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The Trauma Symptom Checklist for Young Children (TSCYC): reliability and association with abuse exposure in a multi-site study

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Abstract

Objective: The Trauma Symptom Checklist for Young Children (TSCYC) is a 90-item caretaker-report measure of children's trauma- and abuse-related symptomatology. It contains two reporter validity scales and eight clinical scales [Post-traumatic Stress-Intrusion (PTS-I), Post-traumatic Stress-Avoidance (PTS-AV), Post-traumatic Stress-Arousal (PTS-AR), Post-traumatic Stress-Total (PTS-TOT), Sexual Concerns (SC), Dissociation (DIS), Anxiety (ANX), Depression (DEP), and Anger/Aggression (ANG)], as well as an item assessing hours per week of caretaker contact with the child. This paper introduces the TSCYC and describes its psychometric properties in a multisite validity study.

Method: A total of 219 TSCYCs administered by six clinician/researchers across the United States were analyzed for scale reliability and association with several types of childhood maltreatment.

Results: The TSCYC clinical scales have good reliability and are associated with exposure to childhood sexual abuse, physical abuse, and witnessing domestic violence. The PTS-I, PTS-AV, PTS-AR, and PTS-TOT scales were most predictive, followed by SC in the case of sexual abuse and

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DIS in the case of physical abuse. There were a small number of age, sex, and race effects on TSCYC scores.

Conclusions: The TSCYC appears to have reasonable psychometric characteristics, and correlates as expected with various types of trauma exposure. Subject to continued validation and the development of general population norms, its use as a clinical measure is supported.

Keywords: Assessment; Trauma; Post-traumatic stress; Child abuse

Introduction

Despite significant advances in our understanding of psychological trauma and its potential effects and the increased availability of effective treatments for trauma-related conditions, there are surprisingly few standardized, trauma-relevant measures available for children. This relative lack of assessment resources becomes especially significant when one considers the wide variety of traumatic events to which children are regularly exposed. These include natural disasters (Green et al., 1991); physical and sexual child abuse (Berliner & Elliott, 1996; Kolko, 1996); witnessing spousal violence (Grych, Jouriles, Swank, McDonald, & Norwood, 2000; Jaffe, Wolfe, & Wilson, 1990); war (Baker, 1990; Sack, Aangel, Kinzie, & Rath, 1986); and physical and sexual assaults by peers or other noncaretakers (Boney-McCoy & Finkelhor, 1995; Singer, Anglin, Song, & Lunghofer, 1995).

Children's exposure to such traumas, in turn, has been associated with a wide variety of negative mental health outcomes, including anxiety and depression (Fergusson, Horwood, & Lynskey, 1996; Lanktree, Briere, & Zaidi, 1991; Margolin & Gordis, 2000; Martinez & Richters, 1993), post-traumatic stress and dissociation (Elliott & Briere, 1994; McLeer et al., 1998; Singer et al., 1995), anger and aggression (Kolbo, Blakely, & Engleman, 1996; Lanktree et al., 1991; Shakoor & Chalmers, 1991), and, especially in sexual abuse victims, sexual symptoms and age-inappropriate sexual behavior (Friedrich, 1993, 1994, 1998).

Those conducting studies on the potential impacts of traumatic events on children's mental health have responded to the relative dearth of standardized tests in this area by creating a number of research measures. These include the Children's PTSD Inventory (Saigh, 1989), Child Post-Traumatic Stress Reaction Index (RI; Pynoos et al., 1993), Child Dissociative Checklist (CDC; Putnam, Helmers, & Trickett, 1993), Children's Attributions and Perceptions Scale (CAPS; Mannarino, Cohen, & Berman, 1994), Children's Impact of Traumatic Events Scale-Revised (CITES-R; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991), and the Sexual Abuse Fear Evaluation (SAFE; Wolfe & Wolfe, 1986).

Unfortunately, these research measures typically lack the norms and data on clinical psychometrics that are needed before the assessor can determine the actual clinical implication of a given score. For example, in the absence of data on the distribution of scores in the general population, a score of Y on measure X cannot be interpreted in terms of its abnormality and, thus, its specific clinical meaning. Similarly, for optimal applicability to clinical settings, the reliability and validity of a test in clinical groups must be known.

Because most research measures typically lack such data, they cannot be applied with confidence in general clinical practice (Briere, 1997).

In contrast to these various research measures, there are only two standardized, normed tests of childhood trauma-related symptomatology available to clinicians: the Trauma Symptom Checklist for Children (TSCC; Briere, 1996), a multiscale self-report measure of trauma-related symptomatology, and the Child Sexual Behavior Inventory (CSBI; Friedrich, 1998), a caretaker-report measure of abnormal sexual behavior frequently seen in sexual abuse victims. The TSCC provides a review of those symptom clusters often associated with trauma in children, but requires that the child be at least 8 years of age for administration. This age limit reflects the concern that younger children may have insufficient cognitive development to fully understand what a given psychological symptom or internal state actually represents, or lack the reading comprehension necessary to respond to written test items regarding that state or symptom. The CSBI avoids this issue by relying on caretaker report, but is limited to a review of sexual behaviors.

The cutoff of 8 years for the TSCC and the absence of other broad-band standardized tests for children under 8 represents a real problem for clinicians specializing in child trauma. Most importantly, many children are first abused, neglected, or otherwise traumatized well before this age. As a result, a significant proportion of children brought to clinics, child crisis centers, or emergency rooms with trauma exposure cannot be evaluated at the level possible for those over age 7.

In the absence of standardized trauma measures, younger children must be assessed either by their responses to clinicians' questions during a diagnostic or intake interview, or through parent/caretaker symptom report. The first option can be helpful, but the subjectivity of the typical clinical interview means that effective and comprehensive evaluation rests on the abilities and training of the interviewer. Furthermore, such informal assessment is intrinsically non-normative: beyond the clinical experience of the interviewer, such an approach offers little information about whether a specific symptom or behavior represents relatively normal functioning, subclinical difficulties, or clinical levels of disturbance.

The limitations of the regular clinical interview approach can be addressed, in part, through the use of structured interviews with specific items tapping trauma-related symptoms. Examples of this approach are the Clinician-Administered PTSD Scale, Child and Adolescent version (CAPS-C; Nader et al., 1996) and the Children's Impact of Traumatic Events Scale-Revised (CITES-R; Wolfe et al., 1991). The CAPS-C yields a DSM-IV diagnosis of PTSD, and appears to have reasonable validity in clinical practice (Nader, 1997). However, this interview can take over an hour to administer; a logistic problem that limits its usefulness in many clinical contexts. In addition, by virtue of its focus on PTSD, per se, it does not evaluate the various other psychological difficulties often associated with childhood trauma.

The CITES-R yields scores on scales measuring post-traumatic stress, sexual issues, perceptions of social support after disclosure, and cognitive attributions. Recent research supports the psychometric reliability and validity of the CITES-R (Crouch, Smith, Ezzell, & Saunders, 1999). However, the interview is limited to sexual abuse impacts, does not have established norms for interpreting scores in clinical settings, and requires that the child be at least 8 years of age.

The second evaluation option (parent-report measures) may be helpful to the extent that it involves standardized assessment and allows the clinician to compare a child's symptomatology to what would be normative for a child of his or her sex and age. Unfortunately, with the exception of the Child Sexual Behavior Inventory (CSBI; Friedrich, 1998), the only standardized, normed parent/caretaker-report tests available to clinicians are generic [e.g., the Child Behavior Checklist (CBCL); Achenbach, 1991] and do not tap post-traumatic symptoms to any major extent. As has been suggested for generic adult measures (Briere, 1997), clinical reliance on generic tests may mean that the post-traumatic symptoms of many abused or traumatized children go unassessed or, in some cases, are misinterpreted as evidence of other forms of disturbance.

An additional problem with parent/caretaker reports of children's symptoms is the second-hand nature of this approach. Whenever the clinician relies on a caretaker's report of a child's functioning, there is the risk that the reporting parent's perceptions are biased by his or her personal concerns, psychopathology, limited contact with the child, or other motivations to see (or present) the child as more or less symptomatic than may actually be the case (Briere & Elliott, 1997). As a result, in the absence of additional data, it is not always clear to what extent the caretaker's responses on caretaker-report measures reflects actual symptomatology in the child.

The trauma symptom checklist for young children (TSCYC)

In response to these various issues, the TSCYC (Briere, in press) was developed. This test is a 90-item caretaker-report measure that can be used to assess trauma symptoms in children from ages 3 to 12. Caretakers rate each symptom on a 4-point scale [from 1 (not at all) to 4 (very often)] according to how often it has occurred in the previous month. Unlike other parent/caretaker report measures, the TSCYC contains specific scales to ascertain the validity of caretaker reports and evaluates a range of post-traumatic symptoms. In addition, on completion of normative studies, the TSCYC will allow comparison of a given child's caretaker-reported symptoms in a given area to a large, representative sample of caretaker reports from the general population.

Validity of caretaker report

Because caretaker-report measures introduce a new source of potential difficulties, that of intentional or inadvertent misreporting of the child's psychological status, the TSCYC includes additional features that assess the caretaker's rating style and actual familiarity with the child. In this regard, the TSCYC contains two validity scales that assess potential over-report (Atypical Response) and under-report (Response Level) of the child's symptoms. Furthermore, the TSCYC includes an item that asks "[o]n average, how many hours do you spend in the same place (for example, at home) with him or her each week, not counting when he or she is asleep?" which is rated on a scale from 1 (0–1 hours) to 7 (over 60 hours).

Assessment of symptomatology

The TSCYC contains eight clinical scales, Post-traumatic Stress-Intrusion (PTS-I), Post-traumatic Stress-Avoidance (PTS-AV), Post-traumatic Stress-Arousal (PTS-AR), Sexual

Concerns (SC), Dissociation (DIS), Anxiety (ANX), Depression (DEP), and Anger/Aggression (ANG), as well as a summary post-traumatic stress scale, Post-traumatic Stress-Total (PTS-TOT). These scales allow a detailed evaluation of post-traumatic stress symptoms (and a tentative PTSD diagnosis), as well as providing information on other symptoms such as anxiety, depression, anger, and abnormal sexual behavior. Typical items of the TSCYC are: Looking sad, Bad dreams or nightmares, Living in a fantasy world, Pretending to have sex, Drawing pictures about an upsetting thing that happened to him or her, and Throwing things at friends or family members.

This paper describes the reliability of the TSCYC and its association with several forms of child trauma/maltreatment in a multisite clinical sample. A future paper will outline the convergent validity of this measure with reference to other common tests of abuse- or trauma-specific symptomatology.

Methods

The preliminary version of the TSCYC consisted of 120 items, adapted and expanded from the TSCC to assess caretaker report of children as young as 3 years of age. Items were written by the first author to tap each of the six symptom groups evaluated by the scales of the TSCC (i.e., Post-traumatic Stress, Sexual Concerns, Dissociation, Anxiety, Depression, and Anger), adjusted to reflect the caretaker's perspective. There was no attempt, however, to create TSCYC items that matched existing TSCC items; instead, the intent was to represent TSCC symptom areas at the scale level. Because the TSCC Post-traumatic Stress scale does not cover all criteria for PTSD (Briere, 1996) and cannot suggest a formal PTSD diagnosis, TSCYC item content was expanded to tap all relevant DSM-IV post-traumatic intrusion, avoidance, and hyperarousal criteria.

Of the original 120 items, 30 were eventually eliminated through a two-step process. First, an expert panel of 11 clinicians (all noted researchers and clinicians in the child abuse/trauma field; see *Acknowledgments*) reviewed the TSCYC and suggested which items might best be deleted. Second, to identify the psychometric quality of each item, a sample of TSCYCs completed by caretakers of traumatized children were analyzed for internal consistency, relationship to specific trauma history, and item frequency of endorsement.

After the final item composition of the TSCYC was determined, this measure was made available to clinicians and researchers in various locations throughout the United States. The current presentation is based on 219 TSCYCs from English-fluent caretakers contributed by these clinicians and researchers, although missing responses (especially for different types of trauma/abuse exposure) resulted in varying sample sizes for different analyses.

TSCYC protocols typically were collected from consecutive abuse or trauma cases presenting to these programs—in no instance known to the authors was a protocol administered based on specific client characteristics (e.g., sex, race, or clinical severity) or type of abuse. All protocols were contributed from child advocacy centers, abuse programs, or child trauma centers, based on their regular intake process, and thus represented the type of children likely to be evaluated with the TSCYC in the future.

Scoring of the TSCYC was done based on the upcoming professional manual for this test

(Briere, in press). TSCYC protocols were considered scorable if the total number of missing responses did not exceed 10, and no scale was scored if it contained more than three missing items. In scorable protocols, "1"s (the lowest possible rating) were substituted for missing values. Items then were summed to form the eight clinical scales and the ATR validity scale of the TSCYC. The exception to this scoring method was the Response Level (RL) validity scale. As per the TSCC, the Response Level (RL) scale is calculated as the total number of "1"s (i.e., "not at all") provided by the caretaker in response to common child behaviors.

Sample sizes for the analyses presented in this paper varied according to the phenomenon studied. The full sample, minus children with missing values on one or more items within a scale, was used to assess the internal consistency (reliability) of the TSCYC scales. Similarly, the full sample was used to determine whether TSCYC scores varied as a function of rater and child characteristics. However, analyses examining the relationship between major forms of child maltreatment (i.e., sexual abuse, physical abuse, and witnessing domestic violence) and TSCYC scores used approximately half of the total sample. This was because TSCYC protocols collected from different programs varied in terms of what types of child maltreatment were queried. For example, some programs coded solely the presence or absence of childhood sexual abuse, whereas others included data on three or more types of maltreatment. Because modern research methodology suggests that the correlates of any given form of maltreatment should be examined while taking other important forms of maltreatment into account (e.g., Briere, 1992), TSCYC data were analyzed in this final section only when complete information was available for three major forms of child maltreatment: sexual abuse, physical abuse, and witnessing parental domestic violence.

Results

Validity sample characteristics

The validity sample consisted of caretaker-reports of 219 children, collected by six clinicians or researchers. The mean age of these children was 7.1 years ($SD = 2.6$), major racial representations were Non-Hispanic Caucasian ($N = 80$, 38.3%), Black/African American ($N = 53$, 25.4%), and Hispanic ($N = 58$, 27.8%), and the majority of children were female ($N = 115$, 62.8%). According to clinician determination of the child's maltreatment history, using whatever interview protocol was normally utilized by that center, 123 of 219 (56.2%) had sexual abuse histories, 54 of 152 (35.5%) had been physically abused, and 63 of 138 (45.7%) had witnessed parental domestic violence. Of all children for whom all three types of maltreatment data were available, only nine were rated as not having experienced any type of maltreatment.

Of the caretaker raters, 195 (91.1%) were female, 153 (70.2%) were biological parents, and 25 (11.5%) were foster parents (the remainder were adoptive parents and extended family member adults), 214 (99.1%) lived with the child, and the modal number of nonsleeping hours spent per week with the child was "41–60" ($N = 73$, 35.1%), followed by "over 60" ($N = 43$, 20.7%).

Table 1
Reliability coefficients for TSCYC scales ($N = 190$)

Validity scales	
Scale	*Alpha*
RL	.73
ATR	.36
Clinical scales	
Scale	*Alpha*
PTS-I	.87
PTS-AV	.82
PTS-AR	.85
PTS-TOT	.93
SC	.81
ANX	.86
DEP	.84
DIS	.91
ANG	.91

Note: RL = Response level; ATR = Atypical Response; PTS-I = Post-traumatic Stress-Intrusion; PTS-AV = Post-traumatic Stress-Avoidance; PTS-AR = Post-traumatic Stress-Arousal; PTS-TOT = Post-traumatic Stress-Total; SC = Sexual Concerns; ANX = Anxiety; DEP = Depression; DIS = Dissociation; ANG = Anger.

Reliability

The individual clinical scales of the TSCYC appear to have good to excellent reliability, as presented in Table 1. *Alpha* internal consistency for the clinical scales ranged from .81 for Sexual Concerns to .93 for PTSD-Total, with an average scale *alpha* of .87. As would be predicted, although the Response Level validity scale (which taps a general tendency to deny even normal, minor problematic behavior in one's child) was relatively reliable (*alpha* = .73), the Atypical Response (which evaluates parent/caretaker willingness to endorse a series of very unusual and unrelated behaviors) did not have good reliability (*alpha* = .36).

Association with child and rater characteristics

Multiple regression analyses of TSCYC scales as a function of child and rater variables revealed that younger children were rated as having more Anger, older children were rated higher on Depression, and older children were rated higher on Response Level. There were two sex differences: male children received higher scores on the Anger scale and female children had higher Response Level ratings. Similarly, there were two race effects: Caucasian children were rated higher on Post-traumatic Stress-Arousal and lower on Response Level. The only significant rater characteristic relationships were that female raters described their children as higher on Depression and Anger than did male raters. Six TSCYC scales were unrelated to either rater or child characteristics (see Table 2).

Because it was anticipated that the number of hours spent with the child might predict caretaker ratings of child symptomatology, a separate 2 (rater sex) × 7 (hours spent with child per week: 0 to 1 h, 2 to 5 h, 6 to 10 h, 11 to 20 h, 21 to 40 h, 41 to 60 h, and over 60 h) MANOVA was run. No effects on TSCYC scores were found for rater sex ($F[10,181] = 1.4$,

Table 2
Multiple regression of TSCYC scores based on child and rater characteristics at Step 1

TSCYC Scale	Child's age β	Child's sex β	Child's race			Biological parent β	Rater's sex β	Hours spent with child β	R	F (8,183)
			Causasian β	Black β	Hispanic β					
RL	.16*	.17*	−.28**	−.03	−.03	.07	−.07	.05	.38	3.92***
ATR	—	—	—	—	—	—	—	—	.21	1.02
PTS-I	—	—	—	—	—	—	—	—	.21	1.02
PTS-AV	—	—	—	—	—	—	—	—	.25	1.53
PTS-AR	.03	−.14	.27**	.05	−.01	.01	.04	.07	.31	2.36*
PTS-TOT	—	—	—	—	—	—	—	—	.24	1.45
SC	—	—	—	—	—	—	—	—	.24	1.41
ANX	−.06	−.02	.18	−.08	.08	−.12	−.02	.11	.31	2.45*
DEP	.23**	−.05	.10	−.03	.09	−.09	.16*	.12	.32	2.56*
DIS	—	—	—	—	—	—	—	—	.20	0.85
ANG	−.21**	−.30***	.10	.07	.06	−.03	.15*	−.01	.42	4.82***

* $p < .05$; ** $p < .01$; *** $p < .001$.

Note: RL = Response level; ATR = Atypical Response; PTS-I = Post-traumatic Stress-Intrusion; PTS-AV = Post-traumatic Stress-Avoidance; PTS-AR = Post-traumatic Stress-Arousal; PTS-TOT = Post-traumatic Stress-Total; SC = Sexual Concerns; ANX = Anxiety; DEP = Depression; DIS = Dissociation; ANG = Anger.

ns), hours per week (F[60,954.3] = .9, *ns*), nor the rater sex × hours per week interaction, F(50,828.8) = .9, *ns*. This analysis also was rerun with the first three time categories combined into one, creating a 0- to 10-h category and the other four time categories, with the same statistical outcome.

Association with childhood abuse/trauma

To examine the effects of all three types of child maltreatment, hierarchical multiple regression analyses of TSCYC scale scores were performed for those subjects who had complete data on demographics, childhood sexual abuse, physical abuse, and witnessing domestic violence ($N = 104$). In each instance, child demographics (sex, age, and race) were entered simultaneously at Step 1, to control for these variables in the abuse-symptom relationship, followed by abuse exposure at Step 2, and all possible two-way interactions between sex and abuse type (e.g., sex × sexual abuse) and within abuse types (e.g., sexual abuse × physical abuse) at Step 3.

Analyses revealed no child demographics effects at Step 1 other than on Depression, where child age was positively associated ($\beta = .3$; $p < .01$), and Anger, which was predicted by lower age ($\beta = -.2$; $p < .05$) and male sex ($\beta = -.3$; $p < .001$). There were, however, a number of relationships between abuse exposure and TSCYC scores (see Table 3). After controlling for child age, sex, and race (i.e., at Step 1), several relationships were found between type of abuse exposure and TSCYC symptomatology at Step 2. Specifically, (1) childhood sexual abuse was associated with ratings of Post-traumatic Stress-Intrusion, Post-traumatic Stress-Avoidance, Post-traumatic Stress-Total, and Sexual Concerns; (2) childhood physical abuse was related to Post-traumatic Stress-Intrusion, Post-traumatic

Table 3
Step 2 (abuse exposure) multiple regression of TSCYC scores, controlling for child sex, age, and race

TSCYC Scale	Sexual abuse β	Physical abuse β	Witnessed domestic violence β	change from Step 1	Change F (3,95)
RL	—	—	—	.02	0.86
ATR	—	—	—	.05	1.66
PTS-I	.26*	.30**	.25*	.12	4.59**
PTS-AV	.32**	.15	.22*	.09	3.15*
PTS-AR	.20	.27**	.22*	.09	3.32*
PTS-TOT	.28**	.26**	.26*	.11	4.20**
SC	.35***	−.14	−.22*	.23	9.76***
ANX	—	—	—	.04	1.45
DEP	—	—	—	.03	1.10
DIS	.17	.31**	.19	.10	3.53*
ANG	—	—	—	.03	1.29

* $p < .05$; ** $p < .01$; *** $p < .001$.

Note: RL = Response level; ATR = Atypical Response; PTS-I = Post-traumatic Stress-Intrusion; PTS-AV = Post-traumatic Stress-Avoidance; PTS-AR = Post-traumatic Stress-Arousal; PTS-TOT = Post-traumatic Stress-Total; SC = Sexual Concerns; ANX = Anxiety; DEP = Depression; DIS = Dissociation; ANG = Anger.

Stress-Arousal, Post-traumatic Stress-Total, and Dissociation; and (3) witnessing domestic violence was related to Post-traumatic Stress-Intrusion, Post-traumatic Stress-Avoidance, Post-traumatic Stress-Arousal, and Post-traumatic Stress-Total, and negatively associated with Sexual Concerns. There were no significant interactions between sex and individual abuse type or between abuse types at Step 3. See Table 3 for significant Step 2 results, reflecting the change in equation variance accounted for (i.e., R^2 change) after abuse exposure was added to the regression equation).

Discussion

This report documents the psychometric characteristics of a new caretaker-report test of post-traumatic symptoms in younger children. The clinical scales of the TSCYC appear to demonstrate good reliability and to be associated with exposure to maltreatment in a clinical sample of generally maltreated children. The TSCYC scales most associated with different types of childhood abuse were those measuring post-traumatic stress, followed by sexual concerns and dissociation. The three mood-related scales, Anxiety, Depression, and Anger were not related to abuse history in this study.

The findings regarding post-traumatic stress, dissociation, and sexual concerns support the construct validity of the TSCYC, because similar relationships have been documented elsewhere in the literature (e.g., Elliott & Briere, 1994; Friedrich, 1993; McLeer et al., 1998; Singer et al., 1995). The lack of association between dysphoric mood and child maltreatment was unexpected, however, given other studies that have found increased anxiety and depression among abused children (e.g., Fergusson et al., 1996; Lanktree et al., 1991; Margolin & Gordis, 2000; Singer et al., 1995). Thus, it is possible that the mood scales of the TSCYC

are less valid, because they did not co-vary with child maltreatment in this sample. However, a review of the content of the actual items suggests reasonable face validity for these scales. For example, typical items of the Depression scale are Looking sad and Acting sad or depressed, and items of the Anger scale include Becoming very angry over a little thing and Temper tantrums. Thus, it is somewhat unlikely that the TSCYC mood scales measure substantially different constructs than those correlating with child maltreatment in other studies, although verification of this supposition awaits convergent validity studies. Instead, it is likely that the relative absence of nonabused children in this sample precluded a meaningful test of the relationship between negative mood and child maltreatment, per se. If this is so, such findings suggest that the various components of post-traumatic stress (reliving, avoidance, and hyperarousal), dissociation, and sexual problems vary as a function of type of abuse, whereas dysphoric mood may be a more generic impact that does not differ meaningfully between abuse types but may, on the other hand, broadly discriminate abused from nonabused children. Test of this hypothesis awaits analysis of the TSCYC in a mixed sample of abused and nonabused children.

As expected, multivariate analyses indicate that there are child sex and age differences on the TSCYC. Anger scores were higher for males and younger children, Depression was higher for older children, and raters of females and older children had higher Response Level scores. These findings are generally as would be expected, except the elevated Anger in younger children relative to their older cohorts. The reason for this latter finding is unknown, although it may be that caretakers can better identify anger (an externalized response) in younger children than they can other symptoms or behaviors in this group, and thus elevated Anger scores may serve as a proxy for other types of distress in caretakers' ratings of young children. Irrespective of their etiology, these data support the widely accepted notion that there are age and sex differences in children's psychological symptoms. On completion of the normative studies, it is anticipated that the TSCYC will have separate child age and sex norms, although the specific age demarcations have yet to be determined.

The relatively small number of relationships between child (and thus, by inference, caretaker) race and symptom scores on the TSCYC is encouraging. In the total sample, Caucasian children received higher post-traumatic hyperarousal ratings than other children, and raters of Caucasian children scored lower on the Response Level validity scale. Such data suggest that the TSCYC is not biased against racial minorities and, subject to replication in the normative sample, may not require normative adjustment for race.

Finally, the current study found few examples of rater variable effects on TSCYC scores. The only significant rater characteristic to correlate with child symptomatology was rater sex in two instances: female raters described children as higher on Depression and Anger. This set of sex differences may reflect differences in caretaker accuracy in rating children's dysphoric symptoms (e.g., mothers may be more attuned to their children's affective states, on average, as compared to fathers), or may reflect caretaker sex biases because of other issues (e.g., mothers may be, on average, more preoccupied or concerned regarding their children's potential dysphoria).

Interestingly, the relative amount of time that a given caretaker spent with his or her child did not significantly predict the amount of symptomatology that he or she identified in that child. This finding held true both when hours per week was treated as a continuous variable

in a multiple regression analysis and as a categorical variable interacting with rater sex in a MANOVA. These data are encouraging regarding the generalizability of caretaker ratings. However, common sense suggests that the symptom ratings of those caretakers reporting very little contact with a child should be given less credence than those of a caretaker with more significant contact. The validity of this supposition remains, however, an empirical question, and is not supported by the current research. It is likely that the relative amount of contact with one's child is a complex variable, reflecting underlying phenomena as divergent as the amount of time or attention needed by more or less symptomatic children and variability because of socioecomomic variables such as mother's (or father's) occupational status and income.

The findings presented here do not bear on the issue of convergent validity (i.e., the extent to which TSCYC results correlate well with those of other instruments), nor do they provide normative data on the clinical interpretability of a given TSCYC score. Studies on these latter two issues are ongoing. However, the current data do suggest that, thus far, the TSCYC has the requisite psychometric characteristics (i.e., reliability, predictive validity, and relative absence of rater characteristic bias) to support it's potential use (1) with children too young (or unwilling) to report on their own internal state or symptomatology, and (2) in instances where another source of information is desired in children who are able to provide symptom self-report.

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References

Achenbach, T. M. (1991). *Manual for the child behavior checklist/4–18 and 1991 profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Baker, A. (1990). The psychological impact of the Intifada on Palestinian children in the occupied West Bank and Gaza: an exploratory study. *American Journal of Orthopsychiatry, 60,* 496–505.

Berliner, L., & Elliott, D. M. (1996). Sexual abuse of children. In J. Briere, L. Berliner, J. A. Bulkley, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment* (pp. 51–71). Thousand Oaks, CA: Sage.

Boney-McCoy, S., & Finkelhor, D. (1995). Psychosocial sequelae of violent victimization in a national youth sample. *Journal of Consulting and Clinical Psychology, 63,* 726–736.

Briere, J. (1992). Methodological issues in the study of sexual abuse effects. *Journal of Consulting and Clinical Psychology, 60,* 196–203.

Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) professional manual.* Odessa, FL: Psychological Assessment Resources.

Briere, J. (1997). *Psychological assessment of adult posttraumatic states.* Washington, DC: American Psychological Association.

Briere, J. (in press). *Trauma Symptom Checklist for Young Children (TSCYC) professional manual.* Odessa, FL: Psychological Assessment Resources.

Briere, J., & Elliott, D. M. (1997). Psychological assessment of interpersonal victimization effects in adults and children. *Psychotherapy: Theory, Research and Practice, 34,* 353–364.

Crouch, J. L., Smith, D. W., Ezzell, C. E., & Saunders, B. E. (1999). Measuring reactions to sexual trauma among children: comparing the Children's Impact of Traumatic Events Scale and the Trauma Symptom Checklist for Children. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children, 4,* 255–263.

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 & 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.

Green, B. L., Korol, M., Grace, M. C., Vary, M. G., Leonard, A. C., Gleser, G. C., & Smitson-Cohen, S. (1991). Children and disaster: age, gender, and parental effects on PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 30,* 945–951.

Grych, J. H., Jouriles, E. N., Swank, P. R., McDonald, R., & Norwood, W. D. (2000). Patterns of adjustment among children of battered women. *Journal of Consulting and Clinical Psychology, 68,* 84–94.

Jaffe, P. G., Wolfe, D. A., & Wilson, S. K. (1990). *Children of battered women.* Newbury Park, CA: Sage.

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.

Kolko, D. J. (1996). Child physical abuse. In J. Briere, L. Berliner, J. A. Bulkley, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment* (pp. 21–50). Thousand Oaks, CA: Sage.

Lanktree, C., Briere, J., & Zaidi, L. Y. (1991). Incidence and impacts of sexual abuse in a child outpatient sample: the role of direct inquiry. *Child Abuse & Neglect, 15,* 447–453.

Mannarino, A. P., Cohen, J. A., & Berman, S. R. (1994). The Children's Attributions and Perceptions Scale: a new measure of sexual abuse-related factors. *Journal of Clinical Child Psychology, 23,* 204–211.

Margolin, G., & Gordis, E. B. (2000). The effects of family and community violence on children. *Annual Review of Psychology, 51,* 445–479.

Martinez, P., & Richters, J. E. (1993). The NIMH Community Violence Project, II: children's distress symptoms associated with violence exposure. *Psychiatry, 56,* 22–35.

McLeer, S. V., Dixon, J. F., Henry, D., Ruggiero, K., Escovitz, K., Niedda, T., & Scholle, R. (1998). Psychopathology in non-clinically referred sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 1326–1333.

Nader, K. O. (1997). Assessing traumatic experiences in children. In J. P. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 291–348). New York: Guilford Press.

Nader, K. O., Kriegler, J. A., Blake, D. D., Pynoos, R. S., Newman, E., & Weathers, F. (1996). *Clinician-Administered PTSD Scale, Child and Adolescent version (CAPS-C).* White River Junction, VT: National Center for PTSD.

Putnam, F. W., Helmers, K., & Trickett, P. K. (1993). Development, reliability, and validity of a child dissociation scale. *Child Abuse & Neglect, 17,* 731–741.

Pynoos, R. S., Goenjian, A., Tashjian, M., Karakashian, M., Manjikian, R., Manoukian, G., Steinberg, A. M., & Fairbanks, L. (1993). Post-traumatic stress reactions in children after the 1988 Armenian earthquake. *British Journal of Psychiatry, 163,* 239–247.

Sack, W. H., Aangel, R. H., Kinzie, J. D., & Rath, B. (1986). The psychiatric effects of massive trauma on Cambodian children. II: the family, the home, and the school. *Journal of the American Academy of Child and Adolescent Psychiatry, 25,* 377–383.

Saigh, P. A. (1989). The validity of the DSM-III posttraumatic stress disorder classification as applied to children. *Journal of Abnormal Psychology, 98,* 189–192.

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.

Singer, M. I., 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.

Wolfe, V. V., Gentile, C., Michienzi, T., & Sas, L., & Wolfe, D. (1991). The Children's Impact of Traumatic Events Scale: a measure of post-sexual-abuse PTSD symptoms. *Behavioral Assessment, 13,* 359–383.

Wolfe, V. V., & Wolfe, D. A. (1986). The Sexual Abuse Fear Evaluation (SAFE): a subscale for the Fear Survey for Children-revised. Unpublished questionnaire, Children's Hospital of Western Ontario, London, Canada.

Résumé

Objectif: Le Trauma Symptom Checklist for Young Children (TSCYC) mesure grâce à une enquête remplie par la personne chargée d'un enfant la symptomatologie liée au traumatisme et aux sévices. Elle comporte deux échelles de validité concernant l'expert et 8 échelles cliniques (stress post-traumatique-intrusion (PTS-I), stress post-traumatique-évitement (PTS-AV), stress-post-traumatique-début (PTS-AR), stress post-traumatique-total (PTS-TOT), intérêts sexuels (SC), dissociation (DIS), anxiété ANX), dépression (DEP) et colère-agressivité (ANG), ainsi qu'une évaluation en heures passées pae semaine par l'adulte concerné avec l'enfant. Cet article présente le TSCYC et décrit ses propriétés psychométriques dans une étude de validité à plusieurs emplacements.

Méthode: Au total, 219 TSCYC ont été administrés par six cliniciens-chercheurs dans l'ensembles des Etats-Unis et analysés selon la fiabilité et l'association avec différents types de mauvais traitements.

Résultats: Les échelles TSCYC ont une bonne fiabilité et sont associées à l'exposition à des sévices physiques et sexuels et au fait d'être témoin de la violence domestique. Les échelles PTS-I, PTS-AV, PTS-AR, et PTS-TOT offrent la meilleure prédiction, suivies par SC dans le cas des sévices sexuels et DIS dans le cas des sévices physiques. Il y a un petit nombre d'effets concernant l'âge, le sexe et la race sur les scores du TSCYC.

Conclusions: Le TSCYC semble posséder des caractéristiques psychométriques raisonnables. Il est en corrélation, comme on s'y attendait, avec l'exposition à des traumatismes variés. Ceci est en faveur de son utilisation en tant que mesure clinique s'il est soumis à une validation continue et au développement de normes pour la population générale.

Resumen

Objetivo: El Trauma Symptom Checklist for Young Children (TSCYC) es una medida de informe cumplimentada por el cuidador y compuesta por 90 items que evalúa la sintomatología relacionada con el maltrato y el trauma infantil. Contiene dos escalas de validez y ocho escalas clínicas (Estrés Postraumático-Intrusión [PTS-I], Estrés Postraumático-Evitación [PTS-AV], Estrés Postraumático-Activación [PTS-AR], Estrés Postraumático-Total [PTS-TOT], Preocupación Sexual [SC], Disociación [DIS], Ansiedad [ANX], Depresión [DEP], e Ira/Agresión [ANG], así como un item que valora el número de horas por semana que el cuidador tiene contacto con el/la niño/a. Este artículo presenta el TSCYC y describe sus propiedades psicométricas en un estudio de validez aplicado varios lugares.

Método: Un total de 219 TSCYCs, administrados por seis médicos/investigadores a lo largo de Estados Unidos, fueron analizados para conocer la fiabilidad de la escala y su asociación con diferentes tipos de maltrato infantil.
Resultados: La escalas clínicas TSCYC tienen una buena fiabilidad y están asociadas con la exposición del niño al abuso sexual, al maltrato físico, y a ser testigo de violencia doméstica. Las escalas PTS-I, PTS-AV, PTS-AR, y PTS-TOT fueron las más predictivas seguidas por el SC en el caso del abuso sexual y por el DIS en el caso de maltrato físico. Hubo un número pequeño de efectos de edad, sexo y raza en puntuaciones de TSCYC.