The Early Trauma Inventory Self Report-Short Form (ETISR-SF): Validation and Psychometric Properties of the Hungarian Version

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Background: Childhood trauma constitutes a major public health issue, as it is associated with enduring mental and physical health complications, as well as an increased risk for a range of psychiatric disorders in adulthood. The Early Trauma Inventory Self Report–Short Form (ETISR-SF) is a concise and effective instrument for assessing early traumatic experiences. The present study aimed to examine the psychometric properties and validate the Hungarian version of the ETISR-SF. **Methods:** In this cross-sectional study, a total of 300 psychiatric patients and 57 non-clinical control participants completed the Early Trauma Inventory Self Report–Short Form (ETISR-SF) and the Childhood Trauma Questionnaire–Short Form (CTQ-SF). **Results:** Confirmatory factor analysis supported the original four-factor structure, yielding satisfactory model fit indices. The ETISR-SF demonstrated high internal consistency across all subscales (Cronbach's $\alpha = 0.78–0.94$). Significant differences between the clinical and non-clinical groups provided evidence of good discriminant validity. Correlations between the ETISR-SF and the CTQ-SF, both at the total and subscale levels, were significant and ranged from low to moderate ($r = 0.22–0.71$, $p < 0.001$), supporting the instrument's convergent and divergent validity. **Conclusions:** The findings of the present study indicate that the Hungarian version of the ETISR-SF is a psychometrically sound instrument, demonstrating validity and reliability for assessing early traumatic experiences in Hungarian clinical populations.
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Keywords: Childhood trauma, Early Trauma Inventory, Validation study

INTRODUCTION

Childhood traumatic experiences constitute a major global public health concern due to their high prevalence and profound psychological and social consequences. According to estimates by the World Health Organization (WHO), approximately 20% of women and 5–10% of men worldwide have experienced sexual abuse during childhood; however, the actual figures are likely higher, as many cases go unreported [1]. A WHO survey of 51,945 adults across 21 countries revealed that between 59.3% and 66.2% had experienced multiple traumatic events before the age of 18, with an average of at least two such incidents [2]. A meta-analysis of over 300 studies conducted between 2000 and 2017 found that in Europe, 14% of girls and 6% of boys reported sexual abuse, while higher rates were observed in North America – 20% for girls and 14% for boys. Physical abuse was most prevalent in Africa, affecting 60% of boys and 51% of girls. Emotional abuse also demonstrated regional variation: in North America, 28% of girls and 14% of boys reported such experiences, whereas in Europe, the prevalence was lower – 13% for girls and 6% for boys [3]. In Hungary, child welfare services recorded 11,000 cases of child abuse and 45,000 instances of parental neglect in 2015, according to the annual review published in 2017 by the Hungarian Central Statistical Office [4]. Furthermore, the number of crimes committed against children rose significantly in 2020, reaching 6,310 cases – nearly 500 more than in 2019 [5].

Experiencing childhood trauma is linked to a broad spectrum of adverse outcomes in adulthood. The developmental timing, duration, and nature of the traumatic experience critically influence its impact on emotional, cognitive, and social development [6–8]. Traumatic events occurring prior to adulthood are more likely to result in severe psychological consequences than those experienced later in life, with earlier exposure being associated with a heightened risk of long-term negative effects [9]. Adverse childhood experiences have been correlated with social, emotional, and behavioral difficulties, subjective health complaints, and eating disorders in adolescents [10–13]. Moreover, greater severity of abuse is more strongly associated with poor outcomes and more serious consequences [14]. A substantial body of international research has established that adverse early life experiences constitute a significant risk factor for adult psychopathology. Childhood trauma – including physical, emotional, and sexual abuse, as well as neglect – is highly prevalent among individuals with psychiatric conditions. Studies indicate that between 30% and 80% of psychiatric patients report a history of early childhood trauma [15]. Such experiences are frequently observed in those diagnosed with mood disorders, including major depressive disorder (MDD) and bipolar disorder [16–18], posttraumatic stress disorder (PTSD) and other anxiety disorders [19–22], borderline personality disorder (BPD) [23–25], attention deficit hyperactivity disorder (ADHD) [26, 27], and psychotic disorders [28–30]. Additionally, early traumatic experiences have been associated with maladaptive metacognitions [31], maladaptive daydreaming [32], and are recognized as risk factors for a wide range of behavioral and substance use disorders [33–35].

Traumatic childhood experiences are also associated with significant functional impairments and reduced quality of life [36–39]. Somatoform symptoms and medically unexplained physical complaints frequently co-occur with a history of early-life trauma [40, 41]. Furthermore, early trauma may have intergenerational effects, increasing the risk of mental health disorders in subsequent generations and perpetuating cycles of trauma and heightened vulnerability to psychiatric conditions [42, 43]. The consequences of such experiences may impair caregiving capacities, thereby elevating the risk of adverse developmental and psychological outcomes in offspring [44, 45]. Individuals with a history of childhood trauma are more likely to present with treatment-resistant psychiatric conditions, demonstrate increased utilization of medical and psychosocial services, and incur substantial healthcare and social support costs [6, 14, 46, 47].

Given the complex and enduring effects of early trauma on mental health, the accurate assessment of childhood traumatic experiences is essential for both clinical practice and research. Recognizing and addressing trauma is vital for effective intervention, as trauma-informed care has been shown to enhance therapeutic outcomes, reduce symptom severity, and improve patient engagement. There is a need for both brief, easily administered screening instruments and more comprehensive tools for the detailed assessment of traumatic events. Self-report questionnaires offer several practical advantages over open-ended clinical interviews, notably by reducing recall bias – since clinicians may not systematically inquire about all relevant events – and minimizing participant avoidance, as written formats are often perceived as less confrontational [48–50]. Moreover, such instruments are particularly valuable in low-resource settings or

environments with limited access to trained personnel, where lengthy clinical interviews may not be feasible.

A variety of well-established instruments are available for the assessment of trauma, including both self-report questionnaires and structured interviews. Among these, the Early Trauma Inventory (ETI) is a widely used tool. Originally developed by Bremner et al. [51] as a comprehensive clinician-administered interview, the ETI was designed to assess a broad range of early traumatic experiences. However, due to certain limitations of the interview format – such as its time-consuming nature, the potential for respondent avoidance in face-to-face settings, and the requirement for trained professionals – a self-report version (ETI-SR) and a shortened version, the 27-item Early Trauma Inventory Self-Report Short Form (ETISR-SF), were subsequently developed [52]. The ETISR-SF retains the core domains of the original instrument while enhancing efficiency and ease of administration. This short form has been translated and validated in several languages, including Spanish [53], Korean [54], Brazilian Portuguese [55], Greek [56], German [57], Swedish [58], Slovenian [59], Colombian Spanish [60], and Turkish [61], demonstrating its cross-cultural applicability. It has been employed in diverse populations, such as general community samples, military personnel, individuals with substance dependence, primary care patients, and those diagnosed with depression, PTSD, borderline personality disorder (BPD), and irritable bowel syndrome [53–55, 58, 62–64]. Across these studies, the ETISR-SF has consistently shown good internal consistency, replicated the original four-factor structure, and demonstrated strong test-retest reliability [53–61], making it a strong candidate for validation in the Hungarian context.

To the best of our knowledge, despite the growing body of evidence supporting the utility of the ETISR-SF, a Hungarian version of the instrument was not available prior to this study. Accordingly, the present study aims to translate and validate the Hungarian version of the ETISR-SF and to examine its psychometric properties.

METHODS

Participants and procedure

The study was conducted among individuals with diagnosed mental disorders and a sample of healthy adults. Participants in the clinical group were recruited from the Crisis Intervention and Psychiatric Ward of Péterfy Sándor Hospital in Budapest, Hungary. Psychiatric diagnoses were established according to the International Classification of Diseases, Tenth Revision (ICD-10), and the Structured Clinical Interview for DSM-IV, administered by psychiatrists and trained clinical psychologists. Inclusion criteria required participants to be literate in Hungarian and willing to participate in the study. Exclusion criteria included the presence of an acute psychotic episode, current alcohol or substance use disorder, a diagnosis of schizophrenia, a history of traumatic brain injury or neurological illness (e.g., dementia), or a serious medical condition. Clinical interviews were primarily conducted by various clinical psychologists; however, information identifying specific interviewers was not recorded. Healthy control participants were recruited from the Hungarian University of Sports Science. These individuals were not undergoing psychiatric treatment and had no history of suicide attempts. All participants were recruited on a voluntary basis, with participation remaining anonymous. Prior to involvement, each participant received an information sheet and provided informed written consent.

Ethical approval

This study was approved by the Institutional Review Board of Péterfy Sándor Hospital and Outpatient Center (approval number: 25/2016) and the Institutional Review Board of the Hungarian University of Sports Science (approval number: MTSE-OKE-KEB/04/2023). The authors affirm that all procedures contributing to this research adhered to the ethical standards of the relevant national and institutional committees on human experimentation and complied with the principles of the Declaration of Helsinki (1975), as revised in 2013. Participation in the study was entirely voluntary. All participants received detailed written information about the study and provided informed written consent prior to their involvement.

Measures

Early Trauma Inventory Self Report–Short Form (ETISR-SF). The ETISR-SF [52] is a self-report instrument designed to assess early traumatic experiences across four domains: general trauma (11 items), physical abuse (5 items), emotional abuse (5 items), and sexual abuse (6 items). The questionnaire comprises 27 dichotomously scored items (Yes/No). General trauma refers to distressing or shocking life

events. Physical abuse includes experiences involving restraint, isolation, or physical contact intended to cause pain or harm. Emotional abuse is characterized by the use of verbal expressions intended to humiliate or degrade the individual. Sexual abuse encompasses any non-consensual sexual contact perpetrated with the aim of asserting dominance, inflicting humiliation, or gratifying the abuser. Subscale scores are calculated by summing the number of "Yes" responses within each domain, and the total score is the aggregate of all subscale scores. Higher scores reflect a greater cumulative exposure to traumatic experiences. Additionally, the instrument includes two supplementary items assessing the respondent's emotional response (e.g., horror, helplessness, or depersonalization) to the most impactful traumatic event. These two items are not included in the total score.

The scale was translated with the written permission of the original author. Initially, the instrument was translated from English into Hungarian by N. Sz. Subsequently, an independent English teacher performed a back-translation into English. The two translators then collaboratively reviewed and refined the Hungarian version until consensus was reached. The back-translated version was reviewed and approved by the original author. To further ensure the accuracy and reliability of the translation, two additional professionals independently evaluated the Hungarian version: one, a psychologist with expertise in trauma research and advanced proficiency in English, and the other, a certified professional English translator. The back-translation from Hungarian to English was performed by the psychologist. Thereafter, the two reviewers independently, and subsequently jointly, examined the original English version, the back-translated version, and the Hungarian translation. No significant semantic discrepancies were identified, and the final Hungarian version was deemed suitable for use in the present study. The validated Hungarian version is provided in the online supplement (S1).

Childhood Trauma Questionnaire–Short Form (CTQ-SF). The CTQ-SF [65] is a 28-item retrospective self-report instrument with robust psychometric properties, validated for use in both clinical and nonclinical populations. It is widely employed due to its brevity (approximately five minutes to complete) and its focus on well-established forms of childhood abuse and neglect. The CTQ-SF assesses five domains of childhood maltreatment: physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. Items are rated on a 5-point Likert scale, ranging from 1 (never true) to 5 (very often true). Each subscale yields a score ranging from 5 to 25, calculated by summing the responses to the relevant items. Higher scores indicate greater severity of maltreatment in the corresponding domain.

SCID-I. The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) was employed as a semi-structured diagnostic interview to assess major Axis I disorders as defined by the DSM-IV. This instrument is intended for administration by clinicians or trained mental health professionals [66].

SCID-II. The Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) was utilized to assess and diagnose personality disorders [66].

Data Analysis

Statistical analyses were conducted using SPSS version 26.0 (IBM Corp., Armonk, NY, USA), R version 4.5.0, and Jamovi version 2.5.4.0. Confirmatory factor analysis (CFA) was performed to evaluate the fit of the Hungarian version of the ETISR-SF with the original four-factor model. Given the binary nature of the ETISR-SF items, we followed the analytical approach adopted in previous validation studies [54, 55, 57, 58, 60, 61], employing the variance-adjusted weighted least squares estimator (WLSMV) for the CFA. Model fit was assessed using the Comparative Fit Index (CFI), Tucker–Lewis Index (TLI), Goodness-of-Fit Index (GFI), and Root Mean Square Error of Approximation (RMSEA). CFI, TLI, GFI, and RMSEA values range from 0 to 1. Values of CFI, TLI, and GFI above 0.90 are considered acceptable, while values exceeding 0.95 indicate a good model fit. For RMSEA, values below 0.06 are deemed acceptable, with those under 0.05 indicating a good fit [67,68]. Internal consistency was evaluated using Cronbach's alpha and McDonald's omega, both calculated based on tetrachoric correlation matrices to accommodate the binary format of the items.

Receiver Operating Characteristic (ROC) analysis was conducted to assess the discriminatory performance of the ETISR-SF in identifying trauma as indicated by the CTQ-SF. Optimal cut-off points for the ETISR-SF total and subscale scores were determined using the Youden Index, which maximizes both sensitivity and specificity. Area Under the Curve (AUC), sensitivity, and specificity were calculated based on these optimal thresholds. The upper 50th percentile of CTQ-SF total scores served as the criterion group for the ROC analysis.

Table 1. Characteristics of the sample

		Total sample (n= 357)	Clinical (n= 300)	Healthy adults (n= 57)
Age, average (SD)		(n= 357)	Clinical	31.96 (8.92%)
Gender	Male	(n= 300)	Healthy adults	37 (64.9%)
	Female	(n= 57)	217 (72.3%)	20 (35.1%)
Education	Primary school	26 (7.3%)	26 (8.7%)	0
	Secondary school	183 (51.3%)	179 (59.7%)	4 (7%)
	University	148 (41.5%)	95 (31.7%)	53 (93%)
Residence	Village	37 (10.4%)	31 (10.3%)	6 (10.5%)
	City	121 (33.9%)	99 (33%)	22 (38.6%)
	Capital city	199 (55.7%)	170 (56.7%)	29 (50.9%)
Marital status	Single	131 (36.7%)	116 (38.7%)	15 (26.3%)
	Living with partner	84 (23.5%)	60 (20%)	24 (42.1%)
	Married	107 (30%)	90 (30%)	17 (29.8%)
	Divorced	24 (6.7%)	24 (8%)	0
	Widowed	11 (3.1%)	10 (3.3%)	1 (1.8%)
Working status	Unemployed	46 (12.9%)	45 (15%)	1 (1.8%)
	Employed	222 (62.2%)	174 (58%)	48 (84.2%)
	Student	47 (13.2%)	40 (13.3%)	7 (12.3%)
	Retired	32 (9%)	32 (10.7%)	0
	Homemaker	10 (2.8%)	9 (3%)	1 (1.8%)
Children	No	207 (58%)	165 (55%)	42 (73.7%)
	Yes	150 (42%)	135 (45%)	15 (26.3%)
Financial Status	Significantly below average	22 (6.2%)	21 (7%)	1 (1.8%)
	Below average	49 (13.7%)	48 (16%)	1 (1.8%)
	Average	192 (53.8%)	163 (54.3%)	29 (50.9%)
	Above average	84 (23.5%)	60 (20%)	24 (42.1%)
	Significantly above average	10 (2.8%)	8 (2.7%)	2 (3.5%)
Diagnosis	Anxiety disorder	159 (44.5%)	159 (53%)	-
	Major depressive disorder	140 (39.2%)	140 (46.7%)	-
	Bipolar disorder	50 (14%)	50 (16.7%)	-
	Borderline personality disorder	89 (24.9%)	89 (29.7%)	-
	Personality disorder not otherwise specified	79 (22.1%)	79 (26.3%)	-
Suicide attempt	Yes	146 (40.9%)	146 (48.7%)	-
	No	211 (59.1%)	154 (51.3%)	-

Note. Patients could have more than one diagnosis.

Table 2. Psychometric Properties of ETISR-SF (n = 357)

Item	Factor loading				McDonald's Omega	Cronbach's Alpha	Cronbach's Alpha (minus item)	CITC
	General trauma	Physical abuse	Emotional abuse	Sexual abuse				
GT1	0.38				0.68	0.78	0.79	0.25
GT2	0.66						0.76	0.65
GT3	0.58						0.76	0.57
GT4	0.37						0.76	0.55
GT5	0.38						0.79	0.27
GT6	0.43						0.76	0.54
GT7	0.55						0.76	0.53
GT8	0.74						0.75	0.64
GT9	0.62						0.76	0.61
GT10	0.41						0.77	0.49
GT11	0.54						0.76	0.55
PA1		0.58			0.71	0.87	0.90	0.49
PA2		0.78					0.83	0.78
PA3		0.83					0.82	0.83
PA4		0.84					0.82	0.86
PA5		0.83					0.83	0.81
EA1			0.82		0.85	0.93	0.92	0.84
EA2			0.96				0.90	0.93
EA3			0.84				0.93	0.79
EA4			0.93				0.91	0.91
EA5			0.78				0.93	0.80
SA1				0.87	0.85	0.94	0.93	0.86
SA2				0.91			0.93	0.89
SA3				0.94			0.92	0.98
SA4				0.89			0.94	0.82
SA5				0.94			0.93	0.89
SA6				0.71			0.95	0.76

Note. CITC = Corrected Item-Total Correlation.

Discriminative validity was examined by comparing clinical and non-clinical groups using Mann–Whitney U tests. To assess convergent and divergent validity, Spearman correlation coefficients were computed between ETISR-SF and CTQ-SF total and subscale scores. The assumption of normality was evaluated using the Kolmogorov–Smirnov test. Given that patients could present with multiple diagnoses, a generalized linear model (GLM) with a gamma distribution and log link function was employed to examine the effect of diagnosis type on ETISR-SF total scores, rather than using Kruskal–Wallis tests.

Missing data were minimal (6.01% across all subscales and total scores) and were imputed using

Table 3. Spearman Correlations Between Constructs of ETISR-SF

	Total score	General trauma	Physical abuse	Emotional abuse	Sexual abuse
Total score	1				
General trauma	.719**	1			
Physical abuse	.645**	.226**	1		
Emotional abuse	.776**	.303**	.456**	1	
Sexual abuse	.569**	.251**	.337**	.350**	1

Note. * = 0.05; ** = 0.01; *** = 0.001.

the participant's median score for the corresponding subscale. Statistical significance was defined as $p < 0.05$.

RESULTS

A total of 357 participants (33.6% male, 66.4% female), comprising 300 clinical and 57 non-clinical individuals aged 18 to 85 years (M = 37.03, SD = 12.86), were included in the study. Diagnoses in the clinical sample included anxiety disorders (44.54%), major depressive disorder (39.2%), bipolar disorder (14%), borderline personality disorder (24.9%), and personality disorder not otherwise specified (22.1%). Demographic and clinical characteristics of the sample are presented in Table 1.

Chi-square tests revealed significant differences between the clinical and non-clinical groups with respect to gender ($\chi^2 = 29.78$, $p < 0.001$), educational attainment ($\chi^2 = 74.28$, $p < 0.001$), marital status ($\chi^2 = 16.89$, $p = 0.002$), employment status ($\chi^2 = 18.20$, $p = 0.003$), parenthood ($\chi^2 = 6.86$, $p = 0.009$), and financial status ($\chi^2 = 19.40$, $p = 0.001$). No significant difference was found between the groups in terms of place of residence ($\chi^2 = 0.73$, $p = 0.69$). A Mann–Whitney U test indicated a statistically significant difference in age between the groups ($U = 6440.5$, $p = 0.003$).

Factor structure and internal consistency

For the confirmatory factor analysis, the Kaiser-Meyer-Olkin (KMO) measure was 0.801, exceeding the recommended threshold of 0.70. Bartlett's Test of Sphericity was statistically significant ($\chi^2 = 2436.63$, $p < 0.001$), supporting the factorability of the correlation matrix. Factor loadings for items across the four subscales ranged from 0.37 to 0.94. Corrected item-total correlations (CITC) ranged from 0.25 to 0.98, indicating acceptable to excellent item discrimination.

Cronbach's alpha values remained consistently high across all subscales, ranging from 0.75 to 0.95 when individual items were removed, suggesting strong internal consistency. Model fit indices indicated an excellent fit to the original four-factor structure: CFI = 0.969, TLI = 0.966, GFI = 0.966, and RMSEA = 0.030. Internal consistency was further evaluated using both Cronbach's alpha and McDonald's omega, calculated from tetrachoric correlation matrices to account for the binary item format. The subscales demonstrated acceptable to excellent reliability, with Cronbach's alpha values ranging from 0.78 (General Trauma) to 0.94 (Sexual Abuse), and McDonald's omega values ranging from 0.68 (General Trauma) to 0.85 (Emotional and Sexual Abuse). The omega value for the General Trauma subscale was relatively low (0.68), which is generally considered unsatisfactory and may be attributed to the poor performance of specific items

A few items within the General Trauma domain exhibited relatively low factor loadings: GT1 (Natural disaster) = 0.38, GT4 (Serious injury/illness of a parent) = 0.37, and GT5 (Parental separation) = 0.38. These items also showed lower CITC values: GT1 = 0.25 and GT5 = 0.27. All remaining items had factor loadings above 0.40 and CITC scores ranging from 0.49 to 0.98 (see Table 2).

To assess the robustness of the factor structure, CFA was conducted on the entire sample, including the non-clinical subgroup, to enhance the generalizability of the findings. A sensitivity analysis excluding the non-clinical participants was also performed. The results of both analyses are presented in the online supplement (S2), and the differences between them were marginal.

Intercorrelations among the subscales were examined as an additional method for evaluating construct validity. Given the conceptual relatedness of the subscales, the observed correlations support

Table 4. Frequency of Reported Traumatic Events Among Healthy Adults and Psychiatric Patients

Item	Controls (n = 57)	Patients					
		Total (n= 300)	AD (n= 159)	MDD (n= 140)	BD (n= 50)	BPD (n= 89)	PD-NOS (n= 79)
GT1 Natural disaster.	2 (3.5%)	32 (10.7%)	23 (14.5%)	15 (10.7%)	6 (12%)	10 (11.2%)	7 (8.9%)
GT2 Serious accident.	11 (19.3%)	61 (20.3%)	35 (22%)	30 (21.4%)	15 (30%)	11 (12.4%)	18 (22.8%)
GT3 Serious personal injury.	19 (33.3%)	108 (36%)	57 (35.8%)	46 (32.9%)	27 (54%)	26 (29.2%)	26 (32.9%)
GT4 Serious injury/illness of parent.	9 (15.8%)	131 (43.7%)	69 (43.4%)	80 (57.1%)	24 (48%)	21 (23.6%)	33 (41.8%)
GT5 Separation of parents.	13 (22.8%)	100 (33.3%)	44 (27.7%)	52 (37.1%)	20 (40%)	24 (27%)	32 (40.5%)
GT6 Serious illness/injury of sibling.	4 (7%)	43 (14.3%)	29 (18.2)	20 (14.3%)	8 (16%)	9 (10.1%)	16 (20.3%)
GT7 Serious injury of friend.	9 (15.8%)	74 (24.7%)	44 (27.7%)	43 (30.7%)	13 (26%)	18 (20.2%)	24 (30.4%)
GT8 Witnessing violence.	2 (3.5%)	66 (22%)	35 (22%)	32 (22.9%)	7 (14%)	20 (22.5%)	15 (19%)
GT9 Family mental illness.	8 (14%)	147 (49%)	72 (45.3%)	76 (54.3%)	28 (56%)	41 (46.1%)	40 (50.6%)
GT10 Alcoholic parents.	13 (22.8%)	135 (45%)	73 (45.9%)	67 (47.9%)	24 (48%)	36 (40.4%)	35 (44.3%)
GT11 Seeing someone murdered.	0 (0%)	9 (3%)	6 (3.8%)	6 (4.3%)	1 (2%)	2 (2.2%)	2 (2.5%)
PA1 Slapped in the face.	30 (52.6%)	77 (25.7%)	122 (76.7%)	102 (72.9%)	37 (74%)	72 (80.9%)	60 (75.9%)
PA2 Burned with cigarette.	2 (3.5%)	9 (3%)	6 (3.8%)	2 (1.4%)	3 (6%)	7 (7.9%)	1 (1.3%)
PA3 Punched or kicked.	5 (8.8%)	68 (22.7%)	40 (25.2%)	31 (22.1%)	16 (32%)	20 (22.5%)	25 (31.6%)
PA4 Hit with thrown object.	5 (8.8%)	64 (21.3%)	34 (21.4%)	30 (21.4%)	15 (30%)	20 (22.5%)	22 (27.8%)
PA5 Pushed or shoved.	12 (21.1%)	105 (35%)	53 (33.3%)	49 (35%)	18 (36%)	32 (36%)	28 (35.4%)
EA1 Often put down or ridiculed.	20 (35.1%)	215 (71.7%)	120 (75.5%)	93 (66.4%)	35 (70%)	73 (82%)	59 (74.7%)
EA2 Often ignored or made to feel you didn't count.	9 (15.8%)	131 (43.7%)	68 (42.8%)	56 (40%)	24 (48%)	42 (47.2%)	39 (49.4%)
EA3 Often told you are no good.	6 (10.5%)	121 (40.3%)	67 (42.1%)	56 (40%)	22 (44%)	31 (34.8%)	38 (48.1%)
EA4 Most of the time treated in cold or uncaring way.	4 (7%)	91 (30.3%)	47 (29.6%)	42 (30%)	16 (32%)	33 (37.1%)	23 (29.1%)
EA5 Parents fail to understand your needs.	17 (29.8%)	204 (68%)	111 (69.8%)	88 (62.9%)	39 (78%)	67 (75.3%)	53 (67.1%)
SA1 Touched in intimate parts in way that was uncomfortable.	7 (12.3%)	74 (24.7%)	37 (23.3%)	37 (26.4%)	15 (30%)	24 (27%)	15 (19%)
SA2 Someone rubbing genitals against you.	4 (7%)	50 (16.7%)	25 (15.7%)	25 (17.9%)	10 (20%)	18 (20.2%)	11 (13.9%)
SA3 Forced to touch intimate parts.	0 (0%)	34 (11.3%)	15 (9.4%)	20 (14.3%)	3 (6%)	11 (12.4%)	10 (12.7%)
SA4 Someone had genital sex against your will.	2 (3.5%)	27 (9%)	14 (8.8%)	16 (11.4%)	4 (8%)	9 (10.1%)	7 (8.9%)
SA5 Forced to perform oral sex.	0 (0%)	14 (4.7%)	7 (4.4%)	6 (4.3%)	2 (4%)	5 (5.6%)	4 (5.1%)
SA6 Forced to kiss someone in sexual way.	2 (3.5%)	29 (9.7%)	18 (11.3%)	18 (12.9%)	3 (6%)	10 (11.2)	7 (8.9%)

Note. AD = Anxiety disorder; MDD = Major depressive disorder; BD = Bipolar disorder; BPD = Borderline personality disorder; PD-NOS = Personality disorder not otherwise specified; GT = General trauma; PA = Physical abuse; EA = Emotional abuse; SA = Sexual abuse.

Table 5. Comparison of ETISR-SF Scores Between Healthy Adults and Patient Groups Using Mann–Whitney U Tests

	Healthy adults (n = 57) Mean (standard deviation)	Patients Mean (standard deviation)					
		Total (n= 300)	AD (n= 159)	MDD (n= 140)	BD (n= 50)	BPD (n= 89)	PD-NOS (n= 79)
Total score	3.77 (3.25)	7.9 (4.52)***	7.99 (4.57)***	8.16 (4.53)***	8.7 (4.93)***	7.78 (4.85)***	8.28 (4.55)***
General Trauma	1.58 (1.71)	3.03 (2.1)***	3.06 (2.21)***	3.36 (1.91)***	3.46 (2.42)***	2.45 (2.13)*	3.19 (2.18)***
Physical Abuse	0.95 (1.04)	1.56 (1.29)***	1.6 (1.28)***	1.53 (1.27)***	1.78 (1.38)***	1.7 (1.41)***	1.72 (1.38)***
Emotional Abuse	0.98 (1.37)	2.54 (1.77)***	2.6 (1.73)***	2.39 (1.88)***	2.72 (1.75)***	2.76 (1.65)***	2.68 (1.77)***
Sexual abuse	0.26 (0.7)	0.76 (1.4)*	0.73 (1.36)*	0.87 (1.51)**	0.74 (1.32)	0.87 (1.55)*	0.68 (1.37)

Note. * = 0.05; ** = 0.01; *** = 0.001; AD = Anxiety disorder; MDD = Major depressive disorder; BD = Bipolar disorder; BPD = Borderline personality disorder; PD-NOS = Personality disorder not otherwise specified.

Table 6. Generalized Linear Model Predicting ETISR-SF Total Score

Predictor	B	Standard error	Wald chi-square	p-value	Exp(B)	95% CI
(Intercept)	1.70	0.07	640.94	< 0.001	5.46	(4.79-6.23)
BP	0.32	0.10	10.26	0.001	1.38	(1.13-1.69)
MDD	0.24	0.07	11.23	0.001	1.28	(1.11-1.47)
AD	0.16	0.07	5.37	0.02	1.17	(1.02-1.34)
PD-NOS	0.17	0.08	4.08	0.04	1.18	(1.01-1.39)
BPD	0.15	0.08	3.34	0.07	1.16	(0.99-1.36)

Note. B= Unstandardized log-coefficients; Exp(B) = Rate ratios; CI = Confidence Interval; AD = Anxiety disorder; MDD = Major depressive disorder; BD = Bipolar disorder; BPD = Borderline personality disorder; PD-NOS = Personality disorder not otherwise specified.

the interpretation that they represent distinct yet interrelated dimensions of a unified construct. The ETISR-SF subscales demonstrated low to moderate, statistically significant Spearman's rho correlations (ranging from $\rho = 0.226$ to $\rho = 0.456$, $p < 0.001$), indicating adequate construct validity (see Table 3). The strongest correlation with the ETISR-SF total score was observed for the Emotional Abuse subscale ($\rho = 0.719$, $p < 0.001$), while the weakest was found for the Sexual Abuse subscale ($\rho = 0.569$, $p < 0.001$).

Descriptive statistics and discriminant validity

When comparing the non-clinical sample with the clinical sample and its diagnosis-based subgroups, the clinical group reported a higher frequency of traumatic events (Table 4) and significantly elevated average scores on the ETISR-SF (Table 5).

Within the clinical group, the most frequently endorsed item in the General Trauma domain was 'family mental illness' (GT9), reported by nearly half of the participants (49%). Among physical abuse items, the experience of being pushed or shoved (PA5) was most common, reported by 35% of the clinical sample. In the Emotional Abuse domain, the most frequently reported item was 'being ridiculed' (EA1), endorsed by 71.7% of clinical participants, making it the most commonly reported traumatic experience overall. In the Sexual Abuse domain, the most frequent item was 'uncomfortable touch' (SA1), reported by 24.7% of clinical participants.

In the non-clinical group, the most commonly reported experiences were: GT3 ('serious personal injury', 33.3%), PA1 ('slapped in the face', 52.6%), EA1 ('often put down or ridiculed', 35.1%), and SA1 ('touched in intimate parts in a way that was uncomfortable', 12.3%).

Across both groups, general traumas were the most frequently reported category (non-clinical: M = 1.58, SD = 1.71; clinical: M = 3.03, SD = 2.10), while sexual traumas were the least frequently endorsed (non-clinical: M = 0.26, SD = 0.70; clinical: M = 0.76,

Table 7. Spearman Correlations Between ETISR-SF and CTQ-SF Scores (n = 357)

ETISR-SF	CTQ-SF					
	Total score	Physical abuse	Emotional abuse	Sexual abuse	Physical neglect	Emotional neglect
Total score	0.67**	0.48**	0.63**	0.56**	0.56**	0.41**
General trauma	0.38**	0.34**	0.28**	0.35**	0.32**	0.22**
Physical abuse	0.44**	0.30**	0.44**	0.30**	0.50**	0.28**
Emotional abuse	0.68**	0.45**	0.71**	0.62**	0.50**	0.28**
Sexual abuse	0.40**	0.27**	0.34**	0.26**	0.28**	0.56**

Note. ** = 0.01

SD = 1.40). However, in the bipolar disorder (BD) and personality disorder not otherwise specified (PD-NOS) subgroups, no significant differences were found in reported sexual abuse compared to the non-clinical group. Furthermore, when comparing clinical subgroups to the non-clinical group, statistical significance levels for sexual abuse ($p < 0.05$ or $p < 0.01$) were lower than those observed for other trauma domains ($p < 0.001$), suggesting a relatively weaker discriminative effect for this dimension.

In both the clinical and non-clinical groups, general traumas were the most frequently reported type of traumatic experience. To compare the effects of different psychiatric diagnoses on trauma exposure, a generalized linear model (Table 6) was employed. This analysis identified bipolar disorder (BD) as the strongest unique predictor of higher total ETISR-SF scores ($p = 0.001$), followed by major depressive disorder (MDD, $p = 0.001$), anxiety disorders (AD, $p = 0.02$), and personality disorder not otherwise specified (PD-NOS, $p = 0.04$). Mann–Whitney U tests revealed no significant differences in total or subscale ETISR-SF scores between patients with and without a history of suicide attempts.

Convergent and divergent validity

To assess the convergent and divergent validity of the ETISR-SF, Spearman correlation coefficients were calculated with the CTQ-SF. As presented in Table 7, a strong correlation was observed between the total scores of the ETISR-SF and CTQ-SF. The ETISR-SF subscale scores demonstrated significant low to moderate correlations with corresponding CTQ-SF domains, ranging from $\rho = 0.22$ to $\rho = 0.71$. These findings support the convergent and divergent validity of the ETISR-SF, indicating meaningful associations between related constructs without substantial conceptual overlap.

Receiver Operating Characteristic (ROC) analyses were conducted to evaluate the predictive performance of the ETISR-SF in relation to the CTQ-SF. The highest predictive accuracy was observed when the upper 50th percentile of the CTQ-SF total score was used as the criterion group (Table 8). Among the ETISR-SF indicators, the total score and the Emotional Abuse subscale demonstrated the strongest predictive performance, with Area Under the Curve (AUC) values of 0.84 and 0.82, and Youden indices of 0.53 and 0.54, respectively. The optimal cut-off scores for classification were 6.5 for the total score and 2.5 for the Emotional Abuse subscale.

DISCUSSION

The primary objective of the present study was to validate and assess the psychometric properties of the Hungarian version of the ETISR-SF in both clinical and non-clinical samples. The findings replicated the original four-factor structure and provided strong evidence for the validity and reliability of the Hungarian adaptation of the ETISR-SF.

The Hungarian version of the ETISR-SF demonstrated psychometric properties comparable to those of the original instrument as well as to previously validated translations. Confirmatory factor analysis supported the original four-factor structure reported in Bremner's developmental study [52], which has been consistently replicated across multiple validation studies [53–61]. Spearman's rho correlations between the ETISR-SF subscales ranged from 0.226 to 0.456 ($p < 0.001$), indicating satisfactory construct validity. The model fit indices (CFI, TLI,

Table 8. Cut-Off Values of ETISR-SF Total and Subscale Scores (n = 357)

	Cut-off	AUC (95%)	Youden index	Specificity	Sensitivity
Total score	6.5	0.84 (0.80-0.88)	0.53	0.76	0.77
General trauma	3.5	0.70 (0.65-0.75)	0.33	0.51	0.83
Physical abuse	1.5	0.69 (0.63-0.74)	0.31	0.52	0.79
Emotional abuse	2.5	0.82 (0.78-0.87)	0.54	0.69	0.85
Sexual abuse	0.5	0.65 (0.60-0.71)	0.31	0.45	0.86

Note. AUC = Area Under the Curve.

GFI, RMSEA) indicated a good fit, comparable to – or in some cases exceeding – those reported in prior validation research [53–58, 60, 61].

In the present study, the ETISR-SF demonstrated high levels of internal consistency. McDonald's omega coefficients ranged from 0.68 to 0.85, and Cronbach's alpha values ranged from 0.78 to 0.94, indicating adequate to strong reliability across the four subscales. In contrast, lower internal consistency values have been reported in several previous validation studies, particularly in samples where the prevalence of certain trauma types was low. For instance, in the Spanish adaptation of the ETISR-SF, the internal consistency coefficient for the General Trauma subscale was 0.42 [53]. In the Brazilian version, Cronbach's alpha was reported at 0.54 [55], and in the Colombian version, administered to a non-clinical sample, it was as low as 0.14 [60].

Two primary factors may account for these lower reliability values. First, in non-clinical populations, the occurrence of specific trauma types – such as sexual abuse or natural disasters – is often infrequent, resulting in low variability and weak inter-item correlations. Second, certain trauma types may be particularly rare in specific cultural or geographical contexts, further contributing to low subscale coherence. These low-frequency items tend to exhibit weak correlations with their respective subscale totals, thereby diminishing internal consistency coefficients.

It is also important to note that, unlike trait-based psychometric instruments in which items are designed to reflect a single latent construct, trauma checklists such as the ETISR-SF encompass a broad range of distinct life events (e.g., physical abuse, emotional neglect, natural disasters) that may not co-occur or correlate strongly. Consequently, the assumption of item homogeneity underlying traditional measures of internal consistency may not hold in this context. Thus, low internal consistency should not necessarily be interpreted as a psychometric deficiency of the instrument, but rather as a reflection of the heterogeneous and culturally variable nature of traumatic experiences [54, 58, 60, 61].

In our analysis, several items – specifically GT1 (natural disaster), GT4 (serious illness or injury of a parent), and GT5 (parental separation) – showed lower factor loadings (0.37–0.38) and low corrected item-total correlations (0.25–0.27). However, in order to preserve the instrument's cross-cultural comparability and content validity, we elected not to remove any items. Given these limitations, alternative methods for assessing reliability may be more appropriate for instruments of this nature.

In the present study, the clinical sample scored significantly higher than the non-clinical sample across all ETISR-SF domains, with the exception of the Sexual Abuse domain. This exception is not unexpected, given the relatively low frequency of reported sexual trauma compared to other trauma types. These findings support the discriminant validity of the ETISR-SF and align with prior research demonstrating the instrument's capacity to distinguish between clinical and non-clinical populations, particularly among individuals with documented trauma histories [51, 54, 58, 69]. In addition, all ETISR-SF subscales showed significant correlations with the CTQ-SF total score and its subscales, providing further evidence for the scale's convergent and divergent validity. To evaluate its diagnostic utility, several ROC analyses were conducted to assess the predictive performance of the ETISR-SF in identifying individuals with elevated levels of childhood trauma as measured by the CTQ-SF. When the upper 50th percentile of CTQ-SF scores was used as the target group, the ETISR-SF total score and the Emotional Abuse subscale demonstrated acceptable classification accuracy, with Area Under the Curve (AUC) values of 0.84 and 0.82, and Youden index values of 0.53

and 0.54, respectively. These results indicate that the ETISR-SF possesses acceptable diagnostic utility within clinical samples.

However, caution is warranted in interpreting these cut-off scores, as ROC-based thresholds are inherently sample-dependent and may not generalize across populations or settings. When alternative target groups were used – such as the top 25% of CTQ-SF scores or CTQ-SF cut-off classifications – the predictive performance of the ETISR-SF was considerably lower. Therefore, the cut-off scores reported here are recommended for research purposes only. Future studies should investigate the replicability and clinical applicability of these thresholds across diverse populations.

Taken together, the convergent and divergent validity results, along with ROC analyses, support the conclusion that the ETISR-SF and CTQ-SF assess theoretically related constructs – namely, physical, emotional, and sexual trauma – but capture different dimensions of traumatization through distinct event types. This distinction underscores the potential utility of employing complementary instruments in the comprehensive assessment of trauma history.

Although prior studies have identified a relationship between early trauma and borderline personality disorder [21–23], our generalized linear model analysis did not reveal a significant association between BPD and ETISR-SF scores. We recommend that future research examine patients with borderline personality disorder both with and without comorbid psychiatric diagnoses to clarify the impact of diagnostic comorbidity on trauma exposure. By contrast, our findings of significant associations between trauma and depression, anxiety, and bipolar disorder are consistent with previous literature [16, 17, 19].

LIMITATIONS

Several limitations of the present study should be considered when interpreting the findings. These include both methodological constraints common to trauma and psychiatric research, as well as study-specific factors. First, the reliance on retrospective self-report measures introduces the potential for response bias, particularly recall bias. Traumatic memories are susceptible to distortion through various psychological mechanisms, including amnesia, suppression, and affective-cognitive dissociation; as a result, trauma-related experiences may be partially blocked, altered, or reconstructed over time [49, 70–72]. Although the accuracy of retrospective recall remains a topic of debate, self-reported memories continue to be among the most practical and widely accepted methods for assessing childhood trauma. Nevertheless, findings derived from self-report instruments should be interpreted with appropriate caution in both research and clinical contexts.

Second, most clinical participants were recruited from an acute psychiatric ward and were undergoing psychopharmacological treatment, with a high prevalence of comorbid psychiatric diagnoses. These factors may have influenced their responses. However, we argue that such characteristics reflect the realities of clinical practice and, rather than detracting from the study's validity, enhance its ecological validity. In psychiatric settings, patients without comorbidities or pharmacological treatment are relatively uncommon. Nonetheless, these contextual variables should be taken into account when evaluating the findings.

Two additional study-specific limitations warrant consideration. First, the non-clinical comparison group was substantially smaller (n = 57) than the clinical sample (n = 300), and the two groups differed significantly in several sociodemographic variables (e.g., age, gender, education). The absence of random sampling and matching between groups limits the generalizability and interpretability of group comparisons. Second, the study did not include a test–retest reliability assessment of the ETISR-SF, although such reliability has been demonstrated in previous validation studies.

Future research should aim to examine childhood trauma in larger, demographically balanced non-clinical samples, ideally using longitudinal designs and including test–retest reliability assessments. Such studies would allow for more robust comparisons across populations and enhance the generalizability of trauma assessment tools like the ETISR-SF.

CONCLUSION

In conclusion, the findings of this study demonstrate that the Hungarian version of the ETISR-SF is a reliable and valid instrument for assessing early traumatic experiences. Its brevity, self-administered format, and comprehensive coverage of diverse trauma types make it a practical and efficient tool for both clinical practice and research. The ETISR-SF offers valuable utility for professionals seeking to evaluate the impact of early trauma on mental and physical health outcomes.

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APPENDIX

KORAI TRAUMA ÖNJELLEMZŐ KÉRDŐÍV – RÖVIDÍTETT VÁLTOZAT

Kitöltő neve: _____ vagy azonosító száma: _____

Születési dátum (év/hó/nap): _____ ____ ____ Életkor: _____ Kitöltés időpontja: (év/hó/nap): _____ ____ ____

Kérjük igen/nem válaszokkal feleljen az alább feltett kérdésekre!

I. Rész. Általános traumatikus események. 18 éves kor után

1. Élt át valaha az életét veszélyeztető természeti katasztrófát?	IGEN	NEM
2. Történt-e Önnel valaha valamilyen súlyos baleset?	IGEN	NEM
3. Érte-e valaha valamilyen súlyos sérülés vagy betegség?	IGEN	NEM
4. Meghalt vagy szenvedett-e súlyos betegségben valamelyik szülője vagy elsődleges gondozója?	IGEN	NEM
5. Elváltak vagy különköltöztek a szülei?	IGEN	NEM
6. Meghalt vagy szenvedett-e súlyos sérülést valamelyik testvére?	IGEN	NEM
7. Meghalt vagy szenvedett-e súlyos sérülést valamelyik barátja?	IGEN	NEM
8. Volt-e szemtanúja mások elleni erőszaknak, beleértve a családtagjait is?	IGEN	NEM
9. A családjában fordult-e elő pszichiátriai betegség vagy „idegösszeomlás”?	IGEN	NEM
10. A szüleinek vagy az elsődleges gondozójának voltak-e alkohol, gyógyszer vagy kábítószer problémái?	IGEN	NEM
11. Volt-e gyilkosság szemtanúja?	IGEN	NEM

II. Rész. Fizikai erőszak. 18 éves kor előtt

1. Előfordult Önnel, hogy megpofozták?	IGEN	NEM
2. Előfordult Önnel, hogy megégették forró vízzel, cigarettacsikkel vagy bármi mással?	IGEN	NEM
3. Előfordult Önnel, hogy öklöllel verték vagy rúgták Önt?	IGEN	NEM
4. Előfordult Önnel, hogy valamilyen tárgy eltalálta, amit szándékosan Önhöz vágtak?	IGEN	NEM
5. Előfordult Önnel, hogy valaki szándékosan lökdöste és/vagy fellökte?	IGEN	NEM

III. Rész. Érzelmi abúzus. 18 éves kor előtt

1. Gyakran előfordult Önnel, hogy leszidták vagy kigúnyolták?	IGEN	NEM
2. Gyakran előfordult, hogy nem vettek Önről tudomást vagy azt éreztették Önnel, hogy Ön nem számít?	IGEN	NEM
3. Gyakran mondták Önnek, hogy Ön nem jó gyerek?	IGEN	NEM
4. Többnyire hideg, nem törődöm módon bántak Önnel vagy éreztették-e azt Önnel, hogy nem szeretik?	IGEN	NEM
5. Gyakran előfordult, hogy a szülei nem értették meg Önt vagy azt, hogy Önnek mire lenne szüksége?	IGEN	NEM

IV. Rész. Szexuális abúzus. 18 éves kor előtt

1. Előfordult-e Önnel, hogy valaki olyan módon érintette meg az intim testrészeit (pl, mell, belső comb, nemi szerv), amely meglepte és kellemetlenül érintette?	IGEN	NEM
2. Előfordult-e, hogy valaki Önhöz dörzsölte a nemi szervét?	IGEN	NEM
3. Előfordult-e Önnel, hogy valaki egy másik ember intim testrészének a megérintésére kényszerítette?	IGEN	NEM
4. Volt-e Önnek olyan szexuális közösülése, amely az Ön akarata ellen történt?	IGEN	NEM
5. Előfordult-e, hogy valaki arra kényszerítette Önt, hogy az akarata ellenére orális szexben részesítsen valakit?	IGEN	NEM
6. Előfordult-e Önnel, hogy valaki arra kényszerítette, hogy érzelmek nélkül, szexuális töltettel csókoljon meg valakit?	IGEN	NEM

Amennyiben „IGEN”-el válaszolt bármelyik fent feltett kérdésre, úgy válaszoljon a következő két kérdésre, hogy kérem, most gondoljon arra az egy eseményre, amelyik a legnagyobb kihatással volt az Ön életére, és a válaszadás során emlékezzen vissza, hogy az esemény bekövetkeztekor Ön hogyan érezte magát?

1. Érzett-e nagyon erős félelmet, rettegést és/vagy tehetetlenséget?	IGEN	NEM
2. Volt-e testen kívüli érzése vagy érezte-e úgy, hogy ami Önnel történik, az olyan, mintha csak álmodná az egészet?	IGEN	NEM

Early Trauma Inventory Self Report-Short Form (ETISR-SF): a magyar verzió validálása és pszichometriai jellemzői

Háttér: A gyermekkori trauma jelentős népegészségügyi problémát jelent, mivel tartós mentális és fizikai egészségügyi következményekkel járhat, valamint növeli számos pszichiátriai zavar kialakulásának kockázatát felnőttkorban. Az Early Trauma Inventory Self Report–Short Form (ETISR-SF) rövid, ugyanakkor hatékony mérőeszköz a korai traumatikus élmények felmérésére. Jelen kutatás célja az ETISR-SF magyar változata pszichometriai jellemzőinek vizsgálata és validálása volt. **Módszerek:** A keresztmetszeti vizsgálatban összesen 300 pszichiátriai beteg és 57 nem klinikai kontrollszemély töltötte ki az Early Trauma Inventory Self Report-Short Form (ETISR-SF) és a Childhood Trauma Questionnaire-Short Form (CTQ-SF) kérdőíveket. **Eredmények:** A megerősítő faktoranalízis alátámasztotta az eredeti négyfaktoros struktúrát, és megfelelő modellilleszkedési mutatókat eredményezett. Az ETISR-SF valamennyi alskáláján magas belső megbízhatóságot mutatott (Cronbach-alfa = 0,78–0,94). A klinikai és nem klinikai csoportok közötti szignifikáns különbségek jó diszkriminatív validitást jeleztek. Az ETISR-SF és a CTQ-SF összpontszámai, valamint alskálái közötti korrelációk szignifikánsak voltak, és alacsony-közepes erősségűnek bizonyultak ($r = 0.22–0.71$; $p < 0.001$), ami alátámasztotta az eszköz konvergens és divergens validitását. **Következtetések:** A vizsgálat eredményei azt mutatják, hogy az ETISR-SF magyar változata pszichometriailag megfelelő mérőeszköz, amely érvényes és megbízható módon alkalmazható a korai traumatikus élmények felmérésére magyar klinikai populációkban.

Kulcsszavak: gyermekkori trauma, Early Trauma Inventory, validációs vizsgálat