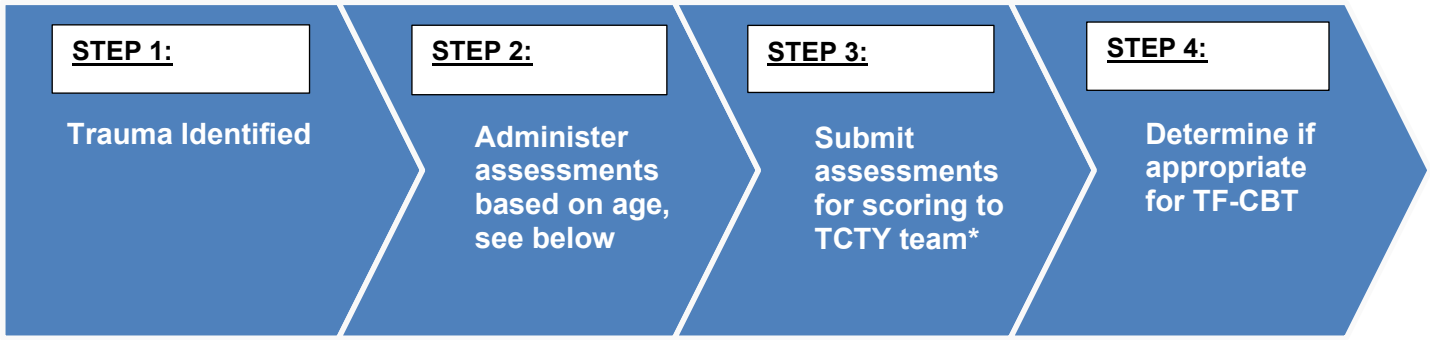
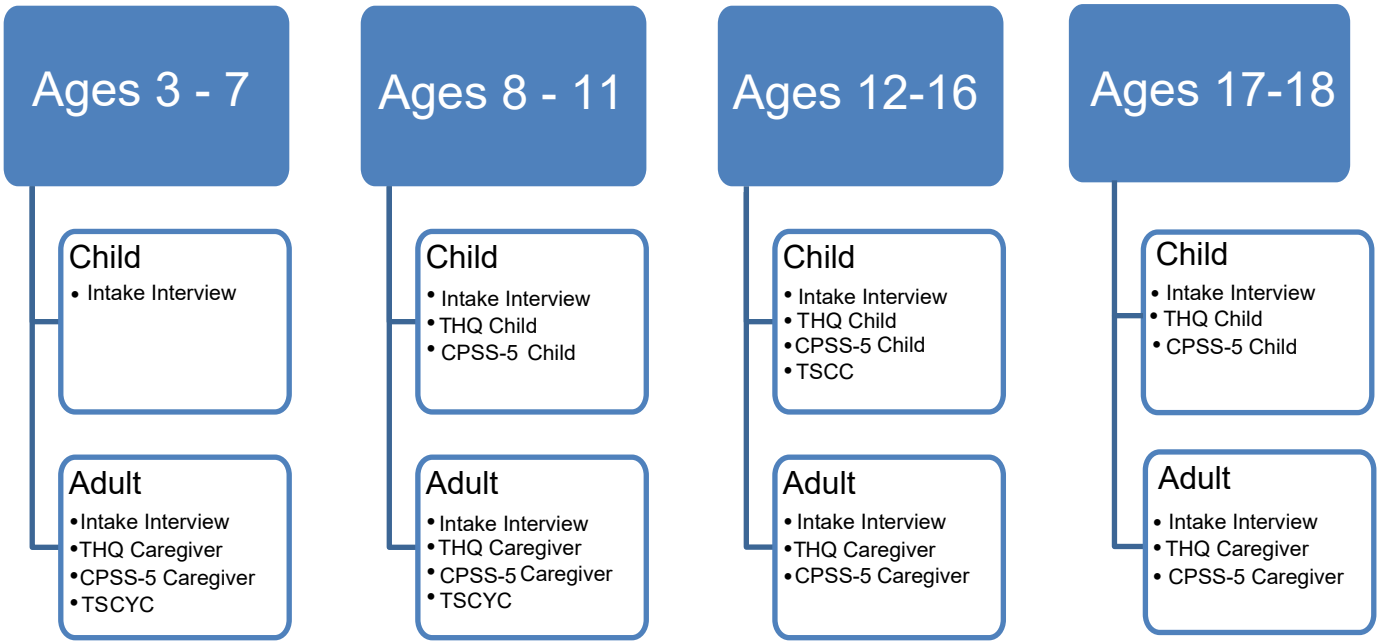
TCTY NORTH DAKOTA TREATMENT COLLABORATIVE FOR TRAUMATIZED YOUTH

ASSESSMENTS

Clinicians will screen for trauma exposure in their own agency's clinical interview (if it is not known prior to intake there is trauma) and then do follow-up assessment. If trauma exposure is identified, follow this process:



TCTY Required Assessments:



Trauma History Questionnaire (THQ) CHILD (*Developed at the Yale Childhood Violent Trauma Center)*

Instructions: I'm going to ask you about different experiences you may have had. Please think about things that may have happened to you *in addition to* the experience that brought you here today.

1. Have you ever been in or seen a serious accident?	☐ Yes	☐ No
2. Has someone close to you ever been very sick or very hurt or injured?	☐ Yes	☐ No
3. Have you ever experienced a severe illness or injury?	☐ Yes	☐ No
4. Have you ever experienced a painful or scary medical treatment when you were injured or sick?	☐ Yes	☐ No
5. Have you ever experienced the death of someone close to you?	☐ Yes	☐ No
6. Have you ever been unexpectedly separated from someone who takes care of you?	☐ Yes	☐ No
7. Has someone close to you ever harmed themselves or attempted or completed suicide?	☐ Yes	☐ No
8. Have you ever been physically hurt (e.g., hit, kicked, punched) or threatened to be hurt?	☐ Yes	☐ No
9. Has someone ever robbed from you? Or have you ever witnessed this?	☐ Yes	☐ No
10. Have you ever been attacked by a dog or other animal?	☐ Yes	☐ No
11. Have you ever seen or heard a family member(s) physically fighting, attacking (e.g., pushing, hitting, punching, or using weapons) or beating each other up or threatening to hurt one another?	☐ Yes	☐ No
12. Have you ever seen or heard someone in your neighborhood or school attacking each other or beating each other up (e.g., pushing, hitting, punching, or using weapons) or threatening to hurt one another?	☐ Yes	☐ No
13. Has someone ever made you watch or do something sexual (e.g., such as touching you in a sexual way, touching your private parts, making you touch their private parts, or made you watch someone else touch themselves in a sexual way?)	☐ Yes	☐ No
14. Has someone important to you ever repeatedly told you that you were no good, repeatedly yelled at you in a scary way, or had someone threaten to abandon you, leave you, or send you away?	☐ Yes	☐ No
15. Has a peer ever bullied you on the internet or in person (e.g., called you names, teased you, made up stories about you, repeatedly told you that you were no good, excluded you or threatened to hurt you)?	☐ Yes	☐ No
16. Have you ever had a time when you did not have enough food or a place to live?	☐ Yes	☐ No
17. Has there ever been a time in your life when an adult wasn't taking care of you? (e.g., when you didn't get fed, didn't have clothes to wear or when you weren't taken to school or to the doctor when you needed to go?)	☐ Yes	☐ No
18. Have you ever seen anyone in your home using drugs like smoking drugs (other than cigarettes) or using needles?	☐ Yes	☐ No
19. Have you ever seen anyone in your home drink too much (get drunk)?	☐ Yes	☐ No
20. Have you ever been exposed to a natural disaster (e.g., been in a really bad storm like a hurricane or tornado or in a fire, flood or earthquake)?	☐ Yes	☐ No
21. Have you ever experienced a man-made disaster (e.g., bombings, or another situation where somebody did something that hurt or killed a lot of people at the same time) or exposure to war?	☐ Yes	☐ No
22. Have you ever witnessed a family member who was arrested, or had a family member in jail?	☐ Yes	☐ No
23. Have there been other very scary or upsetting things that have happened to you? If so, what?	☐ Yes	☐ No
24. Has someone ever made you do sexual things for food, money, or housing?	☐ Yes	☐ No
25. Has someone ever taken sexual pictures of you or made you take sexual photos?	☐ Yes	☐ No
26. Have you experienced discrimination or harassment based on your race or ethnic background?	☐ Yes	☐ No
27. Have you experienced discrimination of harassment based on your actual or perceived gender identity or sexual orientation?	☐ Yes	☐ No
28. Which item in this questionnaire is the most traumatic for you?		

Developed at the Yale Childhood Violent Trauma Center

DATE OF ASSESSMENT: _____ TOTAL: _____

____ PRE TREATMENT ____ POST TREATMENT

TCTY ID: _____

Trauma History Questionnaire (THQ) CAREGIVER (*Developed at the Yale Childhood Violent Trauma Center)*

Instructions: I'm going to ask you about different experiences your child may have had. Please think about things that may have happened to your child *in addition to* the experience that brought you here today.

1. Has your child ever been in or seen a serious accident?	☐ Yes	☐ No
2. Has someone close to your child ever been very sick or very hurt or injured?	☐ Yes	☐ No
3. Has your child ever experienced a severe illness or injury?	☐ Yes	☐ No
4. Has your child ever experienced a painful or scary medical treatment either when they were injured or sick?	☐ Yes	☐ No
5. Has your child ever experienced the death of someone close to him/her?	☐ Yes	☐ No
6. Has your child ever been unexpectedly separated from you (caregiver) or another person significant in the child's life	☐ Yes	☐ No
7. Has someone close to your child ever attempted or committed suicide or harmed him/herself?	☐ Yes	☐ No
8. Has your child ever been physically hurt (e.g., hit, kicked, punched) or threatened to be hurt?	☐ Yes	☐ No
9. Has someone ever robbed from your child? Or has your child ever witnessed this?	☐ Yes	☐ No
10. Has your child ever been attacked by a dog or other animal?	☐ Yes	☐ No
11. Has your child ever seen or heard a family member(s) physically fighting, attacking (e.g., pushing, hitting, punching, or using weapons) or beating each other up or threatening to hurt one another?	☐ Yes	☐ No
12. Has your child ever seen or heard someone in your neighborhood or school attacking each other or beating each other up (e.g., pushing, hitting, punching, or using weapons) or threatening to hurt one another?	☐ Yes	☐ No
13. Has someone ever made your child watch or do something sexual (e.g., such as touching your child in a sexual way, touching your child's private parts, making your child touch their private parts, or made your child watch someone else touch themselves in a sexual way?)	☐ Yes	☐ No
14. Has someone important to your child ever repeatedly told your child that s/he was no good, repeatedly yelled at your child in a scary way, or had someone threaten to abandon your child, leave your child, or send them away?	☐ Yes	☐ No
15. Has a peer ever bullied your child on the internet or in person (e.g., called him/her names, teased him/her, made up stories about him/her, repeatedly told him/her they were no good, excluded them or threatened to hurt him/her)?	☐ Yes	☐ No
16. Has your child ever had a time when s/he did not have enough food or a place to live?	☐ Yes	☐ No
17. Has there ever been a time in your child's life when an adult wasn't taking care of him/her? (e.g., when s/he didn't get fed, didn't have clothes to wear or when s/he weren't taken to school or to the doctor when s/he needed to go?)	☐ Yes	☐ No
18. Has your child ever seen anyone in your home using drugs like smoking drugs (other than cigarettes) or using needles?	☐ Yes	☐ No
19. Has your child ever seen anyone in your home drink too much (get drunk)?	☐ Yes	☐ No
20. Has your child ever been exposed to a natural disaster (e.g., been in a really bad storm like a hurricane or tornado or in a fire, flood or earthquake)?	☐ Yes	☐ No
21. Has your child ever experienced man-made disaster (e.g., bombings, or another situation where somebody did something that hurt or killed a lot of people at the same time) or exposure to war?	☐ Yes	☐ No
22. Has your child ever witnessed a family member who was arrested, or had a family member in jail?	☐ Yes	☐ No
23. Have there been other very scary or upsetting things that have happened to your child? If so, what?	☐ Yes	☐ No
24. Has someone ever made your child do sexual things for food, money, or housing?	☐ Yes	☐ No
25. Has someone ever taken sexual pictures of your child or made them take sexual photos?	☐ Yes	☐ No
26. Is the child's family part of a specific culture, racial or ethnic group that experienced trauma/oppression in the past? (e.g., Colonization of Native Americans, Forces Migration, Refugee, Holocaust) If so, What?	☐ Yes	☐ No
27. Has your child experienced discrimination or harassment based on their race or ethnic background?	☐ Yes	☐ No
28. Has your child experience discrimination or harassment based on their actual or perceived gender identity or sexual orientation?	☐ Yes	☐ No
29. Which item in this questionnaire is the most traumatic for your child?		

Developed at the Yale Childhood Violent Trauma Center

TOTAL: _____

DATE OF ASSESSMENT: _____

____ PRE TREATMENT ____ POST TREATMENT

TCTY ID: _____

The Child PTSD Symptom Scale (CPSS)—5 Interviewer Version

Pre-Treatment

CHILD

Now let's talk about how you have been feeling about the event IN THE LAST MONTH (or since it happened, if less than a month ago).

A month ago (or when the event happened) would have been (insert date).

Can you remember anything special or different that happened around that time? It could be a birthday, a party, a trip, or something else that happened at school or at home (use a calendar if necessary to illustrate the amount of time).

This will help us to remember what has been happening just in the past month (or since the event happened) as I ask you these questions.

I'm going to be asking you how you have been feeling just about (name the event). I'll be sure to mention the amount of time and the event in my questions just so we don't forget.

Show the CPSS Pictorial Rating Sheet.

I will read each item. You can tell me the number that best describes how often each one has bothered you IN THE LAST MONTH.

Question	Not at All (0)	A Little (1)	Somewhat (2)	A Lot (3)	Almost Always (4)
1. Did you have upsetting thoughts or pictures about the experience come into your head when you did not want them to?	☐	☐	☐	☐	☐
2. Did you have bad dreams or nightmares?	☐	☐	☐	☐	☐
3. Did you act or feel like the experience was happening again? (Flashback)	☐	☐	☐	☐	☐
4. Did you feel upset when you were reminded of what happened?	☐	☐	☐	☐	☐
5. Did you have feelings in your body when you were reminded of what happened (e.g., stomach aches, headaches, chills, shaking, etc.)?	☐	☐	☐	☐	☐
6. Did you try not to think about, talk about, or have feelings about the experience?	☐	☐	☐	☐	☐
7. Did you try to avoid activities, people, or places that reminded you of what happened?	☐	☐	☐	☐	☐
8. Did you have trouble remembering important parts of the experience?	☐	☐	☐	☐	☐
9. Did you have bad thoughts about yourself other people or the world?	☐	☐	☐	☐	☐
10. Did you feel like what happened was your fault?	☐	☐	☐	☐	☐

Question	Not at All (0)	A Little (1)	Somewhat (2)	A Lot (3)	Almost Always (4)
11. Did you have strong upsetting feelings like guilt, anger, fear, or shame?	☐	☐	☐	☐	☐
12. Did you have much less interest in doing things you used to like?	☐	☐	☐	☐	☐
13. Did you have trouble feeling close to people? Did you feel like you didn't want to be around other people?	☐	☐	☐	☐	☐
14. Did you have trouble having any good feelings like happiness or love?	☐	☐	☐	☐	☐
15. Did you get angry easily?	☐	☐	☐	☐	☐
16. Did you do anything that might hurt you (e.g., cutting, taking drugs, etc.)	☐	☐	☐	☐	☐
17. Were you very careful or on the lookout (for example, checking to see who is around you and what is around you)?	☐	☐	☐	☐	☐
18. Were you jumpy or easily frightened?	☐	☐	☐	☐	☐
19. Did you have trouble paying attention because the bad event was on your mind?	☐	☐	☐	☐	☐
20. Did you have trouble falling asleep or staying asleep?	☐	☐	☐	☐	☐

TOTAL: _____

Functional Impairment

Question	Yes	No
21. Did your symptoms interfere with you doing your prayers?	☐	☐
22. Did your symptoms interfere with your chores and duties at home?	☐	☐
23. Did your symptoms interfere with your relationships with friends?	☐	☐
24. Did your symptoms interfere with your fun and hobby activities?	☐	☐
25. Did your symptoms interfere with your schoolwork?	☐	☐
26. Did your symptoms interfere with your relationships with your family?	☐	☐
27. Did your symptoms interfere with your overall happiness with your life?	☐	☐

Created by the Yale Child Study Center

DATE OF ASSESSMENT: _____

____ PRE TREATMENT ____ POST TREATMENT

TCTY ID: _____

The Child PTSD Symptom Scale (CPSS)—5 Interviewer Version

Pre-Treatment

CAREGIVER

Now let's talk about how your child has been feeling about the event IN THE LAST MONTH (or since it happened, if less than a month ago).

A month ago (or when the event happened) would have been (insert date).

Can you remember anything special or different that happened around that time? It could be a birthday, a party, a trip, or something else that happened at school or at home (use a calendar if necessary to illustrate the amount of time).

This will help us to remember what has been happening just in the past month (or since the event happened) as I ask you these questions.

I'm going to be asking you how your child has been feeling just about (name the event). I'll be sure to mention the amount of time and the event in my questions just so we don't forget.

Show the CPSS Pictorial Rating Sheet.

I will read each item. You can tell me the number that best describes how often each one has bothered your child IN THE LAST MONTH. You can also answer "I Don't Know."

Question	DK (0)	Not at All (0)	A Little (1)	Some-what (2)	A Lot (3)	Almost Always (4)
1. Did your child have upsetting thoughts or pictures about the experience come into their head when she did not want them to?	☐	☐	☐	☐	☐	☐
2. Did your child have bad dreams or nightmares?	☐	☐	☐	☐	☐	☐
3. Did your child act or feel like the experience was happening again? (Flashback)	☐	☐	☐	☐	☐	☐
4. Did your child feel upset when they were reminded of what happened?	☐	☐	☐	☐	☐	☐
5. Did your child have feelings in their body when they were reminded of what happened (e.g., stomach aches, headaches, chills, shaking, etc.)?	☐	☐	☐	☐	☐	☐
6. Did your child try not to think about, talk about, or have feelings about the experience?	☐	☐	☐	☐	☐	☐
7. Did your child try to avoid activities, people, or places that reminded them of what happened?	☐	☐	☐	☐	☐	☐
8. Did your child have trouble remembering important parts of the experience?	☐	☐	☐	☐	☐	☐
9. Did your child have bad thoughts about themselves other people or the world?	☐	☐	☐	☐	☐	☐
10. Did your child feel like what happened was their fault?	☐	☐	☐	☐	☐	☐

Question	DK (0)	Not at All (0)	A Little (1)	Some-what (2)	A Lot (3)	Almost Always (4)
11. Did your child have strong upsetting feelings like guilt, anger, fear, or shame?	☐	☐	☐	☐	☐	☐
12. Did your child have much less interest in doing things they used to like?	☐	☐	☐	☐	☐	☐
13. Did your child have trouble feeling close to people? Did your child feel like they didn't want to be around other people?	☐	☐	☐	☐	☐	☐
14. Did your child have trouble having any good feelings like happiness or love?	☐	☐	☐	☐	☐	☐
15. Did your child get angry easily?	☐	☐	☐	☐	☐	☐
16. Did your child do anything that might hurt themselves (e.g., cutting, taking drugs, etc.)	☐	☐	☐	☐	☐	☐
17. Was your child very careful or on the lookout (for example, checking to see who is around them and what is around them)?	☐	☐	☐	☐	☐	☐
18. Was your child jumpy or easily frightened?	☐	☐	☐	☐	☐	☐
19. Did your child have trouble paying attention because the bad event was on their mind?	☐	☐	☐	☐	☐	☐
20. Did your child have trouble falling asleep or staying asleep?	☐	☐	☐	☐	☐	☐

TOTAL: _____

Functional Impairment

Question	Yes	No
21. Did your child's symptoms interfere with them doing their prayers?	☐	☐
22. Did your child's symptoms interfere with their chores and duties at home?	☐	☐
23. Did your child's symptoms interfere with their relationships with friends?	☐	☐
24. Did your child's symptoms interfere with their fun and hobby activities?	☐	☐
25. Did your child's symptoms interfere with their schoolwork?	☐	☐
26. Did your child's symptoms interfere with their relationships with their family?	☐	☐
27. Did your child's symptoms interfere with their overall happiness with their life?	☐	☐

Created by the Yale Child Study Center

DATE OF ASSESSMENT: _____

____ PRE TREATMENT ____ POST TREATMENT

TCTY ID: _____

2498101982

Age: ☐☐

TSCYC
TCTY

Date: ☐☐ / ☐☐ / ☐☐☐☐

Timepoint: ○ Pre ○ Post

Gender: ○ Male ○ Female

ID#: _____

Site Name: _____

DIRECTIONS: The following items have to do with things the child does, feels, or experiences. Please indicate how often he or she has done, felt, or experienced each of the following things **in the last month.** Please choose only **ONE** answer for each item.

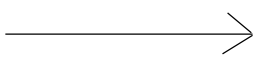
	Not At All 1	Sometimes 2	Often 3	Very Often 4
1. Temper Tantrums	○	○	○	○
2. Looking sad	○	○	○	○
3. Telling a lie	○	○	○	○
4. Bad dreams or nightmares	○	○	○	○
5. Living in a fantasy world	○	○	○	○
6. Seeming to know more about sex than he or she should	○	○	○	○
7. Being easily scared	○	○	○	○
8. Not wanting to go somewhere that reminded him or her of a bad thing from the past	○	○	○	○
9. Worrying that his or her food was poisoned	○	○	○	○
10. Flinching or jumping when someone moved quickly or there was a loud noise	○	○	○	○
11. Being bothered by memories of something that happened to him or her	○	○	○	○
12. Worrying that someone might be sexual with him or her	○	○	○	○
13. Not wanting to talk about something that happened to him or her	○	○	○	○
14. Not doing something he or she was supposed to do	○	○	○	○
15. Breaking things on purpose	○	○	○	○
16. Talking about sexual things	○	○	○	○
17. Having trouble concentrating	○	○	○	○
18. Blaming himself or herself for things that weren't his or her fault	○	○	○	○
19. Acting frightened when he or she was reminded of something that happened in the past	○	○	○	○
20. Pretending to have sex	○	○	○	○
21. Worrying that bad things would happen in the future	○	○	○	○
22. Arguing	○	○	○	○
23. Getting into physical fights	○	○	○	○
24. Drawing pictures about an upsetting thing that happened to him or her	○	○	○	○

Please turn sheet over for questions on the other side

Entered: ☐ ID#
Entered by: ☐☐☐
Date: ☐☐ / ☐☐ / ☐☐☐☐

	Not At All 1	Sometimes 2	Often 3	Very Often 4
25. Not noticing what he or she was doing	○	○	○	○
26. Having trouble sitting still	○	○	○	○
27. Playing games about something bad that actually happened to him or her in the past	○	○	○	○
28. Seeming to be in a daze	○	○	○	○
29. Having trouble remembering an upsetting thing that happened in the past	○	○	○	○
30. Using drugs	○	○	○	○
31. Fear of the dark	○	○	○	○
32. Being afraid to be alone	○	○	○	○
33. Spacing out	○	○	○	○
34. Being too aggressive	○	○	○	○
35. Touching other children's or adults' private parts (under or over clothes)	○	○	○	○
36. Suddenly seeing, feeling, or hearing something bad that happened in the past	○	○	○	○
37. Hearing voices telling him or her to hurt someone	○	○	○	○
38. Staring off into space	○	○	○	○
39. Changing the subject or not answering when he or she was asked about a bad thing that happened to him or her	○	○	○	○
40. Having a nervous breakdown	○	○	○	○
41. Not laughing or being happy like other children	○	○	○	○
42. Crying at night because he or she was frightened	○	○	○	○
43. Hitting adults (including parents)	○	○	○	○
44. Being frightened of men	○	○	○	○
45. Not being able to pay attention	○	○	○	○
46. Seeming to be a million miles away	○	○	○	○
47. Being easily startled	○	○	○	○
48. Watching out everywhere for possible danger	○	○	○	○
49. No longer doing things that he or she used to enjoy	○	○	○	○
50. Becoming frightened or disturbed when something sexual was mentioned or seen	○	○	○	○
51. Not sleeping for two or more days	○	○	○	○
52. Not paying attention because he or she was in his or her own world	○	○	○	○
53. Makingmistakes	○	○	○	○
54. Crying for no obvious reason	○	○	○	○

	Not At All 1	Sometimes 2	Often 3	Very Often 4
55. Not wanting to be around someone who did something bad to him or her or reminded him or her of something bad	○	○	○	○
56. Being tense	○	○	○	○
57. Worrying about other people's safety	○	○	○	○
58. Becoming very angry over a little thing	○	○	○	○
59. Drawing pictures of sexual things	○	○	○	○
60. Pulling his or her hair out	○	○	○	○
61. Calling himself or herself bad, stupid or ugly	○	○	○	○
62. Throwing things at friends or family members	○	○	○	○
63. Getting upset about something in the past	○	○	○	○
64. Temporary blindness or paralysis	○	○	○	○
65. Getting upset about something sexual	○	○	○	○
66. Not going to bed at night the first time he or she was asked	○	○	○	○
67. Fear that he or she would be killed by someone	○	○	○	○
68. Saying that nobody liked him or her	○	○	○	○
69. Crying when he or she was reminded of something from the past.	○	○	○	○
70. Saying that something bad didn't happen to him or her even though it did happen	○	○	○	○
71. Saying he or she wanted to die or be killed	○	○	○	○
72. Acting as if he or she didn't have any feelings about something bad that happened to him or her	○	○	○	○
73. Whining	○	○	○	○
74. Not sleeping well	○	○	○	○
75. Worrying about sexual things	○	○	○	○
76. Being frightened by things that didn't used to scare him or her	○	○	○	○
77. Hallucinating	○	○	○	○
78. Acting like he or she was in a trance	○	○	○	○
79. Forgetting his or her own name	○	○	○	○
80. Getting upset when he or she was reminded of something bad that happened	○	○	○	○
81. Avoiding things that reminded him or her of a bad thing that had happened in the past	○	○	○	○
82. Acting jumpy	○	○	○	○
83. Making a mess	○	○	○	○
84. Acting sad or depressed	○	○	○	○



Please turn sheet over for questions on the other side

	Not At All 1	Sometimes 2	Often 3	Very Often 4
85. Being so absent-minded that he or she didn't notice what was going on around him or her	○	○	○	○
86. Not wanting to eat certain foods	○	○	○	○
87. Yelling at family, friends, or teachers	○	○	○	○
88. Not playing because he or she was depressed	○	○	○	○
89. Being disobedient	○	○	○	○
90. Intentionally hurting other children or family members	○	○	○	○

7347478594 **Age:** ☐☐

TSCC TCTY

Date: ☐☐ / ☐☐ / ☐☐☐☐

Timepoint: ○ Pre ○ Post

Gender: ○ Male ○ Female

ID#: _____

Site Name: _____

DIRECTIONS: The items in this questionnaire describe things that kids sometimes think, feel, or do. Read each item, then mark how often it has happened to you in the past 30 days by filling in the circle under the correct answer. Please choose only ONE answer for each item.

	Never 0	Sometimes 1	Lots of times 2	Almost all of the time 3
1. Bad dreams or nightmares	○	○	○	○
2. Feeling afraid something bad might happen	○	○	○	○
3. Scary ideas or pictures just pop into my head	○	○	○	○
4. Wanting to say dirty words	○	○	○	○
5. Pretending I am someone else	○	○	○	○
6. Arguing too much	○	○	○	○
7. Feeling lonely	○	○	○	○
8. Touching my private parts too much	○	○	○	○
9. Feeling sad or unhappy	○	○	○	○
10. Remembering things that happened that I didn't like	○	○	○	○
11. Going away in my mind, trying not to think	○	○	○	○
12. Remembering scary things	○	○	○	○
13. Wanting to yell and break things	○	○	○	○
14. Crying	○	○	○	○
15. Getting scared all of a sudden and don't know why	○	○	○	○
16. Getting mad and can't calm down	○	○	○	○
17. Thinking about having sex	○	○	○	○
18. Feeling dizzy	○	○	○	○
19. Wanting to yell at people	○	○	○	○
20. Wanting to hurt myself	○	○	○	○
21. Wanting to hurt other people	○	○	○	○
22. Thinking about touching other people's private parts	○	○	○	○
23. Thinking about sex when I don't want to	○	○	○	○
24. Feeling scared of men	○	○	○	○

Please turn sheet over for questions on the other side

Entered: ☐ ID# Entered by: ☐☐☐
Date: ☐☐ / ☐☐ / ☐☐☐☐

	Never 0	Sometimes 1	Lots of times 2	Almost all of the time 3
25. Feeling scared of women	○	○	○	○
26. Washing myself because I feel dirty on the inside	○	○	○	○
27. Feeling stupid or bad	○	○	○	○
28. Feeling like I did something wrong	○	○	○	○
29. Feeling like things aren't real	○	○	○	○
30. Forgetting things, can't remember things	○	○	○	○
31. Feeling like I'm not in my body	○	○	○	○
32. Feeling nervous or jumpy inside	○	○	○	○
33. Feeling afraid	○	○	○	○
34. Not trusting people because they might want sex	○	○	○	○
35. Can't stop thinking about something bad that happened to me	○	○	○	○
36. Getting into fights	○	○	○	○
37. Feeling mean	○	○	○	○
38. Pretending I'm somewhere else	○	○	○	○
39. Being afraid of the dark	○	○	○	○
40. Getting scared or upset when I think about sex	○	○	○	○
41. Worrying about things	○	○	○	○
42. Feeling like nobody likes me	○	○	○	○
43. Remembering things I don't want to remember	○	○	○	○
44. Having sex feelings in my body	○	○	○	○
45. My mind going empty or blank	○	○	○	○
46. Feeling like I hate people	○	○	○	○
47. Can't stop thinking about sex	○	○	○	○
48. Trying not to have any feelings	○	○	○	○
49. Feeling mad	○	○	○	○
50. Feeling afraid somebody will kill me	○	○	○	○
51. Wishing bad things had never happened	○	○	○	○
52. Wanting to kill myself	○	○	○	○
53. Daydreaming	○	○	○	○
54. Getting upset when people talk about sex	○	○	○	○

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