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RESEARCH ARTICLE

The psychometric validity and reliability of the DSM-5 Severity Measure for Social Anxiety Disorder in a Turkish adult clinical population

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ABSTRACT

Objective: This study aimed to examine the psychometric properties of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) Severity Measure for Social Anxiety Disorder—Adult (DSM-5 SAD-S) in a Turkish-speaking clinical population. Specifically, we assessed its factorial structure, internal consistency, and convergent and known-group validity.

Method: The sample included 146 participants (73 diagnosed with social anxiety disorder and 73 healthy controls). All participants completed the DSM-5 SAD-S and the Liebowitz Social Anxiety Scale (LSAS). Exploratory factor analysis (EFA) was conducted using minimum residual extraction with oblimin rotation. Confirmatory factor analysis (CFA), using diagonally weighted least squares (DWLS) estimation, was performed to evaluate model fit. Internal consistency was assessed using Cronbach's alpha. Convergent validity was examined through Pearson correlation with LSAS scores. Known-group validity was evaluated using the Mann–Whitney U test.

Results: EFA supported a unidimensional structure with strong factor loadings (0.561–0.849). CFA indicated acceptable model fit (Comparative Fit Index [CFI]=0.990; Tucker–Lewis Index [TLI]=0.988; Root Mean Square Error of Approximation [RMSEA]=0.106; Standardized Root Mean Square Residual [SRMR]=0.084). Internal consistency was high (α=0.91). The DSM-5 SAD-S score showed a moderate and statistically significant correlation with the LSAS total score (r=0.39, p<0.001). Patients scored significantly higher than controls (t=18.4, p<0.001), supporting known-group validity.

Conclusion: The Turkish adult version of the DSM-5 SAD-S demonstrates strong psychometric properties and is suitable for use in both clinical practice and research to assess the severity of social anxiety symptoms.

Keywords: Anxiety, reliability, social anxiety disorder, social phobia, validation

INTRODUCTION

Social anxiety disorder (SAD) is a common psychiatric condition characterized by a persistent and intense fear of social or performance situations in which individuals may be exposed to possible scrutiny by others. The core fear often involves acting in a way that will be embarrassing or lead to negative evaluation,

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resulting in either avoidance of such situations or enduring them with significant distress (1). Onset typically occurs in childhood or early adolescence, and the disorder frequently disrupts educational, occupational, and interpersonal functioning. Studies have shown that SAD is one of the most prevalent anxiety disorders, with lifetime prevalence rates approaching 10%, and that it is associated with early school dropout and long-term psychosocial impairment (2).

In recognition of the limitations of categorical diagnosis, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), introduced dimensional severity measures to enhance clinical assessment (3). These tools are presented in Section III of the manual and are organized into two main types: (a) Cross-Cutting Symptom Measures and (b) Severity Measures. The latter include disorder-specific instruments developed by expert panels to quantify symptom severity across a spectrum of internalizing conditions, including SAD, generalized anxiety disorder, panic disorder, and others. These self-report scales, each consisting of 10 items, are designed for rapid assessment and are freely available for clinical and research use.

The DSM-5 Severity Measure for Social Anxiety Disorder—Adult (DSM-5 SAD-S) is grounded in well-established models of anxiety that distinguish among cognitive, physiological, and behavioral components of fear (4). The scale items capture these domains using a consistent item template across anxiety disorders, with disorder-specific modifications in wording and context (e.g., "felt anxious, worried, or nervous about social situations"). Responses are rated on a 5-point Likert scale, reflecting the frequency of symptoms over the past seven days.

Psychometric evaluations of the DSM-5 anxiety severity measures—primarily conducted in United States, German, Dutch, Spanish, and Brazilian samples—have demonstrated strong internal consistency, unidimensional factor structures, and convergent validity with both clinician-rated and self-report measures (5-10). Furthermore, studies have reported good test–retest reliability (with the exception of the Specific Phobia scale) and sensitivity to change, supporting their utility for both clinical monitoring and outcome research. However, these findings have not been uniformly replicated across all language adaptations and cultural contexts. Several versions, including the Turkish child adaptation, remain underexplored or only partially validated, particularly in clinical samples (11).

Given that anxiety disorders contribute substantially to chronic disease burden and disability (12, 13), culturally and linguistically validated instruments are essential for accurate diagnosis and effective intervention. Although a Turkish child version of the DSM-5 SAD-S has previously been used in research (11), comprehensive psychometric validation in Turkish adult clinical samples has not yet been published. The present study addresses this gap by evaluating the internal consistency, factor structure, and convergent validity of the Turkish version of the DSM-5 SAD-S in a treatment-seeking sample diagnosed with SAD, alongside a healthy control group. Despite its high prevalence in epidemiological studies, SAD may be underrepresented in psychiatric outpatient settings and, therefore, overlooked in routine clinical practice. As noted by Bandelow and Michaelis (12), even experienced psychiatrists may find it challenging to distinguish mild forms of social anxiety disorder from normative personality traits such as shyness or modesty. This further underscores the importance of reliable dimensional assessment tools in clinical settings.

Accordingly, we aimed to support the use of the DSM-5 SAD-S in Turkish clinical settings as a brief and practical tool for screening social anxiety symptoms, assessing symptom severity, and monitoring patients throughout the treatment. We hypothesized that the Turkish DSM-5 SAD-S would demonstrate high internal consistency and a unidimensional factor structure consistent with the original scale. We further expected DSM-5 SAD-S scores to correlate positively with established measures of social anxiety and related anxiety symptoms, supporting convergent validity. Additionally, we hypothesized that individuals with SAD would score significantly higher than healthy controls, indicating strong discriminative validity. This research contributes to the growing international literature on DSM-5 dimensional assessments and supports their broader application in cross-cultural psychiatric settings.

METHODS

Participants and Procedure

The study sample consisted of 146 Turkish-speaking adults aged between 18 and 45 years (mean [M]=24.86, standard deviation [SD]=5.94), recruited between June 2025 and November 2025 through community outreach and clinical referrals. A total of 110 individuals presenting with suspected social anxiety symptoms were initially evaluated for inclusion in the clinical group. Of these, 31 participants were excluded due to comorbid psychiatric conditions and six were

excluded due to incomplete data. The final SAD group comprised 73 participants who met DSM-5 diagnostic criteria for social anxiety disorder, as determined through a clinical interview using the Structured Clinical Interview for DSM-5 (14). The control group consisted of 73 healthy participants with no current or past psychiatric diagnoses. Participants in the SAD group were recruited from the Psychiatry Outpatient Clinic at the Department of Psychiatry, Faculty of Medicine, Izmir Tinaztepe University, while the control group was recruited from university campuses and the general community.

Inclusion criteria for both groups were Turkish as a native language and completion of at least primary education. Exclusion criteria included the presence of psychotic symptoms, intellectual disability, or a current substance use disorder. Additionally, individuals in the patient group with any comorbid psychiatric disorder were excluded. All participants provided informed consent prior to participation. The study protocol was approved by the International University of Sarajevo Institutional Review Board (Approval No: 01-1810/25), and data collection adhered to the ethical principles outlined in the Declaration of Helsinki. The patient group completed a Sociodemographic Information Form, the Turkish version of the DSM-5 Severity Measure for Social Anxiety Disorder—Adult, and the Liebowitz Social Anxiety Scale (LSAS), all administered in paper-and-pencil format. The healthy control group completed the same questionnaires, with the exception of the LSAS, also in paper-and-pencil format. Clinical participants were additionally asked to provide information regarding age at onset, treatment history, and family psychiatric history.

Measures

Sociodemographic Information Form

A structured Sociodemographic Information Form was developed by the researchers to collect background characteristics of the participants. The form included items assessing age, gender, education level, marital status, psychiatric history, family history of psychiatric illness, and, for clinical participants, age at onset of SAD. Responses were used for descriptive analyses, group comparisons, and examination of known-group differences.

DSM-5 Severity Measure for Social Anxiety Disorder—Adult (DSM-5 SAD-S)

The DSM-5 Severity Measure for Social Anxiety Disorder—Adult is a 10-item self-report scale developed by the American Psychiatric Association (1) to assess the frequency and severity of social anxiety symptoms over the past seven days. Items are rated on a 5-point Likert scale ranging from 0 ("not at all") to 4 ("extremely"), with higher scores indicating greater symptom severity. The scale is designed to be unidimensional and is widely used in both clinical and research settings. In this study, the Turkish-language version of the scale was administered.

A forward–backward translation procedure was employed. The original English version was first translated into Turkish by bilingual professionals and then independently back-translated into English. The back-translated version was reviewed by two bilingual psychiatrists to ensure conceptual and cultural equivalence. Any discrepancies were resolved through consensus.

Liebowitz Social Anxiety Scale

The LSAS is a 24-item clinician-administered or self-report instrument designed to assess fear and avoidance across a range of social interaction and performance situations (15). Each item is rated separately for fear and avoidance on a 4-point scale, yielding subscale scores and a total score. In this study, only the total score was used for the analysis of convergent validity. The validated Turkish version of the LSAS was used (16), which has demonstrated adequate internal consistency and construct validity in previous research.

Statistical Analysis

All statistical analyses were conducted using IBM SPSS Statistics, version 24 (IBM Corp., Armonk, NY, USA) and JASP for structural equation modeling. Descriptive statistics were calculated for all sociodemographic and clinical variables. Continuous variables were summarized using means and standard deviations, whereas categorical variables were reported as frequencies and percentages. Group comparisons between individuals with SAD and healthy controls were performed using the Mann–Whitney U test for non-normally distributed continuous variables, the independent-samples t test for normally distributed continuous variables, and chi-square tests for categorical variables. The internal consistency reliability of the DSM-5 SAD-S was assessed using Cronbach's alpha coefficient, calculated separately for the SAD group and the total sample. Item-level diagnostics, including corrected item–total correlations and Cronbach's alpha if an item was deleted, were also examined. To assess the test–retest reliability, the scale was re-administered two weeks after the initial assessment. A total of 40 participants—20 from the

Table 1: Sociodemographic and clinical characteristics of the study groups

	Social anxiety disorder (n=73)	Control group (n=73)	Statistic	p
Age (years)	26.05 (6.23)	23.68 (5.19)	U=3269.5	**0.011**
DSM-5 SAD-S score	21.50 (8.88)	1.90 (1.96)	t=18.4	**<0.001**
Gender			χ^2=0.030	0.867
Male	34 (46.6%)	32 (43.8%)		
Female	39 (53.4%)	41 (56.2%)		
Education level			χ^2=38.27	**<0.001**
Literate	5 (6.8%)	1 (1.4%)		
Primary school	5 (6.8%)	0 (0%)		
Middle school	4 (5.5%)	1 (1.4%)		
High school	32 (43.8%)	8 (11.0%)		
University	27 (37.0%)	63 (86.3%)		
Marital status			χ^2=10.99	**0.004**
Married	24 (32.9%)	8 (11.0%)		
Single	49 (67.1%)	64 (87.7%)		
Divorced	–	1 (1.4%)		
Psychiatric history			χ^2=35.38	**<0.001**
Present	45 (61.6%)	9 (12.5%)		
Absent	28 (38.4%)	63 (87.5%)		
Family psychiatric history			χ^2=4.52	**0.033**
Present	30 (41.1%)	17 (23.3%)		
Absent	43 (58.9%)	56 (76.7%)		
Age at onset (SAD group only)	20.45 (5.56)	—		

DSM-5 SAD-S: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Severity Measure for Social Anxiety Disorder; SAD: Social anxiety disorder.

patient group and 20 from the healthy control group—completed both administrations. Reliability was evaluated by calculating the correlation coefficient between the two sets of total scores. To examine the underlying factor structure, an exploratory factor analysis (EFA) was conducted in the SAD group using the minimum residual (MINRES) extraction method with oblimin rotation. The number of factors to retain was determined using parallel analysis. Subsequently, a single-factor model was extracted and evaluated in terms of interpretability and item loadings. A confirmatory factor analysis (CFA) was then conducted in the SAD group to test the unidimensional structure of the scale, using the diagonally weighted least squares (DWLS) estimator due to the ordinal nature of the item responses and the moderate sample size (17). Model fit was evaluated using standard fit indices, including the Comparative Fit Index (CFI), Tucker–Lewis Index (TLI), Root Mean Square Error of Approximation (RMSEA) with 95% confidence intervals, and the Standardized Root Mean Square Residual (SRMR). Convergent validity was examined using Pearson bivariate correlations between total scores on the DSM-5 SAD-S and the LSAS. All significance tests were two-tailed, and $p<0.05$ was considered statistically significant.

RESULTS

Sample Characteristics

The two groups differed significantly on several key sociodemographic and clinical variables. Participants in the SAD group were significantly older than healthy controls and reported markedly higher severity scores on the DSM-5 SAD-S, indicating a clear distinction between groups. No significant difference in gender distribution was observed, suggesting comparable male-to-female ratios across groups. In terms of education, a significant disparity was observed: the control group had a substantially higher proportion of university graduates, whereas the SAD group exhibited a broader distribution across lower educational levels. This pattern aligns with previous findings linking social anxiety to educational impairment (18). Marital status also differed significantly between groups. Individuals with SAD were more likely to be married or divorced, whereas the majority of controls were single.

Table 2: Item-level reliability statistics

	Item-total correlation	Cronbach's α if item deleted
Item 1	0.794	0.889
Item 2	0.743	0.893
Item 3	0.744	0.892
Item 4	0.676	0.897
Item 5	0.749	0.892
Item 6	0.661	0.898
Item 7	0.581	0.902
Item 8	0.544	0.904
Item 9	0.566	0.903
Item 10	0.598	0.902

Furthermore, psychiatric history, including both personal and familial history, was significantly more prevalent in the SAD group, supporting the validity of group classification based on diagnostic status. The mean age at onset of social anxiety symptoms in the clinical group was early adulthood, consistent with established epidemiological data (19). Together, these findings underscore the clinical distinctiveness of the SAD group and support the relevance of known-groups validity in the subsequent psychometric analyses (Table 1).

Internal Consistency

The internal consistency of the DSM-5 SAD-S was evaluated using Cronbach's alpha. The scale demonstrated excellent reliability in the total sample (α=0.967). When analyzed separately, internal consistency remained high within the clinical group diagnosed with SAD (α=0.907), indicating that the scale reliably measures symptom severity among individuals with clinically significant social anxiety.

Item–Total Correlations

Item–total correlations for the DSM-5 SAD-S were examined within the clinical sample. Corrected item–total correlations ranged from 0.544 (Item 8) to 0.794 (Item 1), indicating moderate to strong associations between individual items and the overall scale score. Cronbach's alpha values if individual items were deleted ranged from 0.889 to 0.904, suggesting that each item contributes meaningfully to internal consistency and that none warrant exclusion (Table 2).

Test–Retest Correlation Coefficients

The test–retest correlation coefficient for the DSM-5 SAD-S total score was r=0.976. Correlation coefficients for the individual items are presented in Table 3.

Table 3: Test-retest correlation coefficients

	r*
DSM-5 SAD-S	
Item 1	0.939
Item 2	0.932
Item 3	0.994
Item 4	0.975
Item 5	0.956
Item 6	0.956
Item 7	0.960
Item 8	0.963
Item 9	0.949
Item 10	0.877
Total Score	0.976

DSM-5 SAD-S: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Severity Measure for Social Anxiety Disorder—Adult, r*: Pearson correlation coefficient.

Table 4: Exploratory factor analysis of the DSM-5 Social Anxiety Disorder—Adult (unidimensional model; minimum residual extraction, SAD group, n=73)

	Factor 1	Uniqueness
Item 1	0.849	0.279
Item 2	0.798	0.364
Item 3	0.788	0.380
Item 4	0.720	0.481
Item 5	0.799	0.362
Item 6	0.688	0.527
Item 7	0.595	0.647
Item 8	0.561	0.685
Item 9	0.591	0.651
Item 10	0.624	0.611

The minimum residual extraction method was used in combination with oblimin rotation.

Exploratory and Confirmatory Factor Analysis

To evaluate the structural validity of the DSM-5 SAD-S, an EFA was conducted using data from the clinical group (n=73). The analysis employed the MINRES method with oblimin rotation. Initially, eigenvalue-based criteria suggested a potential two-factor solution. However, parallel analysis indicated that only the first factor had an eigenvalue exceeding the corresponding simulated value, supporting a unidimensional structure.

The EFA was subsequently re-run with the number of factors fixed at one. All 10 items loaded positively onto the single factor, with standardized loadings ranging from 0.561 (Item 8) to 0.849 (Item 1). Most

Table 5: Standardized factor loadings for the DSM-5 Social Anxiety Disorder Scale (CFA – DWLS; SAD group, n=73)

Latent factor	Observed item	Estimate	SE	95% CI		β	z	p
				Lower	Upper			
DSM-5 SAD-S	Item 1	1.000	0.0000	1.000	1.000	0.903		
	Item 2	0.976	0.0440	0.889	1.062	0.881	22.20	<0.001
	Item 3	0.906	0.0533	0.801	1.010	0.818	16.99	<0.001
	Item 4	0.836	0.0564	0.725	0.947	0.755	14.82	<0.001
	Item 5	0.958	0.0492	0.862	1.055	0.866	19.50	<0.001
	Item 6	0.828	0.0668	0.697	0.959	0.748	12.40	<0.001
	Item 7	0.750	0.0640	0.625	0.876	0.678	11.71	<0.001
	Item 8	0.653	0.0832	0.490	0.817	0.590	7.85	<0.001
	Item 9	0.681	0.0830	0.519	0.844	0.615	8.21	<0.001
	Item 10	0.742	0.0779	0.589	0.895	0.670	9.52	<0.001

CI: Confidence intervals; SE: Standard error; DSM-5 SAD-S: DSM-5 Severity Measure for Social Anxiety Disorder—Adult. Confirmatory factor analysis (CFA) was estimated using diagonally weighted least squares (DWLS) with robust standard errors. All items were treated as ordered categorical variables.

items demonstrated strong loadings above 0.60, and all exceeded the conventional threshold of 0.40, indicating adequate representation of the underlying construct of social anxiety severity. The majority of items also showed acceptable uniqueness values, suggesting that the common factor accounted for a substantial proportion of item variance. These findings support the use of a single total score on the DSM-5 SAD-S as a valid indicator of symptom severity in clinical populations (Table 4). A CFA was conducted using the DWLS estimator, which is appropriate for ordinal data. The 10 items of the DSM-5 SAD-S, rated on a 5-point Likert-type scale, were treated as ordered categorical variables. DWLS was selected due to its robustness in handling non-normal ordinal indicators and its suitability for small to moderate sample sizes. Robust standard errors and mean- and variance-adjusted chi-square statistics were used to evaluate model fit. The model specified a single latent factor underlying the 10 observed items. The one-factor CFA demonstrated excellent incremental fit (CFI=0.990; TLI=0.988) and marginally acceptable residual-based fit (SRMR=0.084). However, the RMSEA was elevated (0.106; 95% confidence interval [CI]=0.062–0.147), indicating that absolute model fit should be interpreted with caution. We therefore interpret model fit using multiple indices in conjunction with the pattern of strong and statistically significant factor loadings. All items loaded significantly onto the latent factor, with standardized factor loadings ranging from 0.590 (Item 8) to 0.903 (Item 1), further supporting the unidimensional structure of the scale (Table 5). These findings are consistent with theoretical expectations and provide additional evidence for the structural validity of the DSM-5 SAD-S in a clinical population.

Convergent Validity

To assess convergent validity, a Pearson bivariate correlation was computed between total scores on the DSM-5 SAD-S and the LSAS within the clinical sample. The observed association between the DSM-5 SAD-S and the LSAS ($r=0.390$, $p<0.001$, $df=71$) indicates moderate convergent validity. This magnitude is consistent with prior evidence demonstrating moderate correlations between the DSM-5 SAD severity scale and the Liebowitz Social Anxiety Scale–Self-Report (LSAS-SR) (e.g., approximately $r\approx0.47$ in a clinical sample) (20). Differences in correlation magnitude across studies may reflect variations in sample composition, restricted score variability within a single diagnostic group, and the fact that the DSM-5 SAD-S is a brief severity measure while the LSAS is a broader inventory of fear and avoidance across multiple social situations.

Statistical Power

For convergent validity, with n=73 (SAD group) and $\alpha=0.05$ (two-tailed), the sample provided ~80% power to detect correlations of $r\approx0.32$ or greater. The observed association with the LSAS ($r=0.39$) therefore falls within a detectably moderate range. For known-groups validity, with n=73 per group and $\alpha=0.05$ (two-tailed), the sample provided ~80% power to detect group differences of approximately $d\approx0.46$. The observed group separation was extremely large (approximately $d\approx3.05$), indicating statistical power effectively exceeding 0.99 (21).

DISCUSSION

The DSM-5 introduced dimensional severity assessments to complement categorical diagnoses and enhance

clinical precision (1). Among these measures, the Anxiety Severity Measures (ASM) were developed to evaluate core anxiety symptoms in a concise and accessible format (1, 3). Although several international validation studies have supported the reliability and structural validity of these tools (7, 8, 10, 11), the Turkish adult version of the DSM-5 SAD-S had not undergone formal psychometric evaluation prior to the present study.

Our findings support the unidimensional structure of the Turkish version of the DSM-5 SAD-S. Both the EFA and CFA yielded a single-factor solution with high factor loadings across all 10 items, consistent with theoretical models of anxiety that distinguish cognitive, physiological, and behavioral components (22). The CFA demonstrated excellent fit based on the CFI and TLI. However, the RMSEA slightly exceeded conventional cutoff values. This elevation is likely attributable to the sample size and the non-normal distribution of the data, a known issue when applying RMSEA to categorical data estimated using DWLS (17). Although incremental indices supported the one-factor model, the RMSEA exceeded commonly cited heuristic cutoffs. Such elevations can occur in relatively simple CFA models, particularly when degrees of freedom are small, where the RMSEA may over-reject even correctly specified models (23). In our study, structural validity was evaluated within a clinical SAD group (n=73) using a simple one-factor model with 10 indicators, all of which demonstrated moderate-to-strong loadings (EFA: 0.56–0.85; CFA: 0.59–0.90). Simulation research indicates that smaller samples can yield adequate factor recovery when loadings are strong and model complexity is limited, whereas even large samples can perform poorly when communalities are low or models are misspecified (24, 25). These findings are consistent with prior validation studies conducted in German, Brazilian, Dutch, and Spanish samples (6, 7, 9, 10), suggesting that the structure of the SAD scale is stable across diverse cultural and linguistic contexts.

The scale also demonstrated excellent internal consistency (α=0.91), consistent with previous studies reporting Cronbach's alpha coefficients above 0.85 (3). Furthermore, the scale demonstrated strong convergent validity with the LSAS, a well-established clinician-administered and self-report instrument. The correlation coefficient between the total SAD severity score and the LSAS score was significant (r=0.390, $p<0.001$), indicating that the two instruments assess overlapping constructs while still capturing potentially distinct dimensions of social anxiety symptomatology.

Sociodemographic comparisons between the clinical and control groups also supported the discriminative utility of the scale. The clinical group reported significantly higher severity scores and differed across relevant clinical variables, including psychiatric history, family psychiatric background, and earlier age at symptom onset. These findings suggest the scale's clinical sensitivity but further underscore the importance of early identification of individuals at risk.

Nevertheless, certain limitations should be acknowledged. First, the sample size was modest, which may limit statistical power and the stability of model fit estimates, particularly in factor-analytic procedures. Second, we did not conduct discriminant validity analyses using external measures of unrelated constructs (e.g., externalizing behaviors), which limited our ability to fully evaluate the construct boundaries of the SAD severity measure. Accordingly, it remains unclear whether the scale uniquely captures the severity of social anxiety symptoms without substantial overlap with related psychological dimensions such as general distress, depression, or trait anxiety. Future research should incorporate measures of unrelated or adjacent constructs to rigorously examine the discriminant validity of the instrument in diverse clinical and community samples.

An additional limitation is that psychiatric comorbidities were excluded from the SAD group to obtain a diagnostically homogeneous sample and reduce potential confounding effects of other disorders on symptom ratings. However, social anxiety disorder commonly co-occurs with other psychiatric conditions, most notably depressive disorders and other anxiety disorders (26). While this approach allowed for a clearer evaluation of the scale's psychometric properties, it may limit the generalizability of the findings, as patients with SAD frequently present with comorbid conditions in routine clinical settings. Future studies should therefore examine the performance of the scale in more heterogeneous clinical samples to better reflect real-world practice.

Another limitation concerns the translation and cultural adaptation process. Although a forward–backward translation procedure was applied and the final version was reviewed by two independent bilingual psychiatrists to ensure conceptual and cultural appropriateness, additional steps, such as formal committee review, pilot testing, or cognitive debriefing, were not undertaken. Consequently, certain linguistic or contextual nuances may not have been fully addressed. Future studies would benefit

from incorporating these procedures to further strengthen the cross-cultural validity of the scale.

Finally, the cross-sectional design of the study did not permit evaluation of sensitivity to treatment-related change, which is an important consideration for longitudinal clinical applications.

Future research should examine the scale in larger samples that better represent the clinical complexity of social anxiety disorder, including individuals with comorbid psychiatric conditions rather than exclusively diagnostically "pure" cases. Research involving different age groups would also be valuable. Moreover, longitudinal designs are needed to assess the instrument's sensitivity to treatment-related change and its utility in tracking symptom progression over time.

CONCLUSION

Despite these limitations, this study provides the first evidence for the structural validity, internal consistency, and convergent validity of the Turkish version of the adult DSM-5 SAD-S. Given the high prevalence of anxiety-related symptoms among Turkish youth and adults (27), the availability of a psychometrically supported, freely accessible, and time-efficient screening tool represents a valuable resource for both clinical practice and research settings in Turkiye. This tool may facilitate the early identification of individuals in need of treatment, streamline intake procedures, and improve the precision of symptom monitoring in routine clinical care.

Ethical Approval: The International University of Sarajevo Ethics Committee granted approval for this study (Date: 26.06.2025 No: IUS-REC-01-1810-25).

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	Data acquisition	F.P.C.
	Data analysis/Interpretation	F.P.C., K.A., O.A. O.Aydemir.
Category 2	Drafting manuscript	F.P.C., K.A., O.A.
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