

Posttraumatic Stress Symptoms, Depression, Anxiety, and Stress among Somali University Students: A Cross-Sectional Study

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Abstract

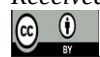
Background: Exposure to traumatic events is a significant risk factor for psychological distress, including depression, anxiety, and stress. In conflict-affected countries such as Somalia, university students may be particularly vulnerable to trauma exposure and its mental health consequences. However, limited empirical research has examined this relationship among Somali university students. **Aim:** This study investigated the relationship between posttraumatic stress disorder (PTSD) symptoms and mental health problems among Somali undergraduate university students. **Methods:** A cross-sectional survey design was employed with a sample of 250 students aged 18–25 years, selected through stratified random sampling based on gender and university year. Data were collected using the Depression Anxiety Stress Scale (DASS-21) and the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5). Descriptive statistics, correlation analysis, regression analysis, t-tests, and ANOVA were conducted using SPSS. **Results:** The findings revealed significant positive correlations between trauma exposure and depression ($r = .510$), anxiety ($r = .549$), and stress ($r = .457$). Regression analyses demonstrated that trauma significantly predicted depression ($\beta = .510$, $p < .001$), anxiety ($\beta = .549$, $p < .001$), and stress ($\beta = .457$, $p < .001$). No significant gender differences were observed in depression, anxiety, stress, or trauma levels. However, stress levels differed significantly across age groups and university years, with younger students and first-year students reporting higher stress levels. **Conclusion:** The study highlights the strong association between trauma exposure and psychological distress among Somali university students and underscores the need for targeted mental health interventions in academic settings.

Keywords: PTSD; Trauma; Depression; Anxiety; Stress; Somali University Students

Introduction

In 1948, the World Health Organization defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1). Recently, the mental health and well-being aspects of this definition have been discussed in US health care and public health. According to WHO (2), a mental disorder is characterized by a clinically signifi-

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cant disturbance in an individual's cognition, emotional regulation, or behavior. It is usually associated with distress or impairment in important areas of functioning. There are many different types of mental disorders. Mental disorders may also be referred to as mental health conditions. The latter is a broader term covering mental disorders, psychosocial disabilities, and other mental states associated with significant distress, impairment in functioning, or risk of self-harm (2).

Globally, approximately 450 million people suffer from mental and behavioral disorders, with approximately one person in four developing such a disorder during their lifetime (3). Worldwide, the burden of mental illnesses poses serious public health challenges, with approximately 7.4% of the global burden of disease attributed to mental disorders (3). In 2010, mental and substance use disorders were the fifth leading cause of disability-adjusted life years (183.9 million) (4). In 2015, 17.9 million years were lost to disability due to mental disorders in Africa; a 52% increase from 2000 (5). In 2019, 1 in every 8 people, or 970 million people around the world were living with a mental disorder, with anxiety and depressive disorders the most common (6). Furthermore, depression has been identified as a leading contributor to global disability (7). In 2020, the number of people living with anxiety and depressive disorders rose significantly because of the COVID-19 pandemic. Initial estimates show a 26% and 28% increase respectively for anxiety and major depressive disorders in just one year (6). While effective prevention and treatment options exist, most people with mental disorders do not have access to effective care. Many people also experience stigma, discrimination, and violations of human rights, especially among university students (6).

One of the most serious trauma-related mental health conditions is Posttraumatic Stress Disorder (PTSD). PTSD develops after exposure to actual or threatened death, serious injury, or sexual violence and is characterized by intrusive memories, avoidance behaviors, negative alterations in cognition and mood, and marked alterations in arousal and reactivity (8). Individuals exposed to traumatic events such as war, physical assault, accidents, natural disasters, or childhood abuse are at increased risk of developing PTSD. PTSD is frequently comorbid with depression and anxiety disorders and significantly impairs social and academic functioning (9). Exposure to traumatic events is strongly associated with the development of PTSD, and lifetime prevalence varies depending on exposure severity and sociopolitical context (10). PTSD frequently co-occurs with depression and anxiety disorders, with comorbidity rates exceeding 50% in many populations (11). Trauma exposure also disrupts neurobiological stress regulation systems, increasing vulnerability to chronic psychological distress (12).

Mental health problems are very common among college students. This may be since attending college corresponds to a challenging time for many traditional and non-traditional undergraduate students (13). A global meta-analysis found that university students experience high rates of anxiety, depression, and stress-related disorders compared to the general population (14). Similarly, recent multinational research indicates increasing mental health concerns among university students worldwide (15). In 2022, over three-quarters of college students (77%) experienced moderate to serious psychological distress. Thirty-five percent of students were diagnosed with anxiety, and 27% had depression (16). University students face academic pressure, financial stress, transition challenges, and separation from family support systems, which may increase vulnerability to psychological distress. When trauma exposure is added to these stressors, the risk of mental health problems may increase substantially (13).

In the Somali context, prolonged civil conflict, political instability, terrorism, displacement, and exposure to natural disasters have resulted in widespread exposure to traumatic events among the population (17). Research conducted in conflict-affected regions demonstrates that prolonged exposure to war and displacement significantly increases the prevalence of PTSD and depressive disorders among young people (18). Studies in sub-Saharan Africa have also reported elevated trauma exposure and limited access to mental health services (19). Many young people have grown up in environments marked by insecurity and adversity. Exposure to such cumulative trauma increases the likelihood of PTSD and related mental health conditions (8). Despite this, limited empirical research has examined PTSD and its relationship with depression, anxiety, and stress among Somali university students. Most available data focus on general mental health prevalence rather than trauma-specific psychological outcomes.

Given the high exposure to traumatic experiences in Somalia and the vulnerability of university students to psychological distress, it is important to examine the relationship between PTSD symptoms and mental health problems in this population. So far no study have been done on this topic in Somalia. Therefore, the present study aims to investigate the association between trauma exposure and symptoms of depression, anxiety, and stress among Somali undergraduate university students.

Method

Study Design and Setting

A cross-sectional survey design was employed to examine the association between trauma exposure and symptoms of depression, anxiety, and stress among Somali undergraduate university students. The study was conducted at Hanuun University and Amoud University, Somalia. Data were collected between March and May 2025.

Participants and Sampling

A cross-sectional survey was conducted among Somali University students. The participants were Somali undergraduate university students that aged between 18 to 25 years old. In order to select the sample, it was employed stratified random sampling technique, and the two gender and the four levels of undergraduate university students were the base of the strata and was given equal number of each strata. The sample size was 221 which established based on the formula of Hair, Black, Babin, and Anderson (19). According to this formula, the sample size is calculated by multiplying minimum 3 and maximum 13 into the number of items in the questionnaire that is used for the research. In this case the researcher chose to multiple numbers of items of the scale into 10, because it is a sample near to the maximum.

Measures

Demographic variables

Demographic variables that the researcher will take for the study is age, gender, and level of university.

Depression Anxiety and Stress Scale

The DASS (20) is a 21-item self-report inventory that provides scores on three subscales: Depression (7-items), anxiety (7-items), and stress (7-items). Each item was rated on a 5-point scale. Factor loadings of the subscales ranged from .39 to .88. The internal consistency alpha coefficients were found for depression, anxiety, and stress .90, .92, and .92 respectively. The test-retest reliability scores after three weeks were found .98 for three subscales. Related with the criterion-related validity of the scale, correlation coefficients between the DASS and the Beck Depression Inventory (Beck, Steer, & Brown, 1996), and the Beck Anxiety Inventory (Beck, Epstein, Brown, & Steer, 1988) were computed as .87 and .84, respectively.

The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)

The Posttraumatic Stress Disorder Checklist (PCL) is a widely used DSM-correspondent self-report measure of PTSD symptoms. The PCL was recently revised to reflect DSM-5 changes to the PTSD criteria. In this article, the authors describe the development and initial psychometric evaluation of the PCL for DSM-5 (PCL-5). Psychometric properties of the PCL-5 were examined in 2 studies involving trauma-exposed college students. In Study 1 ($N = 278$), PCL-5 scores exhibited strong internal consistency ($\alpha = .94$), test-retest reliability ($r = .82$), and convergent ($r_s = .74$ to $.85$) and discriminant ($r_s = .31$ to $.60$) validity. In addition, confirmatory factor analyses indicated adequate fit with the DSM-5 4-factor model, $\chi^2(164) = 455.83$, $p < .001$, standardized root mean square residual (SRMR) = .07, root mean squared error of approximation (RMSEA) = .08, comparative fit index (CFI) = .86, and Tucker-Lewis index (TLI) = .84, and superior fit with recently proposed 6-factor, $\chi^2(164) = 318.37$, $p < .001$, SRMR = .05, RMSEA = .06, CFI = .92, and TLI = .90, and 7-factor, $\chi^2(164) = 291.32$, $p < .001$, SRMR = .05, RMSEA = .06, CFI = .93, and TLI = .91, models. In Study 2 ($N = 558$), PCL-5 scores demonstrated similarly strong reliability and validity. Overall, results indicate that the PCL-5 is a psychometrically sound measure of PTSD symptoms. Implications for use of the PCL-5 in a variety of assessment contexts are discussed (21).

Procedure

Every step of the research was guided by ethics. First, oral consent was obtained from participants before they took part in the study. It was told that they have the freedom to leave the study whenever they want, and no strict rules were applied to them. For the data collection, the participants were told the aims and objectives of the study. The participants were given the two scales, namely, the Depression, Anxiety, and Stress Scale and the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5), and a demographic questionnaire. The participants were approached while they were in the classes and collected data in groups in order to avoid response bias and social desirability bias. The researchers, with the help of the teachers, probably seated the students and made sure to have enough space between each other. The maximum strength of the classes was 20 students. The researcher gave the participants detailed information regarding the study and clarified and answered any questions they asked. The researcher assured the participants of their anonymity, as no names or phone numbers would be given, and assured them that the data would be used only for the purpose of research. After the participants gave oral informed consent and filled out the questionnaires, data entry followed. For data analysis, SPSS was used to help find out the relationships between PTSD and mental health problems.

Result

Table 1: Frequency and percentages of demographic variables and descriptive statistics for main study variables

Variable	Category	Frequency/Mean	Percentage/SD
Age	Up to 20 Years	74	33.5
	20-23 Years	99	44.8
	Above 23 Years	48	21.7
Gender	Male	79	35.7
	Female	142	64.3
University Year	1 st	67	30.3
	2 nd	76	34.4
	3 rd	23	10.4
	4 th	55	24.9
Type TM1	Yes	122	55.2
	No	99	44.8
Type TM2	Yes	88	39.8
	No	133	60.2
Type TM3	Yes	30	13.6
	No	191	86.4
Type TM4	Yes	34	15.4
	No	187	84.6
Type TM5	Yes	83	37.6
	No	138	62.4
Type TM6	Yes	119	53.8
	No	102	46.2
Type TM7	Yes	84	38.0
	No	137	62.0
Type TM8	Yes	9	4.1
	No	212	95.9
Type of Trauma	Serious life-threatening Illness (heart, attack, etc)	47	21.3
	Physical Assault	31	14.0
	Sexual Assault	6	2.7
	Military Combat or lived in a war zone	6	2.7
Single	Child abuse	32	14.5
Bothering	Accident	74	33.5
	Natural Disaster	24	10.9
	Others trauma	1	0.5
Depression		6.56	3.62
Anxiety		6.76	4.08
Stress		7.38	3.79
Trauma		24.82	14.08

Table 1 presents the demographic characteristics of the study participants. A total of 221 undergraduate students participated in the study. The majority were female (64.3%), while 35.7% were

male. Regarding age distribution, 44.8% of participants were aged 20–23 years, 33.5% were aged ≤ 20 years, and 21.7% were above 23 years. In terms of academic year, 34.4% were second-year students, followed by 30.3% first-year students, 24.9% fourth-year students, and 10.4% third-year students.

With respect to trauma exposure, 55.2% of participants reported exposure to trauma type TM1, 39.8% to TM2, and 53.8% to TM6, while exposure to other trauma types ranged from 4.1% to 38.0%. The most frequently reported single traumatic event was accident (33.5%), followed by serious life-threatening illness (21.3%) and child abuse (14.5%). Sexual assault and military combat exposure were reported by 2.7% of participants each.

The men (standard deviation) of depression, anxiety, stress and trauma are 6.56 (3.62), 6.76 (4.08), 7.38 (3.79) and 24.82 (14.08) respectively.

Table 2: Regression analysis by using trauma as independent variable while depression, anxiety and stress as outcome variable

Variables	USC	SC		t	p
	β	Std. Error	β		
Depression as outcome variable					
Constant	3.301	.426		7.744	.000
Trauma	.131	.015	.510	8.778	.000
Overall Model		F _(1, 219) = 77.062			.000
Anxiety as outcome variable					
Constant		2.802			.467
Trauma		.159			.016
Overall Model		F _(1, 219) = 94.551			.000
Stress as outcome variable					
Constant		4.331			.461
Trauma		.123			.016
Overall Model		F _(1, 219) = 57.921			.000

The above table 2 shows the results of regression analysis in which trauma as independent variable while depression, anxiety and stress as outcome variables. From the results we conclude that trauma has significant and positive impact on depression, which shows that higher trauma will lead to depression and one unit change in trauma will .131 positive change in depression.

Similarly, trauma has significant and positive impact on anxiety, which shows that higher trauma will lead to anxiety and one unit change in trauma will .159 positive change in anxiety.

Furthermore, trauma has significant and positive impact on stress, which shows that higher trauma will lead to stress and one unit change in trauma will .123 positive change in stress.

Table 3: The comparison of depression, anxiety, stress and trauma between male and female respondents

Variables	<i>M ± SD</i>		t	P	95% CI	
	Male (n=79)	Female (n=142)			LL	UL
Depression	6.13±3.87	6.80±3.47	-1.319	.189	-1.67	.33
Anxiety	6.28±3.48	7.02±4.37	-1.297	.196	-1.87	.39
Stress	7.04±3.36	7.58±4.00	-1.066	.311	-1.59	.51
Trauma	22.78±13.71	25.95±14.21	-1.607	.109	-7.05	.72

Table 3 represent results for depression, anxiety, stress and trauma between male and female respondents. From the results we conclude that the levels of depression, anxiety, stress and trauma are not significantly different between male and female respondents.

Table 4: The comparison of depression, anxiety, stress and trauma among different age groups of the respondents

Variables	Age Groups			F	p-value
	Up to 20 Years (n = 74)	20-23 Years (n = 99)	Above23 Years (n = 48)		
	Mean ± SD	Mean ± SD	Mean ± SD		
Depression	7.392±3.4	6.162±3.64	6.083±3.77	3.022	.051
Anxiety	6.865±3.92	6.788±4.1	6.521±4.37	.108	.898
Stress	8.405±3.42	7.101±4.1	6.396±3.33	4.754	.010
Trauma	25±11.88	26.293±15.4	21.5±14.1	1.897	.152

Table 4 represents results for comparison of depression, anxiety, stress and trauma among different age groups of the respondents. From the results we concluded that the level of stress is significantly different among different age groups of the respondents similarly, no significant difference found in the levels of depression, anxiety and trauma among different age groups of the respondents. Furthermore, maximum difference is found in the age groups up to 20 years and above 23 years.

Table 5: The comparison of depression, anxiety, stress and trauma among different university years

Variables	University Year				F	p-value
	1 st Years (n = 67)	2 nd Years (n = 76)	3 rd Years (n = 23)	4 th Years (n = 55)		
	Mean ± SD	Mean ± SD	Mean ± SD			
Depression	6.716±3.29	7.066±3.41	5.261±3.43	6.2±4.24.00	1.721	.164
Anxiety	6.985±3.82	6.632±3.89	7.435±4.02	6.364±4.70	.471	.703
Stress	7.478±3.33	8.211±3.84	6.565±2.95	6.473±4.33	2.699	.047
Trauma	26.896±11.95	24.171±14.24	25.565±13.16	22.873±16.46	.910	.437

Table 5 represents results for comparison of depression, anxiety, stress and trauma among different university years of the respondents. From the results we concluded that the level of stress is significantly different among different university years of the respondents. Similarly, no significant difference found in the levels of depression, anxiety and trauma among different university years of the respondents. Furthermore, maximum difference is found in the 1st and 4th years of the university year of respondents.

Discussion

The present study examined the relationship between trauma exposure and symptoms of depression, anxiety, and stress among Somali university students. The findings revealed significant positive correlations between trauma and all three psychological outcomes. Trauma significantly predicted depression, anxiety, and stress, indicating that higher levels of trauma exposure are associated with greater psychological distress. These findings are consistent with extensive international literature demonstrating that exposure to traumatic events is a strong risk factor for a range of mental health problems, particularly posttraumatic stress disorder (PTSD), depression, and anxiety disorders (3,9).

The strong predictive relationship between trauma and depression observed in this study aligns with previous research suggesting that trauma-related cognitive distortions, emotional dysregulation, and chronic stress responses increase vulnerability to depressive symptoms (13). University students represent a particularly vulnerable population, as they are navigating developmental transitions, academic pressures, and social challenges simultaneously. When traumatic experiences are added to these stressors, psychological resilience may be significantly compromised. Globally, mental disorders account for a substantial proportion of the burden of disease, and young adults are disproportionately affected (1,5).

Similarly, trauma significantly predicted anxiety in this study. This finding supports previous evidence that trauma exposure heightens hyperarousal, fear conditioning, and anticipatory anxiety, which can persist even in the absence of immediate threat (9). In contexts such as Somalia, where many individuals may have experienced conflict, displacement, or other adversities, the cumulative impact of trauma may contribute to chronic anxiety symptoms. The significant association between trauma and stress further reinforces the idea that trauma disrupts individuals' coping systems, increasing vulnerability to everyday stressors.

Interestingly, no significant gender differences were found in depression, anxiety, stress, or trauma levels. While many global studies report higher rates of internalizing disorders among females, some research in conflict-affected or resource-limited settings has shown smaller or non-significant gender differences, possibly due to shared exposure to collective trauma (3). Cultural norms regarding emotional expression and reporting may also influence these findings.

Age and university year differences were significant only for stress, with younger students and first-year students reporting higher stress levels. This finding is consistent with literature indicating that the transition to university is associated with adjustment difficulties, academic pressure, and separation from family support systems (9). However, the absence of significant differences in depression and anxiety across age groups suggests that trauma-related psychological symptoms may persist consistently across early adulthood once established.

Overall, the results underscore the importance of trauma-informed approaches in higher education settings. Although effective prevention and treatment strategies exist, many individuals—particularly in low-resource settings—lack access to adequate mental health care (5). The strong association between trauma and psychological distress identified in this study highlights the urgent need for institutional mental health services, early screening, and psychoeducation programs tailored to Somali university students.

Limitations

Several limitations should be considered when interpreting the findings of this study

1. **Cross-sectional design:** The study design limits the ability to establish causal relationships between trauma and mental health outcomes. Longitudinal research is needed to determine directionality.
2. **Self-report measures:** Data were collected using self-report questionnaires, which may be influenced by social desirability bias or inaccurate recall.
3. **Single population focus:** The study included only university students, limiting generalizability to other populations such as non-students or older adults.
4. **Limited demographic variables:** Only age, gender, and university year were considered. Other important variables such as socioeconomic status, social support, and prior psychiatric history were not assessed.

Conclusion

This study provides empirical evidence that trauma exposure is strongly associated with depression, anxiety, and stress among Somali university students. Trauma significantly predicts psychological distress, highlighting its central role in students' mental health. While gender differences were not significant, stress levels varied across age groups and academic years, with younger and first-year students reporting higher stress. The findings underscore the urgent need for structured mental health support systems within Somali universities to address trauma-related psychological problems and promote student well-being.

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