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## CLINICAL RESEARCH

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# The Convergent Validity of the Trauma Symptom Checklist for Young Children for a Sample of Sexually Abused Outpatients

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**ABSTRACT.** The convergent validity of the Trauma Symptom Checklist for Young Children (TSCYC) was examined with a sample of 172 sexually abused outpatient treatment-seeking children and their caregivers. The TSCYC evidenced good convergent validity with other parent ratings (e.g., the Child Behavior Checklist, Child Sexual Behavior Inventory, and the University of California at Los Angeles Post-Traumatic Stress Disorder

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Reaction Index [UCLA PTSD Index]). The convergent validity of the TSCYC and the Trauma Symptom Checklist for Children was weak, perhaps illustrating the lack of agreement often found between children and caregivers and illustrating the need for a multi-informant approach to screening and assessment of sexually abused children. The TSCYC seems to hold promise based on the emerging evidence for its convergent validity.

**KEYWORDS.** Trauma, assessment, abuse, TSCYC

Symptoms resultant from child sexual abuse (CSA) can include a variety of responses (Briere, 1992). Symptoms of child abuse and family violence include post-traumatic stress disorder (PTSD; Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Elliott & Briere, 1994; McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988; McLeer, Deblinger, Henry, & Oraschel, 1992; Singer, Anglin, Song, & Lunghofer, 1995); dissociation (Chu & Dill, 1990); increased sexual behavior (Friedrich, 1993, 1994, 1998; Gale, Thompson, Moran, & Sack, 1988); anger and aggression (Kolbo, Blakely, & Engleman, 1996; Lanktree, Briere, & Zaidi, 1991; Shakoor & Chalmers, 1991); and anxiety, depression, and suicidal behavior (Fergusson, Horwood, & Lynskey, 1996; Lanktree et al., 1991; Margolin & Gordis, 2000; Martinez & Richters, 1993).

While child abuse and family violence have been associated with the aforementioned symptoms, Rind, Tromovitch, and Bauserman (1998) asserted that based on their meta-analysis, the relation between CSA and adjustment was quite small. Spiegel (2000) criticized Rind et al.'s methodology, emphasizing the tendency for victims of CSA to evidence only a subset of all possible symptoms. Therefore, any one symptom may not be elevated in the CSA population as a whole, even though most individuals demonstrate some symptoms. Spiegel also noted that the abuse-specific outcome of PTSD was absent in the list of dependent measures used by Rind et al. The shortcoming of the available data may have reflected (among other things) the lack of adequate measures. Thus, there is a need to assess a variety of symptoms including possible post-traumatic stress.

Some studies assessing trauma-specific symptoms have utilized research measures as opposed to standardized measures. Until recently, there were no measures of trauma (i.e., PTSD, specifically) unless a lengthy, structured interview was used. Two notable exceptions include the Child Sexual Behavior Inventory (CSBI; Friedrich, 1998) and the

Trauma Symptom Checklist for Children (TSCC; Briere, 1996). The CSBI is a parent/caregiver rating scale that focuses exclusively on sexual behavior of children. While covering sexual behavior exhaustively, it measures that single dimension of behavior. The TSCC is a self-report measure that focuses on a variety of abuse- and trauma-related symptoms including post-traumatic stress, dissociation, sexual behavior, anxiety, depression, and anger. As a self-report, the TSCC is helpful, but does not by its purpose include the parental perspective as an informant. The Child Behavior Checklist (CBCL; Achenbach, 1991) is a parent rating scale often used in clinical work and research with children who are abused and/or are exposed to domestic violence; however, the items and scales do not assess trauma and dissociation. In summary, many of the instruments used with children impacted by family abuse and violence: (a) do not assess trauma-related symptoms; (b) assess only one trauma-related symptoms (e.g., sexual behavior); (c) are not standardized; (d) are too lengthy; and/or (e) do not have parallel forms for youth and caregivers (i.e., multi-informant assessment).

Positively, the TSCC addresses all but the multi-informant issue. This becomes especially important since victims may be avoidant or deny the abuse event (Shapiro & Dominiak, 1990), feel ashamed in response to the abuse event (Wyatt, Loeb, Solis, & Carmona, 1998), or young children may lack the meta-cognitive skills to accurately report symptoms.

Briere (1999) has developed the Trauma Symptom Checklist for Young Children (TSCYC), which allows a caretaker to rate trauma-related and sexual symptoms in young children. The preliminary version of the TSCYC consisted of 120 items that were developed to represent areas assessed by the TSCC. Thirty of the items were deleted based on recommendations of an expert panel and/or based on the psychometric properties of each item. The resulting 90 items are scored using a Likert-scale rating. Normative data were collected on 219 children by six clinicians or researchers (Briere et al., 2001). The clinical scales include Post-Traumatic Stress–Intrusion, Post-Traumatic Stress–Avoidance, Post-Traumatic Stress–Arousal, Sexual Concerns, Anxiety, Depression, Dissociation, and Anger/Aggression. Internal consistency for the clinical scales ranged from an alpha of .81 to .93, with an average alpha of .87. Additionally, CSA was related to ratings of TSCYC Post-Traumatic Stress–Intrusion, Post-Traumatic Stress–Avoidance, Post-Traumatic Stress–Total, and Sexual Concerns.

Gilbert (2004) studied the psychometric properties of the TSCYC with 339 abused children. Gilbert's work represents the only published work on the convergent validity of the TSCYC. Internal consistency ranged

from an alpha of .81 to .92. Convergent validity was examined through comparisons to the CBCL. The TSCYC scales were correlated with the CBCL factors as follows: TSCYC Anxiety and CBCL Anxious/Depressed ( $r = .59, p < .01$ ); TSCYC Depression and CBCL Anxious/Depressed ( $r = .73, p < .01$ ), TSCYC Anger/Aggression and CBCL Aggressive ( $r = .81, p < .01$ ), and TSCYC Sexual Concerns and CBCL Sex Problems ( $r = .55, p < .01$ ). The TSCYC Sexual Concerns also was significantly correlated with the total score of the CSBI ( $r = .66, p < .01$ ). However, the TSCYC scores were weakly correlated with self-report measures including the TSCC. Specifically, correlations with the TSCC ranged from .17 to .40 with  $p < .01$ . Finally, TSCYC scores for Post-Traumatic Stress-Arousal, Post-Traumatic Stress-Total, and Sexual Concerns were able to accurately predict abused (75.56% positive predictor power) and non-abused (86.67% negative predictor power) children. The current study replicates and extends the convergent validity of the TSCYC. Convergent validity is a form on construct validity wherein the attempt is to show convergence or correspondence between similar constructs. The measures for comparison were the CBCL, CSBI, TSCC, and the UCLA PTSD Index (Steinberg, Brymer, Decker, & Pynoos, 2004).

## METHOD

### *Participants*

Participants were 172 consecutive child clients, ages 2 to 17, who received treatment services in an outpatient setting. The setting was a child advocacy center on the campus of a state university. Referrals for treatment were accepted from physicians, child protective services, and parents. Only children with a substantiated history of CSA were accepted for treatment. All children and their parents participated in a clinical intake process while beginning therapy. The instruments used in this study as well as additional instruments were administered. Consent to participate was obtained from the parent or guardian, and assent was obtained from child participants. Due to factors including age or availability at intake, not all measures were completed for all children. Measures included: (1) the TSCYC (Briere et al., 2001), (2) the CSBI (Friedrich, 1998), (3) the TSCC (Briere, 1996), and (4) the CBCL (Achenbach, 1991). The use of the UCLA PTSD Reaction Index began about mid-point in the collection of the data. Thus, the number of participants

who completed the UCLA PTSD Reaction Index was less. Additionally, the Abuse Dimensions Inventory (ADI; Dykman et al., 1997) was used to quantify the number and severity of sexually abusive events.

For those completing the CSBI, there were 172 participants with a mean age of 7.19 ( $SD = 2.81$ ); 64% were female, and 36% were male. For this portion of the sample, 55% were Caucasian, 37% were African American, and 8% were other minorities. There were fewer participants for whom there were both a TSCYC and TSCC. That is, there were 84 participants, with a mean age of 9.25 ( $SD = 2.01$ ); 70% were female, and 30% were male. For this portion of the sample, 56% were Caucasian, 42% were African American, and 2% were other minorities.

There were 30 participants who completed the UCLA PTSD Index and the TSCYC. These participants had a mean age of 8.18 ( $SD = 2.66$ ); 43.3% were male, and 56.7% were female. For this portion of the sample 36.7% were Caucasian, 53.3% were African American, 3.3% were Latino, and 6.7% were other minorities. Finally, there were 78 participants with both a CBCL and TSCYC. These children had a mean age of 7.83 ( $SD = 2.82$ ); 63% were female, and 37% were male. For this portion of the sample, 65% were Caucasian, 27% were African American, and 8% were other ethnicities.

For the 172 participants in the study, there were ADIs available for 145. From these reports it was shown that: 16% experienced suggestive talk, hugs, or kissing, 35% experienced visual-exposing of genitals, voyeurism, or pornography, 12% experienced fondling over the child's clothing, 48% experienced fondling under the child's clothing, 5% experienced simulated intercourse over clothing, 17% experienced a masturbating abuser or simulated intercourse under clothes, 30% experienced oral contact from the abuser to the child's genitals, 28% experienced oral contact from the child to the abuser's genitals, 21% experienced digital or object penetration, 20% experienced vaginal or anal intercourse (including attempts), and 4% experienced paraphilic sex or exploitation.

### **Measures**

**TSCYC.** The TSCYC (Briere et al., 2001), developed by Briere in 1999 and published in 2005, is a 90-item parent report measure for the assessment of trauma-related symptoms in children ages 3–12. Each symptom is rated on a 4-point scale. It is the only standardized measure of multiple trauma symptoms as reported by parents/caregivers.

The TSCYC was developed in a two stage process. In its original iteration, there were 120 items. First a panel of researchers and clinicians with

expertise in child trauma reviewed the TSCYC items. Second, a sample of parents/caretakers of children exposed to trauma completed the TSCYC. At the end of these two processes, 30 items were eliminated.

The clinical scales include Post-Traumatic Stress–Intrusion, Post-Traumatic Stress–Avoidance, Post-Traumatic Stress–Arousal, Sexual Concerns, Anxiety, Depression, Dissociation, and Anger/Aggression. The scores of the Post-traumatic Stress scales sum to a Post-traumatic Stress–Total scale score. In Briere's (1999) initial study, the clinical scales had good reliability with alphas ranging from .81 to .93. Additionally, TSCYC scales were predictive of exposure to sexual abuse, physical abuse, and witnessing domestic violence.

*TSCC.* The TSCC (Briere, 1989) is a standardized, 54-item self-report measure for assessing trauma-related symptoms in children ages 8–16. The TSCC yields raw scores and T-scores for validity scales and clinical scales. The clinical scales include Anxiety, Depression, Anger, Post-Traumatic stress, Dissociation, and Sexual Concerns. The alpha coefficients for clinical scales range from .77 to .89 in the standardization sample. Adequate convergent, discriminant, and predictive validity have been demonstrated in normative and clinical samples.

*CBCL.* The CBCL (Achenbach, 1991) is a 113-item parent report that provides a rating of the child's symptomatology. Raw scores are converted into T-scores, and the resulting factor scores include Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, Aggressive Behavior, and the Other Symptoms Scale. The test-retest reliability of the CBCL was supported by a mean test-retest coefficient of .89 for the problem scales over a 7-day period (Achenbach, 1991). Adequate content, construct, and criterion-related validity have been demonstrated in normative and clinical samples. Although the 1991 version was replaced in 2001, the study began prior to the release of the 2001 version. Thus the CBCL data used for the study were those based on the 1991 version.

*The UCLA PTSD Reaction Index—Parent Form.* The UCLA PTSD Index (Steinberg et al., 2004) is 21-item parent-report that screens children and adolescents for all DSM-IV PTSD symptoms. It has gone through a number of iterations beginning in 1985. Part I is a brief survey of lifetime stressor events; Part II assesses the presence or absence of PTSD symptoms from each of the three clusters (i.e., re-experiencing, avoidant, and arousal). Part III allows for an assessment of the frequency of symptoms, however, those data were not obtained in the present study.

The instrument was designed for use with children, adolescents, and parents. The version utilized in this study was the parent version. Steinberg

et al. (2004) suggest that validity across all versions is suggested by numerous studies. This latest version (DSM-IV) also has good convergent validity when compared to the PTSD Module of the Schedule of Affective Disorders and Schizophrenia for School-Age Children, Epidemiologic version (.70). Test-retest reliability is good with a reliability coefficient of 0.84 reported by Roussos et al. (2005).

*CSBI.* The CSBI is a 38-item instrument completed by a parent or caregiver to determine the presence and intensity of a range of sexual behaviors in children 2–12 years (Friedrich, 1997). The items yield three standardized scores: the CSBI Total score, the Developmentally Related Sexual Behavior Scale (DRSB), and the Sexual Abuse Specific Items Scale (SASI). Additional items assess the child's exposure to sexuality in the home (e.g., "My child has seen his/her parents having sex"; "My child has seen naked adults on TV."), and experiencing of life events (e.g., parental divorce, hospitalization, and physical abuse). The CSBI has demonstrated good internal consistency ( $r = .72$  for normative sample) and test-retest reliability ( $r = .85$  after 4 weeks; Friedrich et al., 1992). The mean CSBI Total raw score has discriminated sexually aggressive from physically aggressive and non-aggressive children (Burton, 1996). These new items address more aggressive and/or coercive sexual behaviors, as well as behaviors indicating withdrawal and avoidance of sexual content. In a normative sample of mothers reporting on their children, none of the items assessing aggressive sexual behaviors were endorsed.

### ***Procedure***

The assessment measures used in this study were part of a larger battery of instruments administered during an intake process at the outpatient agency. Consent forms authorized the use of this data for research purposes. These forms and the study itself were approved by the Institutional Review Board. The intake process consisted of approximately three sessions in which an intake clinician gathered data. The first session of the intake process did not include the intake clinician, but rather allowed the individual therapist to meet with the participant and their family in order to build rapport and gather demographic information on the client. During the first session, the therapist obtained consent and assent to participate in the research and scheduled a second appointment. The second session with the family began the administration of the intake measures; the parents of the participant were usually scheduled for this first meeting while the child attended a therapy session. The third session involved

administration of measures to the child. The number of sessions required to complete the data collection differed based on the availability of the participants and the number of sessions necessary for the participants to complete the instruments. All measures, however, were completed within one month of the initial appointment. In addition to the instruments cited in this study, there were measures of abuse severity, social support, coping, cognitive appraisals, and events related to the disclosure of abuse.

## RESULTS

Raw scores of factors measuring sexual concerns from the CSBI, the CBCL, and the TSCYC were correlated to determine the convergent validity of the Sexual Concerns factor of the TSCYC. The Sexual Concerns Factor of the TSCYC was significantly correlated with all measures as follows: CBCL Sexual Problems raw score ( $r = .720, p < .001$ ), CSBI Total Item score ( $r = .624, p < .001$ ), CSBI SASI Item score ( $r = .597, p < .001$ ), and CSBI DRSB Item score ( $r = .444, p < .001$ ).

Raw scores from the TSCC, the CBCL, and the TSCYC were correlated to determine the strength of relationship between scales purporting to measure similar behaviors. Correlation coefficients for the TSCC and the TSCYC are found in Table 1. Correlation coefficients were significant when self-report factors (TSCC) were compared to parent ratings (TSCYC),

TABLE 1. Correlations Between Raw Scores  
for TSCC and TSCYC Factors

TSCYC Factors ( <i>p</i> value)	TSCC					
	1	2	3	4	5	6
1. Anger	.299** ( <i>p</i> = .003)					
2. Sexual concerns		.174 ( <i>p</i> = .057)				
3. Anxious			.248* ( <i>p</i> = .011)			
4. Depressed				.297** ( <i>p</i> = .003)		
5. PTSD					-.047 ( <i>p</i> = .336)	
6. Dissociation						.249* ( <i>p</i> = .011)



with the exception of the Sexual Concerns Factor and the PTSD Factor. While the correlation coefficients with the TSCC were significant, the correlations were weak and accounted for a small amount of the variance (6–9%). Correlations between the CBCL and the TSCYC are found in Table 2. The correlations between these two parent ratings were high for all factors ( $p < .001$ ) and accounted for 30–70% of the variance.

Correlations also were computed for the UCLA PTSD Index (Parent Version) and the TSCYC. All correlation coefficients between corresponding factors/clusters were significant and are found in Table 3. Additionally, the overall index of likely PTSD or PTSD Stress were correlated as well ( $r = .476, p = .004$ ).

TABLE 2. Correlations Between the Raw Scores for CBCL & TSCYC Factors

TSCYC Factors ( <i>p</i> value)	CBCL			
	Delinquency	Aggression	Sexual Concerns	Anxious/Depressed
Anger	.544** $p < .001$	.841** $p < .001$		
Sexual concerns			.702** $p < .001$	
Anxious				.729** $p < .001$
Depressed				.777** $p < .001$

TABLE 3. Correlation Between Raw scores for UCLA PTSD Reaction Index and TSCYC

TSCYC Factors ( <i>p</i> value)	UCLA PTSD		
	Criterion B (Re-Experiencing)	Criterion C (Avoidance)	Criterion D (Arousal)
Intrusion (re-experience)	.574** $p < .001$		
Avoidance		.342** $p < .001$	
Arousal			.591** $p < .001$

## DISCUSSION

These results support the convergent validity of the TSCYC Scales of Anger, Sexual Concerns, Anxious, and Depressed when compared to the CBCL. When compared to its companion self-report measure, the TSCC, there was modest convergent validity of the TSCYC for the Anger, Anxious, Depressed, and Dissociative Scales. However, while statistically significant, the correlations accounted for a small amount of the variance. The lack of relationship between the TSCC and TSCYC Post-traumatic stress factors may highlight the lack of agreement between child and parent reports. This possibility seems plausible since the correlations of the TSCYC and the UCLA PTSD Reaction Index were significant. Thus, the finding may illustrate the need for a multi-informant approach when working with children rather than pointing to some psychometric weakness of the TSCYC. The differences between child and parent reports of trauma may be related to the characteristics of the different PTSD symptom clusters. For example, the symptoms of arousal are primarily behaviors that might otherwise be described as externalizing behaviors. Thus, parents may be organizing and reporting the child's response to trauma through reports of these observable, externalizing behaviors. The re-experiencing symptoms are more like internalizing symptoms. Therefore, children may report more of the re-experiencing symptoms than parents. The avoidant symptoms too represent behaviors which are external, but the attribution of purpose for the behavior must be inferred. These inferences may not be known by parents, and younger children may lack the meta-cognitive skills to report on their behavior, let alone the motivation of the behavior. In the future, an evaluation of parent-child agreement for each specific symptom may clarify possible trends or differences by the source of the report. Additionally, with larger sample sizes, differences and similarities between parent and child reports can be examined as a function of age. That is, agreement for specific clusters may vary as a function of age.

Findings for convergent validity were similar to those reported by Gilbert (2004), though the correlation coefficients were a greater magnitude in this study. The convergent validity of the Anger, Sexual Concerns, Anxious, and Depressed Factors supports the use of the TSCYC in lieu of the CBCL if time and resources are limited. This dilemma frequently presents itself in settings where abused children are screened, evaluated, or provided therapy. That is, there is a need for a quick and accurate assessment of multiple dimensions of symptoms including post-traumatic stress. Thus, with replication of these findings, the TSCYC may have

potential as a screening and assessment measure for children with a known history of sexual abuse and for children with a higher risk of unreported CSA (e.g., children admitted to foster care for a documented history of neglect, physical abuse, parental substance abuse, or witnessing domestic violence).

There are several limitations of the study. First, these were treatment-seeking families and their children. Thus, there were no non-abused children included in the study. Also, not all families and children completed all measures. This was allowed since the clinicians might have judged that immediate therapeutic interventions were warranted as opposed to extensive assessment. While a limitation, it also serves as a practical reminder of the need for a single measure like the TSCYC to be used in screening and assessment. Finally, the sample included some youngsters older than 12. This was done during the research phase of TSCYC development and helped to augment the parent input related to their children.

As suggested future studies examining convergent validity as a function of age of the child may prove useful. The category of avoidant symptoms is particularly perplexing and worthy of further study. Specifically, for parents, they must observe and report ion specific behaviors and infer the function of those specific behaviors. For children, a description of those same behaviors and their function requires a level of meta-cognition that may be beyond children of early elementary age. Further evaluation of these phenomena using a standardized measure like the TSCYC ultimately may lead to developmentally sensitive modifications of the diagnostic criteria in subsequent versions of the DSM.

For now, the TSCYC has great promise as part of a multi-informant package of screening and assessment in the identification of treatment needs of children who are sexually abused. By including parents in the assessment process, not only might the accuracy of the child's functioning be supplemented, but this type of input and engagement may lead to positive involvement of parents in the treatment of their children.

## REFERENCES

- Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 Profile*. Burlington: University of Vermont, Department of Psychiatry.
- Ackerman, P. T., Newton, J. E. O., McPherson, W. B., Jones, J. G., & Dykman, R. A. (1998). Prevalence of post-traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse & Neglect*, 22(8), 759-774.

- Briere, J. (1989). *The Trauma Symptom Checklist*. Odessa, FL: Psychological Assessment Resources, Inc.
- Briere, J. (1992). Methodological issues in the study of sexual abuse effects. *Journal of Consulting and Clinical Psychology, 60*(2), 196.
- Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) professional manual*. Odessa, FL: Psychological Assessment Resources.
- Briere, J. (1999). *The Trauma Symptom Checklist for Young Children*. Odessa, FL: Psychological Assessment Resources, Inc.
- Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., et al. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *International Journal of Child Abuse and Neglect, 25*, 1001–1014.
- Burton, D. L. (1996). *Cognitive factors in sexually aggressive children*. Unpublished doctoral dissertation, University of Washington, Seattle.
- Chu, J. A., & Dill, D. L. (1990). Dissociative symptoms in relation to childhood physical and sexual abuse. *American Journal of Psychiatry, 147*, 887–892.
- Deblinger, E., McLeer, S. V., Atkins, M., Ralphe, D., & Foa, E. (1989). Post-traumatic stress and sexual abuse, physically abused, and non-abused children. *International Journal of Abuse and Neglect, 13*, 403–408.
- Dykman, R., Newton, J., Ackerman, P., Chaffin, M., Wherry, J. N., et al. (1997). Internalizing and externalizing characteristics of sexually and/or physically abused children. *Integrative Physiological and Behavioral Science, 32*(1), 62–74.
- Elliott, D. M., & Briere, J. (1994). Forensic sexual abuse evaluations of older children: Disclosures and symptomatology. *Behavioral Sciences and the Law, 12*, 261–277.
- Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1996). Childhood sexual abuse and psychiatric disorder in young adulthood: II. Psychiatric outcomes of childhood sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1365–1374.
- Friedrich, W. N. (1993). Sexual victimization and sexual behavior in children: A review of recent literature. *Child Abuse and Neglect, 17*, 59–66.
- Friedrich, W. N. (1994). Assessing children for the effects of sexual victimization. In J. Briere (Ed.), *Assessing and treating victims of violence* (pp. 17–27). San Francisco, CA: Jossey-Bass.
- Friedrich, W. N. (1998). *The Child Sexual Behavior Inventory professional manual*. Odessa, FL: Psychological Assessment Resources.
- Friedrich, W. N., Grambsch, P., Damon, L., Hewitt, S. K., Koverola, C., Lang, R. A., et al. (1992). Child Sexual Behavior Inventory: Normative and clinical comparisons. *Psychological Assessment, 4*(3), 303–311.
- Gale, J., Thompson, R. J., Moran, T., & Sack, W. H. (1988). Sexual abuse in young children: Its clinical presentation and characteristic patterns. *Child Abuse & Neglect, 12*, 163–171.
- Gilbert, A. M. (2004). Psychometric properties of the Trauma Symptom Checklist for Young Children (TSCYC). *Dissertation Abstracts International, 65*(01), 478. (UMI No. 3118171)
- Kolbo, J. R., Blakely, E. H., & Engleman, D. (1996). Children who witness domestic violence: A review of empirical literature. *Journal of Interpersonal Violence, 11*, 281–293.

- Lanktree, C., Briere, J., & Zaidi, L. (1991). Incidence and impact of sexual abuse in a child outpatient sample: The role of direct inquiry. *Child Abuse & Neglect, 15*, 447-453.
- Margolin, G., & Gordis, E. B. (2000). The effects of family and community violence on children. *Annual Review of Psychology, 51*, 445-479.
- Martinez, P., & Ritchers, J. E. (1993). The NIMH Community Violence Project, II: Children's distress symptoms associated with violence exposure. *Psychiatry, 56*, 22-35.
- McLeer, S., Deblinger, E., Atkins, M., Foa, E., & Ralphe, D. (1988). Post-traumatic stress disorder in sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry, 27*, 650-654.
- McLeer, S., Deblinger, E., Henry, D., & Oraschel, H. (1992). Sexually abused children at risk for post-traumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 317*, 875-879.
- Rind, B., Tromovitch, P., & Bauseman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin, 124*, 22-53.
- Roussos, A., Goenjian, A. K., Steinberg, A. M., Sotiropoulou, C., Kakaki, M., Kabakos, C., et al. (2005). Post-traumatic stress and depressive reactions among children and adolescents after the 1999 earthquake in Ano Liosia, Greece. *American Journal of Psychiatry, 162*(3), 530-537.
- Shakoor, B., & Chalmers, D. (1991). Co-victimization of African-American children who witness violence: Effects on cognitive, emotional, and behavioral development. *Journal of the National Medical Association, 83*, 233-238.
- Shapiro, S., & Dominiak, G. (1990). Common psychological defenses seen in the treatment of sexually abused adolescents. *American Journal of Psychotherapy, 44*, 68-74.
- Singer, M. L., Anglin, T. M., Song, L. Y., & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association, 273*, 477-482.
- Spiegel, D. (2000). Suffer the children: Long-term effects of sexual abuse. *Society, 37*, 18-20.
- Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles Post-traumatic Stress Disorder Reaction Index. *Current Psychiatry Reports, 6*, 96-100.
- Wyatt, G. E., Loeb, T. B., Solis, B., & Carmona, J. V. (1999). The prevalence and circumstances of child sexual abuse: Changes across a decade. *Child Abuse & Neglect, 23*, 45-60.

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