8. https://doi.org/10.1186/s40359-020-00409-1

Pynoos, R. S., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., Nunez, F., & Fairbanks, L. (1987). Life threat and posttraumatic stress in school-age children. *Archives of General Psychiatry*, *44*(12), 1057-1063. https://doi.org/10.1001/archpsyc.1987.01800240031005

Rezayat, A. A., Sahebdel, S., Jafari, S., Kabirian, A., Rahnejat, A. M., Farahani, R. H., & Nour, M. G. (2020). Evaluating the prevalence of PTSD among children and adolescents after earthquakes and floods: a systematic review and meta-analysis. *Psychiatric Quarterly, 91*, 1265-1290. doi: 10.1007/s11126-020-09840-4

Scardera, S., Perret, L. C., Ouellet-Morin, I., Gariépy, G., Juster, R. P., Boivin, M., Séguin, J. R., Tremblay, R. E., & Geoffroy, M. C. (2020). Association of social support during adolescence with depression, anxiety, and suicidal ideation in young adults. *JAMA Network Open*, *3*(12), e2027491-e2027491. https://doi.org/10.1001/jamanetworkopen.2020.27491

Selçuk, E. B., Demir, A. Ç., Erbay, L. G., Özcan, Ö. Ö., Gürer, H., & Dönmez, Y. E. (2021). Anxiety, depression and post-traumatic stress disorder symptoms in adolescents during the COVID-19 outbreak and associated factors. *International Journal of Clinical Practice*, *75*(11), e14880. https://doi.org/10.1111/ijcp.14880

Shi, C., Ren, Z., Zhao, C., Zhang, T., & Chan, S. H. W. (2021). Shame, guilt, and posttraumatic stress symptoms: A three-level meta-analysis. *Journal of Anxiety Disorders*, *82*, 102443. https://doi.org/10.1016/j.janxdis.2021.102443

Spinazzola, J., Hodgdon, H., Liang, L. J., Ford, J. D., Layne, C. M., Pynoos, R., Briggs, E. C., Stolbach, B., & Kisiel, C. (2014). Unseen wounds: The contribution of psychological maltreatment to child and adolescent mental health and risk outcomes. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(S1), S18. https://doi.org/10.1037/a0037766

Stice, E., Ragan, J., & Randall, P. (2004). Prospective relations between social support and depression: Differential direction of effects for parent and peer support? *Journal of Abnormal Psychology*, *113*(1), 155. https://doi.org/10.1037/0021-843X.113.1.155

Vibhakar, V., Allen, L. R., Gee, B., & Meiser-Stedman, R. (2019). A systematic review and meta-analysis on the prevalence of depression in children and adolescents after exposure to trauma. *Journal of Affective Disorders*, *255*, 77-89. https://doi.org/10.1016/j.jad.2019.05.005

Wang, Y., Chung, M. C., Wang, N., Yu, X., & Kenardy, J. (2021). Social support and posttraumatic stress disorder: A meta-analysis of longitudinal studies. *Clinical Psychology Review*, *85*, 101998. https://doi.org/10.1016/j.cpr.2021.101998

Wang, J., & Wang, X. (2019). *Structural equation modeling: Applications using Mplus*. John Wiley & Sons.

World Health Organization. (2020, September). *ICD-11 for mortality and morbidity statistics*. https://icd.who.int/browse11/l-m/en

Yakşi, N., & Eroğlu, M. (2024). Determinants of Posttraumatic Stress Disorder (PTSD) among children and adolescents in the subacute stage of Kahramanmaras earthquake, Turkey. *Archives of Public Health*, *82*(1), 199. https://doi.org/10.1186/s13690-024-01434-x

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52*(1), 30-41. https://doi.org/10.1207/s15327752jpa5201_2

Appendix

Çocuk TSSB Belirti Ölçeği-Öz-Rapor Versiyonu

Şu ana kadar yaşadığın en üzücü ya da korkutucu deneyimi düşün. Bu deneyim senin başına gelmiş bir şey olabilir, gördüğün bir şey olabilir ya da bir arkadaşının ya da ailenden birinin başına gelmiş bir şey bile olabilir. Bu bir trafik kazası, dayak yemek, deprem yaşamak, soyulmak, anne babadan birinin kaybı, sevmediğin şekilde sana dokunulması, annenin incindiğini görmek gibi bir şey olabilir ya da çok üzücü başka bir olay olabilir.
Şu ana kadar yaşadığın en üzücü ya da korkutucu deneyim nedir?

_____

_____

_____

Bu ne zaman oldu? (Kaç yaşındaydın? Ne kadar zaman önce oldu? Kaçıncı sınıftaydın?)

_____

SON BİR AY İÇİNDE bu deneyim hakkında ne hissediyorsun?

		Hiç	Haftada bir kez ya da daha az biraz	Haftada 2-3 kez oldukça	Haftada 4-5 kez/ çok fazla	Haftada 6 kez ya da Neredeyse her zaman
1.	İstemediğin halde zihnine gelen deneyimle ilgili seni rahatsız eden düşünce ve görüntüler aklına geldi mi?	0	1	2	3	4
2.	Kötü rüyalar ya da kabuslar gördün mü?	0	1	2	3	4
3.	Deneyim sanki yine oluyormuş gibi hissettin ya da davrandın mı? (Bir şeyler görme ya da bir şey duyma ve sanki yine oradaymış gibi hissetme)	0	1	2	3	4
4.	Ne olduğu hatırlatıldığında rahatsız hissettin mi? (Örneğin, korkmuş, öfkeli, üzgün, suçlu, şaşkın hissetmek)	0	1	2	3	4
5.	Ne olduğu hatırlatıldığında vücudunda hisler var mıydı? (Örneğin, ter dökmek, kalbinin hızlı atması)	0	1	2	3	4
6.	Deneyim hakkında düşünmemeye, konuşmamaya ya da hisler beslememeye çalıştın mı?	0	1	2	3	4
7.	Sana ne olduğunu hatırlatan etkinliklerden, insanlardan ya da yerlerden uzak durmaya çalıştın mı?	0	1	2	3	4
8.	Deneyimin önemli bir bölümünü hatırlamakta zorlandın mı?	0	1	2	3	4
9.	Kendin, diğer insanlar, ya da dünya hakkında kötü düşüncelerin var mıydı (Örneğin, "Hiçbir şeyi doğru düzgün yapamam", "Bütün insanlar kötüdür", "Dünya korkutucu bir yerdir")?	0	1	2	3	4
10.	Olanların senin hatan olduğunu hissettin mi? (Örneğin, "Daha iyi bilmeliydim", "Onu yapmamalıydım")	0	1	2	3	4
11.	Korku, öfke, suçluluk ya da utanç gibi güçlü rahatsız edici duygulara sahip miydin?	0	1	2	3	4
12.	Eskiden yapmayı sevdiğin şeyleri yapmakla daha mı az ilgilendin?	0	1	2	3	4
13.	Kendini insanlara yakın hissetmekte sorun yaşadın mı? Başkalarının yanında olmak istemediğini hissettin mi?	0	1	2	3	4
14.	İyi duygular hissetmekte sorun yaşadın mı? (Mutluluk ya da sevgi gibi)	0	1	2	3	4
15.	Kolayca sinirlendin mi? (Örneğin, bağırma, başkalarına vurma, bir şeyleri fırlatma)	0	1	2	3	4
16.	Kendine zarar verebilecek herhangi bir şey yaptın mı? (Örneğin, ilaç içme, kaçma)	0	1	2	3	4
17.	Aşırı dikkatli ya da gözetleme halinde miydin? (Örneğin, etrafında kim olduğuna ve etrafında ne olduğunu kontrol etme)	0	1	2	3	4
18.	Gergin miydin ya da kolayca ürktün mü? (Örneğin arkandan birisi yaklaştığında, yüksek bir ses duyduğunda)	0	1	2	3	4
19.	Dikkatini vermekte zorlandın mı? (Örneğin, televizyondaki hikâyeyi takip edememe, ne okuduğunu unutma, sınıfa dikkat edememe)	0	1	2	3	4
20.	Uykuya dalmada ya da uykuda kalmada güçlük çektin mi?	0	1	2	3	4

Bu semptomlar (belirtiler) gündelik yaşamını ne kadar etkiliyor?

		Hiç	Biraz	Oldukça	Çok fazla	Neredeyse her zaman
21.	Dua ediyorken	0	1	2	3	4
22.	Ev işleri, görevleri	0	1	2	3	4
23.	Arkadaşlarla ilişkileri	0	1	2	3	4
24.	Eğlence ve hobi etkinlikleri	0	1	2	3	4
25.	Okul çalışmaları	0	1	2	3	4
26.	Ailenle ilişkilerini	0	1	2	3	4
27.	Yaşamından genel mutluluğunu	0	1	2	3	4