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THE ADAPTATION OF THE ESTONIAN VERSION OF THE CLINICIAN-ADMINISTERED PTSD SCALE: A PILOT STUDY

Bachelor's thesis

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The Adaptation of the Estonian CAPS-5

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The Adaptation of the Estonian Version of the Clinician-Administered PTSD Scale: A Pilot Study

Abstract

The aim of the current Bachelor's thesis was to produce a comprehensible Estonian version of the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), as part of a more extensive adaptation process. To achieve this objective, the original English version of the CAPS-5 was translated into Estonian and then reviewed and revised by a team of experts comprising of three clinical psychologists with experience in trauma related work and a psychiatrist. The Estonian version of the CAPS-5 was then reviewed by a clinical psychologist and expert in the field in question who did not participate in previous discussion and editing of the Estonian CAPS-5. The final version of the Estonian CAPS-5 was tested with a small community sample of six individuals who had endorsed trauma exposure, in order to examine its comprehensibility and draw primary conclusions about whether or not it indicates the presence or absence of post-traumatic stress disorder (PTSD). The results indicated that the Estonian CAPS-5 was generally clear and understandable and enables to establish a diagnosis.

Keywords: Clinician-Administered PTSD Scale, DSM-5, CAPS-5, posttraumatic stress disorder, adaptation, translation, structured interview

CAPS-5 intervjuu adapteerimine eesti keelde: pilootprojekt

Kokkuvõte

Käesoleva bakalaureusetöö eesmärgiks oli tõlkida ja piloteerida eestikeelset versiooni posttraumaatilist stresshäiret diagnoosida võimaldavast CAPS-5 kliinilisest intervjuust. Selleks teostati antud töö raames kõigepealt tõlge inglise keelest eesti keelde, millele järgnes tõlke toimetamine ja arutelu ekspertide töörühmaga, kuhu kuulusid kolm traumatöö kogemusega kliinilist psühholoogi ja üks psühhiaater. Järnevalt vaatas valminud versiooni üle veel üks valdkonna ekspert, kliiniline psühholoog, kes ei osalenud esialgses arutelus. Lõppversiooni eestikeelsest CAPS-5 intervjuust piloteeriti kuuest trauma kogemusega katseisikust koosneva valimi peal hindamaks selle arusaadavust ning saamaks esmast informatsiooni selle toimivuse kohta diagnostilise vahendina. Testimise tulemusena ilmnes, et eestikeelne CAPS-5 intervjuu on selgesti mõistetav ning võimaldab diagnoosida posttraumaatilist häiret.

Märksõnad: posttraumaatiline stresshäire, CAPS-5, DSM-5, struktureeritud kliiniline intervjuu, adapteerimine, tõlkimine

INTRODUCTION

The aim of the current Bachelor's thesis was to complete the first three steps in the process of the adaptation of the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) into Estonian. This included (1) the translation of the original, English CAPS-5 into Estonian, (2) the revision of the Estonian version in collaboration with a panel of clinical specialists, and (3) piloting the Estonian CAPS-5 on a small sample in order to examine its comprehensibility and acquire primary information about its diagnostic capability. The importance of the adaptation of the CAPS-5 into Estonian lies in providing Estonia's clinical psychologists with a valuable and effective instrument for diagnosing posttraumatic stress disorder and thereby enabling a greater number of PTSD sufferers to receive a diagnosis and therefore appropriate treatment.

Post-traumatic Stress Disorder (PTSD) is a psychiatric disorder which may develop after experiencing a traumatic event or series of events either through direct exposure as a victim or witness; by learning about its occurrence to a close family member or close friend, or by recurrent work-related exposure to aversive details (APA, 2013; WHO, 2018). As defined in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a trauma is actual or threatened death, serious injury, or sexual violence (APA, 2013). The characteristics of PTSD include (1) re-experiencing symptoms, such as intrusive thoughts, flashbacks or nightmares connected to the traumatic event(s), (2) avoidance of thoughts, feelings, people and other reminders of the trauma, (3) negative alterations in cognitions and mood, such as inability to remember important aspects of the trauma, estrangement from other people, diminished interest in activities, blame of self or others, and negative beliefs about self, the world or others, persistent negative emotional state and inability to feel positive feelings, (4) hyperarousal, such as problems with sleeping, concentration, emotion regulation resulting in aggression toward others, increased startle response and hypervigilance (APA, 2013; Rendon, 2015). In addition, some individuals may present with dissociative symptoms (APA, 2013, WHO, 2018). PTSD symptoms may vary in intensity and frequency from mildly distressing to severely incapacitating. In addition, there is a great variation in both symptoms exhibited by different individuals, as well as in the onset of symptoms (Institute of Medicine, 2006). Typically, the onset of symptoms occurs shortly after the traumatic experience, but in case of a delayed onset, symptoms may not commence for over six months after the trauma (APA, 2013; WHO, 2018; Institute of Medicine, 2006).

Even though PTSD can occur alone, it is often comorbid with other mental disorders, such as for instance, major depressive syndrome, anxiety and mood disorders, and substance abuse (Institute of Medicine, 2006), worse physical health (Rendon, 2015), and a higher risk of "functional role impairment, such as unemployment or marital instability (Rendon, 2015)". PTSD is also known for its potentially chronic nature (Liivamägi, 2011; Foa, Yadin, 2011; Institute of Medicine, 2006).

It is estimated that 40-60% of community adults will experience some sort of trauma during their lifetime, however, only about 9% of them will develop PTSD (Taylor, 2017; APA, 2013). This indicates that even though the occurrence of a traumatic event is a necessary precursor to developing PTSD, it is not sufficient. Its development depends on the combination of several protective and risk factors prior to, during and after the traumatic event. Some of the pretraumatic factors include the genetic characteristics of an individual (including gender and ethnocultural background, as well as certain gene variations), age, marital status, preexisting psychopathology, family history of psychopathology, low intelligence, previous exposure to traumatic experiences, past PTSD episodes, aversive social environment (economic deprivation, family instability prior to the traumatic event), social relations with others, social conflict, addiction problems, socioeconomic status, education and social support (Ford , 2015; Taylor, 2017). Some peritraumatic risk factors include the "dose" of trauma exposure and peritraumatic dissociation (Taylor, 2017). As for posttraumatic risk factors, maladaptive coping, aversive posttrauma environments providing low social support and financial or other burdens, as well as new or ongoing aversive life events increase the risk of developing PTSD (Taylor, 2017). However, it is significant to note that none of the aforementioned risk factors are necessary or sufficient for PTSD development.

A significant number of studies have shown that even though women are less likely than men to experience a traumatic event, they are more likely to develop PTSD as a result (Stein, Friedman, Blanco, 2011). There is not a clear and unanimous explanation to this, but it is believed that PTSD rates can be higher among women due to higher frequency of sexual trauma or repeated exposure to the same type of trauma; genetic, biological, social, and cultural aspects may also play an important role (Stein , 2011; Ford , 2015). Moreover, studies have shown that the type of trauma, too, influences the probability of acquiring PTSD. Namely, victims of natural disasters, for instance, have shown lower PTSD rates than victims of interpersonal violence, such as sexual violence, torture or terrorist attacks (Liivamägi, 2011; Breslau, 2009). Although PTSD is a culturally universal syndrome, meaning that it takes similar forms across

diverse cultures, cultural factors can still influence beliefs and interpretations associated with PTSD. For instance, in Cambodian culture, nightmares are interpreted as though the dreamer has a wandering soul which has encountered the dead or is being attacked by evil spirits (Taylor, 2017).

When it comes to global prevalence of PTSD, it is hard to bring out a certain number, as there are numerous factors which affect the prevalence of PTSD in different countries, such as differences in general prevalence, number of studies conducted on the topic, the overall qualities of the environment where people live and work and so forth. That being said, most studies conducted on the topic of PTSD have been carried out in Canada and the United States of America, as well as in bigger Western European countries (Stein, Friedman, Blanco, 2011). In North America, the lifetime prevalence of PTSD is estimated to be 9% (APA, 2013), being higher in some subgroups, such as military or law enforcement workers, emergency services workers, sex-trade workers etc. To illustrate, PTSD prevalence among combat veterans is found to be 22-31% (Taylor, 2017). An extensive European study encompassing 11 countries found that PTSD prevalence ranged from 0,56% to 6,67% (Burri, Maercker, 2014). The results by country were as follows: 0,38% in Romania, 0,56% in Spain, 0,70% in Switzerland, 0,73% in Italy, 0,76% in Belgium, 0,94% in Bulgaria, 2,31% in Germany, 2,32% in France, 3,00% in the UK, 3,30% in the Netherlands, and 6,67% in Croatia (Burri, Maercker, 2014).

In countries where there are ongoing armed conflicts, PTSD rates are naturally higher. To illustrate, lifetime PTSD prevalence is found to be 16% in Ethiopia, 18% in Gaza, 28% in Cambodia, and 37% in Algeria (Taylor, 2017). In the Baltics, there have not been many studies conducted on the topic of trauma and PTSD prevalence. A study covering all three Baltic countries, that is Estonia, Latvia and Lithuania, found that the reported prevalence of traumatic events was 70-75% and the prevalence of PTSD between 2-7% (Kazlauskas, Zelviene, 2015). In Estonia, data about trauma and PTSD prevalence is very scarce, therefore it is very hard to bring out reliable data concerning this topic. As of 2017, the number of patients diagnosed within the diagnostic category of Reaction to severe stress, and adjustment disorders (F43.0 - F43.9) is, according to the National Institute for Health Development, 6296 in total, of which 2997 are new cases, but PTSD diagnoses are not accounted for separately (National Institute for Health Development, 2018). This might suggest that currently, PTSD is not sufficiently applied as a diagnosis in Estonia, or that limitations are caused by the lack of effective diagnostic instruments which complicate the diagnostic process. Because of its complex nature, PTSD might remain unnoticed due to the patient seeking help in connection to other health

problems comorbid with PTSD, such as, for instance, substance abuse or major depressive disorder, or be confused with other disorders such as anxiety disorders.

It is important to bear in mind that PTSD as a clinical diagnosis, is barely four decades old. This means, that although the term “post-traumatic stress disorder” or “PTSD” is fairly novel, the symptomatic phenomena constituting what we now refer to as PTSD are by no means new. It has been recognized throughout history, that experiencing significant trauma can lead to long-term physiological and psychological problems. Recognized since ancient times, it has emerged in literature throughout history. For instance, Greek historian Herodotus described an Athenian soldier in the Marathon battle becoming permanently blind, regardless of having no physical injury, after seeing the soldier next to him being killed, and Homer portrayed in his *Iliad* soldiers’ reactions to war traumatization, including experiencing grief, withdrawal and feelings of guilt toward fallen brothers-in-arms (Gournay, 2015; Ray, 2008).

Since the 19th century, a wide variety of terms has been used to label and describe this disorder, from “railway spine/ brain”, “spinal irritation”, “traumatic neurosis”, “hysterical hemianaesthesia”, and “soldier’s heart” to “shell shock” and “war neuroses”, among many, until finally acquiring the name “post-trauma syndrome” during World War II. Such terminological abundance depicts the evolutionary course of PTSD, providing an overview of how it has been understood and regarded over the course of its development. Initially PTSD symptoms were thought to be caused by somatic strain or injuries such as concussion to the brain or spinal cord in railroad accidents or flying shrapnel embedded into soldiers’ skulls inflicting brain damage which in turn would lead to experiencing symptoms such as fatigue, tremor, confusion, nightmares and visual or auditory impairment, as well as general dysfunction. Since the symptoms exhibited by soldiers suffering from, what was then referred to as “shell shock”, were mainly physical, it wasn’t regarded as a psychogenic disorder (Jones, 2012). One of the first to argue against such theories was H. Page, stating that it was unlikely that minute injuries to the spinal cord would produce abnormalities of psychological functioning after railroad accidents. Instead, he stated that fright, alarm and fear contributed to the formation of the disorder (Ray, 2008). For a long time, it was also assumed, that the symptoms would recede once the individual retired from the stressor and returned to normal life. This however was proven wrong after the Vietnam War, when a number of veterans who returned home continued to exhibit PTSD symptoms and some did so even months or years later (Egan , 2010).

It was only in 1980 that the term “posttraumatic stress disorder” or “PTSD” was adopted, the phenomenon officially recognized as a diagnosable disorder and published in the third edition

of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III; Cantor, 2005; Egan, 2010; Ray, 2008). Since then, PTSD criteria have attracted controversy and substantial changes have been carried out with each revision of the DSM (Pai, Suris, North, 2017). After the publication of the DSM-IV in 1994, deriving from advances in clinical practise and the increasing amount of literature on the topic of PTSD, there was an inundation of criticism, polemical arguments and proposals for change, regarding matters such as the definition of trauma, symptoms to be included in the PTSD criteria, symptom classification and even questions about the validity of PTSD as a diagnosis. In 2000 the text revision edition of the DSM-IV, which bore the name DSM-IV-TR (APA, 2000), the text accompanying the PTSD criteria was revised, but the diagnostic criteria remained the same (Pai , 2017). In 2013, another substantial revision, the 5th edition of the DSM (DSM-5) was published (APA, 2013). Several remarkable changes have been made in the criteria of PTSD since the last version of the manual. Perhaps the most substantial conceptual change regarding PTSD in the DSM-5 is its removal from the anxiety disorders' category and reclassification in the new diagnostic category "Trauma and Stressor-related Disorders" alongside reactive attachment disorder, disinhibited social engagement disorder, acute stress disorder and adjustment disorder (Weathers, Marx, Friedman, Schnurr, 2014; Levin, Kleinman, Adler, 2014; Pai et al, 2017). This is due to a considerable amount of research indicating that PTSD entails emotions reaching outside of the anxiety spectrum, such as for instance guilt, shame and anger, as well as dysphoria, anhedonia, dissociation or the combination of all the aforementioned symptoms, making its inclusion in the anxiety disorders category inconsistent with the new scientific understanding of PTSD (Pai , 2017; Weathers , 2014). All the disorders within the trauma and stressor-related disorders' category require exposure to a stressful event as a precursor to the onset of symptoms (Pai , 2017; Levin , 2014).

In addition, some important changes have been made in criterion A, which requires the individual to have been exposed to a traumatic event. To begin with, stressors qualifying as traumatic experiences have been narrowed, specified and precisely defined in DSM-5 (Pai , 2017). The definition of a traumatic event was very broad in DSM-IV, causing a "conceptual bracket creep" or in other words, making "too many people eligible for a PTSD diagnosis based on exposure to relatively minor stressors or indirect exposure to major stressors (Weathers , 2014)". In DSM-5 trauma is defined as "actual or threatened death, serious injury, or sexual violence (APA, 2013)". The term "threat to physical integrity" in the definition of trauma was removed in DSM-5 due to its vagueness (Weathers et al, 2014). Furthermore, the DSM-IV A2

criterion which required that the individual must experience intense fear, helplessness or horror during the traumatic event, was eliminated in DSM-5 with the implication that not all individuals, such as, for instance, trained military personnel experience fear, helplessness, or horror during or immediately after the traumatic event (Friedman, Resick, Bryant, Brewin, 2010). Therefore, such subjective judgement would exclude individuals who did not experience these emotions yet meet the rest diagnostic criteria for PTSD. Additionally, individuals who have experienced a mild traumatic brain injury (TBI) during the traumatic event, might be unaware of their peritraumatic emotional response to the event due to loss of consciousness (Friedman et al, 2010). However, studies have indicated that individuals with severe TBI have developed PTSD following to traumatic events, even though they were unaware of their emotional response not only during the event but several weeks or months after the incident (Friedman et al, 2010). Therefore, there is strong evidence that people can develop PTSD even without the presence of criterion A2. That being said, another important aspect to consider is that most PTSD sufferers who seek treatment often refer to doctors and clinicians months or years after the occurrence of the traumatic event and therefore do not remember their exact emotional reaction at the time or following the event, thus providing unreliable responses influenced by both ability of recollection and emotional state during evaluation (Friedman et al, 2010).

Lastly, specifications in the definitions of eligible exposure types were made. Not only is the occurrence of a traumatic event required, the individual must also have had a qualifying exposure to the trauma, as stipulated in criterion A. In DSM-IV-TR, the phrase used to refer to the three types of exposure was "experienced witnessed, or was confronted with" (APA, 2000). DSM-5 has retained all three types of exposure, listing and defining them explicitly as A1-A3, i.e. the person must have experienced the trauma personally, witnessed the event, in person, as it was happening to somebody else, or learned about traumatic events that happened to a family member or a close friend (APA, 2013). A fourth exposure type has been added, named A4, encompassing "repeated or extreme exposure to aversive details of the traumatic event(s)" and concerns primarily work-related exposure by professionals such as for instance first responders collecting human remains, military mortuary workers, forensic child abuse investigators etc (Pai et al, 2017; Friedman et al, 2010).

Changes have been made to other criteria as well. To begin with, contrary to DSM-IV-TR, there are four instead of three symptom clusters (re-experiencing, avoidance, numbing and hyperarousal) in DSM-5 (APA, 2013). This is due to the separation of avoidance and numbing

symptoms which were both under Criterion C in DSM-IV-TR. In DSM-5, Criterion C only contains symptoms of avoidance and numbing symptoms are contained in Criterion D (Levin et al, 2014). In addition to the removal or addition of items, DSM-5 contains a multitude of alternations in wording. Subsequently, a review of the most important changes will be provided.

In Criterion B, which measures intrusion symptoms (intrusive thoughts, nightmares, dissociative reactions, psychological and physiological reactions to reminders), the most important change concerns B1 where the phrase "recurrent and intrusive recollections of the event" has been replaced by "recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)", emphasizing the involuntary nature of these memories and distinguishing it from ruminations containing some voluntariness (Weathers et al, 2014). Also, the word "recollections" was replaced with "memories". Some other changes in Criterion B include:

- B2 now clarifies that distressing dreams need to be related to the trauma but must not necessarily be a precise replaying of it;
- B3 emphasizes the dissociative nature of flashbacks, which can include a total loss of awareness of the present surroundings and occur on a continuum;
- B4 which assesses cued distress has undergone a change in wording from "intense psychological distress" to "intense or prolonged psychological distress", suggesting that to satisfy this criterion, the reactions could be either short but intense or less intense but sustained over a longer period of time;
- In B5, which measures cued physiological reactivity, the term "physiological reactivity" was replaced with "marked physiological reactions", raising the threshold for clinical significance (Weathers et al, 2014; Levin et al, 2014)

As mentioned above, avoidance symptoms have been placed in a separate symptom cluster, Criterion C. In this cluster, there are two symptoms: the avoidance of activities and other stimuli associated with the traumatic event(s) (C2), and the avoidance of distressing memories, thought and feelings (C1; APA, 2013; Weathers et al, 2014). Of the four DSM-5 symptom clusters, the new cluster named Criterion D, has undergone the most extensive revision. From DSM-IV-TR, only three of the seven symptoms in this cluster have remained unchanged: amnesia (D1), diminished interest or participation in important activities (D5), and the feeling of detachment or estrangement from others (D6; Weathers et al, 2014; APA, 2013). Of the remaining fours symptoms two are new: distorted cognitions leading to blame of self or others (D3) and persistent negative emotional state (D4); one has been significantly broadened: instead

of DSM-IV-TR's "foreshortened future", which was difficult to comprehend by patients and clinicians alike, it is phrased as "exaggerated negative beliefs about self, others or world" (D2); and one symptom (D7) has been substantially narrowed: "inability to experience positive emotions", as opposed to "restricted range of affect" in DSM-IV-TR (Weathers et al, 2014; Levin et al, 2014; APA, 2013).

Next, hyperarousal and reactivity criteria which are now contained in Criterion E have remained largely unchanged. Here, two new symptoms have been added: reckless or self-destructive behaviour (E2) and verbal or physical aggression (E1; Levin et al., 2014). Anger has been covered more extensively in D4, in DSM-5 (Weathers et al, 2014). The rest of the Criterion E symptoms include hypervigilance (E3), exaggerated startle reaction (E4), concentration problems (E5), and sleep disturbance (E6; APA, 2013; Schupp, 2015; Weathers et al., 2014).

Criterion F, which requires the disturbance to persist more than one month is relatively unchanged. The only alteration in this criterion is that the classifications "acute" and "chronic" have been removed (Levin et al., 2014). According to Criterion G, the disturbance must cause clinically significant distress or functional impairment. This criterion has also remained virtually unchanged, there have been minor specifying alterations in wording (Schupp, 2015). Another criterion, Criterion H, has been added which requires that disturbance is not caused by any substance (e.g. drugs, alcohol, medication) or other medical conditions (Levin et al, 2014). Lastly, there are two specifiers, one of them is new and refers to the subtype "with dissociative symptoms" where the individual recurrently experiences symptoms of derealisation and depersonalization. This addition is important because it "strengthens the recognition of dissociation in PTSD" and suggests that individuals within this subset may not respond well to treatment (Levin et al, 2014). The second specifier, already present in DSM-IV-TR, states that if the onset of symptoms is at least six months after the traumatic event, it should be counted as delayed expression. Here there have been changes made in wording, further specifying the concept (Levin et al, 2014; Schupp, 2015).

According to DSM-5, an individual aged seven years or older can be diagnosed with PTSD if they meet:

- Criterion A, i.e. the so-called gateway traumatic stressor;
- at least one of the five possible re-experiencing symptoms in Criterion B;
- at least one of the two Criterion C avoidance symptoms;

- at least two of the seven Criterion D symptoms indicating negative alteration in cognition and mood;
- at least two of six possible hyperarousal symptoms as stipulated in Criterion E.

Also, these symptoms must persist for longer than one month, cause clinically significant distress or functional impairment and not be caused by substances or medical conditions, hence meeting Criteria F, G, and H. Clinicians can also note whether the symptoms have a delayed expression and whether the individual meets the additional criteria for dissociative symptoms (Rendon, 2015; Schupp, 2015).

In contrast to DSM-5, ICD-11 (revision published in 2018) offers a much more compact diagnostic description of PTSD (WHO, 2018). Like in DSM-5, PTSD among other stressor or trauma related disorders, are situated in their own category labeled "Disorders specifically associated with stress" (WHO, 2018). In comparison to the previous edition, ICD-11 offers two conceptualizations of PTSD: one of them is labeled as "PTSD" and the other "Complex PTSD" (Rendon, 2015). The latter aims to capture, among other aspects, the experience of individuals who have experienced chronic traumas (e.g. torture, childhood sexual abuse, genocide) (Rendon, 2015). These however are not conditions for Complex PTSD, but merely risk factors. Both types require a traumatic event as a precursor to the symptoms, a duration of at least one month, and significant functional impairment. However, which type of diagnosis is given depends on the symptoms the individual exhibits. For a simple PTSD diagnosis, the patient must meet the criteria for at least:

- one re-experiencing symptom (trauma-related nightmares or flashbacks);
- one of two avoidance symptoms (avoidance of people, activities or places which remind of the traumatic event(s); avoidance of thoughts and feelings related to the traumatic event(s));
- one of two hyperarousal symptoms (hypervigilance, heightened startle response).

To be diagnosed with Complex PTSD, the individual must present with, in addition to the aforementioned simple PTSD symptoms falling into three classical PTSD symptom clusters, the following:

- Affect dysregulation (heightened emotional reactivity, violent outbursts, reckless or self-destructive behavior, stress-induced dissociative states, emotional numbing);

- Negative self-concept (feelings of worthlessness or guilt related to overcoming the trauma or protecting others);
- Social impairment (detachment from other people, diminished interest or avoidance of relationships, difficulty maintaining emotional engagement in existing relationships) (WHO, 2018; Rendon, 2015).

After a traumatic event, there is known to be a substantial variation among patients both in terms of the timing of the onset of symptoms and the type of symptoms. In addition, there might me a delay between the onset of the symptoms and the referral of the patient to a mental health professional (Institute of Medicine, 2006). To enable the best possible treatment, it is important that the patient is adequately assessed first. There are several diagnostic tools available for diagnosing PTSD, most of which are available in English. The assessment of PTSD consists of two steps: first, trauma exposure must be evaluated, and then the evaluation of the symptom clusters follows (Rendon, 2015). Measures are available for both the evaluation of trauma exposure and symptoms of PTSD. Some examples of trauma exposure measures, such as for instance the Life Events Checklist (LEC) (also available in Estonian) are listed in Table 1.

Measures which aim to evaluate PTSD symptoms can be categorized as (1) biopsychological measures, (2) self-report measures, and (3) semi-structured interviews (Rendon, 2015; Institute of Medicine, 2006). The two latter are widely used in both clinical and research practice. Examples of the most commonly used self-report and semi-structured interviews are provided in Table 1. In contrast to self-report measures which are normally presented in paper-and-pencil or computer format, allow assessment of PTSD using the full DSM diagnostic criteria, are brief and with relatively short administration time (usually 5-20 minutes), semi-structured interviews provide a comprehensive evaluation of symptoms and the nature of the trauma in a face-to-face interview situation with a trained clinician. These are lengthier in terms of administration time, usually lasting between 40-120 minutes, as they utilize the full scale of DSM or ICD diagnostic criteria and are carried out in the form of an interview, where the clinician asks questions and scores the patient on a rating scale developed specifically to measure the subjective information obtained from the patient, as well as observations made during the interview. These measures feature standardized prompts which can be followed by clarification questions. A higher level of training is required for administration of such interviews, in order to ensure standardized administration and scoring (Rendon, 2015).

Table 1. PTSD Assessment measures for English speakers.

PTSD Assessment Measures for English speakers (Rendon, 2013; Foa, Yadin, 2011)	
TRAUMA EXPOSURE SCALES	
	The Life Events Checklist (LEC) Life Stressor Checklist-Revised (LSC-R) The Trauma History Questionnaire (THQ) Trauma Assessment for Adults (TAA) The Brief Trauma Questionnaire (BTQ)
PTSD SYMPTOM SEMI-STRUCTURED INTERVIEWS	
PTSD-Only Interviews	Clinician-Administered PTSD Scale (CAPS) Structured Interview for PTSD PTSD Symptom Scale Interview (PSS-I) PTSD Interview
PTSD Modules in Diagnostic Tests	Structured Clinical Interview Composite International Diagnostic Interview (WHO CIDI) The Psychiatric Research Interview for Substance and Mental Health Disorders (PRISM) Diagnostic Interview Schedule (DIS) Anxiety Disorders Interview Schedule – Revised (ADIS-R)
PTSD SYMPTOM SELF-REPORT MEASURES	
PTSD-Only Scales	PTSD Symptom Scale – SELF-Report (PSS-S) Posttraumatic Stress Disorder Checklist Posttraumatic Stress Disorder Diagnostic Scale PTSD Checklist (PCL) Posttraumatic Diagnostic Scale (PTDS) Davidson Trauma Scale (DTS) Impact of Event Scale-Revised (IES-R) Mississippi Scale for Combat-related PTSD (M-PTSD) Short PTSD Rating Interview (SPRINT)
PTSD Subscales in Psychometric Tests	Minnesota Multiphasic Personality Inventory 2, Keane PTSD Scale (PK) Personality Assessment Inventory, Traumatic Stress subscale in the Anxiety-Related Disorder scale

One of the most widely used structured interview for diagnosing PTSD is the Clinician-Administered PTSD Scale or CAPS. Often referred to as the “golden standard” for the assessment of PTSD, CAPS has been extensively used in both clinical and research practice since its conception in 1990 by the National Center for Posttraumatic Stress Disorder in the USA (Blake et al., 1995; Rendon, 2015; Elhai, 2005). CAPS measures exclusively PTSD symptoms, i.e. it is not part of a larger diagnostic instrument, such as the Structured Clinical Interview. Even though it was first validated on combat veterans, it is now used in different samples for both civilians and military service members. For instance, studies have been conducted on motor vehicle accident victims, sexual assault domestic violence survivors, and severe mental health patients (Blake et al., 1995; Rendon, 2015).

In addition to being the primary measure for PTSD among practitioners, the CAPS has been used very extensively within the research realm as well. Already in 2000, it had been used in more than 200 studies (Weathers, 2001). Additionally, the CAPS has been widely used as the standard measure against which new PTSD measures are evaluated (Rendon, 2015).

Until the most current, i.e. fifth revision of DSM and thus CAPS, CAPS-IV-TR enjoyed widespread use, had been translated into 15 languages and shown good validity and reliability in multiple studies. CAPS-5 is expected to continue to be used widely as the gold standard of PTSD assessment and has already been translated into several languages, including Turkish, Spanish, and German (Rendon, 2015; Boysan et al, 2016; Müller-Engelmann et al, 2018).

The CAPS-5 is in accordance with the DSM-5 criteria for PTSD, reflecting the symptom criteria and allowing for a direct comparison of the measures against the symptoms presented in the DSM-5 (Rendon, 2015). Other features which make CAPS-5 a comprehensive tool for PTSD assessment include carefully phrased questions and "explicit rating scale anchors with clear behavioral referents (Weathers, 2001)", which aim to standardize administration across different trauma populations, settings and raters (Rendon, 2015). Furthermore, the rating system, which is based on symptom frequency/ amount and severity, allows multidimensional symptom assessment. Severity and presence/absence scores can be qualified at either symptom, cluster, or overall syndrome level (Rendon, 2015). Finally, the CAPS-5 enables the evaluation of PTSD over the past month, past week, or lifetime, thus providing greater flexibility and taking into account the goals of the assessment.

The CAPS-5 interview takes approximately 30-60 minutes to administer and features 30 items, 27 of which reflect the DSM-5 criteria for PTSD. Usually, the administration of CAPS-5 is preceded by the administration of a trauma assessment scale, most commonly the Life Event Checklist (LEC; Rendon, 2015). This is necessary in order to identify a traumatic event which will be the base for all further evaluation. In addition to reflecting and evaluating the 20 PTSD symptoms as presented in DSM-5, CAPS-5 also measures the onset, duration, and intensity of the symptoms as well as their effect on social and professional functioning, subjective distress, overall improvement since previous rating, and dissociative reactions (derealization and depersonalization; Weathers et al., 2015).

The first item, corresponding with DSM-5 Criterion A, assesses trauma exposure. Items 1-20 evaluate the 20 PTSD symptoms as proposed by DSM-5 (Criteria B-E), items 21 and 22 (Criterion F) inquire about symptom onset and duration, items 23-25 measure subjective distress, impairment in social, occupational, or other important areas of functioning (Criterion G). Items 26-28 assess global validity, severity and improvement and are useful for longitudinal evaluation. Finally, items 29 and 30 evaluate dissociative symptoms and are used in the specification of the dissociative PTSD subtype. All symptoms must be connected to the traumatic event rather than other types of life events.

Items 2-30 are rated on a 0 to 4 severity scale (*absent, mild/subthreshold, moderate/threshold, severe/markedly elevated*) and is the combined score of the intensity and severity ratings of the symptom. Frequency is rated as either the number of occurrences or the percent of the time in which the symptom has occurred during the evaluated time period (e.g. past month). Severity scores are derived from self-reported symptom intensity or distress caused by it and can also be dichotomized as *present* or *absent*.

Clinicians are trained to read the standardized prompts verbatim, as much as possible, in order to ensure interrater and test-retest reliability. Clinicians conducting the CAPS-5 interview should have formal training in structured clinical interviewing, have competence in conducting differential diagnoses and must have a thorough understanding of the phenomenology of PTSD symptoms. They must also be very familiar with the items presented in CAPS-5 in order to facilitate administration and make it as smooth as possible (Rendon, 2015; Weathers et al., 2015).

The CAPS-5 was first validated with a veteran sample and showed a good internal consistency for the total severity score ($\alpha = .88$), high interrater reliability (intraclass correlation coefficient [ICC] = .91), and good test-retest reliability (ICC = .78; Weathers et al, 2018). Moreover, the convergent and discriminant validity were also good and there was a strong correspondence with the PTSD diagnoses based on CAPS-IV (Weathers et al., 2018).

Its applicability across different samples has made the CAPS an excellent candidate for cultural adaptation. As of April 2019, it has been translated into at least 18 other languages, including German (Müller-Engelmann, 2018), Turkish (Boysan, 2017), Spanish (Rendon, 2015), Portuguese (Pupo, 2011), Serbian (Priebe, 2010), Croatian (Priebe, 2010), Luo (Ertl, 2010), Bosnian (Charney, Keane, 2007; Priebe , 2010), Cambodian (Hinton, 2006), Japanese (Asukai, 2003), Swedish (Paunovic, Öst, 2005), Korean (Lee, 1999), Farsi (Malekzai, 1996; Renner, 2006), Pushto (Malekzai, 1996), Dutch (Hovens, 1994). Of these the first three are translations of the newest CAPS version, the remaining ones, with the exception of Dutch, Farsi and Pushto versions, are translations of the 1998 CAPS revision (i.e. CAPS-IV).

The psychometric properties of the Turkish version of the CAPS-5 were examined by Boysan and colleagues (2017) in a study enrolling 90 patients (30 with PTSD, 30 with major depressive disorder, and 30 healthy controls) who had endorsed trauma exposure. The participants completed a socio-demographic questionnaire, self-report questionnaires such as the Life Events Checklist for DSM-5 (LEC-5), the Dissociative Experiences Scale (DES), the Beck

Depression Inventory (BDI), the Beck Anxiety Inventory (BAI), and the PTSD Checklist for DSM-5 (PCL-5), prior to the administration of the Turkish CAPS-5. PTSD scores for the CAPS-5 and PLC-5 were compared against each other and both measures demonstrated very good psychometric properties.

A similar study was conducted by Müller-Engelmann and colleagues (2018), where the psychometric properties of the German version of the CAPS-5 were examined in a trauma-exposed sample of 274 individuals (223 with PTSD and 51 without PTSD). The German version of the CAPS-5 was found to have high internal consistency (αs = .65-.93) and high interrater reliability (ICCs = .81-.89). High correlations between the CAPS severity score and both the Posttraumatic Diagnostic Scale sum score (r = .87) and the Beck Depression Inventory total score (r = .72) were found and the German CAPS-5 was deemed a psychometrically sound measure.

In her doctoral dissertation, Rendon (2015) provides a detailed description about the adaptation process of the Spanish version of the CAPS-5 which was directed to Latinos with limited English proficiency. This dissertation does not include an analysis of the psychometric properties of the CAPS-5, but provides a detailed insight to the process of the adaptation and piloting on a small sample to examine the comprehensibility of the translated interview. Some of the changes employed to meet the needs of the target population included changes in wording, modification of some terms and phrases to a more colloquial form to facilitate understanding by people with lower formal education levels, use of visual aids for the clarification of the concepts of percentage in the frequency questions about "how much of the time" and to clarify the referent period of "the past month", reducing the length of question prompts, using either shorter words in sentences or separating longer sentences into several shorter ones, in order to reduce the burden on working memory and taking into consideration that a big proportion of the target group has lower levels of literacy and formal education. The analysis of the psychometric properties of this version of the Spanish CAPS-5 were not a part of Rendon's dissertation and hence are subject to further testing and examination. However, the comprehensibility of the Spanish CAPS-5 for Latinos with limited English proficiency was sufficiently tested and deemed clear and easy to understand and has the potential to increase the accuracy of PTSD assessment within the Spanish-speaking Latino population in the United States of America.

In conclusion, even though the topic of PTSD is well researched in the English speaking world, with the United States and Canada at the head of PTSD-related research, it is still deficient in

many other countries, including Estonia. The cultural adaptation of the CAPS-5 into Estonian would provide a valuable and accurate diagnostic instrument for PTSD and would hopefully increase the number of people who receive the correct diagnosis and thereby appropriate treatment in Estonia.

METHOD

The aim of the current thesis was to translate the original, English version of the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) into Estonian, retaining its items' original meaning and achieving content, semantic and technical equivalence with the original English version. The translation and adaptation of this measure requires a multistep approach, of which the first important steps - the translation, revision and piloting of the interview on a small community sample have been carried out and described in the current research paper.

To begin with the adaptation process, the English version of the CAPS-5 was translated into Estonian by the author of the current thesis. This was followed by a series of meetings with a team of experts in order to review and edit the initial Estonian version. The team of experts included three clinical psychologists, each of whom had experience in trauma related work, and one psychiatrist. The Estonian version was reviewed and edited over the course of three meetings. In addition, after the final corrections had been made, these experts were asked to review the final version once more, in order to assure that it was of good quality and ready for piloting. The same was requested from another clinical psychologist, who had not participated in the previous discussion and revision of the Estonian CAPS-5. Thereupon, six adult individuals who had had a traumatic experience in their adulthood were asked to participate as interviewees in the piloting of the Estonian CAPS-5. The principal aim of this procedure was to acquire feedback about the Estonian version and about its linguistic comprehensibility, as well as to acquire primary information about its diagnostic capability.

The participants were recruited from two clinics located in Tartu - the Katriito Counseling and Psychotherapy Center and the Tartu Sexual Health Clinic. The patients were first contacted by their psychologists and those who were ready to participate were thereafter contacted by the researchers. Additionally, three participants were already participating in a parallel study which, too, included the CAPS-5 interview, and gave an informed consent to partake in the current study as well. Participants were given more information about the procedure prior to participation. The following chapter will provide a detailed overview of the translation process as well as the process of piloting the Estonian CAPS-5.

Translation process

Some of the principal challenges in the process of translating the original English version into Estonian, were differences in the linguistic structure of these two languages, affluence of vocabulary, the lack of a dictionary for specific psychological terms, maintaining the original meaning and essence of questions and terms even if the wording had to be altered when translated, and selecting the best way to say something, in case there were several possible options for translating a phrase or sentence.

As the structure of English and Estonian is rather different at times, the translation of some more complex and long sentences, especially in the rating instructions' part of the CAPS-5 required harder work and creativity. For instance, in the phrase "exposure to actual or threatened death, serious injury, or sexual violence", word order had to be changed in order to constitute a logical and natural-sounding phrase in Estonian, placing the part of "actual or threatened death" first and the experiential part of the phrase last. Also, since it was impossible to use "exposure" for all the traumatic exposure types in Estonian, the phrase was further separated into two parts, and some additional words had to be added. Hence, in Estonian it sounded like this: "contact with actual or potential death, or being in mortal danger, experiencing serious injury or sexual violence" (*Tegeliku või potentsiaalse surma või surmaohuga kokkupuude, tõsiste vigastuste või seksuaalvägivalla kogemine*). Additionally, a great number of the questions in CAPS-5 begin with the words "In the past month". In Estonian, it would, in most cases, sound unnatural or clumsy to begin a sentence with this phrase, so in most cases it would be placed in the middle of the sentence, for a smoother and more natural result, e.g. the word order in the sentence "In the past month, have you tried to avoid thoughts or feelings about (EVENT)?" would be rearranged like this: "Have you, in the past month, tried to avoid (EVENT)-related thoughts or feelings?" *(Kas te olete viimase kuu jooksul püüdnud vältida [T]-ga seonduvaid mõtteid või tundeid?).* Another big difference between the two languages is the extensive use of declensions in Estonian. Thus, some English sentences would have to be translated into either longer or separate sentences in Estonian.

Some other sentences or questions where wording had to be changed were for example "Can you give some examples?" and "How so?". The first could be directly translated, however, after consulting with the expert team, the decision was made to concretize it to simply "Bring some examples!" (*Tooge mõni näide!*). The purpose of this was to avoid possible situations where a patient who is not very collaborative or particularly eager to answer, could give provocative answers such as, for instance, say they can't, while actually simply not being willing to. The

latter, “How so?” which was an additional question for the main question inquiring about whether or not the individual attributes the occurrence of symptoms to the traumatic event, though initially translated as either “How so?”, “Why?”, or “Why so?”, was eventually presented as “Why do you think that?” (*Miks te nii arvate?*). The reason for this was primarily that “How so?” (*Miks nii?*) tends to be perceived as slightly judgemental, and appears in everyday conversations with an inquiring, often slightly judgemental intonation. This is something that should be avoided in a clinical interview, especially one addressing such sensitive topics. Another question which demanded slightly more attention in order not to be perceived as judgemental or deprecative, was in Item 25, and inquired about whether or not the person is currently working. Namely, the question “Why is that?” following a negative response to the question “Are you working now?” attracted some debate during one of the meetings with the group of experts. It was proposed to form the questions as “What is preventing you (from working)? (*Mis teid takistab?*), but this version was discarded due to its potentially judgemental nature. Instead, a direct translation was maintained (*Miks see nii on?*).

Another interesting aspect emerged when translating words such as “problems with concentration”. In Estonian, these could be translated either using one compound word or two separate words, i.e. either “*keskendumisprobleemid*”, which translates into “concentration problems” or “*probleemid keskendumisega*” which means “problems with concentration”. In the context of the CAPS, the first was chosen. In general, there was an enormous amount of phrases and wordings that could be said in several different ways, so one of the most important tasks for the expert group was to choose and modify the best wordings for each question, producing a result which would be understood by a wide variety of people in the population (i.e. with different levels of education, language proficiency, and so forth). Moreover, in many cases, several English terms with a slightly different nuance translate into one word in Estonian due to differences in abundance of vocabulary between the two languages.

The translation of specific diagnostic terms was also challenging. For example, “reminders” was a difficult term to translate, as there wasn’t an exact word like this in Estonian. After some contemplation and discussion, a term “*traumameenutajad*” was introduced, which translates into “trauma reminders” in English. Sometimes the difficulty didn’t lay in translating the word, but in choosing a term used by clinicians and assuring it is unambiguously understood. One such term was for example “loss of sleep”, which was first translated as “*unekadu*”, literally meaning “loss of sleep”, but after consulting with a sleep specialist, it was changed to “*unevõlg*” which would translate directly into English as “sleep debt”. This is however the official term

used by clinicians to refer to this issue and was therefore included in the Estonian version of the CAPS-5.

In some cases, the influence of the English way to name or say something posed a bit of a hindrance when finding an appropriate Estonian term. Then it was necessary to ignore the exact way it was said in English and translate it by meaning or by the essence of the meaning, e.g. “key rating dimensions” wasn’t something that could be directly translated into Estonian, as there is simply no such way of saying it like this. Instead, it was translated as “evaluation criteria” (*hindamiskriteerium*). Another such example is “sleep disturbance”. Initially there were many translations proposed for this, ranging from “sleep disturbance” (*unehäired*) to “sleep problems” (*uneprobleemid*). This was one of the terms which raised much contemplation and debate and was evaluated to be best approached by the definition of it and the perception of the used term. Hence, it was important to establish that sleep disturbance is not something that occurs as a result to outward disturbance, i.e. it is not caused by someone else (like a crying baby, for example), but a spontaneous and autonomic occurrence (i.e. the individual himself has difficulty falling or staying asleep). In addition, in Item 5, there was a question about whether or not there are any physical reactions experienced in connection to remembering the traumatic event, and a part of it inquired about whether one’s heart races or whether their breathing changes. Again, this required some thought, as to find the best possible wording which would be understood by a wide variety of people. The members of the expert team came up with several ways to refer to a “racing heart”, but eventually it was decided to phrase it like this: “Have you noticed changes in the frequency of heartbeats or breathing?” *(Kas olete märganud muutusi südame löögisageduses või hingamises?*). This allowed a clearly understandable and also congruent phrasing of the question while maintaining its original meaning.

Another cause for contemplation was whether to use native Estonian words or borrowed foreign words for some terms. For example, “physical reactions” could be translated as both “*kehalised reaktsioonid”* (native Estonian word) or “*füüsilised reaktsioonid*” (borrowed word). The meaning of both is exactly the same. It was decided to use native Estonian words.

Additionally, as opposed to a single way to say “you” in English, there are two different words for singular and plural/polite “you” in Estonian. Normally, in official settings, the plural version is used, as it also serves the role of a polite and formal way to address someone whom one is either on formal terms with or not very familiar with. In therapy work, the singular or more familiar “you” (*sina/sa*) is often used, to create a more comfortable atmosphere and help break

down barriers between therapist and client and thus encourage the development of trust and convenience, but official and printed documents as well as clinical materials are normally presented using the formal form of "you" (*teie/te*). Therefore, the Estonian CAPS-5 utilizes the formal form of addressing the interviewee, but the clinician could, if appropriate, choose to address the client in the singular form, if this would support the process and create a better atmosphere.

In case of the questions about whether a symptom started or got worse after the traumatic event, an idea introduced by Rendon (2015) in the adaptation of the Spanish version of CAPS-5, was partially adopted. Namely, in the English version, those two aspects are both in one sentence, as in "Did this trouble experiencing positive feelings start or get worse after (EVENT)?". After extensive testing during the piloting process of her Spanish version of the CAPS-5, Rendon found that people found it easier or more effective if separated into two sentences, i.e. "Did this trouble experiencing positive feelings start after the (EVENT)?" or in case the symptoms in question had been present already before the traumatic event, "Did this trouble experiencing positive feelings get worse after the (EVENT)?" could be added. In the Estonian version it was decided that it will remain intact, i.e. in one sentence, but a note was added for the interviewers that it could be asked as two separate questions if necessary.

Once the Estonian version of the CAPS-5 was ready, an application to the Research Ethics Committee of the University of Tartu was submitted. A permit was granted to proceed with the administration of the Estonian CAPS-5 on a small sample of trauma patients in order to examine the comprehensibility of the Estonian CAPS-5.

Piloting the Estonian CAPS-5 for comprehensibility

Of the six interviewees four were women, two were men. The age ranged from 23 to 64 years (average age: 39 years). The criteria for participation were that the individuals had to be adult and have had a traumatic experience in their adulthood, or the potential to meet the PTSD criteria as estimated either by their therapist or themselves. In addition, the participants had to be fluent in Estonian. Each participant was first contacted by their psychologist and then, after they had agreed to participate, contacted by the researchers. They were given information about the thesis and the procedure of piloting the Estonian CAPS-5 and appointments were made for its administration. The interviews were carried out in the rooms of the Institute of Psychology of the University of Tartu. Each participant was tested individually. First, participants were

asked to read and sign an informed consent form where the procedure and aim of study were introduced. Subsequently they were asked to fill in three self-report questionnaires: the Emotional State Questionnaire (EST-Q), the Life Events Questionnaire (LEC), and the Posttraumatic Stress Disorder Checklist-Civilian version (PCL). This was followed by the administration of the Estonian CAPS-5 by a trained clinical psychologist with experience in trauma work. Immediately following the interview each participant had the opportunity to get feedback about their results. Lastly, after the interview, the participants were asked questions about the comprehensibility of the Estonian version of the CAPS-5 by the author of the current thesis. The entire procedure ranged from 1,5 to 2 hours per participant.

RESULTS AND DISCUSSION

The findings of the piloting of the Estonian version of the CAPS-5 are presented and discussed in the following chapter. Even though conducted on a small sample, the piloting of the Estonian CAPS-5 provided important information and aspects to take into consideration in the process of the development of the Estonian CAPS-5. To begin with, it provided a first insight into the experience of both the interviewer and interviewee, as well as produced some initial understanding of its potential to accurately diagnose PTSD within an Estonian sample.

The Estonian CAPS-5 was validated against the Estonian version of the PTSD Checklist for DSM-5 (PCL). The PCL was purposely scored after administering the CAPS-5, in order to avoid biases in the administration and scoring of the CAPS-5 due to knowledge of the expected diagnostic outcome. The cut-point score of the PCL is 44 and four of the participants in the current study scored more than 50 points, meeting the criteria for a diagnosis and two participants scored less than 40. The precise scores are presented in Table 2.

As mentioned previously, the participants in this study were individuals who had endorsed a traumatic experience and were suspected to meet the criteria for PTSD either by their mental health professional or by themselves. The types of traumatic experiences of the participants in this study were domestic violence, accident, work-related exposure to death (death of a patient), severe illness, and a case of workplace bullying by a colleague. The latter two did not produce a PTSD diagnosis according to neither the Estonian CAPS-5 nor the Estonian PCL. However, these results were anticipated, as neither qualifies as an eligible exposure type according to the DSM-5 (APA, 2013). The diagnosis was indicated by both the Estonian CAPS-5 and the Estonian PCL and the results were in accordance with each other on each occasion.

To establish a diagnosis according to the CAPS-5, the number of symptoms in each cluster must be in accordance with DSM-5 requirements, i.e. one must present with at least one symptom from criteria B and C, at least two symptoms from clusters D and E, meet criterion F and G. For this, severity scores and the number of symptoms met are summarized for each symptom cluster using the summary sheet in the end of the CAPS-5 interview. First the severity scores are summarized for each symptom cluster and then all severity scores are summarized in order to obtain the total severity score. The same applies for summarizing the number of symptoms met by the respondent. A symptom is considered present if its severity score is equal or higher than 2. First, it is determined whether or not a symptom is present and then the score of

symptoms that have been met is summed, and finally the total number of met symptoms is calculated. The same model applies for the two dissociation symptoms, which are calculated separately from the rest in order to find out whether the criteria for the dissociative subtype are met. The scores of the EST-Q indicated general disturbance and are presented in Table 2 along with the scores of the remaining self-report questionnaires and the Estonian CAPS-5.

Table 2. Results from the Self-Report Questionnaires and the Estonian CAPS-5.

Code	Trauma type	EST-Q						LEC Number of events			PCL	Estonian CAPS-5		PTSD Diagnosis
		Depression	Generalized Anxiety Disorder	Agoraphobia-Panic	Social Anxiety	Asthenia	Insomnia	Experienced	Witnessed	Work-Related		Sx	Sev	
019	Work-related exposure to death	26	15	0	1	15	7	5	1	12	53	10	31	YES
021	Workplace bullying	16	18	3	2	14	4	0	3	6	36	4	18	NO
013	Severe illness	19	11	2	1	8	5	5	6	1	35	1	8	NO
012	Domestic violence	22	18	3	0	13	12	8	4	0	66	17	43	YES
022	Accident	11	17	2	6	11	8	7	1	0	51	14	39	YES
020	Domestic violence	20	19	7	5	14	9	7	12	0	53	11	27	YES

In terms of content and structure, the Estonian CAPS-5 proved to be comfortable to administer for both the clinician and the interviewees. The structure of the CAPS-5 provided a logical and supportive framework, allowing a smooth and organized administration.

Before the administration of the CAPS-5, it is part of the procedure that the interviewees must fill in the Life Events Checklist (LEC) in order to determine the most traumatic and disturbing event which will serve as the index event for the CAPS-5 interview. The individuals who participated in the piloting of the Estonian version of the CAPS-5 filled in the Estonian version of the LEC prior to the administration of the Estonian CAPS-5. Some of the items in the Estonian LEC caused confusion among the participants, particularly the first item inquiring about whether the individual has experienced a natural disaster such as a flood, hurricane, tornado, or earthquake. The cause of such confusion and difficulty to answer, was the fact that there are no such natural phenomena as hurricanes, tornadoes, and earthquakes in Estonia. This indicates that the Estonian version of the LEC should be further revised and adapted to better match the local conditions and context of Estonia.

The traumatic event used as the index event for all the questions in the CAPS-5 is instructed to be the most severe or horrifying traumatic event experienced by the individual. However, in case of multiple traumatic experiences, it became apparent that the most severe in a lifetime scale might no longer be actual in the person's daily life nor produce PTSD symptoms. Instead, a less severe but more recent traumatic event may cause significant distress or impairment at the time the screening for PTSD. Therefore, in case of many traumatic experiences, it might be better to determine which of those is currently most influential and has caused PTSD symptoms or distress and impairment during the past month. The same suggestion was made by Rendon (2015) regarding the Spanish version directed towards Latinos with limited English proficiency living in the USA.

While administering the Estonian CAPS-5, the traumatic event, which is referred to as (EVENT) in the script of the CAPS-5 and can be substituted with the most suitable word, was referred to as either "the traumatic event" (*traumaatiline sündmus*), "that event" (*see sündmus*) or addressed directly, by the interviewer. The idea of following Rendon's example of separating the question about whether a symptom begun or worsened after the traumatic event into two separate sentences proved to be unnecessary, as it was very natural and effective to ask it as one question.

All six participants found the Estonian CAPS-5 to be clear and comprehensive in general. They also brought out that the structure of the interview was clear, the questions were appropriate and the complementary questions completed the main questions very well, helping the interviewee to go further into detail**.** However, there were some aspects that need further consideration and development. Most of the difficulties were connected to the questions measuring the D cluster symptoms. Many of the questions in D Items were slightly vague or too general and needed either further explanation in order to help the interviewee understand the question, or examples and more structural support from the interviewer for the interviewees to understand exactly how detailed of an explanation is expected from them. 50% of the participants mentioned problems with comprehending some questions in the D section. The issues mentioned were mainly vagueness and therefore difficulty answering due to poor understanding, as well as in one particular question, in Item 9 (D2), it was sometimes confusing what exactly is meant by "negative beliefs" which was translated into Estonian as "*negatiivsed uskumused*". Several of the participants mentioned that examples would have been helpful and made it clear. This was also noticed by the interviewer that in Item 9 (D2) the respondents had notable difficulty answering and most answered only about one of the tree categories ("negative beliefs about yourself, other people, or the world"). The solution to this issue could lie in encouraging the interviewers to bring more examples in this item. In general, the CAPS-5 manual suggests that examples should be scarce and only given if the respondent has serious difficulty answering, but it appears that in Item 9 (D2) they are necessary in order to give the respondent a clearer understanding of what is expected of them and thus avoid confusion.

The clinical psychologist who conducted the interview also brought out a few problematic aspects concerning the D cluster of the CAPS-5. In addition to the D2 question, there are some suggestions regarding Items 11 (D4) and 12 (D5). Namely, in Item 11 (D4), there is a complementary question inquiring about how well one is able to manage strong negative feelings (fear, horror, anger, guilt, shame). The question is posed like this: "How well are you able to manage them?" or "*Kui hästi te nendega toime tulete?*" in Estonian. This however usually cultivates an answer like "more or less" or "fairly well" which does not give any substantial information about the actual severity of the symptom. Instead, it is proposed that this question be changed into "*Mida te teete, et nendega toime tulla?*" meaning "What do you do in order to manage them?". This would urge the respondent to give a more specific and informative response which would allow conclusions to be made about the severity of the symptom. In Item 12 (D5), the question "In the past month, have you been less interested in

activities that you used to enjoy?" or "*Kas teil on viimase kuu jooksul vähenenud huvi tegevuste suhtes, mida varem nautisite?*" would probably be more effective if posed like this: "*Kas teil on viimase kuu jooksul esinenud huvi vähenemist tegevuste suhtes, mida varem nautisite?*" translating into "In the past month, have you experienced loss of interest towards activities you used to enjoy?". This would emphasize the loss of interest, which would, with the initial construction of the sentence, receive less attention due to the natural flow of the sentence, which in turn minimizes the emphasis on the "loss" of interest. Therefore, some of the questions in the D cluster require changes in wording and more examples in order to increase comprehensibility and clarity, as well as effectiveness.

Some other suggestions for changes in wording include Items 16 (E2) and 6 (C1). In the first case, in Item 16 (E2) which inquires about risk taking, the question "In the past month, have there been times when you were taking more risks or doing things that might have caused you harm?" (*Kas te olete viimase kuu jooksul käitunud riskeerivamalt või teinud ohtlikke asju, mille tagajärjel oleksite võinud viga saada?*) would probably serve its purpose better if posed like this: "In the past month, have there been times when you were taking more risks or doing things that have or might have caused you harm?" (*Kas te olete viimase kuu jooksul käitunud riskeerivamalt või teinud ohtlikke asju, mille tagajärjel saite või oleksite võinud viga saada?*), hence adding actual harm to the possibility of being harmed. This suggestion is made due to the fact that often, when it comes to risky or self-harming behaviour, there is actual harm caused, even if it is not severe. For instance, if an individual attempts suicide by jumping off a roof but lands on a life net set up by rescue workers, serious harm is avoided, but the individual will most probably still be concussed. In case of Item 6 (C1), it could prove helpful to add "memories" to the following question: "In the past month, have you tried to avoid thoughts or feelings about (EVENT)?" (*Kas te olete viimase kuu jooksul püüdnud vältida [T]-ga seonduvaid mõtteid või tundeid?*), hence "In the past month, have you tried to avoid memories, thoughts or feelings about (EVENT)?" (*Kas te olete viimase kuu jooksul püüdnud vältida [T]-ga seonduvaid mälestusi, mõtteid või tundeid?*). This proposition is made because sometimes people, especially individuals with lower intelligence or simply lower formal education levels, seem to have difficulty distinguishing between those three concepts of thoughts, feelings, or memories.

Another important aspect to consider is the possible use of visual aids in the form of scales in order facilitate answering to "how much of the time, as a percentage" (*protentuaalselt, kui tihti*), "How much of a problem is this for you?" (*Kui suur probleem see teie jaoks on?*), "How much

does this bother you?" (*mil määral see teid häirib?*) type of questions. A 10-point scale would probably be the best option, as most people tend to naturally think about such things on a 10 point scale. This would not only facilitate answering these questions, but would also provide a more uniform answering style, as all respondents would use the same scale and will not have to come up with their own. One of the participants in the piloting of the Estonian CAPS-5 also mentioned that a scale would have been helpful and that he had to come up with his own, which he chose to be a 10-point scale (participant nr 022). The questions which inquire about the percentage of the time a symptom has occurred in the past month, were the most difficult for both the interviewer and the respondents. The interviewer mentioned that it always required an additional question to clarify what exactly is expected, and it was also mentioned by the participants that it was difficult to think of a percent, especially when thinking back to the extent of the past month. This problem could also potentially be solved by the addition of visual aids, for instance, in the form of a scale. Rendon (2015) also encountered this issue and solved this problem by adding a visual aid containing pie charts of 0%, 25%, 50%, 75%, and 100% of the time. Therefore, it would be necessary to take this approach, i.e. using visual aids to explain the above-mentioned questions and concepts, into consideration and further examine its efficacy.

In conclusion, the current study has produced a generally clear and understandable Estonian version of the Clinician-Administered PTSD Scale for DSM-5 and its piloting has indicated shortcomings and aspects that require further revision. A base has hereby been established for the development of the Estonian adaptation of the CAPS-5. Subsequently, the back-translation process from Estonian to English is to be carried out and revisions in the Estonian CAPS-5 to be made in order to proceed with the process of examining the psychometric properties of the Estonian CAPS-5.

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APPENDIX A: The Estonian Version of the Clinician-Administered PTSD Scale (CAPS-5).

A kriteerium

Tegeliku või potentsiaalse surma või surmaohuga kokkupuude, tõsiste vigastuste või seksuaalvägivalla kogemine ühel (või rohkemal) viisil alljärgnevatest:

1. Traumaatilis(t)e sündmus(t)e ise kogemine.
2. Teis(t)e inimes(t)ega juhtunud traumaatilis(t)e sündmus(t)e pealtnägemine.
3. Lähedase pereliikme või sõbraga juhtunud traumaatilis(t)est sündmus(t)est teada saamine. Juhul kui tegu on pereliikme või sõbra surma või surmaohtu sattumisega, siis peab tegu olema kas vägivaldse või juhusliku sündmuse või sündmustega.
4. Korduv traumaatilis(t)e sündmus(t)ega seonduvate häirivate detailidega kokku puutumine (nt. Päästeteenistujad, kes puutuvad vahetult kokku õnnetuspaigaga; politseinikud, kes puutuvad kokku laste väärkohtlemisega jne). NB! A-4 kriteeriumi alla ei loeta elektronmeedia, televisiooni, filmide ja piltide vahendusel traumaatilis(t)e sündmus(t)ega kokkupuuteid arvatud juhul, kui need on tööalased.

[Patsiendile anda kõigepealt täitmiseks Elusündmuste küsimustik.]

Intervjuu käigus küsin teilt küsimusi nende vastuste kohta, mida andsite Elusündmuste küsimustikku täites. Kõigepealt palun teil rääkida täpsemalt sellest sündmusest, mis oli teie jaoks kõige raskem. Seejärel soovin täpsustada, kuidas see sündmus teid viimase kuu jooksul on mõjutanud. Te ei pea rääkima väga detailselt, ainult nii palju, et saaksin aru, milliseid probleeme või raskusi teil ette on tulnud. Palun andke mulle teada, kui te ennast intervjuu ajal väga halvasti tunnete, siis saame sellest rääkida. Samuti andke märku, kui teil tekib küsimusi või kui midagi jääb arusaamatuks. Soovite te praegu midagi küsida, enne kui alustame?

Te ütlesite, et teie jaoks oli kõige raskem sündmus ____________. Rääkige mulle lühidalt, mis juhtus.

Intervjuu aluseks olev sündmus (täpsustage):__________________________________

Mis juhtus? (Kui vana te olite? Kuidas olite teie juhtunuga seotud? Keda see veel puudutas? Kas keegi sai tõsiselt vigastada või surma? Kas kellegi elu oli ohus? Mitu korda see juhtus?)	**Kogetud trauma tüüp:** ____ Isiklik kogemus ____ Pealtnägemine ____ Teada saamine ____ Kokku puutumine häirivate detailidega **Oht elule?** EI JAH (Enesele___ Teistele___) **Tõsine vigastus?** EI JAH (Enesele___ Teistele___) **Seksuaalvägivald?** EI JAH (Enesele___ Teistele___) **Vastavus A-kriteeriumile?** EI TÕENÄOLINE JAH

Edasise intervjuu käigus esitan ma teile küsimusi võimalike probleemide kohta, mida traumaatilised sündmused võivad tekitada. Vastamisel lähtuge palun sellest sündmusest, mida te just kirjeldasite. Teil võib olla esinenud neid probleeme ka varem, kuid keskendume selle intervjuu ajal ainult viimasele kuule. Ma küsin teilt iga probleemi kohta, kas ja kui tihti see viimase kuu jooksul on esinenud ning mil määral see teid on häirinud.

B kriteerium

Ühe või enama taaskogemise sümptomi esinemine, mis on seotud traumaatilise sündmusega ja on alanud traumajärgselt.

Punkt 1 (B1): Korduvad, tahtmatud ja pealetükkivad häiritust tekitavad mälestused traumaatilis(t)est sündmus(t)est. NB! Üle kuueaastastel lastel võib see avalduda traumaatilist sündmust kordava mänguna.

Kas teil on viimase kuu jooksul ärkvel olles esinenud [T]-ga seonduvaid soovimatuid mälestusi? Unenäod ei lähe praegu arvesse. *(Hinnake 0 = puudub, kui esinevad vaid unenägudes)* **Kuidas teile need traumaatilise sündmusega seotud mälestused meenuvad?** *[Kui jääb selgusetuks:]* **(Kas need on soovimatud ja tekivad iseenesest või tekivad need siis, kui mõtlete sündmuse peale tahtlikult?)** (*Hinnake 0, kui need on tahtlikud)* **Mil määral need mälestused teid häirivad?** **Kas te suudate need kõrvale jätta ja mõelda millelegi muule?** *[Kui jääb selgusetuks:]* **(Kui suur probleem see üldiselt teie jaoks on? Palun täpsustage.)** ______________________________________ *Märgi: Häirituse tase = minimaalne märgatav tugev ekstreemne* **Kui tihti on teil viimase kuu jooksul selliseid mälestusi esinenud?** *Kordade arv:* ________	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium = häirituse sagedus/ intensiivsus** **Mõõdukas** = vähemalt 2 korda kuus / selge häirituse avaldumine, mõningane raskus mälestuste kõrvale jätmisega **Tõsine** = vähemalt 2 korda nädalas/ kõrge häirituse tase, märgatavad raskused mälestuste kõrvale jätmisega

Punkt 2 (B2): Korduvad häirivad unenäod, mille sisu ja/või afekt on seotud traumaatilise sündmusega. NB! Lastel võib esineda hirmutavaid arusaamatu sisuga unenägusid.

Kas teil on viimase kuu jooksul esinenud ebameeldivaid unenägusid selle sündmusega seoses? **Kirjeldage tüüpilist unenägu.** (Mis seal toimub?) **Kas te ärkate nende peale üles?** *[Kui jah:]* **(Mida te kogete, kui nende peale üles ärkate? Kui kaua teil aega kulub, et uuesti magama jääda?)** *[Kui ütleb, et ei lähegi tagasi magama:]* **(Kui palju und te sellepärast kaotate?)** **Mil määral need unenäod teid häirivad?** ______________________________________ *Märgi: Häirituse tase = minimaalne märgatav tugev ekstreemnes* **Kui tihti teil viimase kuu jooksul sellised unenägusid esinenud on?** *Kordade arv:* ________	0 puudub 1 kerge/ alalävine 2 mõõdukas/piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium = häirituse esinemissagedus/ intensiivsus** **Mõõdukas** = vähemalt 2 korda kuus/unevõlg vähem kui 1 tund **Tõsine** = vähemalt 2 korda nädalas/ unevõlg rohkem kui 1 tund

Punkt 3 (B3): Dissotsiatiivsete reaktsioonide esinemine, mille ajal inimene tunneb või käitub, nagu toimuks sündmus uuesti. (Sellised reaktsioonid võivad esineda kontiinuumina, mille kõige äärmuslikum avaldumisviis on täielik teadlikkuse kadu ümbritsevas keskkonnas toimuvast.) NB! *Lastel võib see avalduda traumaatilise mänguna.*

Kas viimase kuu jooksul on esinenud olukordi, kus olete järsku tundnud või käitunud nii, nagu kogeksite [T] uuesti? *[Kui jääb selgusetuks:]* **(See erineb [T] peale mõtlemisest või selle unes nägemisest - praegu tahan ma teada, kas teil on esinenud mälusähvatusi, mille ajal te tunnete, nagu oleksite taas selles olukorras, nagu kogeksite seda uuesti?)** **Kui tõelähedane see kogemus on, kui tunnete, nagu juhtuks see sündmus uuesti?** (Kas te olete segaduses ja ei saa aru, kus te parasjagu viibite?) **Mida te sellises olukorras teete?** (Kas teised märkavad teie käitumist? Mida nad ütlevad?) **Kui kaua see kestab?** ____ *Märgi: Dissotsiatsiooni tase = minimaalne märgatav tugev ekstreemne* **Kui tihti on seda viimase kuu jooksul esinenud?** *Kordade arv:* ________	0 puudub 1 kerge/ alalävine 2 mõõdukas/ subkliiniline/piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium =** dissotsiatsiooniepissoodide esinemissagedus / intensiivsus **Mõõdukas** = vähemalt 2 korda kuus/ selgelt esinev dissotsiatiivsus; võib säilida mõningane teadlikkus ümbritsevast keskkonnast, kuid elab sündmust taas läbi viisil, mis eristub selgelt mõtetest ja unenägudest **Tõsine** = vähemalt 2 korda nädalas/ tugev dissotsiatiivsus; vastaja kirjeldab elavalt sündmuse taas läbielamist (kujutluspiltide, helide, lõhnadega)

Punkt 4 (B4): Ülitundlikkus sisemiste või väliste stiimulite suhtes, mis meenutavad või sümboliseerivad mõnda traumaatilise sündmuse aspekti.

Kas te olete viimase kuu jooksul endast välja läinud, kui miski on teile [T] meenutanud? **Millised sündmust meenutavad asjaolud või tegurid ehk traumameenutajad teid endast välja viivad?** **Mil määral need traumameenutajad teid häirivad?** **Kas te suudate end maha rahustada, kui see juhtub?** (Kui kaua teil selleks aega läheb?) **Kui suur probleem see teie jaoks üldiselt on?** ____ *Märgi: Häirituse tase = minimaalne märgatav tugev ekstreemne* **Kui tihti on viimase kuu jooksul seda esinenud?** *Kordade arv:* ________	0 puudub 1 kerge/ alalävine 2 mõõdukas/ subkliiniline/piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium = häirituse esinemissagedus/ intensiivsus** **Mõõdukas** = vähemalt 2 korda kuus/ selgelt väljendunud häiritus, mõningane raskus taastumisega **Tõsine** = vähemalt 2 korda nädalas/ tugev häiritus, märkimisväärsed raskused taastumisega

Punkt 5 (B5): Tugevad füsioloogilised reaktsioonid sisemistele või välistele stiimulitele, mis sümboliseerivad või meenutavad traumaatilise sündmuse mingit aspekti.

Kas teil on viimase kuu jooksul esinenud kehalisi reaktsioone, kui miski on teile [T] meenutanud? **Tooge mõni näide.** (Kas te olete sel ajal märganud muutusi südame löögisageduses või hingamises? Kas esineb higistamist, tunnete end pinges olevana või värisete?) **Millised traumameenutajad selliseid reaktsioone esile kutsuvad?** **Kui kaua aega teil taastumiseks kulub?** ______________________________ *Märgi: Füsioloogilise reaktsiooni tugevus= minimaalne märgatav tugev ekstreemne* **Kui tihti on seda viimase kuu jooksul esinenud?** *Kordade arv:* ________	0 puudub 1 kerge/ alalävine 2 mõõdukas/ subkliiniline/piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = füsioloogilise erutusseisundi esinemissagedus/ intensiivsus **Mõõdukas** = vähemalt 2 korda kuus/ selgelt avalduv reaktsioon, mõningad raskused taastumisega **Tõsine** = vähemalt 2 korda nädalas/ tugev reaktsioon, püsiv erutusseisund, olulised raskused taastumisega

C kriteerium

Pärast traumat alanud traumaatilise sündmusega seonduvate stiimulite püsiv vältimine, millele viitab kas üks või mõlemad järgnevaist:

Punkt 6 (C1): TS seotud häirivate mälestuste, mõtete või tunnete vältimine või püüd neid vältida.

Kas te olete viimase kuu jooksul püüdnud vältida [T]-ga seonduvaid mõtteid või tundeid? **Milliseid mõtteid või tundeid te väldite?** **Kui suurt pingutust nende mõtete või tunnete vältimine teilt nõuab?** (Mida te selleks teete?) *[Kui jääb selgusetuks:]* **(Mis oleks teie elus teisiti, kui te ei peaks neid mõtteid või tundeid vältima?)** ______________________________ *Märgi: Vältimise tase = minimaalne märgatav tugev ekstreemne* **Kui tihti on seda viimase kuu jooksul esinenud?** *Kordade arv:* ________	0 puudub 1 kerge/ alalävine 2 mõõdukas/piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = vältimise sagedus / intensiivsus **Mõõdukas** = vähemalt 2 korda kuus/ selgelt avalduv vältimine **Tõsine** = vähemalt 2 korda nädalas/ tugevalt väljendunud vältimine

Punkt 7 (C2): Traumaatilist sündmust meenutavate häirivaid mälestusi, tundeid või mõtteid tekitavate väliste stiimulite (inimesed, kohad, vestlused, tegevused, asjad, olukorrad) vältimine või püüd neid vältida.

Kas te olete viimase kuu jooksul püüdnud vältida [T] meenutavaid inimesi, kohti või olukordi? **Mida või keda te väldite?** **Kui palju vaeva te selleks näete, et vältida traumat meenutavaid inimesi või asju?** (Kas peate selleks oma tegevust ette planeerima või oma plaane muutma?) *[Kui jääb selgusetuks:]* **(Mis oleks teie elus teisiti, kui te ei peaks neid traumameenutajaid vältima?)** ____________________________________ *Märgi: Vältimise tase = minimaalne märgatav tugev ekstreemne* **Kui tihti on seda viimase kuu jooksul esinenud?** *Kordade arv:* ________	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = vältimise sagedus / intensiivsus **Mõõdukas** = vähemalt 2 korda kuus/ selgelt avalduv vältimine **Tõsine** = vähemalt 2 korda nädalas/ tugevalt väljendunud vältimine

D kriteerium

Traumaatilise sündmusega seotud negatiivsed muutused kognitsioonides ja meeleolus, mis algasid või ägenesid pärast traumaatilist sündmust ning millele viitab üks või enam järgnevaist:

Punkt 8 (D1): Võimetus meenutada traumaatilise sündmuse olulisi aspekte (tavaliselt seotud dissotsiatiivse amneesiaga, MITTE teiste teguritega, nagu peatrauma, alkoholi või uimastite mõju.

Kas teil on viimase kuu jooksul olnud raskusi mõne T-ga seotud olulise detaili meenutamisega? (Kas teile tundub, et teie mälestustes on lüngad?) **Milliseid detaile on teil raske meenutada?** **Kas teile tundub, et peaksite neid asju mäletama?** *[Kui jääb selgusetuks:]* **(Miks te arvate, et te ei suuda neid asju meenutada? Kas te saite T käigus peatrauma? Olite teadvusetu? Olite alkoholi või uimastite mõju all?)** *[Kui endiselt jääb selgusetuks:] (* **Mis te arvate, kas see on tavapärane unustamine või olete te need detailid oma mälus blokeerinud, kuna nende meenutamine oleks liiga valus?)** ____________________________________ *Märgi: Raskus meenutamisega = minimaalne märgatav tugev ekstreemne* **Mitme T-ga seotud olulise detaili meenutamisega on teil viimase kuu jooksul raskusi olnud?** (Milliseid detaile te mäletate?) *Mittemeenuvate detailide arv:* ______ **Kui te pingutaksite, kas te siis suudaksite neid detaile meenutada?**	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = mittemeenuvate trauma detailide arv /meenutamisraskuste intensiivsus **Mõõdukas** = vähemalt 1 olulist osa raske meenutada, pingutuse korral võimeline mäletama **Tõsine** = raske meenutada mitut olulist trauma osa, isegi ka pingutuse korral raskused püsivad

Punkt 9 (D2): Püsivad ja liialdatud negatiivsed uskumused või ootused enda, teiste või maailma kohta (nt "Ma olen halb", "Kedagi ei saa usaldada", "Maailm on väga ohtlik", „Kogu minu närvisüsteem on püsivalt kahjustunud").

Kas teil on viimase kuu jooksul esinenud tugevaid negatiivseid uskumusi enda, teiste või maailma kohta? **Tooge mõni näide.** (Näiteks "ma olen halb", "minuga on midagi tõsiselt valesti", "kedagi ei saa usaldada", "maailm on väga ohtlik".) **Kui tugevad need uskumused on?** (Kui veendunud te olete, et need uskumused on päriselt tõesed? Kas te kujutate ette, et teie võiksite sellest ka teisiti mõelda?) ____________________________________ *Märgi: Uskumusteste tugevus ja jäikus = minimaalne märgatav tugev ekstreemne* **Kui suure osa ajast, protsentuaalselt, olete te viimase kuu jooksul niimoodi mõelnud?** *% ajast:* ______ **Kas need uskumused tekkisid või võimendusid pärast T? (**Kas te arvate, et need on T-ga seotud? Miks te nii arvate?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas /piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = uskumuste avaldumise sagedus / intensiivsus **Mõõdukas** = aeg-ajalt (20-30%)/ selgelt väljendunud liialdatult negatiivsed ootused, mõningad raskused realistlikumate alternatiivide leidmisega **Tõsine** = suurem osa ajast (50-60%)/ märkimisväärselt liialdatud negatiivsed ootused, arvestatavad raskused realistlikumate uskumuste leidmisega

Punkt 10 (D3): Püsivad moonutatud kognitsioonid traumaatilise sündmuse põhjuse või tagajärgede kohta, mis viivad enda või teiste süüdistamiseni.

Kas te olete viimase kuu jooksul end [T] või selle tagajärgede pärast süüdi tundnud? Rääkige mulle sellest lähemalt. (Kuidas te enda arvates selle sündmuse põhjustajaks olite? Kas see on seotud millegagi, mida te tegite või tegemata jätsite? Või on põhjus hoopis teie olemuses üldiselt?) **Kas te süüdistate kedagi teist T-s või selle tagajärgedes? Rääkige mulle sellest lähemalt.** (Kuidas teie arvates (TEISED) [T]-s süüdi on? Kas millegi pärast, mida nad tegid või tegemata jätsid?) **Mil määral te ennast või (TEISI) juhtunus süüdistate?** **Kui veendunud te olete, et teie (või TEISED) on tõesti süüdi selles, mis juhtus?** (Kas teised inimesed nõustuvad teiega? Kas te suudate sellest ka kuidagi teisiti mõelda?) ____________________________________ *Märgi: Uskumuste jäikus ja tugevus = minimaalne märgatav tugev ekstreemne* **Kui suure osa ajast, protsentuaalselt, olete te viimase kuu jooksul niimoodi mõelnud?** *% ajast:* _______	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = süüdistamise sagedus / intensiivsus **Mõõdukas** = aeg-ajalt (20-30%)/ selgelt esinev enda või teiste juhtunus põhjendamatu süüdistamine, mõningad raskused realistlikumate uskumuste kaalumisega **Tõsine** = suurem osa ajast (50-60%)/arvestatavad raskused realistlikumate uskumuste leidmisega

Punkt 11 (D4): Püsiv negatiivne emotsionaalne seisund (nt hirm, õud, viha, süütunne, häbi).

Kas te olete viimase kuu jooksul tundnud tugevaid negatiivseid tundeid nagu hirm, õud, viha, süü või häbi? **Tooge mõni näide.** (Milliseid negatiivseid tundeid te olete viimase kuu jooksul kogenud?) **Kui tugevad need negatiivsed tunded on?** **Kui hästi te nendega toime tulete?** *[Kui jääb selgusetuks:]* **(Kui suur probleem see teie jaoks üldiselt on? Selgitage!)** ____ *Märgi: Negatiivsete emotsioonide tugevus = minimaalne märgatav tugev ekstreemne* **Kui suure osa ajast, protsentuaalselt, olete te viimase kuu jooksul niimoodi tundnud?** *% ajast:* ______ **Kas need negatiivsed tunded said alguse või võimendusid pärast T?** (Kas te arvate , et need on T-ga seotud? Miks te nii arvate ?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = negatiivsete emotsioonide esinemissagedus/ intensiivsus **Mõõdukas** = aeg-ajalt (20-30%)/selgelt avalduvad negatiivsed emotsioonid, mõningane raskus nendega hakkama saamisel **Tõsine** = suurem osa ajast (50-60%)/ tugevad negatiivsed emotsioonid, märkimisväärsed raskused nendega hakkama saamisel

Punkt 12 (D5): Märgatavalt vähenenud huvi või osavõtt olulistest tegevusvaldkondadest.

Kas teil on viimase kuu jooksul vähenenud huvi tegevuste suhtes, mida varem nautisite? **Milliste asjade vastu teil huvi kadunud on või milliseid tegevusi te enam nii sageli ei tee kui varem?** (Kas on veel midagi?) **Miks see nii on?** **Mil määral see huvi vähenenud on?** (Kas te naudiksite neid tegevusi, kui oleksite juba alustanud?) ____ *Märgi: Huvi vähenemise määr = minimaalne märgatav tugev ekstreemne* **Protsentuaalselt, kui suure hulga tegevuste suhtes teil viimase kuu jooksul huvi kadunud on?** *% tegevustest:* _______ **Milliseid tegevusi teile siiani teha meeldib?** **Kas huvi kadus või vähenes pärast T?** (Kas te arvate, et see on T-ga seotud? Miks te nii arvate?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = mõjutatud tegevuste protsent / huvi vähenemise määr **Mõõdukas** = aeg-ajalt (20-30%)/ huvi selgelt vähenenud, kuid mõningane nauding on säilinud **Tõsine** = suurem osa ajast (50-60%)/ huvi märkimisväärselt vähenenud, väga vähene huvi ja osalemine tegevustes

Punkt 13 (D6): Eraldatuse- või võõrdumistunne teistest inimestest.

Kas te olete viimase kuu jooksul tundnud end teistest inimestest võõrdununa või eraldatuna? **Rääkige mulle sellest lähemalt.** **Kui tugev see tunne on, et olete teistest inimestest justkui ära lõigatud või kaugeks jäänud?** (Kellega te kõige lähedasem olete? Kui paljude inimestega te isiklikest asjadest rääkides end mugavalt tunnete?) ____ *Märgi: eraldumise või võõrdumise määr= minimaalne märgatav tugev ekstreemne* **Kui suure osa ajast, protsentuaalselt, olete te viimase kuu jooksul niimoodi tundnud?** *% ajast:* _______ **Kas need tunded said alguse või võimendusid pärast T?** (Kas te arvate , et need on T-ga seotud? Miks te nii arvate ?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium =** eraldatuse- või võõrdumistunde esinemissagedus / intensiivsus **Mõõdukas** = aeg-ajalt (20-30%)/ esineb selgelt eraldatusetunnet teistest, kuid säilinud on mõningane seotusetunne teiste inimestega **Tõsine** = suurem osa ajast (50-60%)/ tugev eraldatuse- või võõrdumistunne enamik inimestest, tunneb seotust veel vaid mõne üksiku inimesega inimesega

Punkt 14 (D7): Püsiv võimetus kogeda positiivseid emotsioone (nt suutmatus kogeda õnnetunnet, rahulolu armastustunnet).

Kas teil on viimase kuu jooksul olnud raske kogeda positiivseid tundeid nagu armastus- ja õnnetunne? **Rääkige mulle sellest lähemalt.** (Milliseid tundeid on teil raske kogeda?) **Kui raske on teil positiivseid emotsioone tunda?** (Kas te üldse suudate positiivseid emotsioone enam tunda?) ____ *Märgi: Positiivsete emotsioonide vähenemise määr = minimaalne märgatav tugev ekstreemne* **Kui suure osa ajast, protsentuaalselt, olete te viimase kuu jooksul niimoodi tundnud?** *% ajast:* _______ **Kas raskused positiivsete emotsioonide kogemisega said alguse või võimendusid pärast T?** (Kas te arvate , et see on seotud T-ga? Miks te nii arvate ?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium =** positiivsete emotsioonide kogemise vähenemise sagedus / määr **Mõõdukas** = aeg-ajalt (20-30%)/ selgelt vähenenud, kuid mõnevõrra säilinud võime kogeda positiivseid emotsioone **Tõsine** = suurem osa ajast (50-60%)/ positiivsete emotsioonide kogemine tugevalt häiritud

E kriteerium

Märkimisväärsed muutused erutusseisundis ning reaktiivsuses, mis on alanud või halvenenud traumajärgselt ning millele viitavad 2 (või enam) järgnevaist:

Punkt 15 (E1): Ärrituvus ja vihapursked (ilma põhjuseta või vähesest provokatsioonist tingituna), mis väljenduvad tavaliselt verbaalse või füüsilise agressioonina teiste inimeste või asjade suhtes.

Kas viimase kuu jooksul on esinenud olukordi, kus olete tundnud end eriti kergesti ärrituva või vihasena ning see on ka teie käitumises väljendunud? **Tooge mõni näide.** (Kuidas see väljendub? Kas te tõstate häält või karjute? Kas te viskate või lööte asju? Kas te tõukate või lööte teisi inimesi?) ____ *Märgi: Agressiivsuse tase = minimaalne märgatav tugev ekstreemne* **Kui tihti seda viimase kuu jooksul juhtunud on?** *Kordade arv:* ________ **Kas selline käitumine sai alguse või võimendus pärast T?** (Kas te arvate, et see on T-ga seotud? Miks te nii arvate?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = agressiivse käitumise esinemissagedus / intensiivsus **Mõõdukas** = vähemalt 2 korda kuus/ selgelt väljenduv, peamiselt verbaalne agressioon **Tõsine** = vähemalt 2 korda nädalas/ selgelt väljenduv, tugev agressiivsus, vähemalt osaliselt füüsiline agressioon

Punkt 16 (E2): Hooletu või ennastkahjustav käitumine.

Kas te olete viimase kuu jooksul käitunud riskeerivamalt või teinud ohtlikke asju, mille tagajärjel oleksite võinud viga saada? **Tooge mõni näide.** **Kui ohtlikud need asjad on?** (Olete te mingil viisil viga saanud?) ____ *Märgi: Riski tase = minimaalne märgatav tugev ekstreemne* **Kui tihti te viimase kuu jooksul selliseid riske võtnud olete?** *Kordade arv:* ________ **Kas selline käitumine sai alguse või võimendus pärast T?** (Kas te arvate , et see on T-ga seotud? Miks te nii arvate ?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = riskikäitumise esinemissagedus/ riski tase **Mõõdukas** = vähemalt 2 korda kuus/ riskikäitumine selgelt väljendunud, võib olla saanud viga **Tõsine** = vähemalt 2 korda nädalas/ tugevalt väljendunud riskikäitumine, on saanud viga või selleks on olnud suur tõenäosus

Punkt 17 (E3): Ülivalvsus.

Kas te olete olnud viimase kuu jooksul eriliselt valvas ja ohu suhtes tähelepanelik, isegi kui otsest ohtu pole? (Kas te olete tundnud, et peate pidevalt valvel olema?) **Tooge mõni näide.** (Kuidas te siis käitute, kui olete valvas?) *[Kui jääb selgusetuks:]* **(Mis teid selliselt reageerima paneb? Kas teile tundub, et teid ähvardab mõni oht? Kas te tunnete seda tugevamalt kui teised inimesed samas olukorras tunneksid)** ____ *Märgi: Ülivalvsuse tase = minimaalne märgatav tugev ekstreemne* **Kui suure osa ajast, protsentuaalselt, olete te viimase kuu jooksul niimoodi tundnud?** *% ajast:* ______ **Kas selline valvsus ja tähelepanelikkus ohu suhtes said alguse või võimendusid pärast T?** (Kas te arvate, et see on T-ga seotud? Miks te nii arvate ?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = ülivalvsuse esinemissagedus / intensiivsus **Mõõdukas** = aeg-ajalt (20-30%)/ ülivalvsus selgelt väljendunud, ohu seiramine avalikus kohas, kõrgenenud ohutunne **Tõsine** = suurem osa ajast (50-60%)/ tugevalt väljendunud ülivalvsus, pidev ohu seiramine, võib esineda turvalisuskäitumisi, ülemäärane tähelepanu ja liigne muretsemine enda, perekonna, kodu turvalisuse suhtes

Punkt 18 (E4): Suurenenud ehmumisvalmidus.

Kas te olete viimase kuu jooksul väga tugevalt ehmunud millegi peale? **Mis asjad teid ehmatavad?** **Kui tugevalt te ehmute?** (Kas teistega võrreldes ehmute te samade asjade peale tugevamalt? Kas te teete siis midagi, mida teised inimesed võivad märgata?) **Kui kaua teil rahunemiseks aega kulub?** ____ *Märgi: Ehmumisreaktsiooni tugevus = minimaalne märgatav tugev ekstreemne* **Kui tihti seda viimase kuu jooksul juhtunud on?** *Kordade arv:* ________ **Kas selline ehmumine sai alguse või võimendus pärast T? (**Kas te arvate, et see on T-ga seotud? Miks te nii arvate ?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium** = ehmumise esinemissagedus / intensiivsus **Mõõdukas** = vähemalt 2 korda kuus/ selgelt väljendunud ehmumine, mõningased raskused rahunemisega **Tõsine** = vähemalt 2 korda nädalas/ tugevalt väljendunud ehmumine, püsiv erutusseisund, märkimisväärsed raskused rahunemisega

Punkt 19 (E5): Keskendumiraskused.

Kas teil on viimase kuu jooksul olnud raskusi keskendumisega? **Tooge mõni näide.** **Kui te pingutate, kas te siis suudate keskenduda?** *[Kui jääb selgusetuks:]* **(Mis oleks teie elus teisiti, kui kui teil ei oleks raskusi keskendumisega?** ____ *Märgi: Keskendumisraskuste tase = minimaalne märgatav tugev ekstreemne* **Kui suure osa ajast, protsentuaalselt, olete te viimase kuu jooksul niimoodi tundnud?** *% ajast:* ______ **Kas sellised keskendumisprobleemid said alguse või võimendusid pärast T?** (Kas te arvate, et need on T-ga seotud? Miks te seda arvate ?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium =** keskendumisraskuste esinemise sagedus / intensiivsus **Mõõdukas** = aeg-ajalt (20-30%)/selgelt avalduvad keskendumisraskused, pingutuse korral suudab keskenduda **Tõsine** = suurem osa ajas (50-60%)/ tugevalt väljendunud keskendumisraskused, märkimisväärsed raskused keskendumisega isegi pingutuse korral

Punkt 20 (E6): Uneprobleemid (nt uinumisraskused, sagedane ärkamine või rahutu uni).

Kas teil on viimase kuu jooksul olnud raskusi uinumise või magamisega? **Milliseid probleeme teil esineb?** (Kui kaua teil magama jäämine aega võtab? Kui tihti te öösel üles ärkate? Kas te ärkate üles varem kui sooviksite?) **Mitu tundi te kokkuvõttes öösiti magate?** **Mitu tundi te arvate, et peaksite magama?** ____ *Märgi: Uneprobleemide tase= minimaalne märgatav tugev ekstreemne* **Kui tihti teil viimase kuu jooksul selliseid uneprobleeme esinenud on?** *Kordade arv:* ________ **Kas need probleemid unega said alguse või võimendusid pärast T?** (Kas te arvate , et need on T-ga seotud? Miks te nii arvate ?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/ piiripealne 3 tõsine/ toimetulekut pärssiv 4 ekstreemne/ toimetulekut halvav **Hindamiskriteerium = uneprobleemide** esinemissagedus / intensiivsus **Mõõdukas** = vähemalt 2 korda kuus/ selgelt väljendunud uneprobleemid, selgelt väljendunud uinumisraskused, unevõlg 30-90 minutit **Tõsine** = vähemalt 2 korda nädalas/ uni tugevalt häiritud, tugevalt väljendunud uneprobleemid, unevõlg 90 minutit kuni 3 tundi

F kriteerium

Häire (kriteeriumite B, C, D ja E) kestus ületab 1 kuud.

Punkt 21: Sümptomite avaldumise algus.

[Kui jääb selgusetuks:] **Millal need sümptomid algasid, millest mulle selle intervjuu jooksul rääkinud olete?** (Kui palju hiljem peale trauma kogemist need sümptomid algasid? Kas rohkem kui 6 kuud?)	Hilistunud algus kuudes: #__________ Hilistuva algusega (> 6 kuud)? EI JAH

Punkt 22: Sümptomite kestus.

[Kui jääb selgusetuks:] **Kui kaua need sümptomid kokkuvõttes kestnud on?**	Kogukestus kuudes: #__________ kestus enam kui 1 kuu? EI JAH

G kriteerium

Häire põhjustab kliiniliselt olulist häiritust või raskusi sotsiaalses, tööalases või muus olulises valdkonnas tegutsemisel.

Punkt 23: Subjektiivne häiritu.

Kokkuvõtlikult, mil määral need (PTSH) sümptomid teid viimase kuu jooksul häirinud on? [*Arvesta ka eelnevates vastustes väljendunud häiritust]*	0 Puudub 1 Kerge; minimaalne häiritus 2 mõõdukas; selgelt avalduv häiritus, kuid inimene tuleb sümptomaatikaga siiski toime 3 Tõsine; arvestatav häiritus 4 Äärmuslik; toimetulekut pärssiv häiritus

Punkt 24: Sotsiaalse funktsioneerimise kahjustumine.

Kas need sümptomid, mis teil esinevad, on viimase kuu jooksul mõjutanud teie suhteid teiste inimestega? Kuidas? [*Võtke arvesse ka varasemates vastustes välja toodud raskusi sotsiaalses funktsioneerimises.]*	0 Negatiivset mõju puudub 1 Vähene mõju, minimaalne häiritus sotsiaalses funktsioneerimises. 2 Mõõdukas mõju; selgelt avaldunud kahjustus, kuid inimene tuleb mitmetes sotsiaalse funktsioneerimise aspektides toime 3 Tugev mõju; märkimisväärne kahjustus, inimene tuleb vähestes sotsiaalse funktsioneerimise aspektides toime 4 Äärmuslik mõju; sotsiaalne funktsioneerimine suures osas või täielikult kahjustunud

Punkt 25: Raskuses tööalases funktsioneerimises või mõnes muus olulises tegevusvaldkonnas.

[Kui jäi selgusetuks:] **Kas te käite praegu tööl?** *[KUI JAH:]* **Kas need PTSH sümptomid on viimase kuu jooksul mõjutanud teie töövõimet? Kuidas?** *[KUI EI:]* **Miks see nii on?** (Kas te arvate, et need PTSH sümptomid on sellega seotud? Kuidas?) [Kui patsient ei tööta PTSH sümptomite tõttu, siis hinda raskusastet vähemalt 3-ga. Kui mittetöötamine ei ole seotud PTSD sümptomitega või seos ei ole selge, lähtu hindamisel vaid raskustest teistes olulistes tegevusvaldkondades] **Kas need PTSH sümptomid on mõjutanud teie elu teisi olulisi valdkondi***? [Kui vaja, siis pakkuge näiteid nagu vanema roll, majapidamise eest hoolitsemine, õppetöö, vabatahtlik töö vmt]* **Kuidas?**	0 Negatiivne mõju puudub 1 Vähene mõju, tööalases või mõnes muus olulises valdkonnas tegutsemise minimaalne kahjustumine 2 Mõõdukas mõju; selgelt avaldunud kahjustus, kuid inimene tuleb mitmetes tööalastes või muudes olulises tegevusvaldkondades toime 3 Tugev mõju; märkimisväärne kahjustus, inimene tuleb vähestes tööalastes või muudes olulises tegevusvaldkondades toime 4 Äärmuslik mõju; tööalane või mõnes muus olulises valdkonnas funktsioneerimine suures osas või täielikult kahjustunud

Üldised näitajad

Punkt 26: Üldine valiidsus.

Hinnake vastuste üldist usaldusväärsust/valiidsust. Võtke arvesse järgmisi tegureid: • vastamisvalmidus • vaimne seisund (nt keskendumisraskused, väidetest arusaamine, dissotseerumine) ja • tõendid sümptomite suurendamise või vähendamise kohta.	0 Suurepärane; puudub põhjus kahelda vastuste õigsuses. 1 Hea; esineb tegureid, mis võivad valiidsust negatiivselt mõjutada 2 Rahuldav; on tegureid, mis selgelt vähendavad valiidsust 3 Kesine; oluliselt madal valiidsus 4 Kehtetud vastused, tõsiselt häirunud vaimne seisund või võimalik tahtlik vastuste moonutamine halvemuse või paremuse poole.

Punkt 27: Üldine raskusaste.

Hinnake üldist PTSH sümptomite raskusastet. Võtke arvesse subjektiivset häiritust, funktsionaalset kahjustumise määra, inimese käitumist intervjuul ja tema vastamisstiili.	0 Ei esine kliiniliselt olulisi sümptomeid häiritust ega funktsionaalset kahjustust 1 Vähene; minimaalne häiritus või funktsionaalne kahjustus 2 Mõõdukas; selgelt avalduv häiritus või funktsionaalne kahjustus, kuid pingutuse korral funktsioneerimine rahuldav 3 Tugev; arvestatav häiritus või funktsionaalne kahjustus, funktsioneerimine piiratud ka pingutuse korral. 4 Äärmuslik; märkimisväärne häiritus või kahjustus kahes või enamas tähtsamas funktsioneerimise valdkonnas.

Punkt 28: Üldine seisundi paranemine.

Hinnake üldist seisundi paranemist võrreldes eelmise hindamisega. Hinnake muutuse määra ja seda, kas see muutus on teie arvates tingitud ravist.	0 Asümptomaatiline 1 arvestatav paranemine 2 mõõdukas paranemine 3 mõningane paranemine 4 ei ole paranenud üldse 5 puudub informatsioon hindamiseks

Täpsustage, kas esineb dissotsiatiivseid sümptomeid: isikul esinevad posttraumaatilise stressihäire sümptomid ja lisaks kogeb isik vastusena stressoritele püsivaid või korduvaid sümptomeid järgneva kahe seast:

Punkt 29 (1): Depersonalisatsioon: püsivad või korduvalt esinevad kogemused, kus inimene tunneb end iseenda isiksusest või kehast eraldatuna, tunneb end justkui nende välise vaatlejana (nt unenäos viibimise tunne, enese või oma keha ebareaalsena tajumine või tunne, et aeg möödub aeglasemalt).

Kas te olete viimase kuu jooksul tundnud nagu oleksite iseendast eraldunud, nagu vaataksite end väljastpoolt või nagu jälgiksite oma mõtteid ja tundeid kõrvalseisjana? *[Kui ei:]* **(Aga kas te olete tundnud nagu viibiksite unenäos ehkki olete tegelikult ärkvel? Või olete te tundnud nagu miski teie juures poleks päris? Või tundnud, nagu liiguks aeg justkui aeglasemalt?)** **Rääkige mulle sellest lähemalt.** **Kui tugev see tunne on?** (Kas te kaotate võime aru saada, kus te tegelikult olete või mis teie ümber toimub?) **Kuidas te sellistes olukordades käitute?** (Kas teised inimesed märkavad teie käitumist? Mida nad ütlevad?) **Kui kaua see kestab?** *[Kui jääb selgusetuks:]* **(Kas see võis olla tingitud alkoholi või uimastite mõjust? Või mõnest haigusest?)** ____ *Märgi: dissotseerumise tase = minimaalne märgatav tugev ekstreemne* **Kui tihti seda viimase kuu jooksul juhtunud on?** *Kordade arv:* ________ **Kas see sai alguse või võimendus pärast T?** (Kas te arvate, et see on T-ga seotud? Miks te nii arvate?) *Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline*	0 puudub 1 kerge/ alalävine 2 mõõdukas/piiripealne 3 tõsine / toimetulekut pärssiv 4 ekstreemne/toimetulekut halvav **Hindamiskriteerium =** dissotsieerumise esinemissagedus / intensiivsus **Mõõdukas** = vähemalt 2 korda kuus/ dissotsieerumine selgelt väljendunud, kuid kiiresti mööduv, säilib mõningane reaalsustaju endast ja ümbritsevast **Tõsine** = vähemalt 2 korda nädalas/ tugevalt väljendunud dissotsiatiivsus, märkimisväärne eemaldumise ja ebareaalsustunne

Punkt 30 (2): Püsivad või korduvad kogemused, kus inimene tajub ümbrust ebareaalsena (nt tundub ümbritsev maailm ebareaalne, unenäolaadne, kauge või moonutatud).

<table>
<tr>
<td>
Kas te olete viimase kuu jooksul olnud olukorras, kus teile tundub, et teie ümber toimuv on ebareaalne või väga kummaline ja võõras?

[Kui ei:] (Kas teie ümber toimuv oleks justkui filmis või unenäos? Kas see tundub kuidagi kauge või moonutatud?)

Kui tugev see tunne on? (Kas te kaotate võime aru saada, kus te tegelikult olete või mis teie ümber toimub?)

Kuidas te sellistes olukordades käitute? (Kas teised inimesed märkavad teie käitumist? Mida nad ütlevad?)

Kui kaua see kestab?
____
Märgi: dissotseerumise tase = minimaalne märgatav tugev ekstreemne

[Kui jääb selgusetuks:] (Kas see võis olla tingitud alkoholi või uimastite mõjust? Või mõnest haigusest?)

Kui tihti seda viimase kuu jooksul juhtunud on?
Kordade arv: ________

Kas see sai alguse või võimendus pärast T? (Kas te arvate, et see on T-ga seotud? Miks te nii arvate?)

Märgi: Seotus traumaga: kindel tõenäoline ebatõenäoline
</td>
<td>
0 puudub

1 kerge/ alalävine

2 mõõdukas/piiripealne

3 tõsine / toimetulekut pärssiv

4 ekstreemne/toimetulekut halvav

Hindamiskriteerium = dissotsieerumise esinemissagedus / intensiivsus

Mõõdukas = vähemalt 2 korda kuus/ dissotseerumine selgelt väljendunud, kuid kiiresti mööduv, säilib mõningane reaalsustaju endast ja ümbritsevast

Tõsine = vähemalt 2 korda nädalas/ tugevalt väljendunud dissotsiatiivsus, märkimisväärne eemaldumise ja ebareaalsustunne
</td>
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CAPS-5 SKOORIMISLEHT

Tegeliku või potentsiaalse surma või surmaohuga kokkupuude, tõsiste vigastuste või seksuaalvägivalla kogemine	
Vastavus A kriteeriumile	0 = EI 1 = JAH

B. Pealetükkivused sümptomid (diagnoosiks vajalik 1)	**Möödunud kuu**	
Sümptom	**Intensiivsus**	**Sx (Int. ≥ 2)?**
1. B1 – pealetükkivad mälestused		0 = EI 1 = JAH
2. B2 – häirivad unenäod		0 = EI 1 = JAH
3. B3 – dissotsiatiivsed reaktsioonid		0 = EI 1 = JAH
4. B4 – tugev psühholoogiline häiritus		0 = EI 1 = JAH
5. B5 – tugevad kehalised reaktsioonid		0 = EI 1 = JAH
B kokku	B Int. =	# B Sx =

C. vältimise sümptomid?? (diagnoosiks vajalik 1)	**Möödunud kuu**	
	Intensiivsus	**Sx (Int. ≥ 2)?**
Sümptom		0 = EI 1 = JAH
6. C1 – mälestuste, mõtete, tunnete vältimine		0 = EI 1 = JAH
7. C2 – väliste traumat meenutavate stiimulite vältimine		0 = EI 1 = JAH
C kokku	C Int =	# C Sx =

D. Negatiivsete uskumuste ja meeleolu sümptomid (diagnoosimiseks vajalikud 2)	**Möödunud kuu**	
Sümptom	**Intensiivsus**	**Sx (Int. ≥ 2)?**
8. D1 – võimetus meenutada sündmuse olulisi aspekte		0 = EI 1 = JAH
9. D2 –tugevad negatiivsed uskumused või eeldused		0 = EI 1 = JAH
10. D3 – süütunnet tekitavad moonutatud uskumused		0 = EI 1 = JAH
11. D4 – püsiv negatiivne emotsionaalne seisund		0 = EI 1 = JAH
12. D5 – vähenenud huvi või osavõtt tegevustes		0 = EI 1 = JAH
13. D6 – teistest eraldatuse või võõrdumistunne		0 = EI 1 = JAH
14. D7 – püsiv võimetus kogeda positiivseid emotsioone		0 = EI 1 = JAH
D kokku	D Sev =	# D Sx =

E. Erutusseisundi ja reaktiivsuse sümptomid (diagnoosiks vajalikud 2)	**Möödunud kuu**	
Sümptom	**Intensiivsus**	**Sx (Int. ≥ 2)?**
15. E1 – ärrituvus ja vihapursked		0 = EI 1 = JAH
16. E2 – hooletu või ennastkahjustav käitumine		0 = EI 1 = JAH
17. E3 – ülivalvsus		0 = EI 1 = JAH

18.	E4 – suurenenud ehmumisvaldmidus		0 = EI 1 = JAH
19.	E5 – keskendumisraskused		0 = EI 1 = JAH
20.	E6 – uneprobleemid		0 = EI 1 = JAH
	E kokku	E Int =	E# Sx =

PTSD koond	**Möödunud kuu**	
Koondskoor	Int kokku	Sx kokku
Kokku (B+C+D+E)		

Sümptomaatika avaldumise kestus	**Käesolev**
(22) Sümptomaatika avaldumise kestus ≥ 1 kuu	0 = EI 1 = JAH

G. Häirituse kestus (diagnoosiks vajalik 1)	**Möödunud kuu**	
Sümptom	**Intensiivsus**	**Sx (Int. ≥ 2)?**
(23) subjektiivne häiritus		0 = EI 1 = JAH
(24) sotsiaalse funktsioneerimise kahjustumine		0 = EI 1 = JAH
(25) tööalase funktsioneerimise kahjustumise		0 = EI 1 = JAH
G kokku	G Sev =	G# Sx =

Üldised näitajad	**Möödunud kuu**
(26) üldine valiidsus	
(27) üldine raskusaste	
(28) üldine seisundi paranemine	

Dissotsiatiivsed sümptomid (alatüübi jaoks vaja 1)	**Möödunud kuu**	
Sümptom	**Intensiivsus**	**Sx (Int. ≥ 2)?**
(29) 1 – depersonalisatsioon		0 = EI 1 = JAH
(30) 2 - derealisatsioon		0 = EI 1 = JAH
Dissotsiatiivsus kokku	Diss Int =	# Diss Sx =

PTSH diagnoos	**Möödunud kuu**
Kõik kriteeriumid täidetud (A-G)?	0 = EI 1 = JAH
Dissotsiatiivsete sümptomitega	0 = EI 1 = JAH
(21) Hilistuva algusega (≥ 6 kuud)	0 = EI 1 = JAH

Käesolevaga kinnitan, et olen korrektselt viidanud kõigile oma töös kasutatud teiste autorite poolt loodud kirjalikele töödele, lausetele, mõtetele, ideedele või andmetele. Olen nõus oma töö avaldamisega Tartu Ülikooli digitaalarhiivis DSpace.

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