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SPOTLIGHT ON PRACTICE

OUTCOME OF THERAPY FOR SEXUALLY ABUSED CHILDREN: A REPEATED MEASURES STUDY

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Abstract—The outcome of abuse-focused treatment was examined in a sample of 105 sexually abused children, 71 of whom completed 3 months of treatment or longer. Symptom change was measured with the Trauma Symptom Checklist for Children (TSCC; Briere, in press) and the Children's Depression Inventory (CDI; Kovacs, 1983, 1992), administered at 3 month intervals. The CDI and all TSCC scales but Sexual Concerns decreased after 3 months of therapy, and, of these, all but Dissociation continued to decline at one or more assessment periods thereafter. At 6 months, those remaining in therapy continued to decrease on the CDI and on the Anxiety, Depression, Post-traumatic Stress, and Sexual Concerns scales of the TSCC. At 9 months Anxiety and Post-traumatic Stress continued to decrease, and at 1 year those still in treatment showed decrements in Anxiety, Depression, and Post-traumatic Stress. These changes are hypothesized to be due to treatment per se, rather than merely as a result of the passage of time. In this regard, multiple regression analyses indicated that time from the end of abuse to either the beginning or the end of treatment was far less predictive of post-treatment TSCC or CDI scores than was number of months specifically spent in treatment.

Key Words—Sexual abuse, Treatment, Outcome, TSCC.

INTRODUCTION

AS REFLECTED BY the growing body of research on the incidence and psychological effects of childhood sexual abuse, the assessment and treatment of sexually abused children has become an important concern for child psychotherapists. Symptomatology in children found to be associated with sexual abuse includes anxiety and fear, post-traumatic stress, guilt, depression, conduct problems, sexualized behavior, and withdrawal (e.g., Conte & Berliner, 1987; Friedrich 1991b; Friedrich, Urquiza, & Beilke, 1986; Gomez-Schwarz, Horowitz, &

Cardarelli, 1990; Lanktree, Briere, & Zaidi, 1991; McLeer, Deblinger, Henry, & Orvaschel, 1992; Wolfe, Gentile, & Wolfe, 1989).

Growing awareness of the potential impact of sexual abuse has led to the development of a number of therapeutic approaches to the treatment of sexual abuse related problems in children (e.g., Berliner, 1991; Cohen & Mannarino, 1993; Friedrich, 1990, 1991a; Gil, 1991; Lanktree, 1995; Mandell & Damon, 1989; McFarlane, Waterman, & Associates, 1986). Based on clinical experience with these relatively new methodologies, it is the general consensus among child therapists that such treatment can be quite helpful in reducing abuse-related distress and dysfunction. Unfortunately, because of the recency of clinical attention to sexual abuse and its impact on children, relatively little is actually known about the effectiveness of abuse-focused psychotherapy (O'Donohue & Elliott, 1992).

In one of a small number of published outcome studies in this area, Deblinger, McLeer, and Henry (1989) reported on the apparent effectiveness of cognitive behavioral therapy in a sample of 19 sexually abused girls who met DSM-III-R diagnostic criteria for post-traumatic stress disorder (PTSD). The authors found that after 12 sessions of therapy these children exhibited significantly less post-traumatic stress than they did prior to treatment. These changes were in contrast to a several week period prior to treatment when PTSD symptoms remained at stable levels within this group.

A study by Sullivan, Scanlan, Brookhouser, Schulte, and Knutson (1992) examined the outcome of therapy on the symptoms of 35 deaf sexual abuse victims, as compared to 37 sexually abused deaf children whose parents refused to have their children treated. Although it may be argued that these groups were not equivalent on important variables (e.g., parental support), and that data from deaf children may not generalize completely to those without a hearing disability, this study has the advantage of approximating a control/comparison group. Children receiving treatment had significant reductions in Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1979) scores from pre- to post-test relative to untreated children. This effect held for both boys and girls, although the latter experienced somewhat less symptom reduction.

In addition, two studies have examined the impact of short-term group therapy for sexually abused children (Friedrich, Luecke, Bielke, & Place, 1992; Heibert-Murphy, deLuca, & Runtz, 1992). The former involved 33 boys, aged 4 to 16 years, whereas the latter consisted of five girls, aged 7 to 9 years. In each case, the authors report decreased symptoms and problem behaviors following treatment.

As noted by Finkelhor and Berliner (1994), each of these studies can be faulted for the absence of an equivalent, but untreated, comparison group. Because of ethical problems associated with withholding treatment from abused children (Briere & Smiljanich, 1989), none of these studies could compare treated to untreated subjects. Among other threats to internal validity, this absence of a comparison group reduces the researcher's ability to rule out a maturation effect—the possibility that symptom reductions typically attributed to treatment might, in fact, be due to the passage of time associated with the completion of a treatment program.

Based on these concerns, several researchers have either used wait-list controls or have compared two different treatment methodologies, usually only one of which is abuse-specific. As summarized by Finkelhor and Berliner (1994), most of these (primarily unpublished) studies indicate that: (a) abuse-focused therapy appears to be more effective than being on a waiting list; and (b) it is not clear whether abuse-specific treatment is any more effective than is nonspecific therapy. Unfortunately, these studies often suffer from small sample sizes that impede statistical power to determine group differences as well as decreasing the external validity of any findings.

Given the preliminary state of research on treatment of sexual abuse effects, it is clear that

much remains to be explored in this area. In response, the present study examined the relationship between exposure to abuse-focused therapy and changes in symptomatology in a sample of sexually abused children. Although involving a naturalistic (as opposed to experimental) methodology, this study was designed to extend our knowledge of abuse-relevant treatment effects by: (a) using a relatively large sample of abused children in treatment; (b) incorporating a more specific measure of trauma than the majority of those used in previous outcome studies, based upon the supposition that abuse-relevant measures might be more sensitive to abuse-focused therapy effects (Briere, 1992); (c) examining children at 3-month intervals over as long as a year in treatment to probe possible time-related symptom changes; (d) comparing the specific effects of "time since abuse" versus "time in treatment" variables on symptom reduction to evaluate whether it was treatment, per se, or merely the passage of time that produced any symptom decreases; and (e) determining which variables predict treatment-related symptom reduction over time.

METHODS

Subjects

Subjects of the present study were those children between the ages of 8 and 15 years of age who were referred to an outpatient sexual abuse program (Stuart House, Santa Monica Hospital Medical Center) between 1990 and 1994 for evaluation and treatment. Each child and at least one of his or her parents formally consented to participate in this study. Subjects included children already engaged in ongoing treatment (who become eligible for testing on the TSCC at age 8) as well as children entering treatment at age 8 or older.

A total of 105 sexually abused children participated in the present study. Eighty-nine (84.8%) were female, the average age was 11.6 years, and the modal race was Caucasian (42.9%), followed by Hispanic (31.4%). Mean age at first and last sexual abuse incidents were, respectively, 9.3 and 10.5 years. Incest was reported by 49 subjects (46.7%), and 47 cases of oral, anal, or vaginal penetration (44.8%) were documented. Criminal charges against the alleged abuser were pressed in 50 cases (47.5%).

Of all subjects, 34 (32.4%) were in treatment for under 3 months. Of the remaining children, 28 (26.7%) were seen for 3 to 5 months, 12 (11.4%) completed a total of 6 to 8 months, 12 (11.4%) were seen for 9 to 11 months, and 19 (18.1%) completed 12 or more months of treatment.

Measures

Parents of participating child subjects, excluding those who were Spanish- speaking, completed the Parent form of the CBCL. Whenever possible, children completed the Children's Depression Inventory (CDI; Kovacs, 1983, 1992), the Youth form of the CBCL, and the Trauma Symptom Checklist for Children (TSCC; Briere, in press). For reasons noted below in the Procedure section, the current paper is limited to CDI and TSCC data.

The CDI is a 27-item measure of depression in children and adolescents aged 7 to 17. The CDI taps depressed mood, anhedonia, vegetative symptoms, negative self-evaluation, and depressive behavior. This frequently used measure is reliable and valid (Kovacs, 1992), and has been shown to correlate with sexual abuse status (e.g., Mennen, 1994).

The TSCC is a 54-item self-report instrument consisting of six subscales: Anxiety, Depression, Post-traumatic Stress, Sexual Concerns, Dissociation, and Anger. The items of the TSCC are explicitly written at a level thought to be understood by children 8 years of age or older. Data on the TSCC suggest that it is reliable and valid in samples of traumatized and

nontraumatized children, including those who have experienced sexual abuse (Briere, in press; Elliott & Briere, 1994; Evans, Briere, Boggiano, & Barrett, 1994; Friedrich, 1991b; Singer, Anglin, Song, & Lunghofer, 1995).

Procedures

Subjects in this study received abuse-focused individual treatment and, in many cases, family and group therapy. Whenever possible, their parents received collateral individual, conjoint, or group therapy as well. The specific goals, techniques, and content of the therapeutic approach used in the Stuart House program can be found in Lanktree (1994). Over the 4 years of this study, 12 therapists provided the treatment evaluated in this paper. Of these, six had masters degrees in social work and six (four of whom were postdoctoral fellows) had PhD's in clinical psychology. All received extensive inservice training on sexual abuse effects and their treatment, as well as ongoing clinical supervision by the first author (CBL).

Although data were collected on the CBCL, CDI, and TSCC, only the TSCC and CDI data are presented in the current paper. This is because fewer subjects completed CBCL measures over consecutive treatment intervals relative to the TSCC, due to various logistic problems, intermittent parental noninvolvement, and the fact that the CBCL Youth Self Report can be administered only to children age 11 and over. Since the cross-interval comparisons for the CBCL Parent and Youth forms involve relatively small sample sizes, there is less statistical power to detect change in these measures over time. A future paper is planned to report on CBCL changes when sufficient data become available.

TSCCs and CDIs were collected at 3-month intervals, beginning upon entry into the Stuart House program or when the subject turned age 8. Subjects who were younger than age 8 when they began treatment were first tested with the TSCC and other measures after their eighth birthday, at the point when their treatment entered the beginning of a 3-month interval. For example, a 7 1/2-year-old child would be in therapy for at least 6 months before being tested, and his or her first TSCC scores would be associated with the end of the second 3-month treatment interval. Because this study began well after the treatment program was initiated, TSCCs and CDIs for early treatment intervals (e.g., Time 1 and Time 2) were unavailable for some subjects.

For various reasons associated with conducting research in an active clinical setting (e.g., missed appointments, problems in timely administration of measures), not all subjects were given TSCCs or CDIs at each 3-month time period. As a result, missing values decreased the number of subjects who could be compared across any given time period. The diminishing number of subjects in treatment over time represents: (a) some children's need for less time in therapy than others; and (b) the effects of client drop-out from treatment for a variety of reasons (e.g., leaving the area or parental decision to terminate treatment).

Three and 6-month followups are being conducted with all locatable subjects after discharge from treatment, in order to determine the robustness of the treatment effects reported in this paper. These follow-up data will be presented at a later date when sufficient subjects have completed treatment.

RESULTS

Reliability of the TSCC

Reliability analysis of the TSCC indicated relatively high internal consistency, as has been reported by other studies. The mean α value for the TSCC subscales was .86. The highest subscale reliabilities were for Dissociation and Depression (α = .89 in each instance), and the

lowest was for Sexual Concerns (α = .78). The remaining scales (Anxiety, Post-traumatic Stress, and Anger) had αs of .86, .86, and .89, respectively.

Discriminating Those Who Remained in Treatment

Discriminant function analysis indicated that, among the 61 subjects for whom there were complete data on sex, age, abuse characteristics, and Time 1 (baseline) TSCC scores, those who completed at least 3 months of treatment did not differ from those who did not $\chi^2(14)$ = 20.30, ns. Separate analysis of race and treatment also revealed no significant relationship, $\chi^2(5)$ = 7.97, ns. Of the 68 subjects for whom there were complete predictor and CDI score data, completion of 3 or more months of therapy was similarly nonrelated $\chi^2(14)$ = 10.40, ns.

Symptom Changes as a Function of Time in Treatment

Despite the seeming likelihood that increased time in therapy would relate to greater baseline symptomatology, one-way multivariate analysis of variance revealed no relationship between total time in treatment and TSCC scores [$F(24,214.01)$ = 1.48, ns] or CDI scores [$F(4,101)$ = 1.24, ns] upon entry into treatment (Time 1).

Data on the relationship between TSCC and CDI scores and time in abuse- focused therapy are presented in Table 1. Because subject attrition over time decreased the number of subjects for whom there was complete Time 1 through Time 5 data, individual t-tests were calculated to compare each time period with the period immediately following it. All symptom scales but Sexual Concerns decreased to some extent after 3 months of therapy, and—except for Dissociation—each of these continued to decline significantly at one or more assessment periods thereafter. At Time 3 (6 months into treatment), those remaining in therapy continued to decrease in Anxiety, Depression, and Post-traumatic Stress, whereas Sexual Concerns dropped significantly for the first time. At 9 months (Time 4) Anxiety and Post-traumatic Stress continued to decrease, and at 1 year those still in treatment showed significant decrements in Anxiety, Depression, and Post-traumatic Stress. This reduction in symptomatology was not always stepwise, however, as witness the temporarily higher symptomatology exhibited by those children who remained in treatment to the 9-month period (see Table 1).

Table 1. TSCC and CDI Raw Scores as a Function of Time in Treatment

Scale	Time 1 to Time 2 (n = 44–56)[a]			Time 2 to Time 3 (n = 22–26)			Time 3 to Time 4 (n = 19–23)			Time 4 to Time 5 (n = 14–15)		
	T1 M	T2 M	t	T2 M	T3 M	t	T3 M	T4 M	t	T4 M	T5 M	t
Anxiety	8.9	6.4	3.63[b]	6.5	5.0	2.57	7.4	6.3	2.18	6.5	5.2	1.71
Depression	8.6	5.8	3.98	5.9	4.4	2.14	7.0	5.9	1.02	6.0	4.9	1.72
PTS[c]	11.5	9.2	2.57	8.7	6.8	1.92	8.7	7.7	1.86	7.4	5.5	2.18
Sexual Concerns	5.2	4.3	1.29	4.0	2.9	1.77	3.4	4.4	−1.21	3.6	2.9	1.30
Dissociation	9.4	7.6	2.22	7.2	5.7	1.64	7.2	6.6	0.87	6.3	5.1	1.38
Anger	8.5	6.8	2.33	6.2	4.7	1.80	6.6	6.1	0.61	5.9	6.0	−0.09
CDI[d]	11.1	8.8	2.13	8.2	4.6	3.62	7.9	6.4	1.02	5.0	4.4	0.77

[a] Varying ns are due to missing values.
[b] Italic t values are significant at $p \le$ .05.
[c] PTS refers to the Post-traumatic Stress scale.
[d] CDI refers to the Children's Depression Inventory.

Time Since Abuse Versus Time in Treatment

Because considerable time had passed for many subjects from the time of their last sexual abuse experience and their entry into therapy ($M = 10.8$ months, $SD = 20.5$), it was possible to compare the effects of this time period with the effects of actual time in therapy ($M = 4.6$ months, $SD = 4.6$) on ultimate symptom status.

Multiple regression analyses were conducted on the data from 87 subjects for whom time at last abuse experience was known. Results indicated that although more time had passed between the average subject's last sexual abuse experience and the onset of his or her treatment, the time he or she spent in treatment was considerably more predictive of post-treatment symptomatology (see Table 2). Greater time in treatment was related to comparatively lower post-treatment distress on four TSCC scales (Anger, Depression, Dissociation, and Post-traumatic Stress) and marginally on a fifth (Anxiety), as well as on CDI scores. In contrast, greater passage of time from last abuse experience to treatment was related to comparatively greater distress on one TSCC scale (Anger) and marginally on a second (Dissociation), as well as on the CDI. There were no decreases in symptom scores as a function of time before treatment, as would have occurred if subjects' symptomatology decreased merely as a function of time.

A similar test of the "maturation versus treatment" hypothesis would be to compare the effects of total time from last abuse to the end of therapy to those of time in the therapy period alone, as was done by Friedrich and colleagues (1992). The results of this analysis were equivalent to those reported above, despite the longer time period evaluated in this second analysis: Time in treatment was negatively associated with Anger, Depression, Dissociation, Post-traumatic Stress and (marginally) Anxiety, whereas total time from abuse to the end of treatment was positively related to Anger and (marginally) Dissociation.

The interaction between "time from last abuse to the onset of therapy" and "time spent in therapy" was also assessed through multiple regression, to determine whether the effects of the latter were moderated by the former. Tests of the interaction term indicated that, for five of six TSCC scales, shorter or longer time from abuse to the onset of treatment did not moderate the effects of time in treatment. The Dissociation scale of the TSCC and the CDI were affected by this interaction, however; subjects who did not come into treatment until a relatively longer period of time had passed since their abuse and who stayed in therapy for a

Table 2. Regression Analysis of Post-treatment TSCC and CDI Scores as Predicted by Time From Last Abuse Incident to the Onset of Therapy, Time Spent in Abuse-Specific Therapy, and the Interaction of These Two Variables

| | Step 1 | | | | | | | Step 2 | |
| | Time From Abuse to Treatment | | Time in Therapy | | Equation | | | Interaction of Time From Abuse and Time in Therapy | |
TSCC Scale	β	p	β	p	R^2	$F(2, 81)$	p	R^2ch[a]	p
Anxiety	.15	ns	−.21	.060	.05	2.38	.099	.005	ns
Depression	.11	ns	−.26	.018	.07	3.16	.048	.017	ns
PTS	.11	ns	−.35	.001	.10	5.75	.005	.030	ns
Sexual Concerns	.06	ns	−.16	ns	.02	1.05	ns	.008	ns
Dissociation	.18	.097	−.26	.017	.08	3.82	.026	.047	.037
Anger	.34	.001	−.37	.001	.21	10.81	.001	.006	ns
CDI	.28	.008	−.35	.001	.18	8.78	.001	.071	.008

[a] R^2 Change: Increase in R^2 as a function of adding interaction term to regression equation.

relatively short period of time had significantly higher dissociation and CDI scores than did subjects with other combinations of time until treatment and time in therapy.

Predictors of Treatment Outcome

Also examined in this study were variables associated with symptom reduction over time, in an attempt to determine which subjects were most likely to benefit from treatment. For those children who attended treatment for at least one 3-month period, change scores were calculated by subtracting subjects' final TSCC scores from their initial ones. Simple correlation of these change scores with subject and abuse variables revealed surprisingly few significant ($p < .05$) relationships: Treatment-related improvement in Anxiety was negatively associated with age ($r = -.22$) and improvements in Sexual Concerns and Dissociation were positively associated with the child pressing charges against his or her abuse perpetrator ($r = .21$ and $r = .22$, respectively). Improvement on the CDI was related to a shorter time between last abuse and the onset of treatment ($r = -.21$).

DISCUSSION

The current study offers two sets of findings regarding treatment outcome for sexual abuse victims. The first documents different patterns of symptom reduction as a function of time in treatment. The second explores the issue of whether such reductions are, in fact, treatment-specific effects, or whether they merely represent the effects of passing time on symptom acuity.

With regard to the former issue, it appears that psychological symptoms thought to be associated with sexual abuse do decrease during the course of abuse-focused therapy. These decrements vary according to symptom type and time in therapy; although most symptom scales decreased at 3 months, sexual concerns did not change until after 6 months of therapy. Further, whereas the post-traumatic stress scale decreased at each 3-month period, anger did not decrease significantly after 6 months, and dissociation did not lessen after its initial drop at 3 months. Although the lesser response of sexual problems to treatment should be replicated before definitive assertions can be made, the concurrence of this finding with the conclusions of Friedrich (1990), Gil and Johnson (1993), Finkelhor and Berliner (1994), and others suggests that sexual preoccupation and/or sexualized behavior may be especially refractory to shorter-term therapy.

This variability in symptom reduction suggests that post-abuse symptomatology is not a unidimensional phenomenon. Instead, different forms of abuse-related distress or dysfunction may have different etiologies and trajectories, and therefore may respond differently to treatment. Although not examined in the current study, it is possible that Berliner and Elliott's (in press) notion of "targeted intervention" may follow from these findings. Berliner and Elliott suggest that regular, repeated assessments (i.e., with an instrument like the TSCC) may allow clinicians to determine what intervention is working with what symptom clusters at what point in time, and thus what symptomatology requires more concentrated attention. Such attention to differential symptom response might result in tailored treatment approaches based on each child's specific pattern of symptomatology.

In the present study relatively few subject or sexual abuse variables predicted treatment-related reductions in TSCC scores over time. The anxiety symptoms of subjects who were younger at time of treatment were more responsive to therapy, whereas those who pressed charges at the time of therapy evidenced greater reduction of sexual concerns and dissociation. In addition, a shorter time period between the end of abuse and the onset of therapy was

associated with greater improvement on the CDI. These limited findings suggest that treatment success may not be easily predicted by a linear function of client characteristics alone. It is possible that, as has been found in the general psychotherapy outcome literature, prediction of successful treatment will rely on a host of factors, ranging from client variables to the client-therapist "fit" to the type of treatment utilized.

The outcome data further suggest that symptom reduction may require longer- term treatment for some children (i.e., for up to 1 year or longer) than otherwise might be assumed. Noteworthy in this regard is the continued decrease in TSCC scores from Time 4 to Time 5 for three of six TSCC symptom scales (Anxiety, Depression, and Post-traumatic Stress), although only Post-traumatic Stress and Dissociation reach their lowest points at Time 5. It is possible that, were this study to have extended beyond 1 year, further symptom reductions might have been documented. Such data reinforce the notion that recovery from childhood sexual abuse can be an extended process for some children, one that often may not be well-served by shorter-term interventions.

As noted earlier, none of the above results establish in any definitive way that these symptom decrements are due to clinical intervention, since such reductions might arise from time passing during treatment rather than the treatment itself. The multiple regression results, however, suggest that although more time had elapsed from the average subject's last abuse to the onset of his or her treatment, the time he or she spent in treatment was more predictive of symptom level. Further, time from last abuse to the onset of treatment was positively related to subjects' Anger and CDI scores and tended to positively predict subjects' Dissociation score. In other words, children who spent especially long periods of time between their last abuse and the point when they were brought in for treatment were more angry and depressed, and tended to be more dissociated than were children whose wait was shorter. Although not supportive of a maturation hypothesis, this finding does fit with clinical experience, since it suggests that unresolved abuse trauma can produce growing negative effects in the absence of appropriate treatment.

The absence of negative associations between time until treatment and symptom scores seems to suggest that those who had more time to spontaneously recover from abuse-related trauma were, nevertheless, no more likely to have lower symptom scores than those who had less time to recover before treatment. This suggests that the mere passage of time without treatment did not reduce symptom scores, at least in this cohort of children.

It may be argued that subjects who experienced a relatively longer period of time from the offset of abuse to the onset of treatment differ from those who received treatment more quickly, and thus the former cannot be compared meaningfully with other subjects. For example, longer latency to treatment might reflect more dysfunctional family dynamics, more or less severe abuse, or differential access to treatment resources, each of which could impact symptomatology.

Although these concerns are valid, the test of "time from abuse to treatment" in the multiple regression analyses partially examines this hypothesis—generally, few symptom differences were found relative to those who received treatment more immediately. When there were differences, the data suggest that longer time to treatment was associated with greater symptomatology, and thus that such subjects were relatively more symptomatic after treatment than were those with a shorter abuse-to-treatment latency. In addition, the "time from abuse to treatment" by "time in treatment" interaction did not reveal many effects of time pre-treatment on the effects of time spent in treatment. In the few instances where there were interactions, the effect was for longer latency to treatment and shorter time in treatment to be associated with relatively greater symptomatology. Finally, none of the above subject differences would easily explain why the time spent in treatment would be so much more predictive of ultimate symptom level than was the passage of time pre-treatment. Even assuming that those with longer time from abuse to treatment differ from others on important variables, it nevertheless

remains that time in treatment was specifically associated with lower symptom scores whereas time from abuse to treatment was not—the former being exemplified by the data on Time 1 through Time 5 symptom reductions.

These data do not necessarily indicate that all untreated abuse-related symptomatology remains at high levels until addressed. For instance, it has been reported that up to 40% of those sexually abused as children present with no obvious symptomatology on standard psychological tests (Kendall-Tackett, Williams, & Finkelhor, 1993). Such data suggest that sexual abuse may not have significant mental health consequences for all victims, although it is likely that some "asymptomatic" children are actually experiencing postabuse symptoms that are missed by generic (nonabuse-specific) tests (Briere & Runtz, 1993) or that some children seek to suppress or deny abuse-related distress (Elliott & Briere, 1994).

Other research indicates that some abused children demonstrate spontaneous (nontreatment-related) symptom reductions when followed longitudinally (e.g., Gomes-Schwartz, Horowitz, & Cardarelli, 1990). As a result, the failure to document generic time-related effects on symptom-atology in the present study does not indicate that such a phenomenon does not exist—only that it did not appear to be a major factor in the present study.

The authors suspect that there may be at least two general types of childhood response to sexual abuse. Some sexually abused children may either fail to exhibit overt symptomatology on generic psychological tests, or their symptomatology may seemingly resolve as a function of the passage of time. Such children might be less likely to seek treatment or be referred for same, and thus would not be well represented in the present study.

The second group of children may be those for whom sexual abuse has overt symptomatic impacts that do not, in fact, resolve over time. These children would be more likely to be placed in treatment and therefore would tend to appear in studies such as the current one. A study of the latter group would find treatment-related symptom reduction, but little association between symptoms and the pre-treatment period. Given this likelihood, the current data may be generalizable only to those sexual abuse victims who seek (or are referred to) treatment. This group, of course, is the one most of interest to clinicians and clinical researchers.

An interesting finding is the tendency for those subjects who remained in treatment at least until Time 4 (9 months) to have higher symptom levels than those who did not (compare Time 2 to Time 3, versus Time 3 to Time 4 in Table 1). This may reflect the tendency for more distressed children to require a greater amount of time in treatment (i.e., more than 6 months) than do other children. Although time in treatment was unrelated to initial symptom level in the present study, children who respond to treatment more quickly than others (i.e., who have equivalent initial symptom levels, but who "get better" faster) would seem more likely to leave therapy at an earlier point. The current data suggest that abuse-focused treatment continues to assist those (more symptomatic) children who remain in therapy beyond 6 months, as indicated by Time 3 to Time 4 and Time 4 to Time 5 symptom reductions.

Mid-treatment symptom exacerbation also may have increased the need for extended therapy for some children, resulting in somewhat higher Sexual Concerns scores at Time 4 relative to Time 3. Support for the notion of temporary exacerbation of certain symptoms during longer-term therapy can be found in the literature (e.g., Friedrich & Reams, 1987), although this phenomenon has not yet received intensive empirical scrutiny.

In summary, the present study documents a phenomenon reported in several other abuse-specific treatment outcome studies: Symptoms typically related to childhood sexual victimiza-tion appear to decrease during abuse-focused therapy. The current results indicate that the rate of this reduction varies as a function of symptom type, with some symptom groups responding quickly and continuously (i.e., Anxiety and Post-traumatic Stress), and others responding either quickly but incompletely (i.e., Dissociation and Anger) or at a later point in treatment (i.e., Sexual Concerns). Analysis of time from the last abuse to time of therapy revealed no evidence

of symptom reduction, whereas time spent in treatment significantly predicted symptom changes—results suggesting that, for those in therapy, symptom resolution may be more due to time in treatment than to the passage of time per se.

A potential limit to the external validity of the current findings is the fact that this study was conducted at a specialized, intensive sexual abuse treatment center (see Lanktree, 1995, for a description), as opposed to clinics or programs that may lack the funding or support for highly abuse-specific treatment approaches. In such instances, it is not clear to what extent the current findings regarding treatment efficacy would be applicable. Nevertheless, such data are encouraging regarding the responsiveness of post-abuse trauma to, at minimum, abuse-focused treatment.

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Resumen—Se estudió el resultado de un tratamiento focalizado en el abuso, en una muestra de 105 niños/as víctimas de abuso sexual, 71 de los cuales completaron tres meses o más de tratamiento. El cambio en la sintomatología se evaluó con el "Trauma Symptom Checklist for Children" (TSCC; Briere, en prensa) y el "Children's Depression Inventory" (CDI; Kovacs, 1983, 1992), administrados en intervalos de tres meses. El CDI y todas las escalas del TSCC, exceptuando la de Preocupaciones Sexuales, disminuyeron después de tres meses de terapia, y, de ellas, todas excepto la escala de Disociación continuaron disminuyendo a lo largo de una o más evaluaciones posteriores. A los seis meses, los niños/as que seguían en terapia continuaban disminuyendo sus puntuaciones en el CDI y en las escalas de Ansiedad, Depresión, Estrés Postraumático, y Preocupaciones Sexuales del TSCC. A los nueve meses, las escalas de Ansiedad y Estrés Postraumático continuaban disminuyendo, y aquéllos que tras un año seguían en tratamiento, mostraban una disminución en Ansiedad, Depresión, y Estrés Postraumático. Se hipotetiza que estos cambios se deben al tratamiento per se, más que ser meramente resultado del paso del tiempo. En relación a esto, los análisis de regresión múltiple indicaron que el tiempo transcurrido desde la finalización del abuso hasta el comienzo o el final del tratamiento tenía menos poder predictivo que el número de meses de tratamiento, con respecto a las puntuaciones post-tratamiento en el TSCC o en el CDI.