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An Investigation of Trauma Symptom Reduction in a Clinical Sample of Sexually Abused Children Using the Trauma Symptom Checklist for Children

Sarah Denyse Brown

ACCEPTANCE

This dissertation, AN INVESTIGATION OF TRAUMA SYMPTOM REDUCTION IN A CLINICAL SAMPLE OF SEXUALLY ABUSED CHILDREN USING THE TRAUMA SYMPTOM CHECKLIST FOR CHILDREN, by SARAH DENYSE BROWN, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Education, Georgia State University.

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ABSTRACT

AN INVESTIGATION OF TRAUMA SYMPTOM REDUCTION IN A CLINICAL SAMPLE OF SEXUALLY ABUSED CHILDREN USING THE TRAUMA SYMPTOM CHECKLIST FOR CHILDREN

by

Sarah D. Brown

School counselors have a duty to formulate strategies that aid in the detection and prevention of child sexual abuse (ASCA, 2003). This may be accomplished in a number of ways, such as designing programs, providing training to teachers regarding recognizing and reporting abuse indicators, and collaborating with child protection and other mental health professionals to provide additional aftercare for sexually abused children in the school setting. Much can be learned about trauma symptomology from a clinical sample of sexually abused children.

The Trauma Symptom Checklist for Children (TSCC; Briere, 1996) is a 54-item self-report instrument for children and adolescents 8-16 years of age which assesses the frequency of thoughts, feelings, and behaviors related to traumatic events they have experienced. To understand better the trauma symptomology of children and adolescents, the author analyzed an existing data set of TSCC protocols from children who received treatment for sexual abuse from a children's advocacy center in a metropolitan area near a large city in the southeastern United States. Although a large number of potential participants were lost to follow up ($N = 54$), T^2 analyses revealed significant differences between the groups only on the length of time in therapy. A repeated measures analysis of variance was performed on data from children and adolescents who completed therapy

($N = 31$) to test whether differences on Depression and Posttraumatic Stress scale scores would exist across the course of therapy. Although no statistically significant findings emerged, implications for clinical practice and research became apparent. Specifically, differences in cutoff *T*-scores on TSCC scales may be more useful to clinicians for treatment and termination planning purposes than statistically significant differences. In addition, assessing clients at intervals measured by session number, rather than by length of time, may provide more generalizable results for within- and between-participants clinical and research comparisons. These implications may aid clinical and school counselors and researchers to recognize and serve the specific needs of sexually abused children in their respective settings.

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I dedicate this work to my grandmother, Ione Yvonne Stone, whose thirst for knowledge inspired me and also taught me that learning is truly a life-long journey. I love you and miss you very much.

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ABBREVIATIONS

ANG	Anger (scale on TSCC)
ANX	Anxiety (scale on TSCC)
ASCA	American School Counselor Association
CAC	Child Advocacy Center
CBCL	Child Behavior Check List
CPS	Child Protective Services
CRTIR	Child Report of Treatment Resolution
CSBI	Child Sexual Behavior Inventory
CSDQ	Child's Social Desirability Questionnaire
DEP	Depression (scale on TSCC)
DIS	Dissociation (scale on TSCC)
HYP	Hyperresponse (scale on TSCC)
PTS	Posttraumatic Stress (scale on TSCC)
PTSD	Posttraumatic Stress Disorder
RCMAS	Revised Children's Manifest Anxiety Scale
SC	Sexual Concerns (scale on TSCC)
TSCC	Trauma Symptom Checklist for Children
UND	Underresponse (scale on TSCC)

CHAPTER 1

TRAUMATIC SYMPTOMS IN SEXUALLY ABUSED CHILDREN: IMPLICATIONS FOR SCHOOL COUNSELORS

Traumatic events give rise to various symptoms and consequences that differ among affected children (Downs, 1993; Saywitz, Mannarino, Berliner, & Cohen, 2000; Webster, 2001). Children who experience the trauma of sexual abuse are no exception, as they exhibit a highly heterogeneous symptomology (Valle & Silovsky, 2002). Trauma produces profound and prolonged changes in physiological arousal, emotion, cognition, and memory that "may sever these normally integrated functions from one another" (Herman, 1997, p. 34). Research has shown that traumatic symptoms that arise from sexual abuse may be exacerbated by the number of perpetrators, duration, frequency, and severity of abuse, age of victim and of perpetrator at onset, and victim's feelings of responsibility, powerlessness, betrayal, or stigma at the time of the abuse (Briere, 1992a). By better understanding the outcomes of trauma and how symptoms manifest in sexually abused children, school counselors will be better prepared to recognize and identify cognitive, affective, and behavioral patterns of sexually abused children. In so doing, school counselors will be able to adjust their comprehensive guidance and counseling programs to include more appropriate intervention, aftercare, and advocacy strategies on behalf of this vulnerable population of children and adolescents. The purpose of this paper is to first describe how school counselors are charged with helping sexually abused children through prevention and identification of sexual abuse. Additionally, I describe

how to recognize the indicators of sexual abuse based on a child's symptomology and/or behavior and how trauma may affect children in the school setting. Mandated reporting issues and how to talk with children and adolescents about sexual abuse suspicions are also discussed. The Trauma Symptom Checklist for Children (TSCC), as "probably the most frequently used of all standardized trauma measures in the United States and Canada" (Wolpaw, Ford, Newman, Davis, & Briere, 2005, p. 159), is discussed as one of the best means of identifying and measuring children's trauma symptomology (Crouch, Smith, Ezell, & Saunders, 1999; Viswesvaran, 2003). It is important for school counselors to understand what the TSCC measures, as these symptoms contribute to the difficulties that sexually abused children have in school. Finally, I describe how the TSCC can be a helpful tool to clinicians treating children who have been sexually abused through the course of therapy and how school counselors can collaborate in this process.

The School Counselor's Role in Preventing Child Sexual Abuse

The American School Counselor Association (ASCA, 2003) published a position statement regarding the school counselor's role in child abuse and neglect prevention. This position statement clearly reflects ASCA's assertion that school counselors are legally, ethically, and morally responsible for reporting suspected cases of child abuse to the proper authorities. Furthermore, ASCA suggests that counselors should demonstrate understanding of child abuse problems, recognize and detect indicators of abuse, and provide strategies for preventing and combating the cycle of child abuse.

Programs aimed at preventing child abuse may target different levels of prevention (i.e., primary, secondary, or tertiary) and different populations of people in positions to help sexually abused children (e.g., school personnel, students,

parents/guardians, and community members). Primary prevention efforts are those aimed at a broader audience that address underlying societal causes of maltreatment (Geeraert, Van den Noortgate, Grietens, & Onghena, 2004). They may include advocating for a ban on corporal punishment in schools (ASCA, 2003; Geeraert et al.) or addressing social disparities, such as poverty. Secondary prevention efforts are those aimed at specific groups at risk for maltreatment, such as students, that attempt to decrease the risk factors (Geeraert et al.). They may include providing classroom guidance lessons to all students about personal safety and sexual abuse prevention (Hollander, 1992; Schmidt, 2004), psychoeducational presentations to parents explaining how to talk in developmentally appropriate ways to children about protecting their bodies or how to recognize the signs of potential perpetrators in the community (Finkelhor, Asdigian, & Dziuba-Leatherman, 1995; Stop It Now! Georgia, n.d.), or coordinating efforts for other professionals to educate children about sexual abuse prevention (e.g., Hayward & Pehrsson, 2000; Sloan & Porter, 1984). Tertiary prevention efforts are those aimed at specific groups for whom maltreatment has already occurred (Geeraert et al.). These may include providing training to school personnel that focuses on recognition of abuse indicators and reporting procedures, referring suspected abuse cases to the proper child protection authorities, and collaborating with outside child protection and other treatment agencies to coordinate successful intervention and aftercare for the child and support for the family in the school setting (ASCA, 2003; Hollander; Schmidt; Webster, 2001). Because these tertiary prevention efforts are dependent on recognizing indicators of sexual abuse, it is pertinent to discuss what these indicators are in observable terms (i.e., physical and behavioral signs of abuse) so that school counselors can help other school personnel recognize these

indicators and so school counselors may best proceed in gathering information that will be helpful in making a report to the proper authorities.

Recognizing Abuse Indicators

The American School Counselor Association (2003) states that, "Professional school counselors are instrumental in early detection of abuse" (p. 1). The professional practice standard for school counselors is that counselors provide "strategies to help break the cycle of child abuse" and to "report suspected cases of child abuse/neglect to the proper authorities" (ASCA, p. 1). During 2004, an estimated 477,755 children were found to be victims of maltreatment, with 9.7 % of those (or approximately 46, 343 children) being sexually abused (U.S. Department of Health and Human Services [USDHHS], 2006). As mandated reporters of child abuse in all 50 states, school counselors and other educators are responsible for reporting suspicions of child abuse or neglect to the appropriate local authorities. Of all professionally reported cases of child abuse in the United States in 2004, educators filed the highest average number of mandated reports (16.5%), though law enforcement professionals filed the highest average number of sexual abuse reports (26.5%; USDHHS).

Although it is beyond the scope of the school counselor to conduct a formal interview about the abuse or clinically treat substantiated cases of abuse, as these activities require specialized skills and training (Cole, 1995), school counselors can be helpful in gathering pertinent information that aids in child protection or therapy services being rendered. Briere and Scott (2006) note that much data may be gathered when speaking informally or in an unstructured context with a client; this is especially true between school counselors and students. School counselors have the opportunities to

observe students' interactions with teachers, peers, and others, as well as when students meet with them individually, in groups, or during classroom guidance sessions. Different signs of abuse may be evident and noted during these interactions. It is particularly important to attend to any signs or suspicions of abuse early on, as untreated abuse-related distress and abuse-specific coping mechanisms generalize and exacerbate over time (Briere, 1992a) and may manifest in different school-related troubles.

Although signs of physical abuse are often easier to see than signs of sexual or emotional abuse or neglect, there are different physical and behavioral indicators that should raise suspicion of an at-risk situation and possibly of sexual abuse, when noticed. Physical indicators of sexual abuse may include but not be limited to difficulty walking or sitting; torn, stained, or bloody underclothing; pain, swelling, or itching in the genital area; frequent urinary or yeast infections; bruises, bleeding, or lacerations in the external genitalia area; or presence of a sexually transmitted disease (Cobb County Department of Family and Children's Services: Child Protective Services [Cobb County CPS], 2005).

Behavioral indicators of abuse may include but not be limited to inappropriate sex play or advanced sexual knowledge or promiscuity; lack of emotional control; sudden school difficulties; withdrawal or depression; excessive worry about siblings; difficult peer relationships or resisting involvement with peers; self-imposed social isolation; avoidance of physical contact or closeness; or sudden massive weight change (loss or gain; Cobb County CPS). Sexualized behavior in the form of age-inappropriate sexual knowledge, excessive masturbation, seductive behaviors, and sexualized play behaviors is often considered the hallmark symptom of sexual abuse and is most often studied in comparisons between sexually abused children and their nonabused peers (Friedrich,

1993; Kendall-Tackett, Williams, & Finkelhor, 1993). Homeyer (2001) states that children use their behavior to communicate, and it is the responsibility of the adults around them to try to understand what they are trying to say. For children, play is their language and toys are their words (Landreth, 2001, 2002). Therefore, child's play behaviors also may raise suspicions of sexual abuse that warrant further follow up by the school counselor.

Play Behaviors as Indicators of Abuse

Children and adults, alike, often reenact the traumas they have experienced in an attempt, most theorists believe, to heal from the experiences (Herman, 1997). Terr (as cited in Herman) found that children's play often revealed evidence of traumatic memory, as children are often not able to verbalize the nature of their traumas. Ater (2001) categorizes sexually abused children's play during play therapy sessions in several different ways, such as abreactive, aggressive, dissociative, nurturing, perseveration, regressive, and sexualized. I discuss each of these in turn, describing the behaviors and how they may be indicative of abuse history.

Abreactive play behaviors are reenactments of the trauma repeated again and again, and they may literally represent the abuse that occurred (Ater, 2001). Sexually abused children and adults often feel a need to recreate their traumas (Ater; Herman, 1997) in order to integrate the experiences into their life stories (Findling, Bratton, & Henson, 2006; Herman). Some children and adolescents may draw pictures of the abusive acts that happened, tell stories about it, or use dolls, puppets, or other types of stuffed animals to show the things that happened to them. These reenactments may be more literal, in showing exactly what the child reported, or they may be more figurative in

nature, where monsters are drawn or aggressive puppets, such as alligators, are used in order to recreate abusive acts.

Aggressive play may be related to the sexual abuse experiences or may reflect the child's overidentification with his or her abuser (Ater, 2001). Some children may hit a Bobo doll, punch or kick a punching bag, or use other toys, such as plastic guns, knives, handcuffs, or belts, to act out aggressively on dolls or puppets. In addition, these children or adolescents may yell, express anger, or make threats while in the playroom or outside of it to imitate their abuser's actions.

Playing without being connected to the play theme, becoming quiet, and appearing to stare into space are examples of dissociative play (Ater). Dissociation is a common trauma related symptom (Herman, 1997). One 10-year-old boy often scooped sand with his hand or with a shovel, held a funnel over the sandtray, and poured the dry sand into a small pile during the nondirective play therapy portion of his sessions. Although the play therapist tracked his play, he remained quiet and stared at the sand. Water is another material often used in dissociative play (Ater).

Sexually abused children will often use nurturing play to express the lack of nurturing they have experienced and their need to be nurtured (Ater, 2001). Children may take care of dolls or cook food and feed the therapist or dolls (Ater). In addition, other nurturing actions may involve using a medical kit and placing bandages on dolls, the therapist, or himself or herself, listening to his or her heart or to the therapist's, or giving immunizations with a play syringe. Older children may give compliments or attend to their appearance, hair, or makeup, or that of others.

Ater (2001) describes perseverance play as “a constant, monotonous, ritualized, reenactment of the trauma” (p. 122) that “differs from abreactive play in that the children are not able to ‘change’ the ending to create hope for themselves” (p. 122). This reenactment, again, may be literal or figurative, and it may be repeated across several sessions. Some children may consistently use the same puppets to fight with one another or recreate the same battle scenes within a sand tray. What differentiates perseverance play, however, is that the ending is usually the same and is desperate. For example, one 9-year-old boy always set up different army men in the sand tray to do battle with a small group of monsters. In the same manner each time, each line of the regiment was killed by a monster-type figure and eaten by one bigger monster. This child had not only been orally and anally sodomized by an adult male but also by other boys his age at the direction of this abuser. His play theme in the sand was not a literal representation of his abuse, but the ending was repetitive and never changed for the better.

Within regressive play, sexually abused children will often use regressive behaviors to escape from thoughts of abusive experiences (Ater, 2001). Some of these other behaviors may include thumbsucking, using a pacifier, or using baby talk or a high pitched or baby-like voice. The use of a pacifier has also been noted in older, middle and high school aged, children. Other children may hide under tables or in other play structures, such as a tent, tube, or tunnel, to avoid or escape addressing abusive experiences.

Ater (2001) describes three different kinds of sexualized play that sexually abused children use (a) to reenact their abuse (abuse-reactive play) where the child may display oversexualized behaviors indicative of the way he or she was abused, (b) to express their

own emotional reactions to the abuse (reenactment play), and (c) to gain understanding and acceptance of the fact that they were abused (symbolic play). Findling et al. (2006) also found that a particular cluster of play behaviors, when taken together, was successful in discriminating traumatized from nontraumatized children. These factors included intense play, play disruptions, repetitive play, avoidant play behavior, and negative affect. These authors stated that these play behaviors, all together, may denote posttraumatic responses in children. Although descriptions of the play behaviors of sexually abused children have been described above, Homeyer (2001) cautions that sexually abused children's behavior may differ in and outside of the playroom. There are also other problems that known sexual abuse survivors have in school that school counselors may be helpful in addressing through intervention and advocacy efforts.

Problems Sexual Abuse Survivors Have in School

Soloman and Heide (2005) assert that the publication of both human and animal studies has shown that the brains of victims of traumatic stress differ from those of subjects who had not experienced trauma. These authors also state that changes in brain structure and physiology related to traumatic experiences are "thought to affect memory, learning, ability to regulate affect, social development, and even moral development" (p. 53). Given that sexually abused children may exhibit any number of symptoms or problems related to sexual abuse sequelae which can clearly affect learning potential and classroom performance, it is important for the school counselor to use his or her position as a mental health professional and child advocate to help children achieve to the best of their academic, personal, and social abilities in school.

In school, these symptoms may manifest as inability to concentrate, complete work on time, or understand school work; feeling scared, frustrated, stupid, or bad about themselves; achieving low grades; and/or being told they are lazy or slow (Lee, 1995). Lee notes that sexual abuse survivors also cope in negative ways that create problems for them in school, such as lying, making up excuses, placing blame on other people or situations for not completing school work or paying attention, acting apathetic about or refusing to do homework, and getting angry at the teacher. Inability or failure to attend to the academic milieu could result in issues of promotion, retention, and drop out. In a prospective cohort study, Widom (2000) found that the group of children who were abused and neglected by the age of 11 or younger completed significantly fewer years of school and were less likely to have completed high school (fewer than half) than those in the control group (two-thirds).

In addition, children who have been sexually abused may also be at risk for other types of victimization, such as physical abuse at home or bullying at school (Finkelhor, Ormrod, Turner, & Hamby, 2005). Finkelhor and colleagues explain that victim vulnerability may be better understood if one considers that some children experience multiple victimizations of differing types of violence and others do not. In a nationwide study, these researchers found that the average juvenile victim experienced three different types of victimization in separate incidents across the course of a year. Children in their study who had experienced a sexual assault of any kind were also highly likely (97%) to have been victimized in other ways, such as physical assault, witnessing the assault of another, child maltreatment, and property victimization. They suggest that counselors

inquire about the possibility of other victimizations once a child has been identified as having experienced one form of victimization.

By extension, for children who are repeatedly referred to the school counselor's office for victimizations committed against them, it may behoove the counselor to inquire about other forms of victimization, including those of a sexual nature, in order to identify more clearly and help victims of child sexual abuse. Once suspicions of abuse, sexual and other types, are raised, school counselors are mandated to report their concerns to the proper child protection authorities. School counselors may also be helpful in educating other school personnel about their mandated reporting responsibilities.

Mandated Reporting

Once the trauma symptomology is recognized, then the exacting and stressful tasks of mandated reporting are set into motion. At the local level, school counselors can train other educational personnel to understand the definitions of child abuse and maltreatment and to recognize the signs exhibited by abused children and those behaviors and indicators, specifically, of sexually abused children. Kesner and Robinson (2002) reported that this was paramount to increasing mandated reporting from educational personnel. They found that educational personnel underreported child maltreatment and also had the lowest substantiation rate of all categories of mandated reporters, though only significantly less than legal personnel. Schmidt (2004) proclaims that one difficulty for school personnel related to reporting is in defining and understanding what "suspicion" of abuse means. Of course, as school personnel become more cognizant of the Trauma Symptom Checklist for Children (discussed below), such school professionals should more easily recognize and understand childhood abuse.

All school counselors should follow protocol and procedures outlined by their school district and local school administration regarding rendering the mandated report to the appropriate child protection authorities, as state laws require educators to notify Child Protective Services (CPS) agencies of suspected maltreatment (USDHHS, 2006), and failure to do so may result in penalties (Remley & Fry, 1993). Hollander (1992) suggests that the school counselor take a leadership role in establishing local school reporting procedures. In many school districts, school counselors are responsible for taking reports from teachers, other school personnel, parents, and others concerning their suspicions of abuse, talking with the child(ren), utilizing professional discretion to decide whether a report is warranted (Foremen & Bernet, 2000; Remley & Fry) and then making official referrals of suspected abuse to the appropriate authorities.

Some authors state that mandated reporters should welcome reports of suspected abuse from others because usually professionals are first alerted to such concerns from a third party (Foremen & Bernet, 2000; James & Burch, 1999). It is helpful to reporting agencies and for liability purposes for the school counselor to talk with the child and his or her siblings, if possible, to obtain more information prior to rendering a report. Additionally, Foremen and Bernet assert that liability and retribution protection statutes are generally only applicable after performing some kind of initial inquiry into the suspicions of abuse. These authors cited a case in New York (e.g., *Vacchio v. St. Paul's United Methodist Nursery School,* 1995) where a teacher reported suspicions of abuse to child protective services without performing any initial inquiries into her suspicions. The judge cited the teacher's actions as grossly negligent and afforded her no protection under the mandated reporter statutes when the parents sued for unfounded and false allegations.

There is a delicate balance to strike, however, with gathering information to make a professional judgment and conducting a formal child sexual abuse interview. The latter should be left in the hands of the trained child protection authorities. Though the task of talking to children or adolescents about suspicions of the occurrence of sexual abuse can be daunting, there are some helpful things that counselors can ask and say to children when they suspect that sexual abuse has occurred.

Talking with Children and Adolescents about Sexual Abuse Suspicions

Approaching a child or an adolescent to talk about the possibility that he or she may have been abused is a delicate matter. Sexual abuse is often intrusive and violent and initiated when a child is less than 8 or 9 years old by an adult in the mid-20s, usually a man (Briere, 1992a). It should also be noted that children who are sexually abused also are likely to experience psychological or emotional abuse in the forms of betrayal or threats and physical abuse in the forms of bodily harm or physical beatings to establish or maintain compliance (Briere). Perpetrators often induce feelings of shame, guilt, and worthlessness through blame or stigmatization (Briere; Finkelhor & Browne, 1985). For these reasons, children who have been abused are less likely to trust others, especially adults, who are supposed to protect them but from whom they have received abuse (Lee, 1995). Initiating a conversation with a child who may have experienced such abuses may incite fears within the child or adolescent of further victimization from their perpetrator or feelings of shame or embarrassment in being asked for details regarding sexual abuse.

Researchers have found that children are more likely to give accurate statements when interviewed in a warm and supportive manner (Wood & Garven, 2000). A trusted teacher or school counselor may be the first person to whom a child feels comfortable

disclosing sexual abuse. Bradley and Wood (1996) found this to be the case in 13% of the 234 disclosures of child sexual abuse they examined. Victims have displayed a reluctance to discuss the subject of abuse or any specific details they may have experienced between 24-78% of the time (e.g., Bradley & Wood; Sorenson & Snow, 1991). Summit (1983) offered the insights that children may be afraid, confused about the nature of the abuse, itself, or about the potential outcome of disclosing.

It is important to note that because sexually abused children have a difficult time trusting others, they may feel ashamed or embarrassed, or they may fear retribution from perpetrators who may have threatened them not to tell about the abuse; therefore, they may not directly disclose that they were sexually abused. A child may make an indirect or disguised disclosure, or he or she may make a disclosure "with strings attached" (Cobb County CPS, 2005). Such disclosures are vague or indirect, so using open-ended and non-leading follow-up questions and words appropriate to the child's developmental level may help to clarify what the child is trying to communicate without influencing or contaminating the statement, itself (James & Burch, 1999; Wood & Garven, 2000). Foreman and Bernet (2000) are in concordance with this idea, as they state that mandated reporters who suspect "that abuse has occurred should perform assessments that are compatible with their professional roles" (p.191).

Making the child feel comfortable, listening carefully, not interrupting what the child has to say, and building rapport are also commonly recommended interviewing skills (Wood & Garven, 2000) that counselors already regularly use. In fact, good rapport building skills may make the difference between a child's disclosing and not disclosing (Wood & Garven), as "acceptance and validation are crucial to the psychological survival

of the victim" (Summit, 1983, p. 53). DeVoe and Faller (1999) found that boys were less likely to disclose acts of sexual abuse than girls, but once they did disclose, they provided as many details as girls. In light of these findings, the authors suggest that boys may require a longer "warm-up period" (p. 225) before they feel comfortable disclosing and talking about sexual abuse.

In their *Mandated Reporter's Handbook*, Cobb County CPS (2005) offers several good examples of indirect disclosures and how good rapport building and listening skills may be used to obtain further clarification about possible instances of abuse. An indirect disclosure may sound like, "My brother kept me up all night and wouldn't let me sleep." To which a counselor can reply, "I'm sorry to hear that. What was he doing to keep you up?" A disguised disclosure may be used to indicate that a child knows of someone who is being maltreated. Although this may truly be the case, it is highly appropriate to ask if the child, himself or herself, is also being treated in that way. For example, the child may say, "I know someone who is being touched in a bad way." To which the counselor may reply, "That person is lucky to know someone strong and smart like you. I wonder if you can use your 'safe and unsafe touch' skills to tell me how they are being touched in a bad way?" And further follow up with, "You know a lot about safe and unsafe touches. Has anyone ever touched you in an unsafe way?"

A disclosure "with strings attached" will often sound like, "I have a problem, and I'll tell you about it if you promise not to tell anyone else." It is recommended that the counselor empathize with the student and also remind him or her of the limits of confidentiality in a way that reassures the student that he or she will be protected and kept safe. This may sound like, "I'm glad that you let me know that you have a problem. That

means a lot to me. Even though I cannot promise that I will keep your secret, I can promise that I will only tell people who will treat it with respect and keep you safe. So, what is your secret?" (pp. 11-12).

When a child does disclose that he or she has been sexually abused, it is important to note his or her exact words (Webster, 2001), including any slang words that he or she may use to describe body parts, actions, or other contextual details in order to preserve valuable forensic evidence that may be used to retain and later prosecute the alleged abuser. DeVoe and Faller (1999) note that their study is consistent with others in that younger children may be willing and able to tell an interviewer that sexual abuse occurred. However, they note that children may not be able, developmentally, to give many details or elaborate descriptions of the context surrounding the abusive acts or be willing to disclose details if threats or embarrassment were involved in the abuse. The findings of these authors support the notion that sexual abuse disclosure is a process that unfolds over time, rather than a discrete event.

Although both forms of disclosure have been supported in the literature, it is most important for school counselors to let other trained professionals delve more deeply into the disclosure process. If a child begins to disclose alleged occurrences of sexual abuse, the school counselor should note the details disclosed, ask open-ended questions to gather relevant contextual information, and then report the child's exact words to the appropriate child protection authorities. Webster (2001) cautions against attempting to glean specific details of the abuse or challenging the accuracy of the allegations. He also cautions that whether one is involved "either voluntarily or inadvertently, they must know exactly

what they are doing or they may jeopardize the child's present and future safety" (p. 543) because of interviewing errors or legal missteps.

Summit (1983) states that mental health professionals are instrumental to a child "in the crisis of the disclosure" (p. 53) in believing the child's statement and in gathering information that supports the child's statement as credible. After listening to the child and gathering relevant information, there are several important things to say and do to reassure the child or adolescent that he or she made a good choice and will be believed and protected. These include communicating that you believe what the child has said, thanking him or her for sharing such personal information with you, stating that sexual abuse is never his or her fault and that he or she made a good decision in telling, and reassuring him or her that measures will be taken to ensure his or her safety.

Accurately recording notes after the session that includes the child's nonverbal cues, affect, and verbal statements may provide additional protections for the child should these notes be subpoenaed at a later date (James & Burch, 1999; Webster, 2001). After concluding the session and recording notes, the school counselor should not continue to probe for more information but should allow the trained child protection authorities to do so in order to preserve the integrity of the disclosure(s) and collect other relevant information/evidence that will aid in the protection of the child and in the prosecution of the alleged offender. Those authorities are responsible for determining whether or not the reported suspicions of abuse are substantiated (Schmidt, 2004).

For children for whom sexual abuse is substantiated by those police or other child protection authorities, further intervention is usually recommended. On the clinical treatment side, part of this intervention is better understanding which specific symptoms

a child has so that treatment may be properly planned and implemented. A valid and reliable instrument that may be used to measure trauma symptoms for sexually abused children ages 8 to 16 is the Trauma Symptom Checklist for Children (TSCC). It is helpful for school counselors to better understand the symptoms measured by the TSCC so that they can collaborate with other mental health professionals and further advocate for sexually abused children within their school.

Measuring Trauma Symptomology

When discussing trauma symptoms, perhaps the best place to start is with the Trauma Symptom Checklist for Children, as it is a measure specific to the sequelae of trauma and sexual abuse. It is important to note that sexual abuse, in and of itself, is an experience, not a diagnosis. However the experience of being sexually abused may lead to some diagnosable disorders (Babiker & Herbert, 1998; Finkelhor & Berliner, 1995). Because sexual abuse is not a diagnosis, there are a wide variety of symptoms reported by victims (Valle & Silovsky, 2002). Many studies have examined the outcomes of abuse using targeted instruments to measure specific symptoms, such as anxiety, depression, or posttraumatic stress (Fricker & Smith, 2001). These types of instruments and others that were widely used to measure a broader spectrum of clinical symptoms or behaviors in children and adolescents have been found to be less sensitive to the sequelae of sexual abuse (Elliot & Briere as cited in Briere, 1992b).

The Trauma Symptom Checklist for Children operationally defines several important dimensions of how children 8-16 years of age experience the trauma sequelae of sexual abuse. On this 54-item, self-report measure, children indicate what thoughts, feelings, and behaviors about traumatic events and symptoms they have experienced on a

4-point Likert-type scale. Children specify how often those thoughts, feelings, or behaviors occur, ranging from *never* to *all of the time*. The instrument is written on a fourth grade level, according to the Flesch-Kincaid method (Wolpaw et al., 2005) in order to be understood by children ages 8 and older (Lanktree & Briere, 1995), and it takes about 15-20 minutes for the average child to complete and about 5-10 minutes to score either by hand or by computer (Briere, 1996).

The measure includes six clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns), four subscales (Sexual Preoccupation, Sexual Distress, Dissociation Fantasy, and Overt Dissociation), and two validity scales (Underresponse and Hyperresponse). Eight critical items, which tap suicidality, self-injury, desire to harm others, concern about sexual abuse, fear of men or women, fear of death, and involvement in fights, serve to alert responsible adults, such as parents, teachers, school counselors, or clinicians, to potential problems that warrant further assessment (Boyle, 2003; Wolpaw et al., 2005). When used, the TSCC helps clinicians understand and assess an individual child's symptom profile from the child's perspective, plan for treatment, and gauge the child's progress (relative to symptom reduction) throughout the therapy process.

Although the nature of some of the items on the instrument is sensitive, especially those referencing sexual abuse sequelae, Baggerly and Rank (2005) state that school counselors may elect to use instruments such as the (TSCC) to assess students that may be at risk for trauma exposure. Briere (1996) stated that subjects in the normative sample who were tested in schools were administered the TSCC-Alternate version without the sexual abuse items to allay concerns, though he recommends use of the full TSCC where

such use is not precluded. Prior permissions and approvals from administrators and parents/guardians may be necessary before doing so. Whether or not the school counselor uses the TSCC, understanding how the instrument operationalizes trauma symptoms is helpful for the school counselor and may promote more seamless coordination efforts between him or her and the outside therapist when used in the clinical setting.

The six clinical scales of the TSCC measure the extent to which respondents affirm the presence of different trauma related symptoms, including Anxiety (ANX), Depression (DEP), anger (ANG), Posttraumatic Stress (PTS), Dissociation (DIS), and Sexual Concerns (SC; Briere, 1996). Briere notes that the scales are not independent and relationships among scores on the scales should be noted when interpreting the results. The following descriptions for each scale provide an explanation of what the scale measures as well as some specific examples of how these symptoms may manifest in children or adolescents in the school setting.

Anxiety. According to Briere (1996), "scores on the Anxiety scale reflect the extent to which the child is experiencing generalized anxiety, hyperarousal, and worry as well as specific fears of men, women, of the dark, and of being killed" (p. 12). He also notes that free-floating anxiety and fears of impending danger are also tapped by this scale. High scores on the ANX scale may reflect generalized anxiety, trauma-specific hyperarousal, or both (Briere). Hyperarousal is a high state of alertness. Many children who have been abused adapt to the dangerous climate of their surroundings by remaining in high states of alertness and becoming highly attuned to others' nonverbal communication in order to recognize potential warning signs of attack (Herman, 1997). This often occurs unconsciously, and abused children learn to respond automatically, that

is, without knowing what initially triggered their response (Herman). Hyperarousal may also be characterized by an inherent inability to "tune out" repetitive stimuli that other people would find merely annoying; traumatized individuals "respond to each repetition as though it were a new, and dangerous surprise" (Shalev, Orr, & Perry as cited in Herman, p. 36).

Depression. The Depression scale taps "feelings of sadness, unhappiness, and loneliness; episodes of tearfulness; and depressive cognitions such as guilt and self-denigration" (Briere, 1996, p. 12). Briere notes that high scores on the DEP scale may reflect a depressive episode, a grief or depressive reaction, or a more long-term dysthymic (low grade depression) process. In addition, two items address self-injurious and suicidal ideations. Respondents who indicate these ideations should be further evaluated.

Anger. The Anger scale reflects "the extent of angry thoughts, feelings, and behaviors reported by the child" (Briere, 1996, p. 12). Specific items indicate feelings of meanness or hatred, wanting to yell at or hurt others, arguing and fighting, and having difficulty reducing angry feelings (Briere). Wanting to hurt others is a critical item on this scale that should be followed up when the rating is high. High scores on the ANG scale may indicate that a child appears irritable, hostile, or aggressive. Briere explains that in school this may manifest as fighting with others, throwing tantrums, "talking back," and difficulty in making or sustaining friendships because of angry outbursts or aggressive behaviors towards peers. Briere also notes that some children may score high on this scale and not be known for angry outbursts or aggressive tendencies, but they may feel angry and resentful nonetheless.

Posttraumatic Stress. Classic posttraumatic symptoms are measured on the Posttraumatic Stress scale, such as "intrusive thoughts, sensations, and memories of painful past events; nightmares, fears of men or women; and cognitive avoidance of negative thoughts and memories" (Briere, 1996, p. 13). Children with high scores on the PTS scale may appear distracted, irritable, and unable to function. They may repeat stories or play behaviors related to their trauma over and over again in attempts to process and integrate the experiences (Findling et al., 2006). Because posttraumatic symptoms can be frightening to experience, children may feel that they are out of control or "going crazy" (Briere; Herman, 1997).

Dissociation. The Dissociation scale measures "the extent to which the child experiences mild-to-moderate dissociative symptomology" and includes items that tap "derealization, one's mind going blank, emotional numbing, pretending to be someone else or somewhere else, daydreaming, memory problems, and dissociative avoidance" (Briere, 1996, p. 13). There are two subscales within this measure, Overt Dissociation (DIS-O) and Fantasy (DIS-F). Children with overtly dissociative behaviors may appear "spacey" and detached from their environments. In addition, they may actively try to avoid negative emotions (Briere). Children with high scores on the DIS-F subscale "may be seen by others as overinvolved in fantasy to the exclusion of the 'real' world and its demands" (Briere, p. 13). Daydreaming is included as a component on this subscale. Authors are careful to note, however, that dissociation is often a coping mechanism by which traumatized individuals escape from painful experiences (Ater, 2001; Briere, 1992a).

Sexual Concerns. The Sexual Concerns scale is comprised of two subscales, each of which measures different dimensions of sexual concerns: Sexual Distress (SC-D) and Sexual Preoccupation (SC-P). High scores on the SC scale may indicate sexual abuse or traumatization, sexual assault by a peer, or witnessing sexual acts or pornography (Briere, 1996). Scores on the SC-P subscale indicate an age-inappropriate sexual preoccupation that may manifest in "precocious or compulsive sexual behavior, sometimes in inappropriate social contexts" (Briere, p. 14). Briere is cautious to note that elevated scores on the SC-P subscale may reflect cultural norms that espouse earlier sexual awareness and behavior than what might be expected and should be considered in light of this contextual factor. Higher scores on the SC-D scale, however, indicate that a respondent feels distress or conflict around sexual matters or experiences (Briere). Briere also states that the SC-D subscale correlated more closely with the Anxiety scale than the SC-P subscale.

Using the scores. Scores on each scale of the Trauma Symptom Checklist for Children help the clinician to plan treatment to address an individual child's needs. In addition and under proper releases of information, this clinician can apprise the school counselor of the kinds of symptoms the child has reported. Thus, with knowledge of the symptoms and how these may manifest in specific school behaviors or problems, the school counselor can better collaborate in treatment efforts that are aligned with his or her role as a school counselor, such as coordination, follow-up care, and advocacy.

Trauma Treatment and Collaboration

With adequate recognition of the abuse and measurement of the symptoms, treatment can begin on a solid foundation. Understanding methods of trauma treatment

for sexually abused children enables the school counselor to provide better follow-up care and advocacy for the best interests of the child in the school setting. Schmidt (2004) suggests that the school counselor coordinate professional activities with outside agencies to ensure that primary care is provided to the child and family and to prevent "contradictory or confusing relationships from developing that would thwart the child's progress" (p. 175). Different approaches to trauma treatment and resolution exist, and it would be helpful for the school counselor to talk with the outside therapist, after obtaining all requisite releases of information, in order to understand how he or she may best support the child's treatment.

In general, there are three phases of trauma treatment that define the "inherently turbulent and complex" process of recovery from a traumatic event or series of events (Herman, 1997, p. 155). These can be described as (a) establishing safety, which includes rapport building and installing coping strategies within the client, (b) remembering and mourning, which includes the client retelling the story, naming the horrors of the trauma, making meaning of the trauma, and mourning the losses that the trauma captured, and (c) reconnecting with others, which includes developing new relationships and creating a new future for oneself (Herman). However, progression through trauma recovery is neither a straightforward nor a linear process (Herman), and some clients may never complete the entire process. Within these different stages of recovery, child and adolescent clients will have different support needs within the school setting. The aim of this section is not to describe how to provide trauma therapy, which is beyond the scope of the school counselor's role (Remley & Fry, 1993), but to suggest, within the context of

what generally occurs in trauma focused therapy, how the school counselor may best support the interventions of the therapist while the child is in the school setting.

Stage 1: Establishing safety. Within the first stage of establishing safety, the child will need to know that he or she will be physically protected from seeing or interacting with the perpetrator of the abuse. In the school setting, this may mean that the child will live with a foster family and transfer to another school for a certain period of time or, at the very least, that school information and emergency records be updated to prevent perpetrator contact with the child at school. The school counselor can talk discretely with other school staff to ensure that records are updated. In addition, in the case of the child transferring to another school, the school counselor may be able to give contact information for the next school counselor to the child's outside therapist so that releases of information may be obtained and the next school counselor can coordinate school based efforts for the child.

Also within this stage, the child will be developing a healing relationship with his or her therapist. It is important that the child experiences as much empowerment and autonomy as is safely possible (Herman, 1997). In cases of chronic abuse, children do not develop a sense of autonomy because their abuser repeatedly shatters any representations of trustworthy and dependable caretakers that people generally rely upon for coping in moments of distress (Herman). Because these children are unable to develop inner notions of security and safety, they often grow dependent on others and seek comfort and solace from external sources (Herman), which may explain why some children engage in clingy behaviors with adults whom they do trust, such as teachers, school counselors, and nonabusive caregivers. A counselor may advocate for the use of choices and reasonable,

related, realistic, and respectful consequences within the classroom (Albert, 2003) to support autonomous decision making, limit setting, and appropriate boundary formation within the school environment.

Herman (1997) states that survivors in this stage of therapy feel unsafe and out of control. In children and adolescents, these feelings may manifest through anxiety (Cohen & Mannarino, 2000), worry, or fright. For example, the child may talk excessively or ask many questions, express fears that bad things will happen, or freeze up in social or academic situations. For this reason, the greater the amount of predictability in the environment at home (Cohen & Mannarino) and at school, the easier it will be for the child to establish a sense of safety, order, and control. From this point in therapy, coping resources, such as recognizing and managing problematic feelings, thoughts, and behaviors (Soloman & Heide, 2005), are taught and practiced in order to prepare the child for trauma work. School counselors can help children build coping skills through classroom guidance lessons that teach problem solving strategies (e.g., Shure, 2001), relaxation techniques, affect education, and self-esteem. Herman cautions that although acute crisis symptoms may dissipate somewhat quickly, the trauma survivor is not completely recovered until he or she processes and integrates the traumatic events, which takes much more time in the later stages of recovery.

Stage 2: Remembering and mourning. During the second stage of remembering and mourning, the child will remember and recount his or her sexual abuse experiences to the therapist and mourn the losses ensued as a result of the trauma, which may include the integrity of the child's body and the intactness of the child's social network and/or family. Some refer to this stage as the "abyss," (Brack, Brack, & Carlson, 1997; Brack,

Carlson, McMichen, & Dean, 2005), as it is a deep and dark place in which the client must delve in order to resolve the traumatic experiences. The most intense part of the trauma recovery process occurs in this stage. Many sexual abuse survivors have the hardest time beginning their descent into the trauma work because of this intensity, and Oz (2005) states that clients spend most of their time and energy in therapy before a "wall of fear" (p. 36). Some examples of such behaviors may include freezing up, not being able to complete things that he or she once could, and avoiding or actively resisting doing things or accepting help.

Herman (1997) notes that the client "will not be able to function at the highest level of her ability, or even at her usual level, during this time" (p. 176). The school counselor can actively advocate for the child or adolescent to be accommodated with regards to classroom performance at this time. This does not imply that the child or adolescent be absolved of responsibility to complete assignments, but that empathy and understanding be employed as he or she struggles with the darkest parts of the abuse. The school counselor may advocate for extended deadlines or more support in completing assignments.

Because the child's intrusive symptoms need to be closely monitored at this time (Herman), school counselors may provide valuable insights to the therapist and the child's family by alerting teachers to the nature of intrusive symptoms, such as flashbacks, nightmares or negative daydreams, and negative thoughts. School counselors can, then, help teachers understand how to monitor such symptoms during the school day using tallies and objective descriptions of occurrences and report this information back to

the therapist or parent. In so doing, the school counselor can help the therapist and client evaluate the pacing of the therapeutic process.

While the client is reconstructing the traumatic event(s), Herman (1997) states that conflicts typically arise with others important in the survivor's life and that his or her sense of belonging is often shattered as he or she faces having to reconcile once shared beliefs with new realities. Children and adolescents may report feeling different from others their age (Cohen & Mannarino, 2000) and may isolate themselves from others. They may spend time alone, not talk to their friends, or not want to do anything that once gave them pleasure. At this time, validating and normalizing what the child or adolescent is experiencing is of the utmost importance (Herman). School counselors may do this by briefly and periodically checking in with students, providing counseling about healthy friendships and other relationships, and encouraging them to continue their work in therapy, even though it may be a painful process at times.

Stage 3: Reconnecting with others. The last stage of the trauma recovery process entails the client's building new conceptions of himself or herself and more actively engaging with others and the world (Herman, 1997). Many survivors in this stage deal with an identity crisis because, until this point, they had identified as a "victim, and that is no longer appropriate; but they do not yet have an alternative identity" (Oz, 2005, p. 41). Jonzon and Lindblad (2004) noted that although children who have been sexually abused are a group that benefits from social support, they often have problems both seeking and receiving social support from others. This is an especially important task in the last stage of recovery.

Although group counseling may sound like an appropriate intervention, given the goals of this stage of recovery, Schmidt (2004) cautions against offering abuse related group counseling to children or adolescents in the school setting, as they may not be ready or willing to share their experiences in a group. This type of counseling should be provided by professionals familiar with and trained to treat sexual abuse, as it can be an overwhelming and lengthy process (Remley & Fry, 1993). Groups that are not abuse focused but target other communication or relationship skills may be appropriate for some children and adolescents as long as these groups work in tandem with the efforts of the outside therapist. Group members should always be carefully screened into any group (Jacobs, Masson, & Harvill, 2005), and this especially true for children who have been sexually abused. School counselors may also use their coordination skills to pair the student with a healthy adult mentor if the child or adolescent is willing to do so.

What the child comes to understand in this stage is that he or she has been a victim of sexual abuse, that he or she now has control over life, and that he or she can use this knowledge to further protect himself or herself in the future (Herman, 1997). Herman labels one goal of this stage as "learning to fight" (p. 197), which entails the victim's taking calculated and planned risks to exercise new responses to perceived threats. School counselors could help children and adolescents in this stage to develop more assertiveness skills and to role-play those skills in a safe context. During this stage, Herman advises that victims focus on matters of desire and initiative. It would be fruitful for school counselors to encourage such children or adolescents to set some goals for their futures, including career goals, and explore their creativity and imagination.

In this stage of therapy, survivors often report how strange "normality" feels (Herman, 1997), as many trauma survivors experienced chaotic home lives. Validating this experience is important as trauma survivors learn to cope with the mundaneness of ordinary life experiences. Because connecting to others is important and because adjusting to "normal life" is also a challenge for children in this stage of therapy, school counselors may use their specialized counseling, rapport building, collaboration, coordination, and advocacy skills to facilitate these therapeutic goals within the school setting. School counselors can be invaluable in helping sexually abused children fully recover from sexual abuse in role appropriate ways.

Summary

A large number of sexually abused children do not disclose their abuses to anyone. ASCA (2003) charges school counselors with the task of formulating strategies to help this vulnerable population in fulfilling their highest potentials academically, personally, and socially. This may begin with the recognition of sexual abuse symptoms, discussion of suspicions with the child, and referral to appropriate authorities and treatment agencies. Understanding the symptomology that sexual abuse survivors experience and how such symptoms manifest in children's and adolescents' behaviors can be helpful in achieving these tasks. The use of an instrument such as the Trauma Symptom Checklist for Children can clarify the extent to which a child experiences posttraumatic and other symptoms as a result of having been sexually abused. Although school counselors may not be able to use this instrument directly, understanding the information it provides may help school counselors understand the behavioral manifestations and school problems these symptoms give rise to. In addition, with

knowledge of these symptoms and problems, school counselors and mental health professionals outside of the school setting can more easily communicate about a child or adolescent's sequelae and collaborate in providing the best aftercare possible.

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CHAPTER 2

AN INVESTIGATION OF TRAUMA SYMPTOM REDUCTION IN A CLINICAL SAMPLE OF SEXUALLY ABUSED CHILDREN USING THE TRAUMA SYMPTOM CHECKLIST FOR CHILDREN

Introduction

Childhood maltreatment and trauma are known to have both immediate and long-term consequences for their victims (Briere & Runtz, 1989) physically (from minor injuries to death), psychologically (from chronic low self-esteem, depression, and anxiety to substance abuse and suicide attempts), cognitively (from attention problems to poor school performance), and behaviorally (from poor peer relations to antisocial and violent behavior; Widom, 2000). With 477,755 substantiated cases of maltreatment reported to the U.S. government in 2004 (U.S. Department of Health and Human Services, 2006), child maltreatment continues to be a serious concern.

The presence, absence, and extent of trauma suffered by children have been historically determined through clinical observations or parent or teacher reports of symptoms exhibited by a child or adolescent (Babiker & Herbert, 1998; Wolpaw, Ford, Newman, Davis, & Briere, 2005). A few studies relied on children's self-reports (Kendall-Tackett, Williams, & Finkelhor, 1993). Babiker and Herbert suggested that parents may not accurately report child symptoms based on their own belief or disbelief that the abuse occurred, especially in cases of intrafamilial disclosures, and that foster parents may not know a child well enough to rate symptoms accurately. Kendall-Tackett and colleagues reviewed studies raising validity concerns about parent-report measures.

They also note that children have been found to underreport or minimize symptoms such as depression or low self-esteem. In light of these phenomena, they recommend that measures from multiple sources be used in order to form a clearer picture of a child's symptomology. Utilizing instruments with validity scales designed to capture both underreporting and overreporting of symptomology, then, would offer greater confidence in the measured outcomes.

Yet measuring trauma from sexual abuse has proven difficult (Briere, 1992b; Sadowski & Friedrich, 2000) and controversial (Briere & Elliott, 1993; Hopper, 2006). In addition, more generic measures of symptomology were cited as limited and insensitive to the specific sequelae of child sexual abuse (Babiker & Herbert, 1998; Elliot & Briere as cited in Briere, 1992b). Despite arguments that measuring a broad range of symptoms in children is important for gauging the overall functioning of child sexual abuse survivors (Fricker & Smith, 2001), few other scales did so successfully until the development of the Trauma Symptom Checklist for Children (Briere, 1996).

Other instruments confine results to certain aspects of the sequelae, such as attributions and perceptions (Mannarino, Cohen, & Berman, 1994), adaptive skills and behavior problems (Achenbach, 1991), sexual behaviors (Friedrich, 1997), and Posttraumatic Stress Disorder (PTSD) symptoms (Wolfe, Gentile, Michienzzi, Sas, & Wolfe, 1991). Because there is no evidence for a particular syndrome within sexually abused children (Babiker & Herbert, 1998; Crouch, Smith, Ezzell, & Saunders, 1999; Kendall-Tackett et al., 1993), it may be better to use assessments that tap a broader range of sexual victimization effects which include, but are not limited to, PTSD symptoms (Briere & Runtz, 1993).

Sadowski and Friedrich (2000) spoke to the importance of the range of symptoms measured by the Trauma Symptom Checklist for Children (TSCC) and stated that the TSCC is "the only reliable and normed scale available for this [13-17 years old] age group that assesses as crucial a dimension as sexual concerns" (p. 371). Crouch et al. (1999) hailed the TSCC as a "significant advancement" (p. 256) over more general measures that may or may not tap trauma reactions. Fricker and Smith (2001) found that the TSCC exhibited greater sensitivity to sexual abuse sequelae and ability to "capture the heterogeneity of distress that sexually abused children experience" (p. 64) than a generic measure of psychological functioning.

Therefore, it is important for trauma treatment to continue to examine the usefulness of the TSCC. The TSCC (Briere, 1996) is an efficient and standardized 54-item multidimensional self-report measure widely used in the United States and Canada to inform mental health clinicians of thoughts, feelings, and behaviors about traumatic events and symptoms that children and adolescents (ages 8-16 years) have experienced (Boyle, 2003; Wolpaw et al., 2005). Strengths of this instrument are that it was standardized by age and by gender and that it "accurately reflects the current understanding about the role of development and gender on susceptibility to and expression of trauma-related symptoms" (Wolpaw et al., p. 157). Previous studies regarding trauma treatment for children have found mixed results with regard to gender, age, and trauma symptomology over time; some are reviewed below. Spiers (2001) stated that treatment failures often occur as a result of discordance between treatments and clients' needs. Exploring how symptoms manifest in children of different genders and developmental levels over time may assist clinicians in identifying specific therapeutic

goals (Deblinger & Hefflin, 1996) and choosing the most appropriate treatment techniques and strategies for trauma therapy and resolution.

Trauma Symptomology and Gender

Though the TSCC is extremely useful for measuring trauma symptoms, there remain mixed results in the literature with regard to the effects of gender and age on trauma symptoms. For instance, there are serious questions as to whether boys and girls experience different patterns of symptomology. Hébert, Parent, Daignault, and Tourigny (2006) recommended that further research perform gender analyses with a larger sample of male victims in order to document better the clinical profile for boys; only 13 of the 123 sexually abused children in their study were male. Although Mok (1997) found a gender effect on raw scores on several TSCC scales, she found no main gender effect on *T*-scores from any of the scales of the TSCC.

In an analysis of 45 empirical studies, Kendall-Tackett et al. (1993) noted that gender differences had been found only in a few studies and that most studies found no differences. These authors recommended that gender issues be further addressed. In addition, they note that systematic attention has not been given to issues of gender differences because of small sample sizes of male victims, because of the possibility of bias within such samples because "only the most symptomatic boys" (p. 170) may come into clinical focus, and because differences found in the past may have been too slight for researchers to decide to place gender back into primary focus.

Trauma Symptomology and Age

Studies relating age and symptomology have also provided mixed results. Although most studies have shown no relationship between a survivor's age and sexual

abuse sequelae (Browne & Finkelhor as cited in Downs, 1993), other studies have produced inconsistencies (Downs). Some researchers report that younger children may exhibit more anxiety, nightmares, generalized Posttraumatic Stress Disorder (PTSD), and inappropriate sexual behaviors (Finkelhor & Berliner, 1995; Kendall-Tackett et al., 1993). Children of school age were more likely to have school problems and exhibit hyperactivity and regressive behaviors (Kendall-Tackett et al.). Researchers have found that adolescents are more likely than other age groups of sexually abused children to abuse substances, run away, and commit illegal acts and exhibit signs of depression, isolation, self-injurious or suicidal behavior, and somatic illnesses (Kendall-Tackett et al.). However, Kendall-Tackett and colleagues also stated that some symptoms and behaviors were likely to be reported across more than one age group, such as nightmares, depression, neurotic mental illness, isolation, aggression, and regression. Mok (1997) found a main effect for age on three scales of the Trauma Symptom Checklist for Children, where younger children scored lower on Underreporting, Anger, and Dissociation-Fantasy scales, but she failed to find age by gender interactions using this instrument.

Problems assessing developmental impact exist when developmental levels are collapsed together for analysis (Downs, 1993). Kendall-Tackett et al. (1993) found across studies that grouping children into smaller age groups returned "more focused and consistent findings" (p. 167). Another problem cited by Finkelhor, Ormrod, Turner, and Hamby (2005) is that studies reporting crimes against children typically fragment data according to victim age and usually address only one age group. Kendall-Tackett et al. state that children of different ages exhibit different types of symptoms and that most

researchers have examined age range groups that were too large to discriminate the developmental patterns of some symptoms. They recommend that researchers address smaller age groups and relate findings to children's social, emotional, and cognitive development at these different ages.

In an attempt to reconcile some of the disparities and ambiguities present in the literature and to add to the small number of studies regarding abuse characteristics in clinical populations (Naar-King, Silvern, Ryan, & Sebring, 2002), in this study I explore differences between preadolescent children and adolescents with regard to depression and posttraumatic stress symptoms over the course of therapy. The following hypothesis was explored: Differences would exist between preadolescent children (8-12 years) and adolescents (13-16 years) with regard to depression and posttraumatic stress symptoms, as measured by the Trauma Symptom Checklist for Children, reported over the course of therapy.

Method

All data in this study were previously collected and archived at the children's advocacy center as a regular part of ongoing therapy procedures between April 2003, when the current therapeutic model was implemented, and December 2006. Although I had previously completed a therapist internship at the children's advocacy center, I was not a therapist there at the time of the study. I designed this study to capture clinically relevant information that would add to the body of other studies in the literature pertaining to sexual abuse treatment for children and trauma symptomology over the course of therapy.

Treatment for the child sexual abuse survivor begins in the first session with rapport building and assessment. Typically, more projective forms of assessment are used in the first two to three sessions. Objective assessments, such as the Trauma Symptom Checklist for Children and the Child Behavior Checklist, are administered after some rapport is built, on average in this study by the fourth session.

Ideally, objective instruments are readministered every 3 months for the duration of therapy to assess treatment progress and symptom abatement over time (Lanktree & Briere, 1995), with certain notable exceptions. Where missed appointments or untimely administration of instruments occurred, as sometimes happens in a real clinical setting (Lanktree & Briere), and where children were lost to follow up (i.e., dropped out or discontinued for other reasons) prior to the second administration, there may be missing data at those intervals for some children. In this study, I used first and second administrations of the assessment, on average by sessions 4 and 19, respectively, in order to gauge the effects of therapy on symptomology over time.

Participants

Participants selected for this study were those children who received ongoing counseling/therapy services for sexual abuse at a children's advocacy center (CAC) in a large urban area of the southeastern United States between April 2003 and December 2006. In addition, because the TSCC is the main focus of this study, the participant pool was further limited to children who were between 8-16 years of age at the time of initial assessment and clinical intervention. Between April 2003 and December 2006, 98 children between the ages of 8 and 16 (79 female, 19 male) remained in treatment at the CAC for sexual abuse concerns long enough to have been assessed at least once for

traumatic symptoms using the TSCC. Because valid first assessment TSCC scores were important to the study, 13 participants were dropped from consideration in the study because their first assessment scores were invalid. Table 1 lists racial-ethnic demographic information by gender and age group for the 85 participants (68 female, 17 male) included in this study. Table 1 is also further divided by therapy status: those who completed therapy at the CAC and those who were lost to follow up for reasons such as drop out, moving far away from the CAC, or being referred to other treatment centers. The average number of sessions attended by children who completed treatment was 32; the average number of sessions for children lost to follow up was 18.

Table 1

Participants' Race/Ethnicity by Gender, Age Groups, and Treatment Status

	Female		Male	
Race/ethnicity	8-12	13-16	8-12	13-16
	Completed therapy			
African American	1	3	1	0
Hispanic	2	3	0	1
White	7	11	1	1
Biracial	0	0	0	0
	Lost to follow up			
African American	3	6	2	1
Hispanic	5	2	0	1
White	9	12	6	2
Biracial	2	2	1	0

Procedure

The child begins weekly therapy sessions after the therapist meets with a nonoffending caregiver (NOC) to discuss information about the children's advocacy center, the treatment process, and some family history. Willingham (2007) provides further description of services provided by the CAC. In the initial sessions with the child, the therapist builds rapport and assesses the child's specific needs for therapy using both projective and objective instruments. After initial assessment results are scored, specific outcome goals are made for each child. Therapy generally follows a course of building rapport, assessing functioning and symptoms, setting up safety within the therapy relationship, teaching coping skills and affect education, focusing on abuse (affective and cognitive processing), repairing the sense of self, and educating about sexual abuse, healthy sexuality, and personal safety.

Clinical methodology and treatment provision stem from a blend of cognitive-behavioral and both directive and nondirective play therapy approaches and techniques (i.e., Deblinger & Heflin, 1996; Greenwald, 2005; Landreth, 2002). Such a blend of trauma-focused and nondirective play therapies has been found to be effective and necessary in treating sexually abused children (Rasmussen & Cunningham, 1995). Once symptom levels have been substantially reduced, reparation of the sense of self, court preparation when applicable, and termination sessions begin. The Trauma Symptom Checklist for Children provides an excellent indication of trauma symptom levels and abatement, and it is helpful when considering termination of therapy.

Instrument: Trauma Symptom Checklist for Children

The Trauma Symptom Checklist for Children is a 54-item self-report instrument used with male and female children 8-16 years of age to assess how often they have thoughts, feelings, and behaviors about traumatic events and symptoms they have experienced (Briere, 1996). Each item is rated on a 4-point Likert-type scale ranging from 0 (*never*) to 3 (*almost all of the time*), and the TSCC requires about 15-20 minutes for most children to complete. The measure includes six clinical scales, four subscales, and two validity scales. Eight critical items measure potential problems that warrant further assessment (Boyle, 2003; Wolpaw et al., 2005). The trauma symptom profile is generated from the clinical and validity scales of the TSCC, and this profile assists the clinician in understanding a child's symptomology over time. Therefore, further description of these scales is warranted.

Anxiety. According to Briere (1996), "scores on the Anxiety (ANX) scale reflect the extent to which the child is experiencing generalized anxiety, hyperarousal, and worry, as well as specific fears of men, women, of the dark, and of being killed" (p. 12) He also notes that free-floating anxiety and fears of impending danger are tapped by this scale. High scores on the ANX scale may reflect generalized anxiety, trauma-specific hyperarousal, or both (Briere). Sadowski and Friedrich (2000) found a coefficient alpha of .87 for the ANX scale on a sample of hospitalized adolescents, some of whom were also sexually abused.

Depression. The Depression (DEP) scale taps "feelings of sadness, unhappiness, and loneliness; episodes of tearfulness; and depressive cognitions such as guilt and self-denigration" (Briere, 1996, p.12). In addition, two items address self-injurious and

suicidal ideations. Briere notes that high scores on the DEP scale may reflect a depressive episode, a grief or depressive reaction, or a more long-term dysthymic (low grade depression) process. Respondents to the two items indicating ideations about self-injurious behaviors or suicide should be further evaluated. A coefficient alpha of .90 was found for the DEP scale (Sadowski & Friedrich, 2000).

Anger. The Anger (ANG) scale reflects "the extent of angry thoughts, feelings, and behaviors reported by the child" (Briere, 1996, p.12). Specific items indicate feelings of meanness or hatred, wanting to yell at or hurt others, arguing and fighting, and having difficulty reducing angry feelings (Briere). Wanting to hurt others is a critical item on this scale that should be followed up. High scores on the ANG scale may indicate that a child appears irritable, hostile, or aggressive (Briere). Sadowski and Friedrich (2000) reported a coefficient alpha of .91 on this scale.

Posttraumatic Stress. Classic posttraumatic symptoms are measured on the Posttraumatic Stress (PTS) scale, such as "intrusive thoughts, sensations, and memories of painful past events; nightmares, fears of men or women; and cognitive avoidance of negative thoughts and memories" (Briere, 1996, p. 13). Children with high scores on the PTS scale may appear distracted, irritable, and unable to function (Briere). Kendall-Tackett et al. (1993) reported that children who were sexually abused consistently showed more Posttraumatic Stress Disorder symptoms than clinical samples of nonabused children. Sadowski and Friedrich (2000) found a coefficient alpha of .88 and noted that the PTS scale significantly discriminated sexually abused from nonabused adolescents in a psychiatric hospital setting. These authors stated that the PTS scale demonstrated "specific sensitivity…to sexual maltreatment" (p. 370).

Dissociation. The Dissociation (DIS) scale measures "the extent to which the child experiences mild-to-moderate dissociative symptomology" and includes items that tap "derealization, one's mind going blank, emotional numbing, pretending to be someone else or somewhere else, daydreaming, memory problems, and dissociative avoidance" (Briere, 1996, p. 13). There are two subscales within this measure, Overt Dissociation (DIS-O) and Fantasy (DIS-F). Children with overtly dissociative behaviors may appear "spacey" and detached from their environments. In addition, they may try to actively avoid negative emotions (Briere). High scores on the DIS-F subscale "may be seen by others as overinvolved in fantasy to the exclusion of the 'real' world and its demands," (Briere, p. 13), and daydreaming is included as a component on this subscale. Authors are careful to note, however, that dissociation is often a coping mechanism by which traumatized individuals escape from painful experiences (Briere, 1992b). Sadowski and Friedrich (2000) found a coefficient alpha of .71 for the DIS-F subscale, .88 for the DIS-O subscale, and .89 for the DIS total scale.

Sexual Concerns. The Sexual Concerns (SC) scale is comprised of two subscales, each of which measures different dimensions of sexual concerns: Sexual Distress (SC-D) and Sexual Preoccupation (SC-P). High scores on the SC scale may indicate sexual abuse or traumatization, sexual assault by a peer, or witnessing sexual acts or pornography (Briere, 1996). Scores on the SC-P subscale indicate an age-inappropriate sexual preoccupation and may manifest in "precocious or compulsive sexual behavior, sometimes in inappropriate social contexts" (Briere, p. 14). Sexualized behaviors are often considered a hallmark symptom of sexual abuse (Friedrich, 1993). Briere is cautious to note that elevated scores on the SC-P scale may reflect cultural norms that

espouse earlier sexual awareness and behavior that might not be expected and should be considered in light of this contextual factor. Higher scores on the SC-D scale, however, indicate that a respondent feels distress or conflict around sexual matters or experiences (Briere). Briere also states that the SC-D subscale correlated more closely with the Anxiety scale than the SC-P subscale. One study reported a coefficient alpha of .77 for this scale, with subscale alphas of .78 for SC-P and .73 for SC-D (Sadowski & Friedrich, 2000).

Validity scales. The TSCC includes two validity scales to combat the possibility of underreporting or overreporting symptoms on the instrument: Underresponse (UND) and Hyperresponse (HYP). Boyle (2003) noted this as a strength of the instrument, in light of motivational and response distortion tendencies that are more likely to occur on self-report measures with more obvious item wording. According to Briere (1996), high scores on the UND scale may indicate defensiveness, avoidance, opposition to test-taking, or another reason related to unwillingness to endorse commonly endorsed items. Briere states that a high score on the HYP scale indicates "a generalized overresponse style, a desire to appear especially distressed or dysfunctional, or a 'cry for help'" (p. 12). He cautioned that invalid TSCC profiles accompanied by hyperreponse should not be misconstrued as evidence that abuse or other traumas have not occurred but viewed as an inability to interpret the individual scales in a meaningful way. These validity scales address an important concern in the literature regarding children's tendencies to minimize problems on self-report measures (Kendall-Tackett et al., 1993).

Convergent and Discriminant Validity. The TSCC has been tested against several different measures of distress for children and adolescents. Boyle (2003) reported that the

TSCC was moderately correlated with a number of related assessments, such as the Child Behavior Checklist, Children's Depression Inventory, Revised Children's Manifest Anxiety Scale, Children's Social Desirability Questionnaire, and the Child Sexual Behavior Inventory. These correlations demonstrate convergent validity of different scales on the TSCC. Sadowski and Friedrich (2000) tested the TSCC against a number of different measures, both subjective and objective. They found that "the TSCC total score was either the largest (7) or second largest (5) correlation with each of the twelve objective measures" (p.368), suggesting that the TSCC scores successfully measured emotional distress.

Reliability. Lanktree and Briere (1995) reported "relatively high internal consistency" (p. 1148) for the TSCC with reliability estimates for the six scales ranging from .78 to .89 and a mean alpha coefficient of .86 in their sample. Crouch et al. (1999) found reliability estimates for the six scales ranging from .69 to .87 with a mean internal consistency of .81 in their samples, which they considered "generally adequate" (p. 261). In a 6-month follow-up study of Flemmish adolescents who were sexually abused, Bal, De Bourdeaudhuij, Crombez, and Van Oost (2005) found "good to very good" (p. 1397) reliability estimates using the TSCC.

The Trauma Symptom Checklist for Children is one of the most commonly used measures that tap sexual abuse sequelae in children and adolescents (Elhai, Gray, Kashdan, & Franklin, 2005). As a result, it has been used to validate other measures related to sexual abuse specific sequelae, such as the Child Report of Treatment Issue Resolution (Nelson-Gardell, 1997).

Data Analysis

Normality tests were performed using SPSS for all continuous independent (i.e., actual age, number of sessions) and dependent variables (i.e., TSCC scale scores) for Time 1 (T1; $N = 85$) and Time 2 (T2; $N = 31$; Tabachnick & Fidell, 2007). Because a high number of children were lost to follow up, several tests were used to determine whether there were significant differences between the groups on the variables of interest, whether these lost subjects were lost at random, and whether there were bias in the remaining data. Differences between the children who completed therapy ($N = 31$) and those who were lost to follow up ($N = 54$) were compared using Hotelling's T^2 tests with regard to their actual age, number of sessions, and all six scale scores on the TSCC for T1. Gender was compared using a chi-square test.

To examine the relationships and interactions over time on independent variables of interest, I used other statistical analyses. Correlational analyses comparing descriptive (i.e., gender, age, and number of sessions attended) and dependent variables (i.e., TSCC scale scores) for Time 1 ($N = 85$) were utilized primarily to determine whether a relationship existed between length of time in therapy (i.e., the number of sessions attended) and the scale scores on the TSCC. If length of time in therapy were significantly correlated with the TSCC scales, analyses of covariance were planned to account for the variance attributable to the child's length of time in therapy (Tabachnick & Fidell, 2007). For hypothesis testing, a one-way repeated measures ANOVA was used across two age groups on Depression (DEP) and Posttraumatic Stress (PTS) scores. Data from the subjects for whom Time 1 and Time 2 scores were available, (i.e, those not lost to follow up, $N = 31$) were utilized in these analyses. The two age groups on which the

TSCC was normed (i.e., 8-12 years and 13-16 years) were chosen for consistency in potential comparisons. However, gender was not analyzed in this sample because of the small number of male participants ($N = 4$). Therefore, all subjects, female and male, were analyzed together across DEP and PTS scale scores because most previous studies have revealed no significant differences between males and females on TSCC scales (Kendall-Tackett et al., 1993).

The numbers for participants with both Time 1 and Time 2 scores dictated that only two scales could be used for analyses. I selected Depression because this symptom has appeared to be "a robust symptom across age groups" (Kendall-Tackett et al., 1993, p. 167). Posttraumatic Stress Disorder is an anxiety disorder that encompasses other symptoms measured by the TSCC, such as anger, anxiety, and dissociation (American Psychiatric Association, 2000). The Sexual Concerns scale was not selected for further analysis because subjects included in this study initially disclosed that severe acts of sexual abuse, according to Russell's (as cited in Naar-King et al., 2002) criteria were committed against them. This ceiling effect merited selection of other TSCC scales over the Sexual Concerns scale.

Results

Normality tests from SPSS revealed that normal distribution was estimated for all continuous independent and dependent variables. In addition, Hotelling's T^2 and chi-square tests suggested that, despite a large number of potential participants lost to follow up, these individuals appeared to be lost at random, as the only significant difference between the groups was the length of time in therapy, as represented by the number of sessions attended, $F(1, 84) = 19.84$. Table 2 illustrates the differences between

Table 2

Differences Between Participants Lost to Follow Up and Participants Who Completed Therapy

Source	*df*	*F*	*p*
Age (actual)	1	0.06	.8033
Sexual abuse severity	1	1.94	.1673
Number of therapy sessions	1	19.84	<.0001
ANX	1	0.28	.5999
DEP	1	0.08	.7813
ANG	1	0.12	.7264
PTS	1	0.38	.5391
DIS	1	0.12	.7303
SC	1	0.46	.4986

participants lost to follow up and those that completed therapy from TSCC scores at Time 1. A chi-square analysis also showed no differences for gender between the two groups, $\chi^2(1, 84) = 1.5360$, $p = .2152$.

Correlational analyses revealed no significant relationships between length of time in therapy and the independent and dependent variables. Table 3 displays the intercorrelations between independent and dependent variables for subjects at Time 1 ($N = 85$). One-way repeated measures ANOVA tested at the .025 alpha level across participants' age group and Depression ($F(1, 30) = 2.40$, $p = .132$) and Posttraumatic Stress ($F(1, 30) = 0.509$, $p = .481$) from Time 1 (T1) to Time 2 (T2) for those who completed therapy showed no significant time by age group interactions. Table 4 lists means and standard deviations for participants' scores on the six main scales of the Trauma Symptom Checklist for Children.

Table 3

Intercorrelations Between Independent and Dependent Variables at Time 1

	2	3	4	5	6	7	8	9	10	11	12	13	14
1	-.188	.209	.014	-.073	.048	-.103	-.106	-.103	-.080	-.123	-.067	-.036	-.047
2		.019	-.014	-.161	-.053	-.027	-.215*	-.185	-.201	-.112	-.186	-.043	-.257*
3			-.014	-.085	-.081	-.042	-.022	-.114	-.086	-.116	-.073	-.100	-.072
4				.024	.116	.012	.047	.019	.010	.021	.002	.023	.038
5					.701**	.211	.127	.172	.179	.100	.184	.210	.042
6						.218*	.156	.246*	.297*	.073	.103	.131	.004
7							.567**	.624**	.581**	.475**	.525**	.495**	.321**
8								.641**	.683**	.327**	.683**	.402**	.728**
9									.933**	.754**	.561**	.466**	.480**
10										.471**	.613**	.485**	.551**
11											.265*	.270*	.155
12												.830**	.793**
13													.366**

Note. 1=Age (actual), 2= Gender, 3= Sexual abuse severity, 4= Number of sessions, 5= ANX, 6= DEP, 7= ANG, 8= PTS, 9= DIS, 10= DIS-O, 11= DIS-F, 12= SC, 13= SC-P, 14= SC-D. $*p < .05$. $**p < .01$.

Table 4

Participants' Mean Scores on TSCC Scales by Age Group

	8-12		13-16	
TSCC Scale	M	SD	M	SD
Time 1: Lost to follow up				
ANX	53.70	10.95	52.81	11.26
DEP	53.37	9.35	52.30	10.76
ANG	51.74	9.83	50.00	9.68
PTS	52.59	11.33	50.93	10.37
DIS	53.85	9.94	49.89	10.16
SC	60.22	17.66	58.30	18.64
Time 1: Completed therapy				
ANX	52.84	8.25	51.39	11.08
DEP	49.31	7.16	54.33	9.85
ANG	51.85	11.68	48.83	8.52
PTS	53.69	11.79	52.83	7.67
DIS	52.38	10.05	52.78	7.08
SC	66.92	21.01	58.44	14.42
Time 2: Completed therapy				
ANX	52.31	7.97	50.83	13.03
DEP	48.92	6.09	47.22	11.26
ANG	50.92	6.51	46.44	7.57
PTS	53.69	9.61	49.89	10.18
DIS	53.62	8.10	50.50	9.78
SC	58.62	19.19	53.78	14.99

Discussion

In this study, I sought to reveal whether differences in preadolescent children and adolescents' trauma symptoms, such as depression and posttraumatic stress, changed over the course of therapy. Participants in this study were all referred for treatment at the same children's advocacy center because of their disclosures that moderate to severe acts of sexual abuse, as described by Russell (as cited in Naar-King et al., 2002), such as genital fondling, oral, vaginal, or anal sexual intercourse, had been committed against them. The small number of participants in the final comparison sample proved to be more heterogeneous in symptomology patterns, and several studies note that more severe types of abuse typically lead to greater symptomology (Briere, 1992a). No gender effects could be tested because of the small number of boys present in the sample. Finding no significant Time x Age Group interaction effects suggests that, in this study, there were not discernable differences between preadolescent children and adolescent subjects with regard to changes in Depression and Posttraumatic Stress scores on the Trauma Symptom Checklist for Children between first and second administrations of the TSCC.

Limitations

The current study involves a sample of children who disclosed sexual abuse and sought and remained in therapy at the same children's advocacy center over time. Results from this study may not generalize to other sexual abuse survivors who neither disclose sexual abuse nor seek treatment. This sample represents only a subsample of children who do disclose and seek therapy for sexual abuse and who are referred for treatment for their abuse to the same children's advocacy center. Because referrals to this CAC are taken mostly from mandated reporter groups, such as law enforcement, child protective

services, mental health and medical professionals, or prosecutors, the children and adolescents in this sample may be further limited to those who have experienced more severe cases of substantiated sexual abuse.

The use of the Trauma Symptom Checklist for Children instrument in this study limited the age range of potential subjects, and the introduction of new treatment methods at the children's advocacy center further limited the time frame for inclusion in the study. Of 98 participants initially included, 13 (13.3%) were excluded based on invalid TSCC scores. Additionally, the number of potential participants lost to follow up resulted in less data available ($N_{T1} = 85$, $N_{T2} = 31$) for empirical examination. That so many potential participants were lost to follow up and that only a small number of boys remained within the final sample ($N = 4$) also limited comparisons regarding symptomology over time for gender. Because the potential participants lost to follow up appeared to be lost at random, the analyses performed can be considered valid, even if limited. Therefore, data must be interpreted and conclusions generalized from these contexts.

That no statistical differences were found between age groups on Depression and Posttraumatic Stress scores over time may be more indicative of the small sample size or the time between administrations of the instrument. Within the noted time frames, which varied between participants, symptom changes over time were minimal and not statistically significant. Because of the variability in session number at Time 2 administration of the instrument, it is possible that the participants' symptoms were being measured at difference stages in trauma treatment. This variability may also mask any potential differences between participants on the DEP and PTS scales. Therefore,

suggested implications address the processes of providing treatment and conducting research on clinical populations.

Implications

Treatment. Although symptom changes over time were minimal and not statistically significant within this study, symptom changes over time may be better measured by looking at the cutoff *T*-scores for clinical (66 and above), borderline (51-65), and normal (50 and below) ranges across each scale. Within this context, it is easier to gauge how to pace the therapeutic work and when the client may be ready to terminate therapy. For example, Table 4 illustrates that children 8-12 years of age initially scored, on average, within the clinically significant range on the Sexual Concerns scale (M = 66.92). For the same children, this score dropped to a lower level of borderline significance (M = 58.62) by the second administration of the instrument, suggesting that these children were less distressed and preoccupied by sexual matters at that time. This indicates that a level of progress had been achieved with regard to sexual concerns between the first and second administrations of the instrument, despite a lack of statistical significance. Although these numbers also demonstrate great variability, as evidenced by their high standard deviations, using these cut scores to determine the pacing and timing of therapeutic work with an individual child may prove both clinically practical and helpful.

From a trauma treatment perspective, pacing and timing with regard to processing thoughts around sexual concerns, sexuality, and memories is crucial, as the trauma work must remain within bearable limits (Herman, 1997). Herman suggests that safety be safeguarded and balanced against the therapeutic need to face the trauma because the

client's ability to function normally will be affected. When distress symptoms worsen throughout therapy, the pace of therapy should be slowed and the course renegotiated between therapist and client (Herman).

Research. Although the negotiation of pacing in therapy is a highly individualized process, there are also research implications for administering objective instruments after the same number of sessions across clients. The use of the same number of sessions for determining when to administer objective instruments may be more useful than an amount of time, in months, for example, because clients miss appointments but the number of sessions they attend may be easily quantified for within- and between-subjects comparisons. By using the same number of sessions across clients, the trauma treatment process may be better studied with regard to symptom abatement over time.

Conclusions

The experience of having been sexually abused may give rise to various trauma symptoms in children and adolescents. These symptoms may be appropriately documented and analyzed over time through the use of a valid and reliable instrument, such as the Trauma Symptom Checklist for Children. The use of such data can be helpful in planning for treatment, gauging treatment effectiveness over time, and planning for termination from therapy. In this study, age groups of sexually abused children were examined to determine what differences, if any, would exist on Depression and Posttraumatic Stress symptoms over the course of therapy.

No significant Time x Age Group interactions were found on either the Depression or the Posttraumatic Stress scales of the Trauma Symptom Checklist for Children. Although data from this study produced no statistical significance, this does not

necessarily reflect that the treatment protocol at the children's advocacy center yields no benefit. It is more likely that the small number of children sampled here showed no statistically significant changes in Depression or Posttraumatic Stress symptoms over the time frame studied. It is also likely that the variability within the time frame studied also contributed to the lack of significant results reported here.

Future research should seek to study samples with more male subjects in order to be able to draw conclusions based on gender. In addition, studies that evaluate how the timing between instrument administrations may reveal differences in trauma symptoms may also provide practical insights for clinical practice and treatment termination, and, more specifically, for when such instruments should be given across the course of therapy. Further exploring how elements of a trauma treatment model target symptom variables may also provide helpful insights into trauma symptomology and symptom abatement over the course of therapy for child and adolescent sexual abuse survivors.

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