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Behavioral and Emotional Indicators of Sexual Abuse: A Comparison with Physically Abused and Non-Abused Children

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BEHAVIORAL AND EMOTIONAL INDICATORS OF SEXUAL ABUSE:
A COMPARISON WITH PHYSICALLY ABUSED AND
NON-ABUSED CHILDREN

By

Janine L. Post-Anderle

A THESIS

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ABSTRACT

BEHAVIORAL AND EMOTIONAL INDICATORS OF SEXUAL ABUSE: A COMPARISON WITH PHYSICALLY ABUSED AND NON-ABUSED CHILDREN

By

Janine L. Post-Anderle

The focus of this study was to identify behavioral and emotional symptoms among hospitalized children who were 1) sexually abused 2) physically abused 3) non-abused, and non-hospitalized non-abused children.

Information about children between the ages of 6 and 12 was obtained through a retrospective analysis of 120 closed records from two different child psychiatric hospitals. A convenience sample of 40 parents with non-hospitalized children was used to obtain data about non-hospitalized non-abused children.

The "Child Behavior/Emotion Checklist", developed by the author, was used to collect data regarding symptoms exhibited by children. Results indicated no difference in symptoms among the hospitalized groups of children. Significant differences in the areas of depression, anxiety and symptoms of post-traumatic stress disorder were found when the hospitalized children were compared to non-hospitalized children.

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CHAPTER 1

INTRODUCTION

Mental health care professionals encounter children with a variety of different backgrounds and experiences. The biological, psychological and social well-being of children is strongly influenced by their life experiences. Alterations in the well-being of children may lead to the need for hospitalization. Many hospitalized children have experienced physical and/or sexual abuse. As a result of the abuse, psychological disturbances have occurred and the need for assistance from mental health care professionals becomes necessary.

In addition to children with varied backgrounds, mental health care professionals also encounter children with varied symptoms. Children with psychological disturbances display a variety of emotions and behaviors. The Diagnostic and Statistical Manual, 4th edition, (American Psychiatric Association, 1994) lists many childhood disorders with specific symptoms that must be present to meet the criteria for each diagnosis. Symptoms are often similar among different diagnoses. Therefore it is of vital importance to be

aware of the differences as well as the similarities in symptomatology that children may exhibit.

Psychiatric nurses in inpatient settings play an important role in identifying the symptoms that are displayed by children. Current research indicates that abused children can resolve physical and sexual abuse with appropriate treatment (Burgess, Hartman & Kelley, 1990). Nurses can provide effective treatment to children with abuse histories by correctly interpreting their symptoms and implementing appropriate interventions. Awareness of symptoms of sexual and physical abuse is vital to the development of an effective plan of care for the child. Although the histories of children are not always clear, professionals can make interpretations about the child's history based on his/her behavior and symptomatology.

Psychiatric nurses may also encounter children who have not been abused. Non-abused children may display symptom similarities and differences. This poses a challenge to psychiatric nurses to be aware of the similarities and differences in behavior that abused children and non-abused children display, to accurately interpret the symptoms, and to develop effective treatment plans.

Due to the diversity of abuse backgrounds encountered in the mental health field, it is important to clarify if symptomatology is specific to type of abuse and which symptoms differentiate the types

of abuse. Because language skills increase as a child develops, younger children may be more likely to display symptoms rather than verbalize them. Therefore, children may “act out” their thoughts and feelings rather than put them into words. Some questions which arise from this situation are: What symptoms do abused children exhibit that are specific to the type of abuse they have experienced? What symptoms do non-hospitalized and non-abused hospitalized children exhibit that may simply be indicative of normal childhood stress and development? How are these symptoms different between non-hospitalized and hospitalized children? As a means of answering these questions, the purpose of this research study was to determine if a relationship exists between children’s histories of abuse and the symptoms they exhibit.

This study builds on previous research done by Morris and Bihan (1991). Their study focused on the prevalence of history of sexual abuse in 4 to 12 year old children who were hospitalized in an inpatient psychiatric setting. The findings of Morris and Bihan (1991) indicated that a significant proportion of the children’s records which were examined, had a documented history of sexual abuse. Of the records of children with no documented history of sexual abuse, 33% included prevalent symptoms of sexual abuse. The present research study used more data collection sites and

employed the use of a different assessment tool to determine putative sexual abuse symptomatology.

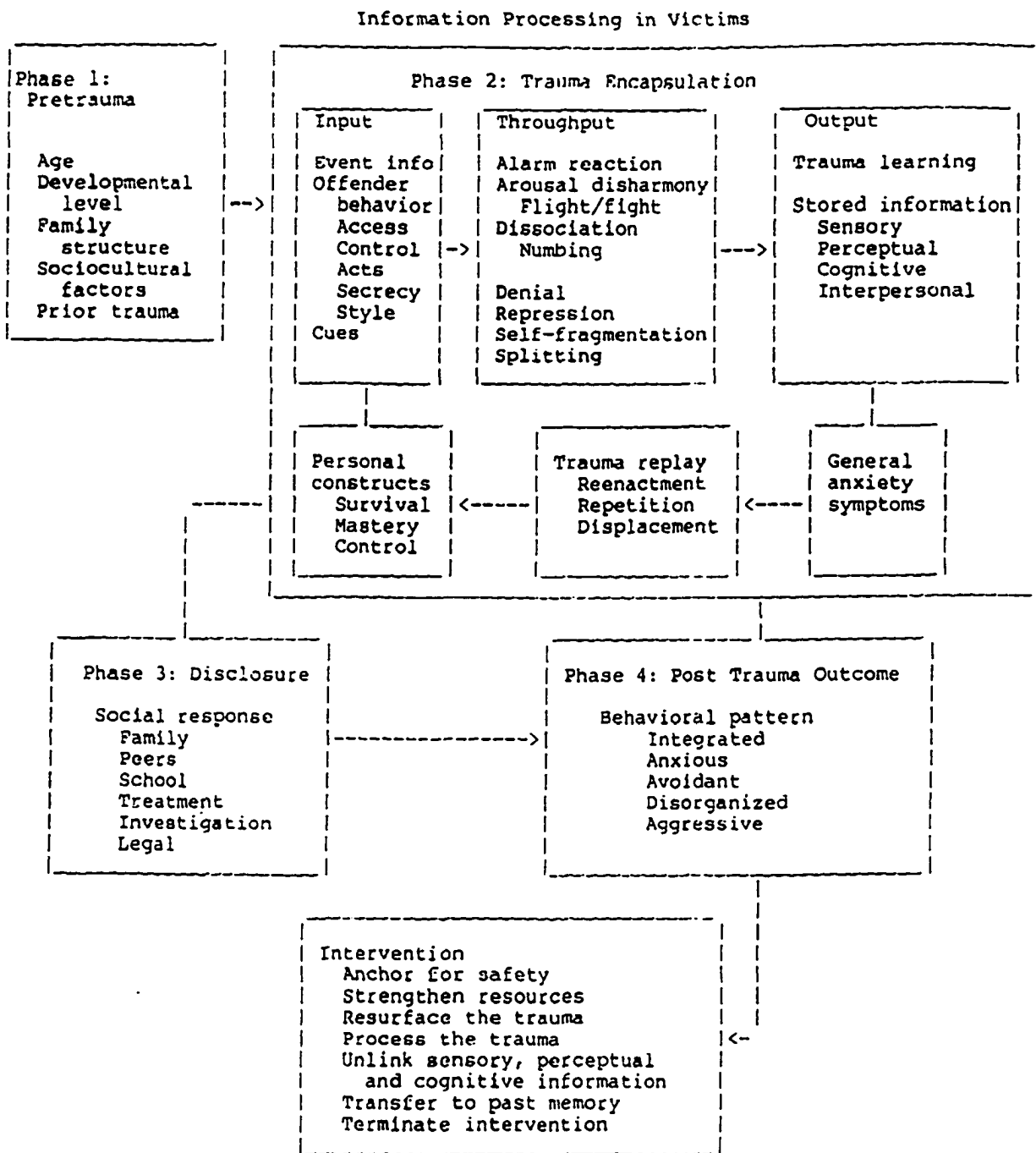
CHAPTER 2

CONCEPTUAL FRAMEWORK AND REVIEW OF THE LITERATURE

Conceptual Framework

The theory of information processing of trauma. Hartman and Burgess (1988) developed a theory of the information processing of trauma. Their theory describes the cognitive processing of traumatic events such as sexual abuse. It includes a framework for understanding the response patterns of traumatized individuals and appropriate interventions for their treatment. Hartman and Burgess's (1988) theory holds particular significance for the treatment of sexually abused children. Health professionals working with victimized children must have knowledge of the trauma that sexually abused children have experienced and the way in which processing of this experience occurs.

Hartman and Burgess (1988) describe four phases in their model of information processing of trauma (Figure 1). Phase I, the pretrauma phase, identifies factors that exist prior to the



Hartman CR and Burgess AW: Information Processing of Trauma, *J Interpersonal Violence* 3 (4) December 1988:443-457.

Figure 1. Information Processing in Victims.

trauma and influence differences in the stress response of traumatized individuals. The factors included in the pretrauma phase are developmental level, family structure, sociocultural factors, and prior trauma. These factors influence the child's response to the trauma and the resolution of the traumatic event.

In phase II, the trauma encapsulation phase, a child uses defense mechanisms to conceal the abuse. The secrecy demands from the offender make the defense mechanisms necessary. These defense mechanisms enable a child to manage his or her daily life while keeping the abuse concealed. The cognitive defense mechanisms protect the individual from the anxiety produced by the trauma. Some individuals may be totally unaware of the traumatic event, while others may be fully aware of the event. These defense mechanisms in the trauma encapsulation phase include: denial, dissociation, repression, self-fragmentation, splitting, drive disharmony, suppression and compartmentalization. As a result of the activation of these defense mechanisms, other psychological development is disrupted and the individual's personality is affected.

The third phase of Hartman and Burgess's (1988) model of information processing of trauma is the disclosure phase. Upon disclosure of the trauma, a secondary trauma impact may occur as a result of the reactions of the child's social network, family, peers and

legal system and other professionals. This secondary impact can result in reformulation of the trauma or a feeling of safety and security for the child. Therefore, appropriate reactions and interventions at this time are vitally important to prevent reformulation of the trauma.

The fourth phase is the posttrauma phase. This phase includes the child's behavioral response pattern which may be integrated, anxious, avoidant, disorganized, or aggressive. Integration, the most healthy response pattern, is achieved by trauma resolution. Mental health professionals can assist a traumatized individual to integrate the trauma by helping the individual remember the event, neutralize the feelings surrounding the event, and gain control over anxiety related to the trauma.

In the event that a child does not disclose the trauma, he/she remains in Phase II, the trauma encapsulation phase. This poses a challenge to professionals to determine the presence of symptomatology which may indicate victimization. Professionals need to have an awareness of trauma symptomatology, excellent assessment skills, and an understanding of the information processing of the traumatized child. This is the focus area of the proposed study and an important area to be explored in psychiatric nursing.

Abused children may display a variety of behavioral and emotional symptoms. Hartman and Burgess include trauma symptoms in their theory when they describe the general anxiety symptoms and trauma replay. Trauma replay is the repetition of the specific action, reactions and behaviors that a child developed during the trauma. This includes children mimicking the abuse with another person (repetition), reliving the event (reenactment), and the use of external objects such as dolls or drawing as a symbolic representation of the abuse (displacement). The general anxiety symptoms described by Hartman and Burgess (1988) include hypervigilance, sleep disturbances, fear and anxiety, enuresis and physical symptoms. The symptoms of child sexual abuse are well represented in Hartman and Burgess's model of information processing of trauma. The general anxiety symptoms and trauma replay that Hartman and Burgess (1988) describe in their model can assist professionals to determine if some type of trauma might have occurred.

Professionals usually become involved when disclosure of the trauma occurs or trauma is suspected. Interventions are used to reveal the structure of the trauma learning, integrate the trauma and eventually transfer the trauma to past memory. Hartman and Burgess(1988) suggest six basic principles professionals can use to

assist individuals in the resolution of the trauma:

1. Anchoring for safety. It is important for abused children to learn how to trust others. The development of safe and therapeutic relationships with reliable adults can help children re-establish a sense of safety and a belief in a safe world.

2. Establish stress reducing resources. Teaching the traumatized children new ways to calm themselves when they feel anxious by capitalizing on their inner resources provides a valuable skill that can be used to reduce anxious feelings. Through relaxation, self-confidence, mastery, control and appropriate ways to ventilate anger, children can manage stress more effectively.

3. Bringing the trauma to surface. This principle involves allowing children to disclose the trauma at their own pace. The first two principles, anchoring for safety and establishing stress reducing resources, create an environment which is conducive to allowing children to disclose the trauma. Stress reducing resources may need to be recalled to assist children in reducing any anxiety created by disclosing the abuse.

4. Process the trauma. Children are assisted in exploring their actions, emotions and thoughts during the trauma. Sensory, perceptual and cognitive aspects of the trauma are explored with the children. The aim is to help the children understand their present

safety.

5. Transferring the processed or integrated trauma to past memory. According to this principle, children place the processed trauma out of the present and into the past. Since the sensory, perceptual and cognitive aspects of the trauma have been explored, children can cope more effectively with the anxiety related to the memory of the trauma.

6. Termination of therapeutic relationship and follow-up. By summarizing the reformulation of the trauma, closure is brought to the processing of the trauma. The therapeutic relationship is terminated and plans for following progress are made.

In summary, Hartman and Burgess's (1988) theory of information processing provides a foundation for professionals working with victimized children. The theory pinpoints areas where professionals need to be especially alert in order to accurately interpret symptoms of trauma in an individual. In addition, this model's clear descriptions of trauma related symptoms and defense mechanisms help professionals understand the effects of trauma and the cycle that can result from unprocessed traumatic experiences. The model also provides professionals with guidelines for treating traumatized children.

Normal growth and development for children of age 6-12. The accurate interpretation of symptoms of traumatized children is extremely important. Symptom similarities and differences may exist among children with different abuse backgrounds. When examining these, the need for an understanding of normal childhood behavior becomes apparent. The behavioral and emotional areas of anger, anxiety, depression, sexual behavior, and dissociation were the focus of this study and will be described for children in the 6-12 year age group. The work by Papalia and Olds (1986) will be the source of the following information.

Anger is sometimes displayed in the form of aggressive behavior. Aggression is a common behavior in young children between the ages of 2 1/2 and 5. These young children show aggression when conflicts arise around toys or space. After age 6-7 children are considerably less aggressive. As children grow older, they develop more positive social skills, more effective communication patterns, and cooperative abilities. The development of these additional skills give children more alternatives to aggression. In addition, as children become less egocentric, they are able to put themselves in another's "shoes" and the resulting empathy causes a decrease in aggressive behavior.

Anxiety or fear is common in middle childhood. Fears of

animals, fears at bedtime and scary dreams are prevalent. Ten to twelve year olds have fears of bodily injury and physical danger. Developmentally, as children age they lose their sense of powerlessness and many of their fears disappear.

Another common life experience for middle childhood is stress. Stress is a part of life even for children. Normal childhood stress influences the behavior and emotions of children. Illness, separation from parents, new siblings, and the death of a pet are some stressful situations children encounter. Some children encounter more severe stressors such as divorce, the death of a parent, hospitalization, poverty, physical or sexual abuse, and environmental disasters.

Since stressful events can affect the normal healthy emotional development of children, emotional disturbances can occur. Depression is one disturbance that can result from childhood stress. Children may develop symptoms of depression which include; anhedonia (the inability to experience pleasure), decrease in school performance, difficulty concentrating, frequent crying, excessive sleeping or insomnia, decreased appetite, unhappy appearance, an increased or decreased activity level, and thoughts about suicide or death. Other symptoms of stress which are classified as posttraumatic stress symptoms by the DSM-IV (American Psychiatric Association, 1994) include: recalling scary experiences, nightmares,

flashbacks, dissociation, denial of feelings, diminished interest in activities, and forgetfulness. When children exhibit several of these symptoms, an emotional disturbance exists, usually as a result of a stressful or traumatic experience.

Dissociative symptoms in children may occur as a result of a traumatic and stressful experience. Children with dissociative symptoms display withdrawal from reality which is not present in normal childhood development. Like depression, dissociation can develop as a result of stressful experiences which indicate emotional disturbance.

Peplau and Olds (1986) suggest that a minimal amount of literature exists on the topic of normal middle childhood sexual behavior, although the literature abounds with normal adolescent sexual behavior. Societal norms determine what is considered appropriate and inappropriate sexual behavior. Any behavior outside of the social norms is considered “inappropriate.” Societal norms for children in middle childhood would classify the following behaviors as inappropriate or abnormal: talking about sex, touching another’s privates, excessive masturbation, and having recurrent thoughts about having sex.

In addition to the influence of stress on normal childhood behavioral and emotional development, academic achievement

affects childhood development. Many children have difficulty in school. Having academic problems can lead to social difficulty and self-esteem problems. Children may have a learning disability, emotional disturbance or, on the other extreme, giftedness. Learning disabled children often are more aggressive and have a lower self-esteem. This can interfere with their personality development and cause emotional as well as behavioral problems. Gifted children may feel unchallenged, bored or frustrated in school, this also can lead to behavioral disturbance resulting in aggression, frustration, and anger.

Review of the Literature

The literature contains research on different aspects of child abuse. In some studies, data have suggested the identifying symptoms of sexual abuse and its long-term effects. Other studies have compared the symptomatology of sexually abused, physically abused and non-abused children. Additionally, research findings indicate the benefit of early treatment for those who have been victims of sexual abuse.

Histories of sexual abuse and symptomatology in children.

Morris and Bihan (1991) and Kolko and Moser (1988) conducted research that is similar to that reported here. The best example is the study conducted by Morris and Bihan (1991). In their research,

Morris and Bihan studied the prevalence of a history of sexual abuse among children in an inpatient setting. Of the 100 charts reviewed, 31% of the children had a documented history of sexual abuse. The remaining 69% had no documented history of sexual abuse. All the records were examined for specific sexual abuse symptomatology using a checklist of 49 symptoms of sexual abuse taken from the literature. The checklist was compiled by the authors. The results indicated that 77% of the total sample displayed prevalent symptoms of sexual abuse. Morris and Bihan (1991) also examined nursing care plans. Of the 31 records of children with a documented history of sexual abuse, only three nursing care plans referred to the sexual abuse. None of the nursing care plans of children with no documented history and prevalent sexual abuse symptoms addressed sexual abuse. These findings emphasize the gap in recognizing and treating sexual abuse in children even when the sexual abuse has been identified. The findings of this study may not be generalizable to other children in child inpatient units because only one inpatient setting was used. Another limitation lies within the methodology. The checklist used had no mention of validity or reliability. One drawback of this research is the lack of a theoretical framework.

Another study by Burgess, Hartman and McCormack (1987)

illustrates the relationship between histories of sexual abuse and symptomatology. Thirty-four sexually abused children were compared to 34 control subjects who had no history of sexual abuse. Study one included a sibling control group ($n=34$). Study two included a school mate control group ($n=34$). The same 34 sexually abused children were compared with the sibling control group and the school mate control group. Both studies collected data through semi-structured interviews using questioning and a variety of data collection tools. Each subject was assessed by using the Piers-Harris Children's Self-Concept Scale and the Moos Family Environment Scale. The sexually abused subjects in both studies showed higher levels of anxiety, fears and intrusive thinking after disclosure of the abuse than the control subjects who had not been abused. The small sample size and lack of random sampling limits the generalizability of this study. In addition there were more males ($n=23$) than females ($n=11$). Various tools with well established reliability and validity were used which increases the credibility of the research.

Friedrich and Ream's (1987) findings were similar. Eight sexually abused children were monitored for 10 to 18 months for psychological responses to the sexual abuse. The Child Behavior Checklist (CBCL), which measures a child's social competence, was the tool used to collect the symptoms of each child. Although this study

did not collect data on a random sample, the results were similar to other studies, and indicated that sexually abused children develop psychological and behavioral responses as a result of the sexual abuse. Common patterns among the sexually abused children were discovered. Children with symptoms of depression and somatic complaints eventually showed an increase in aggressive behavior. In addition, sexualized behavior was prevalent in 5 of the 8 subjects. Another important observation was improved functioning of the sexually abused children who were in treatment. Friedrich and Reams conclude, "Children who did not receive treatment did not get better; in fact, they deteriorated with almost every assessment. Children who received treatment improved their overall functioning as determined by parental report and therapist's impressions " (p.169).

Limitations of this study include a small sample size which was not selected randomly. In addition to the small sample size, five of the eight children were undergoing psychotherapy during the time of the study. The psychotherapy variable was not controlled in the study, limiting the generalizability of the results. A strength of this research is the longitudinal nature of the study. Children were studied for a period of 24 months. Another strength is the use of the Child Behavior Checklist (CBCL) which has well established reliability

and validity.

Briere and Runtz (1987) studied the long-term effects of childhood sexual abuse in 152 teenage and adult women. The Crisis Symptom Checklist (CSC) was used in the data collection process. Of the 152 subjects who sought help from a health center crisis service, 44% of the women reported a history of sexual abuse. Subjects with a history of sexual abuse also reported more dissociation, sleep disturbance, tension, sexual problems and anger than the non abused subjects. This research by Briere and Runtz (1987) emphasizes the prevalence of sexual abuse and the long term psychological effects from childhood sexual abuse. The statistical analysis of the results shows strong evidence of differences between sexually abused and non-abused individuals. The comparison between abused subjects ($n=67$) and non-abused subjects ($n=85$) emphasizes the link between childhood sexual abuse and later psychological disturbance including suicidality, anxiety and chronic anger. The moderate sample size, limited to females seeking psychotherapy indicates some limitations of generalizability.

Comparisons of sexual abuse to physical abuse and non-abuse.

The symptomatology associated with sexual abuse has been described in the previously described research. Other research has focused on comparing symptoms of sexual abuse to symptoms

exhibited by physically abused and non-abused children. Kolko and Moser (1988) compared 29 sexually abused children, 52 physically abused children, and 44 non-abused children in a psychiatric hospital. The children were assessed for behavioral and emotional indicators of sexual abuse. Two methods of data collection were used in this study. First, each child's behavior was rated during a parental interview. Second, data were collected by frequency counts of symptoms exhibited by the children during a three week period of hospitalization. A sexual abuse symptom checklist was used to rate the observations of each child in the two situations. Interrater reliability was established. When the sexually abused children were compared to the non-abused children, a greater degree of deviant behavior was found in the sexually abused subjects. More sexual behavior, fear, anxiety, withdrawal and sadness were observed in the sexually abused children than in the physically abused and non-abused subjects. There were no significant differences between physically abused subjects and non-abused subjects. The physically abused group did not show a clear symptom cluster as did the sexually abused group of children. These results indicate the specific and prevalent symptoms sexually abused children exhibit. The generalizability of the research is weakened by the use of only one child psychiatric unit.

The findings of Johnson and Aoki (1993) were similar to those of Kolko and Moser (1988). The behavior of 158 children between the ages of 6-11 in residential treatment was assessed. The tools for data collection included the Child Behavior Checklist and the Child Sexual Behavior Checklist. For analysis, the subjects were divided into four groups; sexually abused, physically abused, both sexually and physically abused, and non-abused. The most sexualized behavior was found in the subjects that were both sexually and physically abused. The group of subjects who had histories of sexual abuse only also had more sexualized behavior than physically abused and non-abused subjects, but was not significantly different from the group of both sexually and physically abused children. These results indicate that unique clinical symptoms are exhibited by sexually abused children when compared to physically abused or non-abused children. Although the number of subjects is adequate, the use of subjects from one selected site limits the generalizability of this study. In addition, the non-abused children from this residential treatment site may not represent a good comparison of normative sexual behavior.

Play behaviors of sexually abused, physically abused and non-abused preschool children were examined by Fagot, Hagan, Youngblade, and Potter (1989). Fifteen children between the ages of

3 and 5 were observed during free play times. Differences were found between each of the groups. Sexually abused children were more passive and quiet. Physically abused children were more antisocial, disruptive, and aggressive. The abused children reacted to the teacher's feedback more negatively than did the non-abused children. This very small sample size limits the value of this study for the general population, but it does indicate that childhood abuse has effects on the child at early ages.

In contrast to the findings of Johnson and Aoki (1993) and Fagot and associates (1989), Kiser, Heston, Millsap and Pruitt (1991) discovered that children and adolescents develop similar clinical symptoms regardless of the type of abuse (sexual or physical) that they experienced. They studied 163 children and adolescents in a day treatment program. The CBCL and several other standardized measures were used to collect data on the individual, the family, and the treatment group. Eighty-nine of the patients reported a history of physical and/or sexual abuse. Of the subjects with abuse histories, there were 49 who met criteria for Post Traumatic Stress Disorder (PTSD). Discriminant function analysis of the abused subjects with PTSD revealed that PTSD was more likely to develop in the subjects who had more severe physical abuse, more physical abuse perpetrators, and a longer duration of sexual abuse. These

findings indicate that individuals may develop similar clinical symptoms on the basis of victimization and not based on the specific type of abuse. The large sample size strengthens this study. Yet the use of a single site limits its generalizability.

Stovall and Craig (1990) also found similarities in the clinical symptoms of children with sexual abuse and physical abuse histories, but differences when clinical symptoms of abused children were compared with non-abused children from distressed homes. Sixty female children, ages 7-12 were studied using the Thematic Apperception Test (TAT) and Piers-Harris Children's Self-Concept Scale. Statistical analysis showed no difference in mental representations between the sexually abused group and the physically abused group. Yet when the abused subjects were compared to the non-abused subjects a significant difference was observed in mental representations on the TAT and Piers-Harris Children's Self-Concept Scale. The authors suggest that this difference is related to the actual abuse, whether sexual or physical, and not the distress of the family that results in impaired functioning and impaired object relations. The all female sample weakens this study, yet the use of well developed and standardized tools adds strength.

A final study conducted by Hart, Mader and Griffith (1989)

compared sexually abused individuals to physically abused and non-abused individuals. Fifty-one adolescent inpatients were assessed for behavioral and emotional problems through the use of self-report instruments. Adolescents who had been both sexually and physically abused (27%) reported the most problems. The subjects who were sexually abused without accompanying physical abuse (6%) scored higher on the socialized aggression scale. The authors offer this finding as a possible indication of greater social deviance in sexually abused subjects. The small number of subjects, particularly the small number of sexually abused subjects limits the generalizability of this research. It is consistent with Johnson and Aoki (1993) who also found a greater degree of dysfunction in individuals who have both sexual abuse and physical abuse histories.

Histories of sexual abuse and symptomatology in adults. Other research studies focus on the relationship between long-term symptoms of sexual abuse and histories of sexual abuse. One such study was done by van der Kolk, Perry, and Herman (1991). Seventy-four adults with personality disorders or bipolar disorder were followed for four years. These adults were observed for self-destructive behavior such as self-injury, suicide attempts and eating disorders. Of the 74 subjects, 61 (87%) reported histories of self-destructive behavior. Of these, 52 reported childhood trauma.

Sexual abuse was the trauma most strongly correlated to self-destructive behavior ($r=.36$, $p=0.01$). The study concludes that histories of childhood sexual and physical abuse are highly significant predictors of self-cutting and suicide attempts.

Vanderkolk et al. (1991) suggest that histories of childhood physical and sexual abuse are strong indicators of self-destructive behavior in adulthood. The longitudinal nature of this study is beneficial. The limitations of this study are due to a moderate sample size and the acquisition of subjects from a single area.

Briere (1988) conducted a study with 133 sexually abused and 61 non-abused adult female clients in an outpatient setting. Briere looked for differences in the score on the Crisis Symptom Checklist (CSC) which is a compilation of symptoms associated with childhood sexual abuse. The sexually abused clients scored higher on four of the CSC subscales than did the non-abused clients. Higher scores for sexually abused subjects were found on the dissociation, sleep problems, sexual problems and anger subscales. Also sexually abused subjects reported greater substance addiction and self destructiveness and were more likely to be sexually revictimized as adults. The moderate sample size from one location may limit the generalizability of this study. This research is valuable as it offers important information regarding the long-term effects of sexual

abuse on children compared with non-abused children.

Another study done by Briere and Zaidi (1989) examined history of sexual abuse in female psychiatric emergency room patients. The charts of 100 women were reviewed. When the sexually abused clients were compared to the non-abused clients, greater incidence of suicidal ideation, drug abuse, suicide attempts, sexual problems, and self-destructive behaviors were seen in those clients with a history of sexual abuse. Given the moderate and exclusively female sample, the generalizability of this study is limited. In addition, the research is limited by the use of only one site from which charts were selected.

The sexually abused individual and treatment. There is strong evidence that prompt and appropriate treatment for sexually abused individuals can be effective in assisting individuals to overcome this trauma. The previously described study by Friedrich and Reams (1987) points out that when treatment is delayed or no treatment is implemented children act out more. These results emphasize the need for nurses to be alert to histories of sexual abuse and/or behaviors of sexual abuse and to implement appropriate treatment.

A final research study also emphasizes the effectiveness of prompt and appropriate treatment. Burgess, Hartman, Wolbert, and Grant (1987) studied 12 girls who were sexually abused by the same

perpetrator and currently undergoing treatment. The researchers conducted interviews with the children and parents. Data collection for the children included attribution questions and drawings. The study focused on the impact of the abuse on the girls, validating the phases of Hartman and Burgess's theory of the information processing of trauma. The results showed the great impact the sexual abuse had on the children's performance, social interaction and, subsequently, their personalities. Many symptoms of post traumatic stress disorder were apparent. The researchers summarize the results by emphasizing that intervention is needed at the time of disclosure to assist in the recovery of the victim. Although the sample was small and all subjects had the same abuser, the results stress the importance of intervention by the mental health care provider to promote positive processing of the traumatic event.

Summary

The literature reviewed suggests the tremendous impact sexual abuse can have on individuals throughout their lifetime. Although the majority of research has been with female subjects, the results support the early and accurate recognition of sexual abuse to provide direction to mental health care professionals and promote effective treatment to abused individuals.

The purpose of this study is twofold:

(1) To determine if hospitalized children exhibit abuse-specific symptomatology

(2) To identify differences in symptomatology among the three groups of hospitalized children who had been either sexually abused or physically abused or not abused and the non-hospitalized non-abused children

Four groups of children will be examined: (a) hospitalized children with a history of sexual abuse, (b) hospitalized children with a history of physical abuse (c) hospitalized children with no history of abuse and (d) non-hospitalized, non-abused children.

For the purpose of this study, a child with a history of sexual abuse was defined as a child between the ages of 6 and 12 with a history of sexual abuse and no history of physical abuse as documented in the psychosocial history done upon admission. A child with a history of physical abuse was defined as a child between the ages of 6 and 12 with a history of physical abuse and no history of sexual abuse as documented in the psychosocial history done upon admission. Non-abused hospitalized children were defined by no history of sexual or physical abuse in the psychosocial history. Non-hospitalized non-abused children were defined as children between the ages of 6 and 12 without inpatient psychiatric hospitalizations

and no history of physical or sexual abuse.

Hypotheses

Based on the stated research questions, the need for a study to further examine the relationship between children with histories of sexual abuse, physical abuse, and non-abuse and symptomatology was suggested. The following hypotheses were posed:

- H₁ Hospitalized children with a documented history of sexual abuse will have different symptomatology than hospitalized children with a documented history of physical abuse and hospitalized children with no documented history of physical or sexual abuse.
- H₂ Hospitalized children will have a greater number of symptoms than non-abused, non-hospitalized children.
- H₃ Children who are within the ages of 6-9 will demonstrate different symptomatology than children who are within the ages of 10-12.

CHAPTER 3

METHODOLOGY

Design

This was a descriptive-correlational design utilizing a retrospective chart review methodology and a survey methodology. The purpose of the data collection was to gather information regarding the behaviors and emotions exhibited by children. Four groups were examined: (a) hospitalized children with a history of sexual abuse, (b) hospitalized children with a history of physical abuse, (c) hospitalized children with no history of abuse, and (d) non-hospitalized, non-abused children. Data from the hospitalized sample were obtained through closed records of former inpatient children. This chart review focused on whether there was documentation of a history of sexual abuse, physical abuse, or neither and behavioral and emotional symptomatology. Information from non-hospitalized subjects was obtained through a convenience sample of parents and focused on the behavior and emotions of their children.

Subjects

In the Fall of 1994, a psychiatric nurse examined closed records from two different inpatient child psychiatric hospitals in the Midwest region of the United States. One-hundred twenty charts were reviewed. For the chart review, the target population was former child inpatients with a minimum 3 weeks length of stay and no prior psychiatric hospitalizations. Selected records were of children within the ages of 6-12 during their stay. The second and third weeks of hospitalization were selected for review, to avoid the common “honeymoon” period that occurs during the first week.

In addition to the chart review, a convenience sample of parents was used to obtain data from non-hospitalized subjects. Forty subjects from the convenience sample were obtained. All subjects were split evenly between two age groups: 6-9 years old and 10-12 years old.

Sampling Procedures

Records from the Fall of 1992 to the Fall of 1994 were selected using randomly selected months. Records were reviewed until the number and criteria for each group were met. Each record was assigned an identification number. The number of subjects in each group was 40. The four groups were: (a) hospitalized children with a history of sexual abuse and no history of physical abuse,

(b) hospitalized children with a history of physical abuse and no history of sexual abuse, (c) hospitalized children with no abuse history, and (d) non-hospitalized, non-abused children. Each group contained an even distribution of 6-9 year old children and 10-12 year old children. Once a group was filled, the records were reviewed until the numbers for the remaining groups were met.

The criteria for the selection and elimination of records was as follows. For records of children with a history of sexual abuse, the criteria were documentation of a history of sexual abuse and no history of physical abuse in the psychosocial history or nursing assessment. For records of children with a history of physical abuse, the criteria were documentation of a history of physical abuse and no history of sexual abuse in the psychosocial history or nursing assessment. For records of children with no abuse history, the criteria was no documentation of sexual abuse or physical abuse in the psychosocial history or nursing assessment. For the non-hospitalized non-abused children, criteria were no history of hospitalization and no history of physical or sexual abuse.

The chart review was a retrospective review of the data, and therefore no active contact with human subjects was made. No risk to human subjects was involved other than the risk of breaking confidentiality. To uphold confidentiality, the data collector signed

each institution's confidentiality policy and upheld the standards set forth by the institution. Identification numbers were used only by the researcher for the purpose of data analysis.

The convenience sample of non-hospitalized children was obtained through the researcher's Thesis Committee members and their friends. Questionnaires were distributed to friends with children who met the criteria. A letter to parents (Appendix B) accompanied the checklist. It contained a brief explanation of the study, asked them to fill out the checklist, and requested that no identifying information be placed on the questionnaire. Confidentiality was maintained on the parent questionnaire. Return envelopes were given to parents to insure anonymous return of the questionnaires.

Sample Characteristics

For the group of hospitalized subjects, the mean age was 9. Seventy-four percent were male ($n=89$) and 31% were female ($n=31$). In regard to school functioning, 8% were above average, 31% average, and 61% below average. Only 60% had documented I.Q. scores, with a mean of 89, and a range of 46-130. There were a large number of learning disabled subjects (35%) and a small number of gifted subjects (8%). The most common family situation was a single-parent family (55%). Two-percent of the subjects were in residential

settings and 7% were in foster care homes. The mean number of months since a change occurred in the family structure was 32, with common changes at 1, 2, 4 and 5 years. Depressive Disorder was the most common diagnosis (32%), followed by Major Depression (16%). Oppositional Defiant Disorder and Post Traumatic Stress Disorder were the diagnoses in 8% of the subjects. The sample included children with a history of sexual abuse and no history of physical abuse, children with a history of physical abuse and no sexual abuse, and children with no history of physical or sexual abuse.

The characteristics of the non-hospitalized group were similar to those of the hospitalized group in regard to age. The mean age was 9.7. There was almost an even sex distribution, 47.5% male and 52.5% female. Cognitive levels differed greatly from the hospitalized group as 75% of the non-hospitalized subjects functioned above average in school. The remaining 25% functioned at the average level. According to the parent rater, none of the 40 subjects were functioning below average in school.

Instruments

Child Behavior/Emotion Checklist (CBEC). The chart data were recorded using a checklist developed specifically for this research project, the Child Behavior/Emotion Checklist (Appendix C). This checklist is a 48-item tool that was adapted from two previously

developed checklists: the Trauma Symptom Checklist for Children (TSCC)(Briere,1989) and a checklist by Morris and Bihan (1991). The TSCC is a self-report instrument for 8-12 year old children. The TSCC was developed for the purpose of assessing the specific pattern of disturbance manifested by various types of trauma, including sexual abuse. This 54-item instrument is used to measure short-term reactions to abuse among child victims. The TSCC contains six subscales: anxiety, depression, post-traumatic stress, sexual concerns, dissociation, and anger. The tool was found to be reasonably reliable and valid based on the preliminary analysis of Lanktree and Briere (1990). The reliability for the TSCC subscales is .84. and the mean value of the intercorrelation between the TSCC subscales is $r=.63$. The checklist by Morris and Bihan (1991) consists of 50 items specific to sexual abuse as reported in the literature. No reliability and validity data were published with this instrument.

The TSCC items were compared with the checklist of symptomatology of sexually abused children by Morris and Behan (1991). Items from the TSCC were matched with similar symptoms on the Morris and Bihan checklist. (Appendix D). Upon comparison, many similarities were found. All of the items on the TSCC sexual abuse subscale were represented on the Morris and Bihan checklist. Based on the similarities and consistencies between the tools, a new

checklist, named the Child Behavior/Emotion Checklist (CBEC) was developed incorporating these similarities. The number of items is different in the CBEC because the comparison between the TSCC and the Morris and Bihan checklist resulted in item additions and deletions. Some items were changed or deleted because the method was a chart review rather than a self-report. Upon examination of the literature, the CBEC symptoms are consistent with those of other research studies.

Initially the CBEC consisted of 6 subscales (Table 1). These subscales are PTSD (10 items), Depression (10 items), Anxiety (5 items), Sexual Concerns (7 items), Dissociation (8 items), and Anger (8 items). These subscales are the same as those identified in the TSCC. The following rating scale was used to measure each item on the checklist:

0	1	2	3	4	5
Never	Rarely	Once/week	Every other day	Every day	> Every day

Reliability and validity for the checklist was established by the researcher. Internal consistency was established by computing Cronbach's alpha coefficient for the subscales and for the total scale. Reliability for the total scale was .79. For the subscales, initial reliabilities were as follows: PTSD=.29, Depression=.46, Anxiety=.62,

Table 1

Preliminary Subscales of the Child Behavior/Emotion Checklist

Item #	Item descriptor	Item #	Item descriptor
Depression		PTSD	
2	Out of bed at night	1	Bad dreams
8	Feels lonely	4	Scary thoughts
10	Sad or unhappy	11*	Unpleasant memories
16	Cries	13	Recalls scary experience
22*	Hurts self	14	Flashbacks
29*	Washes self/feels dirty	26	Obsessive thoughts
30	Feels stupid/bad	27	Fear of men
31	Blames self	28*	Fear of women
39*	Withdraws from others	36*	Difficulty w/ relationships
42	Feels unliked	47	Unable to concentrate
Dissociation		Anger	
6	Pretends	7*	Argues
12	Daydreams	15	Breaks things
20	Dizzy	18	Difficulty calming
32*	Feels things aren't real	21	Yells
33	Forgets things	23	Hurts others
34*	Feels like not in body	37	Fights
44	Psychotic symptoms	38	Feels angry
46	Denies feelings	45*	Hates others
Sexual Concerns		Anxiety	
5	Says dirty words	3	Feels afraid
9	Touches privates	17	Gets scared suddenly
19	Talks about sex	35*	Shows anxiety
24*	Talks of touching others	40	Fearful of dark
25	Obsessive thought of sex	48	Fearful of safety
41	Upset with talk of sex		
43	Inappropriate sex beh.		

Note: * indicates items deleted from scales due to no variance.

Sexual Concerns=.42, Dissociation=.30, and Anger=.75. To establish interrater reliability, five records were selected and rated using the CBEC by two psychiatric nurses. Eighty-five percent agreement and above was accepted, within the range of plus or minus 1 on the rating scale. This occurred for all items on the checklist. Content Validity was established by having 3 experts in the field of child psychology analyze the checklist to see if it accurately represented abused children's symptoms.

Because some reliabilities were very low, further statistical analysis was done to determine reliability and internal consistency. The initial reliability analysis of the CBEC revealed items with no variance and subscales with low reliability. The following items with no variance were deleted from the data analysis:

#7	Argues	#32	Feels things aren't real
#11	Unpleasant memories	#34	Feels like not in body
#22	Hurts self	#35	Shows anxiety
#24	Talks of touching others	#36	Difficulty with relationships
#28	Fear of women	#39	Withdraws from others
#29	Washes self/feels dirty	#45	Hates other

This resulted in a 36 item instrument. Moderately high internal consistency was found ($\alpha = .78$) for the total scale with these items deleted. Items were clustered according to the subscales they were originally thought to be a part of and internal consistency for the

subscales was examined. The highest subscale reliability was for Anger (.78), and the lowest was for Dissociation (.25). The other subscale reliabilities were as follows: Anxiety= .65, Depression= .58, PTSD= .54, and Sexual Concerns= .42, .

Because of the low internal consistency found for some of the a priori subscales, a factor analysis was used to determine if relationships existed that indicated different subscales. A factor loading criterion of $>.40$ was used to guide the selection of items for each factor. Four factors were found. If the subscales on the CBEC were reconfigured on the basis of the factor analysis, 4 subscales would be indicated (Table 2): Anger (6 items)($\alpha=.78$), Fear (5 items)($\alpha=.71$), Depression (5 items)($\alpha=.76$), and Severe Symptomatology (3 items)($\alpha=.64$). This results in a 19 item instrument with an overall internal consistency of $\alpha =.78$.

Demographic data tool. This second tool was used for each chart reviewed. A demographic sheet (Appendix E) was filled out with information on age, sex, cognitive function, I.Q., learning disabled, gifted, parent information, time since divorce/separation/death of parent, diagnosis and history of sexual abuse or physical abuse. Each demographic sheet included an identification number used only for the purpose of data analysis. To help maintain confidentiality, names, initials, addresses, phone

Table 2

New Subscales Based on Factor Analysis

Item #	Item descriptor	Item #	Item descriptor
Fear		Anger	
13	Recalls scary experience	15	Breaks things
14	Flashbacks	18	Difficulty calming
17	Gets scared suddenly	21	Yells
40	Fearful of the dark	23	Hurts others
48	Fearful of safety	37	Fights
		38	Feels angry
Self-awareness		Severe symptomatology	
6	Pretends		
30	Feels stupid	3	Feels afraid
31	Blames self	26	Obsessive thoughts
42	Feels unliked	44	Psychotic symptoms
33	Forgets things		

numbers and medical record numbers were not included on this sheet. The CBEC distributed to parents included 3 demographic questions regarding age, sex and performance in school (Appendix F).

CHAPTER 4

RESULTS

This chapter will present the data analysis techniques and the results that were obtained when the three hypotheses proposed in this study were tested.

Characteristics of Subjects by Group Membership

There were a total of 120 hospitalized subjects and 40 non-hospitalized subjects. The subjects were split evenly between two age groups: 6-9 years old and 10-12 years old. In Table 3, age, sex, and cognitive function are summarized for each group. In Table 4, family and living arrangement data are compared. There were more males in the hospitalized group than in the non-hospitalized group. The non-hospitalized group rated much higher in school functioning. The most frequent diagnoses were Depressive Disorder (30%) and PTSD (20%).

Data were not collected on the family constellation of the non-hospitalized group. Only data concerning the age, sex, and academic functioning were collected.

Table 3

Age, Sex, Educational and Cognitive Functioning of Subjects

Characteristic	Sexually Abused Group (n=40)	Physically Abused Group (n=40)	Non-Abused Hospitalized Group (n=40)	Non-Abused Non-Hospitalized Group (n=40)
Mean age	9	9	9.5	9.7
Sex				
Male	n=24 (60%)	n=33 (82%)	n=32 (80%)	n=19 (48%)
Female	n=16 (40%)	n= 7 (17%)	n= 8 (20%)	n=21 (52%)
School function				
Above average	n= 3 (7%)	n= 2 (5%)	n= 5 (12%)	n=30 (75%)
Average	n=12 (30%)	n=14 (35%)	n=11 (27%)	n=10 (25%)
Below Average	n=25 (62 %)	n=24 (60%)	n=24 (60%)	n= 0 (0%)
Mean I.Q.**	90 n=26	86 n=24	91 n=22	*
Learning disability	n=13 (32%)	n= 11 (27%)	n=19 (47%)	*
Gifted	n= 3 (7%)	n= 1 (2%)	n= 5 (12%)	*

Note: * indicates data are not available.

** I.Q. scores are based on the Wechsler Intelligence Scale for Children (WISC-R).

Table 4

Family Characteristics of Subjects

Characteristic	Sexually Abused Group (n=40)	Physically Abused Group (n=40)	Non-Abused Hospitalized Group (n=40)	Non-Abused Non-Hospitalized Group (n=40)
Living Arrangement				
Two parent	n=14 (35%)	n=13 (32%)	n=15 (37%)	*
Single parent	n=17 (42%)	n=26 (65%)	n= 23 (57%)	*
Foster parent	n= 6 (15%)	n= 1 (2%)	n= 2 (5%)	*
Residential	n= 3 (7%)	n= 0 (1%)	n= 0 (0%)	*
Months since change in family structure	30	32	33	*

Note: * indicates data are not available.

In summary, the major findings of the demographic data obtained are: A greater number of male subjects in the overall sample; lower school functioning in the hospitalized subjects; similar IQ scores among hospitalized subjects; greater learning disability and giftedness in the non-abused, hospitalized group than in the sexually and physically abused groups; and the sexually abused subjects were more likely to be in foster care or residential settings.

Hypothesis #1

The first hypothesis states that hospitalized children with a documented history of sexual abuse will have different symptomatology than children with a documented history of physical abuse and hospitalized children with no documented history of physical or sexual abuse. To examine differences in the symptoms of sexually abused, physically abused, and non-abused hospitalized children, ANOVA was conducted on the a priori subscales with a reliability $>.45$ (Anxiety, Depression, PTSD, and Anger)(Table 5). One-way ANOVA revealed significant differences between all 3 hospitalized groups and the non-hospitalized subjects regarding Anxiety, Depression, and PTSD, but not on the Anger subscale. Further analysis with the Scheffe-post hoc test indicated no significant differences between the groups of sexually abused, physically abused and non-abused subjects. The significant ANOVA

Table 5

Mean Scores of the a Priori Subscales ($\alpha > .45$) from the Chhild Behavior/Emotion Checklist .

Subscale	Mean of Sexual Abuse Group (range)	Mean of Physical Abuse Group (range)	Mean of Hospitalized Non-Abused (range)	Mean of Non-Hospitalized Non-Abused (range)	d.f.	F	p
Depression	3.9 (0-10)	3.5 (0-12)	3.3 (0-9)	6.8 (2-15)	3,156	15.2	.000
Anxiety	1.1 (0-6)	0.9 (0-4)	0.7 (0-3)	3.0 (0-12)	3,156	15.9	.000
PTSD	1.0 (0-6)	1.2 (0-5)	0.8 (0-6)	3.7 (0-9)	3,156	26.5	.000
Anger	7.4 (0-20)	8.4 (1-19)	7.3 (0-15)	6.9 (1-14)	3,156	0.7	.534

indicated differences between hospitalized groups and non-hospitalized children. Based on these results, H_1 was rejected.

The 4 subscales resulting from factor analysis of the CBEC were also analyzed using ANOVA. The results were somewhat similar to the results of the ANOVA conducted on the a priori subscales (Table 6). On the fear subscale all hospitalized groups were significantly different from the non-hospitalized group. On the Self-awareness scale the mean for the non-abused but hospitalized group was significantly greater than all other groups and the non-hospitalized group was significantly greater than the abused hospitalized groups. No significant differences were found on the Anger and Severe symptomatology subscales. As with the ANOVA conducted on the a priori subscales, one-way ANOVA indicated no difference in symptoms between the sexually abused, physically abused and non-abused, hospitalized children (Table 6)(except on Self-awareness). Based on these results of the ANOVA conducted on the scales identified by factor analysis, H_1 was rejected.

Hypothesis #2

The second hypothesis was that hospitalized children will have a greater number of symptoms than non-abused, non-hospitalized children. ANOVA was performed to determine the differences in symptomatology between hospitalized and non-hospitalized children.

Table 6

Mean Score from the Child Behavior/Emotion Checklist Factor Analyzed Subscales

Subscale	Mean of Sexual Abuse Group (range)	Mean of Physical Abuse Group (range)	Mean of Hospitalized Non-Abused (range)	Mean of Non-Hospitalized Non-Abused (range)	d.f.	F	p
Fear	0.7 (0-6)	0.3 (0-3)	0.3 (0-3)	2.9 (0-12)	3,156	30	.000
Self-awareness	0.4 (0-3)	0.3 (0-2)	8.4 (0-4)	7.3 (0-12)	3,156	92.4	.000
Anger	7.4 (0-20)	8.4 (1-19)	7.3 (0-15)	6.9 (1-14)	3,156	.72	.543
Severe symptoms	0.8 (0-6)	0.9 (0-7)	0.9 (0-6)	1.1 (0-4)	3,156	.18	.909

The a priori subscales with an $\alpha > .45$ were analyzed for differences among the groups. The results indicated differences in children on the following subscales: Depression, Anxiety, and PTSD (Table 5). No significant difference was observed on the Anger subscale ($p > .53$). Although differences were found, the non-hospitalized group had a greater number of symptoms than the hospitalized group. These results indicate the opposite of H2: Non-hospitalized children exhibited greater symptomatology than hospitalized children. Therefore, H2 was rejected.

The ANOVA conducted on the items identified by factor analysis revealed similar results. The ANOVA indicated significant differences between the hospitalized and non-hospitalized groups on the Fear and Self-awareness subscales (Table 6). With the exception that the non-abused hospitalized group had the highest mean on the Self-awareness scale. Overall, this is similar to the results of the ANOVA of the a priori subscales where a greater number of symptoms were found in the non-hospitalized group and a lesser number of symptoms in the hospitalized group. In summary, the ANOVA conducted on the a priori subscales and the factor-identified subscales revealed no differences between the hospitalized groups (with the exception of Self-awareness), but significant differences in symptomatology between hospitalized and non-hospitalized groups

with the greater number of symptoms in the non-hospitalized group. This supports the rejection of H2.

Hypothesis #3

The third hypothesis was that children who are within the ages of 6-9 will demonstrate different symptomatology than children who are within the ages of 10-12. A two-way ANOVA was performed on the a priori subscales of Anxiety, Depression, PTSD and Anger. The ANOVA of the a priori subscales found no significant differences in symptoms between the two different age groups of children (Table 7). A second two-way ANOVA was performed on the items identified through factor analysis of the CBEC. Similar findings resulted. No difference between groups and age group were found (Table 8). Therefore, H3 was rejected and the null hypothesis that no significant differences in symptoms between the age groups existed was accepted.

Table 7

Two -way interactions between Group and Age Group on a Priori Subscales

Group	Age Group	Mean Scores			
		Depression scale	Anxiety scale	PTSD scale	Anger scale
<hr/>					
Sexual Abuse					
	6 - 9	5.0	1.5	1.4	7.1
	10-12	2.8	0.6	0.7	7.7
Physical Abuse					
	6 - 9	4.0	1.0	1.4	7.9
	10-12	3.2	0.8	0.9	8.9
Hospitalized Non-Abused					
	6 - 9	3.5	0.7	0.9	7.1
	10-12	3.2	0.7	0.7	7.6
Non-Hospitalized Non-Abused					
	6 - 9	7.3	3.6	4.1	7.0
	10-12	6.3	2.4	3.3	6.9
		F=1.0	F=1.0	F=.3	F=.1
		p=.378	p=.383	p=.830	p=.957

Table 8

Two -way Interactions between Group and Age Groups on Factor Analyzed Subscales

		Mean Scores			
Group	Age Group	Fear scale	Self-awareness scale	Anger scale	Severe Symptoms scale
<hr/>					
Sexual Abuse					
	6 - 9	1.0	0.4	7.1	1.1
	10-12	0.4	0.2	7.7	0.6
Physical Abuse					
	6 - 9	0.4	0.4	7.9	0.8
	10-12	0.2	0.3	8.8	1.1
Hospitalized Non-Abused					
	6 - 9	0.3	0.4	7.1	0.9
	10-12	0.2	0.3	7.6	0.9
Non-Hospitalized Non-Abused					
	6 - 9	3.3	5.5	7.0	1.3
	10-12	2.5	4.6	6.9	0.9
		F=.53	F=.52	F=.11	F=.69
		p=.663	p=.669	p=.957	p=.562
<hr/>					

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Some of the findings of this study are inconclusive due to the low reliability coefficients for some of the subscales of the CBEC, and the data collection methods. In light of these limitations, a discussion on the limitations of this study will precede the discussion of the implications and application of the research findings.

Limitations

Instrument. Some shortcomings are apparent on examination of this research study. Initially, the CBEC appeared to be an accurate measure of symptoms which would be specific to sexual abuse because of its similarities to two existing scales and its consistency with the symptoms suggested by Hartman and Burgess's (1988) theory. This proved to be false as the CBEC did not differentiate among abuse groups. These results indicate that the CBEC is not a tool to be used to determine the type of abuse children have experienced.

In addition, the CBEC did not demonstrate reliability on the

Dissociation and Sexual concerns subscales. Further analysis of these scales, through factor analysis, deleted all Sexual and Dissociation items (which were the items of most concern in this study).

The CBEC did not differentiate between sexually abused children and non-sexually abused children. Sexually abused children did not exhibit more sexually inappropriate behaviors than children without sexual abuse histories. This may be due to the poor reliability of the Sexual Concerns subscale or the documentation of behaviors in the record.

The CBEC may be more reliable as an observational or self-report tool than a record review tool. Similar studies have been more successful in collecting data by using self report (Lanktree & Briere, 1990), or observational methods (Kolko & Moser, 1988). Although Morris and Bihan (1988) reviewed records, as did this study, they did not count the frequency of each item on their checklist. These differences in data collection methods may explain how studies similar to this study have yielded different results.

Data Collection Methods. Another limitation of this study is the chart review method utilized for the hospitalized sample. Only documented behaviors were included in this study. There may have been symptoms exhibited by the subjects (such as the dissociative and sexual symptoms) that were not documented in their hospital

record. The checklist method's reliance on data in the chart limited the type and amount of data available for collection.

The data, collected from charts from 1991-1994, may reflect changes in inpatient psychiatric hospitals. Recent changes include a greater focus on the behavior of children. Due to reduced lengths of stay, quick recovery and improvement of patients is desired. The obvious and destructive behavioral symptoms are the focus of milieu managers, the milder and more subtle emotional symptoms are ignored. Behavioral problems can be easily controlled with stringent rules and interventions. This is in contrast to emotional symptoms which cannot be as easily controlled in the milieu. Therefore, in order to produce quick improvement, behavioral symptoms become the focus of the interventions of milieu manager.

Behavior has also become the focus of documentation. Insurance companies have become more strict about criteria for inpatient psychiatric hospitalization. Criteria must continue to be met for hospitalization to occur. If a child is not exhibiting overt behavioral disturbance, discharge may occur. Therefore, in order to increase the length of stay, behavioral symptoms (especially acting out and anger symptoms) are most commonly documented. The results of this study may have been affected by the increased documentation of behavioral symptoms and the decreased

documentation of the emotional symptoms.

Utilization of other methods such as self-report, direct questioning, and direct observation may increase the accuracy of the clinical picture of a child. Also, the two week period in which symptoms were recorded from the progress notes may not have provided an accurate sampling of the child's symptoms. Sometimes the child's length of stay was three weeks, and data were collected on the mid and final weeks of their stay. This suggests a limitation to the study as children anticipating discharge in the final week may display uncharacteristic behavior and emotions due to the excitement, anxiety and fear which often accompany discharge. Therefore, the two weeks from which data were recorded may not have been an accurate representation of the child's behavior.

The difference in data collection, chart review versus parent report, may have limited the results of this study. The chart review was dependent on other people's observations. Yet the parents reported direct observation. Parents may be more careful observers of their child's behavior than those who documented the behavior of hospitalized children.

Sampling method. A final limitation of this study relates to the convenience sample of parents used to collect data about non-hospitalized children. The convenience sample was likely very

homogeneous in regard to socioeconomic class and family constellation. A random sample would have been more representative and more generalizable to other populations.

Implications

The results of this study support three main clinical implications regarding symptomatology in children. First, no difference in symptomatology was found between the three hospitalized groups (sexually abused, physically abused, and non-abused). This suggests that hospitalized children exhibit similar symptoms regardless of abuse history. These hospitalized children demonstrated similar emotional and behavioral disturbance whether they had a history of sexual abuse, physical abuse, or no history of abuse.

On the factor analyzed subscales, the higher Self-awareness scores of the non-abused hospitalized group is an interesting finding. In addition to high Self-awareness scores, this group showed the highest percentage of learning disabled and gifted children. Because self-awareness is a higher level task, requiring a greater developmental level, the gifted children in this group may account for this higher score. The Self-awareness score may also have been influenced by the large number of learning disabled children in this group because many of the items are suggestive of low self-esteem.

These results are consistent with the research done by Kiser et al. (1991) and in contrast to research conducted by Johnson and Aoki (1993) and Fagot et al. (1989). Kiser et al. also observed similar clinical manifestations on the CBCL in children regardless of the type of abuse (sexual or physical) that they had experienced. Kiser et al. suggested that individuals may develop similar clinical symptoms on the basis of victimization and not on the basis of the type of abuse.

In contrast, others found differences in symptomatology. Johnson and Aoki used the CBCL and a Child Sexual Behavior Checklist, and Fagot et al. observed play behavior and they found differences in symptomatology between sexually abused and physically abused children. The comparisons from the present study among the hospitalized groups indicates valuable information regarding the similarities among hospitalized children in the areas of emotional and behavioral disturbance, regardless of abuse history.

Second, the results of this study emphasize the difference between the hospitalized and non-hospitalized groups. A significant difference in symptomatology was found between hospitalized children and non-hospitalized children. Greater emotional and behavioral disturbance was demonstrated in the group of non-hospitalized children. This finding may be a result of the moderate reliability of the CBEC. Another explanation may lie within the

methodology of chart review versus parent-report. The chart review method limited the available data to that which was documented in the chart. The parent-report method was less limited because parents were not restricted to documented symptoms and could report any behaviors observed. It is likely that parents were exposed to their child's behavior more and also reported symptoms reported by others such as school teachers or friends.

This finding is still consistent with the theoretical framework of Hartman and Burgess (1988) which suggests that traumatized children develop emotional, behavioral and physical symptoms as a result of trauma. The similar clinical picture of the hospitalized children suggests that children develop behavioral and emotional disturbance on the basis of traumatization and not on the specific type of trauma they have experienced. The general anxiety symptoms described in Hartman and Burgess' theory include fear and anxiety. These symptoms indicate a deviance from "normal" non-disturbed children and warrant close examination by mental health care professionals.

The highest scores for the hospitalized children were on the Anger subscales. These high scores more closely matched the higher non-hospitalized children's scores. Similarities exist between the items on the Anger scales and the response patterns suggested by

Hartman and Burgess (1988). The items on each Anger subscale relate to Hartman and Burgess's fourth phase, the post trauma phase. In this phase, Hartman and Burgess describe an aggressive behavior response pattern. The higher score for hospitalized children on the Anger subscales, and the relationship between these scales and Hartman and Burgess' theory, demonstrates the usefulness of these scales in determining the level of disturbance in children.

The third implication from the results of this study emphasizes the use of the CBEC as a tool that may be utilized to detect emotional and behavioral disturbance in general. The CBEC did not differentiate between the hospitalized groups of sexually abused, physically abused and non-abused subjects. However, based on the reliability data of the CBEC subscales of Depression, Anxiety, PTSD, and Anger and the similarities among the hospitalized subjects, the validity of the CBEC in determining general disturbances in emotion and behavior is suggested. The CBEC can be utilized to determine emotional and behavioral disturbance in children and the need for further intervention when disturbance is found.

The fourth implication from this research supports normal childhood growth and development patterns. According to normal growth and development patterns, anxiety/fear and depression/stress are normal childhood experiences(Papalia & Olds,

1986). In this study, non-hospitalized and non-disturbed children scored high in the Depression and Anxiety scales. These high scores demonstrate that normal/non-disturbed children experience a high rate of anxiety and depression symptoms. Therefore, the idea that depression and anxiety are a part of normal growth and development and not just symptoms of disturbance is supported.

Application to Nursing Practice

The results of this study apply to nursing practice in clinical and educational areas. The most obvious application of the results is to clinical nursing practice. Nurses practicing in various clinical settings such as pediatrics, mental health, and public health encounter children with diverse backgrounds and experiences. The results suggest that these nurses need to be aware of behavioral and emotional indicators of disturbance in children which may warrant further investigation of the child's history. It is important to be aware of the similarities among disturbed children, regardless of abuse history. This awareness can help professionals avoid the pitfall of making false assumptions about the abuse history of a child.

Educators can disseminate the results of this study to nursing students. Two important applications to nursing education are suggested from the results of this study. First, the 19-item CBEC is a tool which can be used by nurses to determine the level of

disturbance in a child. Nurses can use the CBEC to assess a child through observed (preferably) or documented symptoms. If a significant level of disturbance is found, the nurse will be alerted to the need for further assessment and treatment for the child.

A second application of the research results relates to providing nurses with the knowledge of the similarities exhibited by disturbed children regardless of their abuse history. Educating nurses on the similarities in emotions and behaviors exhibited by sexually abused, physically abused, and non-abused but disturbed children can promote accurate assessment, intervention and treatment for disturbed children. In addition, knowledge of the high level of depression and anxiety among normal children is important. If nurses possess this knowledge, they can interpret symptoms more accurately. The dissemination of the results of this research study can improve the nursing care given to children in many areas of nursing, specifically clinical and educational practice settings.

Suggestions for further research

Future research should focus on the use of several different types of assessment to determine the most accurate method for determining the abuse history and symptomatology of a child. The use of a variety of data collection methods which include self-report, parent interview, observer checklist, and direct questioning may be

helpful. Also the use of a standardized child assessment tool would lend credibility and reliability to future research.

Because the 19-item CBEC can be used to determine clinically significant symptoms, clinicians can use the CBEC to rate the symptomatology of children. These data, collected by clinicians, should be analyzed to determine further reliability and validity of the CBEC.

Another area for future research includes the comparison of normal child development to the behavior and emotion of disturbed children. Replication of this study using parent report for the hospitalized group as well as the non-hospitalized group would be beneficial.

Research which compares and contrasts children from different settings would provide valuable information for those working with children. Due to the prevalence of child abuse, and the more recent unveiling of the prevalence of child sexual abuse, abused children can be found in outpatient settings as well as inpatient settings. Research in outpatient settings would be particularly valuable as the focus of psychiatric care shifts from inpatient settings to outpatient settings. In addition, community based in-home psychiatric settings would provide an excellent opportunity for researching child symptomatology. Children in partial hospitalization programs,

outpatient programs, and community based programs as well as inpatient programs can be further studied for symptoms which might be specific to the type of abuse they have experienced.

Summary

This research study suggests similarities in symptomatology among children regardless of their abuse history. In addition, high levels of behaviors consistent with depression, anger, and anxiety were found in normal children. These results indicate the usefulness of the CBEC in determining the level of disturbance a child may be experiencing. The use of the CBEC as an observational tool rather than for record review is also suggested by the results of this study.

APPENDICES

APPENDIX A

Letter of permission for figure 1

Appendix A

Letter of permission for figure 1

To whom it may concern:

I grant permission for the diagram of the Information Processing of Trauma to be published in Janine Post-Anderle's Master's thesis titled "Sexual Abuse Symptomatology in Children: A record review.". I also grant permission for the diagram to be published by University Microfilms.

Ann W. Burgess



date

8/29/95

APPENDIX B

Letter accompanying parent questionnaire

Appendix B

Letter accompanying parent questionnaire

Dear Parent,

December 13, 1994

I am developing an instrument to assess the behavior of children in hospitals. It would be very helpful for me to know the behavior of children who are not hospitalized.

Please take the time to rate your child on the following checklist. I appreciate your help on this project. Please mail the completed checklist to me in the stamped envelope provided. Thank you for taking the time to complete the checklist.

I have no need to know your name or your child's name, so please do not include any of this information on the checklist.

If you have any questions, please feel free to call me at (616) 531-2254.

Thanks again for your participation.

Sincerely,

Janine Post-Anderle, R.N.

APPENDIX C

Child Behavior/Emotion checklist

Appendix C

Child Behavior/	Emotion Checklist						
	Never	Rarely	Once/ week	Every other day	Every day	>Every day	
1. Reports bad dreams or nightmares.....	0	1	2	3	4	5	(22)
2. Out of bed/wandering during the night.....	0	1	2	3	4	5	(23)
3. Reports feeling afraid.....	0	1	2	3	4	5	(24)
4. Reports scary thoughts or ideas.....	0	1	2	3	4	5	(25)
5. Says dirty words.....	0	1	2	3	4	5	(26)
6. Pretends that he/she is someone or something else	0	1	2	3	4	5	(27)
7. Argues with others.....	0	1	2	3	4	5	(28)
8. Reports feeling lonely.....	0	1	2	3	4	5	(29)
9. Touches private parts	0	1	2	3	4	5	(30)
10. Reports or displays sadness or unhappiness.....	0	1	2	3	4	5	(31)
11. Reports unpleasant memories.....	0	1	2	3	4	5	(32)
12. Daydreaming reported by others.....	0	1	2	3	4	5	(33)
13. Recalls scary experiences	0	1	2	3	4	5	(34)
14. Flashbacks reported by others.....	0	1	2	3	4	5	(35)
15. Breaks things.....	0	1	2	3	4	5	(36)
16. Cries.....	0	1	2	3	4	5	(37)
17. Gets scared all of a sudden.....	0	1	2	3	4	5	(38)
18. Has difficulty calming	0	1	2	3	4	5	(39)
19. Talks about having sex.....	0	1	2	3	4	5	(40)
20. Reports feeling dizzy.....	0	1	2	3	4	5	(41)
21. Yells at people.....	0	1	2	3	4	5	(42)
22. Reports or displays desire to hurt self.....	0	1	2	3	4	5	(45)
23. Reports a desire to hurt other people.....	0	1	2	3	4	5	(46)
24. Talks about touching other people's private parts.....	0	1	2	3	4	5	(47)

	Never	Rarely	Once/ week	Every other day	Every day	>Every day	
25. Verbalizes obsessional or repetitive/recurrent thoughts about sex.....	0	1	2	3	4	5	(48)
26. Verbalizes obsessional or repetitive/recurrent thoughts.....	0	1	2	3	4	5	(49)
27. Reports or displays fear of men.....	0	1	2	3	4	5	(50)
28. Reports or displays fear of women.....	0	1	2	3	4	5	(51)
29. Reports washing his/her self because of feeling dirty inside.....	0	1	2	3	4	5	(52)
30. Reports feeling stupid or bad.....	0	1	2	3	4	5	(53)
31. Reports feeling like he/she did something wrong/ Blames self.....	0	1	2	3	4	5	(54)
32. Reports feeling like things aren't real.....	0	1	2	3	4	5	(55)
33. Forgets things, can't remember things.....	0	1	2	3	4	5	(56)
34. Reports feeling like he/she is not in his/her body.....	0	1	2	3	4	5	(57)
35. Reports or displays anxiety.....	0	1	2	3	4	5	(58)
36. Displays difficulty forming and maintaining relationships.....	0	1	2	3	4	5	(59)
37. Gets into fights.....	0	1	2	3	4	5	(60)
38. Reports feeling angry.....	0	1	2	3	4	5	(61)
39. Withdraws from usual activity or relationships.....	0	1	2	3	4	5	(62)
40. Reports or displays a fear of the dark.....	0	1	2	3	4	5	(63)
41. Gets scared or upset when talking about sex/molestation.....	0	1	2	3	4	5	(64)
42. Reports feeling like nobody likes him/her.....	0	1	2	3	4	5	(65)
43. Age inappropriate sexual behavior (ie. touching others private parts).....	0	1	2	3	4	5	(68)
44. Psychotic symptoms (i.e., delusions/hallucinations).....	0	1	2	3	4	5	(69)
45. Reports hating others	0	1	2	3	4	5	(70)
46. Superficial/denies any feelings.....	0	1	2	3	4	5	(71)
47. Inability to concentrate	0	1	2	3	4	5	(72)
48. Fearful of own safety.....	0	1	2	3	4	5	(73)

APPENDIX D

Comparison of the TSCC and the Morris and Bihan checklist

Appendix D

Comparison of the TSCC and the Morris and Bihan checklist

<u>TSC-C</u>	<u>Morris & Bihan, 1991</u>
1. Bad dreams or nightmares	35. Nightmares/sleep disorders
2. Feeling afraid something bad might happen	8. Generalized fear
3. Scary ideas or pictures just pop into my head	31. Obsessional or repetitive/recurrent thoughts
4. Wanting to say dirty words	20. Age inappropriate sexual behavior
5. Pretending I am someone else	6. Withdrawal from usual activity or relationships
6. Arguing too much	5. Depression
7. Feeling lonely	20. Age inappropriate sexual behavior
8. Touching my private parts too much	5. Depression
9. Feeling sad or unhappy	
10. Remembering things that happened that I didn't like	
11. Going away in my mind, trying not to think	13. Daydreaming, loss of memory, inability to concentrate
12. Remembering scary things	22. Fearful of abuse stimuli
13. Wanting to yell and break things	37. Aggressive behavior
14. Crying	29. Emotional upset
15. Getting scared all of a sudden	4. Excessive autonomic arousal
16. Getting mad and can't calm down	4. Excessive autonomic arousal
17. Thinking about having sex	20. Age inappropriate sexual behavior
18. Feeling dizzy	1. Panic/anxiety attacks
19. Wanting to yell at people	37. Aggressive behavior
20. Wanting to hurt myself	21. Hurts self physically
21. Wanting to hurt other people	37. Aggressive behavior
22. Thinking about touching other people's private parts	20. Age inappropriate sexual behavior
23. Thinking about sex when I don't want to	31. Obsessional or repetitive recurrent thoughts
24. Feeling scared of men	22. Fearful of abuse stimuli
25. Feeling scared of women	22. Fearful of abuse stimuli
26. Washing myself because I feel dirty inside	
27. Feeling stupid or bad	26. Low self-esteem
28. Feeling like I did something wrong	
29. Feeling like things aren't real	17. Psychotic episode?
30. Forgetting things, can't remember things	13. Daydreaming, loss of memory, inability to concentrate
31. Feeling like I'm not in my body	17. Psychotic episode?
32. Feeling nervous or jumpy inside	1. Panic/anxiety attacks

(TSC-C)

- 33. Feeling afraid
- 34. Not trusting people because they might want sex
- 35. Can't stop thinking about something bad that happened to me
- 36. Getting into fights
- 37. Feeling mean
- 38. Pretending I'm somewhere else
- 39. Being afraid of the dark
- 40. Getting scared or upset when I think about sex
- 41. Worrying about things
- 42. Feeling like nobody likes me
- 43. Remembering things I don't want to remember
- 44. Having sex feelings in my body
- 45. My mind goes empty or blank.
- 46. Feeling like I hate people
- 47. Can't stop thinking about sex
- 48. Trying not to have any feelings
- 49. Feeling mad
- 50. Feeling afraid somebody will kill me
- 51. Wishing bad things had never happened
- 52. Wanting to kill myself
- 53. Daydreaming
- 54. Getting upset when people talk about sex

(Morris & Bihan, 1991)

- 8 Generalized fear
- 36. Inability to form and maintain relationships
- 31 Obsessional or repetitive/recurrent thoughts
- 37 Aggressive behavior
- 12. Repressed anger/hostility
- 6. Withdrawal from usual activity or relationships
- 39. Afraid to sleep alone
- 22. Fearful of abuse stimuli
- 26. Low self-esteem
- 31. Obsessional or repetitive/ recurrent thoughts
- 20. Age inappropriate sexual behavior
- 12. Repressed anger/hostility
- 31 Obsessional or repetitive/recurrent thoughts
- 12. Repressed anger/hostility
- 10 Suicidal thoughts or statements
- 13. Daydreaming, loss of memory, inability to concentrate
- 43. Victim is uncomfortable when molestation is being discussed

APPENDIX E

Demographic information for record review

Appendix E

Demographic information for record review

Age ____ (4-5)

____ (1-3)

Sex M 1 (6)

F 2

Assessment of Cognitive Function (7)

Above average 1

Average 2

Below average 3

IQ ____ (8-10) Test used _____

Learning disabled Yes 1 (11)
No 0

Gifted Yes 1 (12)
No 0

Family

2-parent 1 (13)

Single parent 2

Foster parent 3

Time since divorce/separation/death of parent
____(months) (14-16)

Diagnosis ____ (17-18)

Documented History of Sexual Abuse Yes 1 (19)
No 0

Documented History of Physical Abuse Yes 1 (20)
No 0

APPENDIX F

Child Behavior/Emotion checklist-Parent Questionnaire

Appendix

Child Behavior/Emotion checklist-Parent Questionnaire

Age of child (Circle One) (4-5)

6 7 8 9 10 11 12

Sex M F (Circle one) (6)

How does your child do in school? (Circle one)

Above average Average Below average
(7)

Please circle the number which indicates the frequency your child exhibits the behavior or emotion listed.	Never	Rarely	Once/ week	Every other day	Every day	>Every day	
1. Reports bad dreams or nightmares.....	0	1	2	3	4	5	(22)
2. Out of bed/wandering during the night.....	0	1	2	3	4	5	(23)
3. Reports feeling afraid	0	1	2	3	4	5	(24)
4. Reports scary thoughts or ideas.....	0	1	2	3	4	5	(25)
5. Says dirty words.....	0	1	2	3	4	5	(26)
6. Pretends that he/she is someone or something else.....	0	1	2	3	4	5	(27)
7. Argues with others.....	0	1	2	3	4	5	(28)
8. Reports feeling lonely.....	0	1	2	3	4	5	(29)
9. Touches private parts	0	1	2	3	4	5	(30)
10. Reports or displays sadness or unhappiness.....	0	1	2	3	4	5	(31)
11. Reports unpleasant memories.....	0	1	2	3	4	5	(32)

	Never	Rarely	Once/ week	Every other day	Every day	>Every day	
12. Daydreaming reported by others.....	0	1	2	3	4	5	(33)
13. Recalls scary experiences.....	0	1	2	3	4	5	(34)
14. Flashbacks reported by others.....	0	1	2	3	4	5	(35)
15. Breaks things.....	0	1	2	3	4	5	(36)
16. Cries.....	0	1	2	3	4	5	(37)
17. Gets scared all of a sudden.....	0	1	2	3	4	5	(38)
18. Has difficulty calming	0	1	2	3	4	5	(39)
19. Talks about having sex.....	0	1	2	3	4	5	(40)
20. Reports feeling dizzy.....	0	1	2	3	4	5	(41)
21. Yells at people.....	0	1	2	3	4	5	(42)
22. Reports or displays desire to hurt self.....	0	1	2	3	4	5	(45)
23. Reports a desire to hurt other people.....	0	1	2	3	4	5	(46)
24. Talks about touching other people's private parts.....	0	1	2	3	4	5	(47)
25. Verbalizes obsessional or repetitive/recurrent thoughts about sex.....	0	1	2	3	4	5	(48)
26. Verbalizes obsessional or repetitive recurrent thoughts.....	0	1	2	3	4	5	(49)
27. Reports or displays fear of men.....	0	1	2	3	4	5	(50)
28. Reports or displays fear of women.....	0	1	2	3	4	5	(51)
29. Reports washing his/her self because of feeling dirty inside.....	0	1	2	3	4	5	(52)
30. Reports feeling stupid or bad.....	0	1	2	3	4	5	(53)

	Never	Rarely	Once/ week	Every other day	Every day	>Every day	
31. Reports feeling like he/she did something wrong/ Blames self.....	0	1	2	3	4	5	(54)
32. Reports feeling like things aren't real.....	0	1	2	3	4	5	(55)
33. Forgets things, can't remember things.....	0	1	2	3	4	5	(56)
34. Reports feeling like he/she is not in his/her body.....	0	1	2	3	4	5	(57)
35. Reports or displays anxiety.....	0	1	2	3	4	5	(58)
36. Displays difficulty forming and maintaining relationships.....	0	1	2	3	4	5	(59)
37. Gets into fights.....	0	1	2	3	4	5	(60)
38. Reports feeling angry.....	0	1	2	3	4	5	(61)
39. Withdraws from usual activity or relationships.....	0	1	2	3	4	5	(62)
40. Reports or displays a fear of the dark.....	0	1	2	3	4	5	(63)
41. Gets scared or upset when talking about sex/molestation.....	0	1	2	3	4	5	(64)
42. Reports feeling like nobody likes him/her.....	0	1	2	3	4	5	(65)
43. Age inappropriate sexual behavior (i.e., touching others private parts).....	0	1	2	3	4	5	(68)
44. Psychotic symptoms (i.e., delusions/hallucinations).....	0	1	2	3	4	5	(69)
45. Reports hating others	0	1	2	3	4	5	(70)
46. Superficial/denies any feelings.....	0	1	2	3	4	5	(71)
47. Inability to concentrate	0	1	2	3	4	5	(72)
48. Fearful of own safety.....	0	1	2	3	4	5	(73)

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